IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

ASTRAZENECA PHARMACEUTICALS LP and ASTRAZENECA AB, Plaintiffs, v. XAVIER BECERRA, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, and CHIQUITA BROOKS-LASURE, in her official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	)	Civil Action No. 23-931-CFC

DECLARATION OF MARLAN GOLDEN IN SUPPORT OF PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT AND REPLY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

1. I am an attorney at the law firm of Hogan Lovells US LLP, and counsel for Plaintiffs in this case.

2. I am over the age of 18. I have personal knowledge of the following facts and, if called and sworn, could competently testify to the facts stated herein.

3. I submit this declaration in support of Plaintiffs' Brief in Opposition to Defendants' Cross-Motion for Summary Judgment and Reply in Support of Plaintiffs' Motion for Summary Judgment.

4. Attached as Exhibit 1 is a true and correct copy of FDA's Guidance for Industry: Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees (Dec. 2004).

5. Attached as Exhibit 2 is a true and correct copy of FDA's Manual of Policies and Procedures, section 5018.2 (eff. Dec. 8, 2022).

6. Attached as Exhibit 3 is a true and correct copy of FDA's Drugs@FDA Glossary of Terms.

7. Attached as Exhibit 4 is a true and correct copy of AstraZeneca's press release, *Lynparza receives additional and broad approval in the US for ovarian cancer* (Aug. 17, 2017).

8. Attached as Exhibit 5 is a true and correct copy of AstraZeneca's press release, *Calquence tablet formulation approved in the U.S. across current indications* (Aug. 5, 2022).

9. Attached as Exhibit 6 is a true and correct copy of an article titled *Seagen Ended a Bladder Cancer Drug Program Due to IRA, CEO Says*, published by Bloomberg (Oct. 26, 2023).

10. Attached as Exhibit 7 is a true and correct copy of a piece titled *The Inflation Reduction Act Is Already Killing Potential Cures*, published by the Wall Street Journal (Nov. 3, 2022).

11. Attached as Exhibit 8 is a true and correct copy of FDA's record of Approval Date(s) and History, Letters, Labels, Reviews for NDA 202293.

12. Attached as Exhibit 9 is a true and correct copy of the comment letter the Haystack Project submitted to Centers for Medicare & Medicaid Services (CMS) in response to the agency's Initial Guidance (Apr. 14, 2023).

13. Attached as Exhibit 10 is a true and correct copy of the comment letter AstraZeneca submitted to CMS in response to the agency's Initial Guidance (Apr. 14, 2023).

14. Attached as Exhibit 11 is a true and correct copy of CMS's final notice publishing the National Drug Rebate Agreement titled *Announcement of Medicaid Drug Rebate Program National Rebate Agreement*, published in the Federal Register (Mar. 23, 2018).

15. Attached as Exhibit 12 is a true and correct copy of CMS's Proposed Rule titled *Updates Under the Medicaid Drug Rebate Program*, published in the Federal Register (May 26, 2023).

16. Attached as Exhibit 13 is a true and correct copy of a CMS data table titled National Health Expenditures by Source of Funds and Type of Expenditures.

17. Attached as Exhibit 14 is a true and correct copy of a regulatory document titled *Medicare Beneficiary Enrollment Trends and Demographic Characteristics*, published by the Department of Health and Human Services (HHS) (Mar. 2, 2022).

18. Attached as Exhibit 15 is a true and correct copy of a regulatory document titled *Monopolization Defined*, published by the Federal Trade Commission.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on December 1, 2023 at Washington, DC.

Marlan Golden

EXHIBIT 1

Guidance for Industry

Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
Center for Biologics Evaluation and Research (CBER)

December 2004
User Fees

Guidance for Industry

Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees

Additional copies are available from:

Office of Training and Communications
Division of Drug Information, HFD-240
Center for Drug Evaluation and Research
Food and Drug Administration
5600 Fishers Lane, Rockville, MD 20857
(Tel) 301-827-4573
http://www.fda.gov/cder/pdufa/default.htm

Office of Communication,
Training, and Manufacturers Assistance (HFM-40)
Center for Biologics Evaluation and Research (CBER)
1401 Rockville Pike, Rockville, MD 20852-1448
http://www.fda.gov/cber/guidelines.htm
(Voice Information) 800-835-4709 or 301-827-1800

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
Center for Biologics Evaluation and Research (CBER)

December 2004
User Fees

TABLE OF CONTENTS

Contains Nonbinding Recommendations

Guidance for Industry[1]

Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees

This guidance represents the Food and Drug Administration's (FDA's) current thinking on this topic. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations. If you want to discuss an alternative approach, contact the FDA staff responsible for implementing this guidance. If you cannot identify the appropriate FDA staff, call the appropriate number listed on the title page of this guidance.

I. INTRODUCTION

This guidance describes FDA's current thinking on what will be considered a separate marketing application and what will constitute clinical data for purposes of the user fee provisions of the Federal Food, Drug, and Cosmetic Act (Act).[2]

FDA's guidance documents, including this guidance, do not establish legally enforceable responsibilities. Instead, guidances describe the Agency's current thinking on a topic and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in Agency guidances means that something is suggested or recommended, but not required.

II. BACKGROUND

The Act levies a user fee on each "human drug application" including applications (1) for approval of a new drug submitted under section 505(b)(1) after September 1, 1992; (2) for approval of a new drug submitted pursuant to section 505(b)(2) after September 30, 1992, for certain molecular entities or indications for a use; and (3) for licensure of certain biological products under section 351 of the Public Health Service Act submitted after September 1, 1992.[3]

[1] This guidance has been prepared by the User Fee Staff in the Center for Drug Evaluation and Research (CDER) at the Food and Drug Administration (FDA) in consultation with the Center for Biologics Evaluation and Research (CBER).

[2] The Prescription Drug User Fee Act was originally enacted in 1992, was amended in 1997 by the Food and Drug Administration Modernization Act, and was amended in June 2002 by the Prescription Drug User Fee Amendments of 2002.

[3] Section 735(1) (21 U.S.C. 379g(1)).

The Act provides for different user fees for original applications depending upon whether they are accompanied by clinical data on safety and/or efficacy (other than bioavailability or bioequivalence studies).[4] The Act also levies fees on supplements to human drug applications that require clinical data.[5] Under the fee schedules provided in the Act, original applications without clinical data and supplements that require clinical data are assessed approximately one-half the fee of original applications. This guidance for industry discusses (1) what should be contained in separate marketing applications and what should be combined into one application (*bundling guidance*) for purposes of assessing user fees and (2) the definition of *clinical data* for purposes of assessing user fees.

Because different user fees are assessed for original applications and supplements, FDA believes it is useful to provide guidance to applicants on the Agency's interpretation of what constitutes a separate original application, amendment, or supplement.

We recommend that a potential applicant consider this guidance when preparing an application or supplement. If FDA determines that an application has been inappropriately bundled, or that an applicant has incorrectly concluded that an application did not contain clinical data, then FDA will notify the applicant and request additional fees, if appropriate. This action will not prevent the filing of the application if it is otherwise suitable for filing, or its review, if it is otherwise ready for review. If an applicant disagrees with the determination, the applicant may formally appeal such disputes to the Office or Center level.[6]

III. PRESCRIPTION DRUG USER FEE BUNDLING POLICY

The factors currently considered by CDER and CBER in determining whether separate applications should be submitted and assessed separate fees are described below. Section A contains the guidance for original applications, and Section B contains guidance on supplements. The Agency may, for administrative reasons (e.g., review across two divisions or offices), assign separate reference numbers and separately track and take regulatory action on the various parts of what is considered to be one application under the policy described here.

[4] Section 736(a)(1) and (b) (21 U.S.C. 379(a)(1) and (b)). Bioavailability/bioequivalence studies are applicable only to applications submitted under section 505 of the Federal Food, Drug, and Cosmetic Act. They are not addressed in section 351 of the Public Health Service Act.

[5] Section 736(a)(1) (21 U.S.C. 379h(a)(1)).

[6] FDA's guidance for industry, *Formal Dispute Resolution: Appeals Above the Division Level*, February 2000.

A. Original Applications and Amendments

1. Different Active Ingredients or Combinations of Active Ingredients or Products

a. Drugs

Every different active ingredient[7] or combination of two or more different active ingredients should be submitted in a separate original application. Products to be marketed as both a racemic mixture and a single enantiomer should be in separate original applications. Similarly, drug substances purified from mixtures with multiple constituents of an active ingredient (e.g., enantiomers) should also be in separate original applications.

b. Biological Products

A biological product is identified in section 351 of the Public Health Service Act (42 U.S.C. 262(i)) as "any virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or analogous product . . . applicable to the prevention, treatment, or cure of a disease or condition of human beings." The Act describes those biologicals that are assessed user fees.[8]

Individual biological product applications can include a single or combination biological product meeting the above definition, which would result in the issuance of a distinct product license. New applications for combination biological products should be submitted when any one of the constituents of the combination is altered in a manner that, for some other reason described in this guidance, warrants a separate application.

2. Different Routes of Administration

Products to be administered using different routes of administration (see FDA's *Approved Drug Products with Therapeutic Equivalence Evaluations* (the Orange Book) Appendix C) should be submitted in separate original applications unless the product(s) for use by all routes in a given application are quantitatively and qualitatively identical (drugs) or alike (biological products) in composition (e.g., an injectable liquid dosage form intended for use by the intravenous and intraperitoneal routes).

3. Different Dosage Forms

Different dosage forms (see the Orange Book, Appendix C) should be submitted in separate original applications unless the products are identical (drugs) or alike (biological products) in quantitative and qualitative composition (e.g., a sterile liquid in a single dose vial that is intended for use as either an injectable or an inhalation solution).

---

[7] For example, different salts, esters, and complexes of the same active moiety are considered to be different active ingredients.

[8] Section 735(1) of the Act (21 U.S.C. 379g(1)).

4. Different Strengths/Concentrations

Different strengths or concentrations of one drug substance, active biological product, or combination product, if they are the same dosage form intended for the same route of administration and the same general indication(s), should be submitted in one original application if their qualitative composition is identical (drugs) or alike (biologicals).

5. Excipients

Single entity or combination products with excipients that differ qualitatively or quantitatively to accommodate different container sizes and configurations, or that differ qualitatively or quantitatively with respect to colors, flavorings, adjustment of pH or osmolality, or preservatives,[9] should be submitted in a single original application unless, for some other reason described in this guidance or elsewhere, a separate application is warranted. Differences in excipients that require separate clinical studies of safety or effectiveness should not be included in the same original application. Differences in excipients in topical products that require separate in vivo demonstration of bioequivalence should be included in separate original applications.

6. Container Sizes and Configurations

Different container sizes and configurations (e.g., filled syringes, ampules, sealed vials) of one finished pharmaceutical product intended to be for the same route of administration for the same indication(s) (or otherwise consistent with sections II.A.2 and II.A.3 above), should be considered one application for purposes of assessing user fees.

7. Different Indications or Claims

If submitted simultaneously in one application, requests for approval of different indications and uses for the same dosage form to be administered by the same route of administration (or otherwise consistent with sections II.A.2 and II.A.3, above) can be regarded, for the purposes of assessing user fees, as one application regardless of:

- the dose to be administered;
- the duration of use;
- the schedule of administration;
- the population in which the product is indicated; or
- the condition for which the product is indicated.

[9] Identical products in both single- and multiple-dose vials with and without preservatives can be submitted in a single application, provided that data are included demonstrating the same clinical activity of the two presentations.

After initial submission, a pending original or supplemental application should not be amended to add a new indication or claim. Previously submitted indications or claims can be modified by, for example, reanalyses of previously submitted data or, in rare instances, supplementary clinical data. Such amendments could result in subsequent adjustments to the user fee review clock. Submitting new clinical or in vitro data to support a new claim(s) to an already submitted original application during the review of that application is not recommended. Such a submission would be considered developing the product on the review clock and is contrary to the spirit and intent of the Act.

If the original application is not yet approved, a request for approval of other new indications or claims should be submitted in a separate, original application. If the initial application is approved, the application can be subsequently supplemented to add a new indication. (See section II.B. on supplemental applications.) At the time of submission, an original application should be complete and ready for a comprehensive review.

8. Medicare Modernization Act Changes

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003[10] may require a new application to be submitted because of a change to the reference listed drug. If there are no other material changes to the new application, other than to specify the new reference listed drug, a fee may not be required consistent with the user fee exception for previously filed applications.[11]

B. NDA and BLA Supplements

1. Changes in Composition

We recommend that a change in the composition of an approved product to support a change in the dosage form or route of administration (other than those discussed in section I.A.2 or I.A.3 above) should be submitted as a separate original application.

2. Other Changes to Approved Products

A change to an approved product based on chemistry, manufacturing, or controls data and bioequivalence, or other studies (e.g., safety and immunogenicity), that changes (1) the strength or concentration; (2) the manufacturing process, equipment, or facility; or (3) the formulation (e.g., different excipients) can be submitted as a supplement to an approved application. Such a change would not ordinarily warrant a new original application unless it changes the dosage form or route of administration (see sections I.A.2 and I.A.3, above).

3. Changes to Indications

[10] Public Law 108-173.

[11] Section 736(a)(1)(C) of the Act (21 U.S.C. 379h(a)(1)(C)).

A request for approval of a new indication, or a modification of a previously approved indication, should be submitted individually in a separate supplement to an approved original application.[12]

The Agency does not recommend that new clinical or in vitro data, submitted in support of a new indication or claim, other than that required in safety updates be submitted as part of the pending supplement during the review of a given supplemental application. Such a submission would be considered developing the product on the review clock and is contrary to the spirit and intent of the Act. Previously submitted indications or claims can, however, be modified by, for example, reanalyses of previously submitted data, or, in rare instances, supplementary clinical data.

FDA recommends the basic operating principle that, at the time of submission, a supplement should be complete and ready for a comprehensive review. Modifications of the supplement should be only to clarify part of the already submitted supplement or to answer specific questions raised by the review team. FDA does not recommend that modifications expand or broaden the scope of the already submitted supplement unless they are requested by the Agency.

IV. DEFINITION OF CLINICAL DATA

Original applications and supplements may be accompanied by data reporting clinical experience in humans. However, not all such reports of experience in humans are regarded by the FDA as *clinical data* for purposes of assessing user fees. The term c*linical data,* for purposes of assessing user fees, encompasses a broad range of studies that are purported to be adequate and well-controlled investigations submitted in support of approval.

User fees will be assessed for original applications (NDAs or BLAs) and supplements containing the following types of clinical data required to form the primary basis for approval:

- Study reports or literature reports of what are explicitly or implicitly represented by the applicant to be adequate and well-controlled trials for safety or effectiveness; or
- Reports of comparative activity (other than bioequivalence and bioavailability studies), immunogenicity, or efficacy, where those reports are necessary to support a claim of comparable clinical effect.

For purposes of assessing user fees, FDA does not consider the following to meet the definition of clinical data:

- Individual case reports describing experience in clinical use submitted in support of a labeling change to add adverse reactions;

[12] The Act states, "The term *supplement* means a request to the Secretary to approve a change in a human drug application which has been approved" (21 U.S.C. 379g(2)). Each indication is considered a separate change, for which a separate supplement should be submitted. FDA can then approve each indication when it is ready for approval, rather than delaying approval until the last of a group of indications is ready to be approved.

- Data used to modify the labeling to add a restriction that would improve the safe use of the drug (e.g., to add an adverse reaction, contraindication, or warning to the labeling);
- Data from bioequivalence studies or studies of bioavailability of a drug submitted in supplements to NDAs, even if the studies include clinical endpoints; or
- Safety, biochemical equivalence, and/or limited comparative product equivalence data used to support BLA supplements for manufacturing process or site changes.

EXHIBIT 2

POLICY AND PROCEDURES

Office of Pharmaceutical Quality

NDA Classification Codes

Table of Contents

PURPOSE

This MAPP describes the new drug application (NDA) classification code assigned by the Center for Drug Evaluation and Research (CDER) to an NDA based on characteristics of the product in the application. This code was previously referred to as "Chemistry Classification Code."

BACKGROUND

- The NDA classification code provides a way of categorizing new drug applications. The code evolved from both a management and a regulatory need to identify and group product applications based on certain characteristics, including their relationships to products already approved or marketed in the United States. Classifying applications based on these characteristics contributes to the management of CDER's workload, promotes consistency across review divisions, enables retrospective analysis of trends, and facilitates planning and policy development.

- The NDA classification codes are not determinative of classification for purposes of exclusivity. These codes are not indicative of the extent of innovation or therapeutic value that a particular drug represents.

POLICY

- FDA tentatively assigns an NDA classification code by the filing date for a new application and reassesses the code at the time of approval. The reassessment will be based upon relationships of the drug product being approved to products already

approved or marketed in the United States at the time of approval. FDA may also reassess the code after approval.

- FDA can tentatively determine a classification code for an investigational new drug (IND) prior to submission of a marketing application. This can be useful particularly with regard to whether or not the active ingredient in the IND may be considered to contain a new molecular entity (NME). Any determination of the chemical type during the IND stage is performed as part of review and may be revised when the marketing application is submitted, or upon approval, or after approval.

- When two or more NDAs for the same active ingredient tentatively considered as an NME are submitted by the same applicant and approved at the same time, the classification is changed for all but one NDA. In this case, the decision as to which NDA should be coded *Type 1* may depend on factors other than timing. For example, the NDA with the bulk of the efficacy data could be coded *Type 1* and the other NDA(s) reclassified, generally as *Type 3* or *Type 5*.[1]

- Generally, only one NDA classification code should be assigned, except that more than one code may be assigned to combination products (see *Type 4* and *Type 5*, subsection 4).

NDA Classification Codes

Type 1 — New Molecular Entity

A *Type 1* NDA is for a drug product that contains an NME.[2] An NME is an active ingredient that contains no active moiety that has been previously approved by the Agency in an application submitted under section 505 of the Act[3] or has been previously marketed as a drug in the United States. A pure enantiomer or a racemic mixture is an NME only when neither has been previously approved or marketed.

An NDA for a drug product containing an active moiety that has been marketed as a drug in the United States, but never approved in an application submitted under section 505 of the Act, would be considered *Type 7*, not *Type 1*.

An NDA for a drug-drug[4] combination product containing an active moiety that is an NME in combination with another active moiety that had already been approved by the

[1] Even though the NDA(s) may be reclassified in this circumstance, the Agency does not consider the active moieties to be previously approved at the time of approval of these NDA(s). The reclassification is made only for administrative purposes.
[2] The terms *New Molecular Entity* (*NME)* and *New Chemical Entity (NCE)* are sometimes used interchangeably; however, they are distinct. An NCE is defined in 21 CFR 314.108(a) as *"a drug that contains no active moiety that has been approved by the FDA in any other application submitted under 505(b) of the Act."* The term NME is not defined in the statute or regulations. An NME is an active ingredient that contains no active moiety that has been previously approved by the Agency in an application submitted under section 505 of the Act or has been previously marketed as a drug in the United States.
[3] This applies to applications approved or deemed approved from 1938 to the present.
[4] For example, a drug-drug combination can include a fixed-combination drug product or a co-packaged drug product with two or more active moieties.

FDA would be classified as a new combination containing an NME (*Type 1,4*).

An active moiety in a radiopharmaceutical (or radioactive drug) which has not been approved by the FDA or marketed in the United States is classified as an NME.

In addition, if a change in isotopic form (e.g., a change from ^{131}I to ^{123}I, ^{12}C to ^{13}C) results in an active moiety that has never been approved by the FDA or marketed in the United States, the active ingredient is classified as an NME.

Type 2 — New Active Ingredient

A *Type 2* NDA is for a drug product that contains a new active ingredient, but not an NME. A new active ingredient includes those products whose active moiety has been previously approved or marketed in the United States, but whose particular ester, salt, or noncovalent derivative of the unmodified parent molecule has not been approved by the Agency or marketed in the United States, either alone, or as part of a combination product. Similarly, if any ester, salt, or noncovalent derivative has been marketed first, the unmodified parent molecule would also be considered a new active ingredient, but not an NME. The indication for the drug product does not need to be the same as that of the already marketed product containing the same active moiety.

If the active ingredient is a single enantiomer and a racemic mixture containing that enantiomer has been previously approved by the FDA or marketed in the United States, or if the active ingredient is a racemic mixture containing an enantiomer that has been previously approved by the FDA or marketed in the United States, the NDA will be classified as a *Type 2*.

Type 3 — New Dosage Form

A *Type 3* NDA is for a new dosage form of an active ingredient that has been approved or marketed in the United States by the same or another applicant but in a different dosage form. (See the Orange Book, Appendix C; or the Electronic Orange Book, Uniform Terms for examples of dosage forms.) The indication for the drug product does not need to be the same as that of the already marketed drug product. Once a new dosage form has been approved for an active ingredient, subsequent applications for the same dosage form and active ingredient should be classified as *Type 5*.

Type 4 — New Combination

A *Type 4* NDA is for a new drug-drug combination of two or more active ingredients. An application for a new drug-drug combination product may have more than one classification code if at least one component of the combination is an NME or a new active ingredient. The new product may be a physical or chemical (e.g., covalent ester or noncovalent derivative) combination of two or more active moieties.

A new ***physical combination*** may be two or more active ingredients combined into a single dosage form, or two or more drug products packaged together with combined labeling. When at least one of the active moieties is classified as an NME, the NDA is classified as a *Type 1,4* application. When none of the active moieties is an NME, but at

least one is a new active ingredient, the NDA is classified as a *Type 2,4* application.

An NDA for an active ingredient that is a ***chemical combination*** of two or more previously approved or marketed active moieties that are linked by an ester bond is classified as a *Type 2,4* application if the active moieties have not been previously marketed or approved as a physical combination. If the physical combination has been previously marketed or approved, however, such a product would no longer be considered a *new* combination and the NDA would thus be classified as a *Type 2*.

Type 5 — New Formulation or Other Differences (e.g., new indication, new applicant, new manufacturer)

A *Type 5* NDA is for a product, other than a new dosage form, that differs from a product already approved or marketed in the United States because of one of the following:

1. The product involves changes in inactive ingredients that require either bioequivalence studies or clinical studies for approval and is submitted as an original NDA rather than as a supplement by the applicant of the approved product.

2. The product is a duplicate of a drug product by another applicant (same active ingredient, same dosage form, same or different indication, or same combination), and

   (a) requires bioequivalence testing (including bioequivalence studies with clinical endpoints), but is not eligible for submission as a section 505(j) application; or

   (b) requires safety or effectiveness testing because of novel inactive ingredients; or

   (c) requires full safety or effectiveness testing because it is:

      (i) subject to exclusivity held by another applicant, or

      (ii) a product of biotechnology and its safety and/or effectiveness are not assessable through bioequivalence testing, or

      (iii) a crude natural product, or

      (iv) ineligible for submission under section 505(j) because it differs in bioavailability (e.g., products with different release patterns); or

   (d) the applicant has a right of reference to the application.

3. The product contains an active ingredient or active moiety that has been previously approved or marketed in the United States only as part of a combination. This applies to active ingredients previously approved or marketed as part of a physical or chemical combination, or as part of a

mixture derived from recombinant DNA technology or natural sources.

4. The product is a combination product that differs from a previously marketed combination by the removal of one or more active ingredients or by substitution of a new ester or salt or other noncovalent derivative of an active ingredient for one or more of the active ingredients. In the latter case, the NDA would be classified as a *Type 2,5*.

5. The product contains a different strength of one or more active ingredients in a previously approved or marketed combination. A *Type 5* NDA would generally be submitted by an applicant other than the holder of the approved application for the approved product. A similar change in an approved product by the applicant of the approved product would usually be submitted as a supplemental application.

6. The product differs in bioavailability (e.g., superbioavailable or different controlled-release pattern) and, therefore, is ineligible for submission as an abbreviated new drug application (ANDA) under section 505(j).

7. The product involves a new plastic container that requires safety studies beyond limited confirmatory testing (see 21 CFR 310.509, *Parenteral drug products in plastic containers*, and MAPP 6020.2, *Applications for Parenteral Products in Plastic Immediate Containers*).

Type 6 — New Indication or Claim, Same Applicant

This NDA classification code is no longer used and is replaced with *Type 9* and *Type 10*. This classification is retained in the MAPP for historical reasons.

A *Type 6* NDA was used for an NDA received prior to July 27, 2009,[5] for a drug product that duplicates a drug product already approved or marketed in the United States by the same applicant, except that it is intended for a new indication or claim (same active moiety or combination of active moieties, same salt(s), ester(s), or other noncovalent derivative(s), same dosage form, and same formulation (including all ingredients used in the manufacturing process whether or not they are present in the final dosage form)).

Type 7 — Previously Marketed But Without an Approved NDA

A *Type* 7 NDA is for a drug product that contains an ***active moiety*** that has not been previously approved in an application, but has been marketed in the United States. This classification applies only to the first NDA approved for a drug product containing this (these) active moiety(ies).

Type 7 NDAs include, but are not limited to:

(1) The first post-1962 application for an active moiety marketed prior to 1938.

[5] July 27, 2009 is the date of implementation of the Document Archiving, Reporting and Regulatory Tracking System (DARRTS), which made *Type 6* obsolete.

(2) The first application for an active moiety first marketed between 1938 and 1962 that is identical, related or similar (IRS)[6] to a drug covered by a Drug Efficacy Study Implementation (DESI) notice.

(3) The first application for an IRS drug product first marketed after 1962.

(4) The first application for an active moiety that was first marketed without an NDA after 1962.

Type 8 — Rx to OTC

A *Type 8* NDA is for a drug product intended for over-the-counter (OTC) marketing that contains an active ingredient that has been approved previously or marketed in the United States only for dispensing by prescription (OTC switch). A *Type 8* NDA may provide for a different dosing regimen, different strength, different dosage form, or different indication from the product approved previously for prescription sale.

If the proposed OTC switch will apply to all indications, uses, and strengths of an approved prescription dosage form (leaving no prescription-only products of that particular dosage form on the market), the application holder should submit the change as a supplement to the approved application. If the applicant intends to switch only some indications, uses, or strengths of the dosage form to OTC status (while continuing to market other indications, uses, or strengths of the dosage form for prescription-only sale), the applicant should submit a new NDA for the OTC products, which would be classified as *Type 8*.

Type 9 — New Indication or Claim, Drug Not to be Marketed Under *Type 9* NDA After Approval

A *Type 9* NDA is for a new indication or claim for a drug product that is currently being reviewed under a different NDA (the "parent NDA"), and the applicant does not intend to market this drug product under the *Type 9* NDA after approval. Generally, a *Type 9* NDA is submitted as a separate NDA so as to be in compliance with the guidance for industry on *Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees*.

Note: When the *Type 9* NDA is submitted, it will be given the same NDA classification as the pending NDA. When one application is approved, the other will be reclassified as *Type 9* regardless of whether it was the first or second NDA actually submitted. After the approval of a *Type 9* NDA, FDA will "administratively close" the *Type 9* NDA and thereafter only accept submissions to the "parent" NDA.

Type 10 — New Indication or Claim, Drug to be Marketed Under *Type 10* NDA After Approval

[6] FDA's regulation at 21 CFR 310.6(b)(1) states that: "An identical, related, or similar drug includes other brands, potencies, dosage forms, salts, and esters of the same drug moiety as well as any of drug moiety related in chemical structure or known pharmacological properties."

A *Type 10* NDA is for a drug product that is a duplicate of a drug product that is the subject of either a pending or approved NDA, and the applicant intends to market the drug product under this separate *Type 10* NDA after approval. A *Type 10* NDA is normally for a drug product that has a new indication or claim, and it may have labeling and/or a proprietary name that is distinct from that of the original NDA.

Note: When the *Type 10* NDA is submitted, it will be given the same NDA classification as the original NDA unless that NDA is already approved. When one application is approved, the other will be reclassified as *Type 10* regardless of whether it was the first or second NDA actually submitted.

Medical Gas — A Designated Medical Gas Certification Request Submitted Under Section 576 of the FD&C Act

A designated medical gas certification request is a request submitted under Section 576 of the Federal Food, Drug, and Cosmetic Act (FD&C Act) to certify a medical gas as a designated medical gas.[7] The requests for Designated Medical Gas Certification for Use in Humans will result in assignment of an NDA number and will have the effect of an approved NDA unless denied within 60 days of filing.

RESPONSIBILITIES

Office of New Drugs (OND) Review Division Project Management Staff will:

- Request a determination of NDA classification codes for new and proposed NDAs from the appropriate Quality Assessment Team.
- Prior to approval of the NDA, request confirmation from the Quality Assessment Team that the NDA classification is still correct.

Quality Assessment Team will:

- Determine the NDA classification codes for new or proposed NDAs, and file a written determination to the administrative record of the IND and/or NDA.
- Prior to approval of the NDA, reassess the NDA classification and document the final classification in the administrative record for the NDA.

Office of Pharmaceutical Quality (OPQ) Regulatory Business Process Manager will:

- Update the administrative record with the current NDA classification code by the filing date.

[7] See FDA guidance for industry on *Certification Process for Designated Medical Gases.*

- At the time of approval, verify the classification code with the Quality Assessment Team, and update, as necessary.

POINTS TO CONSIDER

ESTERS

FDA's regulations at 21 CFR 314.108(a) define the term "active moiety" to mean "the molecule or ion, ***excluding*** those appended portions of the molecule that cause the drug to be an ***ester***, salt (including a salt with hydrogen or coordination bonds), or other noncovalent derivative (such as a complex, chelate, or clathrate) of the molecule, responsible for the physiological or pharmacological action of the drug substance." Esters are, thus, the only molecules containing only covalent bonds for which the active moiety is not the entire molecule. Esters are comprised of an alcohol and an acid fragment, and because either or both of the fragments may be "responsible for the physiological or pharmacological action of the drug substance," either or both may be considered an "active moiety." Whether the ester is stable in vivo, i.e., not metabolized to its constituent alcohol and acid fragments, is not a consideration in the "active moiety" determination. For example, the Agency determined that for purposes of NCE exclusivity, fluticasone furoate contained a previously approved "active moiety," fluticasone, despite the fact that there is no evidence of in vivo cleavage of the ester.[8]

METAL-CONTAINING SUBSTANCES

In the case of drugs containing metals, other than salts, the active moiety may be a coordination complex or chelate of the metal (e.g., gadobutrol), rather than the metal ion itself. This is the case when the complex or chelate has at least one metal-ligand bond that can be considered to be a covalent bond.

To determine whether a metal-ligand bond is covalent, the Agency applies a "weight-of-evidence" test for covalency based on a consideration of data based on factors, such as:

- Evidence of bond energies, and inter-atomic distances consistent with covalent bonds;
- Evidence of existence as independent entity (e.g., elutes in a single chromatographic peak);
- A substantially large equilibrium constant for dissociation of the complex in water (e.g., on the order of 10^{20} for gadolinium contrast agents[9]);
- Observed geometry predicted by theory; and
- A well-defined stoichiometry.

[8] NDA 22-051: Clinical Pharmacology Biopharmaceutics Review, p. 10, http://www.accessdata.fda.gov/drugsatfda_docs/nda/2007/022051s000_ClinPharmR.pdf; Pharmacology Review, p. 26 http://www.accessdata.fda.gov/drugsatfda_docs/nda/2007/022051s000_PharmR.pdf.

[9] Caravan P, Ellison JJ, McMurry TJ, & Lauffer RB, 1999, Gadolinium (III) chelates as MRI contrast agents: structure, dynamics, and applications, Chemical Reviews, 99(9):2293-2352.

REFERENCES

1. IUPAC [International Union of Pure and Applied Chemistry] Compendium of Chemical Terminology -- the Gold Book, http://goldbook.iupac.org/.

2. Orange Book: *Approved Drug Products With Therapeutic Equivalence Evaluations*, published by the FDA, http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm.

DEFINITIONS

- **Act:** the Federal Food, Drug, and Cosmetic Act.

- **Active Ingredient:** A component of the drug product 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 component can be a single chemical substance that includes the appended portions of the molecule that make it a particular salt or other noncovalent derivative or ester. The component can also be a naturally-derived mixture.

- **Active Moiety:** The molecule or ion, excluding those appended portions of the molecule that cause the drug to be an ester, salt (including a salt with hydrogen or coordination bonds), or other noncovalent derivative (such as a complex, chelate, or clathrate) of the molecule, responsible for the physiological or pharmacological action of the drug substance (21 CFR 314.108(a)).

- **Dosage Form:** The physical manifestation containing the active and inactive ingredients that delivers a dose of the drug product. This includes such factors as: (1) the physical appearance of the drug product, (2) the physical form of the drug product prior to dispensing to the patient, (3) the way the product is administered, and (4) the design features that affect frequency of dosing.

- **NDA Classification Code:** Codes that describe FDA's assessment of the relationship of the drug product in the application to its active moieties and to drug products already marketed or approved in the United States. NDA classification codes are usually mutually exclusive. However, a new combination (*4*) can contain a new molecular entity (*1*) or new salt (*2*). In such a case, the classification can be *Type 1,4*; *2,4*; or other coding.

- **New Chemical Entity (NCE):** As defined under 21 CFR 314.108(a), a drug that contains no active moiety that has been approved by FDA in any other application submitted under section 505(b) of the Act.

- **New Molecular Entity (NME):** An active ingredient that contains no active moiety that has been previously approved by the Agency in an application submitted under section 505 of the Act or has been previously marketed as a drug in the United States.

EFFECTIVE DATE

This MAPP is effective upon date of publication.

CHANGE CONTROL TABLE

Effective Date	Revision Number	Revisions
11/4/2015	Initial	N/A
12/8/2022	N/A	Recertified: no changes

EXHIBIT 3

Drugs@FDA Glossary of Terms

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Abbreviated New Drug Application (ANDA)
An Abbreviated New Drug Application (ANDA) contains data that, when submitted to FDA's Center for Drug Evaluation and Research, Office of Generic Drugs, provides for the review and ultimate approval of a generic drug product. Generic drug applications are called "abbreviated" because they are generally not required to include preclinical (animal) and clinical (human) data to establish safety and effectiveness. Instead, a generic applicant must scientifically demonstrate that its product is bioequivalent (i.e., performs in the same manner as the innovator drug). Once approved, an applicant may manufacture and market the generic drug product to provide a safe, effective, low cost alternative to the American public.

Abbreviated New Drug Application (ANDA) Number
This six-digit number is assigned by FDA staff to each application for approval to market a generic drug in the United States.

Active Ingredient
An active ingredient is any component that provides 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 animals.

Approval History
The approval history is a chronological list of all FDA actions involving one drug product having a particular FDA Application number (NDA). There are over 50 kinds of approval actions including changes in the labeling, a new route of administration, and a new patient population for a drug product.

Application
See New Drug Application (NDA), Abbreviated New Drug Application ANDA), or Biologic License Application (BLA)

Approval Letter
An official communication from FDA to a new drug application (NDA) sponsor that allows the commercial marketing of the product.

Top ()

Application Number
See FDA Application Number

Biologic License Application (BLA)
Biological products are approved for marketing under the provisions of the Public Health Service (PHS) Act. The Act requires a firm who manufactures a biologic for sale in interstate commerce to hold a license for the product. A biologics license application is a submission that contains specific information on the manufacturing processes, chemistry, pharmacology, clinical pharmacology and the medical affects of the biologic product. If the information provided meets FDA requirements, the application is approved and a license is issued allowing the firm to market the product.

Biological Product
Biological products include a wide range of products such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances, or may be living entities such as cells and tissues. Biologics are isolated from a variety of natural sources — human, animal, or microorganism — and may be produced by biotechnology methods and other cutting-edge technologies. Gene-based and cellular biologics, for example, often are at the forefront of biomedical research, and may be used to treat a variety of medical conditions for which no other treatments are available.

In general, the term "drugs" includes therapeutic biological products.

Brand Name Drug
A brand name drug is a drug marketed under a proprietary, trademark-protected name.

Chemical Type
The Chemical Type represents the newness of a drug formulation or a new indication for an existing drug formulation. For example, Chemical Type 1 is assigned to an active ingredient that has never before been marketed in the United States in any form.

Company
The company (also called applicant or sponsor) submits an application to FDA for approval to market a drug product in the United States.

Discontinued Drug Product
Products listed in Drugs@FDA as "discontinued" are approved products that have never been marketed, have been discontinued from marketing, are for military use, are for export only, or have had their approvals withdrawn for reasons other than safety or efficacy after being discontinued from marketing.

Top ()

Dosage Form
A dosage form is the physical form in which a drug is produced and dispensed, such as a tablet, a capsule, or an injectable.

Drug
A drug is defined as:

- A substance recognized by an official pharmacopoeia or formulary.
- A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.
- A substance (other than food) intended to affect the structure or any function of the body.
- A substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device.
- Biological products are included within this definition and are generally covered by the same laws and regulations, but differences exist regarding their manufacturing processes (chemical process versus biological process.)

Drug Product
The finished dosage form that contains a drug substance, generally, but not necessarily in association with other active or inactive ingredients.

FDA Action Date
The action date tells when an FDA regulatory action, such as an original or supplemental approval, took place.

FDA Application Number
This number, also known as the NDA (New Drug Application) number, is assigned by FDA staff to each application for approval to market a new drug in the United States. One drug can have more than one application number if it has different dosage forms or routes of administration

Generic Drug
A generic drug is the same as a brand name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use. Before approving a generic drug product, FDA requires many rigorous tests and procedures to assure that the generic drug can be substituted for the brand name drug. The FDA bases evaluations of substitutability, or "therapeutic equivalence," of generic drugs on scientific evaluations. By law, a generic drug product must contain the identical amounts of the same active ingredient(s) as the brand name product. Drug products evaluated as "therapeutically equivalent" can be expected to have equal effect and no difference when substituted for the brand name product.

Top ()

Label
The FDA approved label is the official description of a drug product which includes indication (what the drug is used for); who should take it; adverse events (side effects); instructions for uses in pregnancy, children, and other populations; and safety information for the patient. Labels are often found inside drug product packaging.

Marketing Status
Marketing status indicates how a drug product is sold in the United States. Drug products in Drugs@FDA are identified as:

- Prescription
- Over-the-counter
- Discontinued
- None - drug products that have been tentatively approved

Medication Guide
A medication guide contains information for patients on how to safely use a drug product.

NDA (see New Drug Application)

New Drug Application (NDA)
When the sponsor of a new drug believes that enough evidence on the drug's safety and effectiveness has been obtained to meet FDA's requirements for marketing approval, the sponsor submits to FDA a new drug application (NDA). The application must contain data from specific technical viewpoints for review, including chemistry, pharmacology, medical, biopharmaceutics, and statistics. If the NDA is approved, the product may be marketed in the United States. For internal tracking purposes, all NDA's are assigned an NDA number.

New Drug Application (NDA) Number
This six digit number is assigned by FDA staff to each application for approval to market a new drug in the United States. A drug can have more than one application number if it has different dosage forms or routes of administration. In Drugs@FDA, you can find the NDA number under the column named "FDA Application."

NME (see New Molecular Entity)

New Molecular Entity (NME)
An NME is an active ingredient that contains no active moiety that has been previously approved by the Agency in an application submitted under section 505 of the Federal Food, Drug, and Cosmetic Act, or has been previously marketed as a drug in the United States.

Top ()

Over-the-Counter Drugs (OTC)
FDA defines OTC drugs as safe and effective for use by the general public without a doctor's prescription.

Patient Package Insert (PPI)
A patient package insert contains information for patients' understanding of how to safely use a drug product.

Pharmaceutical Equivalents
FDA considers drug products to be pharmaceutical equivalents if they meet these three criteria:

- they contain the same active ingredient(s)
- they are of the same dosage form and route of administration
- they are identical in strength or concentration

Pharmaceutically equivalent drug products may differ in characteristics such as

- shape
- release mechanism
- labeling (to some extent)
- scoring
- excipients (including colors, flavors, preservatives)

Prescription Drug Product
A prescription drug product requires a doctor's authorization to purchase.

Product Number
A product number is assigned to each drug product associated with an NDA (New Drug Application). If a drug product is available in multiple strengths, there are multiple product numbers.

Reference Listed Drug (see RLD)

Review
A review is the basis of FDA's decision to approve an application. It is a comprehensive analysis of clinical trial data and other information prepared by FDA drug application reviewers. A review is divided into sections on medical analysis, chemistry, clinical pharmacology, biopharmaceutics, pharmacology, statistics, and microbiology.

Review Classification
The NDA and BLA classification system provides a way of describing drug applications upon initial receipt and throughout the review process and prioritizing their review. (List of Review

Top ()

Classifications and their meanings (/drugs/drug-approvals-and-databases/drugsfda-frequently-asked-questions#chemtype_reviewclass))

RLD (Reference Listed Drug)
A Reference Listed Drug (RLD) is an approved drug product to which new generic versions are compared to show that they are bioequivalent. A drug company seeking approval to market a generic equivalent must refer to the Reference Listed Drug in its Abbreviated New Drug Application (ANDA). By designating a single reference listed drug as the standard to which all generic versions must be shown to be bioequivalent, FDA hopes to avoid possible significant variations among generic drugs and their brand name counterpart.

Strength
The strength of a drug product tells how much of the active ingredient is present in each dosage.

Supplement
A supplement is an application to allow a company to make changes in a product that already has an approved new drug application (NDA). CDER must approve all important NDA changes (in packaging or ingredients, for instance) to ensure the conditions originally set for the product are still met.

Supplement Number
A supplement number is associated with an existing FDA New Drug Application (NDA) number. Companies are allowed to make changes to drugs or their labels after they have been approved. To change a label, market a new dosage or strength of a drug, or change the way it manufactures a drug, a company must submit a supplemental new drug application (sNDA). Each sNDA is assigned a number which is usually, but not always, sequential, starting with 001.

Supplement Type
Companies are allowed to make changes to drugs or their labels after they have been approved. To change a label, market a new dosage or strength of a drug, or change the way it manufactures a drug, a company must submit a supplemental new drug application (sNDA). The supplement type refers to the kind of change that was approved by FDA. This includes changes in manufacturing, patient population, and formulation.

Tentative Approval
If a generic drug product is ready for approval before the expiration of any patents or exclusivities accorded to the reference listed drug product, FDA issues a tentative approval letter to the applicant. The tentative approval letter details the circumstances associated with the tentative approval. FDA delays final approval of the generic drug product until all patent or exclusivity issues have been resolved. A tentative approval does not allow the applicant to market the generic drug product.

Top ()

Therapeutic Biological Product

A therapeutic biological product is a protein derived from living material (such as cells or tissues) used to treat or cure disease.

Therapeutic Equivalence (TE)

Drug products classified as therapeutically equivalent can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product. Drug products are considered to be therapeutically equivalent **only** if they meet these criteria:

- they are pharmaceutical equivalents (contain the same active ingredient(s); dosage form and route of administration; and strength.)
- they are assigned by FDA the same therapeutic equivalence codes starting with the letter "A." To receive a letter "A", FDA
- designates a brand name drug or a generic drug to be the Reference Listed Drug (RLD).
- assigns therapeutic equivalence codes based on data that a drug sponsor submits in an ANDA to scientifically demonstrate that its product is bioequivalent (i.e., performs in the same manner as the Reference Listed Drug).

Therapeutic Equivalence (TE) Codes

The coding system for therapeutic equivalence evaluations allows users to determine whether FDA has evaluated a particular approved product as therapeutically equivalent to other pharmaceutically equivalent products (first letter) and to provide additional information on the basis of FDA's evaluations (second letter). Sample TE codes: AA, AB, BC (More on TE Codes (/drugs/development-approval-process-drugs/orange-book-preface#TEC))

- FDA assigns therapeutic equivalence codes to pharmaceutically equivalent drug products. A drug product is deemed to be therapeutically equivalent ("**A**" rated) only if:
- a drug company's approved application contains adequate scientific evidence establishing through *in vivo* and/or *in vitro* studies the bioequivalence of the product to a selected reference listed drug.
- those active ingredients or dosage forms for which no *in vivo* bioequivalence issue is known or suspected.
- Some drug products have more than one TE Code.
- Those products which the FDA does not deem to be therapeutically equivalent are "**B**" rated.

Over-the-counter drugs are not assigned TE codes.

Top ()

Was this helpful? Yes No

EXHIBIT 4

- Skip to content
- Skip to navigation
- Skip to footer

AstraZeneca

Search Enter your search

- What science can do
  - Stories
  - Publications
- R&D
  - R&D
  - Our approach
  - Precision medicine
  - Transformative science
  - Data science & AI
  - Clinical innovation
  - Digital health
  - Our technologies
  - Next generation therapeutics
  - R&D strategic centres
- Our therapy areas
  - All therapy areas
  - Oncology
  - BioPharmaceuticals
  - Cardiovascular, Renal and Metabolism
  - Respiratory & Immunology
  - Vaccines and Immune Therapies
  - Rare Disease
  - Pipeline
  - All medicines
- Our company
  - Our company
  - Our people
  - Our leadership
  - Cambridge
  - Gothenburg
  - Gaithersburg
- Careers
  - Careers website
  - Working with us
  - Inclusion and diversity
- Investors
  - Investor Relations (Global)
  - Investor Relations (Sweden)

Lynparza receives additional and broad approval in the US for ovarian cancer

PUBLISHED 17 August 2017

Lynparza's new tablet formulation approved as maintenance treatment for women with platinum-sensitive recurrent ovarian cancer regardless of BRCA-mutation status

Lynparza tablets also indicated in BRCA-mutated ovarian cancer beyond the third-line setting

Newly-approved tablet formulation means improved patient convenience

17 August 2017

AstraZeneca and Merck & Co., Inc., (Merck: known as MSD outside the U.S. and Canada) today announced that the US Food and Drug Administration (FDA) has granted approval for the PARP inhibitor, *Lynparza* (olaparib), as follows:

- New use of *Lynparza* as a maintenance treatment for recurrent, epithelial ovarian, fallopian tube or primary peritoneal adult cancer who are in response to platinum-based chemotherapy, regardless of BRCA status;
- New use of *Lynparza* tablets (2 tablets twice daily) as opposed to capsules (8 capsules twice daily);
- *Lynparza* tablets also now indicated (conversion from the current accelerated approval) for the use in patients with deleterious or suspected deleterious germline BRCA-mutated advanced ovarian cancer, who have been treated with three or more prior lines of chemotherapy.

Sean Bohen, Executive Vice President, Global Medicines Development and Chief Medical Officer, AstraZeneca, said: “Physicians have almost three years of clinical experience with *Lynparza* on the market and we are now pleased to bring this important medicine, in a new tablet formulation, to a broader group of women. Today’s approvals validate more than 10 years of dedicated research behind *Lynparza*, the world’s first PARP inhibitor, which now provides oncologists with the greater flexibility for use in terms of treatment settings. It builds on our recently-announced collaboration with Merck, which aims to further increase the number of treatment options available to patients.”

Eric Pujade-Lauraine, Head of the Women Cancers and Clinical Research Department at Hôpitaux Universitaires Paris Centre, site Hôtel-Dieu, AP-HP and Principal Investigator of the SOLO-2 trial, one of the trials supporting the approval, said: “Today’s approval is welcome news for US patients with ovarian cancer, who are now able to benefit from treatment with olaparib irrespective of their BRCA-mutation status. This latest regulatory milestone underscores the breadth and depth of clinical data on olaparib, and not only demonstrates its efficacy as maintenance therapy, but adds to the data presented earlier this year showing sustained quality of life for patients undergoing treatment for this serious disease.”

Roger M. Perlmutter, President of Merck Research Laboratories, said: “We congratulate AstraZeneca on the approval of these new indications and the new dosage form and schedule for *Lynparza*, an important therapeutic advance for many patients with ovarian cancer. This is a significant first regulatory event in our collaboration with AstraZeneca. We look forward to working with AstraZeneca in our global collaboration to bring this medicine with its new indications to patients.”

Two randomised trials supported the new approvals and the conversion of accelerated approval to full approval which was originally based on a single-arm trial:

- SOLO-2 (n=295) confirmed the benefit of *Lynparza* in germline BRCA-mutated (gBRCAm) patients, demonstrating a 70% reduced risk of disease progression or death (HR 0.30 [95% CI, 0.22-0.41], P<0.0001) and improved progression-free survival (PFS) to 19.1 vs 5.5 months for placebo by investigator-assessed analysis.
- Study 19 (n=265) showed that *Lynparza* reduced the risk of disease progression or death by 65% and improved PFS compared with placebo in patients of any BRCA status (HR 0.35 [95% CI, 0.25-0.49], P<0.0001; median PFS of 8.4 months vs 4.8 months for placebo). Additionally, patients in Study 19, treated with *Lynparza* as a maintenance therapy, had a

median overall survival (OS) of 29.8 months vs 27.8 months for placebo (HR 0.73 [95% CI, 0.55-0.95]).Table 1. Summary of key efficacy results from randomised trials:

Analysis		Reduction in the risk of disease progression or death (PFS)	Reduction in the risk of death (OS)
SOLO-2 [gBRCAm]	*Lynparza*	70% (HR 0.30 [95% CI, 0.22-0.41], P<0.0001)	Data not yet mature
	Placebo		
Study 19 [PSR OC*]	*Lynparza*	65% (HR 0.35 [95% CI, 0.25-0.49], P<0.0001)	27% (HR 0.73 [95% CI, 0.55-0.95]
	Placebo		

*PSR = Platinum-sensitive recurrent ovarian cancer

The most-common adverse events reported in 20% or more of patients across the SOLO-2 trial in the *Lynparza* arm were anaemia (44%), nausea (76%), vomiting (37%), diarrhoea (33%), fatigue/asthenia (66%), decreased appetite (22%), headache (25%), and dysgeusia (27%). The most-common Grade 3 or 4 adverse events were anaemia (20%), nausea (2.6%), vomiting (2.6%), diarrhoea (1.0%), fatigue/asthenia (4.1%), and headache (0.5%). Discontinuation of *Lynparza* resulting from adverse events was seen in 11% of patients. Dose interruptions of *Lynparza* due to an adverse reaction of any grade was 45%. Dose reductions of *Lynparza* due to an adverse reaction was 25%.

The most-common adverse events reported in 20% or more of patients across the Study 19 trial in the *Lynparza* arm were anaemia (23%), nausea (71%), vomiting (35%), diarrhoea (27%), fatigue (including asthenia) (63%), decreased appetite (21%), and headache (21%). The most-common Grade 3 or 4 adverse events were anaemia (7.4%), nausea (2.2%), vomiting (2.2%), diarrhoea (2.2%), and fatigue (including asthenia) (8.8%). Discontinuation of *Lynparza* resulting from adverse events was seen in 4% of patients. Dose interruptions of *Lynparza* due to an adverse reaction of any grade was 25%. Dose reductions of *Lynparza* due to an adverse reaction was 15%.

The full data from the SOLO-2 trial can be found in the 25 July 2017 publication of The Lancet Oncology.

Lynparza was first approved under the FDA's Accelerated Approval programme in December 2014, as a capsule formulation, making it the first poly ADP-ribose polymerase (PARP) inhibitor approved. Since then, more than 3,000 advanced ovarian cancer patients have been treated with Lynparza capsules in its approved indication.

NOTES TO EDITORS

About SOLO-2

SOLO-2 was a Phase III, randomised, double-blinded, multicentre trial designed to determine the efficacy of *Lynparza* tablets as a maintenance monotherapy compared with placebo, in patients

with platinum-sensitive, relapsed or recurrent gBRCA-mutated ovarian, fallopian tube and primary peritoneal cancer. The trial, conducted in collaboration with the European Network for Gynaecological Oncological Trial Groups (ENGOT) and Groupe d'Investigateurs National pour l'Etude des Cancers de l'Ovaire et du sein (GINECO), randomised 295 patients with documented germline BRCA1 or BRCA2 mutations who had received at least 2 prior lines of platinum-based chemotherapy and were in complete or partial response. Eligible patients were randomised to receive 300mg *Lynparza* tablets twice daily or placebo tablets twice daily.

About Study 19

Study 19 was a Phase II, randomised, double-blinded, placebo-controlled, multicentre trial, which evaluated the efficacy and safety of *Lynparza* compared with placebo in relapsed, high-grade serous ovarian cancer patients, involving 82 sites across 16 countries. Patients received *Lynparza* maintenance monotherapy, at a dose of 400mg per day or matching placebo. Treatment continued until disease progression if toxicities were manageable.

About *Lynparza*

Lynparza is an innovative, first-in-class oral poly ADP-ribose polymerase (PARP) inhibitor that may exploit tumour DNA damage response (DDR) pathway deficiencies to preferentially kill cancer cells. It is approved by regulatory authorities in the EU and US for the treatment of women with BRCAm ovarian cancer.

Lynparza is the foundation of AstraZeneca's industry-leading portfolio of potential new medicines targeting DDR mechanisms in cancer cells. *Lynparza* tablets are currently being tested in combinations in a range of tumour types including breast, prostate, and pancreatic cancers.

About the AstraZeneca and Merck Strategic Oncology Collaboration

On 27 July 2017, AstraZeneca and Merck & Co., Inc., announced a global strategic oncology collaboration to co-develop and co-commercialise AstraZeneca's *Lynparza*, the world's first and leading PARP inhibitor, and potential new medicine selumetinib, a MEK inhibitor, for multiple cancer types. The collaboration is based on increasing evidence that PARP and MEK inhibitors can be combined with PDL-1/PD-1 inhibitors for a range of tumour types and is aimed at maximising the potential of *Lynparza* to become the preferred backbone of combination therapies. Working together, the companies will jointly develop *Lynparza* and selumetinib in combination with other potential new medicines and as a monotherapy. Independently, the companies will develop *Lynparza* and selumetinib in combination with their respective PD-L1 and PD-1 medicines.

About AstraZeneca in Ovarian Cancer

Worldwide, ovarian cancer is the 7th most-commonly diagnosed cancer and the 8th most-common cause of cancer death in women. The risk of developing ovarian cancer is increased in women with specific inherited genetic abnormalities, including BRCA mutations. AstraZeneca is committed to the continued development of our R&D portfolio for ovarian cancer, with a focus on improved care for all patients, including the development of targeted therapies for patients with specific gene mutations such as BRCA.

About AstraZeneca in Oncology

AstraZeneca has a deep-rooted heritage in Oncology and offers a quickly growing portfolio of new medicines that has the potential to transform patients' lives and the Company's future. With at least six new medicines to be launched between 2014 and 2020 and a broad pipeline of small molecules and biologics in development, we are committed to advance New Oncology as one of AstraZeneca's five Growth Platforms focused on lung, ovarian, breast and blood cancers. In

addition to our core capabilities, we actively pursue innovative partnerships and investments that accelerate the delivery of our strategy, as illustrated by our majority investment in Acerta Pharma in haematology.

By harnessing the power of four scientific platforms – Immuno-Oncology, Tumour Drivers and Resistance, DNA Damage Response and Antibody Drug Conjugates – and by championing the development of personalised combinations, AstraZeneca has the vision to redefine cancer treatment and one day eliminate cancer as a cause of death.

About AstraZeneca

AstraZeneca is a global, science-led biopharmaceutical company that focuses on the discovery, development and commercialisation of prescription medicines, primarily for the treatment of diseases in three therapy areas - Oncology, Cardiovascular & Metabolic Diseases and Respiratory. The Company also is selectively active in the areas of autoimmunity, neuroscience and infection. AstraZeneca operates in over 100 countries and its innovative medicines are used by millions of patients worldwide.

For more information, please visit www.astrazeneca.com and follow us on Twitter @AstraZeneca.

CONTACTS

Media Enquiries

Esra Erkal-Paler	UK/Global	+44 203 749 5638
Karen Birmingham	UK/Global	+44 203 749 5634
Rob Skelding	UK/Global	+44 203 749 5821
Matt Kent	UK/Global	+44 203 749 5906
Jacob Lund	Sweden	+46 8 553 260 20
Michele Meixell	US	+1 302 885 2677

Investor Enquiries

Thomas Kudsk Larsen		+44 203 749 5712
Craig Marks	Finance, Fixed Income, M&A	+44 7881 615 764
Henry Wheeler	Oncology	+44 203 749 5797
Mitchell Chan	Oncology	+1 240 477 3771
Nick Stone	Respiratory, *Brilinta*	+44 203 749 5716
Christer Gruvris	Diabetes; Autoimmunity, Neuroscience & Infection	+44 203 749 5711
US Toll-Free		+1 866 381 7277

You are now leaving AstraZeneca.com

You have selected a link that will take you to a site maintained by a third party who is solely responsible for its contents.

AstraZeneca provides this link as a service to website visitors. AstraZeneca is not responsible for the privacy policy of any third party websites. We encourage you to read the privacy policy of every website you visit.

Click ‘cancel’ to return to AstraZeneca’s site or ‘continue’ to proceed.

Important notice for users

You are about to access AstraZeneca historic archive material. Any reference in these archives to AstraZeneca products or their uses may not reflect current medical knowledge and should not be used as a source of information on the present product label, efficacy data or safety data. Please refer to your approved national product label (SmPC) for current product information.

I have read this warning and will not be using any of the contained product information for clinical purposes.

EXHIBIT 5

- Skip to content
- Skip to navigation
- Skip to footer

AstraZeneca

Search Enter your search

What science can do
- Stories
- Publications

R&D
- R&D
- Our approach
- Precision medicine
- Transformative science
- Data science & AI
- Clinical innovation
- Digital health
- Our technologies
- Next generation therapeutics
- R&D strategic centres

Our therapy areas
- All therapy areas
- Oncology
- BioPharmaceuticals
- Cardiovascular, Renal and Metabolism
- Respiratory & Immunology
- Vaccines and Immune Therapies
- Rare Disease
- Pipeline
- All medicines

Our company
- Our company
- Our people
- Our leadership
- Cambridge
- Gothenburg
- Gaithersburg

Careers
- Careers website
- Working with us
- Inclusion and diversity

Investors
- Investor Relations (Global)

Calquence tablet formulation approved in the US across current indications

PUBLISHED 5 August 2022

5 August 2022 12:00 BST

New formulation can be co-administered with gastric acid-reducing agents

Tablet offers equivalent efficacy, safety and consistent dosing compared to current capsule

AstraZeneca's new tablet formulation of *Calquence* (acalabrutinib) has been approved in the US for all current indications, including adult patients with chronic lymphocytic leukaemia (CLL), small lymphocytic lymphoma (SLL) and for patients with relapsed or refractory mantle cell lymphoma (MCL), which is approved under accelerated approval based on overall response rate.

The approval by the US Food and Drug Administration (FDA) was based on results from the ELEVATE-PLUS trials presented during the 63rd American Society of Hematology (ASH) Annual Meeting & Exposition in December 2021.[1]

In the trials, results showed the *Calquence* capsule and tablet formulations are bioequivalent, indicating the same efficacy and safety profile can be expected with the same dosing strength and schedule.[1] The tablet can be taken with gastric acid-reducing agents, including proton pump inhibitors (PPIs), antacids and H2-receptor antagonists (H2RAs).[1,2] The majority of observed adverse events (AEs) in these studies were mild with no new safety concerns identified.[1]

John C. Byrd, MD, Chair of the Department of Internal Medicine at the University of Cincinnati, said: "Patients with blood cancers like chronic lymphocytic leukaemia and mantle cell lymphoma are often older and may face multiple medical conditions that may need intervention, including acid reflux or peptic ulcer disease. The US approval of acalabrutinib in a tablet form enables co-administration of the acalabrutinib tablet alongside a proton pump inhibitor. This provides another option for some patients with chronic lymphocytic leukaemia and relapsed or refractory mantle cell lymphoma, enabling more patients to potentially benefit from this treatment."

Dave Fredrickson, Executive Vice President, Oncology Business Unit, AstraZeneca, said: "Today's approval of the new *Calquence* tablet formulation will offer physicians and patients increased flexibility when devising treatment plans for chronic lymphocytic leukaemia and mantle cell lymphoma. This new option is a result of our focus on understanding the wants and needs of this community and providing patient-focused solutions for their treatment."

Calquence is also approved as a capsule formulation for the same indications as the tablet in the US and in many other countries worldwide.[3] Indications may vary by market.

Notes

CLL
CLL is the most prevalent type of leukaemia in adults, with over 100,000 new cases globally in 2019 and an estimated 20,160 new cases in the US in 2022.[4,5] Although some people with CLL may not experience any symptoms at diagnosis, others may experience symptoms, such as weakness, fatigue, weight loss, chills, fever, night sweats, swollen lymph nodes and abdominal pain.[6]

In CLL, there is an accumulation of abnormal lymphocytes within the bone marrow. As the number of abnormal cells increases, there is less room within the marrow for the production of normal white blood cells, red blood cells and platelets. This could result in anaemia, infection and bleeding.[7] B-cell receptor signalling through BTK is one of the essential growth pathways for CLL.

MCL
MCL is an uncommon subtype of B-cell non-Hodgkin lymphoma.[8] MCL comprises about 3-6% of non-Hodgkin lymphomas, with an annual incidence of 0.5 per 100,000 population in Western

countries; in the US, it is estimated that approximately 4,000 new cases of MCL are diagnosed each year.[8,9] While MCL patients initially respond to treatment, patients do tend to relapse.[8]

ELEVATE-PLUS
ELEVATE-PLUS is comprised of three Phase I, open-label, single-dose, cross-over studies conducted in 116 healthy subjects. The trials established bioequivalence between acalabrutinib tablets (100mg) and acalabrutinib (100mg) capsules, evaluated the PPI effect of acalabrutinib tablets administered in the presence versus absence of PPI rabeprazole and investigated the effect of food by comparing acalabrutinib tablets administered with a high-fat diet versus fasted.[1]

***Calqu*ence**
Calquence (acalabrutinib) is a next-generation, selective inhibitor of Bruton's tyrosine kinase (BTK). Calquence binds covalently to BTK, thereby inhibiting its activity.[3,10] In B cells, BTK signalling results in activation of pathways necessary for B-cell proliferation, trafficking, chemotaxis and adhes*ion.*[3]

Calquence is available for prescribing in capsule and tablet formulations in the US. *Calquence* tablets and capsules are approved in the US for the treatment of CLL and SLL, and for the treatment of adult patients with MCL who have received at least one prior therapy. Capsules have restrictions in relation to use with gastric acid reducing agents. The tablets are not licensed in the European Union.

Calquence capsules are approved for CLL in the EU and many other countries worldwide and approved in Japan for relapsed or refractory CLL and SLL. A Phase I trial is currently underway in Japan for the treatment of front-line CLL.

In the US and several other countries, *Calquence* capsules are also approved for the treatment of adult patients with MCL who have received at least one prior therapy. The US MCL indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. *Calquence* is not currently approved for the treatment of MCL in Europe or Japan.

As part of an extensive clinical development programme, AstraZeneca and Acerta Pharma are currently evaluating *Calquence* in more than 20 company-sponsored clinical trials. *Calquence* is being evaluated for the treatment of multiple B-cell blood cancers, including CLL, MCL, diffuse large B-cell lymphoma, Waldenström's macroglobulinaemia, follicular lymphoma and marginal zone lymphoma.

AstraZeneca in haematology
AstraZeneca is pushing the boundaries of science to redefine care in haematology. We have expanded our commitment to patients with haematologic conditions, not only in oncology but also in rare diseases with the acquisition of Alexion, allowing us to reach more patients with high unmet needs. By applying our deep understanding of blood cancers, leveraging our strength in solid tumour oncology and delivering on Alexion's pioneering legacy in complement science to provide innovative medicines for rare diseases, we are pursuing the end-to-end development of novel therapies designed to target underlying drivers of disease.

Our goal is to help transform the lives of patients living with malignant, rare and other related haematologic diseases, shaped by insights from patients, caregivers and physicians to have the most meaningful impact.

AstraZeneca in oncology
AstraZeneca is leading a revolution in oncology with the ambition to provide cures for cancer in every form, following the science to understand cancer and all its complexities to discover, develop and deliver life-changing medicines to patients.

The Company's focus is on some of the most challenging cancers. It is through persistent innovation that AstraZeneca has built one of the most diverse portfolios and pipelines in the industry, with the potential to catalyse changes in the practice of medicine and transform the patient experience.

AstraZeneca has the vision to redefine cancer care and, one day, eliminate cancer as a cause of death.

AstraZeneca
AstraZeneca (LSE/STO/Nasdaq: AZN) is a global, science-led biopharmaceutical company that focuses on the discovery, development and commercialisation of prescription medicines in Oncology, Rare Diseases, and BioPharmaceuticals, including Cardiovascular, Renal & Metabolism, and Respiratory & Immunology. Based in Cambridge, UK, AstraZeneca operates in over 100 countries and its innovative medicines are used by millions of patients worldwide. Please visit astrazeneca.com and follow the Company on Twitter @AstraZeneca.

Contacts
For details on how to contact the Investor Relations Team, please click here. For media contacts, click here.

References

1. Sharma S, Pepin X, Burri H, *et al.* New acalabrutinib formulation enables co-administration with proton pump inhibitors and dosing in patients unable to swallow capsules (ELEVATE-PLUS). [abstract and poster]. Presented at: 63rd American Society of Hematology (ASH) Annual Meeting and Exposition; December 11-14, 2021; Atlanta, Georgia. Abs 4365.

2. Calquence® (acalabrutinib) tablets [prescribing information]. Wilmington, DE; AstraZeneca Pharmaceuticals LP; 2022.

3. Calquence® (acalabrutinib) capsules [prescribing information]. Wilmington, DE; AstraZeneca Pharmaceuticals LP; 2019.

4. National Cancer Institute. Cancer stat facts: leukemia — chronic lymphocytic leukemia (CLL). Accessed online. Accessed August 2022.

5. Yao Y, Lin X, Li F, *et al.* The global burden and attributable risk factors of chronic lymphocytic leukemia in 204 countries and territories from 1990 to 2019: analysis based on the global burden of disease study 2019. *Biomed Eng Online.* 2022;1: 4. doi: 10.1186/s12938-021-00973-6.

6. American Cancer Society. Signs and Symptoms of Chronic Lymphocytic Leukemia. Accessed online. Accessed August 2022.

7. National Cancer Institute. Chronic lymphocytic leukemia treatment (PDQ®)–Patient version. Accessed online. Accessed August 2022.

8. Cheah C, Seymour J, Wang ML. Mantle cell lymphoma. *J Clin Oncol*. 2016;34(11):1256-1269. doi: 10.1200/JCO.2015.63.5904.

9. MD Anderson Cancer Center. What to know about mantle cell lymphoma. Accessed online. Accessed August 2022.

10. Wu J, Zhang M, Liu D. Acalabrutinib (ACP-196): a selective second-generation BTK inhibitor. *J Hematol Oncol*. 2016;9(21).

Adrian Kemp
Company Secretary
AstraZeneca PLC

You are now leaving AstraZeneca.com

You have selected a link that will take you to a site maintained by a third party who is solely responsible for its contents.

AstraZeneca provides this link as a service to website visitors. AstraZeneca is not responsible for the privacy policy of any third party websites. We encourage you to read the privacy policy of every website you visit.

Click ‘cancel’ to return to AstraZeneca’s site or ‘continue’ to proceed.

Important notice for users

You are about to access AstraZeneca historic archive material. Any reference in these archives to AstraZeneca products or their uses may not reflect current medical knowledge and should not be used as a source of information on the present product label, efficacy data or safety data. Please refer to your approved national product label (SmPC) for current product information.

I have read this warning and will not be using any of the contained product information for clinical purposes.

EXHIBIT 6

Bloomberg Law
Oct. 26, 2023, 5:10 PM EDT

Seagen Ended a Bladder Cancer Drug Program Due to IRA, CEO Says

By Nacha Cattan

Bloomberg Law News 2023-12-01T09:04:19758789508-05:00

Seagen Ended a Bladder Cancer Drug Program Due to IRA, CEO Says

By Nacha Cattan2023-10-26T17:10:26583-04:00

Seagen Inc. ended a program to study one of its drugs to treat an early-stage form of bladder cancer because it would have been subject to government price negotiations shortly after approval, Chief Executive Officer **David Epstein** said.

The company had been looking into using its drug Padcev to treat the nonmuscle-invasive version of the disease that accounts for about 70% of newly diagnosed bladder cancer cases. It stopped after determining that there would be no financial return from the potential use, as approval would have likely come soon before the drug became subject to price bargaining under the Inflation Reduction Act, Epstein said on a panel at the Prix Galien USA conference in New York.

Padcev is an antibody drug-conjugate that uses targeted antibodies to deliver a blast of cancer-killing chemicals directly at a tumor. A recent study found that, in combination with Merck & Co. 's immunotherapy Keytruda, it was highly effective against another, more advanced form of bladder cancer.

Merck, Seagen Drug Combo Seen as New Bladder Cancer Standard

Championed by US President Joe Biden, the IRA allows the government to negotiate with manufacturers over the prices of biologic drugs like Padcev beginning 13 years after their initial approval. Drugmakers have said this discourages them from spending money for research needed to expand drugs into new lines of therapy.

Seagen "killed the program," Epstein said. "Why should we do it? It would come so late in the life cycle that there will be no economic return from doing it."

Epstein said Seagen is talking to Padcev partner Astellas Pharma Inc. about the issue and will "make the right decision. But there's no way anybody can economically justify this."

Seagen agreed in March to be bought by Pfizer Inc. for $43 billion.

To contact the reporter on this story:
Nacha Cattan in New York City at ncattan@bloomberg.net

To contact the editor responsible for this story:
John Lauerman at jlauerman@bloomberg.net

EXHIBIT 7

https://www.wsj.com/articles/the-inflation-reduction-act-killing-potential-cures-pharmaceutical-companies-treatment-patients-drugs-prescriptions-ira-manufacturers-11667508291

OPINION | COMMENTARY Follow

The Inflation Reduction Act Is Already Killing Potential Cures

The law's price controls do away with incentives for research and development of life-saving drugs.

By Joe Grogan

Nov. 3, 2022 6:20 pm ET

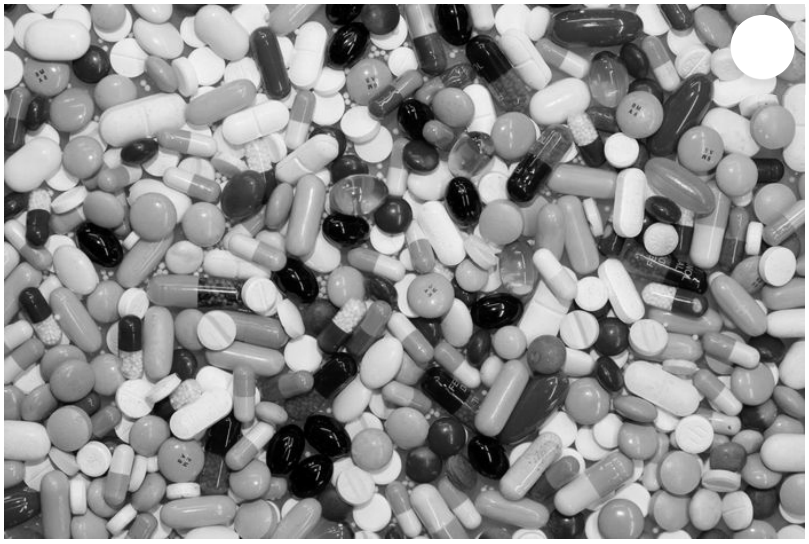


PHOTO: ULRICH BAUMGARTEN VIA GETTY IMAGES

It may take years before we can fully appreciate the impact of the Inflation Reduction Act on the pharmaceutical industry, but we're already getting signs of the damage. While Democrats boast that they've given Medicare the power to "negotiate" drug prices, the effect has been to saddle manufacturers with a complex and ill-conceived price-setting scheme. In response, many have canceled drug-development programs, resulting in an unfortunate but predictable loss for patients nationwide.

One poorly crafted provision is driving companies away from research into treating rare diseases. In its Oct. 27 earnings statement, Alnylam announced it is suspending development of a treatment for Stargardt disease, a rare eye

disorder, because of the company's need "to evaluate impact of the Inflation Reduction Act." Alnylam's decision turns on a provision in the Democrats' bill that exempts from price-setting negotiations drugs that treat only one rare disease. The company's drug is currently marketed as treating only amyloidosis, and thus is exempt from Medicare's price setting. If Alnylam proceeded with research into treating Stargardt, it would lose its exemption.

That disincentive might be most pronounced in cancer treatments. On Tuesday, Eli Lilly announced it is canceling work on a drug that had been undergoing studies for certain blood cancers. "In light of the Inflation Reduction Act," the company wrote to Endpoints News, "this program no longer met our threshold for continued investment."

When pharmaceutical companies develop cancer drugs, they usually first develop them for a single indication. Only after the first approval do they research additional indications. Merck's Keytruda, which successfully treated President Jimmy Carter, was first approved for advanced melanoma in 2014. Today the company lists 19 approved indications on its website. Genentech's Herceptin, a critical breast-cancer treatment, gained approval in the adjuvant cancer setting eight years after its original approval in the metastatic setting. Today it also has an indication for treating gastric cancer.

Nearly 60% of oncology medications approved a decade ago received additional approvals in later years. The new law eliminates the incentive to conduct additional research, because its price-setting mechanisms kick in after nine years for small-molecule drugs and 13 years for biologics, regardless of how much research companies conduct after the drug's initial approval.

In devising their bill this way, Democrats have effectively undone decades of bipartisan policy that promoted research and development by balancing profit incentives with cost concerns. The Orphan Drug Act of 1983, which Alnylam counted on in developing its now-abandoned program, provided a combination of tax credits, grants and market exclusivity to create incentive for investment in rare-disease drugs. Fifty-two Republicans and 118 Democrats co-sponsored the law, which Democratic Rep. Henry Waxman called "an example of government at its finest, demonstrating how Congress applies itself to solve overlooked, but deeply important, problems that affect millions of Americans."

The next year, Mr. Waxman and Republican Sen. Orrin Hatch led another bipartisan coalition to pass the Hatch-Waxman Act. Their bill granted innovators a temporary market monopoly of five years with potential extensions. In return, innovators would submit to generic competition at the end of their monopoly period. The monopoly-to-commodity-pricing pipeline has been a boon for the generic-drug industry and innovators, as well as patients and their families.

The Hatch-Waxman Act also provided six months of market exclusivity for generic manufacturers that undertook the expense and risk of developing first-on-the-market generic drugs. This allowed generics to recoup costs over those first six months as they gained market share against the innovator. As other generics entered the market, prices would plummet for patients and insurers, such as Medicare. According to the Association for Accessible Medicines, more than 90% of prescriptions in Medicare's Part D program in 2019 were for generic drugs, which saves more than $96 billion annually for Medicare and billions more for seniors. With the impending price caps, these incentives are lost.

Yet that's still not all the bipartisan legislation that the Inflation Reduction Act destroys. The Food and Drug Administration Modernization Act (1997) provided six months of market exclusivity to manufacturers that conduct pediatric studies for their drugs. That too was a cross-party success, shepherded by a bipartisan cast of eight senators. Pediatric clinical trials carry a host of challenges: Parents are often reluctant to include their children in them and research ethics boards impose more-stringent protections for kids. These challenges lead companies to test therapies for adult indications first. If these are successful, then they may initiate pediatric trials. The new law undercuts these incentives by mandating drastic Medicare price reductions, reducing resources available for pediatric trials and disrupting entire R&D programs.

The Democrats may have achieved a short-term talking point for the midterm elections, but in the long term this partisan healthcare bill will prevent patients from receiving innovative, lifesaving treatments. A new Congress would serve Americans well by replacing the Inflation Reduction Act with an approach that recognizes the need for economic incentives to bring new treatments to patients.

Mr. Grogan is a visiting senior fellow at the USC Schaeffer Center and served as domestic policy adviser to President Trump, 2019-20. He consults for the pharmaceutical industry.

Appeared in the November 4, 2022, print edition as 'The Inflation Reduction Act Is Already Killing Potential Cures'.

EXHIBIT 8

Drugs@FDA: FDA-Approved Drugs

New Drug Application (NDA): 202293
Company: ASTRAZENECA AB

EMAIL (MAILTO:?SUBJECT=DRUGS@FDA: FDA APPROVED DRUG PRODUCTS&BODY=HTTP://WWW.ACCESSDATA.FDA.GOV/SCRIPTS/CDER/DAF/INDEX.CFM?EVENT=OVERVIEW.PROCESS%26VARAPPLNO=202293)

- Medication Guide (https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/202293s030lbl.pdf#page=53)
- Summary Review (http://www.accessdata.fda.gov/drugsatfda_docs/nda/2014/202293Orig1s000SumR.pdf)

Products on NDA 202293

CSV | Excel | Print

Drug Name	Active Ingredients	Strength	Dosage Form/Route	Marketing Status	TE Code	RLD	RS
FARXIGA	DAPAGLIFLOZIN	5MG	TABLET;ORAL	Prescription	AB	Yes	No
FARXIGA	DAPAGLIFLOZIN	10MG	TABLET;ORAL	Prescription	AB	Yes	Yes

Showing 1 to 2 of 2 entries

Approval Date(s) and History, Letters, Labels, Reviews for NDA 202293

Original Approvals or Tentative Approvals

CSV | Excel | Print

Action Date	Submission	Action Type	Submission Classification	Review Priority; Orphan Status	Letters, Reviews, Labels, Patient F
01/08/2014	ORIG-1	Approval	Type 1 - New Molecular Entity	STANDARD	**Label (PDF) (https://www.accessdata.fd** **Letter (PDF) (https://www.accessdata.fd** **Review (https://www.accessdata.fda.go** **Summary Review (PDF) (https://www.ac**

Showing 1 to 1 of 1 entries

Supplements

CSV | Excel | Print

Action Date	Submission	Supplement Categories or Approval Type	Letters, Reviews, Labels, Patient Package Insert
09/12/2023	SUPPL-30	Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
05/08/2023	SUPPL-26	Efficacy-New Indication	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette** **Review (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/nda/20**
02/17/2023	SUPPL-27	Labeling-Container/Carton Labels, Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
10/13/2022	SUPPL-28	Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
04/30/2021	SUPPL-24	Efficacy-New Indication	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette** **Review (https://www.accessdata.fda.gov/drugsatfda_docs/nda/2021/20**
05/05/2020	SUPPL-20	Efficacy-New Indication	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette** **Review (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/nda/20**
02/03/2020	SUPPL-22	Labeling-Medication Guide, Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**

Action Date	Submission	Supplement Categories or Approval Type	Letters, Reviews, Labels, Patient Package Insert
01/24/2020	SUPPL-21	Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette 209091Orig1s005, 210874Orig1s003ltr.pdf)**
10/18/2019	SUPPL-18	Efficacy-New Indication	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette Review (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/nda/20**
02/22/2019	SUPPL-15	Efficacy-Labeling Change With Clinical Data	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
10/26/2018	SUPPL-17	Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2018/2022**
10/20/2017	SUPPL-12	Efficacy-Labeling Change With Clinical Data	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
03/01/2017	SUPPL-11	Labeling-Medication Guide, Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
08/17/2016	SUPPL-10	Labeling-Medication Guide, Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
06/14/2016	SUPPL-9	Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20 Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
01/12/2016	SUPPL-6	Manufacturing (CMC)	
01/06/2016	SUPPL-7	Manufacturing (CMC)	

Action Date	Submission	Supplement Categories or Approval Type	Letters, Reviews, Labels, Patient Package Insert
12/04/2015	SUPPL-8	Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
03/11/2015	SUPPL-2	Efficacy-Labeling Change With Clinical Data	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
08/08/2014	SUPPL-3	Labeling-Package Insert	**Label (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/label/20** **Letter (PDF) (https://www.accessdata.fda.gov/drugsatfda_docs/applette**
07/31/2014	SUPPL-1	Manufacturing (CMC)	

Showing 1 to 21 of 21 entries

Labels for NDA 202293

Therapeutic Equivalents for NDA 202293

EXHIBIT 9

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

April 14, 2023

The Honorable Chiquita Brooks-LaSure
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 2026**

Dear Administrator Brooks-LaSure:

With the Centers for Medicare & Medicaid Services' (CMS') issuance of its initial set of guidance on implementation of the Inflation Reduction Act of 2022 (IRA), it has become increasingly clear that (a) the IRA has the potential to exact unintended, but catastrophic, consequences for patients with extremely rare conditions; and (b) CMS may not have a sufficient understanding of our communities' unique challenges to steer its policies in a "do no harm" direction. Haystack Project, therefore, appreciates the opportunity to submit its comments on CMS' Initial Guidance.

Haystack Project is a 501(c)(3) non-profit organization enabling rare and ultra-rare (20,000 or fewer US patients) disease patient advocacy organizations to coordinate and focus efforts that highlight and address systemic reimbursement obstacles to patient access. Our core mission is to evolve health care payment and delivery systems with an eye toward spurring innovation and quality in care toward effective, accessible treatment options for all Americans. We strive to amplify the patient and caregiver voice in these disease states where unmet need is high and treatment delays and inadequacies can be catastrophic.

Our comments to the Initial Guidance briefly outline the inherent differences in commercial realities between the treatments our patient and caregivers rely upon and/or hope for and those that address more common diseases and conditions. We also identify specific provisions within the Initial Guidance likely to have unintended consequences for our patient populations as well as actions CMS can take to minimize those consequences.

We ask that CMS fully consider our comments and that it also give Haystack Project and its member organizations the opportunity to meet with IRA-implementation staff and leadership to articulate our concerns in greater detail so that we may work together to protect access to necessary treatments for all patients, regardless of the rarity of their condition(s).

Background: Individuals with Rare and Ultra-Rare Conditions will be Disproportionately Impacted by the IRA's Potential to Deter Innovation.

Although countless lives have been improved or saved by new therapies enabled by Congress' set of incentives for orphan drugs, significant unmet need predominates in extremely rare conditions and rare cancers:

- Of the approximately 7,000 rare diseases identified to date, 95% have no FDA-approved treatment option.
- 80% of rare diseases are genetic in origin, and present throughout a person's life, even if symptoms are not immediately apparent.
- 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 – extreme rarity of a disorder compounds the resources required for diagnosis. Patients often progress to more serious and more costly disease states by the time they receive a diagnosis.
- If a diagnosed condition has no FDA-approved option, treatment often involves off-label use of existing products.
- Approximately half of identified rare diseases do not have a disease-specific advocacy network or organization supporting research and development, and lack of disease-specific natural history severely complicates research toward new, targeted treatments.

Patients suffering from rare diseases that are currently untreatable have maintained hope that the incentives toward innovation, coupled with increased scientific understanding of disease mechanisms, would stimulate progress toward treatment and, eventually, a cure. The economic calculation of unmet patient need balanced against research and development costs, projected risk, and population-based revenue estimates must be accompanied by an analysis of whether it is possible to successfully clear reimbursement mechanisms and hurdles that may tip the scales for or against pursuing a specific drug candidate for an orphan indication. For patient populations approaching the 200,000 orphan disease limit, current incentives have proven to be sufficiently robust to mitigate clinical trial and reimbursement risks. As affected populations dwindle below 20,000 or even into and below the hundreds, the balance can be far more tenuous, and risks or uncertainties can discourage the investor interest required to take promising therapeutic candidates from bench to market.

Patients with rare and ultra-rare conditions as well as rare cancers rely on payers and society in general to lay a strong foundation that gives investors a level of comfort that the costs of research and development can be recouped, either through the price of the new drug, its use in other patient populations, or both. Without this, there is little reason for us to hope they will invest their limited resources in advancing the treatments we need.

Haystack Project and its member organizations have focused on educating stakeholders and shaping health policy to address longstanding challenges to treatment access and innovation. We have engaged with CMS through comments on CMMI model proposals, implementation and refinement of the Medicare Quality Payment Program (QPP) and the Affordable Care Act, as well as throughout annual rulemaking cycles refining policies under Medicare Parts A, B, C and D. In 2019, Haystack Project expressed its increasing concerns that health reform efforts initiated to decrease health care costs would fail to consider our patient communities:

> We are concerned that drug-pricing reforms will all but close the narrow window for commercial viability of ultra-rare disease treatments. Our sincere hope is that a greater understanding of our experiences will enable pragmatic solutions to existing problems and guide future health system refinements that take our unique needs into account.

Since enactment of the IRA, Haystack Project membership has continued to grow – both in numbers (nearly doubling to 150 ultra-rare disease advocacy organizations) and in the acute sense of urgency on the need to be heard, prioritized and accounted for in the policy decisions shaping treatment access and product development for the foreseeable future. We recognize that the IRA offers financial relief to our patient communities in (1) capping Part D out-of-pocket costs and (2) enabling a "smoothing" mechanism so that patients can spread their out-of-pocket costs over the year. We expect that these Part D refinements will reduce financial stress on patients and their families so that more patients can base their treatment decisions on medical need rather than financial resources.

Unfortunately, the drug price negotiation program presents significant threats to 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 and rare cancers. Haystack Project expects that the drug price negotiation program will marginally reduce healthcare costs for patients with relatively common conditions. The vast majority of ultra-rare disease and rare cancer patients - who routinely hit the out-of-pocket cap in Part D - will not experience any benefit from CMS' drug price negotiation. That is not to say that the program will have no impact on our patients. Haystack Project's community of patients and caregivers fear that unless CMS implements the drug price negotiation program with proactive and intentional consideration of the complex set of incentives and risks inherent to developing treatments in the ultra-rare disease space, the scales will inextricably tip away from innovation.

We ask that CMS:

- Engage in meaningful dialogue with Haystack Project and other patient organizations to identify innovative approaches to accommodate challenges associated with developing rare and ultra-rare disease treatments, including through CMMI and CMS' general demonstration authority.

- Expand the window for stakeholder feedback on the Initial Guidance, and in particular, consider implications for rare diseases.

- Identify 'qualifying single source drug' by NDA/BLA.
- implement the orphan drug exemption to maintain incentives for rare disease drug development and expansion of labeled indications for existing therapies

    - Work with patient and other stakeholders to ensure that access to orphan drugs is not impeded by diversity of rare conditions for which a treatment is safe and effective.
    - Implement a transparent process for manufacturers to submit evidence demonstrating that a particular product is eligible for the orphan drug exception.
    - Identify orphan drug designations for a particular product at the time of selection, not the date on which the product achieved one or more of its FDA approvals.

- Apply the small biotech exception with minimal burden to manufacturers.

Haystack Project urges CMS to expand the window for stakeholder feedback on the Initial Guidance.

Haystack Project engages its member organizations by analyzing and educating its members on new policy proposals likely to impact treatment access and innovation. This enables our commuities to contribute general feedback as well as specific examples of how a new policy might impact patients. The Initial Guidance contains a complex set of interconnected proposals and mechanisms that require thorough analysis, substantial knowledge of the drug and biologics manufacturing industry, and significant time to ascertain and convey its impacts to non-industry stakeholders. The 30-day comment period was far too short to enable Haystack Project to collect specific, meaningful input from our member organizations and incorporate the feedback into a comprehensive comment.

In addition, CMS' decision to broadly define ‚qualifying single source drug' for negotiation eligibility purposes was unexpected. Haystack Project had anticipated that CMS would identify negotiation-eligible drugs on the basis of NDA/BLA approvals. This decision will shape the IRA drug price negotiation program to negate existing incentives for securing approvals in small population conditions and burden industry stakeholders in a manner not likely contemplated within the statute. The repercussions from CMS' decision are likely far-reaching and, we believe, warrant a level of consideration that cannot be accomplished without stakeholder feedback. We urge CMS to reverse its finalization of Section 30 of the Initial Guidance and solicit additional stakeholder comments on the entirety of the guidance.

CMS Should Reconsider its Definition of Qualifying Single Source Drug

Haystack Project was both surprised and disappointed that CMS' Initial Guidance finalized a definition of qualifying single source drug that looks to active moiety or active ingredient rather than NDA/BLA. We had expected that CMS would look to the statutory language and its referance to products as negotiation-eligible if the product was approved under an NDA/BLA and seven/eleven years have elapsed since such approval. Under CMS' definition, it would be possible to render a drug eligible for which an NDA is approved, for example, 2 years before a product with the same active moiety/ingredient is selected for negotiation. Under any reading of the plain language of the IRA, the product would not be negotiation-eligible.

We have significant concerns that CMS' approach to identifying products eligible for negotiation (and to which any Maximum Fair Price (MFP) would be applied) maximizes the extent to which the IRA's drug price negotiation program will hinder research and development toward expanded labels for existing treatments. Individuals with relatively common conditions will likely maintain access to promising therapies developed for other conditions based on compendia listings for off-label uses. Off-label treatments for extremely small population conditions are rarely included in the various compendia relied upon for Part D coverage, and patient access is completely foreclosed. In fact, Haystack Project has heard from several patient groups that treatments within the standard of care for their ultra-rare condition fall outside the Part D benefit. Unless CMS retracts its determination to include all NDAs/BLAs for a product as a singular qualifying single source drug for negotiation purposes, our patients have little hope that manufacturers be able to justify investing in NDA/BLA approvals for ultra-rare uses of existing treatments.

In addition to the concerns described above, Haystack Project expects that CMS' definition of qualifying single source drug will place burdens on manufacturers that Congress did not consider in drafting the IRA. We note that CMS' set of examples on application of the qualifying single source drug definition included scenarios with multiple NDAs and multiple manufacturers. The Initial Guidance contemplates requiring the primary manufacturer (NDA/BLA holder) to assume full responsibility and liability for participation in the negotiation process, submission of complete, accurate information and access to the MFP.

Agreements between manufacturers are generally based on contracts negotiated and executed before the parties perform any manufacturing, distribution, and/or marketing activities. They outline the duties and responsibilities of the various parties based on the laws and regulations in place at the time of contract execution and may provide for amendment based on specified legal or regulatory changes. Neither the IRA nor CMS' Initial Guidance provide for any mechanism through which a primary manufacturer can secure information or performance from a secondary manufacturer. While CMS might assume that manufacturers can contract with each other to accommodate the IRA requirements, the substantial liability and potential monetary penalties placed on primary manufacturers negates the potential for a level playing field between the parties. We expect that CMS will face legal challenges to this provision of its Initial Guidance and urge the Agency to take a more pragmatic approach. Identifying negotiation-eligible products by NDA/BLA will preserve incentives for research and development of new uses for existing products, and minimize the potential that manufacturers will be responsible for activities over which they have no control.

The Orphan Drug Exclusion Should be Implemented to Maintain Incentives for Developing New Treatments in Rare Conditions and Expanding Labeled Indications of Existing Therapies

Haystack Project appreciates that CMS recognizes the need to protect access to orphan drugs currently available as well as innovations that have yet to be developed. We fully support CMS' determination to qualify drugs for the exclusion based on whether approved indications are within a single designation. Unfortunately, the policy on defining a qualifying single source drug by active moiety/ingredient discussed above will likely reduce manufacturer interest in pursuing multiple indications within or beyond a single designation.

When the IRA was enacted, our member organizations voiced significant concerns that the narrow exception for orphan drugs would introduce a new set of considerations to deter pursuit of FDA approval for multiple uses of promising new therapies. Drug and biotech manufacturers already face considerable pressures to fulfill their legal

obligations to shareholders while maintaining their commitment to improve care for the patient communities they serve. The landscape envisioned under CMS' Initial Guidance increases the tension between those interests. 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. The smaller the population, the less likely it is that the manufacturer could justify investing in the research needed for FDA approval. Any decision to rely on off-label use (for cancer uses and indications likely to be included in compendia) would be more likely driven by math than an intent to game the system. 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.

Patients with ultra-rare conditions and rare cancers are particularly concerned that:

- Manufacturers will face pressures to focus on an orphan indication with the largest patient population.

- Research and development programs confirming clinical benefit for accelerated approval treatments may be halted and indications withdrawn if those indications fall outside a single orphan drug designation. We note that on April 6, 2023, AbbVie and Johnson & Johnson announced withdraw of the accelerated approvals for Imbruvica (ibrutinib) in mantle cell lymphoma (MCL) and marginal zone lymphoma (MZL). Patients with these rare cancers will have only one BTK inhibitor available to treat their disease.

- Pressures to focus on larger-population orphan designations/indications could delay product approval and increase initial research and development costs. The BTK inhibitor described above was approved for MCL a year before receiving approval in chronic lymphocytic leukemia (CLL).

- 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.

Once again, we appreciate that CMS has limited discretion in implementing the orphan drug exclusion and that the Agency seeks stakeholder feedback on how it might implement the IRA drug price negotiation program without detering access and innovation in rare diseases. We urge CMS to:

- Work with patient and industry stakeholders to remove the single orphan designation requirement from the IRA orphan drug exception.

    - The existing statutory language will severely chill research and development to secure approval for ultra-rare disease uses of existing orphan drugs.
    - The set of compendia used to determine whether a use is medically accepted (and, therefore, a covered Part D drug) tend not to include off-label uses in ultra-rare conditions.
    - Ultra-rare patients can find that treatments that are part of the standard of care are not within the Part D benefit ***for patients like them*** simply because their condition is too rare to catch the attention of drug compendia listings.

- Identify qualifying single source drugs by NDA/BLA (as more fully outlined in the preceding section).

- Engage in meaningful dialogue with Haystack Project and other patient-centered organizations to preserve the balance in incentives and risks that has spurred innovation in rare and ultra-rare disease treatments, including through CMMI and CMS' general demonstration authority.

- Implement a transparent process for manufacturers to submit evidence demonstrating that a particular product is eligible for the orphan drug exclusion.

- Identify orphan drug designations for a particular product at the time of selection, not the date on which the product achieved one or more of its FDA approvals.

The Small Biotech Drug Exception should be Applied with Minimal Burden to Manufacturers.

Haystack Project understands that CMS has been charged with implementing the Inflation Reduction Act provisions related to price negotiation, including the small biotech exception, as Congress directed. In our comments to the Information Collection Request associated with the Small Biotech Drug Exception, we asked that CMS to exercise its implementation discretion to minimize the IRA's potential to disrupt the fragile balance between risk and reward that has fueled hope for new treatments within our patient communities. We reiterate our recommendation that CMS provide stakeholders with greater clarity on the process it will use to determine eligibility for the small biotech drug exception, including that the Agency:

- Ensure that manufacturers know how and when they will be informed of CMS' receipt of a submission and determinations on completeness and eligibility for the exception. CMS' communication could be by email, letter, or other mechanism, but it is essential that manufacturers know what they are looking for and when to look for it.

- Provide a substantive response to submissions when it determines that a small biotech manufacturer's drug is ineligible for the exception. The response should be sufficiently detailed to enable manufacturers to provide any data or other information that may refute a negative CMS determination.

- Implement a dispute resolution process that manufacturers can understand and utilize in the event of a negative determination.

- Accept manufacturer submissions through a dedicated email "inbox." Haystack understands that CMS envisions developing an HPMS tool that manufacturers would use to submit information on the Small Biotech Exception ICR form. Unfortunately, creating new processes within short implementation timeframes increases the likelihood for delays, errors, and inadvertent inclusion or exclusion of information. Emailed submissions with automated receipt response will give manufacturers confidence that the information they intended to send was received.

- Maintain open lines of communication between specific CMS personnel making determinations on small biotech drug exception eligibility and manufacturers submitting information to qualify their drugs. Our patient and caregiver communities know all too well that the decisions on our access to treatments are often made within closed processes that do not include our participation. The IRA implementation processes are new to industry, patients, and CMS, and are therefore vulnerable to miscommunications, inadvertent submission errors, and other missteps that could prove dispositive. A clear and open line of communication between CMS staff and manufacturers can avoid unintended delays and erroneous determinations.

- Streamline continuing eligibility for the small biotech drug exception. Under the IRA, a drug determined to be eligible for the exception would lose its eligibility only if the manufacturer is acquired by a manufacturer that does not qualify for the exception. We urge CMS to apply the exception to drugs for each year upon receipt of a simple statement certifying that the manufacturer has not been acquired by another entity. A new eligibility submission should only be required when an acquisition has occurred, and the new manufacturer seeks to qualify for the exception.

- Allow for small biotech drug exception submissions in each year for which the exception is applicable. This will permit companies that failed to fully submit required information within the timeframe allowed to secure the exception for the drugs it was intended to benefit.

- Furnish a material response to submissions indicating whether the submission was successful. The response should (as noted above) provide a clear and substantive rationale for CMS' decision if the Agency determines that the drug is ineligible for the small biotech drug exception.

Haystack Project has previously expressed its concern that CMS' ICR and the explanations accompanying it did not fully implement the IRA small biotech drug exception. We urge CMS to modify its "form" for small biotech drug exception qualification to fully comply with the statutory two-pronged "test" conferring eligibility when drugs meet ***either*** prong. This means that a drug would be eligible for negotiation applicable to Part D drugs if it meets either the 1%/80% test on Part D expenditures or the 1%/80% test on Part B expenditures.

Conclusion

Haystack Project appreciates the opportunity to submit feedback on the Initial Guidance toward implementing the drug price negotiation program within the IRA. Our member organizations have significant concerns that the decisions CMS makes within the next several months could determine the set of new treatment options in ultra-rare conditions and rare cancers for the foreseeable future. More importantly, the decisions likely to have the greatest impact are being made without a meaningful engagement and dialogue between CMS and the rare and ultra-rare disease community.

We would appreciate the opportunity to meet with IRA implementation staff and leadership to further discuss the concerns within our communities and possible mechanisms to address them, such as:

- Including patient-centered value considerations within the negotiation process.
- Ensuring that the importance of a particular treatment in a rare or ultra-rare condition is not lost within the context of its use in a relatively common condition with multiple available treatment options (i.e., averaging benefit across uses marginalizes the health care needs of ultra-rare patients).
- Incorporating value-based payment arrangements into the drug price negotiation process.
- Developing mechanisms to encourage (carrots rather than sticks) manufacturers to apply discounts throughout a product's lifecycle – not just for Medicare patients after the product has been selected for negotiation.
- Additional ideas within our member organizations to foster innovation and treatment access for patients with ultra-rare conditions and rare cancers.

Once again, we thank you for your consideration of our comments and look forward to a substantive discussion to ensure that all Medicare beneficiaries have access to the treatments they need. In the meantime, if you have any questions, please contact me our policy consultant M Kay Scanlan, JD at 410.504.2324.

Very truly yours,

TSC Alliance

NAF National Ataxia Foundation

ican international cancer advocacy network
the virtual lifeline for proactive cancer patients

NTM Nontuberculous Mycobacteria
NTM Info & Research, Inc.


Exon20
Group
EGFR/HER2
EXON 20 MUTATION GROUP


DEE-P
CONNECTIONS


PDL1
Amplifieds


CDG CARE


USHER 1F
COLLABORATIVE


International
SCN8A ALLIANCE
Collaborating for a cure


Organic Acidemia
Association


ippf
International
Pemphigus&
Pemphigoid
Foundation


SYNGAP1
FOUNDATION
RESEARCH EDUCATION
ADVOCACY


CUTANEOUS
LYMPHOMA
FOUNDATION


THE STURGE-WEBER
FOUNDATION

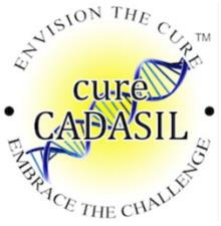

USHER SYNDROME
COALITION


CLL SOCIETY


Galactosemia
Foundation


RASOPATHIES NETWORK
connect · collaborate · accelerate


HOPE FOR
STOMACH
CANCER
PREVENT. TREAT. LIVE.


ENVISION THE CURE
cure
CADASIL
EMBRACE THE CHALLENGE


Over 20 years of C.A.R.E.
MLD
foundation
WE C.A.R.E.


Hairy Cell Leukemia
Foundation


CSNK2A1
FOUNDATION


autoimmune
association


HIDE & SEEK FOUNDATION


IFCR


HealthTree
Foundation


GFPD
GLOBAL
FOUNDATION
for
PEROXISOMAL
DISORDERS


RARE
AND
BLACK


ALGSA
Alagille Syndrome Alliance
Stay strong. Press on.


ifopa


ALPHA-1
FOUNDATION


ASI
Alstrom Syndrome International


CURE
VCP
DISEASE, INC.


ACD
ASSOCIATION FOR
CREATINE DEFICIENCIES

EXHIBIT 10

BY ELECTRONIC SUBMISSION VIA IRAREBATEANDNEGOTIATION@CMS.HHS.GOV

April 14, 2023

Meena Seshamani, M.D., Ph.D
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
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 2026, and Solicitation of Comments

Dear Deputy Administrator Seshamani,

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.

AstraZeneca appreciates the opportunity to submit comments in response to the above captioned guidance (the "Guidance") setting forth the Centers for Medicare & Medicaid Services' (CMS's) proposed policies for implementing the Medicare Drug Price Negotiation Program (Negotiation Program) for initial price applicability year (IPAY) 2026. We have provided comments regarding the Guidance in a section-by-section format, below. Our key areas of focus can be summarized as follows:

- **AstraZeneca appreciates CMS's recognition of Congressional intent to exclude orphan drugs from the Negotiation Program as well as CMS's request for feedback about how to best preserve the orphan drug development pipeline. AstraZeneca urges CMS to support orphan drug development by clarifying 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.** CMS should issue additional guidance to clarify that the orphan drug exclusion entirely insulates a product (including any revenues) from the IRA's negotiation provisions for the entire duration the exclusion applies. Notably, the orphan drug exclusion constitutes a threshold exclusion from the definition of a QSSD. It must follow from this structural placement that the 7- or 11-year pre-negotiation period that would otherwise apply to a QSSD is *tolled* until the first day after the orphan drug no longer meets the requirements of the orphan drug exclusion. This approach will better enable innovator

companies to initially pursue orphan indications by initiating the pre-negotiation period only upon a subsequent approval for a distinct disease or condition. We appreciate CMS's focus on the importance of orphan drugs to the patients who need them and support CMS implementing policies that recognize and considers the individual contributions of each orphan indication as it evaluates Medicare spending and other negotiation factors.

- **To preserve the incentive structure established by the Orphan Drug Act (ODA), AstraZeneca also asks CMS to exclude from negotiation any product for which all indications, in the aggregate, treat fewer than 200,000 patients in the United States.** The express purpose of the ODA is to encourage the development of innovative pharmaceutical products to treat diseases and conditions with very small patient populations, defined by Congress as those affecting fewer than 200,000 persons in the United States. While the IRA includes an orphan drug exclusion, evincing a clear intent to preserve Congress' longstanding support and incentives for drugs treating small patient populations, namely populations of fewer than 200,000 patients, CMS's proposed approach to implementing this exception fundamentally disrupts this purpose by leaving unprotected rare disease therapies that treat fewer than 200,000 patients even across multiple indications.

- **AstraZeneca supports CMS's approach to ranking and selecting drugs based on Total Expenditures.** We support the approach laid out in Section 30.2 for identifying the 50 qualifying drugs with the highest Total Expenditures during the applicable 12-month period and the approach under Section 30.3 for selecting the 10 highest-ranking negotiation-eligible drugs for negotiation in rank order.

- **AstraZeneca urges CMS to take a multi-faceted approach to considering a selected drug's clinical value.** While AstraZeneca appreciates that CMS is required by statute to take into consideration certain manufacturer-specific factors in setting the maximum fair price (MFP) for a selected drug, we note that such factors are to be considered only "as applicable to the drug" and not all of the statutory negotiation factors must be weighted equally. An unbalanced reliance on specific factors may result in an arbitrary pricing methodology. We recommend that CMS replace its proposed approach with one that is multifaceted and accounts for the clinical value of a product using 5 key principles (outlined below). We also encourage CMS to implement an MFP methodology that provides the MFP ceiling price for medicines that either treat conditions with an unmet need or represent a significant therapeutic advance.

- **AstraZeneca urges CMS to provide a more detailed framework regarding how the agency intends to consider therapeutic alternatives and evaluate comparative effectiveness, and to engage manufacturers of selected drugs regarding the selection of therapeutic alternatives.** While CMS outlines a flexible approach to considering therapeutic alternatives and evaluating comparative effectiveness, there are numerous open

questions that warrant CMS engaging the selected drug manufacturer regarding the methodology.

- **AstraZeneca supports CMS's policy of not considering QALYs for purposes of the Negotiation Process, which is consistent with the plain statutory language of the IRA**. We similarly support the agency's scrutiny of any comparative effectiveness research that may rely on QALYs for its conclusions.

Below, we describe each of the above comments in greater detail, in the order they appear in the guidance, and offer additional recommendations for CMS's consideration:

I. Section 30: Identification of Selected Drugs for Initial Price Applicability Year 2026

AstraZeneca understands that CMS is issuing Section 30 of the Guidance in final form without an opportunity to comment. However, AstraZeneca is concerned that CMS is moving forward with policies that significantly reshape the way drugs are priced in the Medicare program without providing the public with the opportunity for comment, particularly because some of the policies described in Section 30 exceed the agency's statutory authority, and others pose significant policy or operational concerns that the agency may not have considered. AstraZeneca is therefore submitting comments on Section 30 and urges CMS to consider these comments as the Agency implements the Negotiation Program.

A. CMS's "qualifying single source drug" definition is overly broad and not supported by the statute. (Section 30.1)

CMS is defining the term "qualifying single source drug" (QSSD) broadly to include all dosage forms and strengths of the drug with the same active moiety (or for biologics, active ingredient) and the same holder of the New Drug Application (NDA) (or for biologics, Biological License Application (BLA)), inclusive of products that are marketed pursuant to different NDAs or BLAs.

CMS's QSSD definition is overly broad and not supported by the statute. Section 1192(e)(1) of the Act outlines the definitional criteria for QSSDs. 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.[1] The statute in no way authorizes CMS to convert the statute's focus on a *singular* FDA

[1] For drugs to be a QSSD, section 1192(e)(1) of the Act requires only that the drug be "approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act and is marketed pursuant to such approval." Likewise for biological products, section 1192(e)(2) requires only that the biological product be "licensed under section 351(a) of the Public Health Service Act and is marketed under section 351 of such Act." Canons of statutory construction suggest 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,

approval to a definition that sweeps in products with multiple separate FDA approvals through the addition of an "active moiety/ingredient" test. As such, the term QSSD should be defined no more broadly than the NDA/BLA, which is the approval under which the product is originally marketed.

CMS's reliance on section 1192(d)(3)(B) of the Act to support its aggregation of NDA/BLAs in identifying QSSDs is misplaced because it ignores sequential placement of the QSSD definition relative to the "total expenditures" calculation. Section 1192(d)(3)(B) of the Act 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. Section 1192(d)(3)(B) does not govern the identification of the underlying QSSD. Stated differently, 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. This requirement is intended to account for the common circumstance where a single NDA/BLA, and even a single supplemental NDA/BLA, can have multiple dosage forms and strengths.

Additionally, CMS's aggregate approach to defining QSSD may stimy innovation and limit patient access to new therapies that could improve their health outcomes. Pursuing FDA approval 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.[2] However, obtaining such approval involves a significant expenditure of resources, even if the new product shares the same active ingredient/moiety with an existing therapy. If CMS aggregates separate NDAs/BLAs into a single QSSD, manufacturers will be deterred from making investments that would otherwise advance the scientific understanding of disease states and bring new scientific applications to bear for patients.

B. AstraZeneca supports CMS's proposal that a generic/biosimilar for "any of the strengths or dosage forms of the potential qualifying single source drug" would disqualify the drug/biological product from the QSSD definition. (Section 30.1)

CMS states that "[i]f 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 biological products that CMS determines are approved and marketed . . . the potential qualifying

---

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).

[2] For instance, we received NDA approval from FDA in 2014 for LYNPARZA (Olaparib) capsules, which had a recommended dosage of 8 capsules per day. Following subsequent research and development, we received a separate NDA approval from FDA in 2017 for LYNPARZA (olaparib) tablets, which formulation reduced the recommended dosage to 2 tablets per day. As another example, CALQUENCE launched a new formulation in 2022, which now allows for co-administration with proton-pump inhibitors. And FASENRA launched a new method of administration in 2019—an autoinjector that can be administered by a patient or caregiver following proper training and if the healthcare provider deems it appropriate.

single source drug will not be considered a qualifying single source drug for initial price applicability year 2026."[3]

While AstraZeneca opposes CMS's QSSD definition, to the extent CMS proceeds with such an overly expansive interpretation, AstraZeneca would support CMS's policy position in relation to the impact of generic/biosimilar competition on a QSSD. Specifically, since CMS's QSSD definition is so broad, it is necessary (as a limiting principle) that a generic/biosimilar for *any* of the branded product's strengths and/or dosage forms is a sufficient condition to disqualify the potential QSSD, particularly because generic/biosimilar manufacturers may not seek approval for all of the strengths or dosage forms of the branded product. However, we have some concerns regarding CMS's proposal with respect to confirming the presence of "bona fide" marketing of the generic or biosimilar product, as outlined in greater detail in our comments in response below to Section 90.4.

C. CMS should support orphan drug development and access. (Section 30.1.1)

CMS proposes to interpret the orphan drug exclusion under section 1192(e)(3)(A) of the Act as applying to a drug or biological product that must (1) be designated as a drug for only one rare disease or condition under section 526 of the Food, Drug & Cosmetics (FD&C) Act and (2) be approved by the FDA only for one or more indications within such designated rare disease or condition.[4] As described in the Guidance, all dosage forms and strengths and different formulations of the QSSD must meet the criteria for the exclusion.[5] CMS would then use the FDA's Orphan Drug Product designation database and approvals on the FDA website to identify a qualifying orphan drug. Importantly, CMS states that it is "considering whether there are additional actions CMS can take in its implementation of the Negotiation Program to best support orphan drug development."[6]

As described below, developing drugs for orphan diseases and rare cancers is an exceedingly challenging proposition and many orphan diseases still lack an approved therapy. It is therefore essential that CMS implement the IRA's orphan drug exclusion in a manner that encourages the continued development of orphan therapies, consistent with the intent of the Orphan Drug Act.

i. Developing drugs for orphan diseases is an exceptionally costly effort that poses unique challenges, but often paves the way for therapeutic advance.

While each rare disease affects a relatively limited patient population, in the aggregate, rare diseases affect a significant number of Americans. There are approximately 30 million

[3] Guidance at 10.
[4] Guidance at 11.
[5] *Id.*
[6] *Id.* at 11.

people living with over 7,000 rare diseases (including rare cancers) in the United States, including millions of Medicare beneficiaries.[7] Many of these rare diseases are debilitating and costly, negatively affecting the quality of life not only for the patients but their families and caregivers.[8] Rare cancer conditions, which are further subdivided into many orphan sub-types, are particularly devastating and are estimated to represent a quarter of all cancer deaths.[9] Further, supporting orphan drug development is a health equity issue. According to the National Institutes of Health, Black Americans have higher death rates for many cancer types, Hispanic and Black women have higher rates of cervical cancer, and American Indians/Alaska Natives have higher death rates from kidney cancer.[10]

Although there has been a significant increase in the number of drugs approved to treat rare diseases since the ODA was enacted 40 years ago, over 90 percent of known rare diseases still do not have a treatment. This is due, in part, to circumstances unique to rare diseases that further complicate the extremely costly[11] and high-risk[12] drug-development process.

The FDA Oncology Center for Excellence (OCE) has outlined some of the challenges to developing drugs to treat rare cancers.[13] For example, it can be challenging to enroll a sufficient number of patients in clinical trials for rare diseases given small patient numbers, uneven distribution of disease across populations, and heterogeneity of diseases (e.g., subtype, states, and exposure to prior treatment). It is similarly challenging to design clinical trials for rare disease populations given difficulties designating an appropriate comparator, validating novel endpoints, and obtaining sufficient data from small patient populations. Obtaining the high-quality data necessary to evaluate the clinical trial outcomes for orphan diseases is also a challenge given diversity in clinical presentation, disease progress, and other patient characteristics. In addition, there may be limited or lack of timely access to molecular testing to determine eligibility for treatment with targeted therapies.

Meanwhile, because many rare disease drugs are the first and/or only products for a given disease, rare diseases lend themselves to being a starting point in the translation of new scientific

---

[7] G. Yang et al. The national economic burden of rare disease in the United States in 2019, Orphanet J. Rare Dis. 17:163 (2022), pp. 1-11.
[8] *Id.* (finding that over half of the $966 billion economic burden of rare disease were indirect and nonmedical costs for patients and families).
[9] "About Rare Cancers", National Cancer Institute (last updated February 27, 2019), https://www.cancer.gov/pediatric-adult-rare-tumor/rare-tumors/about-rare-cancers.
[10] "Cancer Disparities", National Cancer Institute (last updated March 28, 2022), https://www.cancer.gov/about-cancer/understanding/disparities.
[11] The cost of the drug development process has been estimated to take 10 to 15 years and $1-2 billion. 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. (defining the cost of the drug development process to include all costs borne by a manufacturer leading up to FDA-approval or a particular drug).
[12] Ninety percent of clinical trials for candidate drugs ultimately prove unfeasible. H. Dowden, J. Munro. Trends in clinical success rates and therapeutic focus Nat Rev Drug Discov, 18 (2019), pp. 495-496.
[13] FDA, OCE Rare Cancers Program, https://www.fda.gov/about-fda/oncology-center-excellence/oce-rare-cancers-program (last accessed April 4, 2023).

discoveries to clinical medicine. As data emerge, drug manufacturers sometimes identify promising new uses for existing orphan therapies – in many cases for additional orphan indications. In addition to identifying patient needs and scientific pathways, there needs to be a business case for making this investment since the exploration of new indications requires significant resources. Indeed, one of the challenges OCE highlights with respect to the development of drugs for rare cancers is "[d]ecreased financial incentives for drug development."[14]

ii. *We appreciate CMS's focus on the importance of orphan drugs to patients who need them and support CMS implementing policies that recognize and evaluate the individual contributions of each orphan indication as it evaluates Medicare spending and other negotiation factors for orphan products. AstraZeneca believes that CMS can take additional actions to "best support orphan drug development" as it relates to the implementation of the orphan drug exclusion, including by excluding drugs from the Negotiation Program that treat indications with a collective total of fewer than 200,000 patients to preserve the incentives for orphan drug development created by Congress in the Orphan Drug Act.*

The stated purpose of the ODA, as enacted by Congress in 1983, is to "provide financial incentives" to manufacturers for diseases and conditions "which affect such small numbers of individuals residing in the United States."[15] Specifically, the express purpose of the ODA is to encourage the development of innovative pharmaceutical products to treat diseases and conditions with very small patient populations, defined by Congress as those affecting fewer than 200,000 persons in the United States.[16] The FDA, the agency with direct oversight of this program, recognizes this clear purpose, noting that it is challenging to create treatments and cures for rare diseases, including "…the complex biology and the lack of understanding of the natural history of many rare diseases. The inherently small population of patients with a rare disease can also make conducting clinical trials difficult."[17]

In passing the IRA, Congress included orphan drugs as one of just three exclusions from the QSSD definition, evincing a clear intent to preserve Congress' longstanding support and incentives for drugs treating small patient populations, namely populations of fewer than 200,000 patients.[18]

---

[14] *Id.*

[15] Orphan Drug Act of 1983, Pub. L. 97–414, §1(b), Jan. 4, 1983, 96 Stat. 2049.

[16] The ODA defines the term "rare disease or condition" to mean "any disease or condition which (A) affects less than 200,000 persons in the United States, or (B) affects more than 200,000 in the United States and for which there is no reasonable expectation that the cost of developing and making available in the United States a drug for such disease or condition will be recovered from sales in the United States of such drug." *See* 21 U.S.C. § 360bb(a)(2).
"Rare Diseases at FDA," Available at https://www.fda.gov/patients/rare-diseases-fda (Accessed April 7, 2023).

CMS's proposed approach to implementing Congress's exemption, however, fundamentally disrupts this purpose by leaving unprotected rare disease and rare cancer therapies that treat fewer than 200,000 patients even across multiple indications. When designating a drug as an orphan drug, FDA pays careful attention to the 200,000 patient prevalence limit. Further, FDA acknowledges that a drug may show promise even in multiple, different rare diseases. Such drugs may be eligible for multiple orphan designations because FDA considers the prevalence within each disease or condition.

By way of example, in 2014 the FDA approved AstraZeneca's LYNPARZA® (olaparib) as an oral orphan-designated monotherapy for patients with deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA-approved test) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy.[19] AstraZeneca has since continued to invest in advanced clinical research to refine and bring the clinical benefits of LYNPARZA to other patient populations: recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in 2017),[20] human epidermal growth factor receptor 2 (HER-2)-negative metastatic breast cancer (in 2018),[21] gBRCAm metastatic pancreatic adenocarcinoma (in 2019),[22] and somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC) (in 2020).[23] Using the highest U.S. prevalence numbers available, the current total estimated disease prevalence across all four conditions is estimated to be less than 50,000 patients,[24] still far fewer than the 200,000 patient size contemplated by Congress in enacting the ODA. Yet, under CMS' proposed interpretation of the IRA's orphan drug exclusion, the 2018 approval of LYNPARZA for metastatic breast cancer likely would have resulted in the loss of the orphan drug exclusion for LYNPARZA from 2014 for advanced ovarian cancer, at a time when the therapy was approved for a small patient combined population.

LYNPARZA and other rare oncology products are often approved in late-stage treatment before data becomes available in front-line and adjuvant treatment trials. Furthermore, long-term follow-up on overall survivability can take five or more years and comes at significant cost. Moving forward, if a manufacturer knows further investment in an oncology product is running against a negotiation clock, companies may delay launch of or choose to not move forward in advancing research to learn whether a particular drug might also treat other conditions.

As is clear, CMS's approach will have the effect of including in the Negotiation Program orphan drugs treating patient populations well below the 200,000 threshold Congress sought to protect in the ODA, undermining the ODA's purpose and disturbing a carefully crafted framework

---

[19] https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/206162lbl.pdf.
[20] https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/208558s000lbl.pdf.
[21] https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/208558s001lbl.pdf.
[22] https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/208558Orig1s010lblrpl.pdf.
[23] https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/208558s014lbl.pdf
[24] Analysis conducted based on disease prevalence numbers reported in the National Organization for Rare Disorders' Rare Disease Database (available at https://rarediseases.org/rare-diseases).

that has been remarkably successful in bringing new lifesaving treatments to patient populations that may otherwise have lacked access to any therapy for their rare condition.

In light of these significant concerns, we strongly urge CMS to exclude from negotiation any drug that, in aggregate, treats indications for which there are fewer than 200,000 patients.

iii. The 7- or 11-year period that must elapse before a drug or biological can be subject to negotiation should begin on the date a drug loses eligibility for the orphan drug exclusion.

In the case of a drug that initially qualifies for the orphan drug exclusion from inclusion in a QSSD as outlined above, CMS should clarify that the 7- or 11-year period prior to negotiation eligibility begins to run only upon the loss of the orphan drug exclusion.

As discussed above, pursuant to section 1192(e) of the Act, a drug can only be classified as a QSSD (and hence be subject to negotiation) once "*at least 7 years…since the date of such approval [under section 505(c)]*" or "*at least 11 years…since the date of such licensure [under section 351(a)]*" have elapsed. This language must be read in the context of the orphan drug exclusion, which provides that: "[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 [FDCA] and for which the only approved indication (or indications) is for such disease or condition."[25]

Under CMS's guidance, a drug that initially qualifies for the orphan drug exclusion would lose this exclusion, and could potentially be classified as a QSSD, following the approval, with respect to the same active moiety, of a non-orphan indication or a new orphan indication for a distinct disease or condition. CMS's guidance, however, does not address *when* such a drug could potentially be classified as a QSSD and hence becomes eligible for negotiation.

CMS should issue additional guidance to clarify that the 7- or 11-year pre-negotiation period would commence only upon the date a drug loses eligibility for the orphan drug exclusion. This outcome is supported by the statute's plain language and scheme. Notably, the orphan drug exclusion constitutes a threshold exclusion from the definition of a QSSD.[26] It must follow from this structural placement that the 7- or 11-year pre-negotiation period that would otherwise apply to a QSSD is *tolled* until the first day after the orphan drug no longer meets the requirements of the orphan drug exclusion. Indeed, any other approach would defeat the intent of excluding relevant orphan drugs from the QSSD definition, including the statutory sub-elements. (Consider,

[25] *See* SSA § 1192(e)(3)(A).
[26] *See* SSA § 1192(e)(3)(A) ("Exclusions.—In this part, the term [QSSD] does not include any of the following…(A) Certain Orphan Drugs.")

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.)[27]

By issuing guidance that sets forth the interaction between the orphan drug exclusion and the QSSD definition in this way, CMS will be following the plain text of the statute. Additionally, we believe that CMS should interpret the Medicare Negotiation program in a way that supports and safeguards the important progress the ODA has achieved in sharing the benefits of medical innovation with patients with orphan diseases. The approach outlined here better enables innovator companies to pursue orphan indications by initiating the pre-negotiation period only upon a subsequent approval for a distinct disease or condition.

iv. CMS should carve out the original orphan drug exclusion-eligible indication when a product becomes QSSD eligible

Under CMS's guidance, a drug that initially qualifies for the orphan drug exclusion would lose this exclusion, and could potentially be classified as a QSSD, following the approval, with respect to the same active moiety, of a non-orphan indication or a new orphan indication for a distinct disease or condition. In the case of a drug that initially qualifies for the orphan drug exclusion from inclusion in a QSSD as outlined above, CMS should carve out the original approval(s) under the original orphan designation of the active moiety or active ingredient (and associated Total Expenditures) from the resulting QSSD which includes the subsequent or supplemental approvals of the active moiety or ingredient which do not qualify for the orphan drug exclusion.

As also above, pursuant to section 1192(e) "the term 'qualifying single source drug' does not include. . . [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." By carving out the initial exclusion eligible use of the product, CMS can preserve the intent of Congress to protect the development of orphan drugs while maintaining the ability to negotiated expanded uses of the same active moiety or ingredient otherwise identified as a QSSD.

D. <u>CMS should clarify that it will consider only 12 months of claims data to assess the applicability of the low-spend Medicare drug exclusion from the QSSD definition, and should exclude beneficiary cost sharing from such calculation. (Section 30.1.2)</u>

For IPAY 2026, CMS states that it will identify low-spend Medicare drugs with less than $200,000,000 in combined Part B and D expenditures (inclusive of beneficiary cost sharing) and exclude them from the QSSD definition pursuant to section 1192(e)(3)(B) of the Act by considering PDE and Part B claims data for dates of service between June 1, 2022, and May 31,

[27] *See* SSA § 1192(d)(2) (stating that "term 'negotiation-eligible drug' shall not include… a qualifying single source drug that meets [the listed criteria]").

2023. However, CMS states that "[t]o allow a reasonable amount of time" for Part D plan sponsors and Part B providers/suppliers to submit the necessary data, CMS will consider claims submitted by June 30, 2023.

AstraZeneca requests that CMS clarify that the additional 30-day period is merely a "grace period" for submission of claims with a date of service that falls within the 12-month timespan, and any claims with a date of service before or after that 12-month period, including those with a date of service that falls within the 30-day grace period, will not be considered for purposes of applying the low-spend Medicare drug exclusion. If, on the other hand, CMS were to cost data beyond 12 months, this could improperly reduce the number of drugs excluded as low-spend and accelerate a given drug's inclusion in the Negotiation Program.

Furthermore, we request CMS reconsider its proposed policy of including beneficiary cost sharing in determining whether a prospective QSSD falls below the low-spend Medicare drug exclusion threshold of $200,000,000. Because beneficiary cost sharing amounts are not costs paid by Medicare, these amounts should not be considered "total expenditures under Parts B and D" for the purposes of applying the low-spend Medicare drug exclusion.

E. CMS should publicly disclose the methodology for calculating total expenditures and create a process to engage manufacturers to address potentially incorrect total expenditure data. (Section 30.2)

CMS states that it will identify "negotiation-eligible" Part D drugs for IPAY 2026 based on reviewing PDE data for the 12-month applicable period.[28] After calculating total expenditures for each drug, CMS will remove drugs that satisfy the exclusions provided in statute (e.g., small biotech drugs) and then identify the 50 QSSDs that have the highest total expenditures under Part D.[29] AstraZeneca supports this approach. CMS does not indicate that its calculations will be made public.

AstraZeneca supports the modified definition of "gross prescription drug costs" that CMS finalized as part of the CY 2024 Part C & D Policy and Technical rulemaking.[30] However, we urge CMS to publish (1) the rankings of negotiation-eligible drugs, (2) the total expenditures corresponding to each selected drug, and (3) the methodology the agency used to calculate total expenditures. CMS should also provide manufacturers of selected drugs with an opportunity to review and propose corrections to total expenditure data and/or methodological errors prior to the publication of this information. We believe that this transparent approach would improve the operation of the Negotiation Program by establishing accountability and transparency.

---

[28] Guidance at 12.
[29] *Id.*
[30] CY 2024 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, Final Rule (88 Fed. Reg. 22,120 (April 12, 2023)

F. CMS takes a reasonable approach to ranking and selecting drugs based on Total Expenditures (Sections 30.2 & 30.3)

AstraZeneca supports the approach laid out in Section 30.2 for identifying the 50 qualifying drugs with the highest Total Expenditures under Part D of Title XVIII for QSSDs during the applicable 12-month period using Part D prescription drug event (PDE) data for each qualifying single source drug for dates of service beginning June 1, 2022, and ending May 31, 2023. As CMS clarifies in footnote n.3 of this initial guidance, Total Expenditures under Part D of Title XVIII are defined in section 1191(c)(5) as total gross covered prescription drug costs (as defined in section 1860D-15(b)(3)), and further defined in the Part D regulations at 42 CFR § 423.308 as amended in the CY 2024 Part C & D Policy and Technical Rule.[31] This approach removes any ambiguity and applies Congressional intent in ranking negotiation-eligible drugs based on total gross drug spending in Medicare Part D.

CMS also clarifies in Section 30.3, after removing any biological products that qualify for delayed selection for biosimilar market entry, the agency will select the 10 highest-ranking negotiation-eligible drugs for negotiation in rank order. AstraZeneca supports this approach as it provides for the greatest amount of clarity and predictability for all stakeholders and complies with a clear reading of sections 1192(a) and 1192(b) of the statute.

II. Section 40: Requirements for Manufacturers of Selected Drugs for Initial Price Applicability Year 2026

A. CMS should not limit the Medicare Drug Price Negotiation Agreement (the "Agreement") to the Primary Manufacturer as the Primary Manufacturer may not always be in the best position to negotiate with CMS. (Section 40)

AstraZeneca strongly disagrees with CMS's rigid approach to determining with which manufacturer it will sign an Agreement. To the extent that one or more manufacturers meet the statutory definition of a "manufacturer" under the Negotiation Program, CMS states that it intends to enter into an Agreement only with the Primary Manufacturer of a selected drug, and the agency does not intend to enter into an Agreement with any Secondary Manufacturer. CMS intends to designate the entity that holds the NDA(s)/BLA(s) for the selected drug to be the Primary Manufacturer.

As discussed above, co-commercialization agreements are extremely common in the development and marketing of pharmaceutical products. AstraZeneca is concerned that CMS's approach would force manufacturers to potentially share with each other competitively sensitive information that they would not otherwise share pursuant to the terms of the co-commercialization agreement. This is because CMS's approach effectively requires the Primary Manufacturer—the holder of the NDA(s)/BLA(s)—to serve as the intermediary for information that might be pertinent

[31] *Id*.

only to the secondary manufacturer. For example, the statute requires CMS to consider "current unit costs of production and distribution of the drug" and "market data and revenue and sales volume." While the sharing of this information may not necessarily amount to an antitrust violation, it may represent competitively sensitive information that the parties would not otherwise share, even in their co-commercialization agreements. At a minimum, CMS should make available a process to allow Secondary Manufacturers to share information directly with CMS where: (a) the Primary Manufacturer is by statute, regulation or contract prohibited from sharing such information held by the Secondary Manufacturer; and/or (b) sharing of information by the Secondary Manufacturer to the Primary Manufacturer could have an anticompetitive effect.

In the absence of a process whereby CMS permits the submission of data from Secondary Manufacturers (and imposes some burden of compliance on the Secondary Manufacturer), CMS's approach would require manufacturers to revisit their co-commercialization arrangements and revise them to fit CMS's inflexible mold as much as possible. While CMS may believe that contracting with only one manufacturer is administratively simple, AstraZeneca believes that as CMS progresses through the negotiation process itself, it will become increasingly apparent that CMS will not be able to obtain all the necessary information from the holder of the NDA(s)/BLA(s) that is needed to effectively negotiate, particularly if CMS proceeds with aggregating different NDAs/BLAs into a single QSSD. For example, under CMS's overbroad approach to defining a QSSD, there could be multiple NDA/BLA holders and thus multiple Primary Manufacturers for any given QSSD.

CMS's approach would also unfairly expose the Primary Manufacturer to liability for violations to the Agreement perpetrated by the Secondary Manufacturer that are beyond the control of the Primary Manufacturer. Holding the Primary Manufacturer liable for non-compliance of a Secondary Manufacturer is not only unsupported by the statute, it is also an inefficient approach to ensuring compliance. AstraZeneca doubts that it will be administratively burdensome for CMS to require any relevant Secondary Manufacturer to sign what will effectively be a boilerplate Agreement, or at the very least, a shorter agreement that legally obligates the Secondary Manufacturer to comply with the statute's requirements and submit information directly to CMS. Even if there is some administrative burden, such burden is substantially outweighed by the benefits of an approach where CMS is able to independently and separately hold each manufacturer liable for their own non-compliance.

B. <u>CMS should permit the submission of data on a rolling basis and provide manufacturers with the opportunity to review information prior to publication to ensure that there is no competitively sensitive information disclosed. (Section 40.2)</u>

CMS states that the Primary Manufacturer of a selected drug must submit data to inform the negotiation process by October 2, 2023.[32] Data elements will include: information on the non-Federal average manufacturer price (non-FAMP) and any information that CMS requires to carry

[32] Guidance at 27-28.

out negotiation, including the manufacturer-specific negotiation factors (e.g., research and development costs, prior federal financial support, data on pending and approved patent applications).[33] Given the vague and broad nature of these data elements, and the limited time to compile them, AstraZeneca requests that CMS consider using its enforcement discretion to allow manufacturers of selected drugs to submit these data on a rolling basis, as long as a more limited set of data are reported by the October 2 deadline.

Between the time that a manufacturer is formally made aware that their drug has been selected for negotiation on the selected drug publication date (September 1) and the deadline that CMS would impose for the submission of negotiation data (October 2), only 30 days will have elapsed. It will be extremely difficult for manufacturers to collect all of the necessary data within this 30-day period, especially if CMS proceeds with its approach of requiring only the "Primary Manufacturer" to submit all necessary information. Indeed, given that securing competitively sensitive information from Secondary Manufacturers may impact existing regulatory or contractual protections of specific data elements, complying with the 30-day timeline for information held by Secondary Manufacturers and others may be an impossibility.

CMS should permit manufacturers to submit additional information after the October 2 deadline on a rolling basis with a final submission deadline at a later date.

CMS should also provide advance notice to manufacturers of drugs likely to be included on the selected drug list prior to the September 1 selected drug publication date to allow adequate time for data collection. Advanced notice will also provide manufacturers with the opportunity to engage with CMS and collect data in a manner and format that will be most helpful to the agency and the negotiation process.

Finally, AstraZeneca is concerned that CMS intends to treat only certain elements of the submitted data as proprietary information, protected from disclosure under Exemption 4 of the Freedom of Information Act (FOIA) and only available for use by CMS and the Comptroller General.[34] At a minimum, CMS should provide manufacturers of selected drugs with the opportunity to review data in advance of publication, including the explanation for the MFP as required under section 1195(a)(2) of the Act, to ensure that no competitively sensitive information is disclosed to the public.

C. <u>CMS should reconsider the breadth of the destruction of data requirements proposed for Primary Manufacturers and impose parallel data destruction requirements on itself. (Section 40.2.2.)</u>

CMS intends to impose certain requirements on the Primary Manufacturer related to the use, disclosure, and destruction of data and other information received during the negotiation

[33] *Id.*
[34] *Id.* at 29.

process.[35] This includes a prohibition on the Primary Manufacturer conducting audio or video recording of any oral conversation between CMS and the Primary Manufacturer.[36] All information that the Primary Manufacturer receives during the negotiation period from CMS must also be destroyed within 30 days of a determination that the drug or biologic is no longer a selected drug.[37]

AstraZeneca is concerned that CMS's imposition of a destruction of data requirement on manufacturers is overly broad and could undermine the smooth operation of the Negotiation Program. We anticipate that some manufacturers may be "repeat" selected drug manufacturers due to the nature of their drug portfolios and Medicare spending patterns. Indeed, the lack of any limit to the number of drugs subject to future negotiation (subject only to the Low-Spend Medicare Drug Exclusion) means that it is virtually inevitable that multiple drugs of a single manufacturer will be subject to selection and negotiation over time. In such situations, it would be in the interest of the Negotiation Program for that manufacturer to have access to past learnings and negotiation processes to enable their incorporation into business practices that support the manufacturer's future participation in the Negotiation Program. As an example, Primary Manufacturers will need to develop detailed workflows and procedures for the processing of data for submission to CMS, and such processes should not be undone as a result of an overbroad data destruction policy.

At the very least, CMS should clarify that, when it notes "all information…receiv[ed] during the negotiation period from CMS shall be destroyed," this excludes any work product produced by the Primary Manufacturer (as opposed to *received* from CMS) during the negotiation process.[38] For example, AstraZeneca does not believe that written notes of the process itself and relevant issues (e.g., why some R&D data is not acceptable/relevant) should be subject to destruction. Manufacturers should be able to maintain any manufacturer-created documents, including policies and procedures, as a matter of internal record, even if such documents are a reflection of learnings from the negotiation process.

If CMS moves forward with the overly broad data destruction policy proposed in the Guidance, AstraZeneca believes that CMS should hold itself to the same data-destruction requirements in the interest of public accountability and fairness. Nowhere in the Guidance does CMS discuss the agency's own use of the same information exchanged during the negotiation process, suggesting that CMS will be able to keep all information it receives and/or share such information as it pleases, including information *received* from a Primary Manufacturer, even after the selected drug status of the drug or biological product in question terminates. AstraZeneca does not believe that CMS should be able to retain such information in perpetuity, particularly while CMS imposes one-sided data destruction requirements on the Primary Manufacturer.

---

[35] Guidance at 30.
[36] *Id.*
[37] *Id.*
[38] *Id.*

D. CMS should establish a mechanism to allow dispensers access to the MFP at the point-of-sale, similar to the existing Part D Coverage Gap Discount Program. (Section 40.4)

CMS intends to require the Primary Manufacturer to ensure that entities that dispense drugs to MFP-eligible individuals, including pharmacies, mail order services, and other dispensers, have access to the MFP for the selected drug, meaning that the dispensing entity must pay no greater than the MFP for the selected drug.[39] CMS will allow Primary Manufacturers to comply with this requirement in one of two ways: (1) ensuring that the price paid by the dispensing entity when acquiring the drug is no greater than the MFP (point-of-sale access); or (2) providing retrospective reimbursement for the difference between the entity's acquisition cost and the MFP within 14 days.[40] A Primary Manufacturer would be required to retain, for at least ten years from the date of sale, any records relating to sales of the selected drug to entities that dispense the selected drug to MFP-eligible individuals, including pharmacies, mail order services, and other dispensers for units of selected drug.[41]

We do not believe option (1) presents a practical method for providing the MFP to MFP-eligible individuals. As pharmaceutical products are not designated for a specific patient at the point of sale by a dispensing entity from the wholesaler or distributor, no mechanism currently exists in the supply chain to ensure that products purchased at MFP would be dispensed to an MFP-eligible individual. Further, most drug purchases by dispensing entities are from wholesalers and specialty distributors; accordingly, effectuating a patient-based purchasing price model would depend on the cooperation of wholesalers and specialty distributors themselves, who are not held directly liable for non-compliance with the requirement to offer the MFP. Additionally, AstraZeneca believes that these types of models would lead to significant diversion of drugs purchased at MFP to non-MFP eligible patients.

In addition, while we support the concept of providing retrospective reimbursement to effectuate the MFP, existing retrospective reimbursement mechanisms are not designed to provide payment from a manufacturer directly to a dispensing entity, nor do current systems support a payment window as short as 14 days. Rather, these payments are made (after a minimum of 30 days) to large Group Purchasing Organizations or Pharmacy Benefit Managers, who are then responsible for the pass-through of those discounts to their member entities. Existing models also would not presently ensure that MFP-related retrospective reimbursements would be passed through to the dispensing entity itself. Existing infrastructure does not support the exchange of dispensing data from the pharmacy to the manufacturer, nor do manufacturers store payment data for each individual pharmacy to allow for direct reimbursement. Any such exchange of data would almost certainly exceed a 14-day period of time and therefore render CMS's approach operationally unfeasible.

---

[39] *Id.* at 31-32.
[40] *Id.* at 32.
[41] *Id.*

AstraZeneca therefore supports the industry's recommended approach, as outlined by PhRMA and BIO, to implement the MFP along the lines of the current Part D Coverage Gap Discount Program (CGDP), which facilitates manufacturer price concessions at the point-of-sale (POS) for Part D beneficiaries. Under the current CGDP, CMS relies on a third-party administrator (TPA) to aggregate Part D data, distribute invoices to manufacturers, reconcile disputes, and reimburse Part D plans for "advancing" access to the manufacturer discount at the point-of-sale. This current process could easily accommodate access to the MFP at the point-of-sale, ensuring that dispensers receive the full benefit of the MFP at the time of dispensing of an MFP-eligible drug, rather than relying on a lengthy reimbursement methodology. CMS could also impose requirements on Part D sponsors to validate that a drug is a selected drug offered to an MFP-eligible individual, and to ensure there are no multiple discounts (e.g., 340B discounts, discounts provided under the new Manufacturer Discount Program).

AstraZeneca also opposes CMS's requirement that the Primary Manufacturer retain for at least ten years from the date of sale any records relating to sales of the selected drug to entities that dispense the selected drug to MFP-eligible individuals. Maintaining such detailed data for ten years is extraordinarily burdensome and costly. AstraZeneca recommends that CMS reduce the required timeframe to 6 years, consistent with the statute of limitations for the False Claims Act[42].

E. CMS should separately require the Secondary Manufacturer of any selected drug to make the MFP available to MFP-eligible individuals and entities rather than hold the Primary Manufacturer responsible for behavior beyond their control. (Section 40.4)

CMS states that Primary Manufacturers would be responsible for ensuring that the MFP is made available to pharmacies, mail order services, and other dispensers that dispense the selected drug to MFP-eligible individuals, including to ensure that the MFP is available for units of the selected drug for which there is a Secondary Manufacturer.[43]

As stated above, we do not believe it is 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. We further do not see any impediment to CMS directly binding Secondary Manufacturers to these same requirements via separate agreements, particularly if CMS adopts such a broad approach to defining a QSSD under which the manufacturer marketing a particular product may or may not be the Primary Manufacturer. 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.

---

[42] 31 U.S.C. § 3731(b)(1).
[43] Guidance at *32*.

III. Section 50: Negotiation Factors

AstraZeneca supports CMS's solicitation of information from patients and Medicare beneficiaries to inform the negotiation process and urges CMS to give substantial weight to the patient voice. We further support CMS's policy of not considering quality-adjusted life years (QALYs) for purposes of the Negotiation Program and the agency's close scrutiny of any comparative effectiveness research that may rely on QALYs for its conclusions. However, we urge CMS to allow for manufacturer input regarding the selection of therapeutic alternatives, and to develop a more detailed framework for how the agency will consider therapeutic alternatives and comparative effectiveness data based on five core principles.

A. AstraZeneca supports CMS's solicitation of information from patients and Medicare beneficiaries and urges CMS to give substantial weight to the patient voice (Section 50.2).

As described in the Guidance, CMS will consider therapeutic alternative and comparative effectiveness data submitted by Medicare beneficiaries, academic experts, clinicians, and other interested members of the public.[19] We strongly support this solicitation, and we note the patient voice is often ignored, even in the comparative effectiveness research that purports to assess the best treatments for patients. This is particularly true for minority and underserved people living with rare diseases, who face additional disparities in access to care, including differences in health care utilization, delayed or missed care due to a lack of transportation or work flexibility, and a lack of representation in clinical trials and research. AstraZeneca therefore urges CMS to give substantial weight to the patient experience in CMS's evaluation of therapeutic alternatives and comparative effectiveness. Factors such as patient convenience due to route of administration, caregiver burden, and improvements in quality of life not otherwise measured by endpoints in a clinical trial nevertheless represent a significant benefit to the patient experience. Such a seemingly innocuous benefit can directly impact other health outcome metrics, such as medication adherence and patient self-sufficiency, through an improved ability to consistently engage in gainful employment. We urge CMS to not only take into account the beneficiary and caregiver experience, but to prioritize it when evaluating the value of a drug product.

B. CMS should develop a more detailed framework for how the agency will consider therapeutic alternative and comparative effectiveness data based on five core principles (Section 50.2)

As described in the Guidance, CMS will consider therapeutic alternative and comparative effectiveness data submitted by Medicare beneficiaries, academic experts, clinicians, and other interested members of the public.[21] Improved clinical outcomes for patients should be a shared objective between CMS and pharmaceutical manufacturers and multifaceted consideration of a selected drug's clinical value should be the basis of any evaluation. AstraZeneca supports a framework for assessment of clinical value that considers the following five core principles:

1. The process of clinical value assessment should be transparent. Using scientific principles, consistent methodology, and appropriate evidence, various stakeholders should be able to come to similar conclusions.

2. While adhering to consistent methodology, clinical value assessments should consider contextual factors associated with the disease in question. This is particularly important for diseases associated with high unmet need. Aside from the obvious recruitment challenges in rare disease clinical trials, the basic pathophysiology of many rare diseases is less well understood compared to more common diseases. Because of this, clinical trials for rare disease treatments may be non-comparative and often use endpoints that are not specifically developed to capture the full impact of the rare disease or its treatment. Further, cancer is not one disease but rather a cohort of related diseases that requires a range of treatments with different goals and outcomes that can vary over the course of the disease. Relevant trial endpoints therefore also vary according to cancer type (e.g., solid or blood cancers) and staging (I-IV), intent of treatment (e.g., curative vs. palliative) and feasibility, which is the likelihood of capturing relevant endpoint data (e.g., tumor growth and spread, quality of life assessments from people with cancer) within time and cost constraints.

It's also important to consider whether a drug was approved for a disease when there was no available or adequate therapy available, recognize progress against hard-to-treat illnesses, curative potential, impact to public health, and the impact of a product on health disparities and improved outcomes for underserved or historically marginalized groups.

3. Appropriate therapeutic alternatives must be assessed, based on clinical, not economic factors. Therapeutic alternatives should be licensed and approved for the disease in question and there should be sufficient data to make a valid assessment of each alternative's clinical value feasible. For many rare diseases with existing treatments, there may be only one appropriate therapeutic choice. And, as noted above, the manufacturer should have input regarding the identification of therapeutic alternatives.

4. The perspective of clinical value assessment should be multifaceted and inclusive of factors related to health equity. The assessment must include not just short-term efficacy endpoints used in clinical trials, but safety, long-term health outcomes, patient experience factors such as route and frequency of administration, impacts on population health equity, health system resource use, and societal impacts outside the healthcare system as well. A study conducted by the EveryLife Foundation[23] concluded that 55 percent of the total burden of rare diseases is experienced outside of the healthcare system. Importantly, these impacts are still very much part of the lived experience of rare disease patients.

In assessment of cancer treatment effect, particularly for early-stage cancer, consideration should be given to oncology-relevant endpoints other than overall survival (OS) which have intrinsic value for decision-making. In early-stage cancer OS data takes time to mature or may not be possible to collect in the longer term. Indication, intent of treatment, and feasibility of measuring patient-relevant outcomes (e.g., disease-free survival, relapse-free survival, delay or avoidance of

subsequent treatments, QoL) within a reasonable timeframe should be evaluated when considering oncology-relevant endpoints in value assessments to allow patients to benefit from innovative treatments.

Health equity deserves additional consideration. The Centers for Disease Control and Prevention defines health equity as, "the state in which everyone has a fair and just opportunity to attain their highest level of health." Equity of access for cancer patients is vital, as the benefits are only seen if people with cancer are aware of treatment options, and able to access and adhere to treatment. A study in the Journal of the American Medical Association found in disadvantaged neighborhoods, a lack of physicians and healthcare resources, weak referral systems, poor social support networks, and barriers to travel for initial and ongoing care negatively impact outcomes for people with cancer.[44] Access to treatment options for these patients may address a disproportionally higher unmet medical need. Drugs targeting chronic conditions may present additional benefits to undertreated populations or minority groups disproportionately impacted by disease. For example, two recent clinical trials with sodium glucose co-transporter-2 (SGLT2) inhibitors, demonstrated a reduction in heart failure (HF) hospitalization or cardiovascular mortality risk in patients with HF and reduced ejection fraction (HFrEF) and signaled a potentially greater effect in Black and Asian patients randomized to treatment compared to other groups.[45] Health equity is also important in chronic diseases, such as COPD, where socioeconomic, occupational, and environmental factors, as well as access to healthcare, impacts prevalence and outcomes in different patient groups.[46]

5. Data used to inform a clinical value assessment will need to come from a wide variety of sources. Appropriate data sources should include, but should not be limited to, clinical trials, patient registries, and other real-world data. Patient registries and other real-world data have been important sources of data to demonstrate the certain kinds of treatments that are hard to evaluate in clinical settings. Real-world data is also needed to assess some endpoints not easily measured in clinical trial settings, such as caregiver burden and non-medical costs. Data collected from patients via patient-reported outcomes (PROs) including quality of life, should be routinely and consistently incorporated into value assessments, along with the value components that are already used relating to safety and efficacy.

Finally, CMS should consider setting the MFP for selected drugs at the ceiling price for those products that meet the FDA's definition of unmet need, evaluated across a product's lifecycle; and products that represent a significant therapeutic advance. CMS's definition of "unmet need" is narrower than the FDA definition and may dampen industry interest in the post-

---

[44] Cheng E, Soulos PR, Irwin ML, et al. Neighborhood and Individual Socioeconomic Disadvantage and Survival Among Patients with Nonmetastatic Common Cancers + Supplemental content. *JAMA Netw Open*. 2021;.

[45] Morris AA *et al*,. Sodium-Glucose Cotransporter-2 Inhibitors in Heart Failure: Racial Differences and a Potential for Reducing Disparities. Circulation, 2021.

[46] [Pleasants RA, Riley IL, Mannino DM. Defining and targeting health disparities in chronic obstructive pulmonary disease. Int J Chron Obstruct Pulmon Dis. 2016

approval research that often leads to additional indications for conditions or sub-populations with significant unmet need. Further, CMS could leverage the existing New Technology Add-On Pathway (NTAP) definition for "substantial clinical improvement" which provides the agency with an established measure for evaluating the value of certain products.

C. AstraZeneca supports CMS's policy of not considering QALYs in applying comparative effectiveness research, and urges CMS to give substantial weight to the patient voice and experience in its assessment of a selected drug's comparative effectiveness. (Section 50.2)

As required by statute, CMS will assess a selected drug's comparative effectiveness as compared to "therapeutic alternatives."[47] In so doing, CMS stated the agency will not use evidence from comparative clinical 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, including quality-adjusted life years (QALYs).[48] To the extent studies regarding comparative effectiveness employ QALYs in its analysis, CMS will not consider it unless it is able to separate such evidence.[49] AstraZeneca supports CMS's policy of not considering QALYs for purposes of the Negotiation Process, which is consistent with the plain statutory language of the IRA. We similarly support the agency's scrutiny of any comparative effectiveness research that may rely on QALYs for its conclusions.

D. CMS should allow for manufacturer input on the selection of therapeutic alternatives and on the development of a more detailed framework for how the agency will identify therapeutic alternatives and evaluate comparative effectiveness. (Section 50.2)

AstraZeneca further urges CMS to allow for manufacturer input into the selection of therapeutic alternatives in applying comparative effectiveness research as part of the Negotiation Program. In the Guidance, CMS outlines a flexible approach to considering therapeutic alternatives and evaluating comparative effectiveness. We note that AstraZeneca has serious concerns that certain studies have drawn improper comparisons across therapies (e.g., comparing targeted novel treatment to chemotherapy, etc.). As a result, we have a number of open questions including, for example: Will CMS consider products that treat the same disease area, or that treat the same specific indication, as therapeutic alternatives? How will CMS distinguish between different mechanisms of action or routes of administration, even when the drugs under consideration treat the same disease area or specific indication? How will CMS consider comparative effectiveness research in light of demonstrable differences in heterogenous patient populations where what may work for one patient may not work for another, thereby confounding the comparability of comparative effectiveness comparisons? How does CMS intend to resolve conflicting evidence as it relates to a selected drug's comparative effectiveness?

[47] *Id.* at 36.
[48] *Id.*
[49] *Id.*

Given these significant uncertainties, at a minimum, AstraZeneca urges CMS to provide manufacturers with an opportunity to engage with CMS and review CMS's methodology for the selection of therapeutic alternatives, before CMS makes such a determination. We also urge CMS to consider only on-label indications in selecting therapeutic alternatives, as off-label indications have not been approved by FDA and have significantly less robust data regarding safety and efficacy, relative to on-label uses.

IV. Section 60: Negotiation Process

A. CMS should consider a selected drug's multi-faceted clinical value, rather than narrowly focusing on R&D spend and recoupment.

As described in Section 60 of the Guidance, CMS is proposing a four-step process to determine an initial offer and counteroffer for a selected drug. Specifically, CMS intends to: (1) identify indications for the selected drug and therapeutic alternative(s); (2) use as a starting point the Part D net price for Part D drug therapeutic alternative(s) and/or Part B average sales price for Part B therapeutic alternative(s); (3) evaluate clinical benefits of the selected drug to adjust the starting point; and (4) further adjust the preliminary price through consideration of manufacturer-specific data (e.g., R&D costs; current unit costs of production and distribution) to determine the initial offer price. While AstraZeneca supports CMS's proposal to prioritize the consideration of clinical benefits, we are concerned that CMS may be putting undue weight on certain manufacturer-specific factors.

AstraZeneca appreciates that CMS is required by statute to take into consideration certain factors—including R&D costs—in setting the maximum fair price (MFP) for a selected drug. However, such factors are to be considered only "as applicable to the drug" and not all of the statutory negotiation factors must be weighted equally. The manufacturer-specific factors—including R&D costs—are difficult to categorize, and decoupling specific costs for assets does not represent the full cost or value of a given drug. Overreliance on these factors could thus result in an arbitrary pricing methodology.

As also noted in our comments regarding Section 60.3.4 of the Guidance, AstraZeneca urges CMS to instead prioritize the clinical statutory negotiation factors. Specifically, CMS should focus on whether a selected drug demonstrates a clinical benefit and addresses an unmet need in calculating the MFP. This approach would best preserve incentives for innovation, establish a clear and predictable methodology for determining drug pricing, and enable CMS to meet its statutory obligations under the IRA.

B. CMS should allow for manufacturer input on the selection of therapeutic alternatives for purposes of identifying the "starting point" for the initial MFP offer calculation.

As described above, CMS is proposing a four-step process to determine an initial offer and counteroffer for a selected drug. While AstraZeneca broadly agrees with this framework, we have some concerns regarding how it might be implemented.

For instance, as to this first step, as described in response to our comments to Section 50.2, above, manufacturers should be given an opportunity to weigh in regarding CMS's selection of therapeutic alternatives as certain studies have drawn improper comparisons across therapies. In addition, an off-label product is priced for use in its licensed indication, making its price an unsuitable starting point for negotiations.

C. CMS should provide a clearer framework for the directional adjustments it would make when evaluating clinical benefit relative to therapeutic alternatives. (Section 60.3.3.1)

After identification of therapeutic alternatives for purposes of establishing a starting point for negotiations, CMS intends to adjust the starting point based on the clinical benefit that the selected drug confers as compared to its therapeutic alternatives. CMS will broadly evaluate the body of clinical evidence through a CMS-led literature review, and CMS may also analyze Medicare claims data or other pharmaceutical drug datasets for utilization patterns, clinical data, or other information relevant to the selected drug and its therapeutic alternatives. CMS's adjustments to the starting point will be referred to as the "preliminary price."

While AstraZeneca appreciates that CMS is establishing a flexible methodology for adjusting a selected drug's starting point based on clinical benefit, we believe CMS should provide clearer guidance on both specific elements that will be evaluated, the weight applied to any one individual element, and the directional adjustments CMS would make based on its evaluation of such elements and their relative weight. For example, how will CMS weigh the fact that the selected drug in question was the *first* in class among all therapeutic alternatives? This type of innovation should invariably result in an upward adjustment to the starting point (if the starting point is below the statutory ceiling). In short, CMS should provide a framework that clearly indicates what factors and qualitative evidence could result in a selected product achieving a preliminary price at or near the ceiling price and/or an initial offer at or near the relevant ceiling price.

In addition, we recommend if a selected drug's statutory ceiling price is the net price (vs a percentage of non-FAMP), then the MFP should be set at the ceiling price (the net price) for the selected drug. This approach is appropriate because brand-to-brand competition has already resulted in substantial price reductions. This approach is operationally feasible as CMS has access to the necessary price data to determine the ceiling price based on net price.

D. CMS should apply special considerations when evaluating selected drugs, such as orphan drugs due to their unique circumstances. (Sections 60.3.3.2)

AstraZeneca appreciates CMS's thoughtful approach and analytical framework for adjusting the starting point of a selected drug without therapeutic alternatives based on unmet need. CMS intends to adjust the starting point based on whether the selected drug fulfills an unmet medical need, a determination that will be made based on the "totality of relevant information and evidence submitted and gathered through the agency's analysis . . ."[50]

However, as a leader in rare disease and rare cancer treatment development, we are deeply interested that CMS's clinical benefit assessment for selected drugs without therapeutic alternatives is appropriately calibrated to account for the unique characteristics of rare disease. We appreciate that CMS has, elsewhere in the Guidance, recognized the need to work with stakeholders to "support orphan drug development."[51]

As recommended above, CMS should begin at the statutory ceiling price for any selected drugs for which there are no therapeutic alternatives—which would include many rare disease therapies—rather than the FSS or "Big Four Agency" pricing. This would recognize the inherent value of a therapy that addresses an unmet need.

Additionally, regardless of whether it identifies therapeutic alternatives, CMS should apply upward adjustments for drugs with orphan indications, drugs that represent a significant therapeutic advance, and drug which addressed unmet need(s). In particular, determination of unmet medical need must explicitly include a framework for weighing the patient and caregiver voice, in addition to clinical factors.

E. Manufacturer-specific factors should not be used, or should have a limited impact on pricing, for drugs that represent a therapeutic advance or address an unmet need (Section 60.3.4).

As to the fourth step in the process, AstraZeneca urges CMS to prioritize the clinical negotiation factors. Specifically, CMS should focus on whether a selected drug demonstrates a clinical benefit and addresses an unmet need in calculating the MFP. Under these circumstances, CMS should apply little to no weight to the manufacturer-specific factors. This approach would best preserve incentives for innovation, establish a clear and predictable methodology for determining drug pricing, and enable CMS to meet statutory obligations of the IRA.

V. Section 70: Removal from Selected Drug List Before or During Negotiation, or After an MFP is in Effect

A. CMS should establish a grace period to account for situations where a generic/biosimilar is approved prior to the end of the negotiation period but marketed shortly after the negotiation period ends.

[50] *Id.* at 52.
[51] *Id.* at 11.

Under section 1192(c) of the Act, a selected drug will no longer be subject to the negotiation process if FDA has approved a generic drug or licensed a biosimilar product that identifies the selected drugs as its reference product and CMS determines that the generic drug or biosimilar product 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 PDE data reveals that the manufacturer of the generic drug or biosimilar biological product has engaged in bona fide marketing of that drug or product.[52] If CMS makes a determination regarding generic drug or biosimilar biological product market availability on or after the selected drug publication date, and before or during the negotiation period for an initial price applicability year, the selected drug will not be subject to the negotiation process for the negotiation period, and an MFP will not be established.[53]

AstraZeneca urges CMS to establish a "grace period" when a generic/biosimilar to a selected drug receives FDA approval/licensure before the end of the negotiation period. Specifically, CMS should consider marketing data for a specified period *after* the negotiation period ends (e.g., 30 days) to determine whether a generic/biosimilar is in fact being marketed. As some generic/biosimilar manufacturers may encounter unexpected challenges during the marketing ramp-up period, we believe it is appropriate for CMS to exercise some flexibility to consider this marketing data so long as the product was approved/licensed *before* the conclusion of the negotiation period. Allowing this grace period will enable the biosimilar to better compete once it actually enters the market without having the reference product subject to an MFP.

The generic/biosimilar manufacturer would have the burden of submitting such data to CMS. For instance, in the case of IPAY 2026, CMS would consider marketing data between August 1, 2024, and September 1, 2024 so long as the generic/biosimilar is approved/licensed prior to August 1.

CMS should also consider an interpretation of the law that allows a reference product to exit the Program if a generic or biosimilar product is marketed after the "negotiation period" but before the IPAY begins. Such reading aligns with the statutory definition of a "qualifying single source drug" (QSSD)—a threshold requirement for a drug to be subject to price setting. The statute defines a QSSD "with respect to an initial price applicability year," indicating that a product's status as a QSSD should still exist as of the first day of the IPAY. Thus, a product that has become multisource before the IPAY should not be subjected to price setting. This approach would ultimately preserve market incentives for generic/biosimilar resources and avoid spending agency time/resources negotiating a product which will have meaningful generic/biosimilar competition before an IPAY begins.

VI. Section 80: MFP Eligible Individuals

[52] *Id.* at 62.
[53] *Id.*

A. CMS should clarify that the term "MFP eligible individual" excludes an individual receiving services in a Part A hospital stay. (Section 80)

CMS states that in the case of a selected drug that is furnished to an individual enrolled under Medicare Part B (including an individual enrolled in an MA Plan) by a hospital, physician or other provider, the individual must be provided access to the MFP "*if payment may be made under Part B for* such selected drug."[54] This mirrors the underlying statutory definition of an MFP eligible individual, which with respect to a selected drug:

> *in the case such drug is furnished or administered to the individual by a hospital, physician, or other provider of services or supplier, an 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.*[55]

AstraZeneca requests that CMS clarify that manufacturers are not obligated to provide access to the MFP for a Medicare patient in a Part A stay. Notably, the statute makes no reference to Medicare Part A. In addition, while the statute requires only that "payment may be made under Part B," this does not loop in Part A utilization, which is administered in the inpatient setting and therefore not eligible for payment under Part B. This language is instead a clear reference to Medicare Advantage utilization, which involves payment under Part C for a drug that would otherwise be paid for under Part B. While we believe this position is supported by the plain text of the statute, we would appreciate CMS explicitly confirming our understanding to avoid the diversion of MFP-purchased drugs beyond the statutory scope of the Negotiation Program.

VII. Section 90: Manufacturer Compliance and Oversight

A. CMS should issue guidance to assist manufacturers with compliance and establish an enforcement policy to prevent diversion and duplicate discounts. (Section 90.2)

During a price applicability period, a Primary Manufacturer must provide MFP-eligible individuals with access to the MFP for a selected drug at the pharmacy, mail-order service, or other dispenser at the point-of-sale.[56] Additionally, the Primary Manufacturer must provide the pharmacy, mail-order service, or other dispenser with access to the MFP for the selected drug. In the Guidance, CMS proposes that Primary Manufacturers must establish safeguards to ensure that MFP-eligible individuals, pharmacies, mail-order services, and other dispensers can access the MFP on units of the selected drug for which there are Secondary Manufacturers.[57] CMS also

[54] *Id.* at 63 (emphasis added).
[55] SSA, § 1191(c)(2)(B).
[56] Guidance at 64.
[57] *Id.*

proposes to establish procedures for reporting violations related to MFP access for MFP-eligible individuals enrolled in PDPs or MA-PDs.[58]

AstraZeneca is concerned that CMS's proposed approach puts responsibility on the Primary Manufacturer for activity well beyond its control and does not address the possibility of diversion. As discussed above in section II.A of our comments, we do not see any administrative challenges with CMS separately requiring 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. Relatedly, we do not believe that Primary Manufacturers should face potential liability for the pharmacy or provider failing to provide the MFP to MFP-eligible individuals.

AstraZeneca additionally requests that CMS issue guidance to assist manufacturers with compliance (e.g., by outlining verification measures manufacturers may employ to confirm that a particular selected drug was in fact dispensed to an MFP-eligible individual, and to confirm that the drug was not subject to a 340B duplicate discount). CMS should also establish (i) an enforcement policy to take action against the diversion of selected drugs purchased at MFP by dispensing entities, and (ii) a dispute resolution process to adjudicate disputes regarding 340B duplicate discounts, in addition to a patient's or dispensing entity's claim to MFP pricing.

B. <u>CMS's proposed requirement that there must be "robust and meaningful" competition by the generic/biosimilar to exclude the branded drug from being a QSSD is not supported by statute. (Section 90.4)</u>

CMS states that, if it identifies a generic or biosimilar to a selected drug, the agency will additionally require that "robust and meaningful competition exists in the market" prior to concluding that the drug no longer qualifies as a QSSD subject to the Negotiation Program. CMS intends to make this determination based on the monitoring of PDE data and may "include whether the generic drug or biosimilar biological product is regularly and consistently available for purchase through the pharmaceutical supply chain, and whether it is available for purchase by community retail pharmacies in sufficient quantities from their wholesale suppliers."[59]

In adopting this policy, CMS relies on sections 1192(e)(1)(A)(iii) and 1192(e)(1)(B)(iii) of the Act for drug products and biological products, respectively.[60] While these provisions require that a generic or biosimilar be "marketed" in order for the branded product to lose its QSSD status, the term "marketed" is best understood consistent with its ordinary meaning, which is to "expose

[58] *Id.*
[59] *Id.* at 68.
[60] *Id.* 67-68.

for sale in a market"[61] or "to offer products for sale to buyers."[62] Nothing about the "ordinary meaning" of the term "marketed" suggests that sellers must sell the product in a "robust and meaningful" manner.[63] CMS should not operate beyond the statute by establishing a separate "robust and meaningful competition" standard. The availability of the generic/biosimilar for purchase should be sufficient to make a determination that the product is "marketed" as required by the statute. At the very least, a single sale of the generic/biosimilar product should suffice.

To our knowledge, CMS does not apply a "robust and meaningful" standard to any other aspect of its administration of the Medicare program. There are many issues that could arise in the exercise of such a standard for which CMS cannot adequately account. We are concerned that this standard is too vague for CMS to implement in a non-arbitrary manner, and it deprives manufacturers of regulatory predictability regarding the treatment of their products under the Medicare program.

VIII. Section 100: Civil Monetary Penalties

A. CMS should provide manufacturers with an opportunity to cure potential deficiencies in providing access to the MFP, in addition to generally providing more transparency regarding its enforcement policies.

CMS will impose civil monetary penalties (CMPs) on a Primary Manufacturer of a selected drug that enters into an Agreement but does not provide access to a price less than or equal to the MFP for MFP-eligible individuals, pharmacies, mail-order services, other dispensers, hospitals, physicians, or other providers or suppliers.[64] CMPs may also be levied for the provision of false information as it relates to various aspects of the Negotiation Program.[65]

AstraZeneca requests that CMS provide an opportunity for manufacturers to cure any suspected deficiencies identified by CMS prior to the imposition of CMPs. Moreover, we request that CMS provide more transparency regarding how it intends to assess and track potential violations. Specifically, CMS should create a mechanism for notification and engagement around potential concerns about the provision of MFP to MFP-eligible individuals and entities,

---

[61] Definition of "Marketed", Merriam-Webster Online Dictionary (last accessed March 25, 2023), https://www.merriam-webster.com/dictionary/marketed.
[62] Definition of "Marketed", Cambridge Dictionary Online (last accessed March 25, 2023), https://dictionary.cambridge.org/us/dictionary/english/market?q=marketed.
[63] Indeed, in other contexts in the Medicare program, CMS has interpreted the term "marketing" to simply be the date a technology becomes available on the U.S. market. *See* 79 Fed. Reg. 49854, 49931 (Aug. 22, 2014). For example, under the New Technology Add-on Payment Program, CMS can look to the market entry date of a new technology to determine the time period for which this additional payment applies. Consistently, the agency has rejected arguments from applicants related to low volume following FDA approval, stating in part, "we do not believe that case volume is a relevant consideration for making the determination as to whether a product is "new."") *See* 82 Fed. Reg. 37990, 38111 (Aug. 14, 2017).
[64] Guidance at 68.
[65] *Id*. at 70.

compliance with the Negotiation Agreement, and/or concerns about the veracity of manufacturer-submitted information.

IX. Section 110: Part D Formulary Inclusion of Selected Drugs

Within the guidance CMS restates the statutory requirement that any drug selected for negotiation, with an MFP in effect, must be covered on all Part D formularies. We believe CMS should consider additional steps to ensure that patient access to a selected drug remains in place after the product is negotiated. The entrance of negotiated products into the Part D market will undoubtedly impact payer incentives and their approach to formulary and benefit design. Therefore CMS should institute guardrails and monitoring to ensure patients retain access to negotiated products and robust formulary designs capable of providing options which continue to meet patients' needs. In particular, we recommend that CMS closely monitor plans' tiering decisions, cost-sharing levels, and patient OOP exposure for both drugs subject to an MFP and potential class alternatives in order to evaluate impacts on the quality of benefits and access.

X. Conclusion

AstraZeneca thanks you for the opportunity to submit comment regarding the Guidance and look forward to continuing to engage with CMS as it implements the Negotiation Program for IPAY2026 and beyond. I can be reached at 202-350-5542 or christine.bloomquist@astrazeneca.com with any questions.

Sincerely,

Christie Bloomquist
Vice President, US Corporate & Government Affairs

EXHIBIT 11

conducted a review of CHAP's Medicare HHA application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of CHAP's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its surveyors; (4) ability to investigate and respond appropriately to complaints against HHAs; and (5) survey review and decision-making process for accreditation;
- A comparison of CHAP's HHA accreditation standards to our current Medicare HHA conditions for participation (CoPs);
- A documentation review of CHAP's survey processes to:

++ Determine the composition of the survey team, surveyor qualifications, and CHAP's ability to provide continuing surveyor training.

++ Compare CHAP's processes to those we require of state survey agencies, including periodic resurvey and the ability to investigate and respond appropriately to complaints against accredited HHAs.

++ Evaluate CHAP's procedures for monitoring HHAs found to be out of compliance with CHAP program requirements. This pertains only to monitoring procedures when CHAP identifies non-compliance. If non-compliance is identified by a state survey agency through a validation survey, the state survey agency monitors corrections as specified at § 488.9(c)➢

++ Assess CHAP's ability to report deficiencies to the surveyed HHAs and respond to the HHA's plan of correction in a timely manner.

++ Establish CHAP's ability to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ Determine the adequacy of CHAP's staff and other resources.

++ Confirm CHAP's ability to provide adequate funding for the completion of required surveys.

++ Confirm CHAP's policies for surveys being unannounced.

++ Obtain CHAP's agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

In accordance with section 1865(a)(3)(A) of the Act, the October 20, 2017 proposed notice (82 FR 48817) also solicited public comments regarding whether CHAP's requirements met or exceeded the Medicare CoPs for HHAs. There were no comments submitted.

IV. Provisions of the Final Notice

A. Differences Between CHAP's Standards and Requirements for Accreditation and Medicare Conditions of Participation and Survey Requirements

We compared CHAP's accreditation requirements for HHAs and its survey process with the Medicare CoPs at 42 CFR part 484, and the survey and certification process requirements of 42 CFR parts 488 and 489. CHAP's standards crosswalk, which crosswalks CHAP standards to the corresponding Medicare requirements and regulations, was also examined to ensure that the appropriate CMS regulation would be included in citations as appropriate. Our review and evaluation of CHAP's HHA application, which were conducted as described in section III. of this final notice, yielded the following areas where, as of the date of this notice, CHAP has revised its survey processes so that its processes are comparable to CMS requirements:

- § 488.5(a)(4)(vii), to ensure plans of corrections (PoCs) address all non-compliant practices and include policy changes required to correct the deficient practice.
- § 488.5(a)(7) through (9), to ensure surveyors maintain current licensure, that new surveyors receive the minimum number of mentored surveys prior to surveying independently, and that all new surveyors receive a 90-day evaluation of performance.
- § 488.5(a)(12), to ensure the appropriate number of medical records are reviewed during complaint investigations.
- § 488.26(b), to ensure that survey documentation includes a detailed deficiency statement that clearly outlines the number of medical records reviewed, describes the manner and degree of non-compliance, and supports the appropriate level of deficiency citation.

B. Term of Approval

Based on the review and observations described in section III. of this final notice, we have determined that CHAP's requirements for HHAs meet or exceed our requirements. Therefore, we approve CHAP as a national accreditation organization for HHAs that request participation in the Medicare program, effective March 31, 2018 through March 31, 2024.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, record keeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

Dated: March 8, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2018–05891 Filed 3–22–18; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2397–FN]

RIN–0938–ZB29

Medicaid Program; Announcement of Medicaid Drug Rebate Program National Rebate Agreement

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: This final notice announces changes to the Medicaid National Drug Rebate Agreement (NDRA, or Agreement) for use by the Secretary of the Department of Health and Human Services (HHS) and manufacturers under the Medicaid Drug Rebate Program (MDRP). We are updating the NDRA to incorporate legislative and regulatory changes that have occurred since the Agreement was published in the February 21, 1991 **Federal Register** (56 FR 7049). We are also updating the NDRA to make editorial and structural revisions, such as references to the updated Office of Management and Budget (OMB)-approved data collection forms and electronic data reporting.

DATES:

Applicability Date: The updated National Medicaid Drug Rebate Agreement (NDRA) provided in the Addendum to this final notice will be applicable on March 23, 2018.

Compliance Date: Publication of CMS–2397–FN serves as written notice of good cause to terminate all existing rebate agreements as of the first day of the full calendar quarter which begins at least 6 months after the effective date of the updated NDRA (October 1, 2018). Manufacturers with an existing active

NDRA will have at least 2 full calendar quarters as of the effective date of this notice to sign and submit the updated NDRA. We will publish further guidance on this soon.

FOR FURTHER INFORMATION CONTACT: Terry Simananda, (410) 786–8144.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicaid Program, states may provide coverage of outpatient drugs as part of the medical assistance furnished to eligible individuals as an optional benefit as described in sections 1902(a)(10) and (a)(54) and 1905(a)(12) of the Social Security Act (the Act). Section 1903(a) of the Act provides for federal financial participation (FFP) in state expenditures for these drugs. In general, for payment to be made available under section 1903 of the Act for most drugs, manufacturers must enter into, and have in effect, a Medicaid National Drug Rebate Agreement (NDRA, or Agreement) with the Secretary of the Department of Health and Human Services (HHS) as set forth in section 1927(a) of the Act. Additionally, in order to meet the requirement for a rebate agreement in section 1927(a) of the Act, manufacturers must also meet the requirements of section 1927(a)(5) of the Act, which require a manufacturer to enter into an agreement that meets the requirements of section 340B of the Public Health Service Act, as well as section 1927(a)(6) of the Act, which requires a manufacturer to enter into a master agreement with the Secretary of Veterans Affairs in compliance with 38 U.S.C. 8126 (see section 1927(a)(1) of the Act).

Authorized under section 1927 of the Act, the Medicaid Drug Rebate Program (MDRP) is a program that includes CMS, state Medicaid Agencies, and participating drug manufacturers that helps to partially offset the federal and state costs of most outpatient prescriptions drugs dispensed to Medicaid beneficiaries. Currently there are more than 650 drug manufacturers who participate in the MDRP. The NDRA provides that manufacturers are responsible for notifying states of a new drug's coverage. Manufacturers are required to report all covered outpatient drugs under their labeler code(s) to the MDRP and may not be selective in reporting their national drug codes (NDCs) to the program. Manufacturers are then responsible for paying a rebate on those drugs that were dispensed and/or paid for, as applicable, under the state plan. These rebates are paid by manufacturers on a quarterly basis to states and are shared between the states and the federal government to partially offset the overall cost of prescription drugs under the Medicaid Program.

Similarly, manufacturers that wish to terminate an NDRA that have active covered outpatient drugs must request termination for all associated labeler codes, and provide a reason for the request (for example, all covered outpatient drugs under the labeler code are terminated), or if the request for termination is only for certain labeler codes, provide justification for such request. Additionally, as with the current policy, for purposes of ensuring beneficiary access to single source drugs and/or drugs that are not otherwise available in the MDRP, we may choose to grant an exception to issuing or reinstating an NDRA for certain labeler codes of a manufacturer prior to issuing an NDRA for all of the labeler codes under the manufacturer, or terminating certain labeler codes as mentioned above.

II. Summary of Proposed Provisions and Analysis of and Responses to Public Comments on the Proposed Notice

In the proposed notice, published in the November 9, 2016 **Federal Register** (81 FR 78816), we provided a draft agreement updating the NDRA to reflect the changes in the Covered Outpatient Drug final rule with comment period that was published in the February 1, 2016 **Federal Register** (81 FR 5170), as well as operational and other legislative changes that have occurred over the last 20 plus years since the NDRA was first issued in 1991. We indicated in the proposed notice that a sample of the finalized NDRA would be posted on the CMS website after we considered the public comments and published the final notice.

In the proposed notice, we included in the Addendum, a draft of the updated NDRA for use in the MDRP, upon which we requested public comment. In the proposed notice, we indicated that if adopted, a drug manufacturer that seeks Medicaid coverage for its drugs would need to enter into the NDRA with the Secretary agreeing to provide the applicable rebate on those drugs for which payment was made under the state plan. The NDRA is not a contract. Rather, it should be viewed as an opt-in agreement that memorializes the statute and regulations. Therefore, we noted our intention to use the updated NDRA as a standard agreement that will not be subject to further revisions based on negotiations with individual manufacturers. For a complete and full description of the draft agreement of the NDRA, see the ''Addendum—Draft Agreement: National Drug Rebate Agreement Between the Secretary of Health and Human Services (Hereinafter referred to as ''the Secretary'') and the Manufacturer'' published in the proposed notice in the November 9, 2016 **Federal Register** (81 FR 78818 through 78835).

In response to the publication of the November 9, 2016 proposed notice, we received 13 timely public comments, some of which are beyond the scope of our proposals in that notice and will not be summarized and included in our responses below. Revisions made to the NDRA in response specific comments are noted in the applicable response to comments. Additionally, edits have been made to provide further clarity to the NDRA. A summary of revisions and edits made to the NDRA are provided as a summary to each section below. The following are a summary of the relevant public comments that we received related to the proposed notice, and our responses to the public comments.

A. Section I. Definitions

1. General Comments

Comment: One commenter is concerned that it may be overly cumbersome to require the user of the Agreement to look up the referenced regulations to determine the definitions of the terminology used in the Agreement. The commenter suggested that CMS update the text of the definitions and reference existing statute and regulations, rather than just putting forward the latter. In particular, the commenter noted that its recommendation would be most usefully applied to the definitions of the following terms: ''average manufacturer price (AMP),'' ''best price,'' ''covered outpatient drug,'' ''monthly AMP,'' ''quarterly AMP,'' and ''rebate period.''

Response: We disagree with the commenter that the text of the definitions, and references to the relevant statutory and/or regulatory citations, be included in the definitions. We prefer to refer to statute and/or regulations, as well as agency guidance, as opposed to repeating such language in the NDRA, as we believe this decreases the chance of inaccurate or conflicting NDRA text. Additionally, although the updated NDRA cites definitions implemented most recently in the Covered Outpatient Drug final rule with comment period (Final Rule) published in the **Federal Register** on February 1, 2016 (81 FR 5170), and codified in 42 CFR part 447, subpart I, we believe that subsequent statutory and/or regulatory changes are

incorporated by section VIII.(a). of the Agreement, which provides that the Agreement is subject to any changes in the Medicaid statute or regulations that affect the rebate program.

Restore Depot Price and Single Award Contract Price Definitions

Comment: A few commenters recommended that CMS not delete the definitions of ''Depot Price'' and ''Single-Award Contract Price'' from the Agreement as these terms are used but not defined in the MDRP statute and regulations. Specifically, the commenters stated that the MDRP statute defines best price to exclude ''Depot Price'' and ''Single-Award Contract Price.'' These same terms are used in the regulatory definitions of best price and AMP, however they are not defined anywhere except in the current NDRA. Therefore, the commenters recommended that CMS maintain the current definition of ''Depot Price'' and ''Single-Award Contract Price'' in the NDRA.

Response: We agree with the commenter that the definitions of ''Depot Price'' and ''Single-Award Contract Price'' should be retained in the NDRA as they are used in determination of best price and AMP but are not defined anywhere except for the NDRA. In addition, since we are retaining the definition of ''Single-Award Contract Price'', we will also retain the definition of ''Single-Award Contract.'' These definitions are being retained without any revisions. The definitions read as follows:

- ''*Depot Price*'' means the price(s) available to any depot of the federal government, for purchase of drugs from the Manufacturer through the depot system of procurement.
- ''*Single-Award Contract*'' means a contract between the federal government and a Manufacturer resulting in a single supplier for a Covered Outpatient Drug within a class of drugs. The Federal Supply Schedule is not included in this definition as a single award contract.
- ''*Single-Award Contract Price*'' means a price established under a Single-Award Contract.

2. Marketed

Comment: One commenter recommended that CMS retain the original NDRA definition of ''marketed'' so that the base date AMP ties to a sales transaction from which pricing data can be captured. The commenter noted the phrase ''first available for sale'' could be interpreted in a number of ways, including the date the drug receives Food and Drug Administration (FDA) approval, or when finished goods are ready to ship. Furthermore, the commenter stated that a first sale transaction might not occur for some time after those dates.

Response: While the commenter used the phrase ''first available for sale'' in its comment, the definition of ''marketed'' in the proposed notice does not include the word ''first.'' Rather it states that marketed means that a covered outpatient drug is available for sale by the manufacturer in the states (81 FR 78818). We believe the use of the phrase ''available for sale'' in the definition of ''marketed'' is consistent with past operational guidance issued by us regarding manufacturer reporting of base date AMP (see Manufacturer Release #69, in the manufacturer frequently asked questions (FAQs) section where we provide information in the answer A3 concerning the correct reporting of Market Date.) Therefore, we are retaining and finalizing this definition as provided in the proposed notice. Program Releases are available on *www.Medicaid.gov*.

3. State Drug Utilization Data

Comment: A few commenters supported the proposed definition of State Drug Utilization Data because it described the utilization on which rebates are due, and explicitly specified that the state invoice data must exclude drugs purchased under the 340B program. However, the commenters recommended that CMS make the following changes:

- Add the phrase ''consistent with the Unit Type reported by the manufacturer, for the NDC'' to the definition to minimize the significant volume of Unit of Measure disputes generated by state submissions of claimed units in forms different from the types reported by the manufacturers.
- Delete the phrase ''state utilization data is supplied on the CMS–R–144 form (that is, the state rebate invoice)'' because the format and data provided by the states on CMS–R–144 are not sufficient for accurate and timely validation of state claimed units submitted for rebate payments.
- Clarify that such data must exclude any Part D drug utilization by dual eligible individuals, in accordance with section 1935(d)(1) of the Act because some states are reimbursing Part D copayments for dual eligible individuals and are including these copayments in state utilization data.

Accordingly, the commenters suggested modifying the definition of ''State Drug Utilization Data'' to read, ''the total number of both fee-for-service (FFS) and managed care organization (MCO) units of each dosage form and strength, consistent with the Unit Type reported by the manufacturer for the NDC, of the manufacturer's covered outpatient drugs reimbursed during a rebate period under a Medicaid State Plan, other than units dispensed to Medicaid beneficiaries that were purchased by covered entities through the drug discount program under section 340B of the Public Health Service Act and other than units of Part D drugs dispensed to Medicare and Medicaid dual eligibles.''

Response: We disagree with the commenter that the proposed definition of ''State Drug Utilization Data'' should be changed to read, ''consistent with the Unit Type reported by the manufacturer for the NDC.'' Manufacturers do not always report the correct Unit Type for an NDC, and the state's drug utilization data reporting may serve to open the necessary dialogue to make manufacturers aware of the need to report the correct Unit Type, or to discuss the need for the state or the manufacturer to perform a conversion prior to rebate billing or payment.

We further disagree with the commenter's suggestion to delete reference to the CMS–R–144 because that is the Office of Management and Budget (OMB)-approved format and fields to be included on the state's quarterly rebate invoice. The CMS–R–144 is not considered claims-level data (CLD), the exchange of which is sometimes necessary for rebate payment validation purposes.

Finally, we disagree that adding a specific Medicare Part D exclusion is necessary since manufacturers have the right to dispute claims they believe are ineligible for rebate. If states and manufacturers cannot resolve disputes on their own, either party may ask the MDRP Dispute Resolution Program (DRP) team to assist by contacting the CMS Regional Office (RO) DRP Coordinator (a list of the RO DRP Coordinators can be found on *www.Medicaid.gov*).

Comment: One commenter requested that the definition of State Drug Utilization Data be strengthened to explicitly exclude units dispensed to Medicaid beneficiaries that were purchased by covered entities through the 340B program and incorporate specifics into the definition including timeframe in which data must be provided, with cross references to later sections of the rebate agreement, and include the following data elements: Date of service (DOS), prescription number, and billed amount.

Response: We updated the language in the proposed NDRA to explicitly

exclude units dispensed to Medicaid beneficiaries that were purchased by covered entities through the drug discount program under section 340B of the Public Health Service Act (PHSA). We believe this reference is sufficient. As this is an agreement between the Secretary and the manufacturer, not the state, we do not believe it is necessary to include the statutory timeframe for states to transmit the CMS–R–144, or rebate invoice. However, section III.(a)., ''Secretary's Responsibilities'' does include reference to the 60-day timeframe for state reporting of utilization data. Additionally, DOS, prescription number, and billed amounts are not required to be reported on the CMS–R–144; however, manufacturers may request the minimum CLD required to validate the utilization data received from the state. As discussed in Manufacturer Release #95 and State Release #173, we continue to encourage the exchange of the minimum CLD in such situations. Program Releases are available on *www.Medicaid.gov*.

Comment: One commenter expressed concern that the exclusion of 340B-purchased drugs from the definition of State Drug Utilization Data may be misunderstood by 340B covered entities as absolving the covered entities of their responsibility to avoid duplicate discounts under the 340B program, and instead placing such responsibility exclusively on state Medicaid agencies. The commenter further recommended that when updating the definition of State Drug Utilization Data in the Agreement, CMS should express that the update in no way affects the covered entities obligation under the 340B program to avoid duplicate discounts. The commenter further noted that while the administration of the 340B program is primarily the responsibility of the Health Resources and Services Administration (HRSA), the commenter asserted that section 1927(a)(5)(C) of the Act indicates that CMS shares responsibility for providing guidance to 340B covered entities on how to avoid duplicate discounts. The commenter requested that CMS take additional steps to guide 340B covered entities by establishing, in the Medicaid managed care context, a uniform means for 340B claims to be identified, as well as establish specific procedures for states, Medicaid MCOs, and 340B covered entities to follow to ensure that 340B claims are excluded from the data submitted to manufacturers for request rebates.

Response: We disagree that we should discuss 340B covered entity requirements in the NDRA, because those requirements are appropriately communicated by HRSA, the agency that is responsible for administration and oversight of the 340B program. We continue to work with HRSA, manufacturers, states, data vendors, PBMs, and other interested parties to try to identify and ensure exclusion of 340B FFS and MCO units from rebate billing.

Comment: One commenter stated that CMS should revise the definition of State Drug Utilization Data to specifically refer to the statutory prohibition on duplicate discounts in section 340B(a)(5)(A) of the PHSA. The commenter further recommended that CMS reference the duplicate discount prohibition in every instance throughout the revised NDRA in which it is implicated, emphasizing the need for states to request rebates only on FFS and MCO covered outpatient drugs that have not been purchased under the 340B program.

Response: While we appreciate the commenter's concern regarding duplicate discounts, we do not believe that the NDRA is the appropriate avenue to remind states of their obligation to exclude both FFS and MCO 340B claims from their manufacturer rebate requests, as the NDRA is an agreement that applies to manufacturers, not the states. Furthermore, while we added reference to the specific exclusion of 340B units from State Drug Utilization Data, we do not believe that it is necessary, as suggested by the commenter, to add a specific reference to section 340B(a)(5)(A) of the PHSA.

Comment: One commenter recommended that CMS incorporate additional specifics into the definition of State Drug Utilization Data to guide its operationalization including both the applicable timeframe in which the state's drug utilization data must be provided—states are often able to provide drug utilization data within a 7-calendar day timeframe—and the following list of *minimum* claims-level data elements that should be provided: Provider ID; Provider Name and Address; Date of Service; Paid Date; Billed Amount; Prescription Number; and National Drug Code (NDC) 11. Other data elements that the commenter recommended CMS should include in this minimum set are: Original claim quantity; conversion factor; invoice quantity; Healthcare Common Procedure Coding System (HCPCS) code; claim type; days' supply; allowed amount; third-party amount reimbursed; Dispensed-As-Written (DAW) indicator; and Medicaid plan name and identification number (BIN/Processor Control Number). The commenter further recommended that these data be made available in a standardized, downloadable format, and should be provided in addition to those indispensable data elements that are already consistently made available by states.

Response: As this is an agreement between the Secretary and the manufacturer, and not the state, we do not believe it is necessary nor appropriate to include the statutory timeframe for states to transmit the CMS–R–144, or rebate invoice; however, section III.(a)., ''Secretary's Responsibilities'' does include reference to the 60-day timeframe for state reporting of utilization data. We disagree with the commenter that there is a minimum set of CLD that should be expected along with State Drug Utilization Data, as different CLD fields are needed depending on variables such as provider setting, third-party co-pays, and the type of dispute or potential dispute. We continue to encourage states to share the appropriate minimum CLD for payment validation purposes on a case-by-case basis.

4. Unit

Comment: A few commenters disagreed with our proposed change to the definition of ''unit'' from ''drug unit in the lowest identifiable amount'' to ''drug unit in the lowest dispensable amount'' and the removal of the examples in the current definition (for example, tablet, capsule, milliliter, and gram). The commenters stated that the change to ''lowest dispensable amount'' does not define nor clearly address the two product unit data elements reported by manufacturers to CMS and is not consistent with current CMS guidance, including Drug Data Reporting for Medicaid (DDR) system Data Guides, where CMS provides that manufacturers use eight unit types: Injectable anti-hemophilic factor; capsule; each; gram; milliliter; suppository; tablet; and transdermal patch. The commenters suggest renaming ''unit'' to ''unit type'' and adding the specific eight reporting types for consistency with CMS manufacturer product reporting requirements. Specifically, one commenter suggested that ''Unit Type'' means ''one of the eight possible unit types by which the covered outpatient drug, form, and strength will be dispensed, as reported by the manufacturer consistent with the product reporting instructions from CMS (CMS 367–c). The eight possible unit types are injectable anti-hemophilic factor, capsule, each, gram, milliliter, suppository, tablet, and transdermal patch.''

The commenter indicated that if CMS does not accept the suggested changes, then CMS should explain the purpose of the change and whether it implies any change in the unit types reported by manufacturers because the ''unit type'' selected by the manufacturer is the basis for the pricing metrics data and unit rebate amount (URA) calculation.

Response: While we appreciate the comments, we have decided to retain the changes to the definition of ''Unit,'' set forth in the proposed notice as we believe this is more accurate and descriptive of what states receive on their claim than ''lowest identifiable amount.'' We are not including any of the eight specific unit types that are currently used, as those are subject to being updated by operational instruction, including DDR system Data Guides. Our intent is to update the NDRA as appropriate and ensure that we are able to keep pace with the changes in drug delivery processes and manufacturer and drug innovation. We seek to ensure that manufacturers that need a change in unit types based on future products are able to participate in the MDRP and to report their prices accurately in conjunction with necessary unit types, and that our beneficiaries have access to such drugs. ''Unit'' is meant to identify the lowest dispensable ''Units Per Package Size'' field of the ''Unit Type'' reported on the CMS–367. This is meant to better clarify the manufacturer's drug product reporting requirements.

5. Unit Rebate Amount (URA)

Comment: One commenter agreed with the proposed definition of ''Unit Rebate Amount'' as ''the computed amount to which the state drug utilization data is applied by states in invoicing the manufacturer for the rebate payment due,'' but recommended that CMS include additional text indicating CMS's longstanding position that manufacturers remain solely responsible for calculating the URA that is necessary to pay a rebate. Similarly, another commenter suggested that CMS clarify in the definition of ''Unit Rebate Amount'' that this is the amount computed ''by CMS'' to which the State Drug Utilization Data is applied by states and that CMS provide this URA information to states as a courtesy and drug manufacturers remain responsible for correctly calculating the URA for their covered outpatient drugs. The commenter stated this is important because manufacturers face Civil Monetary Penalties and potential False Claims Act liability for any late or misreported prices, and that there are adequate safeguards in place to ensure manufacturer compliance.

Response: We do not believe it is necessary to add language to the definition of ''Unit Rebate Amount'' to specify the manufacturer's responsibility to calculate a URA for each covered outpatient drug for which a state made a payment, or was dispensed, in a rebate period. However, we agree that the manufacturer's responsibility to calculate a URA should be strengthened, and this is carried out in section II, ''Manufacturer's Responsibilities.'' Therefore, in this updated NDRA, we are revising section II.(b)., by changing the last sentence of the proposed paragraph to state that ''[f]urthermore, except as provided under section V.(b). of this agreement, manufacturers are required to calculate a URA and make a rebate payment in accordance with each calculated URA to each State Medicaid Agency for the manufacturer's covered outpatient drug(s) by NDC paid for by the state during a rebate period.'' Additionally, we have added the following sentence to the end of the paragraph to further clarify our calculation of the URA: ''CMS may calculate a URA based on manufacturer-submitted product and pricing data and provide the URA to states in order to facilitate rebate billing. However, CMS's URA calculation does not relieve the manufacturer of its responsibility to calculate the URA.''

B. Section II. Manufacturer's Responsibilities

1. Point of Contact

Comment: Several commenters suggested allowing manufacturers the flexibility to identify more than one contact related to rebate invoice issues. Another commenter recommended that CMS clarify that the reference to a single point of contact refers only to a contact for rebate invoice issues. The commenters suggested that CMS develop more flexible language to allow manufacturers to identify more than one point of contact or permit a general mailbox for communications. Another commenter indicated that CMS should consider establishing both primary and secondary points of contact to ensure consistency of communication between the state and manufacturers in the event the designated contact becomes unavailable. The commenters stated such flexibility would facilitate communication between states and manufacturers while allowing for differences in business models and accommodating the reality of turn-over and employee absences or non-availability.

Response: The CMS–367(d) allows the manufacturer to identify one main contact for each of the following issues: Legal, Invoice, and Technical, and the NDRA has been updated at section II.(a). to specify the three contacts required on the CMS–367(d). Therefore, section II.(a). will now specifically state that ''[t]he manufacturer shall identify an individual point of contact for the Legal, Invoice, and Technical contacts at a United States address to facilitate the necessary communications with states with respect to rebate invoice issues.''

The requirement of the three official manufacturer contacts is to ensure accountability and to facilitate communications between CMS, the states, and manufacturers regarding all aspects of the MDRP. Manufacturers and states often exchange additional contacts with each other; however, for purposes of the MDRP, only one official contact will be submitted for each of the manufacturer's roles. In an effort to ensure there are no delays regarding invoice processing and rebate payments, we allow a general email address to be listed for the invoice contact, but requires that a direct contact name and telephone number be submitted on the CMS–367(d) for the official contact. The official Legal and Technical Contacts are required to list their direct email address and telephone numbers. Although it is the manufacturer's responsibility to ensure that their official contacts on file with CMS are updated at all times, many manufacturers do not update the official contacts on file in a timely manner. It is especially important for manufacturers to notify CMS of Technical Contact changes since the CMS's MDRP staff includes the manufacturer's Technical Contact on all communications with the manufacturer to ensure that the manufacturer's Technical Contact is aware of what is being requested by others with respect to its data.

2. Manufacturer Price Reporting and Rebate Payments

Comment: A few commenters recommended that CMS clarify that a rebate payment under the NDRA is only due on covered outpatient drugs paid for by the state ''under a Medicaid State Plan or approved waiver program'' or ''under Medicaid'' since some states have multiple, non-Medicaid programs under which they pay for covered outpatient drugs.

Response: We agree with the commenter that rebates negotiated as part of a state-only pharmacy program are not subject to the rebate provisions. We believe that the introductory

language of section II., ''Manufacturer's Responsibilities,'' offers these assurances where it provides that ''[i]n order for the Secretary to authorize that a state receive payment for the manufacturer's drugs under Title XIX of the Act, 42 U.S.C. Section 1396 *et seq.,* the manufacturer agrees to the requirements as implemented by 42 CFR 447.510. . .'' Therefore, if a manufacturer receives a request for payment under this agreement that it does not believe is billed under federal Medicaid, we recommend the manufacturer contact the state for clarification.

3. Reporting Inner and Outer NDCs

Comment: A few commenters did not support the additional language that manufacturer drug product pricing reports must ''include all applicable NDCs identifying the drug product which may be dispensed to a beneficiary, including package NDCs (outer package NDCs and inner package NDCs).'' One commenter indicated that sales are based upon the outer NDC, therefore, CMS should remove the language indicating manufacturers have to report information on both inner and outer package NDCs. Another commenter disagreed with using the undefined and often misconstrued terms for describing product NDC–11s as ''outer package'' and ''inner package'' because reporting extraneous information increases the risk of potential error.

In particular, the commenter recommended that we delete the last sentence in section II.(c). which states, ''Reports to CMS should include all applicable NDCs identifying the drug product which may be dispensed to a beneficiary, including package NDCs (outer package NDCs and inner package NDCs)'' and replace it with the following, ''Manufacturer product data reporting to CMS should include all applicable NDCs identifying the drug product, as available for product sales in the states and as listed on the product label, which may be dispensed to a beneficiary.''

Response: We disagree with the comments summarized above in which commenters do not support the addition of the language in II.(c). regarding the inclusion of inner and outer NDCs for package NDCs be reported to us. We issued agency guidance clarifying the requirement for reporting of inner and outer NDCs in Manufacturer Release #106 and State Release #183. Manufacturer sales of NDCs do not determine whether the NDC is reported to us, or the NDC's status as a covered outpatient drug. As we indicated in the above releases, in accordance with section 1927(b)(3)(A) of the Act, manufacturers that have signed a rebate agreement are required to report certain pricing information for all covered outpatient drugs. As was stated in the aforementioned guidance, manufacturers must report all of their NDCs that meet the definition of a covered outpatient drug as described in statute at sections 1927(k)(2) through 1927(k)(4) of the Act, and regulation at § 447.502, to ensure compliance with the applicable reporting and payment requirements.

Also, in accordance with section 1927(b)(1)(A) of the Act, such manufacturers are required to make rebate payments for covered outpatient drugs dispensed after December 31, 1990, for which payment was made under the state plan for such a period. This includes drugs dispensed to Medicaid MCO enrollees. Additionally, per 1927(b)(2)(A) of the Act, states are required to report to manufacturers at the end of each rebate period, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made or which was dispensed under the plan, including information reported by each Medicaid managed care organization. Therefore, if a state has reimbursed a provider for FFS claims for an inner NDC, or if an inner NDC was dispensed for an MCO claim, the state is required to report or invoice the inner NDC to the manufacturer, and the manufacturer is subsequently required to pay rebates in accordance with section 1927(b)(1)(A) of the Act.

We further disagree that describing an NDC as an inner or outer NDC could be misconstrued, or that reporting information on both inner and outer NDCs is extraneous and could lead to potential errors. As noted above, we believe both NDCs may be evaluated as covered outpatient drugs, and if an NDC is a covered outpatient drug, then it should be reported as our guidance further clarifies. In other words, when states receive a claim from and pay a provider for dispensing an inner NDC, the state is required to invoice the manufacturer for that NDC and the manufacturer is subsequently required to pay rebates in accordance with 1927(b)(1)(A) of the Act. Program Releases are available on *www.Medicaid.gov.*

Comment: One commenter requested that CMS clarify the purpose of the following text, proposed for addition in section II.(c). to read, ''CMS uses drug information listed with FDA, such as Marketing Category and Drug Type, to be able to verify in some cases that an NDC meets the definition of a covered outpatient drug . . . [.]'' The commenter stated that this statement may be unnecessary and could lead to confusion if not omitted from the updated NDRA revision. In the absence of such a clarification, the commenter recommended CMS delete this clause.

Also with regard to section II.(c)., the commenter requested that CMS clarify whether the ''reports'' referenced in the text—that is, ''[r]eports to CMS should include all applicable NDCs identifying the drug product . . .''—are meant to be distinct from reports adding product information into the DDR system. The commenter noted this clarification is necessary given that, currently, products must be listed with the FDA before being added to the DDR system.

Response: We have decided to remove the phrase ''in some cases'' from the sentence regarding use of FDA information so that the provision now reads, ''CMS uses drug information listed with FDA, such as Marketing Category and Drug Type, to be able to verify that an NDC meets the definition of a covered outpatient drug . . . [.]'' We believe that the use of the phrase ''in some cases'' is neither necessary nor consistent with the discussion surrounding covered outpatient drugs in the final rule (81 FR 5184). We believe that when the entire sentence is considered (that is, ''CMS uses drug information listed with FDA, such as Marketing Category and Drug Type, to be able to verify that an NDC meets the definition of a covered outpatient drug, therefore, manufacturers should ensure that their NDCs are electronically listed with FDA.''), it is clear to manufacturers how we use drug information listed with FDA, and why it is in a manufacturer's best interests to ensure that their NDCs are electronically listed with FDA. Manufacturers should ensure that their NDCs are electronically listed with FDA for us to have access to information to be able to verify that an NDC meets the definition of a covered outpatient drug.

As for the commenter's request for clarification on the ''reports to CMS'' reference, this text is meant to instruct manufacturers to report all NDCs to CMS that may be dispensed to a beneficiary. This includes, but is not limited to NDCs on inner components within a larger container, if that NDC on the inner component represents a drug that meets the definition of a covered outpatient drug. NDCs must be listed with FDA in order for a manufacturer to be able to certify the product data in DDR. Manufacturers may contact

mdroperations@cms.hhs.gov if they encounter difficulty with this requirement.

4. Quarterly Pricing Adjustment Reporting

Comment: Several commenters stated that the proposed language in section II.(d). could be read to require that manufacturers restate their AMP, best price, customary prompt pay discount data, and nominal price data within 30 days of the end of each quarter in which any adjustment can be made in the last-reported figures. The commenters recommended that CMS not finalize this provision because a requirement to make restatements each quarter whenever an adjustment can be made conflicts with the current regulations at 42 CFR 447.510(b) which provide that ''a manufacturer must report to CMS any revision to AMP, best price, customary prompt discounts, or nominal prices for a period not to exceed 12 quarters from the quarter in which the data were due. Any revision request that exceeds 12 quarters will not be considered . . . A manufacturer must report revised AMP within the 12-quarter time period, except when the revision would be solely as a result of data pertaining to lagged price concessions.''

The commenters noted that the regulation does not require that restatements be filed more than once within that 3-year window—only that the information must be restated by the end of the window. The commenters stated that our proposed language could conflict with the regulations and eliminate the flexibility the regulations provide to manufacturers regarding the timing of restatements, as it suggests that manufacturers would be required to make restatements more frequently than required by the regulations. To ensure that the Agreement aligns with the regulations, the commenters recommended that CMS not finalize this proposed change.

Response: We agree with the commenters that this phrase as originally worded could be misinterpreted. Therefore, we are revising the last sentence of section II.(d). to state that ''adjustments to all prior quarterly pricing data must be reported for a period not to exceed 12 quarters from when the pricing data were originally due as required under § 447.510(b).''

5. Increases and Decreases of Rebate Payment Amounts

Comment: Several commenters disagreed with our proposal to add the following sentence to section II.(f).: ''To the extent that changes in product, pricing, or related data cause increases to previously submitted total rebate amounts, the manufacturer will be responsible for timely payment of those increases in the same 30-day time frame as the current rebate invoice.'' The commenters stated that rebate payments must be adjusted when information changes causing either increases or decreases in previously submitted total rebate amounts and the Agreement must address both scenarios to be consistent with existing standards and that manufacturers continue to be entitled to recoup rebate overpayments as well.

Response: The purpose of this addition to section II.(f). is to state the manufacturers obligations when pricing or product data changes submitted by the manufacturer cause an increase in the amount owed to the state from previously paid rebate amounts. Manufacturer Release #58 provided guidance clarifying that interest applies when manufacturers fail to pay increases due to Prior Period Adjustments (PPAs) timely, and this is reflected in the proposed and updated NDRA. Program Releases are available on *www.Medicaid.gov.*

When PPAs cause a decrease to the amount of rebates previously paid by manufacturers, states will issue a credit upon agreement with the manufacturers about where the manufacturer would like the credit applied. To facilitate timely credits being applied by states, we encourage manufacturers to communicate which NDC line item(s) the credit(s) should be applied to with states. In response to public comment, and consistent with existing guidance, we have revised the updated NDRA at section II.(f). to add: ''To the extent that changes in product, pricing, or related data cause decreases to previously submitted total rebate amounts, the manufacturer should communicate with the states regarding where to apply the line-item (NDC-level) credit.'' to the end of the paragraph. Furthermore, we continue to encourage manufacturers and states to work together to ensure that appropriate payments are made, and credits applied, timely.

Comment: One commenter requested that CMS explain what changes cause decreases to previously submitted total rebate amounts.

Response: As previously stated, when PPAs cause a decrease to the amount of rebates previously paid by manufacturers, states will issue a credit upon agreement with the manufacturers about where the manufacturer would like the credit applied. We continue to encourage manufacturers and states to work together to ensure that appropriate payments are made, and credits applied, timely.

Comment: A few commenters urged CMS to clarify that the 30-day rebate does not conflict with the existing guidance provided under the Medicaid Rebate Data Guide for Labelers (April 2016), which provides that timely rebate payments must be made within 37 calendar days from the date a state receives the adjustment from CMS on the current quarterly URA data file. CMS should clarify that the existing policy permitting manufacturers to make rebate payments within 37 calendar days from the rebate invoice postmark date remain intact. Any confusion to the timeline for rebate payment could have a significant, negative operational impact on manufacturers and create additional administrative burden for manufactures, states, and CMS.

The commenters further noted that CMS recently reminded manufacturers of this ''38th day rule'' in a March 10, 2014 Program Notice, which stated that: ''[f]or purposes of calculating interest on late rebate payments, previously issued guidance (for example, Manufacturer Release #7 and State Release #29) has noted that manufacturers have 37 calendar days (as evidenced by the postmark by the U.S. Postal Service on the envelope) to pay rebates before interest begins to accrue.''

The commenters recommended that the updated NDRA include a new subsection (g) to follow the revised subsection (f) in which the 30-day payment requirement is stated (all other subsections re-lettered accordingly) to read, ''(g) For purposes of calculating interest on late rebate payments, manufacturers have 37 calendar days to pay rebates before interest begins to accrue. Based upon the state's invoice transmission method, manufacturers should use the state's email notification date, or the postmark by the U.S. Postal Service on the envelope.''

Response: While we appreciate the comment, we do not believe that the NDRA is the appropriate vehicle to relay such operational guidance. However, we are clarifying that the statutory requirements have not changed, nor has the language from the current rebate agreement, with respect to the rebate payment being made by the manufacturer in the proposed NDRA. The operational guidance relating to interest application after the 37th day from the postmark date of the invoice can be found in various Program Releases, including State Releases #29, and #166, as well as Manufacturer Release #7. Program Releases are available on *www.Medicaid.gov.*

Comment: One commenter requested revisions to section II.(f). to identify the parties' respective responsibility in the event that changes in product, pricing, or related data cause decreases to previously submitted total rebate amounts, and any credits to the manufacturer that may occur as a result of such decreases. The commenter noted CMS should clearly establish a single process and timeline for resolving changes in data regardless of whether they result in decreases or increases in the submitted total rebate amounts.

Response: As stated in previous responses to comments on decreases in rebate liability necessitated by manufacturer changes to pricing and/or product data, manufacturers are responsible for informing states to which line-item credits are to be applied. State responsibility is not included in the NDRA as the agreement is between the manufacturer and the Secretary and is not the appropriate vehicle for such guidance.

6. Comply With Statute, Regulation, Agency Guidance and Rebate Agreement

Comment: Several commenters noted that CMS should not include ''agency guidance'' among the items listed in section II.(g). as such a provision would circumvent the Administrative Procedures Act (APA), exceed the Secretary's authority under the Medicaid statute, be inconsistent with fundamental principles of contract law, fundamentally unfair, and over broad. The commenters further noted that under the APA, subregulatory guidance does not have the force of law and is not binding. Furthermore, commenters have indicated that the Medicaid rebate statute does not authorize CMS to override the APA, which serves to ensure that binding law is issued through a careful, deliberative process with stakeholder input.

Response: We do not believe that including a reference to agency guidance in this provision implicates the APA. Agency guidance is a reference to the interpretive guidance published by the agency, interpreting the Medicaid Drug Rebate statute and implementing regulations. Including a reference to ''agency guidance'' in this provision in the Agreement is simply a term of the Agreement, and does not suggest that agency guidance carries the force of law, as statutes and regulations do so. Therefore, we have retained ''agency guidance'' in section II.(g). of the rebate agreement.

Comment: A few commenters did not agree with our deletion of the requirement that CMS provide ''actual prior notice to the manufacturer'' before the manufacturer has to meet any change in its compliance obligations. The commenters were concerned that the lack of notice only exacerbates the concern over the addition of ''agency guidance'' to this provision in section II.(g). of the NDRA and as a result, even when manufacturers regularly check on their compliance obligations, they may not succeed in complying with all changes to agency guidance obligated to do under the updated NDRA. The commenters requested that CMS finalize the NDRA with such a notice requirement restored.

Response: We disagree with the commenters that this language remains necessary in the NDRA, as the laws and recently implemented final regulations provide the legal framework for the program. Furthermore, as stated previously, agency guidance is a reference to the interpretive guidance published by the agency, interpreting the Medicaid Drug Rebate statute and implementing regulations. Including a reference to ''agency guidance'' in this provision in the Agreement is simply a term of the Agreement, and does not suggest that agency guidance carries the force of law, as statutes and regulations do.

C. Section III. Secretary's Responsibilities

1. States' Reporting of Drug Utilization Information

Comment: Several commenters were concerned that the language CMS proposed in section III.(a). appears to weaken states' reporting requirements, could impact the reporting of state drug utilization data and conflicts with the Medicaid statute. While commenters acknowledged that CMS are the party to the NDRA, not states, and therefore could not bind states via the NDRA, they asserted that CMS must maintain consistency between the NDRA and the statute, which is binding on the states. Therefore, the commenters noted that CMS should incorporate state obligations by reference or specifically quote section 1927(b)(2)(A) of the Act instead of adopting language that differs substantively from the statute.

The commenters further noted that CMS should use the term ''shall,'' since it is consistent with the statutory requirement, rather than the draft revised NDRA's more permissive ''employ best efforts'' language. The commenters believe the revised text ''employ best efforts'' is open for broad interpretation, and as such lends significant uncertainty to the exact CMS activities that will be undertaken to ensure state compliance with rebate invoice reporting requirements. The commenters noted that CMS should strengthen the language to reflect our responsibility to ensure state's compliance with the applicable statutory provisions. However, if CMS continue to use the language ''employ best efforts'' in the updated NDRA, the commenters urged CMS to issue draft guidance simultaneously to the finalization of the NDRA to provide manufacturers with a more concrete definition of how the Agency will comply with existing statutory obligations.

Response: We agree with the commenter and are updating section III. of the NDRA to reflect that state utilization data are due no later than 60 days from the end of the rebate period. While we appreciate the comments, we do not believe that the description in section III.(a). of the proposed NDRA of the Secretary's responsibilities in regards to states reporting requirements to manufacturers conflicts with the statute. Section 1927(b)(2)(A) of the Act provides the 60-day timeframe for the states reporting obligations under the MDRP to provide relevant information in a format established by the Secretary and section III.(a). reflects that requirement. The rebate invoice (CMS–R–144) or alternative information described is that established format. Furthermore, we believe that the updated section III.(a). does not weaken states' reporting requirements because states are not subject to the agreement. States that opt to cover drugs are subject to applicable statutory, regulatory and sub-regulatory guidance. While we updated the paragraph in the proposed NDRA to be more inclusive of details, we have not changed or noted a change in state process. Additionally, we disagree that retaining the language that the Secretary ''. . . will employ best efforts,'' which is similar to language in the current rebate agreement, is contradictory to the statute or that it will lead to confusion and be open for misinterpretation. The NDRA is an agreement between the Secretary and the manufacturer, and is not the appropriate vehicle to specifically address state reporting requirements.

Comment: One commenter urged CMS to revise the new language at section III.(a). to eliminate any perception that the timeliness requirements apply only to FFS rebate claims since the new language refers to information about Medicaid utilization of covered outpatient drugs that were ''paid for'' during the rebate period. The commenter noted that CMS distinguishes between manufacturer

rebate obligations which accrue for FFS units based on the date of payment to pharmacies and MCO units based on the date of dispensing to Medicaid enrollees. The commenter further noted that the statute refers back to the number of units ''dispensed . . . for which payment was made under the plan during the period, including such information reported by MCOs . . . .'' Accordingly, the commenter recommended that section III.(a). be revised to read, ''. . . that is, information about Medicaid utilization of covered outpatient drugs that were dispensed and for which payment was made under a Medicaid State plan or approved waiver during the rebate period.''

Response: We agree with the commenter that the language in section III.(a). could be misinterpreted to apply only to FFS rebate claims. Therefore, we are revising section III.(a). to state ''. . . information about Medicaid utilization of covered outpatient drugs that were dispensed and/or paid for, as applicable during the rebate period'' to clarify that timeliness requirements apply to both FFS and MCO rebate claims.

D. Section IV. Penalty Provisions

1. Civil Monetary Penalties (CMPs)

Comment: One commenter recommended that CMS keep the phrase ''in connection with a survey'' in the provision of the NDRA on Civil Monetary Penalties (CMPs) in section IV.(a). because the underlying statutory authority only authorizes the Secretary to impose CMPs on a manufacturer that refuses a request for information in connection with a survey about drug charges or prices. The commenter noted that the Medicaid rebate statute states at section 1927(b)(3)(B) of the Act that:

''The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information.''

The commenter believes that the language in the NDRA should accurately reflect this statutory authority.

Response: We agree that the language in the NDRA should accurately reflect the statutory language. Therefore, we are adding back in to this section the phrase ''in connection with a survey''. Section IV.(a). now reads as follows: ''The Secretary may impose a civil monetary penalty under section III.(b)., as set forth in 1927(b)(3)(B) of the Act and applicable regulations, on a wholesaler, manufacturer, or direct seller of a covered outpatient drug, if a wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request by the Secretary, or the Secretary's designee, for information about covered outpatient drug charges or prices in connection with a survey or knowingly provides false information, including in any of its quarterly reports to the Secretary. The provisions of section 1128A of the Act (other than section (a) (for amounts of penalties or additional assessments) and (b)) shall apply as set forth in section 1927(b)(3)(B) of the Act and applicable regulations.''

Comment: One commenter appreciated our reference to existing statute and regulations in updating the penalty provisions of the NDRA, but questioned the proposal to only cite relevant statute/regulation without reference or summary of the text to which the user is referred. In particular, the commenter noted that these revisions may prove overly cumbersome in section IV.(c). that describes the CMPs that may be imposed for failure to provide timely information on AMP, best price, or base date AMP, and if CMS included only a reference to the relevant statute, users would need to separately look up the different penalty amounts referenced in the NDRA text, rather than be able to reference them without requiring a document other than the NDRA itself. Thus, the commenter requested that CMS update the text of the provisions with specific dollar values and reference existing statute and regulations, rather than just putting forward the latter.

Response: We disagree that the statutory and/or regulatory text be restated in section IV.(c). of the NDRA, and that otherwise the provision is overly cumbersome. As stated previously in response to comments, our approach in the proposed and updated NDRA is to refer to statute and/or regulations, as well as agency guidance, as opposed to repeating such language in the NDRA, as we believe this decreases the chance of inaccurate or conflicting NDRA text. The general provisions of the NDRA incorporate such statutory requirements not explicitly referenced in the NDRA. We have added language in the general provisions to reflect this approach.

2. Remedies Available for Violations of the Agreement

Comment: One commenter recommended that CMS revise the language in section IV.(d). to be even-handed and provide the same protection to manufacturers. The commenter specifically recommended revising this sentence to add ''or manufacturers'' to read, ''[n]othing in this Agreement shall be construed to limit the remedies available to the United States, states, or manufacturers for a violation of this Agreement or any other provision of law.''

Response: Manufacturers are afforded protections under section V. of the NDRA, which addresses dispute resolution procedures in the event a manufacturer wishes to dispute state drug utilization data on the rebate invoice. Therefore, we are not adding the reference to ''or manufacturers'' as requested by the commenter.

E. Section V. Dispute Resolution Process

1. Timing of Dispute

Comment: One commenter requested greater clarification around the timing and process of dispute resolution.

Response: We agree with the commenter with respect to clarifying the timing of dispute resolution. Based on many years of experience in assisting with dispute resolution efforts when asked by manufacturers and states, we realize that 60 days is not enough time for a typical dispute to be resolved. Therefore, section V.(c). of the updated NDRA is changed from requiring a dispute to be resolved within 60 days before moving to the state hearing process, to being resolved ''within a reasonable time frame.'' Additionally, as noted in previous responses, we encourage interested parties to go to our DRP web page, *https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/dispute-resolution/index.html,* for more information about our suggestions and information regarding dispute resolution.

2. Audit of State Drug Utilization Data

Comment: A few commenters noted the importance of manufacturers' access to CLD and the need to ensure the accuracy of state-reported data as critical mechanisms to avoid disputes in the first place, and where they cannot be avoided, resolve them more efficiently and expeditiously for all program participants. The commenter noted that CMS requires that state invoices to manufacturers include certain information but permit states to furnish that data at an aggregate level in the rebate invoice. Commenters noted further that CMS also makes it clear in the Final Rule that ''states will need to have detailed, prescription-level information or other mutually-agreeable

data available for dispute resolution purposes, if requested by a manufacturer in accordance with the state provision of information requirements of section 1927(b)(2)(A) of the Act'' (81 FR 5272).

The commenters suggested that CMS specify in the NDRA that minimum CLD elements needed to facilitate dispute resolution include (in addition to the NDC, period covered, and whether the prescription is fee-for-service or managed care) elements such as the pharmacy ID (including pharmacy name and address), units, dispense date, 340B identifier, unit of measure, provider ID (NPI) and any third party payment. Commenters also recommended that CMS specify that states provide CLD in a standard format, and electronically or in a downloadable format on a quarterly basis.

Response: We disagree with the commenters' suggestions to revise the updated NDRA to include specific requirements related to the CLD that may be requested of states and used for payment validation. We also do not believe that it is appropriate to include such detail in the NDRA as it is an agreement between the Secretary and the manufacturer, and is not the appropriate vehicle to specifically address these issues. Manufacturers retain the right to request the minimum CLD required to validate the utilization data received from the state. We further disagree with the commenter that there is a minimum set of CLD that should be expected along with State Drug Utilization Data, as different CLD fields are needed depending on variables such as provider setting, third-party co-pays, and the type of dispute or potential dispute. Consistent with Manufacturer Release #95 and State Release #173, we continue to encourage states to share the appropriate minimum CLD for payment validation purposes on a case-by-case basis. Program Releases are available on *www.Medicaid.gov.*

Comment: One commenter suggested that CMS recognize the need for states to acknowledge disputes within a specified time period and to provide relevant CLD to manufacturers within a specified time frame and that CMS should revise our changes to section V.(d). so that it reads as follows: ''Nothing in this section shall preclude the right of the manufacturer to audit the state drug utilization data reported (or required to be reported) by the state. The Secretary encourages the manufacturer and the state to develop mutually beneficial audit procedures.'' Commenters further suggested that at a minimum, however, CMS shall require the state to make available to the manufacturer claim-level data necessary to review or audit the State drug utilization data.

Response: As the NDRA is an agreement between the Secretary and the manufacturer, we disagree that we should incorporate a state's obligation into the NDRA. However, as referenced in Manufacturer Release #95 and State Release #173, as well as the ''Medicaid Drug Rebate Data Guide for Labelers'' and ''Medicaid Drug Rebate Data Guide for States'' (available as a download in the DDR system), we encourage both manufacturers and states to share such information with others involved in rebate payment and disputes. Official disputes must be entered into by manufacturers via the Reconciliation of State Invoice (ROSI) (Form CMS–304) or Prior Quarter Adjustment Statement (PQAS) (Form CMS–304a), and operational instructions for the ROSI and PQAS are provided in these data guides. Program Releases are available on *www.Medicaid.gov.*

3. State Hearing Process

Comment: One commenter stated it is critical that CMS provide more transparency about the state hearing process that is supposed to be used to resolve disputes that cannot be resolved in good faith within 60 days. The commenter indicated that under current section V.(c). of the current Rebate Agreement, if disputes cannot be resolved after this 60-day period, CMS shall require the state to make available to the manufacturer the state hearing mechanism available under 42 CFR 447.253(e). However, the proposed rebate agreement deletes the reference to § 447.253(e) and instead refers to the state hearing mechanism ''available to providers for Medicaid payment disputes.'' The commenter indicated that this deletion may have been intended to be a substantive change, since § 447.253(e) concerns the appeal procedure for providers to receive administrative review of ''payment rates'' and would appreciate CMS clarifying whether the change it proposes is substantive and (if so) what effect it would have.

The commenter further stated it is difficult to determine what the process is that CMS are referencing with its proposed language and is not certain whether CMS confirmed that such a process exists in each state. The commenter further recommended that if CMS does not intend for the proposed language to constitute a substantive change, CMS should provide more clarity around the practical details regarding how the dispute process available under § 447.253(e) would work, such as how a manufacturer would begin the dispute process, what procedures would be used to facilitate dispute resolution, and where to look for guidance on the process. Even if the proposed changes to section V.(c). are meant to constitute a substantive change, the commenter indicated it would still appreciate receiving guidance about the process ''available to providers for Medicaid payment disputes.''

Response: The current NDRA references the incorrect paragraph for state hearings as § 447.253(c); the commenter is correct that § 447.253(e) is the correct provider hearing reference. The deletion of the reference to the CFR cite was not intended to be a substantive change. We have added the correct CFR cite (§ 447.253(e)) to section V.(c). in the updated NDRA. Furthermore, we have issued guidance for the state hearing process via State Release #181 and Manufacturer Release #105. In these releases, we reminded states and manufacturers that the state hearing process is an option available to both states and manufacturers when they have reached an impasse through the normal dispute resolution process, or when one of the parties is not being responsive to another's efforts to engage in dispute resolution. Given the variability in the states' hearing processes, we recommended that each state make manufacturers aware of the process to request such a hearing in that state. Program Releases are available on *www.Medicaid.gov.*

4. Retain Section V.(e). From Current NDRA

Comment: A few commenters questioned the intent of removing section V.(e). of the existing rebate agreement, which states, ''adjustments to Rebate Payments shall be made if information indicates that either Medicaid Utilization Information, AMP or Best Price were greater or less than the amount previously specified.'' One commenter questioned if it means disputed amounts are not subject to adjustment (either an increase or decrease). Another commenter recommended that CMS retain the current section (e) in the current section V and make adjustments to the language to allow for adjustments that constitute both increases and decreases in the rebate amount since § 447.510(b)(1) requires that ''a manufacturer must report to CMS any revision to AMP, best price, customary prompt pay discounts, or nominal prices for a period not to exceed 12 quarters from the quarter in which the data were due.'' Another commenter specifically also

recommended including section (e) from the current NDRA but also suggested that CMS revise the sentence to read, ''[t]o the extent that changes in product, pricing, or related data cause increases or decreases to previously submitted total rebate amounts, the manufacturer will make appropriate payment adjustments in the same timeframe as the current rebate invoice (that is, 38 days after the state mails the state utilization data).''

Response: We do not believe that any revisions are necessary, as we believe section V.(b). of the updated NDRA captures these concerns and addresses these issues. As stated earlier in response to comments, we updated language in section II.(f). regarding increases and decreases in rebate amount, and believe that this provides sufficient information on processing rebate increases and decreases.

5. General Request for DRP Guidance

Comment: One commenter recommended that CMS take this opportunity to issue additional guidance that can facilitate dispute resolution. Currently, this process can be costly for manufacturers and states, and can delay payment of rebates in cases where disputed utilization data turns out to be correct. The commenter further noted that the HHS Office of Inspector General (OIG) has recommended additional steps to prevent and resolve disputes and found that certain disputes occur frequently due to poor-quality data (disputes over drugs with complicated unit-of-measure conversions, physician-administered drugs, 340B purchased drugs, and terminated drugs). The commenter stated that CMS could accelerate dispute resolution by revising the NDRA to identify minimum steps that states could take to facilitate dispute resolution and to provide that manufacturers will not be responsible for interest payments during periods before these minimum steps are taken.

Response: While we appreciate the comments, we disagree that additional guidance on the dispute resolution process be set forth in the NDRA. Dispute resolution is an alternative to the state hearing mechanism, and is a process between the state and manufacturer. We have no formal role in dispute resolution, but continue to assist to the extent possible, when manufacturers and/or states request support in resolving a dispute. Therefore, we will continue in our role as facilitator when practical, and we encourage interested parties to review our DRP web page, *https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/dispute-resolution/index.html,* for more information about our suggestions regarding dispute resolution.

Comment: One commenter requested more information about our role in facilitating dispute resolution between states and manufacturers. More specifically, the commenter requested additional clarity around our voluntary dispute resolution program process for states and manufacturers such as how the (dispute) program works, how a manufacturer can facilitate use of the program, our role in the dispute process, and our point of contact for the program.

Response: As noted previously, this type of information is generally distributed through operational guidance. In this case, we release information about our role in dispute resolution, the process to request our facilitation of disputes, and our points of contact on our website at *https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/dispute-resolution/index.html.*

6. Retain Section VI. From Current NDRA

Comment: Several commenters stated CMS should not finalize the deletion of section VI.(a). of the current NDRA, which pertains to patient access to outpatient prescription drugs. The commenters stated this provision recognizes that the access requirements in the rebate statute are the reason that manufacturers sign the Medicaid rebate agreement, and CMS has a responsibility to take action if states do not fulfill their obligations under the rebate statute. One commenter suggested that rather than deleting this provision, it should be reinforced and further strengthened in the updated NDRA to conform to the drug access requirements of section 1927 of the Act. The commenter noted that CMS reaffirmed the states' statutory obligation to cover covered outpatient drugs for which the relevant manufacturer has a Medicaid drug rebate agreement in State Release #172 (*https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Prescription-Drugs/Downloads/Rx-Releases/State-Releases/state-rel-172.pdf*) in response to Hepatitis C virus (HCV) therapies being unreasonably restricted by the states. This commenter suggested CMS explicitly refer to the text of State Release #172 that states provide Medicaid beneficiaries with access to prescribed medicines as described under section 1927 of the Act. The commenter stated that CMS may choose to continue to include this text in the ''dispute resolution'' section of the NDRA, or include the text under section III, ''Secretary's Responsibilities[.]''

Response: As stated previously in response to comments, our approach in the proposed and updated NDRA is to refer to or cite statute and/or regulations, as well as agency guidance, as opposed to repeating such language expressly in the NDRA, as we believe this decreases the chance of inaccurate or conflicting NDRA text. We believe section VIII, the General Provisions section of the NDRA incorporates such statutory requirements not explicitly referenced in other sections of the NDRA. However, in order to ensure clarity on this point, we have updated paragraph (a) of Section VIII, General Provisions to add an introductory sentence that reads: ''This agreement is authorized by the applicable provisions in sections 1902, 1903, 1905, and 1927 of the Act, and the implementing regulations at 42 CFR part 447.'' Therefore, in updating the NDRA we do not believe that the current section VI is necessary. Moreover, the drug access requirements in section 1927 of the Act continue to be binding on states, regardless of the inclusion of the state requirement in the NDRA between the Secretary and manufacturers. As the commenter noted, when specific drug access issues arise, as most recently on the HCV drugs referenced in State Release #172, we release agency guidance reminding states of drug access requirements. We have published such guidance over the years, such as State Release #38, about coverage of a new multiple sclerosis drug. Also, we issued State Release #51, in response to proposed state legislation that would limit drug coverage for states seeking to leverage discounts from manufacturers, clarifying that such legislation would not supersede drug coverage requirements in section 1927 of the Act. We will continue, when circumstances arise, to remind states of their coverage requirements under the MDRP. Program Releases are available on *www.Medicaid.gov.*

F. Section VI. Confidentiality Provisions

Comment: One commenter agreed with our updated section VI.(b)., which states that, ''[t]he manufacturer will hold state drug utilization data confidential. If the manufacturer audits this information or receives further information on such data, that information shall also be held confidential. Except where otherwise specified in the Act or Agreement, the

manufacturer will observe confidentiality statutes, regulations, and other properly promulgated policy concerning such data.'' However, the commenter recommended that CMS amend the section to recognize the reality that manufacturers must often share drug utilization data with contractors for various business reasons by adding language to section VI.(b). to read, ''[t]his confidentiality provision does not prevent a manufacturer from sharing drug utilization data with a contractor or other agent that helps the manufacturer perform audits or otherwise assess drug utilization data, provided that the contractor or agent agrees to treat the drug utilization data confidentially.''

Another commenter requested that CMS clarify how the confidentiality provisions relate to a manufacturers' use of third parties for dispute resolution and outsourcing claims processing.

Response: We do not believe that the edits suggested by the commenter are necessary as section VIII.(g). of the updated NDRA provides for the incorporation of contractors in the terms ''State Medicaid Agency'' and ''Manufacturer.'' However, we are revising section VIII.(g). to provide further clarification on this matter. Therefore, section VIII.(g). is being revised to read as follows: ''[t]he terms ''State Medicaid Agency'' and ''Manufacturer'' incorporate any contractors which fulfill responsibilities pursuant to the agreement unless such contractors are specifically excluded in the rebate agreement or such exclusion is specifically agreed to by an appropriate CMS official.''

G. Section VII. Nonrenewal and Termination

1. Re-Entrance After Termination

Comment: One commenter is concerned that the language in section VII.(d). which states that the manufacturer must make ''good faith efforts to appeal or resolve matters pending with the OIG'' could be misinterpreted to include ''matters pending with the OIG'' that are unrelated to violations of a previous Medicaid rebate agreement. Therefore, the commenter suggested revising the sentence to say that a manufacturer may not enter into another rebate agreement until at least one rebate period from the effective date of termination, ''and provided that the manufacturer has addressed to the satisfaction of CMS any outstanding violations from any previous rebate agreements, including but not limited to payment of any outstanding rebates and good faith efforts to appeal or resolve any disputes pending with the OIG concerning violations of a previous rebate agreement.''

Response: We understand the commenter's concerns and have revised the language in section VII.(d). to create two sentences which now reads: If this rebate agreement is terminated, the manufacturer is prohibited from entering into another rebate agreement as set forth in section 1927(b)(4)(C) of the Act for at least one rebate period from the effective date of the termination. The manufacturer must also address to the satisfaction of CMS any outstanding violations from any previous rebate agreement(s), including, but not limited to, payment of any outstanding rebates and also make good faith efforts to appeal or resolve matters pending with the OIG relating to the MDRP or exclusion as referenced in subsection (c) of this section, unless the Secretary finds good cause for earlier reinstatement.

H. Section VIII. General Provisions

1. Transfer of Ownership

Comment: One commenter requested that CMS make it clear that the automatic assignment of rebate liability (as specified in section VIII.(c). applies only when there is a transfer of ownership of the manufacturer as a whole, and not a transfer of specific products or product lines.

Response: Section VIII.(c). of the General Provisions section only speaks to transfer of ownership of the manufacturer, and does not reference transfer of specific products or product lines. We do not believe any revisions to section VIII.(c). of the updated NDRA are necessary.

2. Due Date Falls on Weekend or Federal Holiday

Comment: One commenter sought clarification from CMS regarding what is meant by ''other item'' in the section that reads, ''In the event that a due date falls on a weekend or federal holiday, the report or other item will be due on the first business day following that weekend or federal holiday.''

Response: The reference to ''other item'' is intended to refer to anything due from the manufacturer to us per the rebate agreement.

3. Request for New Subsection: Rebate Payment Deadline

Comment: One commenter recommended that CMS include a new subsection under section VIII in the NDRA to clarify the number of days manufacturers have to pay late rebates before interest begins to accrue. The commenter stated that this subsection should incorporate the guidance CMS provided to manufacturers in Manufacturer Release #7 and #89, which states that, ''[i]nterest will begin accruing on disputed or unpaid amounts 38 calendar days from the date the state mails the state utilization data, as evidenced by the postmark by the United States Postal Service or other common mail carrier on the envelope (not a postage stamp).''

Response: As stated in response to previous comments, statute, regulation, and agency guidance, such as Program Releases, are incorporated by reference in section VIII, General Provisions. As stated previously, we have updated paragraph (a) of Section VIII, to add an introductory sentence that reads: ''This agreement is authorized by the applicable sections of 1902, 1903, 1905 and 1927 of the Act, and the implementing regulations at 42 CFR part 447.'' Therefore, we do not believe it is necessary to specifically incorporate the language suggested by the manufacturer in the updated NDRA.

I. Section IX. CMS–367 Forms of the Drug Rebate Agreement

Comment: One commenter stated that CMS should amend any forms referenced in or attached to the NDRA through the same process by which CMS is required to amend the NDRA itself (bilaterally). For example, CMS proposed that the NDRA would include as an attachment certain CMS forms (CMS–367a, CMS–367b, CMS–367c, and CMS–367d) that are used for reporting data required by the NDRA. Additionally, CMS incorporated by reference in section I.(t). of the proposed NDRA the CMS–R–144 form (state rebate invoice).

While the commenter recognized that CMS has changed these forms in the past through the Paperwork Reduction Act process, without officially amending the rebate agreement, the commenter recommended that CMS amend all forms associated with this NDRA in the same way that CMS amend the NDRA itself. The commenter noted that section VIII.(h). of the proposed NDRA states that ''except for the conditions specified in sections II.(g). and VIII.(a). (which concern changes to the rebate statute or implementing regulations), this agreement will not be altered except by an amendment in writing signed by both parties . . . ,'' which means that (apart from changes associated with statutory and regulatory changes) any changes made to the NDRA, including its attachments, must be in writing and signed by both parties.

The commenter recommended that CMS extend these same requirements to any forms that CMS choose to incorporate by reference, to ensure that the substance of the NDRA cannot be altered by changes in standard CMS forms that technically are not considered part of the NDRA itself.

Response: OMB-approved forms, when changed, are subject to a notice and comment period as required by the Paperwork Reduction Act. We have complied with these requirements and will continue to comply for future updates to these forms. Therefore, we believe it is appropriate to revise section VIII.(h). to include as part of the exclusions all applicable OMB-approved forms. We have revised VIII.(h). to state that ''[e]xcept for the conditions specified in II.(g). and VIII.(a)., as well as all applicable OMB-approved forms, this agreement will not be altered except by an amendment in writing signed by both parties. No person is authorized to alter or vary the terms unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Secretary and the manufacturer.''

J. Miscellaneous Comments

Comment: One commenter urged CMS to include in the updated NDRA the existing mechanism that permits manufacturers to notify CMS of state Medicaid program compliance concerns regarding drug coverage requirements or if there is a pattern or history of inaccuracy in Medicaid utilization reporting.

Response: We disagree with the commenter's suggestion that we memorialize in the NDRA the details of how a manufacturer may contact us regarding concerns with compliance with drug coverage requirements or patterns/historical inaccuracies in state drug utilization data reporting. We will continue to update any operational instructions on the options available or suggestions for manufacturers to communicate such issues to us.

Comment: Several commenters requested that CMS revise the NDRA to more specifically enumerate state requirements with regard to the MDRP.

Response: We disagree that state requirements be enumerated in the NDRA, as this is an agreement between the manufacturers and the Secretary and is not the appropriate vehicle to specifically address state requirements.

III. Provisions of the Final Notice

As stated previously, we are updating the NDRA to reflect the changes in the Covered Outpatient Drugs final rule with comment period that was published in the February 1, 2016 **Federal Register** (81 FR 5170), as well as operational and other legislative changes that have occurred over the last 20 plus years since the NDRA was first issued in 1991. A sample of the finalized NDRA will be posted on the *www.Medicaid.gov.* The publication of the final notice in the **Federal Register** constitutes written notice of good cause to terminate all old rebate agreements as of the first day of the full calendar quarter which begins at least 6 months after the effective date of the updated NDRA. As noted in the proposed notice, the updated NDRA will need to be signed by all participating manufacturers, as well as new manufacturers joining the program (81 FR 78817). Therefore, all currently participating manufacturers wishing to maintain their participation in the MDRP will need to work with CMS to sign and effectuate an updated NDRA for each labeler code by the compliance date specified in the **DATES** section of this public notice. For any current manufacturer that does not sign and effectuate an updated NDRA within the time frame specified above, the result would be termination of the existing NDRA. Per section 1927(b)(4)(B)(iii) of the Act, termination of a rebate agreement does not affect rebates due under that agreement before the effective date of its termination. We will be providing additional instructions and guidance pertaining to how to sign and effectuate the updated NDRA through subregulatory guidance.

Furthermore, prospective manufacturers that request a new NDRA, or reinstatement of a previously active NDRA once the updated NDRA is available, would be subject to the current process of data submission and verification prior to the execution of a NDRA.

Additionally, we are further clarifying that, in keeping with the requirements in the previous and updated NDRA and CMS's policy guidance in Manufacturer Releases #13 and #48, manufacturers that wish to participate in the MDRP are required to report all their covered outpatient drugs to CMS, regardless of labeler code. Therefore, in an effort to prevent selective reporting of NDCs, manufacturers must ensure that all associated labeler codes with covered outpatient drugs enter into a rebate agreement in order to comply with the terms of the NDRA. This requirement is found under section II, Manufacturer's Responsibilities, subsection (a) of the previous NDRA, and in section II, Manufacturer's Responsibilities, subsection (b) of the updated NDRA. When a participating manufacturer requests an agreement for a newly acquired labeler code that has covered outpatient drugs, that NDRA request will be subject to verification of their proposed covered outpatient drug list. Program releases are available at *www.Medicaid.gov.*

A copy of the updated NDRA is included in the Addendum of this notice. Below is a summary of the revisions and edits to the updated NDRA that have been made as a result of comments or to provide conforming or clarifying edits.

A. Definitions

- In response to a comment, we are retaining the definitions of ''Depot Price,'' ''Single-Award Contract,'' and ''Single-Award Contract Price,'' without any revisions to the definitions. As such all numbering is adjusted to account for the retention of these definitions.
- We are adding an opening quotation mark to the definition of ''Marketed'' as it was omitted from the draft NDRA.
- The definition of ''Rebate Period'' is revised to add ''section 1927(k)(8) of the Act as implemented by'' after the word ''in'' and before ''42 CFR 447.502.''
- The definition of ''State Drug Utilization Data'' is revised to replace the word ''reimbursed'' with ''dispensed and/or paid for, as applicable'' so that it now reads: ''. . . covered outpatient drugs dispensed and/or paid for, as applicable during a rebate period. . . .''
- The definition of ''State Drug Utilization Data'' is also revised to add ''(OMB control number: 0938–0582)'' after ''CMS–R–144'' in order to properly identify the form as being OMB approved.
- The definition of ''State Medicaid Agency'' is revised to add ''and 1927(k)(9) of the Act'' after ''sections 1902(a)(5)'' and before ''to administer'' so that it now reads ''. . . under sections 1902(a)(5) and 1927(k)(9) of the Act to administer . . .''.
- The definition of ''Unit'' is revised to add ''(OMB control number 0938–0578)'' after ''CMS–367c form'' in order to properly identify the form as being OMB approved.

B. Manufacturer Responsibilities

- Subsection (a)—Has been revised to add ''for the Legal, Invoice, and Technical contacts'' between the words ''contact'' and ''at'' so that it now reads: ''. . . point of contact for the Legal, Invoice, and Technical contacts at a United States address . . . .''
- Subsection (b)—Is revised to add ''for all covered outpatient drugs in all labeler codes of a manufacturer'' after ''is signed'' and before ''calculated'' so that it now reads ''. . . Beginning with

the quarter in which the National Drug Rebate Agreement (rebate agreement) is signed for all covered outpatient drugs of all labeler codes of a manufacturer, calculate, and report . . .''. It is also revised to add the words ''calculate a URA and'' after ''required to'' and before ''make'' so that it now reads ''. . . manufacturers are required to calculate a URA and make a rebate payment . . . ,'' and is revised to add the following sentences to the end of the subsection: ''CMS may calculate a URA based on manufacturer-submitted product and pricing data and provide the URA to states in order to facilitate rebate billing. However, CMS's URA calculation does not relieve the manufacturer of its responsibility to calculate the URA.''

• Subsection (c)—Has been revised to remove the phrase ''in some cases'' from the third sentence so that it now reads, ''CMS uses drug information listed with FDA, such as Marketing Category and Drug Type, to be able to verify that an NDC meets the definition of a covered outpatient drug, therefore, manufacturers should ensure that their NDCs are electronically listed with FDA.''

• Subsection (d)—First, the first sentence is revised to add ''(OMB control number 0938–0578)'' after ''CMS–367a form'' in order to properly identify the form as being OMB approved. Second, the third sentence is revised to read, ''[t]he manufacturer agrees to provide such information not later than 30 days after the end of each rebate period beginning with the effective date quarter.'' Third, the fourth sentence is revised to read, ''[a]djustments to all prior quarterly pricing data must be reported for a period not to exceed 12 quarters from when the pricing data were originally due as required under 42 CFR 447.510(b).''

• Subsection (e)—First, the first sentence is revised to add ''(OMB control number 0938–0578)'' after ''CMS–367b form'' in order to properly identify the form as being OMB approved. Second, the second sentence is revised to read, ''[t]he manufacturer agrees to provide such information not later than 30 days after the end of the month of the effective date, and not later than 30 days after the end of each month thereafter.''

• Subsection (f)—First, in accordance with section 1927(b)(3)(A) of the Act, the first sentence is revised to replace the word ''within'' with ''not later than'' after ''payments'' and before ''30 days'' so that it now reads ''Except as provided under V.(b)., to make rebate payments not later than 30 days after receiving the state rebate invoice.'' Second, it is revised to add the following sentence to the end of the subsection: ''To the extent that changes in product, pricing, or related data cause decreases to previously submitted total rebate amounts, the manufacturer should communicate with the states regarding where to apply the line-item (NDC-level) credit.''

• Subsection (i)—Is revised to add ''(OMB control number 0938–0578)'' after ''CMS–367d form'' in order to properly identify the form as being OMB approved.

• Subsection (k)—The reference to ''42 CFR 447.534'' in the last sentence of the subsection is replaced with ''42 CFR 447.510'' as this is the valid regulatory reference.

C. Secretary Responsibilities

• Subsection (a)—In accordance with section 1927(b)(2)(A) of the Act, the first sentence is revised to replace the word ''within'' with ''not later than'' after ''manufacturer,'' and ''60 days'' and to add ''dispensed and/or'' before ''paid for,'' and to add the ''as applicable'' after ''paid for'' so that it now reads: ''The Secretary will employ best efforts to ensure the State Medicaid Agency shall report to the manufacturer, no later than 60 days of the last day of each rebate period, the rebate invoice (CMS–R–144) or the minimum utilization information as described in section II.(f). of this agreement, that is, information about Medicaid utilization of covered outpatient drugs that were dispensed and/or paid for, as applicable, during the rebate period.''.

D. Penalty Provisions

• Subsection (a)—Is revised to add ''in connection with a survey'' after ''prices'' and before ''or'' in the first sentence.

• Subsection (d)—Is revised to add ''government'' after ''United States.''

E. Dispute Resolutions

• Subsection (a)—Is revised to add the OMB Control number associated with CMS–304 and CMS–304(a) forms after the reference to each form. The paragraph now read: ''In the event a manufacturer discovers a potential discrepancy with state drug utilization data on the rebate invoice, which the manufacturer and state in good faith are unable to resolve prior to the payment due date, the manufacturer will submit a Reconciliation of State Invoice (ROSI) form, the CMS–304 (OMB control number: 0938–0676), to the state. If such a discrepancy is discovered for a prior rebate period's invoice, the manufacturer will submit a Prior Quarter Adjustment Statement (PQAS) form, CMS–304a (OMB control number: 0938–0676), to the state.''

• Subsection (c)—The phrase ''shall require'' is replaced with ''will employ best efforts to ensure,'' and the phrase ''within 60 days'' is replaced by ''within a reasonable time frame'' in both instances, and the reference to ''42 CFR 447.253(e)'' is added in parentheses to the end of the subsection so that it now reads: ''The state and the manufacturer will use their best efforts to resolve a dispute arising under (a) or (b) above within a reasonable time frame after the state's receipt of the manufacturer's ROSI/PQAS. In the event that the state and manufacturer are not able to resolve the dispute within a reasonable time frame, CMS will employ best efforts to ensure the state makes available to the manufacturer the same state hearing mechanism available to providers for Medicaid payment disputes (42 CFR 447.253(e)).''.

F. Confidentiality Provisions

This section is finalized as proposed.

G. Nonrenewal and Termination

• Subsection (a)—Is revised to add ''from the date specified in section II.(h).,'' between ''year'' and ''unless'' so that in now reads: ''. . . successive terms of one year from the date specified in section II.(h)., unless the manufacturer . . . .''

• Subsection (b)—The first paragraph is revised to add ''and section 1927(b)(4)(B)(ii) of the Act'' after ''this agreement'' and before ''the manufacturer'' so that it now reads: ''In accordance with section VII.(a). of this agreement and section 1927(b)(4) of the Act, the manufacturer may terminate the agreement for any reason . . .''. The second paragraph, is revised to add an ''s'' to the end of ''cause'' to make it plural in both instances.

• Subsection (d)—Is revised to add a period after the word ''termination'' and create a new sentence that begins ''The manufacturer must also address . . .''

• Subsection (d)—Is also revised to add ''also make'' before ''good faith efforts in this new second sentence.

• Subsection (d)—Is further revised to add ''per subsection (c) of this section'' between ''the OIG'' and ''unless'' so it now reads ''. . . resolve matters pending with the OIG per subsection (c) of this section, unless the Secretary finds . . .''.

H. General Provisions

• Subsection (a)—Is revised to add the following sentence to the beginning of the subsection: ''This agreement is authorized by the applicable provisions

of sections 1902, 1903, 1905, and 1927 of the Act, and the implementing regulations at 42 CFR part 447.''.

• Subsection (f)—Is changed to replace the word ''scheme'' with ''construct''.

• Subsection (g)—Is revised to add ''such contractors are'' between ''unless'' and ''specifically,'' to replace ''provided for'' with ''excluded,'' and to add ''such exclusion is'' between ''or'' and ''specifically'' so that it now reads: The terms ''State Medicaid Agency'' and ''Manufacturer'' incorporate any contractors which fulfill responsibilities pursuant to the agreement unless such contractors are specifically excluded in the rebate agreement or such exclusion is specifically agreed to by an appropriate CMS official.

• Subsection (h)—Is revised to add ''as well as applicable OMB-approved forms,'' between ''VIII.(a).,'' and ''this agreement'' and to remove ''except by an amendment in writing signed by both parties. No person is authorized to alter or vary the terms unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Secretary and the manufacturer.'' so that it now reads: ''(h) Except for the conditions specified in II.(g). and VIII.(a)., as well as applicable OMB-approved forms, this agreement will not be altered.''.

I. CMS–367

This section is finalized as proposed.

J. Signatures

This section is finalized as proposed.

IV. Collection of Information Requirements

As stated in section 4711(f) of the Omnibus Budget Reconciliation Act of 1990, Chapter 35 of title 44, United States Code, and Executive Order 12291 shall not apply to information and regulations required for purposes of carrying out this Act and implementing the amendments made by this Act. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

As discussed in sections I and II of this final notice, we have revised the NDRA to add references to the appropriate CMS forms, consisting of: CMS–R–144 (OMB control number: 0938–0582), CMS–367 (OMB control number 0938–0578), and CMS–304 (OMB control number: 0938–0676). While the forms are referenced within the NDRA, there are no new or revised collection of information requirements or burden resulting from the updated NDRA. The forms are simply being referenced for clarity.

Addendum—Updated Agreement:

National Drug Rebate Agreement Between the Secretary of Health and Human Services (Hereinafter Referred to as ''the Secretary'') and the Manufacturer

The Secretary, on behalf of the U.S. Department of Health and Human Services and all states which have a Medicaid State Plan approved under 42 U.S.C. 1396a, and the manufacturer, on its own behalf, for purposes of section 1927 of the Social Security Act (''the Act''), 42 U.S.C. 1396r–8, hereby agree to the following:

I. Definitions

The terms defined in this section will, for the purposes of this agreement, have the meanings specified in section 1927 of the Act and implementing Federal regulations, as interpreted and applied herein:

(a) ''*Average Manufacturer Price (AMP)*'' will have the meaning set forth in section 1927(k)(1) of the Act as implemented by 42 CFR 447.504.

(b) ''*Base Consumer Price Index-Urban (CPI–U)*'' is the CPI–U for September, 1990. For drugs approved by the Food and Drug Administration (FDA) after October 1, 1990, ''Base CPI–U'' means the CPI–U for the month before the month in which the drug was first marketed.

(c) ''*Base Date AMP*'' will have the meaning set forth in sections 1927(c)(2)(A)(ii)(II) and 1927(c)(2)(B) of the Act.

(d) ''*Best Price*'' will have the meaning set forth in section 1927(c)(1)(C) of the Act as implemented by 42 CFR 447.505.

(e) ''*Bundled Sale*'' will have the meaning set forth in 42 CFR 447.502.

(f) ''*Centers for Medicare & Medicaid Services (CMS)*'' means the agency of the U.S. Department of Health and Human Services having the delegated authority to operate the Medicaid Program.

(g) ''*Consumer Price Index-Urban (CPI–U)*'' will have the meaning set forth in 42 CFR 447.502.

(h) ''*Covered Outpatient Drug*'' will have the meaning set forth in sections 1927(k)(2), (k)(3) and (k)(4) of the Act as implemented by 42 CFR 447.502.

(i) ''*Depot Price*'' means the price(s) available to any depot of the federal government, for purchase of drugs from the Manufacturer through the depot system of procurement.

(j) ''*Innovator Multiple Source Drug*'' will have the meaning as set forth in section 1927(k)(7)(A)(ii) of the Act as implemented by 42 CFR 447.502.

(k) ''*Manufacturer*'' will have the meaning as set forth in section 1927(k)(5) of the Act as implemented by 42 CFR 447.502.

(l) ''*Marketed*'' means that a covered outpatient drug is available for sale by a manufacturer in the states.

(m) ''*Monthly AMP*'' will have the meaning as set forth in 42 CFR 447.510.

(n) ''*Multiple Source Drug*'' will have the meaning as set forth in section 1927(k)(7)(A)(i) of the Act as implemented by 42 CFR 447.502.

(o) ''*National Drug Code (NDC)*'' will have the meaning as set forth in 42 CFR 447.502.

(p) ''*Non-innovator Multiple Source Drug*'' will have the meaning as set forth in section 1927(k)(7)(A)(iii) of the Act as implemented by 42 CFR 447.502.

(q) ''*Quarterly AMP*'' will have the meaning as set forth in 42 CFR 447.504.

(r) ''*Rebate period*'' will have the meaning as set forth in section 1927(k)(8) of the Act as implemented by 42 CFR 447.502.

(s) ''*Secretary*'' means the Secretary of the U.S. Department of Health and Human Services, or any successor thereto, or any officer or employee of the U.S. Department of Health and Human Services or successor agency to whom the authority to implement this agreement has been delegated. In this agreement, references to CMS indicate such successor authority.

(t) ''*Single-Award Contract*'' means a contract between the federal government and a Manufacturer resulting in a single supplier for a Covered Outpatient Drug within a class of drugs. The Federal Supply Schedule is not included in this definition as a single award contract.

(u) ''*Single-Award Contract Price*'' means a price established under a Single-Award Contract.

(v) ''*Single Source Drug*'' will have the meaning set forth in section 1927(k)(7)(A)(iv) of the Act as implemented by 42 CFR 447.502.

(w) ''*State Drug Utilization Data*'' means the total number of both fee-for-service (FFS) and managed care organization (MCO) units of each dosage form and strength of the manufacturer's covered outpatient drugs dispensed and/or paid for, as applicable during a rebate period under a Medicaid State Plan, other than units dispensed to Medicaid beneficiaries that were purchased by covered entities through the drug discount program under section 340B of the Public Health Service Act; state utilization data is supplied on the CMS–R–144 form (OMB control number: 0938–0582) (that is, the state rebate invoice).

(x) ''*States*'' will have the meaning as set forth in 42 CFR 447.502.

(y) ''*State Medicaid Agency*'' means the agency designated by a state under sections 1902(a)(5) and 1927(k)(9) of the Act to administer or supervise the administration of the Medicaid program.

(z) ''*Unit*'' means drug unit in the lowest dispensable amount. The manufacturer will specify the unit information associated with each covered outpatient drug per the instructions provided in CMS–367c (OMB control number 0938–0578).

(aa) ''*Unit Rebate Amount (URA)*'' means the computed amount to which the state drug utilization data is applied by states in invoicing the manufacturer for the rebate payment due.

(bb) ''*United States*'' will have the meaning as set forth in 42 CFR 447.502.

(cc) ''*Wholesaler*'' will have the meaning as set forth in section 1927(k)(11) of the Act as implemented by 42 CFR 447.502.

II. Manufacturer's Responsibilities

In order for the Secretary to authorize that a state receive payment for the

manufacturer's drugs under Title XIX of the Act, 42 U.S.C. 1396 *et seq.,* the manufacturer agrees to the requirements as implemented by 42 CFR 447.510 and the following:

(a) The manufacturer shall identify an individual point of contact for the Legal, Invoice, and Technical contacts at a United States address to facilitate the necessary communications with states with respect to rebate invoice issues.

(b) Beginning with the quarter in which the National Drug Rebate Agreement (rebate agreement) is signed for all covered outpatient drugs of all labeler codes of a manufacturer, calculate, and report all required pricing data on every covered outpatient drug by NDC in accordance with section 1927 of the Act and as implemented by 42 CFR 447.510. Furthermore, except as provided under section V.(b). of this agreement, manufacturers are required to calculate a URA and make a rebate payment in accordance with each calculated URA to each State Medicaid Agency for the manufacturer's covered outpatient drug(s) by NDC paid for by the state during a rebate period. CMS may calculate a URA based on manufacturer-submitted product and pricing data and provide the URA to states in order to facilitate rebate billing. However, CMS's URA calculation does not relieve the manufacturer of its responsibility to calculate the URA.

(c) In accordance with the specifications pursuant to Office of Management and Budget (OMB)-approved CMS–367c form, report all covered outpatient drugs and corresponding drug product, pricing, and related data to the Secretary, upon entering into this agreement. This information is to be updated as necessary to include new NDCs and updates to existing NDCs. CMS uses drug information listed with FDA, such as Marketing Category and Drug Type, to be able to verify that an NDC meets the definition of a covered outpatient drug, therefore, manufacturers should ensure that their NDCs are electronically listed with FDA. Reports to CMS should include all applicable NDCs identifying the drug product which may be dispensed to a beneficiary, including package NDCs (outer package NDCs and inner package NDCs).

(d) Beginning with the effective date quarter and in accordance with the specifications pursuant to OMB-approved CMS–367a form (OMB control number 0938–0578), report quarterly pricing data to the Secretary for all covered outpatient drugs in accordance with 42 CFR 447.510. This includes reporting for any package size which may be dispensed to the beneficiary. The manufacturer agrees to provide such information not later than 30 days after the end of each rebate period beginning with the effective date quarter. Adjustments to all prior quarterly pricing data must be reported for a period not to exceed 12 quarters from when the pricing data were originally due as required under 42 CFR 447.510(b).

(e) In accordance with the OMB-approved CMS–367b form (OMB control number 0938–0578), report information including monthly AMPs and monthly AMP units for all covered outpatient drugs in accordance with 42 CFR 447.510. The manufacturer agrees to provide such information not later than 30 days after the end of the month of the effective date, and not later than 30 days after the end of each month thereafter.

(f) Except as provided under V.(b)., to make rebate payments not later than 30 days after receiving the state rebate invoice. The manufacturer is responsible for timely payment of the rebate within 30 days so long as the state invoice contains, at a minimum, the number of units paid by NDC in accordance with 1927(b)(1) of the Act. To the extent that changes in product, pricing, or related data cause increases to previously-submitted total rebate amounts, the manufacturer will be responsible for timely payment of those increases in the same 30-day time frame as the current rebate invoice. To the extent that changes in product, pricing, or related data cause decreases to previously-submitted total rebate amounts, the manufacturer should communicate with the states regarding where to apply the line-item (NDC-level) credit.

(g) To comply with the conditions of 42 U.S.C. 1396r–8, changes thereto, implementing regulations, agency guidance and this Agreement.

(h) In accordance with 1927(a)(1) of the Act, rebate agreements between the Secretary and the manufacturer entered into before March 1, 1991 are retroactive to January 1, 1991. Rebate agreements entered into on or after March 1, 1991 shall have a mandatory effective date equal to the first day of the rebate period that begins more than 60 days after the date the agreement is entered into. Rebate agreements entered into on or after November 29, 1999 will also have an effective date equal to the date the rebate agreement is entered into that will permit optional state coverage of the manufacturer's NDCs as of that date.

(i) To obtain and maintain access to the system used by the Medicaid Drug Rebate program, use that system to report required data to CMS, and ensure that their contact information is kept updated as required in the OMB-approved CMS–367d form (OMB control number 0938–0578).

(j) To continue to make a rebate payment on all of its covered outpatient drugs for as long as an agreement with the Secretary is in force and state utilization data reports that payment was made for that drug, regardless of whether the manufacturer continues to market that drug. If there are no sales by the manufacturer during a rebate period, the AMP and best price reported in the prior rebate period should be used in calculating rebates.

(k) To keep records (written or electronic) of the data and any other material from which the calculations of AMP and best price were derived in accordance with 42 CFR 447.510, and make such records available to the Secretary upon request. In the absence of specific guidance in section 1927 of the Act, federal regulations and the terms of this agreement, the manufacturer may make reasonable assumptions in its calculations of AMP and best price, consistent with the purpose of section 1927 of the Act, federal regulations and the terms of this agreement. A record (written or electronic) explaining these assumptions must also be maintained by the manufacturer in accordance with the recordkeeping requirements in 42 CFR 447.510, and such records must be made available to the Secretary upon request.

(l) To notify CMS of any filing of bankruptcy, and to transmit such filing to CMS within seven days of the date of filing.

III. Secretary's Responsibilities

(a) The Secretary will employ best efforts to ensure the State Medicaid Agency shall report to the manufacturer, not later than 60 days after the last day of each rebate period, the rebate invoice (CMS–R–144) or the minimum utilization information as described in section II.(f). of this agreement, that is, information about Medicaid utilization of covered outpatient drugs that were dispensed and/or paid for, as applicable, during the rebate period. Additionally, the Secretary will expect any changes to prior quarterly state drug utilization data to be reported at the same time.

(b) The Secretary may survey those wholesalers and manufacturers that directly distribute their covered outpatient drugs to verify manufacturer prices and may impose civil monetary penalties as set forth in section 1927(b)(3)(B) of the Act and section IV of this agreement.

(c) The Secretary may audit manufacturer information reported under section 1927(b)(3)(A) of the Act.

IV. Penalty Provisions

(a) The Secretary may impose a civil monetary penalty under section III.(b). as set forth in 1927(b)(3)(B) of the Act and applicable regulations, on a wholesaler, manufacturer, or direct seller of a covered outpatient drug, if a wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request by the Secretary, or the Secretary's designee, for information about covered outpatient drug charges or prices in connection with a survey or knowingly provides false information, including in any of its quarterly reports to the Secretary. The provisions of section 1128A of the Act (other than subsection (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply as set forth in section 1927(b)(3)(B) of the Act and applicable regulations.

(b) The Secretary may impose a civil monetary penalty, for each item of false information as set forth in 1927(b)(3)(C)(ii) of the Act and applicable regulations.

(c) The Secretary may impose a civil monetary penalty for failure to provide timely information on AMP, best price or base date AMP. The amount of the penalty shall be determined as set forth in 1927(b)(3)(C)(i) of the Act and applicable regulations.

(d) Nothing in this Agreement shall be construed to limit the remedies available to the United States government or the states for a violation of this Agreement or any other provision of law.

V. Dispute Resolution

(a) In the event a manufacturer discovers a potential discrepancy with state drug utilization data on the rebate invoice, which the manufacturer and state in good faith are

unable to resolve prior to the payment due date, the manufacturer will submit a Reconciliation of State Invoice (ROSI) form, the CMS–304 (OMB control number: 0938–0676), to the state. If such a discrepancy is discovered for a prior rebate period's invoice, the manufacturer will submit a Prior Quarter Adjustment Statement (PQAS) form, CMS–304a (OMB control number: 0938–0676), to the state.

(b) If the manufacturer disputes in good faith any part of the state drug utilization data on the rebate invoice, the manufacturer shall pay the state for the rebate units not in dispute within the required due date in II.(f). Upon resolution of the dispute, the manufacturer will either pay the balance due, if any, plus interest as set forth in section 1903(d)(5) of the Act, or be issued a credit by the state by the due date of the next quarterly payment in II(f).

(c) The state and the manufacturer will use their best efforts to resolve a dispute arising under (a) or (b) above within a reasonable time frame after the state's receipt of the manufacturer's ROSI/PQAS. In the event that the state and manufacturer are not able to resolve the dispute within a reasonable time frame, CMS will employ best efforts to ensure the state makes available to the manufacturer the same state hearing mechanism available to providers for Medicaid payment disputes (42 CFR 447.253(e)).

(d) Nothing in this section shall preclude the right of the manufacturer to audit the state drug utilization data reported (or required to be reported) by the state. The Secretary encourages the manufacturer and the state to develop mutually beneficial audit procedures.

(e) The state hearing mechanism is not binding on the Secretary for purposes of the Secretary's authority to implement the civil money penalty provisions of the statute or this agreement.

VI. Confidentiality Provisions

(a) Pursuant to section 1927(b)(3)(D) of the Act and this agreement, information disclosed by the manufacturer in connection with this agreement is confidential and, notwithstanding other laws, will not be disclosed by the Secretary or State Medicaid Agency in a form which reveals the manufacturer, or prices charged by the manufacturer, except as authorized under section 1927(b)(3)(D).

(b) The manufacturer will hold state drug utilization data confidential. If the manufacturer audits this information or receives further information on such data, that information shall also be held confidential. Except where otherwise specified in the Act or agreement, the manufacturer will observe confidentiality statutes, regulations, and other properly promulgated policy concerning such data.

(c) Notwithstanding the nonrenewal or termination of this agreement for any reason, these confidentiality provisions will remain in full force and effect.

VII. Nonrenewal and Termination

(a) Unless otherwise terminated by either party pursuant to the terms of this agreement, the agreement shall be effective beginning on the date specified in section II.(h). of this agreement and shall be automatically renewed for additional successive terms of one year from the date specified in section II.(h)., unless the manufacturer gives written notice of intent not to renew the agreement at least 90 days before the end of the current period.

(b) In accordance with section VII.(a). of this agreement and section 1927(b)(4)(B)(ii) of the Act, the manufacturer may terminate the agreement for any reason, and such termination shall become effective the later of the first day of the first rebate period beginning 60 days after the manufacturer gives written notice requesting termination, or CMS initiates termination via written notice to the manufacturer.

The Secretary may terminate the agreement for failure of a manufacturer to make rebate payments to the state(s), failure to report required data, for other violations of this agreement, or other good causes upon 60 days prior written notice to the manufacturer of the existence of such violation or other good causes. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

(c) Manufacturers on the Office of Inspector General's (OIG's) List of Excluded Individuals/Entities (Exclusion List) will be subject to immediate termination from the Medicaid drug rebate program unless and until the manufacturer is reinstated by the OIG. Appeals of exclusion and any reinstatement will be handled in accordance with section 1128 of the Act and applicable regulations. Manufacturers that are on the OIG Exclusion List and are reinstated by the OIG under certain circumstances may be evaluated for reinstatement to the Medicaid drug rebate program by CMS. Reinstatement to the Medicaid drug rebate program would be for the next rebate period that begins more than 60 days from the date of the OIG's reinstatement of the manufacturer after exclusion.

(d) If this rebate agreement is terminated, the manufacturer is prohibited from entering into another rebate agreement as set forth in section 1927(b)(4)(C) of the Act for at least one rebate period from the effective date of the termination. The manufacturer must also address to the satisfaction of CMS any outstanding violations from any previous rebate agreement(s), including, but not limited to, payment of any outstanding rebates and also make good faith efforts to appeal or resolve matters pending with the OIG relating to the MDRP or exclusion as referenced in subsection (c) of this section, unless the Secretary finds good cause for earlier reinstatement.

(e) Any nonrenewal or termination will not affect rebates due before the effective date of termination.

VIII. General Provisions

(a) This agreement is authorized by the applicable provisions of sections 1902, 1903, 1905, and 1927 of the Act, and the implementing regulations at 42 CFR part 447. This agreement is subject to any changes in the Medicaid statute or regulations that affect the rebate program.

(b) Any notice required to be given pursuant to the terms and provisions of this agreement will be permitted in writing or electronically.

Notice to the Secretary will be sent to: Centers for Medicaid and CHIP Services, Disabled & Elderly Health Programs Group, Division of Pharmacy, Mail Stop S2–14–26, 7500 Security Blvd., Baltimore, MD 21244.

The CMS address may be updated upon notice to the manufacturer.

Notice to the manufacturer will be sent to the email and/or physical mailing address as provided under section X of this agreement and updated upon manufacturer notification to CMS at the email and/or address in this agreement.

(c) In the event of a transfer in ownership of the manufacturer, this agreement and any outstanding rebate liability are automatically assigned to the new owner subject to the conditions as set forth in section 1927 of the Act.

(d) Nothing in this agreement will be construed to require or authorize the commission of any act contrary to law. If any provision of this agreement is found to be invalid by a court of law, this agreement will be construed in all respects as if any invalid or unenforceable provision were eliminated, and without any effect on any other provision.

(e) Nothing in this agreement shall be construed as a waiver or relinquishment of any legal rights of the manufacturer or the Secretary under the Constitution, the Act, other federal laws, or state laws.

(f) The rebate agreement shall be construed in accordance with Federal law and ambiguities shall be interpreted in the manner which best effectuates the statutory construct.

(g) The terms ''State Medicaid Agency'' and ''Manufacturer'' incorporate any contractors which fulfill responsibilities pursuant to the agreement unless such contractors are specifically excluded in the rebate agreement or such exclusion is specifically agreed to by an appropriate CMS official.

(h) Except for the conditions specified in II.(g). and VIII.(a)., as well as applicable OMB-approved forms, this agreement will not be altered.

(i) In the event that a due date falls on a weekend or Federal holiday, the report or other item will be due on the first business day following that weekend or Federal holiday.

IX. CMS–367

CMS–367 attached hereto is part of this agreement.

X. Signatures

FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES

By: _____ Date: _____
(signature)

Title: Director
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

ACCEPTED FOR THE MANUFACTURER

I certify that I have made no alterations, amendments or other changes to this rebate agreement.

By: _____ _____
(signature) (please print name)
Title: _____
Name of Manufacturer: _____
Manufacturer Address _____
_____

Manufacturer Labeler Code(s): _____
Date: _____

CMS-367a

CMS RECORD SPECIFICATION
DDR QUARTERLY PRICING DATA
TEXT FILE FOR TRANSFER TO CMS

Source: Drug Manufacturers
Target: CMS

Field	Size	Position	Remarks
Record ID	1	1 - 1	Constant of "Q"
Labeler Code	5	2 - 6	NDC #1
Product Code	4	7 - 10	NDC #2
Package Size	2	11 – 12	NDC #3
Period Covered	5	13 – 17	QYYYY (Qtr/Yr)
Average Mfr Price	12	18 – 29	99999.999999
Best Price	12	30 – 41	99999.999999
Nominal Price	9	42 – 50	***999999999***
Customary Prompt Pay Disc.	9	51 – 59	***999999999***
Initial Drug Available for LE	1	60-60	***Y, N, X or Z***
Initial Drug	9	61-69	***9 digits alpha-numeric***

CMS-367a According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0578 (Expires: 12/31/2019). The time required to complete this information collection is estimated to average 34.8 hours per response, including the time to review instructions, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

QUARTERLY PRICING DATA FIELDS – CMS-367a

Labeler Code: First segment of National Drug Code that identifies the labeler. Numeric values only, 5-digit field, right-justified and zero-filled.

Product Code: Second segment of National Drug Code. Alpha-numeric values, 4-digit field, right justified, zero-filled.

Package Size Code: Third segment of National Drug Code. Alpha-numeric values, 2-digit field, right justified, zero-filled.

Period Covered: Calendar quarter and year covered by data submission. Numeric 5-digit field, QYYYY.

Valid values for Q:

1 = January 1 - March 31
2 = April 1 - June 30
3 = July 1 - September 30
4 = October 1 - December 31

Valid values for YYYY: 4-digit calendar year.

Average Manufacturer's Price (AMP): The AMP per unit per product code for the period covered. If a drug is distributed in multiple package sizes, there will be one "weighted" AMP for the product, which is the same for all package sizes. Compute to 7 decimal places, and round to 6 decimal places. Numeric values, 12-digit field: 5 whole numbers, the decimal place ('.') and 6 decimal places; right-justified, zero-filled.

Best Price: Per the statute and rebate agreement, the lowest price available per product code, regardless of package size. Compute to 7 decimal places and round to 6 decimal places. Zero-fill for Non-Innovator Multiple Source drugs. Numeric values, 12-digit field: 5 whole numbers, the decimal ('.') and 6 decimal places; right-justified, zero-filled.

Nominal Price (NP): Sales that meet the statutory/regulatory definition of NP. Total dollar figure per 11-digit NDC, rounded to nearest dollar. 9-digit field; 9 whole numbers; right-justified, 0-filled. If no sales for a package size, fill with all zeroes.

Customary Prompt Pay Discount (CPP): Labelers may 1) allocate an individual CPP discount dollar amount per 11-digit NDC in each package size's record, or 2) report an aggregate discount dollar amount, by adding up all package sizes, and report this aggregate CPP discount dollar amount in one package size record and zero-fill the remaining package sizes. 9-digit field; 9 whole numbers; right-justified, 0-filled.

Initial Drug Available for LE: Identifies whether a line extension drug has an Initial Drug available for the quarter/year being reported.

Valid Values:

Y = Yes
N = No
X = X-Not an LE Drug
Z = Not Applicable (for quarters prior to 2Q2016, or for quarters in which the NDC or labeler was not active).

Initial Drug: Identifies the drug (from which a line extension drug is derived) with the highest additional rebate ratio (calculated as a percentage of AMP) for the quarter/year being reported. The Initial Drug's additional rebate ratio is then used in the alternative URA calculation for the line extension drug. The Initial Drug should fall under the same corporation as the corresponding line extension drug, and must be active within the MDR Program at the time it is reported as an Initial Drug. Numeric values only, 9-digit field, right-justified and zero-filled.

CMS-367b

CMS RECORD SPECIFICATION
DDR MONTHLY PRICING DATA
TEXT FILE FOR TRANSFER TO CMS

Source: Drug Manufacturers
Target: CMS

Field	Size	Position	Remarks
Record ID	1	1 – 1	Constant of "M"
Labeler Code	5	2 – 6	NDC #1
Product Code	4	7 – 10	NDC #2
Package Size	2	11 – 12	NDC #3
Month	2	13 – 14	MM
Year	4	15 – 18	YYYY
Average Mfr Price	12	19 – 30	99999.999999
AMP Units	14	31 – 44	99999999999.99
5i Threshold	1	45 - 45	Y, N, X, or Z

CMS-367b According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0578 (Expires: 12/31/2019). The time required to complete this information collection is estimated to average 44.8 hours per response, including the time to review instructions, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS-367c

CMS RECORD SPECIFICATION
DDR DRUG PRODUCT DATA
TEXT FILE FOR TRANFER TO CMS

Source: Drug Manufacturers

Target: CMS

Field	Size	Position	Remarks
Record ID	1	1 – 1	Constant of "P"
Labeler Code	5	2 – 6	NDC #1
Product Code	4	7 – 10	NDC #2
Package Size Code	2	11 - 12	NDC #3
Drug Category	1	13 - 13	See Data Element Definitions
Unit Type	3	14 - 16	See Data Element Definitions
FDA Approval Date	8	17 - 24	MMDDYYYY
FDA Thera. Eq. Code	2	25 - 26	See Data Element Definitions
Market Date	8	27 - 34	MMDDYYYY
Termination Date	8	35 - 42	MMDDYYYY
Drug Type Indicator	1	43 – 43	See Data Element Definitions
OBRA'90 Baseline AMP	12	44 – 55	99999.999999
Units Per Pkg Size	11	56 – 66	9999999.999
FDA Product Name	63	67 – 129	FDA Product Name
DRA Baseline AMP	12	130 – 141	99999.999999
Package Size Intro Date	8	142 – 149	MMDDYYYY
Purchased Product Date	8	150 – 157	MMDDYYYY
5i Drug Indicator	1	158 – 158	See Data Element Definitions
5i Route of Administration	3	159 – 161	See Data Element Definitions
ACA Baseline AMP	12	162 - 173	99999.999999
COD Status	2	174 – 175	See Data Element Definitions
FDA Appl. No./OTC Mono. No.	7	176 – 182	See Data Element Definitions
Line Extension Drug Indicator	1	183 – 183	See Data Element Definitions

*Reactivation Date	*n/a	*n/a	*This field may only be submitted online via DDR. See Data Element Definitions

CMS-367c According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0578 (Expires: 12/31/2019). The time required to complete this information collection is estimated to average 53.5 hours per response, including the time to review instructions, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DRUG PRODUCT DATA FIELDS – CMS-367c

Labeler Code: First segment of National Drug Code that identifies the labeler. Numeric values only, 5-digit field, right-justified and zero-filled.

Product Code: Second segment of National Drug Code. Alpha-numeric values, 4-digit field, right justified, zero-filled.

Package Size Code: Third segment of National Drug Code. Alpha-numeric values, 2-digit field, right justified, zero-filled.

Drug Category: Alpha-numeric values, 1 character.

Valid values:

S = Single source
I = Innovator multiple source
N = Non-innovator multiple source

Unit Type: One of the 8 unit types by which the drug is dispensed. Alpha-numeric values, 3-character field, left justified.

Valid values:

AHF = Injectable Anti-Hemophilic Factor
CAP = Capsule
SUP = Suppository
GM = Gram
ML = Milliliter
TAB = Tablet
TDP = Transdermal Patch
EA = EACH

FDA Approval Date: NDA or monograph approval date. Numeric values, 8-digit field, format: MMDDYYYY.

FDA TEC: FDA-assigned Therapeutic Equivalence Codes. Alpha-numeric values, 2 character field.

Valid values:

AA	BC	BS
AB	BD	BT
AN	BE	BX
AO	BN	NR - Not rated
AP	BP	A1 thru A9 = AB value
AT	BR	

Market Date: For S and I drugs, the date the drug was first marketed by the original labeler (i.e., NDA holder). For N drugs, the date the drug was first marketed under the labeler's rebate agreement. If a Market Date falls on a date that is earlier than 9/30/1990, CMS will change it to 9/30/1990 in both the Medicaid Drug Rebate (MDR) system and the Drug Data Reporting for Medicaid (DDR) system since dates earlier than the start of the Drug Rebate Program have no bearing on the program. Numeric values, 8-digit field, format: MMDDYYYY.

Termination Date: The date a drug is withdrawn from the market or the drug's last lot expiration date. (Note: Initial termination date submissions may be provided via file transfer; however, subsequent changes to this field may only be submitted online via DDR.) Zero or blank fill if not present. Numeric values, 8-digit field, format: MMDDYYYY.

Drug Type Indicator: Identifies a drug as prescription (Rx) or over-the-counter (OTC).

Valid Values:
1 = Rx
2 = OTC

OBRA'90 Baseline AMP: The AMP per unit for the period that establishes the OBRA'90 Baseline AMP for innovator drugs. There will be one weighted baseline AMP for the product, which will be the same for all package sizes. Compute to 7 decimal places and round to 6 decimal places. Numeric values, 12-digit field: 5 whole numbers, the decimal ('.') and 6 decimal places; right-justified, zero-filled.

Units Per Package Size: Total number of units in the smallest dispensable amount for the 11-digit NDC. Numeric values, 11-digit field: 7 whole numbers, the decimal ('.') and 3 decimal places; right-justified, zero-filled.

FDA Product Name: Drug name as it appears on FDA listing form. Alpha-numeric values, 63 characters, left justified, blank-fill unused positions.

DRA Baseline AMP (optional): For active innovator drugs with a Market Date less than July 1, 2007, the OBRA'90 or OBRA'93 Baseline AMP revised in accordance with relevant regulations and program guidance. There will be one weighted DRA Baseline AMP for the product, which will be the same for all package sizes. Per CMS-2238-FC, labelers had 4 quarters (i.e., January 2, 2008 – October 30, 2008) to report this optional field. Numeric values, 12-digit field; 5 whole numbers, the decimal ('.') and 6 decimal places, right- justified, zero-filled. Compute to 7 decimal places and round to 6 decimal places.

Package Size Introduction Date: The date the package size is first available on the market. Numeric values, 8-digit field, format: MMDDYYYY

Purchased Product Date: The date the company currently holding legal title to the NDC first markets the drug under this NDC (this date can result, for example, from the purchase of an NDC from one company by another company, the re-designation of an NDC from one of a company's labeler codes to another of that same company's labeler codes, cross-licensing arrangements, etc.). Zero or blank fill if not applicable. Numeric values, 8-digit field, format: MMDDYYYY

5i Drug Indicator: Identifies whether a product is a 5i Drug. Alpha-numeric values; 1-digit field.

Valid Values:

Y = Yes
N = No

5i Route of Administration: Identifies the method by which the 5i drug is administered to a patient. If a product is not a 5i drug, a value of "000" (Not Applicable) should be entered. Numeric values; 3-digit field.

Valid Values:

000 = Not Applicable
001 = Implanted
002 = Infused
003 = Inhaled
004 = Injected
005 = Instilled

ACA Baseline AMP (Optional): For active innovator drugs, the OBRA'90, OBRA'93 or DRA Baseline AMP revised in accordance with the statute and relevant program guidance. There will be one weighted ACA Baseline AMP for the product, which will be the same for all package sizes. Numeric values, 12-digit field; 5 whole numbers, the decimal ('.') and 6 decimal places; right-justified; zero-filled. Compute to 7 decimal places and round to 6 decimal places.

Covered Outpatient Drug (COD) Status: A category that identifies whether or not a product meets the statutory definition of a covered outpatient drug in accordance with sections

1927(k)(2) to 1927(k)(4) of the Social Security Act. Numeric values, 2-character field.

Valid Values:

01 = Abbreviated New Drug Application (ANDA)
02 = Biologics License Application (BLA)
03 = New Drug Application (NDA)
04 = NDA Authorized Generic
05 = DESI 5* – LTE/IRS drug for all indications
06 = DESI 6* – LTE/IRS drug withdrawn from market
07 = Prescription Pre-Natal Vitamin or Fluoride
08 = Prescription Dietary Supplement/Vitamin/Mineral (Other than Prescription Pre-Natal Vitamin or Fluoride)
09 = OTC Monograph Tentative
10 = OTC Monograph Final
11 = Unapproved Drug – Drug Shortage
12 = Unapproved Drug – Per 1927(k)(2)(A)(ii)
13 = Unapproved Drug – Per 1927(k)(2)(A)(iii)

*NDCs with a COD Status of DESI 5/6 are not eligible for coverage or rebates under the Medicaid Drug Rebate Program.

FDA Application Number/OTC Monograph Number: For drugs with a COD status of ANDA, BLA, NDA, or NDA Authorized Generic, this is the seven-digit application number that is assigned by the FDA for approval to market a generic drug or new drug in the United States. Numeric field; 7 characters, fill with leading zeros as needed.

For drugs with a COD status of OTC Monograph Tentative or Final, this is the FDA's regulatory citation for the OTC. 7 alpha-numeric characters. For drugs with a COD Status of OTC Monograph Final, the first four characters are a constant of "PART"; the last three characters are the numeric values for the appropriate regulatory citation for the product (for example, "225"). For drugs with a COD Status of OTC Monograph Tentative, the first four characters are a constant of "PART"; the last three characters are the numeric values for the appropriate regulatory citation for the product, or 3 zeros if a Monograph Number is not available.

For drugs with a COD Status other than ANDA, BLA, NDA, NDA Authorized Generic, OTC Monograph Final, or OTC Monograph Tentative, the FDA Application No./OTC Monograph No. field should be zero-filled.

Reactivation Date: The date on which a terminated product is re-introduced to the market. (Note: This field may only be submitted online via DDR and is **NOT** part of the actual File Transfer Layout.)

Line Extension Drug Indicator: Identifies whether a product is a line extension drug as defined in Section 1927 (c)(2)(C) of the Social Security Act.

Valid Values:

Y = Yes
N = No

CMS-367d

MEDICAID DRUG REBATE AGREEMENT

ENCLOSURE B (PAGE 1 OF 2)
SUPPLEMENTAL DATA

LABELER CODE (as assigned by FDA)

LABELER NAME (Corporate name associated with labeler code)

LEGAL CONTACT – Person to contact for legal issues concerning the rebate agreement

NAME OF CONTACT

AREA PHONE NUMBER EXTENSION

EMAIL ADDRESS:

NAME OF CORPORATION

STREET ADDRESS

CITY STATE ZIP CODE

INVOICE CONTACT – Person responsible for processing invoice utilization data

NAME OF CONTACT

AREA PHONE NUMBER EXTENSION

EMAIL ADDRESS:

NAME OF CORPORATION

STREET ADDRESS

CITY STATE ZIP CODE

Note: This sheet is to be returned with the signed rebate agreement. If more than one labeler code, attach one sheet for each code.

CMS-367d According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0578 (Expires: 12/31/2019). The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

MEDICAID DRUG REBATE AGREEMENT

ENCLOSURE B (PAGE 2 OF 2)
SUPPLEMENTAL DATA

LABELER CODE (as assigned by FDA)

LABELER NAME (Corporate name associated with labeler code)

TECHNICAL CONTACT – Person responsible for sending and receiving data

NAME OF CONTACT

AREA PHONE NUMBER EXTENSION

FAX #

EMAIL ADDRESS:

NAME OF CORPORATION

STREET ADDRESS

CITY STATE ZIP CODE

Note: This sheet is to be returned with the signed rebate agreement. If more than one labeler code, attach one sheet for each code.

CMS-367d According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0578 (Expires: 12/31/2019) . The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Dated: February 20, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: March 16, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–05947 Filed 3–22–18; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3352–N]

Medicare Program; Announcement of the Approval of the American Association for Laboratory Accreditation (A2LA) as an Accreditation Organization Under the Clinical Laboratory Improvement Amendments of 1988

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the approval of the application of the American Association for Laboratory Accreditation (A2LA) as an accreditation organization for clinical laboratories under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) program for all specialty and subspecialty areas under CLIA. We have determined that the A2LA meets or exceeds the applicable CLIA requirements. We are announcing the approval and granting the A2LA deeming authority for a period of 4 years.

DATES: *Applicable Date:* This notice is applicable from March 23, 2018 to March 23, 2022.

FOR FURTHER INFORMATION CONTACT: Cindy Flacks, (410) 786–6520.

SUPPLEMENTARY INFORMATION:

I. Background and Legislative Authority

On October 31, 1988, the Congress enacted the Clinical Laboratory Improvement Amendments of 1988 (CLIA) (Pub. L. 100–578). CLIA amended section 353 of the Public Health Service Act. We issued a final rule implementing the accreditation provisions of CLIA on July 31, 1992 (57 FR 33992). Under those provisions, we may grant deeming authority to an accreditation organization if its requirements for laboratories accredited under its program are equal to or more stringent than the applicable CLIA program requirements in 42 CFR part 493 (Laboratory Requirements). Subpart E of part 493 (Accreditation by a Private, Nonprofit Accreditation Organization or Exemption Under an Approved State Laboratory Program) specifies the requirements an accreditation organization must meet to be approved by CMS as an accreditation organization under CLIA.

II. Notice of Approval of the A2LA as an Accreditation Organization

In this notice, we approve the American Association for Laboratory Accreditation (A2LA) as an organization that may accredit laboratories for purposes of establishing their compliance with CLIA requirements for all specialty and subspecialty areas under CLIA. We have examined the initial A2LA application and all subsequent submissions to determine the equivalency of its accreditation program with the requirements for approval of an accreditation organization under subpart E of part 493. We have determined that the A2LA meets or exceeds the applicable CLIA requirements. We have also determined that the A2LA will ensure that its accredited laboratories will meet or exceed the applicable requirements in subparts H, I, J, K, M, Q, and the applicable sections of R.

Therefore, we grant the A2LA approval as an accreditation organization under 42 CFR part 493, subpart E for the period stated in the **DATES** section of this notice for all specialty and subspecialty areas under CLIA. As a result of this determination, any laboratory that is accredited by the A2LA during the time period stated in the **DATES** section of this notice will be deemed to meet the CLIA requirements for the listed subspecialties and specialties, and therefore, will generally not be subject to routine inspections by a State survey agency to determine its compliance with CLIA requirements. The accredited laboratory, however, is subject to validation and complaint investigation surveys performed by CMS, or its agent(s).

III. Evaluation of the A2LA Request for Approval as an Accreditation Organization Under CLIA

The following describes the process used to determine that the A2LA accreditation program meets the necessary requirements to be approved by CMS and that, as such, CMS may approve the A2LA as an accreditation program with deeming authority under the CLIA program. The A2LA formally applied to CMS for approval as an accreditation organization under CLIA for all specialties and subspecialties under CLIA. In reviewing these materials, we reached the following determinations for each applicable part of the CLIA regulations:

A. Subpart E—Accreditation by a Private, Nonprofit Accreditation Organization or Exemption Under an Approved State Laboratory Program

The A2LA submitted its mechanism for monitoring compliance with all requirements equivalent to condition-level requirements, a list of all its current laboratories and the expiration date of their accreditation, and a detailed comparison of the individual accreditation requirements with the comparable condition-level requirements. The A2LA policies and procedures for oversight of laboratories performing laboratory testing for all CLIA specialties and subspecialties are equivalent to those of CLIA in the matters of inspection, monitoring proficiency testing (PT) performance, investigating complaints, and making PT information available. The A2LA submitted requirements for monitoring and inspecting laboratories in the areas of accreditation organization, data management, the inspection process, procedures for removal or withdrawal of accreditation, notification requirements, and accreditation organization resources. The requirements of the accreditation program submitted for approval are equal to or more stringent than the requirements of the CLIA regulations.

B. Subpart H—Participation in Proficiency Testing for Laboratories Performing Nonwaived Testing

The A2LA's requirements are equal to or more stringent than the CLIA requirements at §§ 493.801 through 493.865. For instance, the A2LA requires that laboratories conduct proficiency testing activities for both primary and secondary test systems for waived and non-waived testing. The CLIA requirement at § 493.801(b)(6) requires proficiency testing activities for the primary test system and for non-waived testing only.

C. Subpart J—Facility Administration for Nonwaived Testing

The A2LA requirements for the submitted subspecialties and specialties are equal to the CLIA requirements at §§ 493.1100 through 493.1105.

EXHIBIT 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 433, 438, and 447

[CMS–2434–P]

RIN 0938–AU28

Medicaid Program; Misclassification of Drugs, Program Administration and Program Integrity Updates Under the Medicaid Drug Rebate Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would seek to implement policies in the Medicaid Drug Rebate Program (MDRP) related to the new legislative requirements in the Medicaid Services Investment and Accountability Act of 2019 (MSIAA), which are needed to address drug misclassification, as well as drug pricing and product data misreporting by manufacturers. Additionally, we are proposing several other program integrity and program administration provisions or modifications in this proposed rule including revising and proposing key definitions used in the MDRP. This proposed rule also designates a time limitation on manufacturers initiating audits with States; clarifies and establishes requirements for State fee-for-service (FFS) pharmacy reimbursement; codifies conditions relating to States claiming FFP for physician-administered drugs (PADs); clarifies the requirement of accumulating price concessions when determining best price; designates drug price verification and transparency through data collection; and proposes two new contracting requirements between States and their Medicaid managed care plans. In addition, this rule includes a proposal unrelated to MDRP that would make revisions to the third-party liability regulation due to Bipartisan Budget Act (BBA) of 2018. Finally, we are proposing to rescind revisions made by the December 31, 2020 final rule ''Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements'' to the Determination of Best Price and Determination of Average Manufacturer Price (AMP) sections.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by July 25, 2023.

ADDRESSES: In commenting, please refer to file code CMS–2434–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2434–P, P.O. Box: 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2434–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Ruth Blatt, (410) 786–1767, for issues related to the definitions of vaccine, noninnovator multiple-source drug, market date, and covered outpatient drug (COD).

Ginger Boscas, (410) 786–3098, for issues related to third party liability.

Michael Forman, (410) 786–2666, for issues related to physician-administered drugs.

Whitney Swears (410) 786–6543, for issues related to time limitation on audits, definition of vaccine, diagnosis on prescriptions, professional dispensing fees, definition of a manufacturer.

Christine Hinds, (410) 786–4578, for issues related to internal investigation, removal of manufacturer rebate cap, drug cost transparency in Medicaid managed care contracts, ''stacking'' when determining best price, and drug price verification through data collection.

Lisa Shochet, (410) 786–5445, for issues related to Beneficiary Identification Number and Processor Control Number (BIN/PCN) and drug misclassifications.

Terry Simananda, (410) 786–8144, for issues related to the Collection of Information and Regulatory Impact Analysis sections.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov*. Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

A. Introduction

Under the Medicaid program, States may provide coverage of prescribed drugs as an optional benefit under section 1905(a)(12) of the Social Security Act (the Act). Section 1903(a) of the Act provides for Federal Financial Participation (FFP) in State expenditures for these drugs. In the case of a State that provides for medical assistance for covered outpatient drugs (CODs), as provided under section 1902(a)(54) of the Act, the State must comply with the requirements of section 1927 of the Act. Section 1927 of the Act governs the Medicaid Drug Rebate Program (MDRP) and payment for CODs, which are defined in section 1927(k)(2) of the Act. In general, for payment to be made available for CODs under section 1903(a) of the Act, manufacturers must enter into a National Drug Rebate Agreement (NDRA) as set forth in section 1927(a) of the Act. See also section 1903(i)(10) of the Act. The rebates paid by manufacturers to States help to partially offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid beneficiaries. The MDRP provides specific requirements for manufacturer rebate agreements, drug pricing submission and confidentiality requirements, the formulas for calculating rebate payments, drug utilization reviews (DUR), and requirements for States for CODs.

With limited exceptions, if a manufacturer wants payment to be

available under Medicaid for their CODs, the manufacturer must participate (have entered into and have in effect a rebate agreement) in the MDRP, and agree to pay rebates for CODs dispensed and paid for under the State Plan. The amount of the rebate is determined by a formula set forth in section 1927(c) of the Act. Generally, the formula to calculate the rebate that applies to a particular drug depends on whether the drug is classified as (1) a single source drug (S drug) or innovator multiple source drug (I drug) (commonly referred to as a brand-name drug), or (2) other drugs, which include noninnovator multiple source drugs (N drug), commonly referred to as generic drugs, among others.

Consistent with section 1927(b)(3)(A) of the Act, a manufacturer must report and certify certain drug product and drug pricing information for CODs to CMS not later than 30 days after the last day of each month and certain drug pricing information and drug product data 30 days after the last day of each quarter of a rebate period. For example, drug pricing information that manufacturers must submit and certify includes average manufacturer price (AMP) and best price data in addition to other information consistent with section 1927(b)(3)(A) of the Act each quarter. We use the reported data to calculate an accurate unit rebate amount (URA) for each covered outpatient drug to assist States with billing manufacturers for rebates. Drug product information that is reported includes the name of the drug, its National Drug Code (NDC), drug category, and drug type, among other items. However, manufacturers ultimately remain responsible for accurately calculating the URA for their drug products. Manufacturers pay rebates to States for each unit of the drug dispensed and paid for under the State Plan on the basis of the URA.

Thus, the failure of a manufacturer to submit and certify timely monthly and quarterly pricing and drug product data for a drug may impede the States' ability to invoice and collect appropriate rebate amounts. If a manufacturer fails to submit timely information, or misreports information, we may be unable to establish accurate URAs due to the misreporting or late reporting. While we provide URAs to the States each quarter to help facilitate billing manufacturers for rebates, it is ultimately the manufacturer's responsibility to assure that accurate rebates are paid to States for their CODs.

One specific element of drug product information that is required to be submitted by manufacturers includes drug category or drug classification information. Generally, drugs classified as single source or innovator multiple source pay higher rebates than those that are classified as an ''other drug,'' such as noninnovator multiple source drugs. In accordance with section 1927(c) of the Act and 42 CFR 447.509, the rebate calculation for a particular COD may also include an additional inflationary component to account for increases in the drug's Average Manufacturer's Price from the base date AMP quarter to the current calendar quarter's AMP. That is, this additional rebate is generally calculated based on the difference between the drug's current quarter AMP and its base date AMP adjusted to the current period by the Consumer Price Index for All Urban Consumers (CPI–U).

Prior to the enactment of the Medicaid Services Investment and Accountability Act of April 2019 (MSIAA) (Pub. L. 116–16; enacted April 18, 2019), section 1927(k)(7)(A)(iv) of the Act defined a single source drug as a covered outpatient drug which is produced or distributed under an original new drug application. Section 1927(k)(7)(A)(ii) of the Act similarly defined an innovator multiple source drug as a multiple source drug that was originally marketed under an original new drug application. A noninnovator multiple source drug was defined at section 1927(k)(7)(A)(iii) of the Act as a multiple source drug that is not an innovator multiple source drug.

Prior to the 2016 Medicaid Covered Outpatient Drug final rule with comment period (COD final rule) (81 FR 5170), the regulatory definitions of a single source and an innovator multiple source drug largely mirrored the statute and defined a drug as a single source or innovator multiple source drug based on whether it was produced, distributed, or marketed under an ''original new drug application.'' The statute did not expressly define ''original NDA''. However, CMS' longstanding interpretation of the term was that an original new drug application (NDA) is an NDA approved under section 505(b)(1) or (2) of the Federal Food, Drug, and Cosmetic Act (FFDCA), as distinguished from one approved under an abbreviated NDA (ANDA) under section 505(j) of the FFDCA (Manufacturer's Release 113).

We codified new regulatory definitions of single source and innovator multiple source drugs in the COD final rule and added a narrow exception for ''certain drugs [that] might be more appropriately treated as if they were approved under an ANDA and classified as a noninnovator multiple source drug'' (81 FR 5191). The COD final rule also added a drug approved under a Biologics License Application (BLA) to the definition of single source drug (81 FR 5203).

In the COD final rule, we also introduced a process by which drug manufacturers could submit a request for a narrow exception to have us recognize individual drugs approved under an NDA as noninnovator multiple source drugs prospectively from the effective date of the COD final rule. Instructions to manufacturers regarding this process were included in Manufacturer Release #98, May 2, 2016 (*https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/mfr-releases/mfr-rel-098.pdf*). The COD final rule did not, however, excuse manufacturers from their obligation to correctly report drugs approved under an NDA as either single source or innovator multiple source drugs prior to the effective date of the COD final rule, which was April 1, 2016.

Yet, notwithstanding our interpretation of the statute, many manufacturers have disregarded our reasonable interpretation of the statute and have continued to misreport drugs marketed under an NDA as noninnovator multiple source drugs for periods prior to April 1, 2016 (Manufacturer Release #113-*https://www.medicaid.gov/prescription-drugs/downloads/mfr-rel-113.pdf*).

B. Amendments Made by the Medicaid Services Investment and Accountability Act of 2019 (MSIAA) to Section 1927 of the Act Regarding MDRP Drug Classification Enforcement and Penalties

Section 6 of the MSIAA, titled ''Preventing the Misclassification of Drugs Under the Medicaid Drug Rebate Program,'' amended sections 1903 and 1927 of the Act to specify the definitions for multiple source drug, single source drug and innovator multiple source drug, and to provide the Secretary with additional compliance, oversight and enforcement authorities to ensure compliance with program requirements with respect to manufacturers' reporting of drug product and pricing information, which includes the appropriate classification of a drug. Drug classification refers to how a drug should be classified—as a single source, innovator multiple source, or noninnovator multiple source drug for the purposes of determining the correct rebates that a manufacturer owes

the States.[1] In general, a misclassification in the MDRP occurs when a manufacturer reports and certifies its covered outpatient drug under a drug category that is not supported by the statutory and regulatory definitions of S, I, or N. A drug that is misclassified is likely paying different rebates to States than those supported by statute and regulation.

We published guidance to manufacturers regarding compliance with drug pricing and drug product information reporting under this new law in Manufacturer Release #113 on June 5, 2020. See *https://www.medicaid.gov/prescription-drugs/downloads/mfr-rel-113.pdf*. Here, although much of this law is self-implementing, we are proposing a series of regulatory amendments at §§ 447.509 and 447.510 to implement and codify the statutory changes in regulation. We propose that a misclassification of a drug under the MDRP has occurred or is occurring when a manufacturer reports and certifies to the agency a drug category or drug product information relating to that COD that is not supported by the statutory and regulatory definitions of S, I, or N. We also define a misclassification as a situation in which a manufacturer is correctly reporting its drug category or drug product information for a COD, but is paying a different rebate amount to the States than is supported by the classification.

The MSIAA also amended the Act to expressly require a manufacturer to report not later than 30 days after the last day of each month of a rebate period under the agreement, such drug product information as the Secretary shall require for each of the manufacturer's covered outpatient drugs. We are proposing a definition of ''drug product information'' for the purposes of the MDRP.

Similarly, the MSIAA amended the Act to specify that the reporting of false drug product information and data related to false drug product information would also be subject to possible civil monetary penalties (CMPs) by the HHS Office of the Inspector General (OIG), and to provide specific new authority to the Secretary to issue civil monetary penalties related to knowing misclassifications of drug product or misreported information. These new OIG authorities will not be the subject of this rulemaking.

Under the MSIAA, if a manufacturer fails to correct the misclassification of a drug in a timely manner after receiving notification from the agency that the drug is misclassified, in addition to the manufacturer having to pay past unpaid rebates to the States for the misclassified drug if applicable, the Secretary can take any or all of the following actions: (1) correct the misclassification, using drug product information provided by the manufacturer on behalf of the manufacturer; (2) suspend the misclassified drug, and the drug's status as a covered outpatient drug under the manufacturer's national rebate agreement, and exclude the misclassified drug from FFP (correlating amendments to section 1903 of the Act); and, (3) impose CMPs for each rebate period during which the drug is misclassified subject to certain limitations. The Act expressly provides that the imposition of such penalties may be in addition to other remedies, such as termination from the MDRP, or CMPs under Title XI.

The manufacturer has an affirmative legal obligation to correctly report all necessary drug product and pricing information to the agency on a timely basis as described in the statute and regulations. When issues or questions regarding a drug's classification arise, we generally rely upon various sources of information to be able to determine if a drug is misclassified in MDRP. In its oversight role, the agency will use information reported by manufacturers to us, in combination with publicly available information, to be able to make determinations of whether a drug is misclassified in the MDRP. The agency also uses manufacturer reported information, such as the COD status code, in combination with information available on the Food and Drug Administration's (FDA's) Comprehensive NDC Structured Product Labeling (SPL) Data Elements file (NSDE) *https://download.open.fda.gov/Comprehensive_NDC_SPL_Data_Elements_File.zip*, and information from FDA's drugs@fda web page *https://www.accessdata.fda.gov/scripts/cder/daf/* to be able to verify that the national drug codes (NDCs) reported to the MDRP by manufacturers are appropriately classified and reported.

Codifying these statutory amendments in our regulations provides an opportunity for the agency to give additional clarity to and guidance on the new legal authorities for ensuring oversight of, compliance with, and enforcement of the provisions of the MDRP, and ultimately, to ensure that Federal and State programs are receiving appropriate rebates and that CMS continues to be a stringent steward of the Medicaid program.

TABLE 1—HISTORY OF THE CHANGES IN THE DEFINITION OF SINGLE SOURCE DRUG AND INNOVATOR MULTIPLE SOURCE DRUG

	Statute	Regulation
Prior to April 18, 2019 MSIIA enactment.	Single Source drug Section 1927(k)(7)(A)(iv) of the Act A covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration (FDA), including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.	

[1] Section 1927(c)(3) of the Act describes rebates for ''other drugs'' and section 1927(c)(3)(A) of the Act, more specifically describes rebates for covered outpatient drugs ''other than single source drugs and innovator multiple source drugs.'' The MDRP reporting system provides for all ''other drugs'' that are covered outpatient drugs to be classified in the system as N drugs, regardless of whether they expressly meet the definition of noninnovator multiple source drug. This reporting methodology has been in effect for the history of the program and interested parties have understood that a covered outpatient drug that was not an S or an I drug is reported in the system as an N drug. In a later section of this proposed rule, we are proposing changes to the regulatory definition of a N drug to more clearly align with the statutory definition of N drug. This is a technical change and is not intended to modify any reporting requirements.

TABLE 1—HISTORY OF THE CHANGES IN THE DEFINITION OF SINGLE SOURCE DRUG AND INNOVATOR MULTIPLE SOURCE DRUG—Continued

	Statute	Regulation
	Innovator Multiple Source Drug Section 1927(k)(7)(A)(ii) of the Act A multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.	
2007 Final Rule	.....	§ 447.502 Single source drug A covered outpatient drug that is produced or distributed under an original new drug application (NDA) approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the NDA. It also includes a covered outpatient drug approved under a biological license application (BLA), product license approval (PLA), establishment license approval (ELA) or antibiotic drug approval (ADA) PLA, ELA, or ADA. Innovator Multiple Source Drug A multiple source drug that was originally marketed under an original NDA approved by the FDA, including an authorized generic drug. It includes a drug product marketed by any cross-licensed producers, labelers, or distributors operating under the NDA and a covered outpatient drug approved under a PLA, ELA, or ADA.
2016 Final Rule	.....	The term ''single source drug'' means a covered outpatient drug that is produced or distributed under an original NDA approved by FDA and has an approved NDA number issued by FDA, including a drug product marketed by any cross licensed producers or distributors operating under the NDA. It also includes a covered outpatient drug approved under a BLA, PLA, ELA, or ADA. For purposes of this definition and the MDR program, an original NDA means an NDA, other than an ANDA, approved by the FDA for marketing, unless CMS determines that a narrow exception applies. The term ''innovator multiple source drug'' means a multiple source drug that was originally marketed under an original NDA approved by FDA, including an authorized generic drug. It also includes a drug product marketed by any cross-licensed producers, labelers, or distributors operating under the NDA and a covered outpatient drug approved under a BLA, ELA, or ADA. For purposes of this definition and the Medicaid drug rebates (MDR) program, an original NDA means an NDA, other than an Abbreviated New Drug Application (ANDA), approved by the FDA for marketing, unless CMS determines that a narrow exception applies.
MSIAA enactment on April 18, 2019.	Single Source drug Section 1927(k)(7)(A)(iv) of the Act The term ''single source drug'' means a covered outpatient drug, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4), which is produced or distributed under a new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application unless the Secretary determines that a narrow exception applies (as described in 42 CFR 447.502 (or any successor regulation)). Such term also includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the Food and Drug Administration.	

TABLE 1—HISTORY OF THE CHANGES IN THE DEFINITION OF SINGLE SOURCE DRUG AND INNOVATOR MULTIPLE SOURCE DRUG—Continued

	Statute	Regulation
	Innovator Multiple Source Drug Section 1927(k)(7)(A)(ii) of the Act The term ''innovator multiple source drug'' means a multiple source drug that is marketed under a new drug application approved by the FDA, unless the Secretary determines that a narrow exception applies (as described in 42 CFR 447.502 (or any successor regulation)).	
2020 Final Rule	.....	The term ''single source drug'' means a covered outpatient drug, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under section 1927(k)(4) of the Act, which is produced or distributed under a new drug application [*removing 'original'*] approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application unless the Secretary determines that a narrow exception applies (as described in this section), and includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the FDA. The term ''innovator multiple source drug'' means a multiple source drug that is marketed [removing 'was originally marketed'] under a new drug application [*removing 'original'*] approved by the Food and Drug Administration, unless the Secretary determines that a narrow exception applies (as described in 42 CFR 447.502 (or any successor regulation)).

C. MDRP Program Administration Proposed Changes

We are focused on increasing efficiency and economy of directing overall operations, resources, and activities of MDRP to better facilitate the needs of Medicaid beneficiaries. In that regard, we are proposing a number of new regulatory policies and clarification of existing policies.

Specifically, consistent with our statutory authorities, we are proposing to define, specify or amend the definitions for COD, internal investigation (for restatement purposes outside the 3-year time window), manufacturer (for NDRA purposes), market date, noninnovator multiple source drug, drug product information, and vaccine for the purpose of MDRP. We are also proposing to specify that the rebate provisions for a drug other than a single source drug or an innovator multiple source drug apply to an array of drugs, including those that may not satisfy the definition of multiple source drug. As noted above, based on longstanding operational processes, such drugs are properly classified as N drugs in the MDP reporting system.

Next, we are also proposing new policies, including to add a time limitation on manufacturer ability to initiate audits with States, to further clarify and establish the requirements for FFS pharmacy reimbursement, and to clarify the required collection of all National Drug Codes (NDC) for single and multiple source physician-administered drugs to receive FFP and secure manufacturer rebates.

We also propose to revise Medicaid managed care standard contract requirements to adopt a requirement for inclusion of Beneficiary Identification Number and Processor Control Number (BIN/PCN) numbers on Medicaid prescription identification cards, as well as enhance drug cost transparency by adopting specific requirements relating to the third-party administration of the pharmacy benefit.

These proposed revisions are designed to improve CMS oversight, and State administration of Medicaid pharmacy benefits by promoting greater consistency and accuracy of reporting, strengthened data, and robust stewardship of State and Federal funds. These proposals would help to strengthen and preserve the foundation of the MDRP by ensuring proper payments so Federal expenditures are spent appropriately on delivering quality, necessary care, while also ensuring sufficient access to care for Medicaid beneficiaries.

1. Proposal To Modify the Definition of Covered Outpatient Drug

Sections 1927(k)(2) and (3) of the Act provide a definition of the term ''covered outpatient drug'' (COD) and a limiting definition, which excludes certain drugs, biological products, and insulin provided as part of, or as incident to and in the same setting as, enumerated services and settings. This exclusion is subject to a parenthetical, however, which limits the exclusion to when payment may be made as part of payment for the enumerated service or setting, and not as direct reimbursement for the drug. In the COD final rule, we finalized a regulatory definition of covered outpatient drug in § 447.502 that substantially mirrors the statutory definition, and consistent with section 1927(k)(3) of the Act, the regulatory language includes a limiting clause at § 447.502 (covered outpatient drug) that excludes from the definition of COD any drug, biological product, or insulin provided as part of or incident to and in the same setting in a list of services, and for which payment may be made as part of that service instead of as a direct reimbursement for the drug.

Over the years we have received questions about when a payment is considered to be a direct reimbursement for a drug and whether identifying a

drug separately on a claim for payment may qualify as direct reimbursement for a drug, rendering the drug eligible for rebates under section 1927 of the Act, or in other words, making the limiting definition inapplicable. To provide greater clarity, we propose to amend the regulatory definition of the term covered outpatient drug at § 447.502 to clarify when a payment is considered direct reimbursement for the drug.

Additionally, we propose to more closely align the regulatory language to the statute by changing ''. . . instead of as a direct reimbursement . . .'' to ''. . . and not as direct reimbursement . . .''

2. Proposed Definition of an Internal Investigation for Purposes of Pricing Metric Revisions

In accordance with section 1927(b)(3) of the Act, § 447.510 of the applicable regulations, and the terms of the NDRA, manufacturers are required to report certain pricing and drug product information to CMS on a timely basis or could incur penalties or other compliance and enforcement measures. As explained in the ''Medicaid Program; Time Limitation on Price Recalculations and Recordkeeping Requirements Under the Drug Rebate Program'' final rule (final time limitation rule) (68 FR 51912, August 29, 2003), in an effort to improve the administration and efficiency of the MDRP and assist States and manufacturers that would otherwise be required to retain drug utilization pricing data records indefinitely, we established the 12-quarter time frame for reporting revisions to AMP or best price information.

Despite the 12-quarter time frame, we continued to receive requests from manufacturers to make revisions to their pricing data that fall outside of the 12-quarter period. Consequently, in the COD final rule (81 FR 5278) we established § 447.510(b)(1), which provides that a manufacturer must report to CMS any revision to AMP, best price, customary prompt pay discounts or nominal prices (pricing data) for a period not to exceed 12 quarters from the quarter in which the data were due unless one of a number of enumerated exceptions applies. See § 447.510(b)(1)(i) through (vi).

Section 447.510(b)(1)(v) provides an exception to the 12-quarter price reporting rule if the change is to address specific rebate adjustments to States by manufacturers, as required by CMS or court order, or under an internal investigation, or an OIG or Department of Justice (DOJ) investigation. However, as part of that rule, we did not define the term internal investigation which has led to different interpretations of the nature of an internal investigation. Therefore, we propose to add a definition of internal investigation at § 447.502 and additional clarity around the 12-quarter rule at § 447.510.

3. Proposal To Modify the Definition of Manufacturer for National Drug Rebate Agreement (NDRA) Compliance Purposes

At times, we receive requests from manufacturers to allow them to exclude a particular labeler that they may own or have a business affiliation with from participation in the MDRP, even though the labeler markets products that meet the definition of covered outpatient drug. It is our view that the statute requires that all labelers of a manufacturer that market CODs be required to participate in the MDRP to meet the statutory requirement that FFP is only available for a manufacturer's drugs if they participate in the program. That is, all the labelers of the manufacturer have to be in the program, or none of the labelers can be in the program.

We are proposing to further refine the definition manufacturer at § 447.502 to codify the requirements under section 1927(a)(1) of the Act which specifies that a manufacturer has to have entered into and have in effect a rebate agreement with the Secretary in order for payment to be available for their CODs under Medicaid. We are also proposing to codify in regulation that all labelers (with their applicable codes) that are associated or affiliated with a manufacturer must have a rebate agreement in effect in order for the manufacturer to satisfy the statutory requirement that the manufacturer have a rebate agreement in effect with the Secretary.

Additionally, we are also proposing a new paragraph (h) in § 447.510 to further specify the responsibilities of a manufacturer with respect to rebate agreements when that manufacturer acquires or purchases another labeler, acquires or purchases covered outpatient drugs from another labeler, or forms a new subsidiary or associated entity to ensure that any of a manufacturer's labeler codes that market CODs are included in the MDRP. We also specify that termination of one of the manufacturer's labelers from the program results in all labelers of that manufacturer being terminated from the program whether initiated by the manufacturer or the government. If the manufacturer is terminated for noncompliance, they can come back into the program under certain conditions, including resolving all compliance issues. However, the one-quarter delay in program re-entry provided for in section 1927(b)(4)(C) of the Act still applies unless good cause is found.

4. Proposal To Establish a Definition of Market Date for a COD for the Purposes of Determining a Base Date AMP for a COD

Section 1927 of the Act governs the MDRP and payment for CODs which are defined in section 1927(k)(2) of the Act. Manufacturers that participate in the MDRP are required to pay rebates for CODs that are dispensed and paid for under the State Medicaid plan. See section 1927(b)(1)(A) of the Act.

The rebates due by manufacturers are calculated based on statutory formulas described in section 1927(c) of the Act and consist of a basic rebate and, in some cases, an additional rebate that is applicable when an increase in the AMP, with respect to each dosage form and strength of a drug, exceeds the rate of inflation. One of the factors in the calculation of the additional rebate is the base date AMP of the drug, a value that is determined based on the market date of the drug. Manufacturers are required to report the market date of each dosage form and strength of a COD for all of its CODs.

We have received numerous inquiries regarding the determination of market date for reporting to MDRP, and some manufacturers have reported incorrect market dates for their CODs. Because the term market date has not been previously defined in regulation and it is a critical factor in the determination of base date AMP, and ultimately, the calculation of applicable rebates, we are proposing to define the term market date at § 447.502 for the purpose of the MDRP.

5. Proposal To Modify the Definition of Noninnovator Multiple Source Drug

As discussed previously in this proposed rule, section 6(c) of the MSIAA included a number of amendments to statutory definitions in section 1927 of the Act. Generally, those statutory amendments were discussed in the ''Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements'' final rule published in the December 31, 2020 **Federal Register** (the December 31, 2020 final rule) (see 85 FR 87000, 87032), where the regulatory definitions of multiple source drug, innovator multiple source (I) drug, and single source drug were amended

consistent with the MSIAA. One of the amendments to the regulatory definitions was to remove the phrase ''was originally marketed'' from the definition of an I drug and replace it with ''is marketed.''

The change in the statutory and regulatory definitions of an I drug should have prompted us to also change the regulatory definition of noninnovator multiple source (N) drug, however we neglected to do so in the December 31, 2020 final rule. We are now proposing to amend the definition of an N drug at § 447.502 to maintain the clear distinction between an I drug and an N drug.

6. Proposal To Define Vaccine for the Purposes of the MDRP Only

Section 1927(k)(2)(B) of the Act specifically excludes vaccines from the definition of COD for purposes of the MDRP. This exclusion is codified in paragraph (1)(iv) of the regulatory definition of COD at § 447.502. Section 1927 of the Act, specifically, does not define vaccine. Nor is there a definition of vaccine in Title XI, XVIII, XIX, or XXI of the Act (applicable to Medicare, Medicaid, and Children's Health Insurance Program (CHIP)), that speaks to the specific kinds of biological products that qualify as vaccines, in terms of their actions in the human body and how and when they are used.[2] Moreover, we are not aware that any authorizing statutes for any other Department of Health and Human Services agencies include such a statutory definition of the term ''vaccine.''

To date, we have not established a regulatory definition of the term vaccine as used in section 1927(k)(2)(B) of the Act for the specific purposes of the MDRP. However, given therapeutic advances that have occurred since 1990, when the original rebate statute was enacted, we believe that a regulatory definition is necessary to identify which products are considered vaccines for the purposes of the MDRP and thus, appropriately excluded from the definition of COD. We are therefore proposing a definition of vaccine at § 447.502 for the purpose of identifying products that do not satisfy the definition of COD and are therefore not subject to possible required coverage under the prescribed drugs benefit consistent with section 1927 of the Act, and applicable rebate liability under the MDRP. The regulatory definition of vaccine that is proposed to be added to § 447.502 would be established solely for the purposes of the MDRP, and be applicable only to that program. It would not apply under any title XIX statutory provisions other than section 1927(k)(2), or to separate CHIPs operating pursuant to 42 CFR 457.70(a)(1) and (d), or for purposes of the Vaccines for Children Program. Nor would it apply to any other programs within CMS or any other agencies within the Department of Health and Human Services, (for example, FDA, Centers for Disease Control and Prevention (CDC), or Health Resources and Services Administration (HRSA)). We note that these proposed changes would only specify which products are vaccines and are therefore excluded from the definition of a covered outpatient drug and are not subject to Medicaid drug rebates. This proposed policy would not apply with regard to any applicable Federal or State requirements to cover vaccines for Medicaid beneficiaries, as applicable.

7. Proposal To Accumulate Price Concessions and Discounts (''Stacking'') When Determining Best Price

Section 1927(c)(1)(C) of the Act defines the term ''best price'' to mean with respect to a single source drug or innovator multiple source drug of a manufacturer (including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, subject to certain exceptions and special rules.

The implementing regulations for the determination of best price are found at § 447.505, and we propose to revise § 447.505(d)(3) to add language to make clearer that the manufacturer must adjust the best price for a drug for a rebate period if cumulative discounts, rebates, or other arrangements to best price eligible entities subsequently adjust the prices available from the manufacturer, and that those discounts, rebates, or other arrangements must be stacked for a single transaction to determine a final price realized by the manufacturer for a drug. In other words, we are proposing to make clearer that manufacturers have to stack all applicable discounts that they offer on a single sale of a covered outpatient drug, including discounts or rebates provided to more than one best price eligible entity.

8. Proposal To Establish a Time Limitation for Audits Over Utilization Data With States: 12-Quarter Rebate Dispute Time Limitation

Currently, there is no time limit for a manufacturer to initiate an audit or resolve previously disputed State utilization data with respect to rebates owed, and section 1927 of the Act does not impose a specific timeframe on a manufacturer's audit authority. As a result, any dispute of State invoices arising from audits, reviews, or hearings of State information on State utilization data is not limited to current quarter rebate invoices, but may also be initiated for prior quarterly rebate invoices that have been previously paid in full. We are proposing to limit the time period for manufacturers to initiate disputes, hearing requests and audits of State-invoiced utilization data to 12 quarters from the last day of the quarter from the date of State invoice to the manufacturer. We propose to include a new paragraph (j), titled ''Manufacturer audits of State-provided information,'' at § 447.510, to limit the time a manufacturer has to initiate a dispute, hearing request or audit of State-invoiced utilization data with a State, to ensure more efficient administration of the Medicaid Drug Rebate Programs.

9. Proposal Regarding Drug Price Verification and Transparency Through Data Collection

Since the beginning of the MDRP in 1991, the Secretary has had the authority, under section 1927(b)(3)(B) of the Act, to survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices that are reported under section 1927(b)(3)(A) of the Act, if required to make a payment. The prices that are subject to this survey include a manufacturer's AMP, best price, Average Sales Price (ASP), and in certain cases, Wholesale Acquisition Cost (WAC) for a drug. (Note that in 2003, Congress amended section 1927(b)(3)(B) of the Act in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173, enacted December 8, 2003), to expand the original survey authority to include manufacturer's average sales prices (including wholesale acquisition cost or WAC).) These prices that are reported to the agency under section 1927(b)(3)(A) of the Act are used by various CMS programs, such as

[2] While section 1928(h) of the Act defines ''pediatric vaccine'' and ''qualified pediatric vaccine,'' those definitions do not speak to the actions of a vaccine in the human body and how and when it is used, and therefore do not help CMS determine when a product should count as a vaccine (as opposed to a drug) for purposes of the Medicaid Drug Rebate Program.

Medicare Part B and State Medicaid agencies, to pay for drugs for beneficiaries, as well as calculate rebates paid by manufacturers to States under MDRP. Thus, there is a direct connection between the prices reported to us and the payments made by Medicaid.

The types of drugs paid for by Medicaid, manufacturers' pricing structures for these drugs, as well as the methods used by manufacturers to distribute these drugs, have evolved since the enactment of the MDRP, as well as the enactment of the MMA. New highly individualized gene and cell therapy drug treatments have resulted in manufacturer launch prices that have increased dramatically, impacting the manufacturers' prices reported to CMS. In addition, manufacturers and health plans now own pharmacy benefit managers (PBMs), and manufacturers are more frequently limiting the distribution of drugs through specialty pharmacies, some of which are owned by the PBMs themselves.

All of these factors impact how manufacturers set drug pricing, and, given that these prices are used to set payment rates, it affects the payments that State Medicaid programs make for these drugs. For example, State Medicaid programs use the ASP values reported by manufacturers to make payment for many physician-administered drugs. A product's WAC has generally tracked its acquisition cost to providers for brand name drugs, and this WAC value is used by payers to reimburse them for the drug cost component of providing the drug. AMP is used to calculate Federal Upper Limits (FULs) for multiple source drugs.

While the model of distribution from manufacturer to wholesaler to provider still exists, and the predominant provider of pharmacy services remains the community-based pharmacy, there are other arrangements emerging for the production and distribution of specialty and high-cost gene therapy drugs, and pricing structures for these drugs that were not necessarily existing in the market when the MDRP was enacted.

Section 1902(a)(30)(A) of the Act requires that Medicaid payments be consistent with economy, efficiency, and quality of care to enlist enough providers so that care and services are available under the plan to Medicaid beneficiaries at least to the extent that such care and services are available to the general population in the geographic area. It is important that the Medicaid program understand the production and distribution method for these drugs, as well as the impact on prices and charges, to assure beneficiary access to these medications. Therefore, using the authority at section 1927(b)(3)(B) of the Act, which grants the Secretary the ability to survey wholesalers and manufacturers to obtain information about manufacturer's prices for a drug reported to us under section 1927(b)(3)(A) of the Act, we are proposing rules to describe those situations when it is necessary for surveys to be sent to manufacturers and wholesalers to verify prices and charges, and the information that would be requested, to verify prices or charges such that payments can be made.

10. Proposal To Clarify and Establish Requirements for FFS Pharmacy Reimbursement

In the COD final rule, we finalized regulations to move FFS pharmacy reimbursement to an actual acquisition cost-based reimbursement, under which pharmacists would be paid for the ingredient costs of the drug that was dispensed, and a professional dispensing fee (PDF) that reflected their costs of dispensing. Since that time, almost every State has made the appropriate transition, and the updated pharmacy reimbursement methodology is accurately reflected in approved amendments to their State Plans. Nonetheless, we are proposing to revise § 447.518, ''State plan requirements, findings, and assurances,'' in paragraph (d)(1) to ensure that pharmacy providers are reimbursed adequately for both their pharmacy ingredient costs and professional dispensing services costs consistent with the applicable statutory and regulatory requirements.

This regulation currently indicates that States are required to provide adequate data to support any proposed changes to either component of the reimbursement methodology (ingredient cost or PDF), such as a State or national survey of retail pharmacy providers or other reliable data other than a survey. We are proposing to provide clarity regarding adequate data so that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area, by expressly providing in regulation that the research and data must be based on costs and be sufficient to establish the adequacy of the pharmacy reimbursement methodology under the State Plan. In addition, we are proposing to state in regulatory text that other data, such as reimbursements that pharmacies accept from third parties, are not cost-based data, and therefore, cannot be used by States to justify PDFs.

11. Proposals Implementing Section 1927(a)(7) of the Act and Federal Financial Participation (FFP): Conditions Relating to Physician-Administered Drugs

Generally, physician-administered drugs may satisfy the definition of a covered outpatient drugs (COD) under section 1927(k)(2) of the Act, subject to the limiting definition at section 1927(k)(3) of the Act. Prior to the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171, enacted February 8, 2006), States did not collect rebates on all physician-administered drugs when they were not identified by NDC number, because the NDC number is necessary for States to invoice manufacturers for rebates.

Section 6002 of the DRA added sections 1903(i)(10)(C) and 1927(a)(7) to the Act to require the States to collect and submit certain utilization data on certain physician-administered drugs in order for FFP to be available for these drugs, and for States to secure rebates. More specifically, in accordance with section 1927(a)(7) of the Act, titled ''Requirement For Submission Of Utilization Data For Certain Physician-Administered Drugs'', States are required to provide for the collection and submission of utilization data and coding (such as J-codes [3] and NDC numbers) for a covered outpatient drug that is a single source or a multiple source drug that is a top 20 high dollar volume physician-administered drug on a published list (based on highest dollar volume dispensed under Medicaid identified by the Secretary) that the Secretary may specify in order for payment to be available under section 1903 of the Act and for States to secure applicable Medicaid rebates.[4] This list may be modified year to year to reflect changes in such volume.

Regulations at § 447.520 were established to implement these statutory provisions in the final rule entitled ''Medicaid Program; Prescription Drugs'' (72 FR 39142, 39162) (hereinafter referred to as the July 17, 2007 final rule), specifying the conditions for FFP for physician-administered drugs.[5]

We are proposing to amend § 447.520 to require States to collect NDC information on all covered outpatient single and multiple source physician-

[3] J codes are a subset of the Healthcare Common Procedure Coding System (HCPCS) Level II code set used to primarily identify injectable drugs.

[4] *https://www.govinfo.gov/content/pkg/CFR-2007-title42-vol4/pdf/CFR-2007-title42-vol4-sec447-520.pdf.*

[5] Ibid.

administered drugs and to specify that States should be invoicing for rebates for all covered outpatient physician-administered drugs to receive FFP and secure manufacturer rebates.

12. Proposal Related to Suspension of a Manufacturer's Drug Rebate Agreement

We are proposing regulatory changes to further implement section 1927(b)(3)(C)(i) of the Act, which provides authority to suspend a rebate agreement for a manufacturer's failure to timely report drug pricing or drug product information to the agency, required under section 1927(b)(3)(A) of the Act, and when there is a continued failure to report after a 90-calendar day deadline for reporting of information is imposed by the agency. Specifically, the new § 447.510(i) proposes that a manufacturer who has failed to report timely information to the agency under § 447.510(a) and (d), would be imposed a 90-calendar day deadline determined by the agency, and communicated to electronically and in writing by the agency to report such information, or the manufacturer would have its rebate agreement suspended.

This section further proposes that failure to report such information to the agency after the end of the imposed 90-calendar day period would result in suspension of the rebate agreement, and that such agreement shall not be reinstated until such information is reported in full and certified, but not for a period of suspension of less than 30 calendar days. This suspension would apply to all of the manufacturer's labelers that have a rebate agreement with the Secretary, consistent with the proposed regulatory definition of ''manufacturer.''

This rule also proposes that continued suspension of the rebate agreement could result in termination for cause. During the period of time of the suspension, FFP would not be available to the States for a manufacturer's CODs. The States would be given 30 calendar days' notice before such a suspension is implemented. This would allow States to notify prescribers and beneficiaries that a specific COD or specific CODs may be unavailable for a period of time, and to allow the beneficiary to switch to a different medication, if necessary. We are proposing that the suspension would only be applicable to the manufacturer's Medicaid program participation, and would not affect manufacturer participation in Medicare Part B or the 340B Drug Pricing Program during the time the rebate agreement is suspended. However, if continued suspension results in termination, such termination could affect Medicare Part B and 340B Drug Pricing Program participation.

13. Proposals Related to Managed Care Plan Standard Contract Requirements

a. Requirement of BIN/PCN Inclusion on Medicaid Managed Care Pharmacy Identification Cards

Patients enrolled in health care plans, including in Medicaid managed care plans such as Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs), generally use identification cards at the pharmacy so they can obtain prescription drug benefits, as well as allow pharmacies to process and bill claims in real time. Health plans use two codes on the card to identify a patient's prescription health insurance and benefits—the National Council for Prescription Drug Programs (NCPDP) Processing Bank Identification Number (BIN) and Processor Control Number (PCN). This information, along with a group number, can specify that a beneficiary is part of a specific patient insurance group, such as being a Medicaid managed care beneficiary.

However, it is often difficult to determine from a Medicaid managed care beneficiary's health insurance card if he or she is covered under a Medicaid managed care plan or under non-Medicaid coverage, such as an employer-sponsored group health plan or individual market insurance, offered by the same organization or entity that offers the Medicaid managed care plan. This is due to the fact that Medicaid-specific BIN, PCN, and group numbers are not always placed on Medicaid managed care plan identification cards. However, if Medicaid-specific BIN/PCN and group information were included on the card, the pharmacy could enter this information into its claims processing system which would identify that the beneficiary is enrolled in a Medicaid managed care plan. We believe it is important that unique BIN/PCN/group numbers are established for Medicaid managed care plans for several program needs, including facilitating the appropriate identification of cost sharing and ensuring claims are billed and paid for appropriately.

Use of Medicaid-specific BIN/PCN/group numbers can help States and their managed care plans identify claims for drugs paid for under the 340B Drug Pricing Program (340B Program) and avoid invoicing for rebates on 340B drugs. Section 340B(a)(5)(A) of the Public Health Service Act (the PHS Act) prohibits duplicate discounts for drugs purchased under the Medicaid drug rebate program. Section 1927(a)(5)(C) of the Act requires the establishment of a mechanism to ensure against duplicate discounts or rebates and section 1927(j)(1) of the Act provides that covered outpatient drugs are not subject the requirements of section 1927 of the Act if they are dispensed by health maintenance organizations (HMOs), including MCOs that contract under section 1903(m) of the Act, and are subject to discounts under section 340B(a)(5)(A) of the PHS Act. Certain eligible entities and hospitals are permitted to purchase drugs under the 340B Drug Pricing Program and dispense these drugs to Medicaid beneficiaries. Identifying claims where the dispensed drug has been discounted under the 340B program is necessary to avoid duplicating that discount in the MDRP.

Duplicate discounts occur when a State erroneously bills a manufacturer for a Medicaid drug program rebate involving a drug that was purchased under the 340B Drug Pricing Program. That occurs because the claim was not identified as a 340B claim before it was sent to the State. If the identification card included a unique Medicaid BIN/PCN/group number, and the State permits the use of 340B drugs at contract pharmacies for individuals enrolled in Medicaid managed care, then it would allow for the inclusion of a modifier at the point of dispensing that would identify the claim as ineligible for a Medicaid rebate. This would assist States with identifying 340B drug claims that should not be invoiced for Medicaid drug rebates.

Section 1902(a)(4) of the Act allows the Secretary to specify ''methods of administration'' that are ''found by the Secretary to be necessary for . . . proper and efficient operation.'' We believe that having States require their MCOs, PIHPs, or PAHPs that provide CODs to Medicaid beneficiaries to add unique identifiers onto the identification cards would make the Medicaid drug program run more efficiently, help avoid duplicate discounts, and improve the level of pharmacy services provided to Medicaid beneficiaries.

Therefore, under the authority of section 1902(a)(4) of the Act, as well as to ensure effective implementation of and compliance with sections 1927(a)(5)(C) and 1927(j)(1) of the Act, we are proposing to amend 42 CFR 438.3(s) to require MCOs, PIHPs, and PAHPs that provide coverage of CODs to assign and exclusively use unique Medicaid BIN, PCN, and group number identifiers for all Medicaid managed

care beneficiary identification cards for pharmacy benefits.

b. Drug Cost Transparency in Medicaid Managed Care Contracts

Medicaid managed care plans often contract with a subcontractor PBM to operate the pharmacy benefit provided to Medicaid beneficiaries. In order for a Medicaid managed care plan to appropriately calculate and report its Medical Loss Ratio (MLR) under § 438.8, the plan must know from the subcontractor certain information relating to how much of the payments made to the Medicaid managed care plan by the State was used to pay for health care services and other specific categories outlined in § 438.8. To correctly report the MLR, a Medicaid managed care plan must distinguish between expenses that are for covered benefits (such as healthcare services and drug costs) and administrative expenses, such as fees paid to its PBM for PBM services (for example, claims adjudication, processing prior authorization requests, etc.).

Therefore, we are proposing that MCOs, PIHPs, and PAHPs that provide coverage of CODs structure any contract with any subcontractor to require the subcontractor report the amounts related to the incurred claims described in § 438.8(e)(2), such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to providers or pharmacies for dispensing or administer a covered outpatient drug, separately from any administrative costs, fees, and expenses of the subcontractor.

14. Proposal To Rescind Revisions Made by the December 31, 2020 Final Rule to Determination of Best Price (§ 447.505) and Determination of Average Manufacturer Price (AMP) (§ 447.504) Consistent With Court Order

On May 17, 2022, the United States District Court for the District of Columbia vacated and set aside the ''accumulator adjustment rule of 2020'' in response to a complaint filed against the Secretary regarding the best-price accumulator provisions within the December 31, 2020 final rule ''Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements.'' See *Pharm. Rsch. & Mfrs. of Am.* v. *Becerra,* 1:21–cv–01395–CJN (D.D.C. May 17, 2022). This final rule had revised the conditions for excluding patient assistance from AMP at § 447.504(c)(25) through (29) and (e)(13) through (17), and best price at § 447.505(c)(8) through (12), to add language (effective January 1, 2023) that would require manufacturers to ''ensure'' the full value of the assistance provided by patient assistance programs is passed on to the consumer and that the pharmacy, agent, or other AMP or best price eligible entity does not receive any price concession. While the district court's order focused on the changes to the patient-assistance program exclusions from best-price determinations, to which it referred as the ''accumulator adjustment rule of 2020,'' for consistency, we propose to withdraw the changes to both the AMP and best-price sections made by the December 31, 2020 final rule.

As a result, the regulations would maintain the language that has been in place since 2016.

15. Proposals Related to Amendments Made by the American Rescue Act of 2021—Removal of Manufacturer Rebate Cap (100 Percent AMP)

Section 9816 of the American Rescue Plan Act of 2021 (Pub. L. 117–2, enacted March 11, 2021) sunsets the limit on maximum rebate amounts for single source and innovator multiple source drugs by amending section 1927(c)(2)(D) of Act by adding ''and before January 1, 2024,'' after ''December 31, 2009''. In accordance with section 1927(c)(3)(C)(i) of the Act and the special rules for application of provision in section 1927(c)(3)(C)(ii)(IV) and (V) of the Act, this sunset provision also applies to the limit on maximum rebate amounts for CODs other than single source or innovator multiple source drugs. Therefore, to conform § 447.509 with section 1927(c)(2)(D) of Act, as amended by the American Rescue Plan Act of 2021, and sections 1927(c)(3)(C)(i), (ii)(IV), and (ii)(V) of the Act, we are proposing to make conforming changes to § 447.509 to reflect the removal of the maximum rebate amounts for rebate periods beginning on or after January 1, 2024.

16. Request for Information—Comments on Issues Relating to Requiring a Diagnosis on Medicaid Prescriptions as a Condition for Claims Payment

Under the MDRP, a COD is generally defined as a prescribed drug that is FDA approved and used for a medically accepted indication. While the statute limits the definition of a COD to those products used for ''medically accepted indications,'' without a diagnosis on a prescription drug claims, it is difficult to determine whether a drug is being used for a medically accepted indication, and if it therefore satisfies the definition of a COD, and is rebate eligible. We are soliciting comments on the possibility and potential impact of proposing a requirement that a patient's diagnosis be included on a prescription as a condition of receiving Medicaid FFP for that prescription. We are soliciting comment on the patient care, clinical, and operational impact of requiring that a patient's diagnosis be included on a prescription as a condition of a State receiving FFP for that prescription. We are particularly interested in understanding any operational implications, privacy related concerns, the burden associated, and how to negate any foreseeable impact on beneficiaries and providers, including what steps would be needed by States to successfully implement a Medicaid requirement for diagnosis on prescriptions. This is a request for information only.

17. Background on Coordination of Benefits/Third Party Liability Regulation Due to Bipartisan Budget Act of 2018 (BBA 2018)

Medicaid is generally the payer of last resort, which means that other available resources—known as third party liability, or TPL—must be used before Medicaid pays for services received by a Medicaid-eligible individual. Title XIX of the Act requires State Medicaid programs to identify and seek payment from liable third parties, before billing Medicaid. Section 53102 of the Bipartisan Budget Act of 2018 (BBA 2018) (Pub. L. 115–123, enacted February 9, 2018) amended the TPL provision at section 1902(a)(25) of the Act.

Specifically, section 1902(a)(25)(A) of the Act requires that States take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan. That provision further specifies that a third party is any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan. Section 1902(a)(25)(A)(i) of the Act specifies that the State Plan must provide for the collection of sufficient information to enable the State to pursue claims against third parties. Examples of liable third parties include: Private insurance companies through employment-related or privately purchased health insurance; casualty coverage resulting from an accidental injury; payment received directly from an individual who has voluntarily accepted or been assigned legal responsibility for the health care of one or more Medicaid recipients;

fraternal groups, unions, or State workers' compensation commissions; and medical support provided by a parent under a court or administrative order.

To update the regulation for the recent statutory changes, a final rule was published on December 31, 2020, which went into effect on March 1, 2021, to include changes as authorized under the BBA 2018. We are submitting a correction due to an omission in the regulation text to require a State to make payments without regard to TPL for pediatric preventive services unless the State has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

II. Provisions of the Proposed Regulations

A. Payment of Claims (42 CFR 433.139)

In 1980, under the authority in section 1902(a)(25)(A) of the Act, we issued regulations at part 433, subpart D, establishing requirements for State Medicaid agencies to support the coordination of benefits (COB) effort by identifying third party liability.

Section 433.139(b)(3)(i) and (b)(3)(ii)(B) detail the exception to standard COB cost avoidance by allowing pay and chase for certain types of care, as well as the timeframe allowed prior to Medicaid paying claims for certain types of care. Specifically, we proposed to revise § 433.139(b)(3)(i) by adding—''that requires a State to make payments without regard to third party liability for pediatric preventive services unless the State has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.'' We propose to revise § 433.139(b)(3)(i) and (b)(3)(ii)(B) by adding ''within'' prior to the waiting periods Medicaid has to pay claims for preventive pediatric and medical child support claims. We also propose to revise § 433.139(b)(3)(ii)(B) by removing ''from'' and replacing it with ''after;'' and by removing ''has not received payment from the liable third party'' and adding the following language at the end of the sentence ''provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.'' These revisions in language would permit States to pay claims sooner than the specified waiting periods, when appropriate.

B. Standard Medicaid Managed Care Contract Requirements (§ 438.3(s))

1. BIN/PCN on Medicaid Managed Care Cards

We propose to amend § 438.3(s) to add a new paragraph (s)(7) to require States that contract with MCOs, PIHPs, or PAHPs that provide coverage of CODs, to require those managed care plans to assign and exclusively use unique Medicaid-specific BIN, PCN, and group number identifiers for all Medicaid managed care beneficiary identification cards for pharmacy benefits. We propose that the managed care contracts, and thus MCOs, PIHPs and PAHPs, must comply with this new requirement no later than the next rating period for Medicaid managed care contracts, following the effective date of the final rule adopting this new regulatory provision. We believe that the delay between the effective date of the final rule and the start of the next rating period would provide both States and the affected Medicaid managed care plans with adequate time to prepare both the necessary contract terms, and finish the necessary administrative processes for creating and issuing beneficiary identification cards with these newly required Medicaid-specific BIN, PCN, and group number identifiers.

This proposal is under our authority in section 1902(a)(4) of the Act to specify ''methods of administration'' that are ''found by the Secretary to be necessary for . . . proper and efficient operation.'' Having States require their MCOs, PIHPs, or PAHPs that provide CODs to Medicaid beneficiaries to add these types of unique identifiers to the identification cards would make the Medicaid drug program run more efficiently, and improve the level of pharmacy services provided to Medicaid beneficiaries. With the inclusion of Medicaid-specific BIN/PCN and group numbers on the pharmacy identification cards issued to the enrollees of MCOs, PHIPs and PAHPs, pharmacies would be able to identify patients as Medicaid beneficiaries, and better provide pharmacy services. This would be helpful to all parties to ensure that Medicaid benefits are provided correctly, including the confirmation of accurate cost sharing amounts, along with assisting that claims are billed and paid for appropriately.

This proposed change would also help to reduce the incidence of 340B duplicate discounts. Section 340B(a)(5)(A) of the PHS Act prohibits duplicate discounts; that is, manufacturers are not required to both provide a 340B discounted price and pay the State a rebate under the Medicaid drug rebate program for the same drug. Section 1927(a)(5)(C) of the Act requires the establishment of a mechanism to ensure against duplicate discounts or rebates, and section 1927(j)(1) of the Act also provides that CODs are not subject to, among other requirements of section 1927 of the Act, MDRP rebates if: (1) they are dispensed by health maintenance organizations, including MCOs that contract under section 1903(m) of the Act, and are subject to 340B discounts and (2) the drugs are subject to 340B discounts. Therefore, CODs covered by MCOs, PIHPs, and PAHPs are within the scope of this provision designed to prevent duplicate discounts. The existing regulation at § 438.3(s)(3) already reflects the position that CODs covered by MCOs, PIHPs, and PAHPs must be identified to prevent duplicate discounts under both section 1927 of the Act and section 340B of the PHS Act. The identification of a Medicaid beneficiary at the point of dispensing can result in the pharmacy placing a code on the prescription, such as the NCPDP ''20'' submission clarification code, so that the claim will be excluded from the Medicaid rebate pool.

Medicare Part D has supported the inclusion of BIN/PCN numbers for pharmacy cards. That is, 42 CFR 423.120(c)(4) requires that Part D sponsors assign and exclusively use a unique Part D BIN or RxBIN and Part D processor control number (RxPCN) combination in its Medicare line of business. The use of the BIN/PCN ensures that a pharmacy claim can be accurately billed by the pharmacy. Medicare made the BIN/PCN unique to Part D so that a Part D sponsor clearly identifies the Medicare enrollee as part of a particular Part D plan and the pharmacy knows that Medicare statute and rules may apply, such as not allowing certain manufacturer coupons, which plan benefits apply, appeals rights, etc.

In the absence of Medicaid-specific BIN, PCN, and group numbers to identify beneficiaries as being Medicaid participants, it is difficult for pharmacies and other providers, such as physicians and hospitals that administer drugs to Medicaid beneficiaries, to determine whether the beneficiary is enrolled in a Medicaid managed care plan, since a group number alone is not sufficient for Medicaid identification. Adding unique identifiers would make the beneficiary's Medicaid managed care status distinguishable from the other lines of business offered by the same organization or entity that contracts with the State to offer an

MCO, PIHP or PAHP for Medicaid beneficiaries.

Accordingly, we propose to amend the regulatory language in § 438.3(s) to add paragraph (s)(7) to mandate that Medicaid managed care contracts require that Medicaid MCO, PIHPs, or PAHPs that provide coverage of CODs must assign and exclusively use unique Medicaid BIN, PCN, and group number identifiers for all Medicaid managed care beneficiary identification cards for pharmacy benefits. We propose that Medicaid managed care contract must include this new requirement (which would require compliance by MCOs, PIHPs, and PAHPs) no later than the next rating period for Medicaid managed care contracts, following the effective date of the final rule adopting this new provision. We are soliciting comments on the implementation time frame and other possible operational issues of requiring unique Medicaid BIN, PCN, and group numbers to be on Medicaid managed care beneficiary identification cards.

2. Drug Cost Transparency in Medicaid Managed Care Contracts

We propose that the contracts between States and MCOs, PIHPs, or PAHPs that provide coverage of CODs require those plans to structure contracts with any subcontractor for the delivery or administration of CODs, in a manner that ensures drug cost spending transparency by requiring the subcontractor to report separately certain expenses and costs. These subcontractors may include PBMs.

Most Medicaid beneficiaries receive either all or part of their health care benefits, including CODs, through Medicaid managed care plans. Because of the specialized nature of the COD benefit, many Medicaid managed care plans (that is, the MCOs, PIHPs, or PAHPs) may contract with, or have their own PBMs to administer the COD benefit.

PBMs are the middlemen of the relationship between the managed care plans and the health care (medical and pharmacy) providers that provide CODs. That is, they have contracts with both the managed care plans to administer the pharmacy benefit, as well as with the health care providers that administer or provide the drugs to patients that are enrolled in the managed care plan. Among other tasks in the marketplace, a PBM may be responsible for developing a drug formulary, collecting manufacturer rebates on behalf of the managed care plan, performing drug utilization review (DUR), adjudicating claims, and contracting with retail community pharmacies and other health care providers to develop a network of pharmacy providers that can dispense drugs to managed care enrolled patients.

The PBM also negotiates reimbursement rates on behalf of the various health plans, including managed care plans with which it contracts, and pays the pharmacy and other health care providers for the drugs that are dispensed or administered. In most cases, the pharmacy reimbursement rates are specified in the contract between the PBM and the pharmacy providers, and these include reimbursement rates for brand name and generic prescription drugs, as well as the dispensing fees paid to dispense or administer the prescription drug to the beneficiary. There are also administrative fees paid to the PBM by the managed care plans for its administration and operation of the pharmacy benefit.

PBMs' methods of reimbursing health care providers for prescription drugs may differ from those used to determine the charges to managed care plans for the dispensed prescription. That is, a PBM's set of reimbursement benchmarks can be used in one relationship, and another set of reimbursement benchmarks in another, making it difficult for health plans or Medicaid managed care plans to know how much they are paying for the actual cost of the drug compared to the fees for administering the benefit. For this reason, under Part D, CMS requires that the price the PBM pays to the pharmacy for the cost of the drug is passed through to the plan, and any ''spread'' that the PBM keeps is an administrative cost that must be reported to the plan.

Medicaid-contracted PBMs (that is, PBMs contracted with or on behalf of Medicaid managed care plans) often reimburse health care providers using methods similar to those used in the commercial and Medicare Part D markets, which are heavily dependent on drug pricing benchmarks provided by manufacturers, and published by commercial publishers of drug pricing data (that is Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC)). The PBMs may also use a Maximum Allowable Cost (MAC) benchmark for generic drugs, which is a PBM proprietary benchmark that reimburses pharmacy providers for generics.

For PBMs' payment to contracted health care providers, reimbursement might be based on a discount off AWP, a markup on WAC, or the Maximum Allowable Cost (MAC) for generics, plus any contractually defined professional dispensing fee (PDF), which determines the total reimbursement for each COD. In contrast, the PBM might charge the managed care plans for dispensing that same COD based upon a different fixed percentage discount from AWP, or a higher percentage of WAC, either on a per-claim or aggregate spend basis. That is, a PBM's benchmarks, markups, or discount percentages may differ for the same COD. The result is that there is little to no transparency to the managed care plan as to how much the plan actually pays for the COD administered or dispensed to the patient, and how much is paid to the PBM for fees related to the administration of the COD benefit. The cost charged to the managed care plan for the COD by the PBM often includes both the amount that the PBM reimbursed the medical or pharmacy provider for the COD as well as the PBM's administrative fees for operating the benefit program.

The margin between the amount charged to a managed care plan for a COD, and the amount paid by a PBM to a pharmacy provider is referred to as the ''spread'' or ''spread pricing.'' This margin or ''spread'' may only be known by the PBM, unless a State Medicaid program or managed care plan (or other prime contractor in other contexts) specifically requires disclosure of the charge and payment data that are used to make these calculations. This information deficit results in a lack of accountability and transparency to the Medicaid program, which we believe is contrary to proper and efficient operation of the State Medicaid program and potentially creates conflicts of interest in connection with payment for CODs.

Section 1902(a)(4)(A) of the Act requires that the State Plan for medical assistance comply with methods of administration that are found by the Secretary to be necessary for the proper and efficient operation of the State Plan. Greater transparency and accountability by Medicaid managed care plans (and their subcontractors) to the States for how Medicaid benefits are paid compared to how administrative fees or services are paid are necessary for efficient and proper operation of Medicaid programs. Moreover, this lack of transparency makes it more difficult for Medicaid managed care plans to assure that the plan's MLR calculation is limited to the true medical costs associated with the provision of CODs.

Medicaid managed care regulations at § 438.8 require States, through their contracts with managed care plans, to require each managed care plan to calculate and report an annual MLR starting on or after July 2017, consistent with the requirements of the regulation

detailing the calculation, including which expenses are in the numerator and the denominator. We issued a Center for Medicaid & CHIP Services (CMCS) Informational Bulletin on May 15, 2019, for Medicaid Managed Care plans, titled ''Medicaid Loss Ratio (MLR) Requirements Related to Third Party Vendors'' (''2019 CIB'') (see *https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051519.pdf*), regarding calculation of the MLR when a managed care plan uses subcontractors for plan activities.

MLR calculations are used to develop capitation rates paid to Medicaid managed care plans, thus their accuracy is critical in assuring that Medicaid payments are reasonable, appropriate and necessary for health care services when using a Medicaid managed care plan. Managed care capitation rates must (1) be developed such that the plan would reasonably achieve an 85 percent MLR (§ 438.4(b)(9)) and (2) are developed using past MLR information for the plan (§ 438.5(b)(5)). In addition to other standards outlined in §§ 438.4 through 438.7, these requirements for capitation rates related to the MLR are key to ensuring that Medicaid managed care capitation rates are actuarially sound. In addition, Medicaid managed care plans may need to pay remittances (that is, refund part of the capitation payments) to States should they not achieve the specific MLR target. Thus, the accuracy of MLR calculation is important to conserving Medicaid funds.

This 2019 CIB provided additional guidance regarding the calculation of the MLR when third party vendors, such as PBMs, are involved. The purpose was to assist States in ensuring that revenues, expenditures and amounts are appropriately identified and classified for the MLRs submitted by managed care plans, especially when a subcontractor is used. The 2019 CIB uses PBM spread pricing as a specific example. Several States have already implemented prohibitions or other restrictions on the PBM practice of spread pricing. Although there is not currently a Federal prohibition on using spread pricing in Medicaid, as noted, we issued the 2019 CIB regarding the impact of the lack of transparency between costs for administrative functions versus actual Medicaid services on the managed care plan's MLR calculation. The 2019 CIB is clear that when the subcontractor, in this case the PBM, is performing administrative functions, such as eligibility and coverage verification, claims processing, utilization review, or network development, the expenditures and profits on these functions are a non-claims administrative expense as described in § 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations.

In addition, the Medicaid managed care regulation at § 438.230(c)(1) requires, through contractual requirements in the managed care contract between the managed care plan and the State, certain agreements to be in subcontracts, including that subcontractors agree to perform the delegated activities and reporting responsibilities in compliance with the managed care plan's contract obligations. Moreover, the reporting standards at § 438.8(k)(3) specify that managed care plans must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR calculation and reporting. The 2019 CIB explains how these regulatory obligations mean that all subcontractors that administer claims for the managed care plan must report the incurred claims, expenditures for activities that improve health care quality, and information about mandatory deductions or exclusions from incurred claims (overpayment recoveries, rebates, other non-claims costs, etc.) to the managed care plan.

The requirements and definitions in § 438.8 for these categories of costs and expenditures must be applied to the required reporting. The reporting from the subcontractor must have sufficient detail to allow a managed care plan to accurately incorporate the expenditures associated with the subcontractor's activities into the managed care plan's overall MLR calculation. The level of detail must meet the requirements in § 438.8(k)(3) and the level of detail that is required may vary based on what is necessary to accurately calculate an overall MLR or to comply with any additional reporting requirements imposed by the State in its contract with the managed care plan.

Medicaid managed care plans are generally paid by States using single monthly capitation payments that for the plan's coverage of the health care services covered under the Medicaid managed care contract, including CODs. If the managed care plan contracts with a PBM, there are different options for the managed care plan to pay the PBM for the administrative services provided by the PBM. Payment for administrative services is made in addition to the amount the managed care plan would reimburse the PBM for the actual COD and dispensing fee costs. In general, managed care plans have paid PBMs for administrative services in one of two ways, or a mix of these approaches—either through a flat administrative fee per prescription, or, as described above, by including it in the overall COD payment (that is through ''spread pricing'').

When payments to the PBM for the administration services are included in the managed care plans' total COD payment without a clear delineation of which amount is for administrative services, it obscures how much of that total payment is actually paid to the provider for the prescription and what is paid for administrative services furnished by the PBM. In other words, it is difficult for the managed care plan to determine the proportion of the payment to the PBM that is attributable to the administrative service costs provided by the PBM.

Furthermore, incorrectly attributing administrative service costs as medical expenditures, may increase the MLR numerator, and thus increase the per-member-per-month (PMPM) revenue a managed care entity can receive while appearing to meet MLR requirements. Given this lack of transparency, the ''spread'', which has been the basis for generating significant PBM profit, obscures from Medicaid and the managed care plans the actual cost of the CODs dispensed to plan enrollees. This makes it difficult for managed care plans and State Medicaid agencies to determine whether the amount that the PBM is charging to administer the benefit is a reasonable expense to be borne by a Medicaid program. Moreover, it makes it difficult for plans to ensure that their MLR calculations appropriately classify and account for expenditures.

We provide a representative example of how spread pricing occurs in the context of Medicaid prescription drug coverage provided by a managed care plan. Specifically, in Table 2, we illustrate how a PBM might leverage a 5 percent difference in the AWP value between the amount charged to the plan and the amount paid to the pharmacy for a commonly-dispensed generic drug product, to ultimately capture 30.76 percent of the dollars spent by the managed care plan for the prescription.

TABLE 2—EXAMPLE OF SPREAD PRICING

Drug Product	NDC 1234567890, Drug 300 MG CAPSULE, 60 capsules in prescription.
Published AWP	$1.33 per capsule.
PBM Reimbursement to pharmacy (MAC)	((AWP − 90%) * 60) + $1 dispensing fee = $8.98.
Amount PBM billed to Managed care plan	((AWP − 85%) * 60) + $1 dispensing fee = $12.97.
PBM spread =	($12.97 − $8.98) = $3.99.
PBM spread percentage =	($3.99/$12.97) = 30.76% of total cost to managed care plan.

Table 2 shows that, while the pharmacy only received $8.98 in reimbursement from the PBM for the prescription, PBM charged the managed care plan $12.97, or about 31 percent more for the same prescription. Depending on the specifics of the contract that the PBM has with the managed care plan, some of this margin or spread might be used to pay the PBM for managing or administering the pharmacy benefit but in some cases, this spread may be in addition to administrative fees paid by the plan to the PBM. For example, there may already be included in the contract a specific fee that the Medicaid MCO is paying for the administration of the COD benefit. These fees would be in addition to the amounts being paid as part of the ''spread pricing.''

However, unless the managed care plan knows the amounts that the pharmacy providers are being paid by the PBM, the managed care plan is unable to assess the full scope of payments to the PBM for administrative services furnished by the PBM. As a result, the plan may not know whether the PBM is being appropriately compensated for administering the COD benefit.

While the per-prescription dollar amounts above may not appear substantial, the overall impact to a Medicaid managed care pharmacy program may be significant given generic claims represent greater than 90 percent of total pharmacy claims. For example, an analysis of Ohio's Medicaid managed care program by the Ohio Auditor of State revealed $208.4 million of spread within their managed care plan's PBM transactions for generic drug claims between April 1, 2017, and March 31, 2018.[6] For the time period analyzed, this amount of PBM spread represented 31.4 percent of total generic drug expenditures within the State's Medicaid managed care program.

CMS has determined that 11 States[7] have enacted relevant legislation related to the practice of spread pricing. Four of these States (Arkansas, Delaware, Michigan, and Oklahoma) have complete State-wide prohibitions on the practice of spread pricing for any PBM operating within the State, regardless of the payer. Five States (Kentucky, Louisiana, New York, Pennsylvania, and Virginia) prohibit the practice of spread pricing by PBMs or MCOs in Medicaid, explicitly. One State (Pennsylvania) further requires that all Medicaid MCOs include a spread pricing prohibition clause in all contracts with PBMs. Only 2 of the 11 States with spread pricing laws (Alabama and Montana) merely require disclosure of certain spread pricing information (that is, annual report of aggregate rebate information and whether the PBM engages in spread pricing). Spread pricing can increase Medicaid pharmacy program costs, reduce efficient operation of the Medicaid program, and reduce the transparency of State Medicaid expenditures within managed care programs. This makes it more difficult for managed care plans and States to discern which participants of the pharmacy supply chain retain the bulk of the COD reimbursement.

For these reasons, we are proposing to amend § 438.3(s) to require Medicaid MCOs, PIHPs, and PAHPs that provide coverage of CODs to structure any contract with any subcontractor for the delivery or administration of the COD benefit require the subcontractor to report separately the amounts related to the incurred claims described in § 438.8(e)(2), such as reimbursement for the CODs, payments for other patient services, and the dispensing or administering providers fees, and subcontractor administrative fees. The proposal would ensure that MLRs reported by MCOs, PIHPs, and PAHPs that use subcontractors in the delivery of COD coverage would be more accurate and transparent. The separate payment requirements would help States and managed care plans better understand whether they are appropriately and efficiently paying for the delivery of CODs, a significant part of which is funded by the Federal Government. We note that this proposal does not change the applicability of the 2019 CIB to PBM subcontractors or to other subcontracting arrangements used by a Medicaid managed care plan; the 2019 CIB remains CMS' position on how §§ 438.8 and 438.230 apply. This proposal would create additional requirements for MCOs, PIHPs and PAHPs that help ensure that the objectives and responsibilities outlined in the 2019 CIB are met.

The proposal requires MCOs, PIHPs, and PAHPs that cover CODs to require their subcontractors to report their costs in a way that aligns more fully with the specific categories specified in § 438.8(e)(2) regarding the MLR numerator. Fully aligning the subcontractor's reports and billing (invoices) with how the MLR regulation categorizes and treats specific costs and expenditures would make clearer for the MCOs, PIHPs, and PAHPs how its payments to a subcontractor are used that would be subject to proposed § 438.3(s)(8), and allow those managed care plans to incorporate the subcontractor's costs into the MLR reporting and calculation. However, having the subcontractor's (in particular a PBM's) expenditures and costs reported in the categories that we are proposing might not be representative of how the industry works, might require systems changes and impose burden that we have not taken into account, or might result in unintended consequences. Therefore, we are specifically soliciting comment on this point and on other alternatives for how MCOs, PIHPs, and PAHPs should require information from their subcontractors and how they should structure payment or billing arrangements to achieve the policy goals we have outlined.

We believe this new transparency requirement would assist States and Medicaid managed care plans in complying with § 438.8 and related guidance because subcontractor PBMs would be required to appropriately identify certain costs, so that the managed care plan can appropriately calculate its MLR. In particular with COD spending, the managed care plan would have to separately identify prescription drug and dispensing or administration fee claim costs when calculating the MLR, in contrast to

[6] David Yost, Ohio's Medicaid Managed Care Pharmacy Services Auditor of the State Report (2018), available at *https://tinyurl.com/mbn75c.*

[7] *https://nashp.org/comparison-of-state-pharmacy-benefit-managers-laws/.*

administrative costs. As a result, any payments for costs over and above the cost of the prescription and dispensing fee would be separately identifiable by the managed care plan and cannot be used to inappropriately inflate the MLR which may result in managed care plan capitation rates that are not actuarially sound.

C. MDRP Administrative and Program Integrity Changes

1. Proposed Definitions (§ 447.502)

a. Proposal To Modify the Definition of Covered Outpatient Drug (§ 447.502)

Sections 1927(k)(2) and (3) of the Act provide a definition of the term ''covered outpatient drug'' (COD) and a limiting definition, which excludes certain drugs, biological products, and insulin provided as part of, or as incident to and in the same setting as, enumerated services and settings from the definition of COD. This exclusion is subject to a parenthetical, however, which limits the exclusion to when payment may be made as part of payment for the enumerated service or setting, and not as direct reimbursement for the drug.

In the COD final rule, we finalized a regulatory definition of COD in § 447.502 that substantially mirrors the statutory definition. Consistent with section 1927(k)(3) of the Act, the regulatory definition includes a limiting definition in paragraph (2) of the definition of covered outpatient drug at § 447.502 that excludes from the definition of COD any drug, biological product, or insulin provided as part of or incident to and in the same setting as any one in a list of services, and for which payment may be made as part of that service instead of as a direct reimbursement for the drug.

Over the years we have received questions about when a payment is considered to be a direct reimbursement for a drug and whether identifying a drug separately on a claim for payment may qualify as direct reimbursement for a drug, rendering the drug eligible for rebates under section 1927 of the Act as a COD, or in other words, garnering the limiting definition exclusion inapplicable. If a drug and its cost can be separately identified on a claim for payment it can be considered subject to direct reimbursement. That is, if the payment to the provider includes any reimbursement for the drug and the drug is separately identified, then the reimbursement for the drug is a direct reimbursement. Additionally, if the payment to the provider is solely for the drug (and no other services), and the drug is separately identified, it is also a direct reimbursement. Therefore, direct reimbursement may be reimbursement for a drug alone, or reimbursement for a drug plus the service, in one inclusive payment, if the drug plus the itemized cost of the drug are separately identified on the claim. In other words, the payment for the drug is not required to be a separate payment in order for such payment to be considered direct reimbursement.

To provide greater clarity on this point and the application of the limiting definition, we propose to amend the regulatory definition of the term covered outpatient drug at § 447.502 to add that direct reimbursement for the drug includes when a claim for payment identifies the drug plus the itemized cost of the drug. Specifically, we propose to add to the regulatory definition of covered outpatient drug at § 447.502 that the direct reimbursement for a drug may include both reimbursement for a drug alone, or reimbursement for a drug plus the service, in one inclusive payment, if the drug and the itemized cost of the drug are separately identified on the claim.

Additionally, the limiting definition in section 1927(k)(3) of the Act includes the following parenthetical: ''. . . (and for which payment may be made under this subchapter as part of payment for [certain services] and not as direct reimbursement for the drug).'' The term covered outpatient drug is defined in § 447.502 and includes this limiting definition parenthetical at paragraph (2): ''. . . (and for which payment may be made as part of that service instead of as a direct reimbursement for the drug).''

There is no meaningful distinction between the statutory and regulatory language for purposes of the MDRP, and thus, we are proposing to make a technical change by modifying the regulatory language so that it more closely mirrors the statutory language. We propose to add ''payment for'' after ''and for which payment may be made as part of'' and to delete ''instead of as a'' in the limiting definition of covered outpatient drug and replace it with ''and not as''.

The proposed definition would then read, in significant part, as ''. . . (and for which payment may be made as part of payment for that service and not as direct reimbursement for the drug).''

b. Proposal To Define Drug Product Information (§ 447.502)

Section 6(a)(1)(A)(iv) of MSIIA amended section 1927(b)(3) of the Act by adding the words ''and drug product'' to the title of section (b)(3), and adding section (b)(3)(A)(v), to require a manufacturer to report drug product information that the Secretary shall require for each of the manufacturer's CODs no later than 30 days after the last day of each month of a rebate period. Section 1927(b)(3)(A) of the Act describes the manufacturer drug product and pricing information that is required to be reported to the agency by statute, and with respect to the pricing information, specifically provides for the reporting of such information, such as AMP and best price. To support the implementation of this new statutory requirement to report drug product information, we propose to define drug product information at § 447.502.

We currently require manufacturers to submit drug product information when the covered outpatient drug is entered into the MDP system, although there is no regulatory definition of drug product information. When initially reporting drug product data upon the execution of an NDRA, manufacturers have 30 days after the date on which they enter into an NDRA to report drug product data for their existing CODs under section 1927(b)(3)(A) of the Act. After the execution of an NDRA, manufacturers have 30 days from the end of each rebate period to report drug product data for new CODs under section 1927(b)(3)(A)(v) of the Act.

We propose to define ''drug product information'' in § 447.502 as information that includes, but is not limited to, NDC number, drug name, units per package size (UPPS), drug category (''S'', ''I'', ''N''), unit type (for example, TAB, CAP, ML, EA), drug type (prescription, over-the counter), base date AMP, therapeutic equivalent code (TEC), line extension drug indicator, 5i indicator and route of administration, if applicable, FDA approval date and application number or OTC monograph citation if applicable, market date, COD status, and any other information deemed necessary by the agency to perform accurate URA calculations.

As previously discussed in this proposed rule, the drug category for an NDC should be single source or innovator for the entire history of the NDC if it was always produced, distributed, or marketed under an NDA, unless a narrow exception applies, or single source if marketed under a BLA. If a narrow exception has been granted by CMS, the drug category for that NDC should historically be reported as single source or innovator, and can be changed to noninnovator, effective April 1, 2016. We use the FDA ''applications.txt'' file to verify the type of application associated with an application number. The file may be accessed using the link to the Drugs@FDA download file found

on the FDA web page at *https://www.fda.gov/drugs/drug-approvals-and-databases/drugsfda-data-files*.

The only situation in which a drug that is produced or marketed under an NDA may be reported as a noninnovator drug is if a narrow exception was granted by CMS in accordance with the process established in the COD final rule. See 81 FR 5191. Definitions for these drug categories can be found at section 1927(k)(7) of the Act and at § 447.502.

Manufacturers should evaluate all of their NDCs for compliance with drug product information reporting, and if they determine corrections are required, they should contact the agency for assistance. In Manufacturer Release No. 113, we address a manufacturer's responsibility to ensure that all of their CODs are correctly classified and reported in the Drug Data Reporting system (DDR) for the history of the NDC, including such NDCs that may no longer be active: *https://www.medicaid.gov/prescription-drugs/downloads/mfr-rel-113.pdf*.

As part of a manufacturer's evaluation of their NDCs for compliance with accurate drug product information reporting, they should ensure that each NDC is reported with an accurate market date. In this proposed rule, we are proposing to add a definition for ''market date'' for the purposes of the MDRP. Please see proposed § 447.502 for that proposed definition and elsewhere in this preamble for an explanation of how market date is used to determine the quarter that establishes each drug's base date AMP.

Generally, a manufacturer cannot make the drug product information corrections in the CMS system without our intervention. To request corrections, a manufacturer should contact CMS using instructions that are available on *Medicaid.gov* (*https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/medicaid-drug-rebate-program-change-request/index.html*) to correct drug product and pricing information. If we identify a misclassified or misreported NDC as part of the review of the information submitted by the manufacturer to support these drug pricing or product information changes, and notify the manufacturer, the link to the instructions for correcting the data would generally be included as part of that notification.

For most drug product information changes, as outlined above, we would make the requested changes on behalf of the manufacturer in the CMS system, and those changes would subsequently be available for manufacturer certification. However, in some situations where monthly and/or quarterly pricing data must be updated as a result of the drug product information change, if necessary, we would notify the manufacturer that certain pricing data fields have been ''unlocked'' in the CMS system to allow the manufacturer to enter or correct required pricing information if applicable.

Regardless of whether we make a data change on behalf of a manufacturer or whether the manufacturer enters required data directly in the CMS system, manufacturers would be required to certify the information in accordance with § 447.510. If we make a data change at the request of a manufacturer, the manufacturer is not relieved of its responsibility to ensure the accuracy of such data, nor should it be inferred that we have approved a variance from the requirements of the statute.

Until certification is complete, the changes in the CMS system are not considered final and would not be used in any quarterly rebate calculations or transmitted to the States as part of the quarterly rebate files; however, the manufacturer is still responsible for correct URA calculations and rebate payments. If drug product information changes are left uncertified, the previously certified values would remain in effect; therefore, corrections made in the CMS system that remain uncertified would result in the drug continuing to be considered misclassified or misreported. We would consider this to be late reporting of product data for which a manufacturer's rebate agreement may be suspended from the MDRP under section 1927(b)(3)(C)(i) of the Act, and eventually terminated as authorized under section 1927(b)(4)(B) of the Act.

c. Proposal To Define Internal Investigation for Purposes of Pricing Metric Revisions (§§ 447.502 and 447.510)

In accordance with section 1927(b)(3) of the Act, § 447.510 of the implementing regulations, and the terms of the NDRA, manufacturers are required to report certain pricing and drug product information to CMS on a timely basis or else they could incur penalties or be subject to other compliance and enforcement measures. As explained in the final time limitation rule, in an effort to improve the administration and efficiency of the MDRP and assist States and manufacturers that would otherwise be required to retain drug utilization pricing data records indefinitely, we established the 12-quarter time frame for reporting revisions to AMP or best price information. Notwithstanding the 12-quarter time frame for reporting revisions, we continued to receive requests outside of the 12-quarter period from manufacturers to revise pricing data. These types of manufacturer requests, which could span multiple years prior to the 12-quarter timeframe, and could sometimes result in substantial recoupment of Medicaid rebates already paid to States, impede the economic and efficient operation of the Medicaid program.

Consequently, in the COD final rule (81 FR 5278) we finalized § 447.510(b)(1), which provides that a manufacturer must report to CMS any revision to AMP, best price, customary prompt pay discounts or nominal prices (pricing data) for a period not to exceed 12 quarters from the quarter in which the data were due unless one of a number of enumerated exceptions applies. See § 447.510(b)(1)(i) through (vi). Of note, § 447.510(b)(1)(v) provides an exception to the 12-quarter price reporting rule if the change is to address specific rebate adjustments to States by manufacturers, as required by CMS or court order, or under an internal investigation, or an OIG or Department of Justice (DOJ) investigation.

In a response to comment in the preamble of the COD final rule, which added § 447.510(b)(1)(v), we indicated that internal investigation is intended to mean a manufacturer's internal investigation, and we further explained that in the event that a manufacturer discovers any discrepancy with its reported product and pricing data to the MDRP that are outside of the applicable timeframes, the manufacturer should determine if the change satisfies one of the enumerated exceptions. (81 FR 5280)

However, we did not further define or give any greater explanation for the applicability of the exception to the 12-quarter rule, particularly in instances when manufacturers perform an internal investigation of the prices (AMP and best price) reported and certified in the Medicaid Drug Product systems by another manufacturer. Given the absence of a definition of internal investigation or specificity as to when this exception applies, some manufacturers have broadly interpreted the internal investigation exception to the 12-quarter rule.

Some manufacturers have requested revisions to AMP and best price outside of the 12-quarter rule based upon an internal investigation related to newly acquired products or lines of business

previously certified by the prior manufacturers without making findings that the prior manufacturer violated any law. For example, some requests from manufacturers to revise AMP or best price for drug product and drug pricing information previously reported and certified from another manufacturer were based on internal reviews that did not result in proof that the prior manufacturer misapplied the laws or regulations, or acted in a fraudulent or illegal manner.

In cases when a manufacturer requests an exception to the 12-quarter rule due to an internal investigation, we propose to specify that the manufacturer must make a finding that indicates a violation of statute or regulation made by the prior manufacturer before we consider such a request. For example, a request to restate or revise pricing outside of the 12-quarter time frame by a manufacturer to previously reported and certified data of a prior manufacturer based upon a mere disagreement with the prior manufacturer's government pricing calculations and assumptions would not be considered a valid reason to revise a prior manufacturer's pricing outside of the 12-quarter time frame. The manufacturer must make findings that include actual data as evidence that the prior manufacturer violated statute or regulation.

Manufacturers should not use the internal investigation exception to permit restatements to allow manufacturers to apply a different methodology or reasonable assumption to determine AMP and best price to its favor when the methodology originally applied was consistent with statute and regulation, and drug product and pricing information was properly reported and certified by the manufacturer at the time. To ensure clarity on when the internal investigation exception may be appropriately applied, we are proposing to define internal investigation at § 447.502 to mean a manufacturer's investigation of its AMP, best price, customary prompt pay discounts or nominal prices that have been previously certified in MDRP that results in a finding made by the manufacturer of fraud, abuse or violation of law or regulation. A manufacturer must make data available to CMS to support its finding. We are also proposing to amend § 447.510(b)(1)(v) to reference the proposed definition of internal investigation at § 447.502.

d. Proposal To Revise Definition of Manufacturer for NDRA Compliance (§ 447.502)

When Congress passed the drug rebate provisions in 1990, they established a framework for coverage and payment of covered outpatient drugs under Medicaid, and prescribed drugs, generally. Often referenced as the ''grand bargain'' between the States, the Federal Government, and manufacturers, the MDRP made clear that if manufacturers paid rebates for the covered outpatient drugs dispensed and paid for under the State Plan, States would be required to cover their covered outpatient drugs, subject to limited permissible restrictions and exclusions. These policies would help increase Medicaid beneficiaries' access to medications, while assisting States in striving to deliver an economic and efficient Medicaid program. A key piece of the coverage and payment framework the MDRP established is captured in section 1927(a)(1) of the Act, which provides that in order for payment to be available under section 1903(a) or under part B of title XVIII for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement with the Secretary as described in section 1927(b) of the Act.

With an effectuated rebate agreement in place, manufacturers participating in the MDRP are required to provide periodic rebates for CODs dispensed and paid for under the State Plan, and also provide certain drug price and drug product information on a monthly and/or quarterly basis to the agency. While entering into a rebate agreement is voluntary, a manufacturer that does not enter into such an agreement forgoes payment and coverage, for their covered outpatient drugs under Medicaid. It also affects coverage under the 340B Drug Pricing Program and may affect Medicare Part B reimbursement.

To implement the important requirement set forth at section 1927(a)(1) of the Act, and in an effort to prevent selective reporting of NDCs, the agency has required manufacturers to ensure that all their associated labeler codes with CODs enter into a rebate agreement to comply with the terms of the NDRA. This requirement has been included in the NDRA since the inception of the program. (See section II., Manufacturer's Responsibilities, subsection (a) of the previous NDRA, and section II., Manufacturer's Responsibilities, subsection (b) of the updated NDRA.) We also reiterated this point most recently in the preamble to the updated NDRA, 83 FR 12770 (Mar. 23, 2018). In that final notice, we explained that manufacturers are required to report all CODs under their labeler code(s) to the MDRP, and may not be selective in reporting their national drug codes (NDCs) to the program.

We continue to maintain that this requirement applies to all the manufacturer's labeler codes, including newly acquired labeler codes, newly formed subsidiaries, and labeler codes previously omitted from the original rebate agreement. 83 FR 12771; see also Manufacturer Releases #13 and #48. Thus, once we review a request for a rebate agreement and the manufacturer confirms, among other things, that all of a manufacturer's CODs are listed, a rebate agreement will be issued. Manufacturers are then responsible for paying a rebate on those CODs that were dispensed and/or paid for, as applicable, under the State Plan. These rebates are paid by manufacturers on a quarterly basis to States, and are shared between the States and the Federal Government to partially offset the overall cost of prescription drugs under the Medicaid program.

The term ''manufacturer'' was first defined in statute in 1990, when section 1927 of the Act was established, and was interpreted in regulation in 2007 at § 447.502. Section 1927(k)(5) of the Act defines the term ''manufacturer'' as any entity which is engaged in: (1) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or (2) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

The regulations at § 447.502 define ''manufacturer'' to mean any entity that holds the NDC for a covered outpatient drug or biological product and meets the following criteria:

- Is engaged in the production, preparation, propagation, compounding, conversion, or processing of covered outpatient drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or
- Is engaged in the packaging, repackaging, labeling, relabeling, or distribution of covered outpatient drug products and is not a wholesale distributor of drugs or a retail pharmacy licensed under State law.

• For authorized generic products, the term ''manufacturer'' will also include the original holder of the NDA.

• For drugs subject to private labeling arrangements, the term ''manufacturer'' will also include the entity under whose own label or trade name the product will be distributed.

The labeler code is a unique 5-digit number within the NDC,[8] assigned by the FDA, and one manufacturer may be assigned multiple labeler codes by FDA. A manufacturer can obtain a different labeler code for each manufacturing establishment or company under the same ownership since the labeler code identifies a company marketing a drug product.[9] Some drug companies that have several divisions have more than one labeler code, and a single manufacturer may be marketing its drugs across or under multiple labeler codes. Furthermore, a manufacturer may own, operate, or be associated or affiliated with several labeler code subsidiaries, each of which makes CODs.

Consistent with the statute and regulation, our current policy is that each of these associated labeler codes would have to have an effectuated rebate agreement in order for the single manufacturer to be considered to be in compliance with the requirement under section 1927(a)(1) of the Act that a manufacturer have a rebate agreement in effect, and this has been noted in related guidance.[10] We treat each associated labeler code as part of the single manufacturer, and if any of the labeler codes of a manufacturer do not have an NDRA in effect, no FFP would be available for any of the CODs of the labeler codes of the manufacturer, and all of the labelers would be subject to potential termination from the MDRP.

We also explained in the final notice for the updated NDRA that manufacturers that wish to terminate an NDRA that have active CODs must request termination for all associated labeler codes, and provide a reason for the request (for example, all CODs under the labeler code are terminated), or if the request for termination is only for certain labeler codes, provide justification for such request (83 FR 12770, 12771). In that same final notice, we indicated that for purposes of ensuring beneficiary access to single source drugs and/or drugs that are not otherwise available in the MDRP, we may choose to grant an exception to issuing or reinstating an NDRA for certain labeler codes of a manufacturer prior to issuing an NDRA for all of the labeler codes of the manufacturer, or terminating certain labeler codes as mentioned above (83 FR 12771).

The requirement that manufacturers that enter into a rebate agreement cannot exclude any covered outpatient drug from their listings applies to all CODs associated with any of the manufacturer's labeler codes that market CODs, including newly-purchased labeler codes, and newly-formed subsidiaries. This means a manufacturer has to be ''all in'' for all its drugs, or ''all out''. Otherwise, there is a possibility that a manufacturer would create separate labeler codes for some of its drugs, and enter into a rebate agreement for some of its labeler codes, and not others. Permitting a manufacturer to do so would allow them the benefit of receiving FFP for some of their CODs, while potentially avoiding the financial obligation to pay rebates for other drugs that would otherwise qualify as CODs and be subject to rebates. If a product meets the definition of a covered outpatient drug, but the manufacturer of such drug does not have a rebate agreement in effect, that drug is not eligible for FFP and may not be claimed on the CMS–64 form, even though the drug may meet the definition of a prescribed drug. In these situations, while States would not be required to provide mandatory coverage of such drugs, a State may still elect to cover these products with State only funds.

While we believe that the overwhelming majority of manufacturers are compliant with section 1927(a)(1) of the Act, and have had all their associated labelers enter into and maintain drug rebate agreements, this issue has been challenged by a few manufacturers. In more recent times, manufacturers have suggested certain associated labelers are exempt or not required to be included in the program under the manufacturer's rebate agreement, stating that such associated companies, parent entities and brother-sister entities are distinct separate manufacturers. They have stated that the agency has not required such a policy through final regulations, but rather has articulated this policy only in program releases and preamble statements, which are subregulatory guidance that do not carry the force of law.

To codify the requirement at section 1927(a)(1) of the Act, that a manufacturer have entered into and have in effect an agreement with the Secretary to receive FFP for its CODs, we are now proposing to modify the regulatory definition of manufacturer to specify how the term ''manufacturer'' is defined for purposes of complying with this statutory requirement. To satisfy the requirement that a manufacturer have entered into and have in effect an agreement with the Secretary, we are specifying at proposed § 447.510(h) that manufacturers must provide CMS with all labeler codes for all the manufacturer's applicable drugs. More specifically, we are proposing at § 447.510(h)(2) that if any manufacturer with a signed rebate agreement in effect, acquires or purchases another labeler, acquires or purchases covered outpatient drugs from another labeler code, or forms a new subsidiary, they must ensure that a signed rebate agreement is in effect for these entities or covered outpatient drugs, consistent with the definition of manufacturer at § 447.502, within the first 30 days of the next full calendar quarter beginning at least 60 days after the acquisition, purchase, asset transfer, or formation of the subsidiary.

As first described in the ''Medicaid Program; Payment for Covered Outpatient Drugs Under Drug Rebate Agreements With Manufacturers'' proposed rule (95 FR 48442; hereinafter referenced as the ''1995 proposed rule''), we have noted our intent that each associated manufacturer's labeler codes would have to have an effectuated rebate agreement in order for the single manufacturer to be considered to be in compliance with the requirement under section 1927(a)(1) of the Act that a manufacturer have a rebate agreement in effect. This 1995 proposed rule is informative and helpful to understanding and describing the agency's initial proposed policy and intentions with the Medicaid Drug Rebate Program.[11] In this proposal, CMS proposed to interpret the term ''manufacturer'' to specify that if a corporation meets the statutory definition of manufacturer (that is, section 1927(k)(5) of the Act) and possesses legal title to the NDC, the agency would consider the term to include associated companies, including parent corporations, brother-sister corporations, and subsidiary corporations. In addition, we further proposed to interpret the term to specify that if a corporation meets the statutory definition of manufacturer, and possesses legal title to the NDC number, we would consider the term to include: (1) Any corporation that owns at least 80 percent of the total combined voting power of all classes of stock or 80 percent of the total value of shares in all

[8] See 21 CFR 207.33.

[9] Electronic Drug Registration and Listing Instructions | FDA.

[10] Manufacturer Release 013 (October 6, 1994), Manufacturer Release 048 (November 15, 2000) and 83 FR 12770, 12771 (Mar. 23, 2018).

[11] 60 FR 48447 through 48448.

classes of stock in such entity (that is a parent corporation); (2) Any other corporation in which a parent corporation of the entity owns at least 80 percent of the total combined voting power of all classes of stock or 80 percent of the total value of shares. (60 FR 48447–48448)

This policy comports with Congress' desire to maximize recipient access to medically necessary drugs, while at the same time providing a more favorable drug purchasing arrangement for State Medicaid programs.[12] When Congress passed the drug rebate provisions in 1990, they made it clear that States that elect to cover prescription drugs must, except for certain restrictions or exclusions allowed under the statute, cover the CODs of a manufacturer that enters into and complies with a drug rebate agreement. In return for such coverage, a manufacturer would be responsible for providing a rebate to the State that would give the Medicaid program the benefit of those discounts that other large public and private purchasers receive.[13]

We believe it would be directly contrary to Congressional intent to apply the definition of a manufacturer in a manner that would permit a manufacturer (that is by forming a subsidiary corporation) to exclude some of its drugs from the drug rebate program.[14] Our proposal would prevent manufacturers from manipulating the system as to select drugs by assigning separate labeler codes, without consequence to all of their CODs, and codify a longstanding policy that has faced scrutiny more recently. As such, we continue to believe that when defining a manufacturer, the term ''entity'' should be interpreted to include parent, brother-sister, or subsidiary corporations, as well as, labelers that are owned, acquired, subsidiaries, affiliates, parent companies, franchises, business segments, part of holding companies, or under common corporate ownership or control.

Therefore, to provide a clearer definition of the meaning of manufacturer with respect to section 1927(a)(1) of the Act, we are proposing to amend the regulatory definition of manufacturer at § 447.502. Consistent with the statute and our understanding of Congressional intent of the MDRP, which was increasing access to medications while at the same time helping States manage pharmacy program costs and maximizing Medicaid savings, we are proposing to include a new paragraph (5) as part of the definition of a manufacturer. This change explains that, for purposes of meeting the requirements in section 1927(a)(1) of the Act of maintaining an effectuated rebate agreement, that the term ''manufacturer'' means that all associated labeler entities of the manufacturer that sell prescription drugs, including, but not limited to, owned, acquired, affiliates, brother or sister corporations, operating subsidiaries, franchises, business segments, part of holding companies, divisions, or entities under common corporate ownership or control, must each maintain an effectuated rebate agreement in order for a manufacturer to satisfy the requirement at section 1927(a)(1) of the Act to have entered into and have in effect a rebate agreement with the Secretary.

Additionally, we are proposing a new paragraph (h), ''Participation in the Medicaid Drug Rebate Program (MDRP),'' in § 447.510 to further specify the responsibilities of a manufacturer, specifying in § 447.510(h)(1) that manufacturers participating in the MDRP must have a signed rebate agreement that complies with paragraph (5) in the definition of the manufacturer in § 447.502.

Furthermore, with respect to rebate agreements when a manufacturer acquires or purchases another manufacturer, acquires or purchases covered outpatient drugs from another manufacturer, or forms a new subsidiary, we are proposing to add § 447.510(h)(2), ''Newly purchased labeler codes and covered outpatient drugs.'' We are proposing that any manufacturer with a rebate agreement in effect that acquires or purchases another labeler code, acquires or purchases covered outpatient drugs from another labeler, or forms a new subsidiary, must have in effect a rebate agreement for these entities or covered outpatient drugs consistent with definition of manufacturer at § 447.502. The newly associated entity of the manufacturer must also have a rebate agreement in effect within the first 30 days of the next full calendar quarter beginning at least 60 days after the acquisition, purchase, asset transfer, or creation of a subsidiary has occurred. By including these provisions in regulation, we would better specify that a manufacturer must, in part, assure that a NDRA is in effect with the Secretary for all associated labeler codes and that MDRP requirements apply to all CODs of a manufacturer, including newly associated entities.

Finally, we are proposing to add a provision on termination in at § 447.510(h)(3) specifying that each associated labeler code of a manufacturer is considered to be part of the single manufacturer, and if any of the associated labeler codes as defined in paragraph (5) of the definition of manufacturer at § 447.502 do not have an NDRA in effect, or are terminated, then all of the labeler codes will be subject to termination.

e. Proposal To Define Market Date (§ 447.502)

Section 1927 of the Act governs the MDRP and payment for CODs which are defined in section 1927(k)(2) of the Act. Manufacturers that participate in the MDRP are required to pay rebates for CODs that are dispensed and paid for under the State Medicaid plan. (See section 1927(b)(1)(A) of the Act.) Section 1927 of the Act provides specific requirements for program implementation, including requirements for rebate agreements, submission of drug pricing and product information, confidentiality, the formulas for calculating rebate payments, and many others related to State and manufacturer obligations under the program. The rebates due by manufacturers are calculated based on statutory formulas described in section 1927(c) of the Act and consist of a basic rebate and, in some cases, an additional rebate that is applicable when an increase in the AMP, with respect to each dosage form and strength of a drug, exceeds the rate of inflation. This additional rebate formula is set forth in sections 1927(c)(2) and 1927(c)(3)(C) of the Act, and codified in regulation at § 447.509(a)(2) and (7).[15]

The additional rebate calculation requires a determination of the AMP for the dosage form and strength of the drug for the current rebate quarter, and a comparison of that AMP to the AMP for the dosage form and strength of that drug for a certain calendar quarter, generally referenced as the base date AMP quarter.[16] For S or I drugs, that

[12] H.R. Conf. Rept. No. 964, 101st Cong., 2d Sess. 822, 832 (1990); H.R. Rept. No. 881, 101st Cong., 2d Sess. 996 (1990).

[13] Id.

[14] Id.

[15] Section 602 of the Bipartisan Budget Act (BBA) of 2015 amended section 1927(c)(3) of the Act, to require that manufacturers pay additional rebates when their covered outpatient drugs other than single source or innovator multiple source drugs' average manufacturer prices increase at a rate that exceeds the rate of inflation. In accordance with section 1927(c)(3) of the Act, as revised by section 602 of the BBA of 2015, manufacturers must calculate these additional rebates for these drugs beginning with the January 1, 2017 quarter (that is, first quarter of 2017).

[16] Base Date AMP is defined in the National Drug Rebate Agreement (NDRA) at I.(c) as follows: ''Base

base date AMP quarter is the third quarter of 1990, for drugs that were first marketed prior to fourth quarter of 1990, or the first full calendar quarter after the day on which the drug was first marketed for drugs that were first marketed on or after October 1, 1990.[17] See sections 1927(c)(2)(A) and 1927(c)(2)(B) of the Act. For other drugs (including N drugs and other drugs reported as N), that base date AMP quarter is the third quarter of 2014 for drugs that were first marketed prior to April 1, 2013, or the fifth full calendar quarter after the day on which the drug was first marketed for drugs that were first marketed on or after April 1, 2013. See section 1927(c)(3)(C) of the Act. To determine the applicable base date AMP, and ultimately, to calculate the additional rebate for a quarter, a critical data point is the day on which the drug was first marketed. We reference this date as a COD's ''market date.'' Manufacturers are required to report to CMS the market date of each dosage form and strength of a COD for all of its CODs.

Section 1927(c)(2)(A)(ii)(II) of the Act expressly provides that the base date AMP quarter, with respect to a dosage form and strength of a drug, is established ''without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer. . .'' This means the market date of a drug is the date that the drug was first marketed, regardless of the entity that marketed the drug. Consistent with the statute, the market date of a drug is not and cannot be based on the first date upon which a subsequent manufacturer first markets the drug, but rather the earliest date on which the drug was first marketed, by any manufacturer, or under any NDC.

A new market date cannot be established for a drug that is marketed under the same FDA-approved NDA number, ANDA number or BLA license unless the drug is a new dosage form or strength because the rebate statute requires an additional rebate amount based on the market date for each dosage form and strength of a COD.[18] Thus, if a drug is purchased or otherwise acquired from another manufacturer, the market date should not change, and should equal the market date of the drug first marketed under the approved application.

Some manufacturers have attempted to set a new market date to establish a new base date AMP for a drug by making changes to a drug already approved under an FDA application that are something other than changes to the dosage form or strength. If changes to the drug are approved under the same FDA application and do not constitute changes to the dosage form or strength, a new base date AMP is not appropriate.

Over the years, manufacturers have sporadically engaged in debate regarding the determination of a COD's market date, base date AMP quarter, and base date AMP under varied fact-driven scenarios. This proposed definition seeks to clarify the term ''market date'' as used in the MDRP and to end any further such debates.

AMP is defined in section 1927(k)(1) of the Act and the definition includes that it is ''. . . the average price paid to the manufacturer for the drug. . . .'' If there have not been any sales of the drug, there is no data upon which to determine an average price paid to the manufacturer to most accurately calculate the AMP value. Historically, in such cases where no sales may have occurred in a base date AMP quarter (because sometimes a new NDC may be available for sale during a quarter, but no sales occurred during that quarter), we have advised manufacturers to use reasonable assumptions, as appropriate, and consistent with applicable law to establish an AMP.

To assist manufacturers in reporting a more accurately calculated AMP, we are proposing to define market date based on the first sale of the drug, rather than the date the drug was first available for sale. Linking the market date determination to the date of the first sale, rather than the date the drug was first available for sale, would permit a manufacturer to establish and report a base date AMP without reliance on reasonable assumptions, and based on actual data. As a result, the URA would also be calculated more accurately because actual sales would be available for reporting.

For purposes of determining the base date AMP quarter and base date AMP, we propose that market date be based upon the earliest date on which the drug was first sold, by any manufacturer, or under any NDC, and define the term to mean the date on which the COD was first sold by any manufacturer.

We propose that first sold means any sale of the COD. We understand defining market date, for purposes of determining a COD's base date AMP, based on when the COD was first sold, may not completely eliminate a manufacturer's need to make reasonable assumptions because the first sales may include only AMP ineligible sales. For example, if all the sales during the first quarter of a drug's availability are made to entities other than retail community pharmacies or wholesalers, and are not eligible for a 5i AMP calculation, then there may not be any AMP eligible sales to use for the calculation of AMP for that quarter. In such cases, a manufacturer may still need to use reasonable assumptions to report an AMP for that quarter.

We propose that ''sold'' means that the drug has been transferred (including in transit) to a purchasing entity. We are requesting comments on this topic to determine what qualifies as ''sold'' for the purposes of determining the market date of a drug, as we have also experienced manufacturers interpreting the term ''sold'' differently across the industry.

Because the term market date has not been previously defined in regulation and it is data used in the determination of base date AMP, we are proposing a definition of market date for the purposes of the MDRP. We are proposing at § 447.502 that market date, for the purpose of establishing the base date AMP quarter, means the date on which the COD was first sold by any manufacturer.

f. Proposal To Modify the Definition of Noninnovator Multiple Source Drug (§ 447.502)

As discussed previously in this proposed rule, section 6(c) of the MSIAA included a number of amendments to statutory definitions in section 1927 of the Act. Generally, those statutory amendments were discussed in the December 31, 2020 final rule (85 FR 87000, 87032) where the regulatory definitions of multiple source drug, innovator multiple source drug, and single source drug were amended consistent with the MSIAA.

Although we made conforming changes to the regulatory definition of an I drug in the December 31, 2020 final rule, because the MSIAA did not

Date AMP'' will have the meaning set forth in sections 1927(c)(2)(A)(ii)(II) and 1927(c)(2)(B) of the Act. See also I.(l) definition of ''marketed''. Section VIII.a, provides that the agreement is subject to any changes in the Medicaid statute or regulations that affect the rebate agreement. Thus, any changes to regulations will be incorporated into rebate agreements without further action. See also Manufacturer Release 113—Misclassification of Drugs (*medicaid.gov*); *https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/mfr-releases/mfr-rel-009.pdf Manufacturer release No. 9; form 367c data definitions.*

[17] For a drug with a market date prior to October 1, 1990, the MDRP reporting system defaults to a market date of September 30, 1990. The system assigns a base date AMP quarter of fourth quarter of 1990 to such drugs as the statute defines (section 1927(c)(2)(A)(ii) of the Act).

[18] The FDA approved application (for example the NDA itself) includes all FDA approved supplements to the application.

expressly amend or clarify the statutory definition of an N drug we did not consider whether any changes to the regulatory definition of an N drug were necessary at that time. After further evaluation, we propose to amend the regulatory definition of an N drug to conform the regulatory definition of an N drug to the regulatory definition of an I drug. When we established a regulatory definition of an N drug in the July 17, 2007 final rule, we did so to distinguish between multiple source drugs approved under an ANDA (generally referenced as N drugs) and multiple source drugs approved under an NDA (that is, S or I drugs). Both I drugs and N drugs are generally multiple source drugs. The main difference between the definitions is the authority under which the drug is marketed. Generally speaking, I drugs are marketed under an NDA and N drugs are marketed under ANDA, or are unapproved.

Section 1927(k)(7)(A)(iii) of the Act, which was not expressly amended or clarified by the MSIAA, defines a noninnovator multiple source (N) drug as a multiple source drug that is not an I drug. As noted, the MSIAA amended the statutory definition of an I drug by removing ''was originally marketed'' and adding ''is marketed,'' and we made conforming changes to the regulatory definition of an I drug in the December 31, 2020 final rule. When we modified the regulatory definition of an I drug to replace ''was originally marketed'' with ''is marketed'', we neglected to make a corresponding change to the definition of an N drug to maintain the clear distinction between an I drug, which is marketed under an NDA, and an N drug, which is not marketed under an NDA. Paragraph (3) of the regulatory definition of an N drug, codified at § 447.502, continues to refer to a COD that entered the market before 1962 that was not originally marketed under an NDA.

To maintain the clear distinction between an I drug and an N drug, we propose to amend paragraph (3) of the definition of an N drug at § 447.502 by removing ''was not originally marketed'' and inserting in place ''is not marketed.'' As amended, the regulatory definition of an N drug would, in relevant part, have the same structure as the statutory and regulatory definitions of an I drug and distinguish between a multiple source drug approved under an ANDA (that is, an N drug) and a multiple source drug approved under an NDA (that is, an S or I drug) based on the authority under which the drug is marketed, not how the drug was originally marketed.

Accordingly, we propose to amend § 447.502 by revising paragraph (3) of the definition of an N drug to read, a COD that entered the market before 1962 that is not marketed under an NDA. We believe this to be a technical correction to the regulatory text.

g. Proposal To Define Vaccine for Purposes of the MDRP Only (§ 447.502)

States that opt to cover prescribed drugs under section 1905(a)(12) of the Act in their State Plan are required to do so consistent with section 1927 of the Act, as set forth at section 1902(a)(54) of the Act. With limited exceptions, if a manufacturer wants payment to be available under Medicaid for their CODs, the manufacturer must participate (have entered into and have in effect a rebate agreement) in the MDRP, and agree to pay rebates for CODs dispensed and paid for under the State Plan. States are then required to cover the drugs of a manufacturer participating in the MDRP, if the drug satisfies the definition of COD, and then are required to invoice manufacturers for rebates on those CODs that are dispensed and paid for under the State Plan. If a particular drug or biological product of a participating manufacturer is excluded from or does not satisfy the definition of COD, then with limited exceptions, a State is not required to cover the product under the prescribed drugs benefit nor would it be subject to section 1927 of the Act. Moreover, those drugs or biological products are not eligible for rebate invoicing, even though a State may cover them and seek FFP.

Section 1927(k)(2)(B) of the Act specifically excludes vaccines from the definition of COD for purposes of the MDRP. This exclusion is codified in paragraph (1)(iv) of the regulatory definition of COD at § 447.502. Section 1927 of the Act, specifically, does not define vaccine. Nor is there a definition of vaccine in Title XI, XVIII, XIX, or XXI of the Act (applicable to Medicare, Medicaid, and CHIP), that speaks to the specific kinds of biological products that qualify as vaccines, in terms of their actions in the human body and how and when they are used. Moreover, we are not aware that any authorizing statutes for any other Department of Health and Human Services agencies include such a statutory definition of the term ''vaccine.'' We have not established a regulatory definition of vaccine for purposes of the MDRP, and we are not aware of any other statutory or regulatory definition of vaccine (that speaks to the actions of a product in the human body and how and when it is used) that would be applicable for purposes of the MDRP. However, for the reasons discussed in this section, we believe that a regulatory definition of vaccine is necessary for the purposes of the MDRP to specify which products are considered vaccines and thus excluded from the definition of COD.[19]

Generally, drugs and biological products that are used to treat a disease fall into one of the categories of CODs set forth at section 1927(k)(2) of the Act. Since Congress excluded vaccines from the definition of COD in the original 1990 law, and vaccines that were licensed at that time have a different intended use than therapeutics, we believe that vaccines were excluded because of their unique characteristics among medical products marketed at the time of preventing disease by inducing an immune response.

When the MDRP statute was enacted as part of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508, enacted November 5, 1990), the term ''vaccine'' referred to a product administered to provide active immunity to a person to prevent an infectious disease.[20] At the time, it was generally understood that vaccines are administered prophylactically, to prevent the development of an infectious disease, not to treat an existing non-infectious disease (such as a cancer). Although we have not found any legislative history specifically indicating why Congress chose to exclude vaccines from the definition of COD, it is likely Congress understood the term ''vaccine'' to refer to preventive vaccines only (that is, we do not believe that Congress understood the term to

[19] Currently, for vaccines other than COVID–19 vaccines, Medicaid coverage of vaccines and vaccine administration for adults is generally optional for States. Coverage of certain vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP) is required for children and youth under age 21 who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and for beneficiaries receiving Medicaid coverage through an Alternative Benefit Plan. Additionally, to receive a one percentage point increase in the Federal medical assistance percentage for certain expenditures, States must cover certain services, including approved adult vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP), without cost-sharing. See *https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf* for more information. Beginning October 1, 2023, under section 11405 of the Inflation Reduction Act of 2022, States are required to cover approved adult vaccines recommended by the ACIP, and their administration, for many adults enrolled in Medicaid and the CHIP program, without cost sharing.

[20] See *https://purplebooksearch.fda.gov/*. The database at this link provides information about all FDA-licensed biological products, including the date on which they were licensed. All the vaccines listed in the ''Purple Book'' are licensed to prevent an infectious disease.

include therapeutic vaccines) because all licensed vaccines at the time the law was enacted shared those characteristics.

As the science of immunology has become more advanced, drugs and biological products have been, and continue to be, developed that treat diseases using immunotherapy, such as immunotherapy used to treat certain cancers. Some manufacturers refer to such products as ''therapeutic'' vaccines. While both preventive vaccines and ''therapeutic vaccines'' work by creating an immune response, each type of product has a unique role in health care.

In general, a preventive vaccine provides active immunity to a disease, that is, it causes the body's immune system to produce an antigen-specific immune response (for example, antibodies and/or a cellular immune response) to antigens of the disease-causing organism.[21] A preventive vaccine is generally administered to induce immunity and a ''memory'' response to a particular infectious disease-causing organism so that in the event an individual is later exposed to that disease, the body will recognize the disease and respond before the disease has a chance to manifest or to reduce the severity of illness. There are also situations in which a preventive vaccine may be administered to an individual who has already been exposed to a disease-causing organism but the disease has not yet developed and may be prevented by a timely and robust vaccine-induced immune response (for example, rabies and anthrax vaccines).

In contrast, ''therapeutic vaccines'' are generally biological products that are intended to induce an antigen specific immune response to treat an already established disease (for example, treatment of cancer by inducing a specific immune response to the tumor). This type of product is generally intended to be a treatment modality similar to other forms of immunotherapy such as the checkpoint inhibitors or strategies that are based on the transfer of a preformed immune response (for example, transfer of antibodies or immune effector cells.)

If ''therapeutic vaccines'' were considered vaccines that are excluded from the definition of COD at section 1927(k)(2)(B) of the Act, a Medicaid beneficiary's access to these products under the prescribed drugs benefit could be limited because States would not be required to cover them under that benefit. Moreover, coverage of such a product under other benefits might only be available if the CDC's Advisory Committee on Immunization Practices (ACIP) issued a recommendation for such a product. This potential lack of access to important therapies for Medicaid beneficiaries is a critical concern. Clinical research into ''therapeutic vaccines'' has been increasing and several have been licensed by FDA that offer treatments for diseases that previously had limited or no effective treatment available. Similarly, if products that provide passive immunity, such as immune globulins, were excluded from the definition of a COD, because they were identified as vaccines, such treatments may not be made available to Medicaid beneficiaries.

Thus, with the increasing development and availability of products that use immunology to treat diseases, and because sometimes these products are referred to as ''therapeutic vaccines'', we believe that adopting an MDRP regulatory definition of ''vaccine'' that reflects Congress' likely intent at the time of the enactment of section 1927 of the Act is imperative to ensure that only the appropriate products are excluded from the definition of a COD. This would ensure manufacturers are able to report their drug product and drug pricing data for all CODs accurately, pay appropriate rebates to States, and most critically, that Medicaid beneficiaries have access to these important therapies under the prescribed drugs benefit.[22]

Therefore, we are proposing to define ''vaccine'' at § 447.502 for the specific purposes of the MDRP, so that manufacturers understand which products are considered vaccines under the MDRP and are excluded from the definition of COD, and not subject to rebates. The definition would be applicable only to the MDRP and would not be applicable to any other agencies or agency program implementation, including FDA, CDC, and HRSA. The proposed definition of vaccine would not apply under any Title XIX statutory provisions other than section 1927(k)(2), or to separate CHIPs operating pursuant to § 457.70(a)(1) and (d), or for purposes of the Vaccines for Children Program. The definition would apply to the MDRP for purposes of Medicaid expansion CHIPs, pursuant to § 457.70(c)(2). This proposed policy would not alter any applicable Federal or State requirements to cover immunizations for Medicaid beneficiaries, as applicable. Specifically, we are proposing to define ''vaccine'' to mean a product that is administered prophylactically to induce active, antigen-specific immunity for the prevention of one or more specific infectious diseases and is included in a current or previous FDA published list of vaccines licensed for use in the United States.

We are including in the proposed definition that a vaccine must be administered prophylactically—that is, to prevent a disease and not to treat a disease—because we believe that States should generally not exclude from coverage, under the prescribed drugs benefit, drugs or biologicals that treat disease. We are also proposing that a vaccine must be administered to induce active, antigen-specific immunity because that is a characteristic of preventive vaccines.

Finally, we are proposing to limit the definition of vaccine to those products that satisfy the conditions of being administered prophylactically, to prevent a disease, and induce active antigen-specific immunity, that also appear on a current or previous list compiled by FDA. FDA publishes a list of vaccines licensed for use in the United States.[23] As FDA is the agency responsible for licensing vaccines, we believe that if a product satisfying the previously described conditions appears on this list, it should be treated as a vaccine for the purposes of the MDRP. We seek comment on whether the proposed definition of vaccine, for purposes of the MDRP only, appropriately distinguishes between preventive vaccines (which would satisfy the definition of vaccine and, therefore, not satisfy the definition of a covered outpatient drug and would not be eligible for statutory rebates), and therapeutic vaccines (which would not satisfy the definition of vaccine and therefore could satisfy the definition of a covered outpatient drug and could therefore be eligible for statutory rebates).

Additionally, while we propose to cabin this definition to the MDRP, we seek comment on whether this definition might result in indirect consequences for Medicaid benefits other than the prescribed drugs benefit. We are also requesting comment about the consequences for Medicaid of ACIP recommending immunization with a

[21] CDC describes active immunity as a long-lasting immunity that develops by triggering antibody production. Conversely, they describe passive immunity as a short-term immunity provided by the administration of antibody-containing products. See *https://www.cdc.gov/vaccines/vac-gen/immunity-types.htm.*

[22] Even if a ''therapeutic vaccine'' product is required coverage under other Medicaid benefits, this proposal would help to ensure that manufacturers report product and pricing data accurately and pay rebates to States, as applicable.

[23] Vaccines Licensed for Use in the United States.

product that would not qualify as a vaccine under this definition.

D. Proposal To Account for Stacking When Determining Best Price—(§ 447.505)

Section 1927(c)(1)(C) of the Act defines the term ''best price'' to mean with respect to a single source drug or innovator multiple source drug of a manufacturer (including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, subject to certain exceptions and special rules. The implementing regulations for the determination of best price are at § 447.505.

In the COD final rule, we addressed a comment to our proposal to make revisions to the determination of best price, and specify which prices are included in best price. The comment requested that CMS further adopt a policy with regard to the practice of a manufacturer stacking two different price concessions provided to two different entities, such that under these circumstances, the best price for a drug should reflect all rebates and payments associated with a transaction of a covered outpatient drug to a particular customer. (See 81 FR 5252.) In response to the commenter's request, we indicated that a manufacturer is responsible for including all price concessions that adjust the price realized by the manufacturer for the drug in its determination of best price. We also explained that if a manufacturer offers multiple price concessions to two entities for the same drug transaction, such as rebates to a PBM where the rebates are designed to adjust prices at the retail or provider level, in addition to discounts to a retail community pharmacy's final drug price, all discounts related to that transaction which adjust the price available from the manufacturer should be considered in the final price of that drug when determining best price (81 FR 5252 through 5253).

In the COD final rule with comment, we made minor revisions to the regulatory text at § 447.505(b) by deleting the reference to ''associated'' rebate and discounts and inserting a reference to ''applicable discounts, rebates'' so that it presently reads that the best price for CODs includes all prices, including applicable discounts, rebates or other transactions that adjust prices either directly or indirectly to the best price-eligible entities listed in § 447.505(a).

We addressed the question regarding stacking in the response to comments in the COD final rule, specifying that if multiple price concessions are provided to two entities for the same drug transaction, all discounts related to that transaction which adjust the price available from the manufacturer should be considered when determining best price. However, we did not revise or propose to revise the regulation text at § 447.505(d)(3) to address stacking in such detail. Section 447.505(d)(3) currently indicates that the manufacturer must adjust the best price for a rebate period if cumulative discounts, rebates or other arrangements subsequently adjust prices available, to the extent that such cumulative discounts, rebates or other arrangements are not excluded from the determination of best price by statute or regulation.

However, in the case *United States ex rel. Sheldon* v. *Allergan Sales, LLC.,* a relator alleged that a drug manufacturer failed to aggregate discounts provided to separate customers for purposes of determining best price, and the manufacturer argued that the stacking requirement was not sufficiently clear. The district court granted Allergan's motion to dismiss, ruling that relator failed to plausibly allege either falsity or knowledge because Allergan's interpretation ''is objectively reasonable'' and CMS' rule had not specifically warned against it. On appeal, a panel of the United States Court of Appeals for the Fourth Circuit stated that, in that case, the drug manufacturer had not been ''warned . . . by the authoritative guidance from CMS'' and that CMS had ''failed to clarify'' the stacking issue.[24] The Government filed an amicus brief supporting the relator's petition for rehearing en banc, which the Fourth Circuit granted. Following argument, the Fourth Circuit issued its decision with no substantive opinion that vacated the prior panel decision and affirmed the district court by an equally divided court.

As noted, section 1927(c)(1)(C) of the Act defines the term ''best price'' to mean with respect to a single source drug or innovator multiple source drug of a manufacturer (including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States. We interpreted this section expansively as the statute refers to a manufacturer's lowest price ''available'' ''to any'' entity on this statutory list. That is, if a manufacturer provides a discount to a wholesaler, then a rebate to the provider who dispensed the drug unit, and then another rebate to the insurer who covered that drug unit, CMS has concluded that ''best price'' must include (or ''stack'') all the discounts and rebates associated with the final price, even if the entity did not buy the drug directly from the manufacturer. By stacking, best price reflects the lowest realized price at which the manufacturer made that drug unit available. We also note that manufacturers are required to take rebates into account for multiple entities when calculating AMP, and for logical reasons, best price should do so as well, since including them in AMP and not accounting for them in best price could result in AMP being lower than best price.

Therefore, to remove any potential doubt prospectively, we are proposing to revise § 447.505(d)(3) to add to the existing regulatory statement that the manufacturer must adjust the best price for a covered outpatient drug for a rebate period if cumulative discounts, rebates or other arrangements to best price eligible entities subsequently adjust the price available from the manufacturer for the drug. We are adding the clarifying statement that cumulative discounts, rebates or other arrangements must be stacked to generate a final price realized by the manufacturer for a covered outpatient drug, including discounts, rebates or other arrangements provided to different best price eligible entities.

E. Proposal To Rescind Revisions Made by the December 31, 2020 Final Rule to Determination of Best Price (§ 447.505) and Determination of Average Manufacturer Price (AMP) (§ 447.504) Consistent With Court Order

Pharmaceutical manufacturers have provided purported financial assistance payments (for example, in the form of copay coupons) to patients for purposes of paying the patient cost obligation of certain drugs.

[24] *United States ex rel. Sheldon* v. *Allergan Sales, LLC,* 24 F.4th 340, 351, 354 (4th Cir. 2022), *reh'g en banc granted,* No. 20–2330, 2022 WL 1467710 (4th Cir. May 10, 2022).

On June 19, 2020, CMS proposed regulations to address the effect of PBM accumulator adjustment programs on best price calculations (85 FR 37286) in relation to these purported manufacturer financial assistance payments by instructing manufacturers on how to consider the implementation of such programs when determining best price and AMP for purposes of the Medicaid Drug Rebate Program (MDRP). In particular, CMS proposed revising its regulations to provide that the exclusions for manufacturer's financial assistance payments ''apply only to the extent the manufacturer ensures the full value of the assistance or benefit is passed on to the consumer or patient'' (85 FR 37299). On December 31, 2020, CMS finalized its proposed revisions (85 FR 87000, 87048 through 87055, and 87102 through 87103). The final rule codified the proposed language to require that ''the manufacturer ensures that the full value'' of the assistance or benefit is passed on to the consumer or patient to exclude that assistance or benefit to an insured patient from the manufacturer's best price calculation and AMP. The final rule also delayed the effective date of the change until January 1, 2023, to ''give manufacturers time to implement a system that will ensure the full value of assistance under their manufacturer-sponsored assistance program is passed on to the patient.''

In May 2021, the Pharmaceutical Research and Manufacturers of America (PhRMA) filed a complaint against the Secretary asking the court to vacate these amendments to § 447.505(c)(8) through (11) (85 FR 87102 and 87103), as set forth in the 2020 final rule (referred to by the Court as ''the accumulator adjustment rule of 2020''). On May 17, 2022, the United States District Court for the District of Columbia ruled in favor of the plaintiff and ordered that the accumulator adjustment rule of 2020 be vacated and set aside.

In response to this court order, we propose to withdraw the changes made to best price and to also withdraw the changes to AMP to apply consistent rules for determining best price and AMP. Therefore, we propose to remove the language added to these sections as part of the 2020 final rule: §§ 447.504(c)(25) through (29) and (e)(13) through (17) and 447.505(c)(8) through (12). *See* 85 FR 87102 and 87103. Specifically, we would remove ''the manufacturer ensures'' from these provisions. As a result, these regulations would maintain the language that has been in place since 2016. To be clear, the changes to these regulations made by the 2020 final rule on January 1, 2023, were not effective as a result of the court's order.

F. Drug Classification; Oversight and Enforcement of Manufacturer's Drug Product Data Reporting Requirements—Proposals Related to the Calculation of Medicaid Drug Rebates and Requirements for Manufacturers (§§ 447.509 and 447.510)

1. Medicaid Drug Rebates (MDR) and Penalties (§ 447.509)

Section 6 of the MSIAA, titled ''Preventing the Misclassification of Drugs Under the Medicaid Drug Rebate Program,'' amended sections 1903 and 1927 of the Act to clarify the definitions for multiple source drug, single source drug and innovator multiple source drug, and to provide the Secretary with additional compliance, oversight and enforcement authorities to ensure compliance with program requirements with respect to manufacturers' reporting of drug product and pricing information, which includes the appropriate classification of a drug. Drug classification refers to how a drug should be classified—as a single source, innovator multiple source, or noninnovator multiple source drug—for the purposes of determining the correct rebates that a manufacturer owes the States.[25] When manufacturers misclassify their drugs in the rebate program, it can result in manufacturers paying rebates to States that are different than those that are supported by statute and regulation, and in some cases, can result in the manufacturer paying a lower per-unit rebate amount to the States.

Specifically, section 1927(c)(4)(A) of the Act, ''Recovery of Unpaid Rebate Amounts due to Misclassification of Drugs,'' was added to the statute to provide new authorities to the agency to identify and correct a manufacturer's misclassification of a drug, as well as impose other penalties on manufacturers that fail to correct their misclassifications. In general, a misclassification in the MDRP occurs when a manufacturer reports and certifies its covered outpatient drug under a drug category, or uses drug product information, that is not supported by the statutory and regulatory definitions of S, I, or N.

We published guidance to manufacturers regarding compliance with drug pricing and drug product information reporting under this new law in Manufacturer Release #113 on June 5, 2020. See *https://www.medicaid.gov/prescription-drugs/downloads/mfr-rel-113.pdf*.

Although much of this law is self-implementing, we are proposing a series of regulatory amendments at §§ 447.509 and 447.510 to implement and codify the statutory changes in regulation. We propose that a misclassification of a drug under the MDRP has occurred or is occurring when a manufacturer reports its drug under a category that is not supported by the statutory and regulatory definitions of S, I, or N. A misclassification can also occur when a manufacturer's drug is appropriately classified, but the manufacturer is paying rebates at a different amount than required by the statute, or where the drug manufacturer's certified drug product information for the COD is also inconsistent with statute and regulation.

The MSIAA also amended the Act to expressly require a manufacturer to report not later than 30 days after the last day of each month of a rebate period under the agreement, such drug product information as the Secretary shall require for each of the manufacturer's covered outpatient drugs. In a separate section, we are proposing a definition of ''drug product information'' for the purposes of the MDRP.

Similarly, the MSIAA amended the Act to clarify that the reporting of false drug product information and data related to false drug product information would also be subject to possible CMPs by the HHS Office of the Inspector General (OIG), and to provide specific new authority to the Secretary to issue civil monetary penalties related to knowing misclassifications of drug product or misreported information. These new OIG authorities will not be the subject of this rulemaking.

Under the MSIAA, if a manufacturer fails to correct the misclassification of a drug in a timely manner after receiving notification from the agency that the drug is misclassified, in addition to the manufacturer having to pay past unpaid rebates to the States for the misclassified drug if applicable, the Secretary can take any or all of the following actions: (1) correct the misclassification, using drug product information provided by the manufacturer on behalf of the manufacturer; (2) suspend the misclassified drug, and the drug's status as a covered outpatient drug under the

[25] Note that section 1927(c)(3) of the Act describes rebates for covered outpatient drugs other than single source and innovator multiple source drugs in section 1927(c)(3) of the Act as ''rebates for other drugs.'' The MDRP reporting system provides for all ''other drugs'' that are covered outpatient drugs to be classified in the system as N drugs, regardless of whether they expressly meet the statutory definition of noninnovator multiple source drug. This reporting methodology has been in effect for the history of the program and interested parties have understood that a covered outpatient drug that was not an S or an I drug is reported in the system as an N drug.

manufacturer's national rebate agreement, and exclude the misclassified drug from FFP (correlating amendments to section 1903 of the Act); and, (3) impose civil monetary penalties (CMP) for each rebate period during which the drug is misclassified subject to certain limitations. The Act expressly provides that the imposition of such penalties may be in addition to other remedies, such as termination from the MDRP, or CMPs under Title XI.

In § 447.509, we propose to include a new paragraph (d), ''Manufacturer misclassification of a covered outpatient drug and recovery of unpaid rebate amounts due to misclassification and other penalties,'' to implement additional penalty and compliance authorities outlined in section 6 of the MSIAA, which amended sections 1903 and 1927 of the Act. As some manufacturers may continue to misclassify drug products, we believe these proposed penalties are necessary so that manufacturers do not neglect to correct and certify their information, to assure that States receive the rebates that they deserve, to assure that public MDRP data are accurate, to protect the integrity of the MDRP, and to ensure the efficient and economic administration of the Federal Medicaid program.

Under the MDRP, a drug should be classified as a single source, innovator multiple source, or noninnovator multiple source drug for the purposes of determining the correct rebates that a manufacturer owes the States. We propose that a misclassification in the MDRP occurs when a manufacturer reports and certifies its covered outpatient drug under a drug category or other drug product data related to a COD that is not supported by the statutory and regulatory definitions of S, I, or N. We also propose to define as a misclassification a situation in which the manufacturer accurately reports and certifies its COD under a drug category or other related drug product data for a COD, but is paying a different rebate amount than that required by the statute and regulations. The statute expressly indicates at section 1927(d)(4) of the Act that a misclassification can occur without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification was being made.

It is the legal responsibility of the manufacturer to report and certify the correct classification of its covered outpatient drugs to the agency, and the drug product information related to a COD. The agency does not as a routine matter review or verify the drug category classifications and related drug product information reported and certified by the manufacturer. However, in its oversight role, the agency will review the classification and other drug product and pricing information reported by the manufacturer for a drug to determine its accuracy, as needed. For example, when questions arise, the agency will generally review the drug product and pricing information reported and certified by a manufacturer. To this end, we generally rely upon various sources of information to determine if a drug is misclassified in the MDRP. This includes information reported by manufacturers to CMS in combination with publicly available information in making determinations of whether a drug is misclassified in the MDRP. The agency also uses manufacturer reported information, such as the COD status code, in combination with information available on the FDA's Comprehensive NDC SPL Data Elements file (NSDE) *https://download.open.fda.gov/Comprehensive_NDC_SPL_Data_Elements_File.zip,* and information from FDA's Drugs@FDA web page *https://www.accessdata.fda.gov/scripts/cder/daf/* to verify that the national drug codes (NDCs) reported to the MDRP by manufacturers are appropriately classified and reported to MDRP.

Therefore, we propose in the new § 447.509(d), the following process to identify, notify and correct a manufacturer's drug category misclassifications, and impose other penalties, while at the same time notifying the HHS OIG and/or other governmental agencies about possible violations of MDRP requirements.

a. Identification and Notification to Manufacturer To Correct Misclassification (§ 447.509(d)(1) Through (4))

We are proposing in new paragraphs (d)(1) through (4) of § 447.509, requirements relating to the process by which the agency would identify when a misclassification of a drug has occurred in MDRP, subsequently notify a manufacturer that we have determined that a drug is misclassified in MDRP, indicate the penalties that may be imposed on the manufacturer, as well that the manufacturer may owe past due rebates.

We propose to define what constitutes a misclassification in paragraph (d)(1). As proposed at § 447.509(d)(1)(i), misclassification in the MDRP occurs when a manufacturer reports and certifies to the agency its drug category or drug product information related to a covered outpatient drug that is not supported by applicable statute or regulation. For example, a drug is misclassified by the manufacturer if it is reported as a noninnovator multiple source drug when the correct classification for the COD, as determined by the agency, is a single source drug or an innovator multiple source drug, based on application of relevant statutes and regulations. In such an example, it is likely that the manufacturer has paid or is paying a lower per unit rebate amount to a State as a result of the misclassification, and the agency would notify the manufacturer as part of the communication regarding the misclassification that rebates are owed to the States.

However, there may be circumstances where a manufacturer is reporting its drug as a S or I drug, when the appropriate category is a N drug. For example, a manufacturer may be categorizing a non-prescription drug as a brand drug, when it should be classified as a noninnovator drug for the purposes of MDRP. These situations would be considered misclassifications as well. These situations may result in States needing to pay rebates back to the manufacturer, which creates recordkeeping and fiscal issues for the States, as well as the need for the States to request FFP from the Federal Government to pay its share of the rebates that are due back to the manufacturer. There are two-year timely claims filing deadlines under section 1132(A) of the Act, which may prohibit States from claiming FFP in these situations.

A manufacturer may also have reported and certified an incorrect base date AMP to calculate its inflation penalty rebates, thus paying overall lower rebates to the States. This example would also be considered a misclassification under paragraph (d)(1)(i), as the incorrect drug product information related to a COD is being used by the manufacturer.

We also propose in § 447.509(d)(1)(ii) that a misclassification includes a situation where a manufacturer has correctly reported and certified its drug classification as well its drug product information for a COD, but is paying rebates to States at a level other than that supported by statute and regulation applicable to the reported and certified data. For example, if a manufacturer is correctly reporting and certifying a COD as an S or I drug, but paying rebates that would be expected for that of an N drug, we would consider that to be a misclassification as well. Note that while the statute and regulations specify that rebates are paid to States based on classifications of CODs as S, I, or ''other

drugs'', the MDP system only allows for the classification of CODs as S, I, or N. The N category would include any drug that is not an S or I, which may include non-prescription drugs. Manufacturers should assure that those drugs that are classified as N in the MDP system are drugs other than S or I drugs.[26]

We propose at § 447.509(d)(2) that if the agency makes a determination of a misclassification, the agency would send a written and electronic notification to the manufacturer that misclassified a drug of such misclassification, and any past rebates due, and the manufacturer would have 30 calendar days from date of the notification to submit to the agency the drug product and pricing information necessary to correct the misclassification or the incorrect product information, and calculate rebate obligations. If the manufacturer misclassified the drug as an N when it should have been an S or I, then the data submitted to the agency must include the drug's ''best price'' data for the period or periods during which it was misclassified. Once the information is changed in the MDP, the manufacturer must certify the data.

Upon receipt from the manufacturer of the requested corrected information as proposed in § 447.509(d)(2), we propose in § 447.509(d)(4) to review the information submitted by the manufacturer in response to the notice sent under proposed § 447.509(d)(2) to ensure consistency with published drug product information, and if the manufacturer fails to correct the misclassification, fails to certify applicable pricing and product data, and/or fails to pay rebates due as a result of misclassification in the timeframes proposed, we propose the enforcement actions the agency may further take. Upon notification by CMS that the manufacturer's information was updated in the system, we propose that the manufacturer certify the applicable price and drug product data. The proposed time period the manufacturer has to correct the misclassification, and respond to the agency's request to certify the information in the system, is 30 calendar days from the date of the original notification to the manufacturer of the misclassification.

The determination made by CMS and notification provided by CMS to the manufacturer as a result of the process proposed in § 447.509(d) regarding misclassification is limited by the information available to CMS and is specific to the facts and circumstances for each scenario. It does not release the manufacturer from any additional liabilities, or preclude actions against manufacturers by HHS, OIG, DOJ, or otherwise.

b. Manufacturer Payment of Unpaid Rebates Due to Misclassification (§ 447.509(d)(3))

As required in section 1927(c)(4)(A) of the Act, the manufacturer is required to pay unpaid rebates to the State for a misclassified drug in an amount equal to the product of the difference of the URA paid to the State for the period, and the URA that the manufacturer would have paid to the State for the period, as determined by the agency, if the drug had been correctly classified or correctly reported by the manufacturer, or the drug product information had been reported correctly, and the total units of the drug paid for under the State Plan in the rebate period(s).

Therefore, once we determine that a misclassification has occurred in § 447.509(d)(1) and notify the manufacturer of the misclassification in accordance with the proposed process steps at § 447.509(d)(2), we are proposing in § 447.509(d)(3) the process by which manufacturers would pay unpaid rebates to the States resulting from a misclassification of a drug in the MDRP.

Specifically, we propose at § 447.509(d)(3) that when the agency determines that a misclassification of COD occurs as proposed under § 447.509(d)(1), and notification has been provided to the manufacturer as proposed under § 447.509(d)(2), a manufacturer shall pay to each State an amount equal to the sum of the products of the difference between: the per URA paid by the manufacturer for the COD to the State for each period during which the drug was misclassified, and the per URA that the manufacturer would have paid to the State for the COD for each period, as determined by the agency based on the data provided by the manufacturer under proposed paragraph (d)(2), if the drug had been correctly classified by the manufacturer, multiplied by the total units of the drug paid for under the State Plan in each period.

Consistent with section 1927(d)(4)(A) of the Act, we are proposing regulatory text in § 447.509(d)(3)(i) that requires manufacturers to pay these unpaid rebates amounts. We are also proposing to codify at § 447.509(d)(3) the time frame by which the manufacturer shall pay such unpaid rebates to the States for the period or periods of time that such COD was misclassified, based upon the proposed URA provided to the States by the agency for the unpaid rebate amounts. We are proposing to include a regulatory provision that requires such rebates be paid to the States by the manufacturer within 60 calendar days of the date of the notice that is sent by the agency to the manufacturer indicating that the drug is misclassified, and specifies that it is the manufacturer's burden to contact the States and pay the rebates that are due. We are also proposing that a manufacturer would be required to provide documentation to the agency that all past due rebates have been paid to the States within the 60 calendar day timeframe.

c. Agency Authority To Correct Misclassifications and Additional Penalties for Drug Misclassification (§ 447.509(d)(4))

Consistent with section 1927(c)(4)(B) of the Act, which provides the authority to the Secretary to correct drug misclassifications in the system and impose other penalties, we propose to add § 447.509(d)(4), allowing CMS to correct the drug's misclassification on behalf of the manufacturer, as well as provide a plan of action for enforcement against the manufacturer. Specifically, we propose at § 447.509(d)(4) that the agency would review the information submitted by the manufacturer based on the notice sent under proposed paragraph (d)(2), and if a manufacturer fails to correct the misclassification within 30 calendar days from the date of the notification of the misclassification by the agency to the manufacturer, fails to certify applicable pricing and drug product data, and/or fails to pay the rebates that are due to the States as a result of the misclassification within 60 calendar days of receiving such notification, the agency may do any or all of the following:

- Correct the misclassification of the drug in the system, using any pricing and drug product information that may have been provided by the manufacturer, on behalf of the manufacturer;
- Suspend the misclassified drug, and the drug's status as a COD under the manufacturer's rebate agreement from the MDRP, and exclude the

[26] Since the beginning of the MDRP, the term noninnovator multiple source drug, and its abbreviation (N), has been used very generally to identify a covered outpatient drug other than a single source drug or an innovator multiple source drug. The rebate is calculated using the same formula for all drugs other than a single source drug or an innovator multiple source drug, including both those that satisfy the definition of noninnovator multiple source drug and those that do not. Therefore, manufacturers are to report all of their drugs other than a single source drug or an innovator multiple source drug and identify them with the drug category of N, regardless if they satisfy the statutory definition of noninnovator multiple source drug.

misclassified drug from FFP in accordance with section 1903(i)(10)(E) of the Act;

• Impose a Civil Monetary Penalty (CMP) for each rebate period during which the drug is misclassified, not to exceed an amount equal to the product of:

++ The total number of units of each dosage form and strength of such misclassified drug paid for under any State Plan during such a rebate period; and

++ 23.1 percent of the AMP for the dosage form and strength of such misclassified drug for that period.

Also, we propose at § 447.509(d)(4)(iv) to indicate that, in addition to the actions described previously in this proposed rule, we may take other actions or seek additional penalties that are available under section 1927 of the Act (or any other provision of law), against manufacturers that misclassify their drugs including referral to the HHS OIG and termination from the MDRP. Section 1927(b)(4)(B)(i) of the Act provides that the Secretary may terminate a manufacturer from the program for violation of the rebate agreement or other good cause. Furthermore, section 1927(c)(4)(D) of the Act indicates that other actions and penalties against a manufacturer for misclassification of a drug include termination from the program.

Therefore, we propose that a manufacturer is subject to termination from the program if it fails to meet agency's specifications for participation in the MDRP program as proposed when it is in violation of section 1927(b)(4)(B)(i) or 1927(c)(4)(D) of the Act, which includes failing to correct misclassified drugs as identified to the manufacturer by the agency, and continuing to have one or more drugs suspended from MDRP because of the lack of certification of the correct drug classification data in the system.

We note that as provided in section 1927(b)(4)(C) of the Act, a manufacturer with a terminated NDRA is prohibited from entering into a new NDRA for a period of not less than one calendar quarter from the effective date of the termination until all of the above or any subsequently discovered violations have been resolved, unless the Secretary finds good cause for an earlier reinstatement. In accordance with section 1927(b)(4)(B)(ii) of the Act, and section VII.(e) of the NDRA, termination shall not affect the manufacturer's liability for the payment of rebates due under the agreement before the termination effective date. Consequently, invoicing by States may continue beyond the manufacturer's termination from the program for any utilization that occurred prior to the effective date of the termination.

In addition to affecting Medicaid coverage of a manufacturer's drugs, the termination of the manufacturer's NDRA may impact the coverage of the drugs under the Medicare Part B program as well as the 340B Drug Pricing Program. Alternatively, we propose that suspension of a drug under this section as a COD would not affect its status as a reimbursable drug under the 340B Drug Pricing Program or Medicare Part B.

d. Transparency of Manufacturer Misclassification (§ 447.509(d)(5))

Section 1927(c)(4)(C)(i) and (ii) of the Act requires information on CODs that have been identified as misclassified be reported to Congress on an annual basis, and that the annual report be made available to the public on a public website. Therefore, we propose to add new paragraph (d)(5) to § 447.509 to indicate that the agency would make available on a public website an annual report as required under section 1927(d)(4)(C)(ii) of the Act on the COD(s) that were identified as misclassified during the previous year. This report would include a description of any steps taken by the agency with respect to the manufacturer to reclassify the drugs, ensure the payment by the manufacturer of unpaid rebate amounts resulting from the misclassifications, and disclose the use of the expenditures from the fund created in section 1927(b)(3)(C)(iv) of the Act.

2. Proposed Requirements for Manufacturers Relating to Drug Category—Requirements for Manufacturers (§ 447.510)

To implement section 1927(c)(4) of the Act, we propose to rename § 447.510 as ''Requirements and penalties for manufacturers''.

a. Suspension of Manufacturer NDRA for Late Reporting of Pricing and Drug Product Information (§ 447.510(i))

In accordance with section 1927(b)(3)(C)(i) of the Act, we propose to add paragraph (i) to § 447.510 to describe the process by which the suspension of a manufacturer's NDRA would occur when a manufacturer fails to report timely information, which includes drug pricing and drug product information, as described in section 1927(b)(3)(A) of the Act, which also includes the reporting timeframes for such information. This drug product and pricing information includes, but is not limited to AMP, best price, and drug product information as described in the proposed definition of drug product information included in this rule.

Specifically, the new paragraph § 447.510(i)(1) proposes that if a manufacturer fails to provide timely information required to be reported to the agency under § 447.510(a) and (d) of this section, the agency would provide written notice to the manufacturer of the failure to provide timely information. If such information is not reported within 90 calendar days of a deadline determined by the agency, and communicated to the manufacturer electronically and in writing by the agency, it shall result in suspension of the manufacturer's rebate agreement for all CODs furnished after the end of the 90-calendar day period for purposes of Medicaid and the MDRP only, and the rebate agreement shall remain suspended for Medicaid until such information is reported in full and certified, but not for a period of suspension of less than 30 calendar days. This section also proposes that continued suspension of the rebate agreement could result in termination for cause.

During the period of the suspension, the CODs of the manufacturer are not eligible for Medicaid coverage or reimbursement and Medicaid FFP. However, the manufacturer must continue to offer its CODs for purchase by 340B eligible entities, and reimbursement availability for such drugs under Medicare Part B would not change because, while suspended for purposes of the MDRP, the Medicaid drug rebate agreement with the manufacturer would remain in effect for purposes of Medicare Part B reimbursement and the 340B Drug Pricing Program.

Under proposed § 447.510(i)(2), the agency would notify the States 30 calendar days before the effective date of the manufacturer's suspension, which is 60 calendar days after the notice is sent to the manufacturer that the data are late. If a manufacturer fails to report and certify the complete information within this 30-calendar day period before the suspension begins, they would continue to be suspended from the program until such information is reported and certified, and would be subject to termination of the manufacturer rebate agreement.

We understand that suspension of a manufacturer's agreement, and loss of the availability of FFP for a period of time, would likely mean that these manufacturers' drugs would not be available to Medicaid beneficiaries during the period of the suspension. We would give States sufficient time before

the suspension begins—30 calendar days—to work with beneficiaries and their prescribers to transition to other covered outpatient drugs that would meet the clinical needs of the beneficiaries during the suspension period. We believe that the intermediate step of suspension rather than termination should be sufficient incentive to manufacturers to report pricing and product information within the statutory and regulatory requirements, without initially resorting to termination, which means that a manufacturer's drug could be unavailable to beneficiaries for a possible longer period of time.

We believe this proposed process provides clearer implementation of the statutory authority to suspend a manufacturer's rebate agreement in the event of a failure to provide timely information, and would hopefully incentivize manufacturers to ensure the timely reporting of pricing and drug product information, which would further the efficient and economic operation of the MDRP.

For example, every month it is common that several manufacturers either do not report or only partially report their AMP data to the agency, which are used to calculate the Federal Upper Limits (FULs) for multiple source drugs, among other purposes. Such conduct reduces the agency's ability to set FULs on Medicaid payment for certain drugs, which means States may spend more money on multiple source drugs than they otherwise should. As a standard practice, we already notify these manufacturers that they are late in reporting or only have partially reported their information, and we also provide information about late reporting by manufacturers to OIG for possible imposition of CMPs. We consider partial reporting of information to also be late reporting, as the information that was not reported is late.

Consistent with the proposed clarification to the definition of manufacturer, the proposed suspension of the manufacturer's NDRA would be applied to all the associated labeler rebate agreements of the manufacturer.

G. Proposals Related to Amendments Made by the American Rescue Act of 2021—Removal of Manufacturer Rebate Cap (100 Percent AMP)

Section 9816 of the American Rescue Plan Act of 2021 sunsets the limit on maximum rebate amounts for single source and innovator multiple source drugs by amending section 1927(c)(2)(D) of Act by adding ''and before January 1, 2024,'' after ''December 31, 2009''. In accordance with section 1927(c)(3)(C)(i) of the Act and the special rules for application of provision in sections 1927(c)(3)(C)(ii)(IV) and (V) of the Act, this sunset provision also applies to the limit on maximum rebate amounts for CODs other than single source or innovator multiple source drugs.

Section 2501(e) of the Affordable Care Act amended section 1927(c)(2) of the Act by adding a new subparagraph (D) and established a maximum on the total rebate amount for each single source or innovator multiple source drug at 100 percent of AMP, effective January 1, 2010. This limit on maximum rebate amounts was codified at § 447.509(a)(5) for single source and innovator multiple source drugs, effective January 1, 2010. This limit was later extended to apply to drugs other than single source or innovator multiple source drugs by section 602 of the Bipartisan Budget Act of 2015 (Pub. L. 114–74, enacted November 2, 2015) (BBA 2015), which amended section 1927(c)(3) of the Act to require that manufacturers pay additional rebates on such drugs if the AMPs of the drug increase at a rate that exceeds the rate of inflation. This provision of BBA 2015 was effective beginning with the January 1, 2017 quarter, and the limit on maximum rebates for drugs other than single source or innovator multiple source drugs was added at § 447.509(a)(9).

Therefore, to conform § 447.509 with section 1927(c)(2)(D) of the Act, as amended by the American Rescue Plan Act of 2021, and sections 1927(c)(3)(C)(i), (ii)(IV), and (ii)(V) of the Act, we are proposing to make conforming changes to § 447.509 to reflect the removal of the maximum rebate amounts for rebate periods beginning on or after January 1, 2024. Specifically, we propose to amend § 447.509(a)(5) and (9) to state that the limit on maximum rebate amounts applies to certain time frames, which for all drugs, ends on December 31, 2023. That is, no maximum rebate amount would apply to rebate periods beginning on or after January 1, 2024.

H. Proposal To Clarify § 447.509(a)(6), (7), (8), and (9) and (c)(4) With Respect to ''Other Drugs''

Section 1927(c) of the Act describes how the unit rebate amount (URA) is determined for a covered outpatient drug. There is a defined calculation of the applicable basic rebate and additional rebate for a covered outpatient drug that is either a single source drug or innovator multiple source drug at sections 1927(c)(1) and (2) of the Act, and a different defined calculation for ''other drugs,'' that is, a covered outpatient drug that is a drug other than a single source drug or an innovator multiple source drug at section 1927(c)(3) of the Act.

Section 1927(c)(3) of the Act, titled ''Rebate for other drugs,'' describes in subsections (c)(3)(A) and (B) the basic rebate calculation for covered outpatient drugs other than single source drugs and innovator multiple source drugs. Section 1927(c)(3)(C) of the Act describes the additional rebate calculation for a covered outpatient drug other than a single source drug or an innovator multiple source drug. Thus, the statute makes it clear that rebates are applicable to all covered outpatient drugs, whether they are single source drugs, innovator multiple source drugs, or drugs other than such drugs.

Manufacturers are required to report all of their covered outpatient drugs in our MDRP reporting system and must select the appropriate drug category for each (that is, S, I, or N). Since the beginning of the MDRP, the term noninnovator multiple source drug, and its abbreviation (N), have been used very generally to identify a covered outpatient drug other than a single source drug or an innovator multiple source drug in our system for operational purposes. Choosing N in our reporting system thus can result in capturing drugs that satisfy the statutory definition of an N drug, but also other drugs that are not single source or innovator multiple source drugs. Because manufacturers are to report all of their covered outpatient drugs and identify the applicable drug category, all covered outpatient drugs other than a single source drug or an innovator multiple source drug should be identified with the drug category of N, regardless if they satisfy the definition of noninnovator multiple source drug.

In the July 17, 2007 final rule, we finalized a definition for ''noninnovator multiple source drug'' to clarify the distinction between multiple source drugs approved under an abbreviated new drug application (ANDA) and multiple source drugs approved under a new drug application (NDA). We also finalized that the term includes a drug that entered the market prior to 1962 that was not originally marketed under an NDA (72 FR 39162).

Over the years, interested parties too have used the term ''noninnovator multiple source drug'' synonymously with ''a covered outpatient drug that is a drug other than a single source drug or an innovator multiple source drug.'' However, the statute specifically defines ''noninnovator multiple source drug'' at section 1927(k)(7)(iii) of the Act as a multiple source drug that is not an

innovator multiple source drug. The regulatory definition of noninnovator multiple source drug goes beyond this statutory definition but does not capture every covered outpatient drug that is something other than a single source drug or an innovator multiple source drug because not every ''other drug'' is a multiple source drug. As a result, ''other drugs'' and ''noninnovator multiple source drugs'' are not synonymous. While the terms are not synonymous, they are treated so for purposes of reporting the COD in the MDRP system, as ''other drugs'' should be classified as N, if not an S or I drug.

As noted previously, the statute makes it clear that rebates apply to all covered outpatient drugs, regardless if they are single source drugs, innovator multiple source drugs or something other than a single source drug or innovator multiple source drug. To align our longstanding policy and practices of identifying ''other drugs referenced in section 1927(c)(3) of the Act as N drugs, for purposes of the MDRP, we are proposing to modify language in § 447.509 by replacing each appearance of ''noninnovator multiple source drug(s)'' with ''drug(s) other than a single source drug or an innovator multiple source drug.'' [27]

We propose to delete each appearance of ''noninnovator multiple source drug(s)'' in § 447.509 and replace it with ''drug other than a single source drug or innovator multiple source drug(s).'' The clarification is proposed to be made in § 447.509(a)(6), (7), (8), and (9) and (c)(4), and the language would change as set out in the proposed regulatory text at the end of the document.

- In paragraph (a)(8), we would specify the ''total rebate''. Specifically, the total rebate amount for a drug other than a single source drug or innovator multiple source drug is equal to the basic rebate amount plus the additional rebate amount, if any.
- In paragraph (a)(9), we would specify the ''limit on rebate''. Specifically, in no case would the total rebate amount exceed 100 percent of the AMP for a drug other than a single source drug or innovator multiple source drug.
- In paragraph (c)(4), we would specify that for a drug other than a single source drug or innovator multiple source drug, the offset amount is equal to 2.0 percent of the AMP (the difference between 13.0 percent of AMP and 11.0 percent of AMP).

[27] Drugs other than single source drugs and innovator multiple source drugs should continue to be reported in the MDRP system with the drug category of ''N''.

I. Proposal To Establish a 12-Quarter Rebate Audit Time Limitation (§ 447.510)

In accordance with sections 1927(b)(1) and 1927(c) of the Act, and section II. (b) of the NDRA, manufacturers are required to pay quarterly rebates to States for the CODs dispensed and paid for under the State Plan for the rebate period. Section 1927(b)(2)(B) of the Act provides that a manufacturer may audit the rebate billing information provided by the State as set forth under section 1927(b)(2)(A) of the Act on the total number of units of each dosage form, strength and package size of each COD dispensed and paid for under the State Plan during a rebate period, and authorizes that adjustments to rebates shall be made to the extent that the information provided by States indicates that utilization was greater or less than the amount previously specified. The statute does not impose a specific timeframe on a manufacturer's audit authority or limit when adjustments to rebates may occur.

For the purposes of this proposed regulation, audit authority is intended to refer to any process a manufacturer is using to seek an adjustment to utilization data under section 1927(b)(2)(B) of the Act. That audit authority encompasses many processes for seeking adjustments in utilization data, including disputes, assessments, reviews and hearings, and may involve paper procedures, informal phone calls, and emails or other mechanisms. This proposed provision is intended to provide a 12-quarter timeline for any of those processes related to initiation of audits.

Section V. of the NDRA describes how the agency operationalizes the manufacturer audit authority; that is, it describes the procedures for dispute resolution once an audit identifies a dispute with the utilization data (that is, number of units for any given quarter) for which States are requesting rebates using a rebate invoice. A manufacturer can dispute State utilization on an original invoice or initiate a dispute on utilization that was previously paid. See section V, Dispute Resolution, ''Medicaid Program: Announcement of Medicaid Drug Rebate Program National Rebate Agreement,'' Final Notice, 83 FR 12770 (Mar. 23, 2018). The audit/dispute resolution processes are further discussed in a number of manufacturer releases (State Release 177,[28] State Release 181,[29] Manufacturer Release 95,[30] Manufacturer Release 105,[31] and Manufacturer Release 115 [32]).

As provided at section 1927(b)(2)(A) of the Act, no later than 60 days of the end of each quarter, States invoice manufacturers for rebates based on utilization of the manufacturer's drugs in that quarter (§ 447.511(a)). Consistent with section 1927(b)(2)(B) of the Act, manufacturers may audit State utilization data for their covered outpatient drugs reported under section 1927(b)(2)(A) of the Act to determine if the data are accurate and appropriate. If a manufacturer's review of a quarterly State invoice determines that no adjustments are necessary, and that the total quarterly rebate amount can be paid as reflected on the invoice, the manufacturer pays the total invoiced amount in full. The manufacturer will use identifying documentation about payment from the State's records which may include, for example, the labeler code, the labeler name, the quarter and applicable Federal program(s) covered by the payment, or any other such pertinent information that would help identify from whom the rebate payment is being sent and for which quarter and Federal program the payment applies.

In the event a potential discrepancy with State drug utilization data on the rebate invoice is discovered for a current period, the manufacturer will submit a Reconciliation of State Invoice (ROSI) form to the State, or if such a discrepancy is discovered for a prior rebate period's invoice after that rebate period has already been invoiced and paid, the manufacturer will submit a Prior Quarter Adjustment Statement (PQAS) to the State. When completing the ROSI or the PQAS, manufacturers must enter the appropriate code(s) to explain the bases or reasons for any adjustments. Both forms assist in standardizing data exchange elements and improving communication between manufacturers and States. Consistent with section 1927(b)(2)(B) of the Act, adjustments to rebates are made to the extent that the audit results in information indicating that utilization was greater or less than the amount previously specified by the State in its rebate invoice, and can result in manufacturers owing additional rebate

[28] *https://www.law.cornell.edu/definitions/index.php.*

[29] *https://www.cbo.gov/system/files/2020-03/PDPRA-SFC.pdf.*

[30] *https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/mfr-releases/mfr-rel-095.pdf.*

[31] *https://www.medicaid.gov/prescription-drugs/downloads/mfr-rel-113.pdf.*

[32] *https://www.accessdata.fda.gov/scripts/cder/daf/.*

amounts to the States, or the States owing credits to manufacturers.

In State Release 56 and Manufacturer Release 20, we explained an adjustment is a correction in the number of units for any given NDC, or a correction to the unit rebate amount (URA) by the labeler for any given NDC. We clarified a dispute to mean ''a disagreement between the labeler and the State regarding the number of units the State invoiced for any given quarter.'' Consistent with section 1927(b)(2)(B) of the Act, all disputes must be resolved on a unit basis only, and not on any other factor (for example, monetary amounts, percentages, etc.) (State Release 181).

State Release Number 45 sets forth the Dispute Resolution Process for manufacturers and States to follow when engaged in a dispute. In that release, we specified that the manufacturer should notify a State of the disputed data no later than 38 days after the State utilization data is sent. However, we have been made aware that manufacturers initiate disputes far past this suggested timeline. For example, States have reported receiving new disputes on claims from more than 30 years ago.

Previous OIG reports indicated that manufacturers have initiated disputes dating back many years. Although the rebate agreement notes that States and manufacturers should strive to resolve disputes within a reasonable timeframe, there is no mention of how far back a dispute can be initiated once a manufacturer receives an invoice.[33] While section V. of the NDRA, along with several CMS-issued program releases address dispute resolution procedures for when a manufacturer identifies State drug utilization data (SDUD) discrepancies based on the audit authority at section 1927(b)(2)(B) of the Act, no law or regulation, provides a specific time limitation for initiating a dispute over drug utilization data.[34]

Section V of the NDRA describes the dispute resolution processes available to manufacturers and States when a manufacturer discovers a potential discrepancy with State drug utilization data on the rebate invoice, when the manufacturer and State in good faith are unable to resolve prior to the payment due date. As noted above, manufacturers use the ROSI or PQAS process, and shall use their best efforts to resolve a dispute within a reasonable timeframe, and if they are not able to resolve the dispute within a reasonable time frame, CMS will employ best efforts to ensure the State makes available to manufacturers (in accordance with § 447.253(e)) and as explained in State Release 181, the same State hearing mechanism available to providers for Medicaid payment disputes. The State hearing option is available to both States and manufacturers when they have reached an impasse through the normal dispute resolution process, or when one of the parties is not being responsive to another's efforts to engage in dispute resolution. Once a hearing has taken place and a finding is issued, States and manufacturers are expected to act in accordance with the finding. We believe having an unlimited timeframe to initiate such disputes on rebates can result in manufacturer, State and Federal resources being spent to adjudicate excessively old disputes and is not an efficient use of resources.

Given the lack of timeframe for dispute resolution, both States and manufacturers have requested greater CMS involvement in resolving disputes.[35] More specifically, States have requested we establish a time limit for when a manufacturer may initiate a dispute. Establishing a time limit for manufacturers to initiate a dispute concerning State utilization data on the rebate invoice would promote the timely identification of outstanding disputes. Having an unlimited period to initiate disputes is not consistent with the proper and efficient operation of the rebate program. Due to recalculations involving hundreds of millions of State and Federal Medicaid dollars involving years of paperwork, we believe it is essential that a standard timeframe be established within which disputes are permitted.

We propose to use our authority under sections 1102 and 1902(a)(4) of the Act to require efficient handling of disputes by limiting the period for manufacturers to initiate disputes, hearing requests and audits concerning State-specified COD utilization data to 12 quarters from the last day of the quarter from the date of the State invoice. Section 1102 of the Act requires the Secretary to ''make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which [he or she] is charged'' under the Act.

Consistent with this authority, and with the authority found in section 1902(a)(4) of the Act, which allows the Secretary to specify such methods necessary for the proper and efficient operation of the plan, we are proposing to establish a 12-quarter time limit for manufacturers to initiate disputes, hearing requests, and audits for State-invoiced units on current rebates as well as to initiate disputes, hearing requests, and audits on rebates that have been paid in full. We are proposing a time limitation to help ensure that discrepancies are timely identified and resolved, thereby providing increased financial certainty to manufacturers and States and promoting the efficient operation of the MDRP. This limitation would only apply to disputes regarding State drug utilization data on State rebate invoices. We would continue to work with manufacturers to process appropriate change requests (for example: COD Status change requests, Market Date change requests, Base Date AMP change requests, and 5i Drug Indicator change requests).

We understand this proposal implicates the authority at section 1927(b)(2)(B) of the Act, and would result in adding a time limitation to a manufacturer's authority to audit information provided by States under section 1927(b)(2)(A) of the Act. However, we believe that this proposal and implications to the authority to audit comport with our policy goals and the authority bestowed by Congress to ensure the proper and efficient operation of the program.

In considering an approach that is fair for both States and manufacturers, we believe that a regulation adopted in 2003 provides a way forward. The ''Medicaid Program; Time Limitation on Price Recalculations and Recordkeeping Requirements Under the Drug Rebate Program'' final rule with comment period, 68 FR 51912 (August 29, 2003), set forth a 12-quarter time limitation during which manufacturers must report changes to average manufacturer price and best price for purposes of reporting data to CMS.[36] Establishing a 12-quarter time limitation for manufacturers to initiate disputes concerning State-invoiced utilization data would align with the timelines for manufacturers to report changes to data elements relevant to the calculation of

[33] United States, Congress, Office of Inspector General. Medicaid Drug Rebate Dispute Resolution Could Be Improved, OEI–05–11–00580. Available at *https://oig.hhs.gov/oei/reports/oei-05-11-00580.pdf.*

[34] *https://www.ncpdp.org/NCPDP/media/pdf/WhitePaper/Medicaid-Drug-Rebate-Program-Challenges-Across-the-Industry.pdf?ext=.pdf.*

[35] United States, Congress, Office of Inspector General. Medicaid Drug Rebate Dispute Resolution Could Be Improved, OEI–05–11–00580. Available at *https://oig.hhs.gov/oei/reports/oei-05-11-00580.pdf.*

[36] As stated in current regulation in § 447.510(b), manufacturers must report to CMS any revision to AMP, best price, customary prompt pay discounts, or nominal prices for a period not to exceed 12 quarters from the quarter in which the data were due, with limited exceptions.

MDRP rebate amounts and for manufacturers to initiate disputes concerning State-supplied utilization data also necessary to the rebate calculation (§ 447.510(b)(1)), and would allow for more efficient administration of State operated drug rebate programs. This 12-quarter timeframe would also assist States that would otherwise be required to retain their drug utilization data indefinitely to verify changes in rebate amounts resulting from retroactive manufacturer recalculations. We would also like to specify, whenever we refer to a 3-year timeframe for disputes, we are interpreting it as 12 quarters from the last day of the quarter from the date of the State invoice.

We recognize the potential burden for States and manufacturers to comply with a 38-day dispute initiation timeframe as mentioned in State Release Number 45; however, we believe that a 12-quarter timeframe is reasonable because it comports with requirements for maintenance of records on State Medicaid expenditures at § 433.32. It also mirrors the manufacturer's timeline for reporting revisions to monthly AMP at § 447.510(d)(3). We also understand that there are two-year timely claims filing deadlines under section 1132(A) of the Act, and regulations at 45 CFR 95.7, which may prohibit States from claiming FFP in these situations, unless under a good cause waiver. Therefore, consistent with our authority at sections 1102 and 1902(a)(4) of the Act, we propose to ensure the efficient handling of rebate disputes, by limiting the period for manufacturers to initiate disputes, hearing requests or audits concerning State utilization data submitted pursuant to section 1927(b)(2)(A) of the Act to 12 quarters from the last day of the quarter from the date of the State invoice.

Accordingly, we are proposing a new paragraph (j), titled ''Manufacturer audits of State-provided information,'' at § 447.510, specifying that a manufacturer may, within 12 quarters from the last day of the quarter from the State invoice date, initiate a dispute, request a hearing or seek an audit with a State for any discrepancy with State drug utilization data reported under section 1927(b)(2)(A) of the Act on the State rebate invoices.

J. Proposal To Establish a Drug Price Verification Survey Process of Certain Reported CODs (§ 447.510)

In this section of the proposed regulation, we describe the legal basis, rationale, and process we propose to survey manufacturers and wholesalers that directly distribute their CODs using our authority at section 1927(b)(3)(B) of the Act to obtain information about the prices they are reporting to us under section 1927(b)(3)(A) of the Act and in accordance with § 447.510. The purpose of this survey is to verify prices reported under section 1927(b)(3)(A) of the Act to assure that Medicaid payments and applicable rebates for CODs can be made, and that Medicaid payments are economical and efficient, as well as sufficient, to provide access to care.

Currently, there is no centralized collection of specific data from manufacturers (or wholesalers) used by CMS to verify prices manufacturers reported to us under section 1927(b)(3)(A) of the Act. Our proposal to survey manufacturers for certain information on specific CODs and our proposal to make certain manufacturer information publicly available (unless it is proprietary), would allow States to access this information and understand the derivation of a COD's price so that States may establish and negotiate payment for Medicaid CODs consistent with section 1902(a)(30)(A) of the Act. For example, transparency into a manufacturer's costs and process for establishing a drug price via the survey, along with other factors, would give States the ability to better negotiate supplemental rebates, and better understand the impact of the drug on its budget as supplemental rebates are negotiated.

The proposed drug price verification survey is not intended to limit or deny access to any of the CODs included on the survey list, assess cost effectiveness of such drugs, or supplant findings from the applicable FDA approval process. That is, we would not be using the survey data to further assess either the clinical or cost effectiveness of the COD. Furthermore, neither the selection of CODs subject to the survey, nor the information collected in response to a survey under this proposal, would impact coverage of a COD consistent with section 1927 of the Act, or supplant any of the Federal requirements established under section 1927 of the Act and the implementing regulations at 42 CFR part 447, subpart I. Section 1902(a)(30)(A) of the Act (42 U.S.C. 1396a(a)(30)(A)) requires that States have a State Plan that provides methods and procedures to ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. In turn, the agency has an overarching obligation under section 1902(a)(30)(A) of the Act to ensure that Medicaid payments are made in an economical and efficient, as well as sufficient, manner to provide access to care.

Section 1927(b)(3)(B) of the Act authorizes the Secretary to survey wholesalers and manufacturers that directly distribute their CODs, when necessary, to verify manufacturer prices reported to us under section 1927(b)(3)(A) of the Act. We are proposing to interpret this language broadly to provide authority to verify prices and charges from wholesalers and manufacturers that distribute their own drugs, including when the manufacturer distributes drugs directly to pharmacies and other providers. In other words, we believe it is meant to allow the Secretary to verify prices reported in both situations in which a manufacturer sells to wholesalers and/or distributes them directly on their own. The statute expressly provides at section 1927(b)(3)(B) of the Act the authority to verify ''manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost)'' and that requests for information may span ''charges or prices.'' We discuss later in this section which charges and prices we may request to verify the reported manufacturer prices.

The meaning of the term ''verify,'' as set forth in the Oxford English Dictionary means ''make sure or demonstrate that (something) is true, accurate, or justified''. Viewing the authority provided under section 1927(b)(3)(B) of the Act through the lens of section 1902(a)(30)(A) of the Act obligations, we are proposing the following: (1) to describe the criteria by which we would develop a list of CODs (identified by NDC) that may be subject to a survey, and the manufacturers to whom the agency intends to send such a survey, to obtain additional information from said manufacturers or wholesalers to verify prices or charges of certain CODs that are reported to us under section 1927(b)(3)(A) of the Act; and, (2) the information that manufacturers and wholesalers would be required to report to satisfy the verification survey request.

Under our proposal, a process would be established such that once the agency determines that a manufacturer and its COD would be subject to verification, the prices or charges that would be subject to verification may include those that are described in section 1927(b)(3)(A) of the Act and reported by manufacturers, including a manufacturer's AMP, best price, ASP, and WAC for a drug. We note that WAC is generally available through public sources, while the manufacturer reported AMP, best price, and ASP for

CODs are generally not available through public sources.

The CODs to which this verification survey would apply would be limited to those for which manufacturers that have a National Drug Rebate Agreement in place with the Secretary of HHS, as required under section 1927(a)(1) of the Act. Only these manufacturers would report applicable product and pricing data under section 1927(b)(3)(A) of the Act and proposed § 447.510. We note this rulemaking does not address the separate authority to conduct surveys under section 1847A(f)(2) of the Act to verify prices reported under section 1847A(f)(2).

We note that participating manufacturers are required to report and certify certain product and pricing data for each of their CODs on a monthly and quarterly basis to CMS. The COD pricing and product information is primarily used for the determination of the quarterly Medicaid drug rebates paid by participating manufacturers, but also serves as the basis for Medicaid payment for CODs. For example, the AMPs that are reported to the agency are used in the calculation of the Medicaid Federal Upper Limits (FULs) for payment of certain multiple source CODs under section 1927(e)(5) of the Act. The 340B Drug Pricing Program uses the AMP and the Unit Rebate Amount (which is the amount calculated to determine the Medicaid rebate for each dosage form and strength of a COD, and is based in part on AMP) to calculate the 340B ceiling price. Many States require that 340B entities are paid no more than the 340B ceiling price for CODs dispensed by 340B entities. Additionally, many State Medicaid programs use the ASP (as defined in section 1847A(b)(4)(A) of the Act) and the Wholesale Acquisition Cost (as defined in section 1847A(b)(4)(B) of the Act) for Medicaid payment for physician administered drugs, such as those administered in hospital outpatient departments and physician offices.

Since the aforementioned pricing data that manufacturers report to us under section 1927(b)(3)(A) of the Act (AMP, ASP, WAC) are often used by States for reimbursement under Medicaid, serve as a basis for payment to providers for CODs, including physician administered drugs, and thus have a significant impact on how much the Federal Government pays for CODs under Medicaid, CMS must ensure, in accordance with section 1902(a)(30)(A) of the Act, that Medicaid payments for CODs based on these reported prices, are made in an economical and efficient, as well as sufficient manner, to provide access to care.

To provide additional background on the need for the agency to use this survey authority, we note that Medicaid pays for CODs under both FFS programs and through Medicaid managed care plans. State Medicaid programs and their contracted managed care plans have been successful in managing the costs of the pharmacy benefit programs through the implementation of various drug cost containment strategies. The primary mechanisms used by States and managed care plans to manage their pharmacy program spending consist of manufacturer rebates that are collected under the MDRP, the use of lower-cost generic or multiple source drugs, prior authorization, and preferred drug lists, which allow States to leverage crowded therapeutic classes to negotiate supplemental rebates with manufacturers. Manufacturer rebates collected by the States totaled $42.9 billion on a total drug spending of $77.6 billion for the four-quarter period Q1 2022 through Q4 2022 or 55.3 percent of total drug spending.

We also finalized regulations in the COD final rule that require that reimbursement for drugs dispensed through retail pharmacies be based on a two-part formula which consists of: (1) the ingredient cost of the drug based on actual acquisition costs (AAC); and, (2) a professional dispensing fee (PDF) for the drug based on the pharmacy's cost of professional dispensing. See §§ 447.502, 447.512, and 447.518. States establish reimbursement methodologies for these two components based on actual acquisition cost data and costs associated with dispensing. To further assist States to pay for CODs, the agency publishes the National Average Drug Acquisition Cost (NADAC) file on a monthly basis, which is based on community pharmacy invoice prices for CODs. The NADAC is one source States can use to support their ingredient cost AAC-based portion of pharmacy reimbursement. This methodology provides greater transparency into Medicaid payment for prescription drugs dispensed through community pharmacies, and most States use this file to help assure that pharmacies are paid for the cost of the drug that is dispensed and the professional dispensing costs. No such survey process, however, exists for CODs paid for by Medicaid that are not traditionally dispensed through retail pharmacies, such as many physician-administered drugs and gene therapy drugs, which are not required to follow the regulations noted above with regard to pharmacy reimbursement and AAC and PDF requirements.

Thus, while Medicaid has implemented policies that generally provide effective management of traditional retail community pharmacy drug spending, while creating greater transparency around payment for drugs dispensed by retail community pharmacies, there are fewer effective policies in place for management of COD purchasing and reimbursement to non-retail health care providers.

Substantial growth in non-retail community pharmacy drug spending is expected to continue. In March 2022, we estimated that for CY 2022, drugs that may require special handling or inpatient or outpatient hospitals stays will account for about 50 percent of the drug supply chain spending.[37] Additionally, Medicaid expenditures for CODs dispensed in non-retail community pharmacy settings continue to experience similar growth. Based on an analysis of CMS State utilization data from 2012 to 2019, total Medicaid non-retail community pharmacy drug expenditures as a percentage of total Medicaid drug expenditures grew from 28 percent to 47 percent, and total Medicaid non-retail community pharmacy dispensed drug expenditures grew from $10.58 billion to $30.70 billion.[38]

Thus, it is evident that the evolution in the types of drugs paid for by Medicaid, manufacturers' pricing structures for these drugs, as well as the methods used by manufacturers to distribute these drugs, have changed since the enactment of the MDRP, as well as the enactment of the MMA. While the model of distribution from manufacturer to wholesaler to provider still exists, and the predominant provider of pharmacy services remains the community-based pharmacy, there are other distribution and pricing arrangements for certain drugs, including high-cost gene therapy drugs that were not necessarily in existence in the market when the MDRP was enacted.

In some of these situations, there is a need for more information or verification regarding how certain prices or charges reported to us for these high-cost CODs are calculated in order to make payment under Medicaid. For example, there is little or no public information available about the factors

[37] Iqvia, National Sales Perspective, February 2022. Presentation given by Doug Long at Asembia, May 2022.

[38] Myers and Stauffer LC, Specialty Drugs Spend Trend 2012–2019 (2020) (unpublished analysis) (on file with Agency) (this analysis reviewed FFS and MCO combined spend for specialty drugs included on the Myers and Stauffer LC specialty list, based upon eight years of CMS National Utilization Data).

that influence the pricing of drugs dispensed in non-retail community pharmacy settings in Medicaid, the prices that pharmacies or wholesalers pay for these CODs, whether the prices or charges bear any relationship to the cost components of the COD, or whether the costs of distribution or preparation methods are included in the prices reported to us.

States do not have access to invoice data of manufacturers or purchasers, or information as to how manufacturers have arrived at the prices they charge wholesalers or direct distributers. Therefore, States may assume that manufacturer prices reflect the manufacturer's cost inputs such as research, development, and production costs. However, States do not know how those costs relate to the prices available from the manufacturer. Manufacturers may also consider the relative value of that drug to the patient/payer versus other treatments for similar conditions when developing their prices. As such, States may assume that the manufacturer prices its drug(s) at a certain value because it either has the potential to cure the patient or substantially reduce other medical costs (for example, reduces a patient's need for higher cost inpatient hospital care). However, these assumptions may not be accurate since how the manufacturer arrives at its price is generally opaque.

We believe our proposed drug price verification survey process, along with the NADAC that we publish for retail community pharmacy costs, should provide CMS and the States a clearer understanding into a manufacturer's pricing for its covered outpatient drug to verify those prices and charges, and ensure that Medicaid payments are made in an economical and efficient, as well as sufficient manner, to provide access to care. A lack of current understanding of manufacturer pricing bears directly on whether payments can be made consistent with section 1902(a)(30)(A) of the Act. Moreover, Medicaid managed care plans may be able to use such public information about the prices or charges that are collected under this process to determine the appropriateness of their payments to PBMs, or for States and managed care plans to determine the appropriateness of the drug spending component of the overall Medicaid managed care capitation rate attributable to pharmacy services.

For the foregoing reasons, and as described below, we propose to use the statutory authority in section 1927(b)(3)(B) of the Act, coupled with that in section 1902(a)(30)(A) of the Act, and this proposed regulatory process, to collect additional charges and pricing information from manufacturers to verify the prices reported to us for CODs. We believe this verification is extremely important given the significant number of high cost drugs and biologics, including cell and gene therapy drugs entering the market; the prices associated with new and different distribution channels; and the continued use of WAC as a pricing metric in instances when actual acquisition cost data are not available. Gene and cell therapy drugs especially, while transformative in terms of therapeutic benefits, are being priced in the millions of dollars. States, with their limited budgets, are concerned about how they would be able to afford these medications as they are generally required to pay for these drugs that are CODs as part of the prescribed drugs benefit in accordance with the requirements of section 1927 of the Act and the Medicaid drug rebate program. As stated earlier in this rule, our proposal to survey manufacturers to verify price(s) and charge(s) involves collecting certain information on specific CODs, and our proposal to make certain manufacturer information publicly available (unless it is proprietary), would give States an additional tool to negotiate payment for Medicaid CODs consistent with section 1902(a)(30)(A) of the Act. For instance, while the survey would be used by CMS to verify prices, the access to certain non-proprietary data via the survey, for example, patient outcomes of the covered outpatient drug, could give States the ability to negotiate supplemental rebates with a full understanding of the impact of the drug on its budget and Medicaid patient population. This is important, particularly in light of the limited ability of States to negotiate additional supplemental rebates because of the few novel products in a particular drug class.

We have also seen pricing-related issues relating to the production methods for these drugs, and query whether and how such methods should factor into the prices that are reported to us under section 1927(b)(3)(A) of the Act. For example, there are new preparation methods that modify or treat a patient's own cells, which are then placed back into the body to treat the patient's condition. This type of preparation method, while novel, raises issues of how such costs are included in the prices that are reported to us. We have also observed that certain manufacturers are using limited-distribution specialty pharmacies to distribute their drugs to providers and patients. Certain closed-door specialty pharmacies may have access to limited-distribution specialty drugs due to specific arrangements with pharmaceutical manufacturers or special monitoring provisions required by FDA.[39] Of the drugs approved by FDA in 2020 that were distributed through specialty pharmacies, 96 percent were for limited-distribution drugs.[40]

In addition to retail community and closed-door specialty pharmacies, other provider types may dispense and/or administer drugs dispensed in non-retail community pharmacy settings to Medicaid beneficiaries. These providers include, but are not limited to, physicians, home infusion pharmacies, hemophilia treatment centers, and clinics. In these situations, there may be questions regarding how a manufacturer calculates its AMP and best price that are reported to us under section 1927(b)(3)(A) of the Act, and how those data points compare to the actual invoice cost of the drug to the pharmacy. This directly affects Medicaid payments and rebates.

Manufacturers are also using innovative versions of third-party logistic arrangements to distribute their drugs, which include specialty pharmacies, under which the title of the drug does not transfer to the pharmacy. Questions have been raised by States as to how such arrangements work with respect to the Medicaid program's payment to the pharmacy, as well as the calculation of the covered outpatient drug's AMP and best price that are reported to us under section 1927(b)(3)(A) of the Act and used for purposes of calculating Medicaid rebates.

And we note that many States and Medicaid programs continue to use WAC as the basis for reimbursement of many drugs dispensed in a non-retail community pharmacy setting—because of the lack of availability of acquisition cost data. However, we have observed that there may be a trend in Medicaid by some manufacturers with recently-marketed high cost CODs to increase their WACs at a rate faster than their AMPs, especially for specialty drugs. We have not identified this trend with respect to long-marketed drugs covered by Medicaid and dispensed at retail community pharmacies based upon a

[39] Erin M. Turingan, et al., *Financial Effect of a Drug Distribution Model Change on a Health System.* 52 Hosp. Pharm. 422 (2017).

[40] Anton Health, *2020 Specialty Approvals—96% Via Limited Distribution,* Anton RX Report (Jan. 15, 2021), *https://antonhealth.com/2020-specialty-pharmacy-approvals/.*

May 2023 CMS comparison research of changes to invoice prices vs. changes in WAC. This comparison showed consistent changes in invoice pricing and WAC. We believe consistent changes in invoice pricing and WAC also occur for drugs covered by Medicare Part D and dispensed at retail community pharmacies. Generally, when manufacturers increase their WACs at a rate faster than their AMPs, the higher the WAC for the COD, the greater the spread between the Medicaid reimbursement and the actual acquisition cost. This trend could affect whether Medicaid payments are consistent with sections 1927 and 1902(a)(30)(A) of the Act, as discussed previously in this proposed rule. That is, the use of WAC by the State for reimbursement purposes for certain drugs, such as high cost specialty drugs, may result in States overspending for a drug and manufacturers underpaying in rebates because of the much lower reported AMP for the drug.

For example, based on an agency analysis of the relationship between WAC and AMP for a specific high-cost specialty drug, we found in 2018 that there was an 8.5 percent difference between the WAC and the AMP. Based on the latest data available, that difference is now 23 percent. Thus, States that use WAC that is reported to us under section 1927(b)(3)(A) of the Act to pay providers may significantly overspend for specialty drugs, given that AMP has traditionally been considered a closer proxy for the approximate revenues received by the manufacturer from sales of the drugs in the non-retail community pharmacy setting.

Given these situations, we propose that significant enough changes have occurred in the marketplace to warrant the use of the Secretary's authority to survey manufacturers and wholesalers in certain situations with respect to the prices and charges reported to us under section 1927(b)(3)(A) of the Act to make payment. Specifically, section 1927(b)(3)(B) of the Act gives the Secretary the authority to survey wholesalers and manufacturers that directly distribute their CODs, when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under section 1927(b)(3)(A) of the Act.

Therefore, we propose at § 447.510(k)(1) to use the authority granted to the Secretary under section 1927(b)(3)(B) of the Act to survey manufacturers with rebate agreements in effect with the Secretary to verify prices or charges for certain CODs for which drug product and pricing information is submitted under section 1927(b)(3)(A) of the Act and § 447.510, to make payment for the COD.

We do not believe it is required or necessary that we survey every manufacturer's price or charge submitted under section 1927(b)(3)(A) of the Act, as the authority to verify via a survey of the prices under section 1927(b)(3)(B) of the Act indicates that the Secretary ''may'' verify. Notably, we propose to exclude those CODs that are subject to certain CMS drug pricing program(s) or initiatives under which participating manufacturers negotiate the COD's price directly with CMS. For example, under the Medicare Drug Price Negotiation program established under sections 11001 and 11002 of the Inflation Reduction Act of 2022, or potentially certain CMMI models that are developed in response to the President's Executive Order 14087 (see HHS response at *https://innovation.cms.gov/data-and-reports/2023/eo-rx-drug-cost-response-report*), participating manufacturers will negotiate and collaborate with CMS on prices for certain CODs. This being the case, we propose to exclude CODs subject to these programs and initiatives from the survey verification, as CMS may have already successfully negotiated lower prices for the Medicare and/or Medicaid programs with these manufacturers. We intend to include a list of CMS drug pricing programs and initiatives under which manufacturers directly negotiate with CMS on a public website and would expect to update that list to reflect any future CMS drug pricing programs and initiatives that result in manufacturers' directly negotiating COD pricing with CMS.

We further note that under section 1927(c)(1)(C)(ii)(V) of the Act, maximum fair prices (MFPs) that are negotiated for selected drugs under the Medicare Drug Price Negotiation Program would be included in the Medicaid best price; thus, State Medicaid programs will benefit from the MFPs negotiated under Medicare Part B and Part D to the extent that such drugs are CODs. In other words, the MFP negotiated for these drugs could potentially lower the best price and potentially increase the Federal Medicaid drug rebate. Furthermore, it is unlikely that CODs with an MFP would be selected for the proposed drug price verification survey under section 1927(b)(3)(B) of the Act because we expect that our proposal would verify drug prices that are more recently marketed high cost drugs not typically dispensed at non-retail community pharmacies, while drugs for which an MFP has been negotiated must have been approved for at least 7 years, in the case of drugs approved and marketed under section 505(c) of the FFDCA, or licensed for at least 11 in the case of biological products that are licensed and marketed under section 351 of the PHS Act. Moreover, as noted previously in this proposed rule, we do not believe the trend of WACs increasing at a rate faster than their AMPs is relevant for the types of drugs for which MFP likely will be negotiated. Therefore, in this rule, we are proposing to survey manufacturers to verify price (or prices) and/or charges regarding specific CODs based on a three-step process.

The first step would use objective measures related to Medicaid spending to identify CODs with the highest drug spending per claim, highest total Medicaid drug spending, highest 1 year price increase, or highest launch price, as determined and explained below. Specifically, we propose at § 447.510(k)(2) that CMS, on an annual basis, would compile a list of single source CODs that may be subject to a survey based on one or more of the criteria proposed at § 447.510(k)(2)(i) through (iv).

The proposed measures in § 447.510(k)(2)(i) (highest drug spending per claim) and (ii) (highest total Medicaid drug spending) would use Medicaid drug spending data as reported from States to CMS in accordance with the State drug utilization data (SDUD) reporting (*https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html*). We note that the per claim Medicaid spending data used in § 447.510(k)(2)(i) is not reduced by Federal rebates since such rebates are not reported at the claim level. Further, the supplemental rebate data are reported in the aggregate to CMS from States on a quarterly basis, thus it is difficult to identify individual State supplemental rebate data to net State supplemental rebates from per claim Medicaid spending. However, we would review the reported annual total Medicaid spending at § 447.510(k)(2)(ii) as reported by the States net of Federal rebates when determining if a COD spend is greater than 0.5 percent of total annual Medicaid drug spend, net of Federal rebates.

For proposed measure § 447.510(k)(2)(iii), we would look at published WACs to determine when a COD's price increase falls in the top 1 percent of CODs with the highest median WAC increase over a 12-month period.

In proposed measure § 447.510(k)(2)(iv), we propose to look at the highest launch price, which we

propose to do by estimating whether or not the covered outpatient drug's cost would be in the top 5th percentile of Medicaid spending by comparing a manufacturer's published launch price (available as a published WAC or published by the manufacturer) to Medicaid per claim spending or if treatment costs are greater than $500,000 (indexed for inflation using the CPI–U).

We expect application of the measures proposed at § 447.510(k)(2)(i) through (iv) would capture an initial set of high-cost CODs that could significantly impact Medicaid covered outpatient drug spending. From a process standpoint, in subregulatory guidance, we would provide the applicable time periods that CMS would review the data in order to determine the initial list of CODs, which we propose to be finalized in April following publication of this final rule, and each April thereafter. We expect that we would use data from the prior calendar year or Federal fiscal year. The list of CODs as a result of this analysis would not be made public.

We propose at § 447.510(k)(3) to further refine this initial survey list of CODs in the second step by considering additional criteria such as a manufacturer's willingness to negotiate further rebates either through a CMS-authorized supplemental rebate, or a manufacturer's participation in a CMS drug pricing program or initiative under which participating manufacturers negotiate directly with CMS (see discussion above about proposal to exclude drugs under a CMS drug pricing program or initiative). At § 447.510(k)(3)(i), CMS proposes to exclude the CODs of manufacturers that participate in any CMS pricing program or initiative under which participating manufacturers negotiate a COD's price directly with CMS.

CMS believes that a manufacturer's willingness to negotiate also may be demonstrated by the manufacturer's level of effort to work with States to make the identified COD more affordable, especially considering States' limited budgets. Therefore, by way of a State survey to determine a manufacturer's level of effort, we propose at § 447.510(k)(3)(ii) to further exclude covered outpatient drugs of manufacturers that have negotiated CMS-authorized supplemental rebates with at least 50 percent of the States, that when in combination with the Federal rebate results in a total (State and Federal) rebate for the drug of interest to total Medicaid spend (State and Federal) for the drug of interest, that is greater than the total Medicaid rebates (State and Federal) to total Medicaid drug spend for States that cover CODs only through fee-for-service, as reflected in the most recent Medicaid Financial Management Report (FMR).[41] The FMR reflects annual State expenditures collected on the CMS–64 report.[42] We propose to use the Federal fiscal year Medicaid FMR and analyze the rebates for those States that currently provide coverage of covered outpatient drugs only through fee-for-service (fee-for-service States). Specifically, we would determine total computable prescribed drugs expenditures for the States that cover CODs only through fee-for-service (currently 10 States) and determine the percentage of prescribed drug expenditures that are offset by State and Federal drug rebates. We propose to consider only States that cover CODs entirely through fee-for-service because the prescribed drugs expenditures in the FMR do not include COD expenditures made by managed care entities, while the rebate lines do include the managed care rebate offset. In other words, the denominator in the comparison of rebates to total expenditures would be understated, resulting in a higher percentage, if we included managed care COD expenditures and rebates in the calculation. Based upon the Federal fiscal year 2021 Medicaid FMR, the total Federal and State rebates range from 38 percent to 72 percent of total prescribed drug expenditures based upon analysis of eight States that pay for CODs entirely through fee-for-service (2 of the 10 such States had insufficient data reported for Federal fiscal year (FFY) 2021). We request comment on this proposal to refine the list of covered outpatient drugs to be surveyed, based upon a manufacturer's level of effort at reducing the price for the identified high cost drugs (that is, those drugs identified by applying measures proposed at § 447.510(k)(2)).

We also propose § 447.510(k)(3)(iii)(A) that if after application of § 447.510(k)(3)(i) and (ii), more than 10 CODs still remain, CMS would proceed to the third step and consider soliciting State-specific Medicaid program information as to the manufacturer's level of effort to lower drug price for the Medicaid program, such as a manufacturer offering other programs to lower the cost of the drug to the State such as subscription models, VBP arrangements under the multiple best price approach, or other special arrangements. We do not intend these examples of manufacturer effort to lower drug prices in § 447.510(k)(3)(iii)(A) to be exclusive or to encourage or discourage specific pricing approached; CMS recognizes that the pharmaceutical pricing market is fluid and States and manufacturers may pursue or negotiate arrangements not specifically listed in regulation. Additionally, we propose at § 447.510(k)(3)(iii)(B) that we would consider narrowing the list based on the highest cost CODs based on the factors outlined under § 447.510(k)(2) of this section, and before application of § 447.510(k)(3). We propose to collect the information in § 447.510(k)(3)(ii) and (k)(3)(iii)(A) using a State survey tool that we would develop if the rule is finalized as proposed. Once CMS determines a final list of CODs to be verified after the application of 447.510(k)(3), we would send a letter to the manufacturers of the identified drugs sometime in August, as discussed further below.

While currently not proposed in regulation at § 447.510(k)(2) and (3), we also invite comments on whether CMS should consider surveying manufacturers of certain CODs that are identified under the proposed criteria at § 447.510(k)(2)(i) through (iv) that are also granted accelerated approval by FDA. The approval of a COD using the accelerated approval pathway relies on demonstrating an effect on surrogate or intermediate endpoint(s) that is reasonably likely to predict clinical benefit. Drug sponsors have been required by the FDA to conduct confirmatory trials after approval to verify and describe the predicted clinical benefit. However, the HHS OIG[43] found that drug sponsors do not always complete trials promptly, which can result in drugs staying on the market—often at high prices with limited competition—and being administered for years with unverified clinical benefit. Subjecting accelerated approval drugs to the drug price verification survey process would not supplant any determination made by the FDA. However, CMS surveying manufacturers for verification of prices may be warranted by recent trends of high costs of some of these therapies, particularly in view of some manufacturers' noncompliance with FDA's requirement for further confirmatory trials. Accordingly, we seek comments regarding whether CODs included on the list under the proposed

[41] *https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.*

[42] *https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-medicaid-chip/index.html.*

[43] *https://oig.hhs.gov/oei/reports/OEI-01-21-00401.asp.*

§ 447.510(k)(2) that are approved under the FDA accelerated approval pathway should be surveyed when a manufacturer has failed to demonstrate the clinical benefits of the drug through further confirmatory trials required by the FDA.

We propose at § 447.510(k)(4) that after a survey list of CODs is compiled after the application of the criteria in § 447.510(k)(2) and (3), the agency would post on a publicly accessible, government website the letter sent to the manufacturer indicating the name of the COD to be surveyed and the request for completion of the drug price verification survey.

In proposed § 447.510(k)(5), we propose that such survey to a manufacturer or wholesaler would request in a standard reporting format specific information that would include the information proposed at § 447.510(k)(5)(i) through (iv). The survey tool would be developed after the publication of the final rule, if this proposal is finalized.

In § 447.510(k)(5)(i), we propose to collect information on the pricing, charges, distribution and utilization for the COD. We propose to collect these utilization and pricing metrics from manufacturers to verify that the prices reported at section 1927(b)(3)(A) of the Act do not have the potential to negatively impact State budgets to the extent States are not able to cover the drugs, thus impeding Medicaid beneficiary access to treatment.

In § 447.510(k)(5)(ii), we propose to collect product and clinical information for the COD described in the proposed regulation text at § 447.511(k)(5)(ii)(A) through (E) to understand the clinical benefits and risks of the covered outpatient drug to verify that the price reported fairly represents the benefits and/or risks of the COD.

In § 447.510(k)(5)(iii), we propose to collect information on the costs of production, research, and marketing of the COD. We believe it is important to understand the costs to the manufacturer of researching, producing, and marketing of the drug and how those costs are accounted for in the prices and charges they report. We also note in this proposed subparagraph that research and development costs of a line extension drug shall not include the research and development costs of the initial single source or innovator multiple source covered outpatient drug.

In § 447.510(k)(5)(iv), we propose to collect other information as determined by the Secretary specific to the particular COD in question that would help inform CMS and States with their verification of drug prices. This additional information would likely be specific to each individual covered outpatient drug and may include additional requests associated with changes to the pharmaceutical marketplace. We may consider issuing additional guidance on the nature and scope of the other information we may request.

The agency understands that some of the data proposed to be collected would be confidential and likely protected under section 1927(b)(3)(D) of the Act, in addition to other privacy and confidentiality provisions, including the Trade Secrets Act.

Although the statute does not prescribe a method to verify prices or charges, we propose in § 447.510(k)(6) that CMS may post non-proprietary information provided by the manufacturer and wholesaler in response to the verification survey. By posting the non-proprietary information on our website, the public, beneficiaries, State Medicaid agencies, other Federal Government agencies and other affected interested parties would be afforded the opportunity to comment on public information as part of the verification process to ensure that those Medicaid payments are economical and efficient, as well as sufficient, to provide access to care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

Finally, section 1927(b)(3)(B) of the Act allows the Secretary to impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey as proposed under § 447.510(k) or knowingly provides false information. The provisions of section 1128A of the Act (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty (CMP) under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of the Act. The civil monetary penalty authority set forth in section 1927(b)(3)(B) of the Act has been delegated to OIG. We would provide information obtained through, and in connection with, this survey to OIG for the purposes of potential imposition of CMPs for failure to report information in connection with a survey or for knowingly providing false information. Therefore, we propose at § 447.510(k)(7) that if a manufacturer or wholesaler refuses a request for information pursuant to a drug price verification survey within 90 calendar days of CMS' request, or knowingly provides false information, the manufacturer or wholesaler would be referred to OIG for possible imposition of civil monetary penalties (CMPs) as set forth in section 1927(b)(3)(B) of the Act and section IV of the National Drug Rebate Agreement.

K. Proposals Related to State Plan Requirements, Findings, and Assurances (§ 447.518)

Section 1902(a)(30)(A) of the Act requires that States include in their State Plan, methods and procedures to ensure that payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to the general population in the geographic area. Under that authority, the Secretary issued Federal regulations at §§ 447.502, 447.512, and 447.518 that further elaborate that generally, payments to pharmacies for drugs that they dispense, and are paid for under the State Plan, are to be based on a two-part formula which consists of: (1) the ingredient cost of the drug that is dispensed based on the actual acquisition cost (AAC); and, (2) a professional dispensing fee (PDF) for the drug based on the pharmacy's cost of dispensing, that is, the cost of the pharmacist's professional services for ensuring that the appropriate COD is dispensed or transferred to a Medicaid beneficiary.

AAC is defined at § 447.502 to mean the agency's determination of the pharmacy providers' actual prices paid to acquire drug products marketed or sold by specific manufacturers. As discussed in the COD final rule implementing this definition of AAC, a State can implement an AAC model of reimbursement based on various pricing methodologies for the ingredient cost of the drug so long as the ingredient cost represents the actual, current ingredient cost of the drug and is calculated based on the amounts that pharmacies pay for the drug (§ 447.518).

We also discussed our view that the definition of AAC requires that States establish payment rates based on pharmacies' actual prices paid to acquire drug products, and explained that the expectation is that those prices would reflect current prices (see 81 FR 5176). In accordance with § 447.502, the professional dispensing fee is incurred at the point of sale or service and pays for pharmacy costs in excess of the

ingredient cost of a COD each time a COD is dispensed. The fee includes, but is not limited to, reasonable costs associated with delivery, special packaging and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy. Costs also include a pharmacist's time spent checking the computer for information about an individual's coverage, performing drug utilization review (DUR) and preferred drug list review activities, measuring or mixing, filling the prescription, counseling a beneficiary; and physically providing the completed prescription to the Medicaid beneficiary.

Under § 447.518, States are required to ensure that pharmacy providers are reimbursed adequately for both their pharmacy ingredient costs and professional dispensing services in accordance with the requirements of section 1902(a)(30)(A) of the Act. The State Plan must comprehensively describe the agency's payment methodology for prescription drugs, including the agency's payment methodology for drugs and the professional dispensing fee. As provided under § 447.518(d)(1), when proposing changes to either AAC (ingredient cost reimbursement) or PDF reimbursement, States are required to evaluate their proposed changes consistent with section 1927 of the Act, and must consider both parts of the reimbursement formula to ensure that total reimbursement under the proposed changes are consistent with section 1902(a)(30)(A) of the Act.

These reimbursement formulas and any proposals to change either or both components of the reimbursement formula are subject to review and approval by CMS through the State Plan Amendment (SPA) process. In their SPA submission, States must provide adequate data such as a State or national survey of retail pharmacy providers or other reliable data (other than a survey) to support any proposed changes to either or both of the components of the reimbursement methodology.

While States are afforded the flexibility to adjust their professional dispensing fees through the SPA process in accordance with the requirements of sections 1902(a)(30)(A) and 1927 of the Act, they must substantiate how their reimbursement to pharmacy providers reasonably reflects the actual cost of the ingredients used to dispense the drug, and the actual costs of dispensing the drug, consistent with the regulatory definitions of AAC and professional dispensing fee. We review each State's proposed reimbursement methodology to assure it meets Federal requirements under sections 1902(a)(30)(A) and 1927 of the Act, and the implementing regulations, specifically at §§ 447.502, 447.512, and 447.518.

More recently, we have seen States submit proposed changes to either or both of the components of the reimbursement methodology without adequate supporting data that reflects current drug acquisition cost prices or actual costs to dispense. This is inconsistent with applicable law because the data submitted should reflect the actual cost of dispensing, consistent with Federal requirements under sections 1902(a)(30)(A) and 1927 of the Act and the implementing regulations, specifically at §§ 447.502, 447.512 and 447.518.

The professional dispensing fee should be based on pharmacy cost data, and not be based on a market-based review, such as an assessment or comparison of what other third-party payers may reimburse pharmacies for dispensing prescriptions. A State's periodic review and examination of market-based research for a comparison of what other payers reimburse for dispensing costs is an insufficient basis for determining or proposing changes to professional dispensing fees because it does not reflect actual costs to pharmacies to dispense prescriptions. The State must submit adequate cost data to CMS as part of its SPA process to justify its professional dispensing fee amounts. We are proposing that the data submitted cannot solely rely on the amounts that pharmacies are accepting from other private third-party payers.

Similarly, with respect to reimbursement of drug ingredient costs, which must be consistent with AAC, States must support determinations or proposed changes for ingredient cost reimbursement with adequate cost based data. With respect to the AAC, we discussed in the preamble of the COD final rule our view that the definition of AAC requires that States establish payment rates based on pharmacies' actual prices paid to acquire drug products, and explained that the expectation is that those prices would reflect current prices. (See 81 FR 5176.)

Pharmacy purchase prices for drugs are subject to many external factors and market conditions which can cause purchase prices to go up or down. Many of these factors are out of the control of the purchasing pharmacy. We explained various ways States could establish pharmacy reimbursement methodologies, noting that the pricing benchmarks CMS provide to States, for example, the weekly NADAC files, and the weekly and monthly AMP are updated regularly to reflect current prices.

After the COD final rule was issued, we issued further guidance to States in the State Medicaid Directors Letter, SHO #16–001, dated February 11, 2016, and Frequently Asked Questions (FAQs), dated July 6, 2016. In that SHO, CMS provided further detail on ways States can implement an AAC model of reimbursement, including utilizing a nationwide survey, like the NADAC files (which are published on a monthly basis and updated weekly, and are designed to represent a current national pricing methodology based upon a simple average of voluntarily-submitted retail pharmacy acquisition costs for most covered outpatient drugs), a State survey of retail community pharmacy providers' pricing, published compendia prices, or average manufacturer price-based pricing. In each of these instances, the ingredient cost represents the actual, current ingredient cost of the drug and is calculated based on the amounts that pharmacies pay for the drug.

Freezing AAC rates and establishing a static provider reimbursement would not be consistent with applicable laws and regulations. Reduced beneficiary access to medically necessary drugs can result if pharmacy providers are unable to purchase drugs at a rate reflective of current market conditions. Pharmacies are not likely to purchase and dispense a covered outpatient drug to a Medicaid beneficiary if the reimbursement for the drug is not sufficient. Certain pharmacies, such as small rural pharmacies, rely primarily on revenue from prescriptions. When reimbursement rates for drugs do not adapt to changing market conditions, pharmacies may stop filling prescriptions for Medicaid beneficiaries, or, depending on the number of Medicaid prescriptions they fill, could have to permanently go out of business. This can result in reduced access to medications and negatively impact health equity, as Medicaid beneficiaries may have to go to multiple pharmacies to obtain the medication, or may not be able to obtain it at all. This can also result in the need for other costlier medical interventions, such as hospitalization.

In this proposed rule, we are proposing to clarify the data requirements that States must submit to establish the adequacy of both the current ingredient cost and the professional dispensing fee reimbursement. Furthermore, we are specifying professional dispensing fees cannot simply be determined by a market-based review of what other

third-party payers may reimburse for dispensing prescriptions. That is, we are proposing to clarify in regulatory text that in a State's periodic review of the rates being paid to pharmacies, the examination of market-based research data used to justify dispensing costs is an inappropriate basis for determining professional dispensing fees. A State cannot rely on the amounts that pharmacies are accepting from other third-party payers as a means of determining professional dispensing costs. The data that are acceptable could be a State's own survey, a neighboring States' survey, or other credible survey data, but it must be adequate and must reflect the current cost of dispensing a prescription in the State (81 FR 5311).

To pay based on costs, States need to periodically assess whether current rates being paid to pharmacies to reflect current costs. There is no specific requirement as to how often and when States have to review their current fees. However, any State currently reimbursing pharmacy providers a professional dispensing fee that does not reflect the pharmacy's actual acquisition cost and cost of dispensing must come into compliance.

Therefore, in consideration of ensuring that payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers, we believe an update to the regulatory text is necessary so that care and services continue to be available to the general population. Accordingly, we are proposing to update § 447.518(d) heading as ''Data requirements'' and to include paragraph (d)(1) as set out at in the regulatory text at the end of this document.

Updating this language would assure that States provide adequate data to establish pharmacy reimbursement for ingredient costs and professional dispensing fees, and that such reimbursement is based on current actual costs.

L. Federal Financial Participation (FFP): Conditions Relating to Physician-Administered Drugs (§ 447.520)

Generally, physician-administered drugs (PADs) may satisfy the definition of a covered outpatient drugs (COD) under section 1927(k)(2) of the Act, subject to the limiting definition at section 1927(k)(3) of the Act, and manufacturer rebates can be collected on these PADs.

Prior to section 6002 of the DRA of 2005, which added sections 1927(a)(7) and 1903(i)(10)(C) to the Act to require the States to collect and submit certain utilization data on certain PADs in order for FFP to be available for these drugs, and for States to secure rebates, many States did not collect rebates on PADs when they were not identified by a National Drug Code (NDC) number because the NDC number is necessary for States to bill manufacturers for rebates. The NDC identifies the specific manufacturer, product, and package size.

In the past, many PADs were classified by Healthcare Common Procedure Coding System (HCPCS) [44] codes (commonly referred to as J-codes), which group together different manufacturers of the same drug in the same code. These broad codes cannot be used to bill for rebates, as they do not identify the specific manufacturer. Many providers were submitting only these HCPCS codes to the States, rather than the NDC code of the specific drug, making it difficult for the State to bill for rebates.

In its report titled ''Medicaid Rebates for Physician Administered Drugs'' (April 2004, OEI–03–02–00660),[45] the OIG reported that, by 2003, 24 States either required providers to bill using NDC numbers or identified NDC numbers using a HCPCS-to-NDC crosswalk for PADs to collect rebates. Four of the 24 States were able to collect rebates for all PADs, both single source and multiple source drugs (one State only collected these rebates from targeted providers).

To address this situation, and to increase the rebates being invoiced by States for PADs, section 6002 of the DRA added sections 1927(a)(7) and 1903(i)(10)(C) to the Act to require the States to collect and submit certain utilization data on certain PADs in order for FFP to be available for these drugs, and for States to collect manufacturer rebates. More specifically, these provisions required that for payment to be available under section 1903(a) of the Act for a COD that is a PAD, States had to provide for the collection and submission of utilization data and coding (such as J-codes and NDC numbers) for a PAD that is a single source (after January 1, 2006) or a multiple source drug (after January 1, 2008) that is a top 20 high dollar volume PAD on a published list (based on highest dollar volume dispensed under Medicaid identified by the Secretary, after January 1, 2007) that the Secretary may specify in order for payment to be available under section 1903 of the Act and for States to secure applicable Medicaid rebates.

This list of the top 20 multiple source drugs may be modified year to year to reflect changes in such volume. (See section 1927(a)(7)(B)(i) of the Act.) The statute also required that only NDCs be used after January 1, 2007 for billing for all PADs that are CODs, unless the Secretary authorized that another alternative coding system be used. If States are not collecting NDCs and submitting the appropriate utilization data for these drugs, States should not receive Federal matching payments. In addition, States would be foregoing available rebates for these drugs.

Regulations at § 447.520 were established to implement these statutory provisions in the 2007 Medicaid Program; Prescription Drugs; Final Rule, specifying the conditions for FFP for PADs (72 FR 39142). Section 447.520(a) specifies that no FFP is available for PADs if the State has not required the submission of codes from its providers that allow it to appropriately bill manufacturers for rebates for PADs. For single source PADs, the requirement to submit appropriate coding went into effect as of January 1, 2006, and specifies under § 447.520(a)(1) that States must require providers to submit claims for single source PADs using HCPCS or NDC codes to secure rebates. Section 447.502(a)(2) further specifies that as of January 1, 2007, a State must require providers to submit claims for single source and the top 20 multiple source PADs identified by the Secretary, using NDC codes.

Under § 447.520(b), as of January 1, 2008, a State must require providers to submit claims for the top 20 multiple source drugs identified by the Secretary as having the highest dollar volume using NDC numbers to secure rebates, and § 447.520(c) provided the opportunity for States that require additional time to comply with the requirements of the applicable laws and regulations to apply for an extension to comply with the requirements. We proposed to retain this current regulatory language without modification in the 2012 COD proposed rule (77 FR 5367) and since no comments were received on that proposal, the current regulations were finalized without any modifications in the 2016 COD final rule. See 81 FR 5322.

We propose to update the regulatory language at § 447.520 to more

[44] HCPCS is a collection of standardized codes that represent medical procedures, supplies, products and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers. HCPCS is divided into two subsystems, Level I and Level II. Level I is comprised of Current Procedural Terminology codes (HCPT). Level II HCPCS codes identify products, supplies, and services not included in CPT.

[45] *https://oig.hhs.gov/oei/reports/oei-03-02-00660.pdf.*

specifically and accurately conform with the statutory requirements captured at section 1927(a)(7) of the Act. In proposed § 447.520(a)(1) through (3) we specify the conditions under which FFP is available for States, as they relate to the codes they must require providers to use in order for the State to secure rebates for PADs that are CODs. The proposed language clarifies that rebates are only due for PADs that are CODs, and provides the conditions that data must be submitted by providers in the State in order for States to receive FFP and secure applicable rebates. We are proposing at § 447.520(b) a State require providers to submit claims for all covered outpatient drug single source and multisource physician-administered drugs using NDC numbers to collect FFP and secure rebates.

States also need to ensure that their managed care plans report required drug utilization data in order for States to invoice manufacturers for rebates for CODs, consistent with § 438.3(s)(2) and (3), which were adopted in the 2016 Medicaid Managed Care final rule.[46] Per § 438.3(s)(2) and (3), an MCO, PIHP or PAHP that covers CODs under its Medicaid managed care contract must (1) report drug utilization data to the State that is necessary for the State to bill manufacturers for rebates under section 1927 of the Act using NDC numbers for all CODs, including all single and multiple source PADs; and, (2) establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from those reports if the State does not require submission of managed care drug claims data from covered entities directly to the State.

Additionally, we are proposing at § 447.520(c) to continue to publish the top 20 list of multiple source PADs on an annual basis, as statutorily required, but it is our expectation that States would invoice rebates for all multiple source physician-administered drugs that are CODs. This section would make it clear that States are required to invoice for rebates for multiple source PADs on this list to receive Federal matching funds and to secure rebates. The proposed regulation would specify to States that they should invoice for rebates for all multiple source PADs that are CODs, and not limit such rebate invoicing to the top 20 high dollar volume list. As technology and systems are currently in place, this proposed regulation would reduce the administrative burden of monitoring any revisions to the top 20 multiple source PADs and allow States to secure rebates for these PADs that are CODs.

M. Request for Information on Requiring a Diagnosis on Medicaid Prescriptions

Generally, a COD is a prescribed drug approved under section 505(c) or 505(j) of the FFDCA or section 351 of the Public Health Service (PHS) Act when used for a medically accepted indication. The term ''medically accepted indication'' is defined in statute at section 1927(k)(6) of the Act and means any use for a COD which is approved under the FFDCA or the use of which is supported by one or more citations included or approved for inclusion in compendia described in section 1927(g)(1)(B)(i) of the Act, which is the American Hospital Formulary Service–Drug Information (AHFS–DI), Drugdex, or United States Pharmacopoeia–Drug Information (USP–DI). Medicaid COD claims do not currently require a diagnosis code as a condition for payment. When reviewing claims, without a diagnosis, it is difficult to determine whether a drug is indeed being used for a medically accepted indication, and appropriately satisfies the definition of a COD, and therefore, is rebate eligible. Despite statutory language limiting Medicaid payment for covered outpatient drugs to when used for a ''medically accepted indication,'' there are not systems in place for States to determine whether a patient's outpatient prescription drug use is in fact for a medically accepted indication, or in other words, there is no mechanism to cross-reference a prescription drug use with a Medicaid patient's medical diagnoses to ensure a drug is being used for a medically accepted indication.

In 2011, the OIG discovered in a Medicare audit that without a diagnosis, it is difficult for Part D sponsors to determine whether a drug claim is medically appropriate.[47] OIG stated that without access to diagnosis information, Part D sponsors cannot determine the indications for which drugs were used. Although this audit referenced Medicare, the same issue is applicable to Medicaid prescriptions. If States are not aware of the diagnosis for which the medication is being used, they are unable to determine if the drug is being used for a medically accepted indication and cannot determine if they should bill for rebates or if coverage is mandatory. Additionally, an article written by then Principal Deputy Inspector General (and now current Inspector General) and Chief Medical Officer from OIG. recently advocated for a new mandate that physicians include a diagnosis code with prescriptions.[48] In 2011, CMS did not concur with OIG's finding, stating that diagnosis information is not a required data element of pharmacy billing transactions, nor is it generally included on prescriptions.

Since 2011, automation of prescribing has grown significantly, and in 2020 an estimated 84 percent of all prescriptions were e-prescriptions.[49] Electronic prescribing has increased so much so that in early 2021, most prescriptions for controlled substances under Medicare Part D must be transmitted electronically.[50]

There are several instances in which a diagnosis on a prescription could help States implement certain Medicaid programs in which they are eligible for enhanced Federal matching funds, or for which they must implement a mandatory benefit. Federal funds support States in responding to the increased need for services, such as testing and treatment during the COVID–19 public health emergency, family planning, or allows States to provide innovative treatment services. For certain conditions, an increase in States' Federal medical assistance percentage (FMAP) leverages Medicaid's existing financing structure and allows enhanced Federal funds to treat that condition. For example, to be eligible for enhanced Federal funds in certain instances, such as when birth control drugs are used for family planning as opposed to other indications such as acne, moderate to severe abnormal vasomotor function, or postmenopausal osteoporosis the State needs to document when expenditures are being used to treat that condition. Without access to diagnosis information, States cannot accurately determine the indications for which drugs were used, especially when drugs have multiple indications, making identification of these costs very difficult, if not impossible, and very resource intensive. For example, if a family planning drug has multiple indications, and the family planning indication is eligible for enhanced Federal matching, then the State will only know when the drug is

[46] 86 FR 27498, May 6, 2016 (*https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf*).

[47] *https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf*.

[48] STAT Op-Ed by Christi A. Grimm & Julie K. Taitsman | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services (*hhs.gov*).

[49] E-prescription rate U.S. 2020 | Statista available at *https://www.statista.com/statistics/864380/share-of-us-e-prescriptions/?msclkid=a1c545e9b44d11ec81f5391e8e8d23cb*.

[50] E-Prescribing | CMS available at *https://www.cms.gov/Medicare/E-Health/Eprescribing?msclkid=27a13cf3b44e11ecb30d5dd85675d203*.

being used for birth control if there is a related diagnosis on the prescription. A requirement of diagnosis on prescriptions would allow States to easily and accurately identify drug expenditures qualifying for these enhanced Federal matching funds. State programs will be able to better determine if prescriptions meet payment requirements and can more accurately capture expenditures required for Federal matching.

There are additional benefits for adding diagnosis on prescriptions for both providers and beneficiaries. For example, practitioners and beneficiaries benefit from systematic authorizations that are diagnosis based. Vulnerable groups, such as pregnant women, or specific diagnoses (COVID–19) can be easily exempt from out-of-pocket costs and copayments for certain services or conditions. Diagnosis information on prescriptions can help pharmacists identify safety issues and helps supplement prior DUR standards under section 1927(g) of the Act in ensuring prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. Adding diagnosis to prescriptions can contribute to safer prescribing, improved patient outcomes and medication use in multiple, synergistic ways. Including diagnosis on prescriptions may be a way to ensure drugs are being only used for FDA approved indications. State Medicaid programs may also be able to better manage drug utilization by mandating diagnosis codes on drug claims to ensure payments are limited to drugs with medically accepted indications as required by statute.

Finally, we believe, if such a provision were implemented, that the design and implementation of any adjudication specifications would be left to the States' discretion to meet State-specific needs. Given this flexibility, States can continue to monitor and fine-tune program specifics as they determine what works best for their population's health and well-being. For continuity of care among programs, if this provision was implemented in the future, we envision all Medicaid managed care programs would be included in this requirement, including MCOs, PIHPs, or PAHPs.

There are many interested parties that would have views on this requirement to include diagnosis on a prescription: patients, prescribers, pharmacists, States, and drug manufacturers. We are specifically soliciting comments on this topic, its impact on beneficiaries, providers, States, Medicaid, and any operational implications. We are particularly interested in understanding the burden with such a proposal and seeking comments on how to negate any foreseeable impact on beneficiaries and providers and steps which would be needed by States to successfully implement a Medicaid requirement for diagnosis on prescriptions as a condition of FFP. We are requesting comments regarding the potential impact of supporting such a policy to require Medicaid diagnoses on prescriptions on payment, health care quality, stigma and access to care, and program integrity. We are also requesting comments on what steps we should take to protect beneficiary access to commonly used, medically accepted, compendia supported, off-label prescriptions if we propose to implement such a policy. We are seeking comments from all interested parties on potential approaches and invite all comments on this topic.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a ''collection of information'' requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purposes of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment (see section III.D. of this proposed rule) on each of these issues for the following sections of this document that contain collection of information requirements. Comments, if received, will be responded to within the subsequent final rule.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS') May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 3 presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 3—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGES ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and other indirect costs ($/hr)	Adjusted hourly wage ($/hr)
Operations Research Analyst	15–2031	46.07	46.07	92.14

As indicated, we are adjusting our hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate the total cost is a reasonably accurate estimation method.

B. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding Identification and Notification to Manufacturer To Correct Misclassification (§ 447.509(d)(1) Through (4))

As discussed in section II.F.1.a. of this proposed rule, we are proposing to add

new paragraphs (d)(1) through (4) to § 447.509 that would add new requirements relating to the process by which CMS would identify when a misclassification of a drug has occurred in MDRP and subsequently notify the manufacturer of the misclassified drug. As such, a manufacturer's efforts to address the misclassification is currently approved by OMB under control number 0938–0578 (CMS–367). This package currently takes into account the time and cost incurred by manufacturers when compiling and reporting, or changing, Medicaid drug product and price information on a monthly, quarterly, and on an as-needed basis. The burden, however, is subject to a regulatory impact analysis which can be found in section V. of this proposed rule.

2. ICRs Regarding Definitions (§ 447.502)

As discussed in section II.C.1.d. of this proposed rule, we are proposing to modify the definition of manufacturer for NDRA purposes. The modification would establish a regulatory definition of manufacturer for purposes of satisfying the requirement that a manufacturer maintain an effectuated rebate agreement with the Secretary consistent with section 1927(a)(1) of the Act. Specifically, we are proposing that the term ''manufacturer'' means that all associated labeler entities of the manufacturer that sell CODs, including, but not limited to, owned, acquired, affiliates, brother or sister corporations, operating subsidiaries, franchises, business segments, part of holding companies, divisions, or entities under common corporate ownership or control, must each maintain an effectuated rebate agreement. The preparation and maintenance of an effectuated rebate agreement has been a long-standing requirement that we propose to codify in this rule. The effectuated rebate agreement requirement and burden are currently approved by OMB under control number 0938–0578 (CMS–367). This rule's proposed actions have no impact on our currently approved requirements and burden estimates and assumptions, including the universe of manufacturers. Consequently, we are not making any changes under that control number.

Additionally, we do not believe any of the following new terms and definition modifications and clarifications would require any effort or impose burden on any public or private entities: (1) proposal to modify the definition of ''covered outpatient drug (§ 447.502), (2) proposal to define ''drug product information'' (§ 447.502), (3) proposal to define ''market date'' (§ 447.502), (4) proposal to modify the definition of ''noninnovator multiple source drug'' (§ 447.502), (5) proposal to clarify § 447.509(a)(6) through (9) and (c)(4) with respect to ''other drugs'', and (6) proposal to define ''vaccine for purposes of the MDRP only'' (§ 447.502). Consequently, none of the definition changes are subject to the requirements of the PRA.

3. ICRs Regarding Proposals Related to State Plan Requirements, Findings, and Assurances (§ 447.518)

As discussed in section II.K. of this proposed rule, we are proposing to specify in § 447.518(d)(1) that the professional dispensing fee (PDF) must be based on pharmacy cost data, and that it cannot be solely determined or supported by a market-based review or by an assessment or comparison of what other payers may reimburse pharmacies for dispensing prescriptions. The clarification also specifies the type of supporting data that we would accept as adequate to support a change to the PDF. The proposed clarification would not add any new or revised requirements or burden. If a State chooses to revise their State Plan for any updates to include a modification to their PDF, a SPA can be submitted to CMS for review and approval. The burden for such SPA submissions is currently approved by OMB under control number 0938–0193 (CMS–10398 #179 under attachment 4.19–B pertaining to the: methods and standards used for the payment of certain services, and methods and standards used for establishing payment rates for prescribed drugs). Since the proposed clarification would not add any new or revised requirements or burden, we are not making any changes under that control number.

4. ICRs Regarding Federal Financial Participation (FFP): Conditions Relating to Physician-Administered Drugs (§ 447.520)

We propose to update § 447.520 to make it consistent with section 1927(a)(7) of the Act, and to codify the requirement that States must collect NDC information on all single and multiple source physician-administered drugs that are CODs for the purposes of invoicing manufacturers for rebates, and ensuring that FFP is available, as appropriate. We are proposing to require that States must be invoicing for rebates for all physician-administered drugs that are CODs. We propose to continue to publish the top 20 high dollar volume list of multiple source physician-administered drugs, as statutorily required, to provide a means of prohibiting Federal matching funds, as necessary, if States are not requiring the use of NDC codes, and invoicing for rebates on these drugs. This proposal would be applicable to all 50 States and the District of Columbia; however, we believe that this proposal would have no additional burden because States, based on their State Drug Utilization Data (SDUD) reported to CMS, are currently collecting NDC numbers for all CODs, including all single and multiple source physician-administered drugs and invoicing manufacturers for rebates as applicable under OMB control number 0938–1026 (CMS–10215). Since the proposed provisions would not add any new or revised requirements or burden, we are not making any changes under that control number.

5. ICRs Regarding Verification Survey of Reported CODs Through Data Collection (§ 447.510)

We are proposing at § 447.510(k) a process to survey wholesalers and manufacturers to verify prices and charges for certain CODs by requesting and collecting certain information about such prices and charges for a drug reported to us under section 1927(b)(3)(A) of the Act. The proposed survey instruments will be submitted to OMB for review after this proposed rule is finalized and our survey instruments (one for requesting information from States as proposed under § 447.510(k)(3)) and another for surveying manufacturers) have been developed. The tools are not ready yet, but will be made available to the public for its review under the standard non-rule PRA process which includes the publication of 60- and 30-day **Federal Register** notices. The CMS ID number for that package is CMS–10822 (OMB control number 0938–TBD 1). Since this would be a new collection of information request, the OMB control number has yet to be determined. OMB would issue that number upon its approval of the non-rule collection of information request. We are however setting out our preliminary burden figures (see below) as a means of scoring the impact of the proposed provisions.

Since the beginning of the MDRP in 1991, the Secretary has had the authority, under section 1927(b)(3)(B) of the Act, to survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices, such as AMP and ASP, including wholesale acquisition cost (WAC), reported under section 1927(b)(3)(A) of

the Act, if required to make payment. Furthermore, section 1902(a)(30)(A) of the Act (42 U.S.C. 1396a(a)(30)(A)) requires that States have a State Plan that provides methods and procedures to ensure that such payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. Therefore, the agency has an overarching obligation under section 1902(a)(30)(A) of the Act to ensure that Medicaid payments are made in an efficient, economical, as well as sufficient manner to provide access to care.

We have never used the section 1927(b)(3)(B) of the Act authority to survey manufacturers or wholesalers, nor have we interpreted this statutory section in regulation. Therefore, we are proposing at § 447.510(k) to identify a process to survey wholesalers and manufacturers to verify prices and charges for certain CODs by requesting and collecting certain information about such prices and charges for a drug reported to us under section 1927(b)(3)(A) of the Act. As part of the drug price verification survey process, CMS proposes to post the survey's non-proprietary information on its website.

In addition to the manufacturer survey, CMS also proposes to collect information from States to determine which drugs would be surveyed under § 447.510(k)(3). The simplified State survey would ask States whether or not manufacturers meet any of the criteria for excluding drugs from the list from application of § 447.510(k)(2) from such drug verification surveys, such as the level of manufacturer's effort in accordance with proposed § 447.510(k)(3)(ii). That is, the survey will ask a State if they were able to negotiate with the manufacturer a CMS-authorized supplemental rebate that when in combination with the Federal rebate results in a total (State and Federal) rebate that is greater than the average percentage of total national average Medicaid rebates (State and Federal) to total Medicaid drug spend as reflected in the most recent Medicaid Financial Management Report.

With regard to the State survey, we estimate that once a year, 52 respondents consisting of: the 50 States, the District of Columbia, and one territory participating in the Medicaid drug rebate program (Puerto Rico), would be surveyed to determine if manufacturers of high cost drugs are participating in negotiating supplemental rebates and any additional State Medicaid input under § 447.510(k)(3)(iii)(A). At this time, we estimate that the simplified State survey would take 15 minutes at $92.14/hr for an operations research analyst to complete. In aggregate, we estimate an annual burden of 13 hours ((52 surveys × 0.25 hr/survey) at a cost of $1,198 (13 hr × $92.14/hr). While CMS may seek additional information via non-standardized follow-up questions, the burden associated with such a request is not subject to the requirements of the PRA as described under 5 CFR 1320.3(h)(9).

With regard to the manufacturer survey, there are currently 792 labelers participating in the MDRP. While there is no way to know the exact number of labeler codes used by these manufacturers, most manufacturers have at least 2 labeler codes, so we are estimating approximately selecting from a universe of 396 (792 labelers/2 labeler codes) manufacturers could potentially be subject to completing a verification survey. However, the proposed requirement to survey would be limited to only when the Secretary determines it is necessary, such as when the drug prices reported under section 1927(b)(3)(A) of the Act exceed a proposed criteria. While we anticipate that there is the potential that 396 manufacturers may be eligible to receive a survey, we estimate that based upon the criteria proposed at § 447.510(k) for when a COD would be identified and selected and a manufacturer would be surveyed with respect to that drug, we would likely to undertake a minimum of three manufacturer surveys per year, with a maximum of ten surveys per year, taking 5 hours at $92.14/hr for an operations research analyst to complete the survey. So as to not under estimate the impact of this rule's proposed provisions, we are using the maximum of ten manufacturers surveyed per year. In aggregate, we estimate an annual burden of 50 hours (10 surveys × 5 hr/survey) at a cost of $4,607 (50 hr × $92.14/hr). While CMS may seek additional information via non-standardized follow-up questions, the burden associated with such a request is not subject to the requirements of the PRA as described under 5 CFR 1320.3(h)(9).

Through this proposed rule we are soliciting comments to help us develop the manufacturer survey and the State survey.

6. ICRs Regarding Standard Medicaid Managed Care Contract Requirements (§ 438.3(s))

The following proposed changes regarding drug cost transparency in Medicaid managed care contracts will be submitted to OMB for review under control number 0938–TBD 2 (CMS–10855).

We are proposing to amend § 438.3(s) to require MCOs, PIHPs, and PAHPs that provide coverage of covered outpatient drugs to assign and exclusively use unique Medicaid-specific BIN, PCN, and group number identifiers on all issued Medicaid managed care beneficiary identification cards for pharmacy benefits. It is a usual and customary business practice for the MCOs, PIHPs, and PAHPs to routinely issue identification cards for pharmacy benefits, as they do routinely for all of their lines of business across the industry, to include commercial/private and public sector programs, such as Medicare and Medicaid. Since we believe that this is a usual and customary business practice that is exempt from the PRA (see 5 CFR 1320.3(b)(2)), we are not setting out such burden for managed care entities to program the new codes onto the cards and to issue such cards under this section of the preamble. The burden, however, is subject to a regulatory impact analysis which can be found in section V. of this proposed rule.

Additional proposed amendments to § 438.3(s) would require that MCOs, PIHPs, and PAHPs that provide coverage of covered outpatient drugs structure any contract with any subcontractor for the delivery or administration of the covered outpatient drug benefit to require the subcontractor to report separately the amounts related to:

(1) The incurred claims described in § 438.8(e)(2) such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to providers or pharmacies for dispensing or administering a covered outpatient drug; and

(2) Administrative costs, fees and expenses of the subcontractor.

We estimate that the proposed reporting requirements would affect 282 managed care plans in the country and 40 States. We further estimate that it would take an operations research analyst at the State level, 25 hours at $92.14/hr to restructure 282 managed care contracts to require those plans to structure their subcontracts to require the subcontractor to separately report incurred claims expenses described in § 438.8(e)(2) from fees paid for administrative activities. In aggregate, we estimate a one-time burden of 1,000 hours (40 State responses × 25 hr/response) at a cost of $92,140 (1,000 hr × $92.14/hr).

For the same contract changes between the MCOs and the subcontractors (mainly PBMs), we also estimate a one-time private sector burden of 7,050 hours (282 managed care plans × 25 hr/response) at a cost of $649,587 (7,050 hr × $92.14/hr).

With respect to the reporting burden, we estimate that 282 PBMs of those 282 managed care plans to separately report incurred claims expenses described in § 438.8(e)(2) from fees paid for administrative activities would take approximately 2 hours to identify these costs separately and report separately to the managed care plans. In aggregate we estimate an annual burden of 564 hours (282 PBMs × 2 hr/response) at a cost of $51,967 (564 hr × $92.14/hr).

C. Summary of Proposed Burden Estimates

In Table 4, we present a summary of this rule's proposed collection of information requirements and associated burden estimates.

TABLE 4—SUMMARY OF PROPOSED BURDEN ESTIMATES

Regulatory section(s) under title 42 of the CFR	OMB control No. (CMS ID No.)	Number of respondents	Total number of responses	Time per response (hr)	Total time (hr)	Labor cost ($/hr)	Total cost ($)
§ 447.510	0938–TBD 1 (CMS–10822)	52 States	52	0.25	13	92.14	1,198
§ 447.510	0938–TBD 1 (CMS–10822)	10 manufacturers	10	5	50	92.14	4,607
§ 438.8(e)(2) ..	0938–TBD 2 (CMS–10855)	40 States	40	25	1,000	92.14	92,140
§ 438.8(e)(2) ..	0938–TBD 2 (CMS–10855)	282 managed care plans	282	25	7,050	92.14	649,587
§ 438.8(e)(2) ..	0938–TBD 2 (CMS–10855)	Subcontractor PBMs of the 282 managed care plans.	282	2	564	92.14	51,967
Total	344	(52 States + 10 manufacturers + 282 managed care plans).	666	Varies	8,677	92.14	799,499

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule's information collection requirements to OMB for their review. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit the CMS website at *https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** sections of this proposed rule and identify the rule (CMS–2434–P), the ICR's CFR citation, and OMB control number.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

The intent of this proposed rule is to implement several new legislative requirements relating to the operation of the MDRP and other program integrity, and program administration proposals.

For example, section 6 of the MSIAA was signed into law on April 18, 2019. Section 6 of the MSIAA amended sections 1903 and 1927 of the Act to grant the Secretary additional authorities needed to address drug misclassification, drug pricing, and product data misreporting by manufacturers for purposes of the MDRP. This proposed rule includes policies to implement these new statutory authorities, as required.

This proposed regulation also aims to implement a provision in section 9816 of the American Rescue Plan Act of 2021, which amended section 1927(c)(2)(D) of the Act, by inserting a sunset date on the limitation on the maximum rebate amount for single source and innovator multiple source drugs, and other drugs.

We are also proposing several important MDRP program administration and integrity policies, which include the following: clarifying the definition of manufacturer for NDRA purposes; adopting a regulatory definition of vaccine for MDRP purposes; and, implementing a time limitation on manufacturer disputes and audits with States regarding rebates. This proposed rule also proposes to specify a number of existing policies, including: requirements for manufacturers for determining their best price for a covered outpatient drug; the requirements for State reimbursement for prescribed drugs, and the conditions relating to payment of FFP for PADs that are CODs dispensed and paid for under the State Plan.

We are proposing to include two new requirements for the contracts between States and their Medicaid managed care plans, specifically MCOs, PIHPs, and PHAPs. That is, States would be required to include in their contracts with MCOs, PIHPs, and PHAPs a requirement that each Medicaid enrollee's identification card used for pharmacy benefits would include a unique Medicaid-specific BIN/PCN. This inclusion of this unique Medicaid-specific BIN/PCN on these cards would have to be effective no later than the next rating period for Medicaid managed care contracts, following the effective date of the final rule adopting this new regulatory requirement. This requirement would assist providers in identifying patients as Medicaid beneficiaries.

In addition, we are proposing that Medicaid managed care plans that subcontract with a pharmacy benefit administrator or pharmacy benefit manager require the subcontractor to provide specific details to the Medicaid managed care plans about the various pharmacy and non-pharmacy (administrative) costs associated with providing the pharmacy benefit, so the managed care plan can appropriately calculate its Medicaid managed care MLR.

Moreover, we are also proposing additional program integrity and administration policies including: amending the regulatory definition of noninnovator multiple source drug; adding regulatory definitions of a manufacturer's internal investigation; drug product information; market date; and, modifying the definition of COD. There is also included a proposal

unrelated to MDRP; that, is a proposed revision to third party liability regulation resulting from statutory changes in the BBA 2018.

We are solicitating comments relating to the issues, benefits and challenges of requiring a patient's diagnosis be included on Medicaid prescriptions, and the patient care and operational aspects of such a requirement. We are particularly interested in understanding the burden with such a proposal and seeking comments on how to mitigate any foreseeable impact on beneficiaries and providers, and steps which would be needed by States to successfully implement a Medicaid requirement for diagnosis on prescriptions.

On May 17, 2022, the United States District Court for the District of Columbia vacated and set aside the ''accumulator adjustment rule of 2020'' in response to a complaint filed against the Secretary regarding the accumulator provisions within the December 31, 2020 final rule.

The December 31, 2020 final rule had revised the various the regulatory patient assistance program exclusions from AMP and best price at §§ 447.504(c)(25) through (29) and (e)(13) through (17) and 447.505(c)(8) through (12), to add language (effective January 1, 2023), such that they would require manufacturers to ''ensure'' the full value of the assistance provided by these patient assistance programs is passed on to the consumer and that the pharmacy, agent, or other AMP or best price eligible entity does not receive any price concession, before excluding such amounts from the determination of best price or AMP. In response to the district court's order, we propose to withdraw the changes made to these sections by the December 31, 2020 final rule.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $200 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues or which centralized review would meaningfully further the President's priorities or the principles set forth in the Executive order.

Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) as measured by $200 million or more in any 1 year. Therefore, OMB has reviewed this proposed rule, and the Departments have provided the following assessment of their impact.

C. Detailed Economic Analysis

There is a need for greater clarity regarding some of the administrative policies of the MDRP, and this proposed rule aims to establish regulations to provide guidance to States, manufacturers and other related parties. This proposed rule addresses these policy issues after considering the evolution of the pharmaceutical marketplace since the development of the MDRP, and the economic, social and other factors affecting Medicaid providers and beneficiaries. At the same time, this proposed rule is mindful of the impact of changes in regulations on affected interested parties, and the degree of compliance promulgated by the agency. Therefore, for these reasons, we prepared the economic impact estimates utilizing a baseline of ''no action,'' comparing the effect of the proposals against not proposing the rule at all.

If the proposals in this rule are not implemented, there would be no specific policies in place in the MDRP related to the new legislative requirements in the MSIAA, and no clear policies to address drug misclassification, drug pricing and product data misreporting by manufacturers. Accordingly, this proposed rule would address other situations in which manufacturers are paying fewer rebates to States than are supported by the pricing and product data that they are currently reporting to MDP. While we believe that most of the drugs in MDP are appropriately classified, we do not know an exact number of those which may be misclassified. For this reason, a robust analytical framework, with baseline scenarios and benchmarks, cannot be conducted at this time.

Additionally, if these proposals are not implemented, there would be no regulatory policies for addressing the authority for the American Rescue Plan Act to sunset the date on the limitation on the maximum rebate amount paid by manufacturers for single source and innovator multiple source drugs, in addition to noninnovator multiple source drugs.

At this time, program integrity and program administration provisions need to be proposed or specified to address the definitions for: covered outpatient drug (COD); drug product information; internal investigation; manufacturer; market date; noninnovator multiple source drug; and vaccine. Moreover, at this time there is a need to: establish a time limitation on manufacturer rebate disputes and audits with States; refine State requirements for State reimbursement for prescribed drugs; specify conditions relating to payment for PAD; specify the process for manufacturer to accumulate price concessions and discounts (''stacking'') when determining best price; establish a drug price verification survey process through data collection. The reasons and rationales for these provisions were detailed in the preamble section of this proposed rule. The economic impacts of these provisions are detailed below.

We are solicitating comments relating to the issues, benefits and challenges of requiring a diagnosis be included on Medicaid prescriptions, as well as any current data and estimates that could be used to develop an analytical framework for the proposals in this rule.

1. Benefits

The provision requiring that PBAs and PBMs report specific categories of drug expenditures to their contracted managed care entity would benefit States and Medicaid managed care plans, since it can help assure a more accurate calculation of their MLRs and managed care plan capitation rates, resulting in more accurate Medicaid spending. Some States have already eliminated ''spread pricing'' in their managed care contracts, meaning that the State requires the PBM pays the

pharmacy the same price that the managed care plan is charged for the prescription, such that there would be no ''spread'' or difference between the two prices. That is, the PBM would not be allowed to charge the managed care plan a higher price than the amount paid to the pharmacy. This removes the ''spread'' or the difference of which is traditionally kept by the PBM to pay for administrative and other fees. Instead, such administrative fees would have to be separately identified by the PBM for the managed care plan. While this shift in policy has begun in many States, this benefit cannot be quantified at the national level as we do not have data on which States do this now versus States that would need to implement this because of the proposed rule.

However, a March 2020 Congressional Budget Office (CBO) estimate of the Federal proposal [51] to require pass through pharmacy pricing finds the spread pricing provision would produce Federal savings of $929 million over 10 years, which translates to a less than 1 percent drop in Federal Medicaid prescription drug spending. It is unclear what analysis or assumptions went into these estimates, but they are highly dependent on assumptions or understanding of the extent to which spread pricing currently exists in Medicaid. We are soliciting comments relating to this provision.

In regards to Medicaid Drug Rebates (MDR) and penalties with respect to manufacturer misclassification of drugs, benefits also include monetary and non-monetary penalties, which are not quantifiable at this time. For example, these provisions would implement the existing statute and would benefit States as they would be receiving any past rebates that are due to them as a result of a manufacturer's misclassification of drugs. That is, the manufacturers would be finally paying the appropriate amount in past due rebates.

The overwhelming majority of drugs are appropriately classified in the manufacturer discount program (MDP) at this time, but there may be some manufacturers that continue to list their drug as a noninnovator multiple-source drug in MDP, when the drug should be listed as a single-source drug or an innovator multiple source drug. The provision allows us to also pursue penalties against manufacturers that will not change their classification as a result of the denial of their narrow exception request, and would also allow us to impose penalties on manufacturers that pay a different amount in rebates to States than is supported by the product and pricing data that they are reporting to MDP.

For example, manufacturers have the opportunity to request that certain drugs be classified in the MDP as a noninnovator multiple source drug instead of a single source or innovator multiple source drug. If this request is denied, and the manufacturer will not change the classification, CMS can use the authority under the misclassification provisions of the statute to change the classification. Moreover, we have had instances of manufacturers who have decided to take it upon themselves to pay fewer rebates to States, even though the product and pricing information they report to MDP would support a different rebate amount, in most cases, a higher rebate than they are paying to States. This provision would allow us to consider both these situations to be misclassifications, subject to the penalties that are identified in the statute, and that we further describe in the proposed regulation.

Modifying the definition of covered outpatient drug would benefit the manufacturers, States, and CMS. The provision would support the States' ability to collect rebates on drugs administered in certain settings when a drug and its reimbursement amount are separately identified on a claim billed. It would benefit manufacturers by providing clarity on drugs that would satisfy the definition of covered outpatient drug and for which compliance with section 1927 of the Act is required. This is currently not quantifiable because we do not know how many drugs this would affect.

Defining internal investigation for purposes of pricing metric revisions would benefit States and manufacturers. It would benefit manufacturers because it would provide a clear definition of what CMS views as an internal investigation for purposes of requesting CMS consideration of recalculation of AMP, best price, and customary prompt pay outside of the 12-quarter rule as permitted under § 447.510. Additionally, defining this term would benefit States because it would deter manufacturers from submitting to CMS a request for restatement of AMP, best price, and customary prompt pay discounts outside of the 12-quarter timeframe, which could trigger manufacturers seeking to collect overpaid rebates unexpectedly. This benefit is not quantifiable as it is not known how many manufacturers would be deterred from submitting the request to restate outside of the 12-quarter timeframe. However, we do not get these requests frequently.

Revising the definition of manufacturer for greater NDRA compliance would benefit CMS and States, as well as manufacturers, by providing greater clarity, codifying existing policy, and specifying direction on an area of statutory and regulatory compliance that some manufacturers previously interpreted as ambiguous. Manufacturers would now know, with certainty, that all of their associated labeler codes with CODs must enter into a rebate agreement to comply with section 1927(a)(1) of the Act and the terms of the NDRA. The benefit is not quantifiable as we do not know how many manufacturers are not reporting all of their CODs because they do not have rebate agreements in effect for all of their associated labeler codes. However, we believe the majority of manufacturers have entered into a rebate agreement for all of their associated labeler codes.

The States also benefit as noncompliant manufacturers must now enter into the rebate program and pay rebates on all their CODs. While the clear majority of manufacturers are compliant with this provision, any manufacturer that is noncompliant must ensure that every labeler code that satisfies the definition of manufacturer has a rebate agreement in effect and that the manufacturer pays rebates on all of their CODs for all labeler codes. Rebates are paid by drug manufacturers on a quarterly basis to States and are shared between the States and the Federal Government. These outstanding manufacturers' rebates would be paid to the States and shared with the Federal Government to offset the overall cost of prescription drugs under the Medicaid program. This requirement helps ensure program integrity and prevents future underpayments of rebates by noncompliant manufacturers. As previously stated, the benefit is not quantifiable as we do not know how many manufacturers are not reporting all of their CODs because they do not have rebate agreements for all of their associated labeler codes. However, we believe the majority of manufacturers have entered into a rebate agreement for all of their associated labeler codes.

The proposal to define market date using the date of first sale, rather than the date first available for sale, would benefit some manufacturers, CMS, and States. Manufacturers would not be required to report AMP information until they have actual data to report. They will appreciate not having to rely on reasonable assumptions to report AMP without actual data on which to

[51] *https://www.kff.org/medicaid/issue-brief/costs-and-savings-under-federal-policy-approaches-to-address-medicaid-prescription-drug-spending/#:~:text=This%20estimate%20is%20based%20in,between%20states%20and%20the%20federal.*

base the AMP. CMS and States would also benefit because we would now have regulatory support for the longstanding policy of determining the baseline information for a drug based on the date the drug was first sold by any manufacturer. Some manufacturers have been incorrectly interpreting that the market date of their drug is the date on which their NDC was first sold or marketed, regardless of any prior manufacturer's marketing or sale of the same drug. That is, some manufacturers believe that they can reset the baseline information for a drug once they purchase the drug.

States are likely to benefit from the proposal to establish a 12-quarter rebate manufacturer dispute, hearing, and audit time limitation in § 447.510(j). While the NDRA addresses rebate disputes, the lack of policy on audit and dispute-initiation timeframes has been interpreted as there being no timeline on initiation of disputes on drug utilization data, unreasonably burdening State rebate programs. We have heard from States that manufacturers are initiating rebate audits and disputes on claims greater than 30 years old. Some States have even stated that there have been repeated disputes on the same paper claim over the years. With this provision, States would no longer have to look back at and research paper claims dating back to as early as 1991 and the origin of the Medicaid Drug Rebate Program. We estimate this proposal would reduce the amount of time it would take States to research disputes on rebate claims since manufacturer disputes, hearing requests, and audits initiated after 12-quarters from the last day of the quarter from the date of State invoice would no longer be considered.

In regards to the proposed regulatory revisions regarding Federal Financial Participation for conditions relating to physician-administered drugs, these provisions would benefit States and the Federal Government. By revising the regulations to be consistent with the statute, States would gain a better understanding of the requirement that they must invoice for all covered outpatient single and multiple source physician-administered drugs. This proposed rule would assure Federal financial participation and provide additional rebate collection to increase State and Federal revenue. This benefit is not quantifiable because PAD utilization and costs vary among all State programs, but we believe that most if not all States are already billing for rebates for all PADs.

The proposal for inclusion of a BIN/PCN on Medicaid Managed Care Cards would benefit States, the Federal Government, providers and manufacturers. With the inclusion of Medicaid-specific BIN/PCN and group numbers on the pharmacy identification cards issued to the enrollees of MCOs, PHIPs and PAHPs, pharmacies would be able to identify patients as Medicaid beneficiaries. This would be helpful to all parties to ensure that Medicaid benefits are applied appropriately. This would also help avoid duplicate discounts between Medicaid and the 340B Drug Pricing Program, which occurs when a State bills for a Medicaid rebate on a discounted 340B drug, by providing notice to the provider that the claim should be identified as being for a 340B drug. This benefit is not quantifiable because it is currently unknown how often patients are not identified as Medicaid beneficiaries. However, we do believe that a significant number of duplicate discounts can be avoided through better identification of a 340B eligible individual at the time the prescription is being filled.

The provision for drug cost transparency in Medicaid Managed Care Contracts would benefit States and the Federal Government. It would assist Medicaid managed care plans in complying with Federal regulations regarding MLRs and guidance by effectively requiring subcontractors to appropriately identify and classify certain costs, so that the managed care plan can appropriately calculate their MLR.

In particular, we propose that managed care plans that provide coverage of covered outpatient drugs must structure any contract with any subcontractor for the delivery or administration of the covered outpatient drug benefit to require the subcontractor to report separately the amounts related to the incurred claims described in § 438.8(e)(2) (such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to providers or pharmacies for dispensing or administering a covered outpatient drug) from administrative costs, fees and expenses of the subcontractor. By receiving reports that separately identify fees that are outside of the prescription and dispensing fee costs of a drug, the MCO, PIHP, or PAHP would be able to accurately calculate and report its MLR.

MLR calculations are used to develop capitation rates paid to Medicaid managed care plans, thus their accuracy is critical in assuring that Medicaid payments are reasonable, appropriate and necessary for health care services when using a Medicaid managed care plan. Managed care capitation rates must (1) be developed such that the plan would reasonably achieve an 85 percent MLR (§ 438.4(b)(9)) and (2) are developed using past MLR information for the plan (§ 438.5(b)(5)). In addition to other standards outlined in §§ 438.4 through 438.7, these requirements for capitation rates related to the MLR are key to ensuring that Medicaid managed care capitation rates are actuarially sound. In addition, Medicaid managed care plans may need to pay remittances (that is, refund part of the capitation payments) to States should they not achieve the specific MLR target. Thus, the accuracy of MLR calculation is important to conserving Medicaid funds.

The payment of claims provision would benefit States, the Federal Government, providers, and beneficiaries. This provision would benefit both the Federal Government and States as it corrects omissions in regulatory language to align with statutory language, permitting Medicaid to remain the payer of last resort. These revisions would also benefit beneficiaries and providers as it permits States to pay claims sooner than the specified waiting period, when doing so is cost-effective and necessary to ensure access to care.

The proposal to account for manufacturer stacking of discounts when determining best price would benefit the States and Federal Government. It would remove any potential doubt prospectively that when determining the best price for a COD, the manufacturer should aggregate discounts such that cumulative discounts, rebates or other arrangements must be stacked to generate a final price realized by the manufacturer for a covered outpatient drug, including discounts, rebates or other arrangements provided to different best price eligible entities.

The proposal regarding verification of manufacturer drug prices for certain CODs through data collection would benefit the States, Federal Government, consumers, and insurers. The impact is that it would allow the Federal Government to verify prices by obtaining from the manufacturer various related information used by the manufacturer to determine a drug's list price and, when permissible, share the non-proprietary information submitted by the manufacturer with the general public. This would benefit States in that it could help them negotiate further rebates with manufacturers for certain

high cost or high spending Medicaid CODs.

2. Costs

a. Medicaid Drug Rebates (MDR) and Penalties

In regards to the costs associated with this provision, if CMS identifies a drug misclassification, or other situations that would fall under the misclassification provisions, the manufacturer would be responsible for paying back past rebates to the States as a result of the misclassification. This would mean that the manufacturers would have to determine which prices to use to calculate the past due rebates, and for which units rebates are owed, and pay the States for these rebates. They would also have to proactively determine that all States that are due rebates are subsequently paid. In some cases, the States may have to pay rebates back to the manufacturer if the manufacturer's misclassification resulted in overpayment of rebates to the States.

This provision will not impose new costs on States, rather it will help assure that manufacturers are accurately paying rebates to States, thus benefitting the States. However, the amount of rebates that would be recovered because of these new misclassification provisions cannot be estimated. While there are several validation checks, we cannot predict how many, if any, drugs are or would be misclassified especially since the amount would also include penalties for misclassification of future drugs that have yet to be released to market.

b. Suspension of Manufacturer NDRA for Late Reporting of Pricing and Drug Product Information

This provision would implement existing statute and is being implemented to encourage manufacturer adherence with program requirements and enhance administrative efficiency. Manufacturers that are not reporting their pricing or product information in a timely manner per statutory and regulatory requirements would have their rebate agreement (and those of their associated labelers) suspended for purposes of Medicaid and the MDRP. This means that States would not have to cover or pay for the drugs of the manufacturer during the period of the suspension. Lack of timely reporting by manufacturers can also reduce rebates that are owed to States by a manufacturer, and can affect the number of multiple source drugs for which Federal Upper Limits (FULs) can be established. Thus, this suspension authority would serve as an incentive for manufacturers to report their product and pricing information timely so that drugs of the manufacturer would continue to be covered under Medicaid and the drug rebate program.

This provision would have minimal cost to the States as their only responsibility would be to notify prescribers and patients that a drug is not available under the MDRP for the period of the suspension. Similar to §§ 431.211 and 435.917, we are requiring that States notify beneficiaries at least 30 days before a drug is no longer available because of a suspension of a manufacturer's drug rebate agreement. Since States may choose their preferred method of notification of beneficiaries including through email, form letters, list serves, or Medicaid portals, we are requesting comments on how to develop a cost estimate.

c. Modify the Definition of Covered Outpatient Drug

This proposed provision may increase manufacturers' rebate liability to the States because it would clarify those CODs that could be billed for rebates. At this time, we cannot determine an estimate of burden for manufacturers regarding this item because we do not have an estimate of the number of drugs that could potentially be billed for rebates as result of this clarification. States only have to report utilization of drugs for which rebates are invoiced. If States were not invoicing for rebates for certain types of claims previously, we do not have quantifiable information about the additional rebates that may be now collected. Additionally, States may need to educate their providers on billing procedures. We believe this would be involve minimal burden, as States could inform their providers as part of their regular communications.

d. Define Internal Investigation for Purposes of Pricing Metric Revisions

The cost of this new proposed definition would be the amount of time that needs to be taken by manufacturers' personnel to determine how to apply the definition of internal investigation when considering submitting a request to CMS for a recalculation. Furthermore, this legal analysis would not apply to every manufacturer or to every drug of the manufacturer. It would only apply if the manufacturer wants to submit a request for CMS to consider recalculation outside of 12-quarters for one or more of its CODs. At this time, we have received only a minimal number of such requests from manufacturers. We assume the time to perform legal analysis is 5 hours. Using the May, 2021 mean (average) wage information from the BLS for lawyers (Code 23–1011), we estimate that the cost of reviewing this provision is $142.34 per hour, including fringe benefits and other indirect costs (*https://www.bls.gov/oes/current/oes231011.htm*) with a total cost of ($142.34 × 5) is $711.70 for each manufacturer. We estimate that only one percent of manufacturers would submit a request for a recalculation annually outside of the 12-quarters. One percent of 792 manufacturers is approximately 8 manufacturers, with a total one-time cost of $5,693.60 (8 × $711.70). We estimated one percent because currently only one manufacturer has submitted such a request. This proposed provision will not impose substantial costs on the State.

e. Revise Definition of Manufacturer for NDRA Compliance

To better assess current manufacturer compliance with the requirement that all associated labeler codes of a manufacturer have a rebate agreement in effect, several analyses and reviews were performed. Our initial analysis identified 24 instances of related-party manufacturers and labelers that appear to have included some, but not all, of their product line within the MDRP representing 144 products, approximately 0.3 percent of all products in MDRP.

Additionally, if a manufacturer is noncompliant, the manufacturer would be responsible for having associated entities sign a rebate agreement and agree to participate in MDRP. That is, the manufacturers would have to determine which labelers are not currently participating in the program, submit rebate agreements, and pay the States for rebates for CODs of those labelers. For this reason, we are estimating a collection burden to allow manufacturers time to review and ensure compliance with this requirement. Manufacturers would need to review their respective labeler codes in the CMS-hosted online information technology system and ensure the list is complete.

We estimate that the burden associated with the proposed modification to the definition of manufacturer is a one-time cost of $43,884.72, estimating it would take 792 manufacturers 0.5 hours at $110.82 per hour, including fringe benefits and other indirect costs, for an operations manager to log onto the CMS system and review associated labeler codes. This provision will not impose substantial costs on States. States would receive additional monetary rebates if a noncompliant manufacturer comes into compliance.

While this policy has already been specified in guidance and preambles, codifying the requirement is necessary to ensure compliance and eliminate ambiguity.

f. Define Market Date

In regards to costs associated with defining market date, if manufacturers have not provided CMS with accurate market dates, they may need to develop a methodology to determine the accurate dates. In addition, going forward, manufacturers will have to identify when their first sales of the COD occur to accurately identify the market date of the COD. At this time, we cannot determine cost estimates associated for this provision. This provision will not impose substantial costs on States.

g. Modify the Definition of Noninnovator Multiple Source Drug

This provision proposes a technical correction to the regulatory text to conform the language in the definition of an N drug to the language in the definition of an I drug. We do not anticipate any impact on interested parties.

h. Define Vaccine for Purposes of the MDRP Only

In regards to costs associated with the provision, if a manufacturer has not been reporting and paying rebates on a product because it believed the product was a vaccine, and the proposed definition would result in the product being a COD, not a vaccine, then the manufacturer would have both reporting and rebate liability on that product if the proposed definition is finalized. At this time, we cannot determine an estimate for this item. This provision would not impose substantial costs on the State.

i. Proposal To Establish a 12-Quarter Rebate Audit Time Limitation

We are estimating a decrease in burden associated with this proposal. After contacting several States, we estimate that per State, between 10 and 80 disputes are initiated routinely in a quarter on rebate claims greater than 3 years old, and those disputes on average take an Operations Research Analyst between 30 minutes to 4 months to resolve, depending on the complexity of the dispute and how long ago the claim was paid. For our best estimate of the quantifiable impact, with all 50 States, the District of Columbia, and Puerto Rico being affected, we estimate it would take 52 Operations Research Analysts (1 for each State) 7 hours to resolve a dispute at $92.14/hr (*https://www.bls.gov/oes/current/oes152031.htm*) $644.98 ($92.14 × 7) (for 45 outstanding disputes [(10 disputes + 80 disputes)/2] per State for claims greater than 3 years old. We, therefore, estimate a one-time decreased burden reduction of $6,037,012.80 (45 disputes × $644.98 hr/dispute × 52 States × 4 quarters (1 year)). Once this rule is finalized, manufacturers will only have the ability to dispute claims for up to 12-quarters, from the last day of the quarter from the date of State invoice.

j. Proposals Related to State Plan Requirements, Findings, and Assurances

This proposed clarification is necessary so payments to pharmacy providers are consistent with efficiency, economy, and quality of care, and are sufficient to provide access to care equivalent to the general population. Pharmacists must be accurately reimbursed by the State for drug ingredient costs and professional dispensing services under § 447.518.

All but one State, are currently in compliance with the PDF requirements. We have not included time and cost burdens for individual State dispensing fee surveys in this proposed rule because we cannot accurately determine whether a State would choose to conduct a State-specific cost of dispensing survey or use another State's survey. As such, this is an unquantifiable cost to States and therefore, we have not included an estimate. States have several options when reviewing and adjusting their professional dispensing fee (including using a neighboring State's survey results, conducting their own survey, or using survey data from a prior survey).

In this proposed rule, we specify that the type of data that States must submit to justify their professional dispensing fees must be based on actual costs of dispensing.

k. Federal Financial Participation: Conditions Relating to Physician-Administered Drugs

All States currently have an existing process in place to collect and invoice for covered outpatient single source and the top 20 high volume multiple source physician-administered drugs in accordance with regulatory language in § 447.520, which may limit the additional burden associated with collecting and invoicing NDC information for all covered outpatient single and multiple source physician-administered drugs.

It is difficult to quantify a specific dollar value for the expected revenue increase at this time. PAD utilization and costs vary among all State programs; however, once implemented, and all States are collecting rebates for all single and multiple source COD PADs, a baseline can be established. All States currently have this process well established pursuant to regulatory language in § 447.520.

These provisions clarity the existing statute to ensure Federal financial participation and rebate collection for all covered outpatient single and multiple source physician-administered drugs.

l. BIN/PCN on Medicaid Managed Care Cards

The cost is limited to the time the Medicaid managed care entities need to program the new codes onto the cards.

m. Drug Cost Transparency in Medicaid Managed Care Contracts

The costs associated with this change is the cost to managed care plans and their subcontractors to negotiate and revise contracts to ensure administrative fees are separately identifiable from reimbursement for CODs, dispensing fee costs and other patient costs that need to be captured as incurred claims under § 483.8(e)(2). As discussed in the section III. of this proposed rule, we estimate that these requirements would affect 282 managed care plans and their subcontractors (mainly PBMs) in the country and 40 States. We estimate it would take an Operations Research Analyst (Code 15–2031) 25 hours at $92.14 per hour, including fringe benefits and other indirect costs, to renegotiate and restructure 282 Medicaid managed care contracts to require the MCO, PIHP or PAHP to require its subcontractors to separately report information on incurred costs (as described in § 438.8(e)(2)) and fees paid to the subcontractor for administrative services. We, therefore, estimate that the burden associated with the proposed dispute timeline limitation would be a one-time cost for each managed care plan of $2,303.50 or $649,587 for all managed care plans. There are 40 States with Medicaid managed care plans, therefore, we estimate the State's Operations Research Analyst (Code 15–2031) 25 hours at $92.14 per hour including fringe benefits and other indirect costs to restructure State contracts for a one-time cost per State of $2,303.50 or $92,140 for all 40 States.

Federal savings may be captured by an estimate associated with a statutory change to eliminate PBM spread pricing

at $929 Million over 10 years.[52] A March 2020 CBO *estimate* for the Federal proposal to require pass through pricing finds the spread pricing provision would produce Federal savings of $929 million over 10 years, which translates to a less than 1 percent drop in Federal Medicaid prescription drug spending. It is unclear what analysis or assumptions went into these estimates, but they are highly dependent on assumptions or understanding of the extent to which spread pricing currently exists in Medicaid.

There is not currently a Federal prohibition on using spread pricing in Medicaid. As noted, we issued guidance in 2019 regarding the impact of the lack of transparency between costs for administrative functions versus actual costs for Medicaid-covered benefits on the managed care plan's MLR calculation. The 2019 CIB is clear that when the subcontractor, in this case the PBM, is performing administrative functions such as eligibility and coverage verification, claims processing, utilization review, or network development, the expenditures and profits on these functions are a non-claims administrative expense as described in § 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations.

If a subcontractor incorrectly categorizes these administrative fees as incurred claims under § 438.8(e)(2), it increases the MLR numerator, and thus increases the per-member-per-month (PMPM) revenue a managed care entity can receive from the State while still appearing to meet MLR requirements. By proposing to require that managed care plans require subcontractors to separately report their administrative fees (that is, separately identified from incurred claims such as reimbursement for covered outpatient drugs, dispensing fees, and other patient services), the managed care plan is better able to ensure the accuracy of MLR, which sets the PMPM revenue for Medicaid managed care plans, and accurately reflects only medical expenditures, thus generating savings to the Medicaid program. For those States that may not already have this requirement as part of its contract with the managed care plan, this provision would be a cost to the State to revise managed care plan contracts. It provides transparency to the State and the managed care plan as to which subcontractor costs are incurred claims under § 438.8(e)(2) (costs of CODs and dispensing fees) versus administrative fees.

n. Proposals Related to Amendments Made by the American Rescue Act of 2021—Removal of Manufacturer Rebate Cap (100 Percent AMP)

This provision is a direct result of a statutory change to remove the cap on Medicaid drug rebates (the maximum rebate amount). Medicaid savings would be generated by the increased rebates due to the removal of the cap on rebates with an estimate of an average of $14.21 billion over 10 years.[53] [54] By removing the cap on the amount manufacturers would be required to pay for Medicaid drug rebates, Medicaid rebate revenue would increase thus producing savings to the Federal Government (Table 6 includes the savings which are CBO estimates from when statute was amended). The costs associated with this requirement are to manufacturers. Manufacturers would also need to make minor changes to their systems to address the removal of the cap. As stated previously in this proposed rule, States would realize some savings because of the increase in rebates; however, it is not known if manufacturer drug prices to Medicaid would decrease because of the removal of the cap as manufacturers adjust pricing to reflect the increase in Medicaid drug rebates.

o. Payment of Claims

At this time, there is no need to determine cost estimates for this item. The December 31, 2020 final rule revised the regulations and captured cost estimations and collection of information. This revision would add omitted statutory language to the existing regulation. This change would not produce new burden not already captured in final rule CMS–2482–F.

p. Requests for Information on Requiring a Diagnosis on Medicaid Prescriptions

This provision is a request for information only. We are seeking comments on how to negate any foreseeable impact on beneficiaries and providers and steps which would be needed by States to successfully implement a Medicaid requirement for diagnosis on prescriptions.

q. Proposal To Account for Stacking When Determining Best Price

When calculating the lowest price realized by a manufacturer by aggregating discounts and rebates across all best price eligible entities, the Medicaid drug rebate to the State and Federal Government increases. At this time, we cannot determine cost estimates for this item.

r. Proposal Regarding Drug Price Verification Survey Through Data Collection

The costs for States to determine which manufacturers would be included in the State survey would be 0.25 hours per State for an Operations Research Analyst (Code 15–2031) at $92.14 an hour, including fringe benefits and other indirect costs, or $23.04 per State. We estimate that the Federal Government would survey 52 States (including the District of Columbia and Puerto Rico) annually for a cost of $1,198.08 (52 States × $23.04 per State).

The costs for the manufacturer/wholesaler who are selected for completing the survey would be 50 hours per manufacturer for an Operations Research Analysts (Code 15–2031) at $92.14 an hour, including fringe benefits and other indirect costs, or $4,607.00 per manufacturer (50 hrs × $92.14/hr). Federal Government would survey a minimum of three manufacturers per year, with a maximum of ten surveys per year, for an annual cost of $46,070.00 ($4,607.00 × 10 surveys), using the maximum of ten surveys per year. Savings is not quantifiable because we do not know if manufacturers would revise pricing in the event they are requested to verify their drug prices.

s. Proposal To Rescind Revisions Made by the December 31, 2020 Final Rule to Determination of Best Price (§ 447.505) and Determination of Average Manufacturer Price (AMP) (§ 447.504) Consistent With Court Order

In the December 31, 2020 final rule, CMS revised the various patient assistance program exclusions from AMP and best price at §§ 447.504(c)(25) through (29) and (e)(13) through (17) and 447.505(c)(8) through (12) to add language that would require manufacturers ''to ensure'' the assistance provided by these patient assistance programs is passed on to the consumer, to the pharmacy, to the agent, or to other AMP or best price eligible

[52] *https://www.kff.org/medicaid/issue-brief/costs-and-savings-under-federal-policy-approaches-to-address-medicaid-prescription-drug-spending/#:~:text=This%20estimate%20is%20based%20in,between%20states%20and%20the%20federal.*

[53] *https://www.kff.org/medicaid/issue-brief/costs-and-savings-under-federal-policy-approaches-to-address-medicaid-prescription-drug-spending/#:~:text=This%20estimate%20is%20based%20in,between%20states%20and%20the%20federal.*

[54] *https://www.macpac.gov/wp-content/uploads/2019/06/Next-Steps-in-Improving-Medicaid-Prescription-Drug-Policy.pdf.*

entity who does not receive any price concession.

As part of the December 31, 2020 final rule, the impact analysis for the exclusions to ensure such patient assistance is passed on to the patient is discussed at length (see 85 FR 87098 through 87100). We concluded at that time that based upon the studies noted in the analysis, the value of patient assistance programs are being eroded by PBM copay accumulator programs because the patient assistance is accumulating to the economic benefits of health plans, not to patients, given that the health plans' spending on drugs for patient decreases. We also believed even with the changes in the rule, that manufacturers would continue to offer patient assistance because the infrastructure was there to ensure, in accordance with the regulation, the patient assistance accrued to the patient, rather than the plan. Therefore, we believed that patients would not be significantly impacted by the modifications that the manufacturers may have needed to do to ensure the pass through of the patient assistance to the patient consistent with section 1927 of the Act.

In May 2021, the Pharmaceutical Research and Manufacturers of America (PhRMA) filed a complaint against the Secretary asking the court to vacate these amendments to § 447.505(c)(8) through (11) (85 FR 87102 and 87103), as set forth in the 2020 final rule (referred to by the Court as ''the accumulator adjustment rule of 2020''). On May 17, 2022, the United States District Court for the District of Columbia ruled in favor of the plaintiff and ordered that the accumulator adjustment rule of 2020 be vacated and set aside.

In response to the order made by the United States District Court for the District of Columbia to vacate the ''accumulator adjustment rule of 2020,'' we are proposing to withdraw the changes made to these sections and, for consistency, withdraw revisions to regulations addressing AMP made by the accumulator adjustment rule. At the time of the December 31, 2020 final rule, we could not quantify to what degree the changes would impact manufacturers or patients. Therefore, we cannot quantify the impact on manufacturers and patients because of the rescinding of this rule.

TABLE 5—SUMMARY OF THE ONE-TIME QUANTITATIVE COSTS AND BENEFITS

Line item	Cost	Entity	Timeframe
Regulatory review	$851,977.32	Manufacturers, States, Trade Association.	One-time cost.
Define manufacturer internal investigation	5,693.60	Manufacturers	One-time cost.
Modify definition of manufacturer/labeler	43,884.72	Manufacturers	One-time cost.
Establish a 12-Quarter Rebate Audit Time Limitation.	(6,037,012.80)	States and Federal Government	One-time cost savings.
Restructure State Contracts	92,140.00	States	One-time cost.
Total	(5,043,317.16)		

TABLE 6—SUMMARY OF THE ANNUAL QUANTITATIVE COSTS AND BENEFIT

Line item	Cost	Entity	Timeframe
Federal Government Survey for States	$1,198.08	Federal Government	Annually over 10 years.
Federal Government Survey for Manufacturers	46,607.00	Federal Government	Annually over 10 years.
Drug cost transparency in Medicaid managed care contracts.	(929,000,000.00)	Federal Government	Annually over 10 years.
Removal of manufacturer rebate cap (100% of AMP).	(14,211,000,000.00)	Federal and State Governments	Annually over 10 years.
Total	(15,139,952,731.92)		

3. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will be directly impacted and will review this proposed rule, we assume that the total number of unique commenters are based on the current 792 manufacturers participating in the MDRP. While there is no way for CMS to specify the exact number of how many labeler codes are associated with each other, most manufacturers have at least 2 labeler codes. Nevertheless, we are estimating that the current 792 manufacturers would need to review the proposed rule.

Furthermore, we anticipate one medical and health service manager (Code 11–9111) from each of the 50 States, the District of Columbia, and Puerto Rico that cover prescription drugs under the MDRP, will review this proposed rule. Additionally, we estimate that 19 trade organizations may review the proposed rule. This estimate of trade organizations is based on a previous rule pertaining to the MDRP, in which 19 formal comments were received from trade organizations. It is possible that not all commenters or drug manufacturers will review this proposed rule in detail, and it is also possible that some reviewers will choose not to comment on the proposed rule. In addition, we assume that some entities will read summaries from trade newsletters, trade associations, and trade law firms within the normal course of keeping up with current news, incurring no additional cost. Therefore, we assume that approximately 863 (792 manufacturers + 52 States + 19 trade associations) entities may review the proposed rule. For these reasons, we thought that the number of commenters would be a fair estimate of the number of reviewers who are directly impacted by this proposed rule. We are soliciting comments on this assumption.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule. However, for the purposes of our estimate, we assume

that each reviewer reads 100 percent of this proposed rule.

Using the May 2021 mean (average) wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this proposed rule is $115.22 per hour, including fringe benefits and other indirect costs (*https://www.bls.gov/oes/current/oes119111*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 230 minutes (3.833 hours) for the staff to read this proposed rule, which is approximately 57,500 words. For each medical and health service manager (Code 11–9111) that reviews the proposed rule, the estimated cost is (3.833 × $115.22) or $441.64. In part, we estimate that the cost of reviewing this proposed rule by medical and health service managers is $381,133.82 ($441.64 × 863 reviewers). Additionally, there is also a lawyer who will review this proposed rule. Using the May, 2021 mean (average) wage information from the BLS for lawyers (Code 23–1011), we estimate that the cost of reviewing this proposed rule is $142.34 per hour, including fringe benefits and other indirect costs (*https://www.bls.gov/oes/current/oes231011.htm*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 230 minutes (3.833 hours) for the staff to review this proposed rule, which is approximately 57,000 words. For each lawyer (Code 23–1011) that reviews the proposed rule, the estimated cost is (3.833 × $142.34) or $545.59. In part, we estimate that the cost of reviewing this proposed rule by lawyers is $470,843.50 ($545.59 × 863 reviewers). In total, we estimate the one-time cost of reviewing this proposed rule is $851,977.32 ($381,133.82 + $470,843.50).

We acknowledge that these assumptions may understate or overstate the costs of reviewing this proposed rule.

D. Alternatives Considered

Some provisions are directly linked to statute and therefore alternatives cannot be considered. Nevertheless, alternatives which we have considered are detailed below.

We are proposing to modify the definition of manufacturer for purposes of satisfying the requirement at section 1927(a)(1) of the Act which requires a manufacturer to have entered into and have in effect a NDRA. While this policy has already been specified in guidance and preambles, codifying the requirement is necessary to ensure compliance and eliminate ambiguity. We have reiterated this point several times in subregulatory guidance; however, some manufacturers still challenge our policy. We do not permit manufacturers to selectively report CODs which would allow a manufacturer to benefit from the coverage of some of their CODs, while avoiding their financial obligation to pay rebates.

Therefore, we considered an alternative to retain the current definition of manufacturer for the NDRA, however, we believe the term ''manufacturer'' needs to be updated in regulation to ensure legal compliance with this requirement.

In regards to proposing to define vaccine, we could have refrained from defining the term and relied on manufacturers to make their own determination. At this time, we are only aware of one manufacturer who is making a claim that a product that would not be a vaccine under the proposed definition should be treated as a vaccine for the purposes of the Medicaid Drug Rebate Program. However, we are endeavoring to prevent future disputes of this type given that there may be more products coming to market for which this definition might help provide clarity.

We are proposing to specify the time limitation on manufacturers initiating disputes, hearings, or audits with States. While the NDRA addresses dispute resolution, it provides no guidance on whether a timeline applies to the initiation of such disputes, hearings or audits. There have been reports of new disputes being initiated on claims dating back several decades to paper claims, which is placing unnecessary burden on many State rebate programs. Implementation of this provision is necessary to ensure administrative efficiency. An alternative considered was to not clarify this provision; however, then disputes initiated on claims would continue to be disputed ongoing for any defined time-period, causing undue strain, work hours and costs on rebate programs, which directly counters the purpose of the program to offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid patients.

E. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 7 showing the classification of the impact associated with the provisions of this proposed rule.

TABLE 7—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED COSTS/SAVINGS

Category	Estimates	Units		
		Year dollar	Discount rate (%)	Period covered
Costs/Savings:				
Annualized Monetized ($million/year)	($0.67)	2021	7	2024–2034
	(0.57)	2021	3	2024–2034
Costs/Savings	−1,328.91	2021	7	2024–2034
Annualized Monetized ($million/year)	−1,433.49	2021	3	2024–2034

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that almost all Pharmaceutical and Medicine manufacturers are small entities, as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having employees of less than 1,250 in any 1 year) for businesses classified in the Pharmaceutical and Medicine

Manufacturing industries. Note, the SBA does not provide any revenue data at this time as a measure of size for these industries.

According to the SBA's website at *https://www.sba.gov/content/small-business-size-standards,* the drug manufactures referred to in this proposed rule fall into both NAICS 325412, Pharmaceutical Preparation Manufacturing and NAICS 325414, Biologic Product (except Diagnostic) Manufacturing. The SBA defines small businesses engaged in Pharmaceutical and Medicine Manufacturing as businesses having less than 1,250 employees annually each for Pharmaceutical Preparation Manufacturing and Biologic Product (except Diagnostic) manufacturing industries. Table 8 presents the total number of small businesses in each of the two industries mentioned.

TABLE 8—NAICS 32541 PHARMACEUTICAL AND MEDICINE MANUFACTURING SIZE STANDARDS

NAICS (6-digit)	Industry subsector description	SBA size standard/ small entity threshold	Total small businesses
325412	Pharmaceutical Preparation Manufacturing	1,250 Employees	2,722
325414	Biologic Product (except Diagnostic)	1,250 Employees	587

Source: 2019 Economic Census.

TABLE 9—CONCENTRATION RATIOS (NAICS 325412) PHARMACEUTICAL PREPARATION

Firm size (by number of employees)	Firm count	Percentage of small firms (%)	Total employees	Employee per firm to total employee (%)
Small Firms:	2,722	100	93,181	100
02: <5 employees	390	14	633	0.679
03: 5–9 employees	159	6	1,058	1.135
04: 10–14 employees	65	2	752	0.807
05: 15–19 employees	48	2	766	0.822
06: <20 employees	662	24	3,209	3.444
07: 20–24 employees	25	1	535	0.574
08: 25–29 employees	25	1	648	0.695
09: 30–34 employees	19	1	587	0.630
10: 35–39 employees	21	1	700	0.751
11: 40–49 employees	30	1	1,329	1.426
12: 50–74 employees	45	2	2,600	2.790
13: 75–99 employees	31	1	2,439	2.617
14: 100–149 employees	49	2	5,292	5.679
15: 150–199 employees	27	1	3,793	4.071
16: 200–299 employees	42	2	6,853	7.355
17: 300–399 employees	22	1	6,204	6.658
18: 400–499 employees	13	0	3,907	4.193
19: <500 employees	1,011	37	38,096	40.884
20: 500–749 employees	19	1	6,514	6.991
21: 750–999 employees	10	0	3,635	3.901
22: 1,000–1,499 employees	9	0	3,631	3.897
Large Firms:				
Employees >1,499	68	NA	94,707	NA

Source: 2019 Economic Census.

TABLE 10—CONCENTRATION RATIOS (NAICS 325414) BIOLOGIC PRODUCT (EXCEPT DIAGNOSTIC) MANUFACTURING

Firm size (by number of employees)	Firm count	Percentage of small firms (%)	Total employees	Employee per firm to total employee (%)
Small Firms:	587	100	21,789	100
02: <5 employees	71	12	141	0.65
03: 5–9 employees	42	7	282	1.29
04: 10–14 employees	13	2	145	0.67
05: 15–19 employees	13	2	224	1.03
06: <20 employees	139	24	792	3.63
07: 20–24 employees	12	2	261	1.20
08: 25–29 employees	7	1	167	0.77
09: 30–34 employees	6	1	184	0.84
11: 40–49 employees	6	1	247	1.13
12: 50–74 employees	13	2	624	2.86
13: 75–99 employees	5	1	384	1.76
14: 100–149 employees	8	1	799	3.67
15: 150–199 employees	6	1	720	3.30
16: 200–299 employees	8	1	1,561	7.16

TABLE 10—CONCENTRATION RATIOS (NAICS 325414) BIOLOGIC PRODUCT (EXCEPT DIAGNOSTIC) MANUFACTURING—Continued

Firm size (by number of employees)	Firm count	Percentage of small firms (%)	Total employees	Employee per firm to total employee (%)
18: 400–499 employees	5	1	1,758	8.07
19: <500 employees	219	37	8,012	36.77
20: 500–749 employees	4	1	1,293	5.93
21: 750–999 employees	5	1	1,868	8.57
22: 1,000–1,499 employees	5	1	2,327	10.68
Large Firms:				
Employees >1,499	41	NA	42,822	NA

Source: 2019 Economic Census.
Note: data are not available for businesses with 1,500 to 2,500 employees.

As can be seen in Tables 9 and 10, the economic impacts are disproportionate for small firms. Tables 9 and 10 show the employees for each of the size categories and the employee impact per small entity. For example, in Table 9, 390 of the smallest firms employ only 0.68 percent of the employees in its industry; while, in Table 10, 71 of the smallest firms employ only 0.65 percent of the employees in its industry.

Therefore, as can be seen in Tables 9 and 10, almost all Pharmaceutical and Medicine Manufactures are small entities as that term is used in the RFA. Additionally, Tables 9 and 10 show the disproportionate impacts among firms, and between small and large firms. In Tables 9 and 10, each industry, Pharmaceutical Preparation Manufacturing and Biologic Product (except Diagnostic) manufacturing (by employment), firm count, percentage of small firms, total employee and percentage of total employee per firm size to total employees of the small firms were estimated separately to determine the Pharmaceutical and Medicine manufacturer concentration ratios.

For purposes of the RFA, approximately 98 percent of Pharmaceutical Preparation Manufacturing (2,722/2,790 firms) and approximately 93 percent of Biologic Product (except Diagnostic) (587/628) firms are considered small businesses according to the SBA's size standards with total employee of 1,250 in any one year.

At this time, revenue data are not currently available. However, 2012 revenue data from the U.S. Economic Census was used to obtain a proxy for revenue earned in the Pharmaceutical Preparation Manufacturing industry. Therefore, as of 2012, the total annual receipts for small establishments in the Pharmaceutical Preparation Manufacturing industry, earning less than $45 million accounted for approximately 3.1 percent of the revenue. Similarly, according to the 2012 data, total annual receipts for small establishments in the Biologic Product (except Diagnostic) accounted for approximately 3.5 percent of the revenue in its industry.

Individuals and States are not included in the definition of a small entity. This proposed rule will not have a significant impact measured change in revenue of 3 to 5 percent on a substantial number of small businesses or other small entities. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. At this time, we do not believe that this threshold will be reached by the requirements in this proposed rule. Therefore, the Secretary has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This proposed rule will not have a significant impact on small rural hospitals. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary has certified, that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million.

This proposed rule imposes mandates that would result in anticipated costs to State, local, and Tribal governments or private sector, but the transfer costs will be less than the threshold. Some of the costs that the States may incur for the requirements of reimbursement for prescribed drugs is the cost of conducting an individual State survey as an optional tool. This proposed rule would result in multiple benefits to the States including assuring that rebates would be paid accurately and timely to the States. States would receive additional monetary rebates from manufacturers brought into compliance with drug misclassification, would limit the timeframe manufacturers have to dispute rebates, identify patients to the pharmacist as Medicaid beneficiaries, provide transparency to the State as to which PBM costs are true services costs (costs of prescriptions and dispensing fees) versus administrative costs, and permit States to pay claims sooner than the specified waiting period, when doing so is cost-effective and necessary to ensure access to care.

As a result, this proposed rule would not impose a mandate that would result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $165 million in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency

must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. This proposed rule will not have a substantial direct effect on State or local governments, preempt States, or otherwise have a federalism implication, therefore the requirements of Executive Order 13132 are not applicable.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on May 2, 2023.

List of Subjects

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 438

Citizenship and naturalization, Civil rights, Grant programs—health, Individuals with disabilities, Medicaid, Reporting and recordkeeping requirements, Sex discrimination.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 433—STATE FISCAL ADMINISTRATION

■ 1. The authority citation for part 433 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 2. Amend § 433.139 by revising paragraphs (b)(3)(i) and (b)(3)(ii)(B) to read as follows:

§ 433.139 Payment of claims.

* * * * *

(b) * * *

(3) * * *

(i) The claim is for preventive pediatric services, including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B, of this chapter, that are covered under the State Plan that requires a State to make payments without regard to third party liability for pediatric preventive services except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services; or

(ii) * * *

(B) For child support enforcement services beginning February 9, 2018, the provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited up to 100 days after the date of the service and provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.

* * * * *

PART 438—MANAGED CARE

■ 3. The authority citation for part 438 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 4. Amend § 438.3 by adding paragraphs (s)(7) and (8) to read as follows:

§ 438.3 Standard contract requirements.

* * * * *

(s) * * *

(7) Assign and exclusively use unique Medicaid-specific Beneficiary Identification Number (BIN), Processor Control Number (PCN), and group number identifiers for all Medicaid managed care beneficiary identification cards for pharmacy benefits, beginning no later than the State's next rating period for the applicable Medicaid managed care contract, following [effective date of final rule].

(8) Structure any contract with any subcontractor for the delivery or administration of the covered outpatient drug benefit to require the subcontractor to report separately the amounts related to:

(i) The incurred claims described in § 438.8(e)(2) such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to providers or pharmacies for dispensing or administering a covered outpatient drug; and,

(ii) Administrative costs, fees and expenses of the subcontractor.

* * * * *

PART 447—PAYMENTS FOR SERVICES

■ 5. The authority citation for part 447 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1396r–8.

■ 6. Amend § 447.502 by—

■ a. In the definition of ''Covered outpatient drug'':

■ i. In the introductory text, adding ''*(COD)*'' immediately following ''Covered outpatient drug''; and

■ ii. Revising paragraph (2) introductory text;

■ b. Adding the definitions of ''Drug product information'' and ''Internal investigation'' in alphabetical order;

■ c. In the definition of ''Manufacturer,'' adding paragraph (5);

■ d. Adding the definition of ''Market date'' in alphabetical order;

■ e. In the definition of ''Noninnovator multiple source drug,'' revising paragraph (3); and

■ f. Adding the definition of a ''Vaccine'' in alphabetical order.

The revisions and additions read as follows:

§ 447.502 Definitions.

* * * * *

Covered outpatient drug (COD) * * *

(2) A covered outpatient drug does not include any drug, biological product, or insulin provided as part of or incident to and in the same setting as any of the services in paragraphs (2)(i) through (viii) of this definition (and for which payment may be made as part of payment for that service and not as direct reimbursement for the drug). Direct reimbursement for a drug may include both reimbursement for a drug alone, or reimbursement for a drug plus the service, in one inclusive payment if the drug and the itemized cost of the drug are separately identified on the claim.

* * * * *

Drug product information includes but is not limited to National Drug Code (NDC), drug name, units per package size (UPPS), drug category (''S'', ''I'', ''N''), unit type (for example, TAB, CAP, ML, EA), drug product type (prescription, over-the-counter), base date AMP, therapeutic equivalent code (TEC), line extension indicator, 5i indicator and route of administration, if applicable, FDA approval date, FDA application number or OTC monograph citation as applicable, market date, COD status, and any other information deemed necessary by the agency to perform accurate unit rebate amount (URA) calculations.

* * * * *

Internal investigation means a manufacturer's investigation of its AMP,

best price, customary prompt pay discounts or nominal prices that have been previously certified in the Medicaid Drug Rebate Program (MDRP) that results in a finding made by the manufacturer of fraud, abuse, or violation of law or regulation. A manufacturer must make data available to CMS to support its finding.

* * * * *

Manufacturer * * *

(5) For the purposes of maintaining an effectuated rebate agreement consistent with section 1927(a)(1) of the Social Security Act, the term ''manufacturer'' means that all associated entities of the manufacturer that sell prescription drugs, including, but not limited to, owned, acquired, affiliates, brother or sister corporations, operating subsidiaries, franchises, business segments, part of holding companies, divisions, or entities under common corporate ownership or control, must each maintain an effectuated rebate agreement.

Market date, for the purpose of establishing the base date AMP quarter, means the date on which the covered outpatient drug was first sold by any manufacturer.

* * * * *

Noninnovator multiple source drug * * *

(3) A covered outpatient drug that entered the market before 1962 that is not marketed under an NDA;

* * * * *

Vaccine means a product that is administered prophylactically to induce active, antigen-specific immunity for the prevention of one or more specific infectious diseases and is included in a current or previous FDA published list of vaccines licensed for use in the United States.

* * * * *

■ 7. Amend § 447.504 by revising paragraphs (c)(25) through (29) and (e)(13) through (17) to read as follows:

§ 447.504 Determination of average manufacturer price.

* * * * *

(c) * * *

(25) Manufacturer coupons to a consumer redeemed by the manufacturer, agent, pharmacy or another entity acting on behalf of the manufacturer, but only to the extent that the full value of the coupon is passed on to the consumer and the pharmacy, agent, or other AMP-eligible entity does not receive any price concession.

(26) Manufacturer-sponsored programs that provide free goods, including but not limited to vouchers and patient assistance programs, but only to the extent that: The voucher or benefit of such a program is not contingent on any other purchase requirement; the full value of the voucher or benefit of such a program is passed on to the consumer; and the pharmacy, agent, or other AMP eligible entity does not receive any price concession.

(27) Manufacturer-sponsored drug discount card programs, but only to the extent that the full value of the discount is passed on to the consumer and the pharmacy, agent, or other AMP eligible entity does not receive any price concession.

(28) Manufacturer-sponsored patient refund/rebate programs, to the extent that the manufacturer provides a full or partial refund or rebate to the patient for out-of-pocket costs and the pharmacy, agent, or other AMP eligible entity does not receive any price concessions.

(29) Manufacturer copayment assistance programs, to the extent that the program benefits are provided entirely to the patient and the pharmacy, agent, or other AMP eligible entity does not receive any price concession.

* * * * *

(e) * * *

(13) Manufacturer coupons to a consumer redeemed by the manufacturer, agent, pharmacy or another entity acting on behalf of the manufacturer, but only to the extent that the full value of the coupon is passed on to the consumer and the pharmacy, agent, or other AMP eligible entity does not receive any price concession.

(14) Manufacturer-sponsored programs that provide free goods, including, but not limited to vouchers and patient assistance programs, but only to the extent that the voucher or benefit of such a program is not contingent on any other purchase requirement; the full value of the voucher or benefit of such a program is passed on to the consumer; and the pharmacy, agent, or other AMP eligible entity does not receive any price concession.

(15) Manufacturer-sponsored drug discount card programs, but only to the extent that the full value of the discount is passed on to the consumer and the pharmacy, agent, or other AMP eligible entity does not receive any price concession.

(16) Manufacturer-sponsored patient refund/rebate programs, to the extent that the manufacturer provides a full or partial refund or rebate to the patient for out-of-pocket costs and the pharmacy, agent, or other AMP eligible entity does not receive any price concessions.

(17) Manufacturer copayment assistance programs, to the extent that the program benefits are provided entirely to the patient and the pharmacy, agent, or other AMP eligible entity does not receive any price concession.

* * * * *

■ 8. Amend § 447.505 by revising paragraphs (c)(8) through (12) and (d)(3) to read as follows:

§ 447.505 Determination of best price.

* * * * *

(c) * * *

(8) Manufacturer-sponsored drug discount card programs, but only to the extent that the full value of the discount is passed on to the consumer and the pharmacy, agent, or other entity does not receive any price concession.

(9) Manufacturer coupons to a consumer redeemed by a consumer, agent, pharmacy, or another entity acting on behalf of the manufacturer; but only to the extent that the full value of the coupon is passed on to the consumer, and the pharmacy, agent, or other entity does not receive any price concession.

(10) Manufacturer copayment assistance programs, to the extent that the program benefits are provided entirely to the patient and the pharmacy, agent, or other entity does not receive any price concession.

(11) Manufacturer-sponsored patient refund or rebate programs, to the extent that the manufacturer provides a full or partial refund or rebate to the patient for out-of-pocket costs and the pharmacy, agent, or other entity does not receive any price concession.

(12) Manufacturer-sponsored programs that provide free goods, including but not limited to vouchers and patient assistance programs, but only to the extent that the voucher or benefit of such a program is not contingent on any other purchase requirement; the full value of the voucher or benefit of such a program is passed on to the consumer; and the pharmacy, agent, or other entity does not receive any price concession.

* * * * *

(d) * * *

(3) The manufacturer must adjust the best price for a drug for a rebate period if cumulative discounts, rebates, or other arrangements to best price eligible entities subsequently adjust the price available from the manufacturer. Cumulative discounts, rebates, or other arrangements must be stacked to determine a final price realized by the manufacturer for a covered outpatient drug, including discounts, rebates, or

other arrangements provided to different best price eligible entities.

■ 9. Amend § 447.509 by—

■ a. Revising paragraphs (a)(5), (a)(6) introductory text, (a)(7) introductory text, (a)(8) and (9), and (c)(4); and

■ b. Adding paragraph (d).

The revisions and addition read as follows:

§ 447.509 Medicaid drug rebates (MDR).

(a) * * *

(5) *Limit on rebate.* For a rebate period beginning after December 31, 2009, and before January 1, 2024, in no case will the total rebate amount exceed 100 percent of the AMP of the single source or innovator multiple source drug.

(6) *Rebate for drugs other than a single source drug or innovator multiple source drug.* The amount of the basic rebate for each dosage form and strength of a drug other than a single source drug or innovator multiple source drug will be equal to the product of:

* * * * *

(7) *Additional rebate for drugs other than a single source drug or innovator multiple source drug.* In addition to the basic rebate described in paragraph (a)(6) of this section, for each dosage form and strength of a drug other than a single source drug or innovator multiple source drug, the rebate amount will be increased by an amount equal to the product of the following:

* * * * *

(8) *Total rebate.* The total rebate amount for a drug other than a single source drug or innovator multiple source drug is equal to the basic rebate amount plus the additional rebate amount, if any.

(9) *Limit on rebate.* For a rebate period beginning after December 31, 2014, and before January 1, 2024, in no case will the total rebate amount exceed 100 percent of the AMP for a drug other than a single source drug or innovator multiple source drug.

* * * * *

(c) * * *

(4) For a drug other than a single source drug or innovator multiple source drug, the offset amount is equal to 2.0 percent of the AMP (the difference between 13.0 percent of AMP and 11.0 percent of AMP).

(d) *Manufacturer misclassification of a covered outpatient drug and recovery of unpaid rebate amounts due to the misclassification and other penalties*—(1) *Definition of misclassification.* A misclassification in the MDRP has occurred when a manufacturer has:

(i) Reported and certified to the agency its drug category or drug product information related to a covered outpatient drug that is not supported by the statute and applicable regulations; or,

(ii) Reported and certified to the agency its drug category or drug product information that is supported by the statute and applicable regulations, but pays rebates to States at a level other than that associated with that classification.

(2) *Manufacturer notification by the agency of drug misclassification.* If the agency determines that a misclassification has occurred as described in paragraph (d)(1) of this section, the agency will send written and electronic notification of this misclassification to the manufacturer of the covered outpatient drug, which may include a notification that past rebates are due. The manufacturer has 30 calendar days from the date of notification to:

(i) Provide the agency such drug product and drug pricing information needed to correct the misclassification of the covered outpatient drug and calculate rebate obligations due, if any pursuant to paragraph (d)(3) of this section. The required pricing data submitted by the manufacturer to the agency shall include the best price information for the covered outpatient drug, if applicable, for the rebate periods for which the manufacturer misclassified the covered outpatient drug; and,

(ii) Certify applicable price and drug product data after entered into the system by the agency.

(3) *Manufacturer payment of unpaid rebates due to misclassification determined by agency.* (i) When the agency has determined that a manufacturer has misclassified a covered outpatient drug as described in paragraph (d)(1) of this section, such that rebates are owed to the States, and notification has been provided to the manufacturer as provided under paragraph (d)(2) of this section, a manufacturer must pay to each State an amount equal to the sum of the products of:

(A) The difference between:

(*1*) The per URA paid by the manufacturer for the covered outpatient drug to the State for a period during which the drug was misclassified; and

(*2*) The per URA that the manufacturer would have paid to the State for the covered outpatient drug for each period, as determined by the agency based on the data provided and certified by the manufacturer under paragraph (d)(2) of this section, if the drug had been correctly classified by the manufacturer; and,

(B) The total units of the drug paid for under the State Plan in each period.

(ii) Manufacturers must pay such rebates to the States for the period or periods of time that such covered outpatient drug was misclassified, based on the formula described in this section, within 60 calendar days of notification by the agency to the manufacturer of the misclassification, and provide documentation to the agency that the States were contacted by the manufacturer, and that such payments were made to the States within the 60 calendar days.

(4) *Agency authority to correct misclassifications and additional penalties for drug misclassification.* The agency will review the information submitted by the manufacturer based on the notice sent under paragraph (d)(2) of this section. If a manufacturer fails to comply with paragraph (d)(2) of this section within 30 calendar days from the date of the notification by the agency of the misclassification to the manufacturer under paragraph (d)(1) of this section, fails to pay the rebates that are due to the States as a result of the misclassification within 60 calendar days from the date of the notification, if applicable, and/or fails to provide to the agency such documentation that such rebates have been paid, as described in paragraph (d)(3) of this section, the agency may do any or all of the following:

(i) Correct the misclassification of the drug in the system on behalf of the manufacturer, using any pricing and drug product information that may have been provided by the manufacturer.

(ii) Suspend the misclassified drug and the drug's status as a covered outpatient drug under the manufacturer's rebate agreement from the MDRP, and exclude the misclassified drug from FFP in accordance with section 1903(i)(10)(E) of the Act.

(iii) Impose a civil monetary penalty (CMP) for each rebate period during which the drug is misclassified, not to exceed an amount equal to the product of:

(A) The total number of units of each dosage form and strength of such misclassified drug paid for under any State Plan during such a rebate period; and

(B) 23.1 percent of the AMP for the dosage form and strength of such misclassified drug for that period.

(iv) Other actions and penalties available under section 1927 of the Act (or any other provision of law), including referral to the HHS Office of the Inspector General and termination from the MDRP.

(5) *Transparency of manufacturers' drug misclassifications.* The agency will make available on a public website an annual report as required under section 1927(c)(4)(C)(ii) of the Act on the covered outpatient drug(s) that were identified as misclassified during the previous year, any steps taken by the agency with respect to the manufacturer to reclassify the drugs and ensure the payment by the manufacturer of unpaid rebate amounts resulting from the misclassifications, and a disclosure of the expenditures from the fund created in section 1927(b)(3)(C)(iv) of the Act.

■ 10. Amend § 447.510 by—

■ a. Revising the section heading and paragraph (b)(1)(v);

■ b. Adding paragraphs (h) through (k).

The additions and revision read as follows:

§ 447.510 Requirement and penalties for manufacturers.

* * * * *

(b) * * *

(1) * * *

(v) The change is to address specific rebate adjustments to States by manufacturers, as required by CMS or court order, or under an internal investigation as defined at § 447.502 or an Office of Inspector General (OIG) or Department of Justice investigation.

* * * * *

(h) *Participation in the Medicaid Drug Rebate Program (MDRP).* Manufacturers that participate in MDRP must meet the following requirements:

(1) *Signed rebate agreement with the Secretary.* Manufacturers participating in the MDRP must have a signed rebate agreement in effect that complies with paragraph (5) in the definition of *manufacturer* in § 447.502.

(2) *Newly purchased labeler codes and covered outpatient drugs.* Any manufacturer with a signed rebate agreement in effect that acquires or purchases another labeler, acquires or purchases covered outpatient drugs from another labeler code, or forms a new subsidiary, must ensure that a signed rebate agreement is in effect for these entities or covered outpatient drugs, consistent with the definition of *manufacturer* at § 447.502, within the first 30 days of the next full calendar quarter beginning at least 60 days after the acquisition, purchase, asset transfer, or formation of the subsidiary.

(3) *Termination.* Each associated labeler code of a manufacturer is considered to be part of the single manufacturer. If any of the associated labeler codes as defined in paragraph (5) in the definition of *manufacturer* at § 447.502 do not have a National Drug Rebate Agreement (NDRA) in effect, or are terminated, all of the labeler codes will be subject to termination.

(i) *Suspension of manufacturer's NDRA for late reporting of drug pricing and drug product information.* (1) If a manufacturer fails to timely provide information required to be reported to the agency under section 1927(b)(3)(A) of the Act, and paragraphs (a) and (d) of this section, the agency will provide written notice to the manufacturer of failure to provide timely information. If such information is not reported within 90 calendar days of the date of the notice communicated to the manufacturer electronically and in writing by the agency, such failure by the manufacturer to report such information in a timely manner shall result in suspension of the manufacturer's rebate agreement for all covered outpatient drugs furnished after the end of the 90-day calendar period. The rebate agreement will remain suspended until the date the information is reported to the agency in full and certified, and the agency reviews for completeness, but not for a period of fewer than 30 calendar days. Continued suspension of the rebate agreement could result in termination for cause. Suspension of a manufacturer's rebate agreement under this section applies for Medicaid purposes only, and does not affect manufacturer obligations and responsibilities under the 340B Drug Pricing Program or reimbursement under Medicare Part B during the period of the suspension.

(2) During the period of the suspension, the covered outpatient drugs of the manufacturer are not eligible for FFP. The agency will notify the States 30 calendar days before the beginning of the suspension period for the manufacturer's rebate agreement and any applicable associated labeler rebate agreements.

(j) *Manufacturer audits of State-provided information.* A manufacturer may only initiate a dispute, request a hearing, or seek an audit of a State regarding State drug utilization data, during a period not to exceed 12 quarters from the last day of the quarter from the date of the State invoice.

(k) *Verification survey of reported covered outpatient drug pricing*—(1) *Survey of manufacturers.* CMS may survey a manufacturer with a rebate agreement with the Secretary under this section, or a wholesaler as defined in § 447.502, to verify prices or charges for a covered outpatient drug identified through paragraphs (k)(2) and (3) of this section, reported to the agency under section 1927(b)(3)(A) of the Act and this section, to make payment for the covered outpatient drug.

(2) *Identification of covered outpatient drugs potentially subject to price verification.* On an annual basis, CMS will compile a list of single source covered outpatient drugs that may be subject to a survey based on one or more of the following criteria (further refined based upon criteria in paragraph (k)(3) of this section). This list will identify drugs that have:

(i) The highest Medicaid drug spend per claim, which is when the claim is in the top 5th percentile of Medicaid spending per claim;

(ii) The highest total Medicaid drug spend, which is when the annual Medicaid drug spend, net of Federal Medicaid drug rebates, is greater than 0.5 percent of total annual Medicaid drug spend, net of Federal Medicaid drug rebates;

(iii) The highest 1-year price increase among single source covered outpatient drugs, which is when the covered outpatient drug falls in the top 1 percent of covered outpatient drugs with the highest median Wholesale Acquisition Cost (WAC) increase over 12 months; or

(iv) The highest launch price, which is a launch price estimated to be in the top 5th percentile of Medicaid spending per claim, or a launch price that is estimated to result in a total annual treatment price that is greater than $500,000 (indexed annually for inflation using the Consumer Price Index for all Urban Consumers (CPI–U)).

(3) *Selection of covered outpatient drugs for price verification.* The survey list compiled under paragraph (k)(2) of this section will be further refined by excluding covered outpatient drugs of manufacturers that have:

(i) Participated in any CMS drug pricing program or initiative under which participating manufacturers negotiate a covered outpatient drug's price directly with CMS; or,

(ii) Negotiated CMS-authorized supplemental rebate with at least 50 percent of States, that when in combination with the Federal rebate results in a total (State and Federal) rebate for the drug of interest to total Medicaid spend (State and Federal) for the drug of interest, that is greater than the total Medicaid rebates (State and Federal) to total Medicaid drug spend for States that cover CODs only through the FFS delivery system, as reflected in the most recent Medicaid Financial Management Report.

(iii) If after application of the criteria in paragraphs (k)(3)(i) and (ii) of this section more than 10 covered outpatient drugs remain on the survey list, CMS

will consider narrowing the list based on:

(A) State-specific Medicaid program input regarding manufacturer effort to lower drug price (including through mechanisms such as subscription models, value-based purchasing arrangements under the multiple best price approach, or other purchasing arrangements favorable to the Medicaid program); or,

(B) Highest cost covered outpatient drugs based on the factors outlined under paragraph (k)(2) of this section, and before application of paragraph (k)(3) of this section.

(4) *Posting of survey request.* After a survey list is compiled based on the application of the criteria in paragraphs (k)(2) and (3) of this section, the agency will post on a publicly accessible, government website, the letter sent to the manufacturer indicating the name of the covered outpatient drug to be surveyed and the request for completion of the drug price verification survey.

(5) *Covered outpatient drug price verification survey.* Such survey to a manufacturer or wholesaler will request in a standard reporting format specific information that will include:

(i) *Pricing, charges, distribution, and utilization.* (A) WAC of the covered outpatient drug, including the types of discounts available to purchasers on the commercial market, or for a wholesaler or pharmacy affiliated with a manufacturer or wholesaler, the invoice price for the drug;

(B) Calculated average price of the drug from the manufacturer to wholesalers and other direct purchasers for sales outside of the U.S.;

(C) Actual or expected utilization of the covered outpatient drug in the United States, including among the Medicare and Medicaid populations;

(D) Public prices for the drug to other Federal agencies, such as the Department of Veterans Affairs; and,

(E) Information relating to the costs of distribution of the covered outpatient drug.

(ii) *Product and clinical information.* (A) Characteristics of the covered outpatient drug, including route and setting of administration, dosing frequency, duration of therapy, side effects, interactions and contraindications, and potential for misuse or abuse.

(B) Manufacturer information regarding the clinical efficacy, effectiveness and outcomes of the drug.

(C) Therapeutic benefits to the patient including information such as the:

(*1*) Seriousness and prevalence of the disease or condition that is treated by the covered outpatient drug.

(*2*) The extent to which the covered outpatient drug addresses an unmet medical need.

(*3*) The extent to which the use of the covered outpatient drug will reduce or eliminate the need for other health care services.

(*4*) Whether there are therapeutic equivalents and the number of such equivalents available for the covered outpatient drug.

(D) Whether there are other existing therapies (pharmacological and non-pharmacological) available to a patient to address the indicated medical condition and the estimated costs of such other therapies to the patient compared to the price of the covered outpatient drug.

(E) If the drug is approved using FDA's accelerated approval pathway in section 506(c) of the FFDCA, any additional post-market studies required by FDA.

(iii) *Costs of production, research, and marketing.* (A) Manufacturer expenditures on materials and manufacturing for such covered outpatient drug, any costs of purchasing or acquiring the covered outpatient drug, and other processes needed to obtain, manufacture or license the covered outpatient drug.

(B) Research and development costs, including total public funds used for such research and development. If the covered outpatient drug is a line extension of a single source or innovator multiple source drug, manufacturers shall not include the research and development costs of the initial single source or innovator multiple source covered outpatient drug.

(C) Total expenditures of the manufacturer associated with marketing and advertising for the applicable covered outpatient drug.

(D) Total revenue and net profit generated from the covered outpatient drug for each calendar year since drug approval, if applicable.

(iv) *Secretary information.* Any other information as determined by the Secretary to verify the price or charge of the covered outpatient drug reported under section 1927(b)(3)(A) of the Act and this section.

(6) *Posting of manufacturer/wholesaler information from survey for further verification.* To further verify the prices and charges submitted by the manufacturer for a covered outpatient drug, CMS may post publicly non-proprietary information provided by the manufacturer and wholesaler in response to the verification survey. CMS may request that a manufacturer address the non-proprietary information specified in paragraph (k)(6) of this section in a public forum. CMS will seek comments from the public, beneficiaries, State Medicaid agencies, other governmental agencies, and other affected interested parties on the information posted.

(7) *Civil monetary penalties (CMPs).* A manufacturer or wholesaler that refuses a request for information pursuant to the drug price verification survey within 90 calendar days of CMS' request for such information, or knowingly provides false information, will be referred to the OIG for possible imposition of CMPs as set forth in section 1927(b)(3)(B) of the Act and section IV of the National Drug Rebate Agreement.

■ 11. Amend § 447.518 by adding a heading to paragraph (d) and revising paragraph (d)(1) to read as follows:

§ 447.518 State plan requirements, findings, and assurances.

* * * * *

(d) *Data requirements.* (1) When proposing changes to either the ingredient cost reimbursement or professional dispensing fee reimbursement, States are required to evaluate their proposed changes in accordance with the requirements of this subpart, and States must consider both the ingredient cost reimbursement and the professional dispensing fee reimbursement when proposing such changes to ensure that total reimbursement to the pharmacy provider is in accordance with requirements of section 1902(a)(30)(A) of the Act. States must provide adequate cost-based data, such as a State or national survey of retail pharmacy providers or other reliable cost-based data other than a survey to support any proposed changes to either or both of the components of the reimbursement methodology. States must submit to CMS the proposed change in reimbursement and the supporting data through a State Plan Amendment formal review process. Research and data must be based on pharmacy costs and be sufficient to establish the adequacy of both current ingredient cost reimbursement and professional dispensing fee reimbursement. Submission by the State of data that are not based on pharmacy costs, such as market-based research (for example, third party payments accepted by pharmacies) to support the professional dispensing fee would not qualify as supporting data.

* * * * *

■ 12. Revise § 447.520 to read as follows:

§ 447.520 Federal Financial Participation (FFP): Conditions relating to physician-administered drugs.

(a) *Availability of FFP.* No FFP is available for physician-administered drugs that are covered outpatient drugs for which a State has not required the submission of claims using codes that identify the drugs sufficiently for the State to invoice a manufacturer for rebates.

(1) *Single source drugs.* For a covered outpatient drug that is a single source, physician-administered drug, administered on or after January 1, 2006, a State must require providers to submit claims for using National Drug Code (NDC) numbers to secure rebates and receive FFP.

(2) *Multiple source drugs.* For a covered outpatient drug that is a multiple source, physician-administered drug on the list published by CMS described in paragraph (c) of this section, administered on or after January 1, 2008, a State must require providers to submit claims using NDC numbers to secure rebates and receive FFP. States are required to invoice for rebates for all multiple source physician-administered drugs that are CODs, and not limit such rebate invoicing to the top 20 multiple source physician-administered drug list.

(b) *Required coding.* As of January 1, 2007, a State must require providers to submit claims for a covered outpatient drug that is described in paragraph (a)(1) or (2) of this section (any covered outpatient drug that is a physician-administered drug) using NDC numbers.

(c) *Top 20 multiple source physician-administered drug list.* The top 20 multiple source physician-administered drug list, identified by the Secretary as having the highest dollar volume of physician administered drugs dispensed under the Medicaid program, will be published and may be modified from year to year to reflect changes in such volume.

(d) *Hardship waiver.* A State that requires additional time to comply with the requirements of this section may apply to the Secretary for an extension.

Dated: May 18, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–10934 Filed 5–23–23; 4:15 pm]

BILLING CODE 4120–01–P

EXHIBIT 13

Table 4
National Health Expenditures by Source of Funds and Type of Expenditure: Calendar Years 2014-2021

Year and Type of Expenditure	Total	Out of Pocket	Health Insurance	Private Health Insurance	Medicare	Medicaid	Other Health Insurance Programs[1]	Other Third Party Payers[2]	Government Public Health Activities	Investment
			Health Insurance							
Year 2014					Amount in Billions					
National Health Expenditures	$3,002.6	$340.8	$2,151.1	$923.0	$617.3	$498.2	$112.6	$266.8	$84.4	$159.6
Health Consumption Expenditures	2,843.1	340.8	2,151.1	923.0	617.3	498.2	112.6	266.8	84.4	-
Personal Health Care	2,527.1	340.8	1,948.8	815.5	579.3	446.9	107.1	237.5	-	-
Hospital Care	940.5	32.4	810.4	324.5	253.4	171.7	60.7	97.7	-	-
Professional Services	795.3	120.6	597.4	326.9	161.3	80.2	28.9	77.3	-	-
Physician and Clinical Services	598.3	52.9	480.0	247.9	142.2	64.5	25.4	65.4	-	-
Other Professional Services	82.4	20.4	51.4	26.5	18.7	6.0	0.3	10.5	-	-
Dental Services	114.7	47.3	66.0	52.6	0.4	9.8	3.2	1.5	-	-
Other Health, Residential, and Personal Care[3]	151.3	5.9	102.5	10.6	5.2	84.8	1.9	42.9	-	-
Home Health Care[4]	84.7	8.5	73.6	9.7	34.3	29.1	0.5	2.6	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	152.6	39.3	101.6	12.1	35.5	49.2	4.7	11.7	-	-
Retail Outlet Sales of Medical Products	402.7	134.1	263.3	131.7	89.5	31.8	10.3	5.3	-	-
Prescription Drugs	290.6	48.6	237.7	122.8	79.5	25.3	10.2	4.3	-	-
Durable Medical Equipment	46.6	22.3	23.3	8.8	7.8	6.5	0.1	1.0	-	-
Other Non-Durable Medical Products	65.5	63.2	2.3	-	2.3	-	-	0.0	-	-
Government Administration[6]	41.8	-	36.6	-	9.7	22.5	4.0	5.3	-	-
Net Cost of Health Insurance[7]	189.7	-	165.7	107.5	28.4	28.7	1.1	24.0	-	-
Government Public Health Activities	84.4	-	-	-	-	-	-	-	84.4	-
Investment	159.6	-	-	-	-	-	-	-	-	159.6
Research[8]	46.0	-	-	-	-	-	-	-	-	46.0
Structures and Equipment	113.5	-	-	-	-	-	-	-	-	113.5
Year 2015					Amount in Billions					
National Health Expenditures	$3,165.4	$353.5	$2,288.8	$976.9	$647.9	$543.0	$121.1	$274.4	$85.5	$163.1
Health Consumption Expenditures	3,002.3	353.5	2,288.8	976.9	647.9	543.0	121.1	274.4	85.5	-
Personal Health Care	2,674.3	353.5	2,076.1	870.2	606.2	484.5	115.2	244.6	-	-
Hospital Care	989.0	30.6	862.1	350.3	261.8	186.1	63.9	96.2	-	-
Professional Services	844.7	127.3	634.6	344.3	170.0	88.1	32.1	82.8	-	-
Physician and Clinical Services	637.4	55.5	511.4	263.7	149.3	70.1	28.3	70.5	-	-
Other Professional Services	87.3	21.5	55.0	27.7	20.2	6.8	0.3	10.8	-	-
Dental Services	120.0	50.4	68.1	52.9	0.5	11.2	3.5	1.5	-	-
Other Health, Residential, and Personal Care[3]	164.1	5.1	113.0	11.7	5.0	94.1	2.2	46.0	-	-
Home Health Care[4]	89.6	8.7	78.3	10.3	35.8	31.5	0.7	2.6	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	156.8	40.2	105.1	13.4	37.0	49.7	5.0	11.5	-	-
Retail Outlet Sales of Medical Products	430.2	141.6	283.1	140.3	96.6	35.0	11.3	5.5	-	-
Prescription Drugs	312.2	52.0	255.7	130.6	86.4	27.7	11.1	4.5	-	-
Durable Medical Equipment	48.7	22.5	25.1	9.7	8.0	7.3	0.1	1.0	-	-
Other Non-Durable Medical Products	69.3	67.0	2.3	-	2.3	-	-	0.0	-	-
Government Administration[6]	41.8	-	37.0	-	9.8	22.6	4.3	4.8	-	-
Net Cost of Health Insurance[7]	200.7	-	175.7	106.7	31.8	35.9	1.3	25.0	-	-
Government Public Health Activities	85.5	-	-	-	-	-	-	-	85.5	-
Investment	163.1	-	-	-	-	-	-	-	-	163.1
Research[8]	46.4	-	-	-	-	-	-	-	-	46.4
Structures and Equipment	116.7	-	-	-	-	-	-	-	-	116.7

Table 4 - Continued
National Health Expenditures by Source of Funds and Type of Expenditure: Calendar Years 2014-2021

Year and Type of Expenditure	Total	Out of Pocket	Health Insurance	Private Health Insurance	Medicare	Medicaid	Other Health Insurance Programs[1]	Other Third Party Payers[2]	Government Public Health Activities	Investment
			Health Insurance							
Year 2016					Amount in Billions					
National Health Expenditures	$3,307.4	$365.9	$2,397.0	$1,030.8	$675.9	$564.9	$125.4	$288.3	$90.0	$166.2
Health Consumption Expenditures	3,141.2	365.9	2,397.0	1,030.8	675.9	564.9	125.4	288.3	90.0	-
Personal Health Care	2,795.6	365.9	2,170.0	918.6	629.0	503.4	119.0	259.6	-	-
Hospital Care	1,035.4	31.6	903.4	372.9	274.1	190.1	66.3	100.5	-	-
Professional Services	895.0	133.7	671.2	368.7	176.3	92.2	34.0	90.1	-	-
Physician and Clinical Services	676.8	58.1	541.3	283.6	154.5	73.1	30.1	77.4	-	-
Other Professional Services	92.1	22.6	58.3	29.5	21.2	7.3	0.3	11.2	-	-
Dental Services	126.2	53.0	71.6	55.6	0.5	11.9	3.6	1.5	-	-
Other Health, Residential, and Personal Care[3]	174.2	5.2	120.2	12.1	4.9	100.8	2.4	48.8	-	-
Home Health Care[4]	93.7	9.0	82.0	11.5	37.2	32.7	0.7	2.6	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	162.0	43.1	106.6	13.9	37.0	50.7	5.1	12.2	-	-
Retail Outlet Sales of Medical Products	435.2	143.2	286.6	139.6	99.6	37.0	10.5	5.4	-	-
Prescription Drugs	313.3	50.3	258.6	129.1	89.9	29.3	10.3	4.4	-	-
Durable Medical Equipment	50.0	23.1	25.9	10.4	7.6	7.6	0.2	1.0	-	-
Other Non-Durable Medical Products	71.9	69.8	2.1	-	2.1	-	-	0.0	-	-
Government Administration[6]	44.1	-	40.0	-	10.3	24.7	4.9	4.1	-	-
Net Cost of Health Insurance[7]	211.5	-	186.9	112.2	36.5	36.8	1.4	24.6	-	-
Government Public Health Activities	90.0	-	-	-	-	-	-	-	90.0	-
Investment	166.2	-	-	-	-	-	-	-	-	166.2
Research[8]	47.6	-	-	-	-	-	-	-	-	47.6
Structures and Equipment	118.6	-	-	-	-	-	-	-	-	118.6
Year 2017					Amount in Billions					
National Health Expenditures	$3,446.5	$372.9	$2,495.5	$1,080.0	$704.9	$578.5	$132.1	$302.0	$95.5	$180.6
Health Consumption Expenditures	3,265.9	372.9	2,495.5	1,080.0	704.9	578.5	132.1	302.0	95.5	-
Personal Health Care	2,903.8	372.9	2,258.2	957.7	659.1	516.0	125.4	272.7	-	-
Hospital Care	1,077.6	32.8	938.5	390.0	286.5	192.2	69.8	106.3	-	-
Professional Services	937.5	138.2	705.0	386.4	188.3	94.4	36.0	94.2	-	-
Physician and Clinical Services	709.4	59.6	568.6	297.8	164.1	74.9	31.8	81.3	-	-
Other Professional Services	96.9	23.9	61.6	30.7	23.2	7.3	0.4	11.4	-	-
Dental Services	131.1	54.8	74.8	57.9	0.9	12.2	3.8	1.6	-	-
Other Health, Residential, and Personal Care[3]	184.0	6.1	127.1	12.4	4.9	107.3	2.5	50.8	-	-
Home Health Care[4]	99.4	10.5	86.0	13.2	38.4	33.6	0.7	2.9	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	163.4	41.8	108.4	14.3	37.4	51.3	5.4	13.2	-	-
Retail Outlet Sales of Medical Products	442.0	143.6	293.2	141.4	103.6	37.2	11.0	5.3	-	-
Prescription Drugs	315.8	47.3	264.3	130.5	93.5	29.4	10.8	4.3	-	-
Durable Medical Equipment	51.6	23.6	27.0	10.9	8.1	7.8	0.2	1.0	-	-
Other Non-Durable Medical Products	74.6	72.6	2.0	-	2.0	-	-	0.0	-	-
Government Administration[6]	44.0	-	41.1	-	9.7	26.0	5.3	3.0	-	-
Net Cost of Health Insurance[7]	222.6	-	196.3	122.4	36.1	36.5	1.3	26.3	-	-
Government Public Health Activities	95.5	-	-	-	-	-	-	-	95.5	-
Investment	180.6	-	-	-	-	-	-	-	-	180.6
Research[8]	50.9	-	-	-	-	-	-	-	-	50.9
Structures and Equipment	129.7	-	-	-	-	-	-	-	-	129.7

Table 4 - Continued
National Health Expenditures by Source of Funds and Type of Expenditure: Calendar Years 2014-2021

Year and Type of Expenditure	Total	Out of Pocket	Health Insurance	Private Health Insurance	Medicare	Medicaid	Other Health Insurance Programs[1]	Other Third Party Payers[2]	Government Public Health Activities	Investment
			Health Insurance							
Year 2018					Amount in Billions					
National Health Expenditures	$3,604.4	$386.8	$2,612.1	$1,129.8	$749.6	$596.2	$136.5	$316.3	$99.4	$189.9
Health Consumption Expenditures	3,414.6	386.8	2,612.1	1,129.8	749.6	596.2	136.5	316.3	99.4	-
Personal Health Care	3,019.8	386.8	2,348.5	990.4	696.7	531.5	129.9	284.5	-	-
Hospital Care	1,122.7	34.3	977.3	408.2	300.6	197.9	70.7	111.1	-	-
Professional Services	978.1	144.0	736.7	394.1	204.9	98.7	39.0	97.4	-	-
Physician and Clinical Services	736.2	60.8	592.0	300.8	178.1	78.4	34.6	83.4	-	-
Other Professional Services	104.5	25.9	66.4	32.8	25.6	7.7	0.4	12.2	-	-
Dental Services	137.4	57.3	78.3	60.5	1.2	12.6	3.9	1.8	-	-
Other Health, Residential, and Personal Care[3]	189.9	6.2	130.1	12.6	4.9	110.0	2.7	53.6	-	-
Home Health Care[4]	105.6	11.9	90.7	14.4	40.5	35.1	0.8	3.0	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	167.7	43.6	110.2	15.3	37.6	51.5	5.7	13.9	-	-
Retail Outlet Sales of Medical Products	455.9	146.9	303.5	145.8	108.2	38.5	11.0	5.5	-	-
Prescription Drugs	324.2	47.4	272.3	133.9	97.2	30.4	10.8	4.4	-	-
Durable Medical Equipment	54.1	24.0	29.0	11.9	8.9	8.1	0.2	1.1	-	-
Other Non-Durable Medical Products	77.6	75.5	2.1	-	2.1	-	-	0.0	-	-
Government Administration[6]	46.5	-	43.5	-	11.5	26.8	5.1	3.0	-	-
Net Cost of Health Insurance[7]	249.0	-	220.2	139.5	41.4	37.8	1.5	28.7	-	-
Government Public Health Activities	99.4	-	-	-	-	-	-	-	99.4	-
Investment	189.9	-	-	-	-	-	-	-	-	189.9
Research[8]	53.7	-	-	-	-	-	-	-	-	53.7
Structures and Equipment	136.1	-	-	-	-	-	-	-	-	136.1
Year 2019					Amount in Billions					
National Health Expenditures	$3,757.4	$403.0	$2,719.8	$1,157.8	$802.0	$615.0	$145.0	$333.5	$107.1	$194.1
Health Consumption Expenditures	3,563.3	403.0	2,719.8	1,157.8	802.0	615.0	145.0	333.5	107.1	-
Personal Health Care	3,173.1	403.0	2,468.1	1,029.8	746.6	553.6	138.1	302.0	-	-
Hospital Care	1,193.6	36.4	1,034.1	433.6	318.9	207.4	74.2	123.1	-	-
Professional Services	1,022.5	149.4	773.7	400.9	224.9	105.2	42.8	99.5	-	-
Physician and Clinical Services	767.9	62.0	621.0	304.5	194.3	83.9	38.4	85.0	-	-
Other Professional Services	110.9	27.0	71.4	34.2	28.7	8.1	0.4	12.6	-	-
Dental Services	143.7	60.4	81.4	62.2	1.9	13.2	4.0	1.9	-	-
Other Health, Residential, and Personal Care[3]	194.8	6.4	132.7	13.3	4.8	111.6	2.9	55.7	-	-
Home Health Care[4]	112.4	12.3	97.0	15.6	43.3	37.1	0.9	3.1	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	174.1	46.0	113.0	16.7	38.1	52.2	6.0	15.1	-	-
Retail Outlet Sales of Medical Products	475.7	152.4	317.7	149.8	116.6	40.1	11.2	5.6	-	-
Prescription Drugs	338.1	48.3	285.2	137.9	104.6	31.7	11.0	4.5	-	-
Durable Medical Equipment	56.5	25.1	30.2	11.9	9.8	8.3	0.2	1.1	-	-
Other Non-Durable Medical Products	81.2	79.0	2.2	-	2.2	-	-	0.0	-	-
Government Administration[6]	47.6	-	44.8	-	11.5	27.8	5.4	2.7	-	-
Net Cost of Health Insurance[7]	235.6	-	206.8	128.0	43.8	33.7	1.4	28.8	-	-
Government Public Health Activities	107.1	-	-	-	-	-	-	-	107.1	-
Investment	194.1	-	-	-	-	-	-	-	-	194.1
Research[8]	56.6	-	-	-	-	-	-	-	-	56.6
Structures and Equipment	137.5	-	-	-	-	-	-	-	-	137.5

Table 4 - Continued
National Health Expenditures by Source of Funds and Type of Expenditure: Calendar Years 2014-2021

Year and Type of Expenditure	Total	Out of Pocket	Health Insurance	Private Health Insurance	Medicare	Medicaid	Other Health Insurance Programs[1]	Other Third Party Payers[2]	Government Public Health Activities	Investment
			Health Insurance							
Year 2020					Amount in Billions					
National Health Expenditures	$4,144.1	$392.3	$2,805.6	$1,145.2	$831.2	$672.0	$157.1	$514.0	$238.3	$193.9
Health Consumption Expenditures	3,950.1	392.3	2,805.6	1,145.2	831.2	672.0	157.1	514.0	238.3	-
Personal Health Care	3,367.0	392.3	2,492.4	995.6	759.6	587.7	149.4	482.3	-	-
Hospital Care	1,267.8	32.4	1,026.7	404.3	321.1	221.4	80.0	208.7	-	-
Professional Services	1,075.5	140.3	776.0	395.4	225.4	108.2	47.0	159.2	-	-
Physician and Clinical Services	818.4	60.3	629.9	305.7	194.0	87.3	42.8	128.3	-	-
Other Professional Services	117.7	26.2	71.0	33.4	28.8	8.3	0.5	20.5	-	-
Dental Services	139.3	53.7	75.2	56.2	2.5	12.6	3.8	10.4	-	-
Other Health, Residential, and Personal Care[3]	210.7	6.6	142.5	13.6	4.4	121.5	2.9	61.6	-	-
Home Health Care[4]	125.0	12.2	100.1	15.6	43.8	40.1	0.6	12.7	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	196.9	45.5	116.5	16.7	39.8	53.5	6.5	34.9	-	-
Retail Outlet Sales of Medical Products	491.1	155.2	330.7	150.2	125.1	43.0	12.4	5.3	-	-
Prescription Drugs	350.6	48.3	298.0	139.8	111.6	34.4	12.2	4.3	-	-
Durable Medical Equipment	55.1	23.8	30.3	10.4	11.1	8.5	0.2	1.0	-	-
Other Non-Durable Medical Products	85.4	83.0	2.3	-	2.3	-	-	0.0	-	-
Government Administration[6]	48.1	-	45.9	-	11.5	28.8	5.3	2.2	-	-
Net Cost of Health Insurance[7]	296.8	-	267.3	149.6	60.1	55.5	2.1	29.5	-	-
Government Public Health Activities	238.3	-	-	-	-	-	-	-	238.3	-
Investment	193.9	-	-	-	-	-	-	-	-	193.9
Research[8]	60.1	-	-	-	-	-	-	-	-	60.1
Structures and Equipment	133.8	-	-	-	-	-	-	-	-	133.8
Year 2021					Amount in Billions					
National Health Expenditures	$4,255.1	$433.2	$3,018.4	$1,211.4	$900.8	$734.0	$172.1	$409.0	$187.6	$207.0
Health Consumption Expenditures	4,048.1	433.2	3,018.4	1,211.4	900.8	734.0	172.1	409.0	187.6	-
Personal Health Care	3,553.4	433.2	2,739.3	1,091.0	839.9	644.8	163.6	380.9	-	-
Hospital Care	1,323.9	34.1	1,136.5	448.8	350.7	245.3	91.7	153.3	-	-
Professional Services	1,157.0	158.5	866.5	430.5	263.1	124.1	48.8	132.0	-	-
Physician and Clinical Services	864.6	65.6	693.1	328.1	222.1	99.3	43.6	105.9	-	-
Other Professional Services	130.6	29.5	83.7	37.5	36.2	9.5	0.5	17.5	-	-
Dental Services	161.8	63.4	89.6	64.9	4.7	15.3	4.7	8.7	-	-
Other Health, Residential, and Personal Care[3]	223.5	7.0	151.6	14.8	4.3	129.6	2.9	64.9	-	-
Home Health Care[4]	125.2	12.9	106.1	15.9	46.6	42.8	0.8	6.2	-	-
Nursing Care Facilities and Continuing Care Retirement Communities[4, 5]	181.3	44.4	118.0	16.3	40.6	54.3	6.8	19.0	-	-
Retail Outlet Sales of Medical Products	542.5	176.3	360.8	164.8	134.6	48.7	12.6	5.5	-	-
Prescription Drugs	378.0	49.8	323.7	151.7	119.9	39.6	12.4	4.5	-	-
Durable Medical Equipment	67.1	31.4	34.8	13.1	12.4	9.1	0.2	1.0	-	-
Other Non-Durable Medical Products	97.4	95.1	2.3	-	2.3	-	-	0.0	-	-
Government Administration[6]	51.5	-	49.1	-	13.1	29.6	5.9	2.3	-	-
Net Cost of Health Insurance[7]	255.7	-	229.9	120.4	47.9	59.6	2.1	25.7	-	-
Government Public Health Activities	187.6	-	-	-	-	-	-	-	187.6	-
Investment	207.0	-	-	-	-	-	-	-	-	207.0
Research[8]	61.5	-	-	-	-	-	-	-	-	61.5
Structures and Equipment	145.6	-	-	-	-	-	-	-	-	145.6

[1] Includes Children's Health Insurance Program (Titles XIX and XXI), Department of Defense, and Department of Veterans Affairs.

[2] Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

[3] Includes expenditures for residential care facilities (NAICS 623210 and 623220), ambulance providers (NAICS 621910), medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.

[4] Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care.

[5] Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (623311), state and local government nursing facilities, and nursing facilities operated by the Department of Veterans Affairs (DVA).

[6] Includes all administrative costs (federal and state and local employees' salaries, contracted employees including fiscal intermediaries, rent and building costs, computer systems and programs, other materials and supplies, and other miscellaneous expenses) associated with insuring individuals enrolled in the following health insurance programs: Medicare, Medicaid, Children's Health Insurance Program, Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, and other federal programs.

[7] Net cost of health insurance is calculated as the difference between CY incurred premiums earned and benefits paid for private health insurance. This includes administrative costs, and in some cases, additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following programs: Medicare, Medicaid, Children's Health Insurance Program, and workers' compensation (health portion only).

[8] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

Note: Numbers may not add to totals because of rounding. The figure 0.0 denotes amounts less than $50 million. Dashes (--) indicate "not applicable". Dollar amounts shown are in current dollars. Percent changes are calculated from unrounded data.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

EXHIBIT 14

ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF

March 2, 2022

HP-2022-08

Medicare Beneficiary Enrollment Trends and Demographic Characteristics

Medicare served nearly 63 million beneficiaries in 2019. 62 percent were enrolled in Part A or Part B, and the rest (37 percent) were in Medicare Advantage (Part C). 74 percent were enrolled in Part D drug coverage, 13 percent had private drug coverage, and nearly 9 percent had no drug coverage. Demographic characteristics and health status varied across these groups.

Wafa Tarazi, W. Pete Welch, Nguyen Nguyen, Arielle Bosworth, Steven Sheingold, Nancy De Lew, and Benjamin D. Sommers

KEY POINTS

- In 2019, nearly 63 million beneficiaries were enrolled in one or more Parts of the Medicare program.
- Of these beneficiaries, most were enrolled in fee-for service (FFS) Part A or B coverage (62.3 percent), with a growing share (37.0 percent) enrolled in Medicare Advantage (MA, or Part C coverage). MA enrollees were disproportionally lower-income, Black or Latino, and dually enrolled in Medicaid.
- 7.5 percent of beneficiaries were enrolled in Part A only, which includes people 65 and over who are still employed and may be covered by employer sponsored insurance (ESI). White beneficiaries and those with higher incomes and college education are disproportionately represented in those who are enrolled in Part A only. A very small percentage of beneficiaries, 0.4 percent, were enrolled in Part B only.
- Most beneficiaries with both Parts A and B coverage had supplemental coverage – either through self-purchased plans (32.9 percent of FFS beneficiaries), ESI (27.4 percent), Medicaid (17.6 percent), or other supplemental coverage. Nearly 16 percent of beneficiaries had no supplement.
- About 74.4 percent of beneficiaries were enrolled in Part D, 2.9 percent were enrolled in the Retiree Drug Subsidy program, and 13.4 percent had private drug coverage. About half of Part D enrollees were enrolled in standalone Part D plans and about half in MA Prescription Drug plans, with similar characteristics of beneficiaries in both groups.
- 9.1 percent of Medicare beneficiaries did not have drug coverage. Beneficiaries in this group were more likely to have lower incomes, have less than a college degree, be unmarried, and have multiple health conditions, compared to beneficiaries with private drug coverage.
- Understanding the demographic characteristics and medical conditions of Medicare beneficiaries enrolled in the four different Parts of Medicare can help policymakers better address their needs.

BACKGROUND

Medicare serves nearly 63 million beneficiaries, providing critical access to health care services and financial security for the nation's seniors, people with disabilities, and people with end-stage renal disease (ESRD). Medicare beneficiaries may enroll in Parts A, B, C, and D which cover different services as described below. The four "Parts" of Medicare are a result of statutory changes to the program over the years.

Medicare started in 1965 with eligibility requirements that are different for Parts A and B.

Part A covers inpatient services at providers including hospitals, skilled nursing facilities, home health, and hospice services. **Part B** covers professional, outpatient hospital, lab, and other ambulatory services. If a person works at least 40 quarters and pays the Hospital Insurance payroll tax into the Part A trust fund, they become entitled to Part A without paying a premium upon reaching age 65. In contrast, Part B is voluntary; eligibility is based on turning age 65. Part B enrollees must pay a premium, which on average covers a quarter of Part B spending. People younger than 65 may become eligible for Medicare two years after receiving Social Security disability benefits.

Most beneficiaries are enrolled in Medicare fee-for-service (FFS), sometimes called "original" or "traditional" Medicare, while a growing share is enrolled in Medicare Advantage (MA), or Medicare **Part C**, which offers private plan options. Medicare beneficiaries can choose their Medicare coverage: FFS (Part A "hospital insurance," Part B "medical insurance," or both), or Part C (MA) for those enrolled in both Parts A and Part B. Beneficiaries in the traditional program can also obtain supplemental coverage from several possible sources, which provide additional coverage for out-of-pocket expenses.

Starting in 2006, Medicare added voluntary drug coverage – **Part D** – that beneficiaries can receive if they choose to enroll in a Medicare drug coverage plan. Part D coverage, like Part B, is also voluntary and generally requires a premium payment by beneficiaries. Beneficiaries who opt not to enroll in Part B or Part D when first eligible to do so must pay a higher premium for the rest of their lives if they enroll at a later date. Those in FFS can choose a freestanding Medicare Prescription Drug Plan (PDP) while those in Medicare Advantage can receive their drug coverage through their MA plan that also offers prescription drug coverage (MA-PD). In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 encourages employers to continue to offer prescription drug benefits to their Medicare-eligible retirees[*] through the retiree drug subsidy (RDS) program.[1] Employers participating in this program must offer drug benefits that are actuarially equivalent to, or more generous than, PDP coverage. The different Parts of Medicare mean that there is a variation in the coverage of health services across beneficiaries, with some beneficiaries having all available coverage while others have only one type of coverage. A number of beneficiaries do not have coverage for their drugs under Part D or another source of health insurance coverage.

Enrollment in the different Parts of Medicare has changed over time. During the last decade, enrollment in MA plans more than doubled.[2] In 2020, approximately 25.1 million beneficiaries (40.0 percent of Medicare beneficiaries) were enrolled in MA plans.[3] This percent increased to 43.6 in 2021 and is projected by the Congressional Budget Office (CBO) to become 55.1 percent by 2030.[4,5] [†]

The purpose of this Issue Brief is to analyze the most recently available Medicare administrative and survey data to paint a detailed profile of Medicare enrollees across the program's four Parts.

---

[*] Medicare-eligible retirees are defined as individuals who are entitled to Medicare benefits under Part A and/or are enrolled in Part B, and who live in the service area of a Part D plan

[†] These percentages include beneficiaries enrolled in either Part A or Part B. However, enrollment in MA requires enrollment in both Parts A and B. MA enrollment has grown since 2019 (the year of data used in this issue brief).

METHODS

We used the 2019 Medicare Current Beneficiary Survey (MCBS) linked to Medicare administrative data. The MCBS is a continuous, multipurpose survey of a nationally representative sample of the Medicare population, conducted by Centers for Medicare & Medicaid Services (CMS).[6] In addition to beneficiary demographics, the MCBS includes information on medical conditions, health insurance type, and coverage eligibility. We used the CMS administrative data (Common Medicare Environment / Enrollment Database) as the main source of the Medicare coverage categories to capture all four Parts of Medicare; information on supplemental coverage other than Medicare was self-reported and came from the MCBS. We also used the CMS Risk Adjustment Payment System to obtain information on the Hierarchical Condition Category (HCC) score. We linked data from the survey participants to their information in the administrative data.

We used the following Medicare coverage categories:

- Parts A and B:
  - FFS Part A and/or Part B, Part A only, Part B only
  - For those with both FFS Parts A and B, we assessed the presence and type of supplemental coverage based on survey self-report: self-purchased private plan, employer sponsored insurance (ESI), Medicaid, other coverage, and no-supplement.[‡] We used self-purchased private plan as a proxy for Medigap/Medicare supplement plans.[§]
- Part C: MA enrollment[**]
- Part D: total enrollment, Medicare Prescription Drug Plan (PDP), other PDP, or Medicare Advantage Prescription Drug (MA-PD) plans, retiree drug subsidy (RDS), private drug coverage, and no drug coverage.[††]

We identified enrollment in each Part of Medicare in 2019 and assessed the following demographic characteristics from the MCBS: income as a percent of federal poverty level [FPL], reason for Medicare eligibility, age, race/ethnicity, education, marital status, sex, and Medicare-Medicaid dual enrollment. The administrative data provided information on HCC scores, which were used to create number of health conditions. HCC is a diagnostic classification system that classifies all ICD-10 diagnostic codes into Diagnostic Groups.[7] Each Diagnostic Group represents a well-specified medical condition or set of conditions. Hierarchies are used to group and order clinically related CCs within the classification. In addition to examining the demographic characteristics and health conditions, we examined need for assistance with Activities of Daily Living (ADLs) that came from the MCBS.[‡‡] We applied the MCBS survey weights to estimate the total population size in each Part of Medicare.

FINDINGS

Most of the 62.5 M Medicare beneficiaries were enrolled in FFS Part A or B (62.3 percent) and the rest were enrolled in MA / Part C (37.0 percent). Approximately 7.5 percent of beneficiaries were enrolled in Part A only,

---

[‡] Both self-purchased and ESI include specialty plans. Other coverage includes Veteran's affairs plan, Tricare plan, other public plan, and other unknown insurance plan type. No-supplement is defined as no coverage by any of these types of coverage (self-purchased, ESI, Medicaid, or other). The survey data do not include detailed information on enrollment in either the Medicare Savings Program (MSP) or Part D Low-income Subsidy (LIS).

[§] Our dataset does not have information on Medigap enrollment. In the MCBS questionnaire, self-purchased private plan is defined as Medigap or private plans purchased through other sources (e.g., Health Exchange). So, we used self-purchased private plans as a proxy for Medigap/Medicare Supplement plans.

[**] Beneficiaries enrolled in Medicare-Medicaid Plans (MMPs), Medicare cost plan, or the Program for All-inclusive Care for the Elderly (PACE) are included under Part C.

[††] Part A or B, Part A only, Part B only, Parts A & B, and Part D (PDP, other PDP) are for FFS enrollees only. MA-PD is for MA enrollees only.

[‡‡] ADLs include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

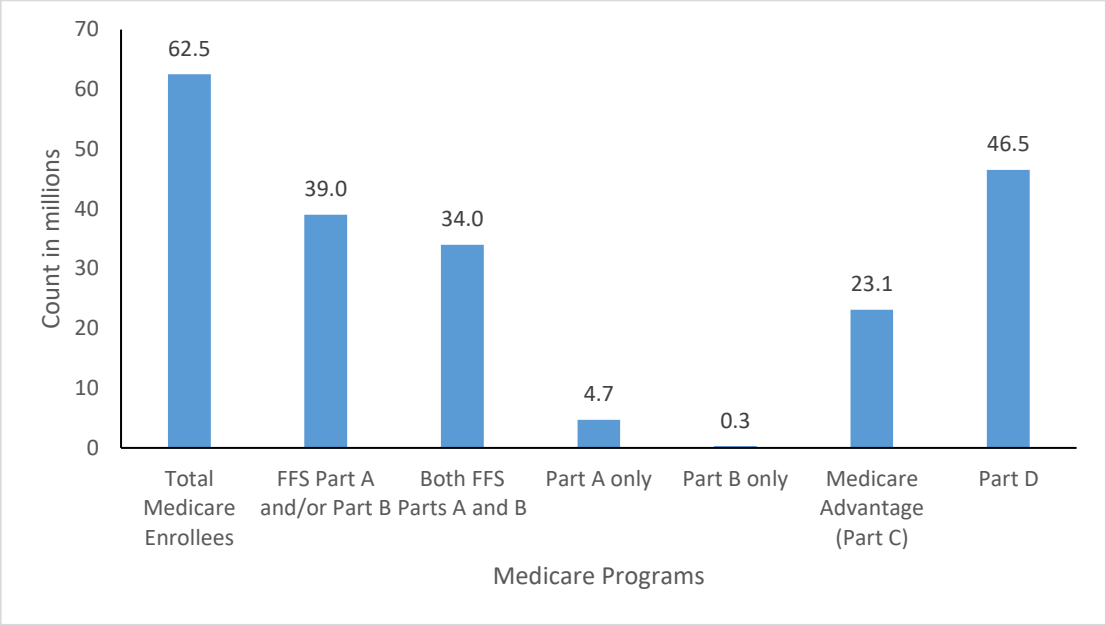
while only 0.4 percent were enrolled in Part B only. About 74.4 percent of beneficiaries had Part D coverage (Table 1).

Table 1. Distribution of Medicare Beneficiaries in 2019, by Program Part

Medicare Coverage Categories	Number of Medicare Beneficiaries (in millions)	Percentage of All Medicare Beneficiaries
Total Medicare Beneficiaries	62.5	100.0%
FFS (Part A and/ or Part B)	39.0	62.3%
Part A only	4.7	7.5%
Part B only	0.3	0.4%
Both Parts A and B	34.0	54.5%
Self-purchased private plan	11.2	17.9%
Employer sponsored insurance (ESI)	9.3	14.9%
Medicaid	6.0	9.6%
Other coverage	2.1	3.4%
No supplement	5.4	8.7%
MA (Part C)	23.1	37.0%
Part D Eligible	62.5	100.0%
Part D Enrollees	46.5	74.4%
PDP Plan	26.3	42.1%
MA-PD Plan	20.0	32.0%
Other Part D Plan	0.2	0.3%
No Part D Enrollment		
Retiree Drug Subsidy (RDS)	1.8	2.9%
With private drug coverage	8.4	13.4%
No drug coverage	5.7	9.1%

Notes: Analysis of the 2019 Medicare Current Beneficiary Survey (MCBS) linked to Medicare administrative data. Total Medicare beneficiaries included FFS Part A and B, Medicare Advantage, and a small percentage (less than 1 percent) of beneficiaries who were reported as deceased more than a month before their MCBS interview date (a proxy was utilized during the interview). Self-purchased private plan as a proxy for Medigap/Medicare supplement plans and includes self-purchased specialty plans. ESI is employer sponsored insurance, including ESI specialty plans. Other coverage includes Veteran's affairs plan, Tricare plan, other public plan, and other unknown insurance plan type. No-supplement is defined as no coverage by any of these types of coverage (self-purchased, ESI, Medicaid, or other). All percentages are relative to total number of Medicare beneficiaries.

Figure 1. Distribution of Medicare Beneficiaries in 2019, by Program Part (Millions)



Notes: Analysis of the 2019 Medicare Current Beneficiary Survey (MCBS) linked to Medicare administrative data. Total Medicare beneficiaries included FFS Part A and B, Medicare Advantage, and a small percentage (less than 1 percent) of beneficiaries who were reported as deceased more than a month before their MCBS interview date (a proxy was utilized during the interview).

Table 2 presents characteristics of Medicare beneficiaries by program Part. Overall, the majority (86.2 percent) of Medicare beneficiaries were 65 or older. About 76.0 percent of beneficiaries were White non-Latino, and 52.1 percent reported that they had attended college. 15.4 percent of beneficiaries reported incomes below 100% FPL, and 16.8 percent were dually enrolled in Medicare and Medicaid. In terms of health and functional status, 16.6 percent reported needing assistance with at least one or two ADLs, and 27.9 percent had multiple health conditions. Overall, Medicare beneficiaries are disproportionately White, older, and have lower incomes and lower levels of education compared to the U.S. population.

Compared to beneficiaries enrolled in both Part A and Part B,[§§] beneficiaries enrolled in MA were more likely to report incomes below 100% FPL (17.6 percent vs. 14.6 percent), be 75 or older (39.6 percent vs. 37.5 percent), and have educational attainment less than high school (17.5 percent vs. 12.3 percent). MA included a higher percent of Black and Latino beneficiaries (13.7 percent and 10.6 percent) than in FFS Parts A and B (8.5 percent and 5.2 percent, respectively). MA enrollees were more likely than FFS enrollees to be dually enrolled (20.1 percent vs. 16.5 percent) and to have multiple health conditions (34.2 percent vs. 25.4 percent).

Compared to the overall Medicare population, beneficiaries only enrolled in Part A were more likely to be younger than 75, have higher incomes, and have attended college; they were less likely to be dually enrolled, have multiple health conditions, or functional limitations. Beneficiaries enrolled in Part B only were more likely to be dually enrolled, have lower incomes, and have health conditions and functional limitations compared to all Medicare beneficiaries. In the Discussion section, we explore what pathways commonly lead beneficiaries to be enrolled in either just Part A or just Part B.

[§§] Characteristics of beneficiaries enrolled in both Parts A and B are presented in Table 3.

Table 2. Characteristics of Beneficiaries Enrolled in Medicare in 2019, by Program Part

Beneficiary Characteristics	Total Beneficiaries	FFS (Part A or B)	Part A Only	Part B Only	MA (Part C)
Total (in millions, weighted)	62.5	39.0	4.7	0.3	23.1
Income as % of Federal Poverty Level (FPL)					
<=100%	15.4%	13.9%	5.1%	77.6%	17.6%
>100-120	6.0%	4.9%	1.9%	12.1%	7.8%
>120 -135	3.9%	3.5%	1.9%	3.3%	4.5%
>135-200	15.6%	13.8%	8.5%	5.3%	18.7%
>200	59.1%	64.0%	82.5%	1.7%	51.4%
Reason for Medicare Eligibility					
Age 65 or Older	86.2%	85.4%	83.8%	100.0%	87.6%
Disabled	13.7%	14.5%	16.0%	0.0%	12.4%
ESRD only	0.1%	0.1%	0.1%	0.0%	0.0%
Age					
<65	13.7%	14.6%	16.2%	0.0%	12.4%
65-74	49.6%	50.8%	71.0%	49.5%	47.9%
75 and Older	36.7%	34.6%	12.9%	50.5%	39.6%
Race					
White (Non-Latino)	76.0%	79.3%	73.2%	27.6%	70.5%
Black (Non-Latino)	10.9%	9.2%	12.9%	28.4%	13.7%
Latino	7.4%	5.5%	6.6%	23.9%	10.6%
Other/Unknown	5.7%	6.0%	7.3%	20.2%	5.2%
Education					
Less than High School	14.0%	11.8%	5.1%	66.5%	17.5%
High School Graduate or Vocational	32.3%	31.5%	23.8%	16.0%	33.7%
Attended College	52.1%	55.2%	71.0%	13.3%	47.1%
Marital Status					
Married	51.0%	52.3%	67.0%	25.1%	49.2%
Not-married	48.9%	47.6%	33.0%	74.1%	50.6%
Sex					
Male	45.4%	46.6%	54.6%	27.7%	43.4%
Female	54.6%	53.4%	45.4%	72.3%	56.6%
Medicare-Medicaid Dual Enrollment					
Non-dual	82.5%	84.9%	99.4%	9.4%	79.9%
Dual	16.8%	15.1%	0.6%	90.6%	20.1%
Count of Activities of Daily Living (ADLs)					
0 ADL	67.6%	68.3%	76.9%	38.9%	67.7%
1 or 2 ADLs	16.6%	16.0%	15.4%	26.0%	18.0%
3+ ADLs	9.2%	9.3%	4.7%	21.3%	9.2%
Count of HCC Scores					
0	39.3%	44.6%	94.0%	26.3%	30.9%
1 or 2	32.8%	31.8%	3.1%	24.2%	35.0%
3+	27.9%	23.6%	2.9%	49.5%	34.2%

Notes: Analysis of the 2019 Medicare Current Beneficiary Survey (MCBS) linked to Medicare administrative data. Total Medicare beneficiaries included FFS Part A and B, Medicare Advantage, and a small percentage (less than 1 percent) of beneficiaries who were reported as deceased more than a month before their MCBS interview date (a proxy was utilized during the interview). HCC scores are Hierarchical Condition Category scores. The sample of total Medicare beneficiaries had 1.7% unknown education, 0.1% unknown marital status, and 6.6% unknown ADLs count.

Table 3 presents characteristics of Medicare beneficiaries enrolled in both FFS Parts A and B, by type of self-reported supplemental coverage.

Most beneficiaries with both Parts A and B coverage reported having supplemental coverage – either through self-purchased plans (32.9 percent), ESI (27.4 percent), Medicaid (17.6 percent), or other supplement (6.2 percent). In this analysis, self-purchased private plan is used as a proxy for Medigap/Medicare supplement plans. Nearly 16 percent of Medicare beneficiaries enrolled in both Parts A and B had no supplement. Notably, nearly half of Medicare beneficiaries with no supplemental coverage had incomes above 200% FPL.

Beneficiaries with a self-purchased private plan or ESI were more likely to report higher incomes, be White non-Latino, and have attended college; they were less likely to be dually enrolled or have multiple health conditions or functional limitations.

Beneficiaries with Medicaid or no supplemental coverage were more likely to be Black, covered by Medicare based on disability, and have functional limitations. In addition, those with Medicaid coverage were more likely to be Latino. A small share of those reported Medicaid coverage in the MCBS did not in fact have Medicaid based on administrative data.

Table 3. Supplemental Coverage and Demographic Characteristics Among Medicare FFS Beneficiaries in 2019

Beneficiary Characteristics	Part A and B					
	Overall	Self-purchased	ESI	Medicaid	Other	No Supplement
Total (in millions, weighted)	34.0	11.2	9.3	6.0	2.1	5.4
Income as % of Federal Poverty Level (FPL)						
<=100%	14.6%	3.4%	1.5%	60.6%	3.7%	12.9%
>100-120	5.2%	2.5%	0.8%	15.3%	2.2%	8.5%
>120 -135	3.7%	3.0%	1.1%	6.3%	2.0%	7.7%
>135-200	14.5%	16.1%	8.9%	11.3%	17.6%	23.5%
>200	61.9%	75.0%	87.7%	6.5%	74.5%	47.4%
Reason for Medicare Eligibility						
Age 65 or Older	85.5%	98.7%	93.2%	53.8%	87.1%	80.0%
Disabled	14.3%	1.3%	6.6%	45.8%	12.9%	20.0%
ESRD only	0.1%	0.0%	0.1%	0.4%	0.0%	0.0%
Age						
<65	14.4%	1.3%	6.8%	46.1%	12.9%	20.0%
65-74	48.1%	56.5%	53.0%	27.6%	40.1%	48.2%
75 and Older	37.5%	42.2%	40.2%	26.3%	47.0%	31.7%
Race						
White (Non-Latino)	80.6%	90.7%	85.1%	58.7%	80.3%	76.3%

Black (Non-Latino)	8.5%	3.0%	6.1%	18.9%	8.7%	12.6%
Latino	5.2%	2.0%	3.4%	14.6%	4.0%	5.1%
Other/Unknown	5.7%	4.3%	5.4%	7.7%	6.9%	6.0%
Education						
Less than High School	12.3%	6.7%	4.8%	32.1%	8.2%	16.4%
High School Graduate or Vocational	32.6%	31.0%	27.8%	39.1%	27.7%	39.1%
Attended College	53.3%	62.0%	67.3%	22.7%	61.6%	42.1%
Marital Status						
Married	50.5%	60.1%	65.0%	19.8%	54.3%	38.3%
Not-married	49.4%	39.8%	35.0%	79.8%	45.3%	61.6%
Sex						
Male	45.7%	42.2%	48.0%	43.1%	45.1%	52.1%
Female	54.3%	57.8%	52.0%	56.9%	54.9%	47.9%
Medicare-Medicaid Dual Enrollment						
Non-dual	83.5%	100.0%	100.0%	7.9%	99.8%	98.8%
Dual	16.5%	0.0%	0.0%	92.0%	0.2%	1.2%
Count of Activities of Daily Living (ADLs)						
0 ADL	67.4%	75.9%	75.7%	45.0%	62.0%	62.5%
1 or 2 ADLs	16.0%	15.0%	14.2%	19.2%	18.9%	16.0%
3+ ADLs	9.8%	5.8%	7.2%	19.3%	8.9%	12.3%
Count of HCC Scores						
0	38.0%	37.2%	39.8%	28.4%	35.4%	48.4%
1 or 2	36.6%	39.0%	38.0%	35.2%	33.1%	32.3%
3+	25.4%	23.7%	22.2%	36.4%	31.6%	19.4%

Notes: Analysis of the 2019 Medicare Current Beneficiary Survey (MCBS) linked to Medicare administrative data. Self-purchased private plan is a proxy for Medigap/Medicare supplement plans and includes self-purchased specialty plans. ESI is employer sponsored insurance, including ESI specialty plans. Other coverage includes Veteran's affairs plan, Tricare plan, other public plan, and other unknown insurance plan type. Some beneficiaries in the "other" group are facility residents with an ESI or a self-purchased plan. MCBS facility interviews are conducted with facility staff, rather than beneficiaries themselves. While staff members know whether a beneficiary is covered by a private plan, they may not know whether coverage is obtained through employment or self-purchase. Therefore, their responses are reported as "other". No-supplement is defined as no coverage by any of these types of coverage (self-purchased, ESI, Medicaid, or other). HCC scores are Hierarchical Condition Category scores. The sample of total Medicare Part A and B enrollees had 1.8% unknown education, 0.1% unknown marital status, and 6.9% unknown ADLs count.

5.7 million Medicare beneficiaries (9.1%)

had no drug coverage at all. Beneficiaries in this group were more likely to have lower incomes, have less than a college degree, be unmarried, and have multiple health conditions, compared to beneficiaries with private drug coverage.

Table 4 presents characteristics of beneficiaries by drug coverage. There were 46.5M beneficiaries (74.4 percent) enrolled in Part D, 1.8M (2.9 percent) enrolled in the retiree drug subsidy program, and 8.4M (13.4 percent) had private drug coverage. Overall, beneficiaries enrolled in PDP and MA-PD plans had similar characteristics. However, beneficiaries enrolled in MA-PD plans were more likely to be Black or Latino and have multiple health conditions.

5.7M beneficiaries (9.1 percent) had no drug coverage at all. Beneficiaries in this group were more likely to have lower incomes, have less than a college degree, be unmarried, and have multiple health conditions, compared to beneficiaries with private drug coverage.

Table 4. Characteristics of Medicare Beneficiaries by Drug Coverage Type, 2019

	Part D Eligible						
	Part D Enrollees				No Part D Enrollment		No Drug Coverage
	Overall	PDP	MA-PD	Other Part D Plan Types	Retiree Drug Subsidy	With Private Drug Coverage	
Total (in millions, weighted)	46.5	26.3	20.0	0.2	1.8	8.4	5.7
Income as % of Federal Poverty Level (FPL)							
<=100%	18.8%	18.3%	19.6%	1.9%	1.3%	2.3%	11.5%
>100-120	6.9%	5.6%	8.6%	0.0%	1.6%	0.7%	7.9%
>120 -135	4.2%	3.7%	4.8%	0.0%	1.8%	1.0%	6.9%
>135-200	16.3%	13.9%	19.7%	2.2%	9.9%	8.9%	21.4%
>200	53.9%	58.5%	47.3%	95.9%	85.4%	87.2%	52.2%
Reason for Medicare Eligibility							
Age 65 or Older	85.8%	85.6%	86.0%	99.3%	95.7%	86.8%	85.9%
Disabled	14.1%	14.3%	14.0%	0.7%	4.3%	13.1%	14.1%
ESRD only	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%
Age							
<65	14.2%	14.4%	14.0%	0.7%	4.3%	13.2%	14.1%
65-74	47.7%	47.6%	47.8%	62.9%	49.4%	58.8%	51.2%
75 and Older	38.1%	38.0%	38.2%	36.4%	46.3%	28.0%	34.6%
Race							
White (Non-Latino)	75.1%	80.1%	68.3%	88.0%	84.8%	78.5%	77.3%
Black (Non-Latino)	11.1%	8.6%	14.5%	2.9%	6.6%	10.3%	11.4%
Latino	8.3%	5.9%	11.6%	0.0%	3.5%	4.8%	5.2%

Other/Unknown	5.5%	5.4%	5.6%	9.1%	5.1%	6.5%	6.2%
Education							
Less than High School	15.9%	13.7%	19.0%	3.3%	6.4%	4.9%	13.8%
High School Graduate or Vocational	33.0%	32.7%	33.7%	18.3%	34.4%	23.9%	37.8%
Attended College	49.1%	51.5%	45.6%	78.4%	57.8%	70.9%	46.6%
Marital Status							
Married	48.9%	49.4%	48.1%	70.2%	58.6%	69.6%	38.0%
Not-married	50.9%	50.5%	51.7%	29.8%	41.3%	30.4%	61.8%
Sex							
Male	42.8%	42.2%	43.5%	49.0%	49.6%	49.8%	59.1%
Female	57.2%	57.8%	56.5%	51.0%	50.4%	50.2%	40.9%
Medicare-Medicaid Dual Enrollment							
Non-dual	77.5%	77.5%	77.3%	98.1%	99.0%	99.5%	92.3%
Dual	22.4%	22.4%	22.7%	1.9%	1.0%	0.5%	0.4%
Count of Activities of Daily Living (ADLs)							
0 ADL	66.8%	66.9%	66.7%	79.4%	73.2%	72.5%	65.1%
1 or 2 ADLs	16.7%	15.5%	18.4%	17.6%	14.7%	17.4%	14.4%
3+ ADLs	9.9%	10.1%	9.7%	1.6%	7.1%	7.5%	6.9%
Count of HCC Scores							
0	32.4%	34.3%	29.8%	31.8%	38.1%	63.4%	60.8%
1 or 2	37.2%	38.0%	35.8%	52.2%	39.0%	21.4%	21.4%
3+	30.5%	27.6%	34.5%	16.0%	22.9%	15.2%	17.7%

Notes: Analysis of the 2019 Medicare Current Beneficiary Survey (MCBS) linked to Medicare administrative data. PDP is Medicare prescription drug plan, and MA-PD is Medicare Advantage prescription drug plan. HCC scores are Hierarchical Condition Category scores. The sample of total Medicare Part D enrollees had 1.9% unknown education, 0.1% unknown marital status, and 6.5% unknown ADLs count.

DISCUSSION

Of the 62.5 million beneficiaries enrolled in Medicare in 2019, approximately 39 million (62.3 percent) had FFS Part A or B coverage and 23.1 million (37.0 percent) had MA coverage. Enrollment in MA has been increasing over time and was 43.6 percent in 2021, this number is expected to continue to grow.[3,4] MA enrollees were more likely than FFS enrollees to be Black or Latino and were also disproportionally lower-income, dually enrolled, and had a higher number of health conditions. However, this worse apparent health status among MA beneficiaries likely reflects at least in part higher rates of coding health conditions in MA data compared to FFS data ("coding intensity").[8]

Approximately 4.7 million beneficiaries (7.5 percent) were enrolled in Part A only, while only 260,000 beneficiaries (0.4 percent) were enrolled in Part B only. Beneficiaries only enrolled in Part A were disproportionately higher income, White, college-educated, without Medicaid coverage, and in better health. One common population enrolled only in Part A is individuals who continue to work after turning 65. If these individuals have ESI, that would generally be the primary payer; since these employees will not be required to

pay premiums for Part A coverage, they enroll in Part A only until they lose their ESI upon retirement. Consistent with this explanation, the percentage of aged enrollees who have only Part A declines with age.*

Beneficiaries with only Part B are all older than 65 and generally have not worked enough quarters in the U.S. to be eligible for subsidized Part A coverage. If these beneficiaries chose to enroll in Part A, they would have to pay $471 per month ($5,652 per year) in 2021.[9] One population enrolled only in Part B are individuals who immigrated to the U.S. late in their working career or after retirement. After five years of legal permanent residence (i.e., "green card") in the U.S., they are eligible to enroll in Part B like U.S. citizens 65 and older, but may find Part A premiums unaffordable.

Most beneficiaries with both Parts A and B coverage (nearly half of total beneficiaries) had supplemental coverage through self-purchased plans, ESI, Medicaid, or another supplement, while nearly 9 percent had no supplement. Beneficiaries with a self-purchased private plan or ESI were more likely to report higher incomes, be White, and have attended college; they were less likely to be dually enrolled or have multiple health conditions or functional limitations. Beneficiaries without any supplemental coverage were more likely to be Black, covered by Medicare based on disability, and have functional limitations. Those without supplemental coverage can face significant cost-sharing (20 percent or more on average, especially because there isn't an out-of-pocket cap), raising important concerns about inequitable access to financial protection for these populations. Nearly half (2.6 million) of Medicare beneficiaries with no supplemental coverage had incomes above 200% FPL, which suggests cost-sharing in Medicare may present affordability challenges even in middle-income families.

46.5M (74.4 percent) of beneficiaries had Part D coverage. Enrollment in Part D plans roughly equally divided between PDP and MA-PD, with similar characteristics of enrollees in both groups. However, beneficiaries enrolled in MA Prescription Drug plans were more likely to be Black or Latino and have multiple health conditions — which again may reflect higher MA coding intensity.

Nearly 1.8M beneficiaries (2.9 percent) were covered by the retiree drug subsidy program, and 8.4M beneficiaries (13.4 percent) had private drug coverage. About 5.7M beneficiaries (9.1 percent) had no drug coverage at all. This percent is slightly lower than the projection reported by the Medicare Payment Advisory Commission (MedPAC) that 12 percent of Medicare beneficiaries would have no drug coverage in 2021; the differences are likely due to using alternative data sources and timeframe.[10] We found that beneficiaries who did not have any drug coverage were more likely to have lower incomes, have less than a college degree, be unmarried, and have multiple health conditions, compared to beneficiaries with private drug coverage.

Medicare plays a critical role in providing health coverage and access to care for the nation's seniors and people with disabilities or end-stage renal disease. Examining the demographic characteristics and medical conditions of Medicare beneficiaries enrolled in the different Parts of Medicare is important to identifying these groups and better addressing their needs.

* Among 65-year-olds in 2020, 22% of beneficiaries had only Part A (or only Part B). This percentage falls to 10% for 70-year-olds and 4% for 80-year-olds. Source: ASPE's analysis of data with 100% of Medicare enrollment.

REFERENCES

1. Congressional Research Service. Medicare Part D Prescription Drug Benefit. 2020; https://crsreports.congress.gov/product/pdf/R/R40611. Accessed January 28, 2022.
2. Freed M, Fuglesten Biniek, J, Damico, A, Neuman, T. Medicare advantage in 2021: enrollment update and key trends. 2021; https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/. Accessed September 8, 2021.
3. Centers for Medicare and Medicaid Services. 2021 Annual Report of The Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2021; https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf. Accessed November 22, 2021.
4. Centers for Medicare and Medicaid Services. Medicare Monthly Enrollment. 2021; https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment. Accessed January 14, 2022.
5. Congressional Budget Office. Medicare Baseline Projections. 2021; https://www.cbo.gov/system/files/2021-07/51302-2021-07-medicare.pdf. Accessed January 14, 2022.
6. Centers for Medicare and Medicaid Services. Medicare Current Beneficiary Survey (MCBS). 2017; https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/index.html?redirect=/MCBS/. Accessed June, 1, 2017.
7. Centers for Medicare and Medicaid Services. Potential Updates to HHS-HCCs for the HHS-operated Risk Adjustment Program 2019; https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf. Accessed January 14, 2022.
8. MedPAC. Rebalancing Medicare Advantage benchmark policy. 2021; https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_ch1_medpac_report_to_congress_sec.pdf. Accessed February 7, 2022.
9. Centers for Medicare and Medicaid Services. 2021 Medicare Parts A & B Premiums and Deductibles. 2020; https://www.cms.gov/newsroom/fact-sheets/2021-medicare-parts-b-premiums-and-deductibles. Accessed January 14, 2022.
10. MedPAC. July 2021 Data Book: Health Care Spending and the Medicare Program, Section 10: Prescription Drugs. 2021; https://www.medpac.gov/document/http-medpac-gov-docs-default-source-data-book-july2021_medpac_databook_sec-pdf/. Accessed January 14, 2022.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Assistant Secretary for Planning and Evaluation
200 Independence Avenue SW, Mailstop 447D
Washington, D.C. 20201

For more ASPE briefs and other publications, visit:
aspe.hhs.gov/reports

ABOUT THE AUTHORS

Wafa Tarazi is a Health Economist in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation. **W. Pete Welch** is a Senior Analyst in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation. **Nguyen Nguyen** is a Senior Economist in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation. **Arielle Bosworth** is an Economist in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation. **Steven Sheingold** is the Director of Healthcare Financing Policy in the Office of Health Policy in the Office of Assistant Secretary for Planning and Evaluation. **Nancy De Lew** is the Associate Deputy Assistant Secretary of the Office of Health Policy in the Office of Assistant Secretary for Planning and Evaluation. **Benjamin D. Sommers** is the Deputy Assistant Secretary of the Office of Health Policy in the Office of Assistant Secretary for Planning and Evaluation.
The authors are grateful to the contributions of Acumen LLC to the analysis of this report

SUGGESTED CITATION

Tarazi, W., Welch, WP., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., and Sommers, BD. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. (Issue Brief No. HP-2022-08). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2022.

COPYRIGHT INFORMATION

DISCLOSURE

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

Subscribe to ASPE mailing list to receive email updates on new publications:
https://list.nih.gov/cgi-bin/wa.exe?SUBED1=ASPE-HEALTH-POLICY&A=1

For general questions or general information about ASPE:
aspe.hhs.gov/about

EXHIBIT 15

Monopolization Defined

The antitrust laws prohibit conduct by a single firm that unreasonably restrains competition by creating or maintaining monopoly power. Most Section 2 claims involve the conduct of a firm with a leading market position, although Section 2 of the Sherman Act also bans attempts to monopolize and conspiracies to monopolize. As a first step, courts ask if the firm has "monopoly power" in any market. This requires in-depth study of the products sold by the leading firm, and any alternative products consumers may turn to if the firm attempted to raise prices. Then courts ask if that leading position was gained or maintained through improper conduct—that is, something other than merely having a better product, superior management or historic accident. Here courts evaluate the anticompetitiv effects of the conduct and its procompetitive justifications.

Market Power

Courts do not require a literal monopoly before applying rules for single firm conduct; that term is used as shorthand for a firm with significant and durable market power — that is, the long term ability to raise price or exclude competitors. That is how that term is used here: a "monopolist" is a firm with significant and durable market power. Courts look at the firm's market share, but typically do not find monopoly power if the firm (or a group of firms acting in concert) has less than 50 percent of the sales of a particular product or service within a certain geographic area. Some courts have required much higher percentages. In addition, that leading position must be sustainable over time: if competitive forces or the entry of new firms could discipline the conduct of the leading firm, courts are unlikely to find that the firm has lasting market power.

Exclusionary Conduct

Judging the conduct of an alleged monopolist requires an in-depth analysis of the market and the means used to achieve or maintain the monopoly. Obtaining a monopoly by superior products,

innovation, or business acumen is legal; however, the same result achieved by exclusionary or predatory acts may raise antitrust concerns.

Exclusionary or predatory acts may include such things as exclusive supply or purchase agreements; tying; predatory pricing; or refusal to deal. These topics are discussed in separate Fact Sheets for Single Firm Conduct.

Business Justification

Finally, the monopolist may have a legitimate business justification for behaving in a way that prevents other firms from succeeding in the marketplace. For instance, the monopolist may be competing on the merits in a way that benefits consumers through greater efficiency or a unique set of products or services. In the end, courts will decide whether the monopolist's success is due to "the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident."

Example: The Microsoft Case

Microsoft was found to have a monopoly over operating systems software for IBM-compatible personal computers. Microsoft was able to use its dominant position in the operating systems mar to exclude other software developers and prevent computer makers from installing non-Microsoft browser software to run with Microsoft's operating system software. Specifically, Microsoft illegally maintained its operating systems monopoly by including Internet Explorer, the Microsoft Internet browser, with every copy of its Windows operating system software sold to computer makers, and making it technically difficult not to use its browser or to use a non-Microsoft browser. Microsoft also granted free licenses or rebates to use its software, which discouraged other software developers from promoting a non-Microsoft browser or developing other software based on that browser. These actions hampered efforts by computer makers to use or promote competing browsers, and discouraged the development of add-on software that was compatible with non-Microsoft browsers. The court found that, although Microsoft did not tie up all ways of competing, its actions did prevent rivals from using the lowest-cost means of taking market share away from Microsoft. To settle the case, Microsoft agreed to end certain conduct that was preventing the development of competing browser software.

Previous:
Exclusive Supply or Purchase Agreements

Up

Next:
Predatory or Below-Cost Pricing