

LEAPS

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Patient-centered, Sustainable innovation



DESIGN LAB BRIEFING

Value-Based Contracts for Accelerated Approval products

June 2023

CONFIDENTIAL

Executive summary

The information contained in this briefing book is divided into three sections 1) Product Description, 2) Context/Background, and 3) Challenges to Address, with preliminary solutions. The product description will include development status, population effect size, market authorization, and other cure characteristics.

Target Area Group: Products that receive Accelerated Approval Program (AAP) market entry.

Design Lab Date: June 2023

Product: Astrotuminib (synthetic oncology case)

Key Questions: How can Value-Based Contracts (VBCs) help resolve the key challenges AAP-approved products present for patient access, payer value assessments, and regulatory confirmatory evidence?

Financing Challenge(s) and Proposed Solution(s): AAP-approved products use surrogate endpoints for clinical benefit and often have relatively small trials and shorter-term readouts. While the AAP approval grants commercial approval for a labelled indication, it also requires confirmatory clinical trials to be run, where a clinical benefit endpoint is investigated. The clinical evidence at time of launch is therefore uncertain and payers find it difficult to assess financial value for their coverage and reimbursement decisions. As a result, payers may restrict patient access, seek price reductions, or even deny coverage entirely.

This case does not focus primarily on the structure of a Value-Based Contract (VBC) but whether VBCs can 1) Address the value uncertainties perceived by payers [enabling patient access], 2) Inform the value-setting process [Payer Value Assessments (PVA)] itself, and 3) Contribute to the regulatory totality of evidence.

Breakout Group structured discussions will address the following areas:

Breakout 1: Patient Access Impact







Breakout 2: Payer Value Assessment (PVA) Impact

Breakouts 3 & 4: Contribution to Regulatory Totality of Evidence

Astrotuminib product description

Our synthetic oncology case study will address “Astrorenoma”, a malignant tumor of the kidney, affecting men and women equally, at a rate of approximately 1 in 30,000 people in the United States. Astrorenoma generally attacks both kidneys simultaneously and later metastasis primarily attacks the brain. Because both kidneys are impacted together and because Astrorenoma is not related to renal cell carcinoma, the current standard of care is kidney removal and transplant. After surgery, patients are placed on long-term dialysis (always for bilateral nephrectomies, often for patients with unilateral nephrectomies). Patients may then become eligible for transplant after 5 years of observation for recurrence in other organs.

Patients most often face disease onset at 35-65 years of age. While the objective would be to diagnose early, most patients progress to bilateral disease and frank hematuria prior to confirmation by biopsy. In early stages, it presents as micro-hematuria and often goes undetected unless urine samples are taken for other purposes. Even then, micro-hematuria is often disregarded if less than 10 cells per hpf, delaying diagnosis. It has been challenging to identify targeted diagnostics for Astrorenoma and liquid tumor assays have also been unsuccessful in identifying patients early in the disease progression. A high degree of morphologic and molecular characteristics have challenged the development of targeted therapies.

Astrotuminib for Astrorenoma	
	<p>Condition</p> <ul style="list-style-type: none"> • Malignant tumor of the kidney, unrelated to renal cell carcinoma • Propensity for occurring in both kidneys or early metastasis • Late metastasis to brain primarily • Current standard of care is kidney removal/transplant
	<p>Population</p> <ul style="list-style-type: none"> ▪ Onset at 35-65 years old, gender agnostic ▪ Commercial insurer population ▪ Prevalence in this population is 1 in 30,000
	<p>Product</p> <ul style="list-style-type: none"> ▪ Daily, oral small molecule targeting the “Metaphor Pathway” ▪ Approved on an accelerated basis ▪ Used as first line treatment
	<p>Clinical Evidence</p> <ul style="list-style-type: none"> ▪ 40-55 years old with involvement of a single kidney; no metastasis ▪ Responses split between dramatic responders (30% sub-population) with 24-month PFS and non-responders (70%) ▪ Possibility of preventing life-long dialysis or transplant ▪ No history of heart disease
	<p>Label</p> <ul style="list-style-type: none"> ▪ Any patients with Astrorenoma with no metastasis ▪ Any age ▪ Involvement of both kidneys
	<p>Payer Segmentation, Coverage & VBC</p> <ul style="list-style-type: none"> ▪ Commercial population (majority of patients in commercial insurance, including ACA) ▪ Price set at \$240K/year, \$20K/month, in use as first-line therapy ▪ The VBC would track discontinuation at <24 months and provides a pro-rata performance rebate of total net spend (100% if discontinued in months 1-3, with linear reduction to 0% if discontinued in month 24).

Clinical Evidence of Benefits and Harms

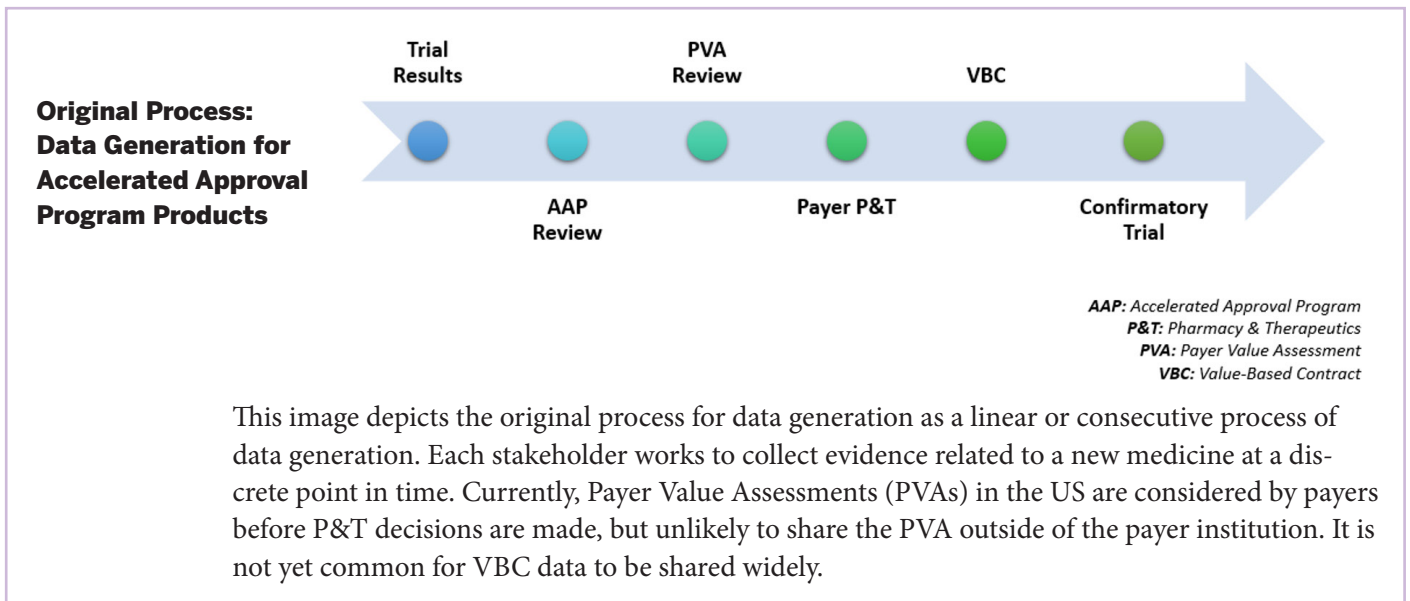
Astrotuminib was awarded orphan drug status and granted AAP approval. Early trials have been promising but are split between dramatic responders (30% subpopulation) with Progression Free Survival (PFS) at 24-months, and non-responders (70%) of the small population treated to date, with no clear identifying characteristics between the two groups. However, the possibility of preventing life-long dialysis or transplant has spurred early release and plans for capturing

Real-World Evidence (RWE) for Astrorenoma patients. It is expected that Astrorenoma will be the first of multiple indications for this tumor agnostic drug, Astrotuminib. Therapy has less toxicity than the current standard of care, allowing for an earlier return to work timeframe.

Payer Segmentation, Coverage, and Value-Based Contract (VBC)

The VBC tracks discontinuation at <24 months and provides a pro-rata performance rebate of total net spend (100% if discontinued in months 1-3, with linear reduction to 0% if discontinued in month 24). The VBC parameters would be agreed to by both developers and private payers, with some differences in populations versus the clinical evidence available at time of launch.

The commercial population, which includes the majority of patients in commercial insurance, including ACA, would have a price set at \$240K/year, \$20K/month, in use as first-line therapy. VBC data would be available in real time so that payments reflect specific patient outcomes, and the accumulated picture over time will inform developers and payers about actual per patient costs. Such information is especially useful when early diagnosis is a challenge, and where markers to identify responders/non-responders are not possible.



Motivation and context/background

Value-Based Contracts as Evidence Generation Opportunities

At the time of market authorization and especially for products that receive Accelerated Approval, key stakeholders, including payers, providers, regulators, patients, and Payer Value Assessments departments, are making decisions based on registrational clinical trial safety and efficacy data that typically do not reflect the real-world outcomes of the patients receiving the product. While the AAP was initiated to ensure early patient access, investigations have shown that the assumed benefit is often left unproven, prompting payers, providers, and patients to resist the opportunity to use these medicines. As a result, patient access is impeded.

With AAP-approved products, the FDA has agreed that surrogate endpoints in oncology are stable predictors of clinical benefit¹ recognizing that cancer patients face life-threatening needs.

The FDA guidance has been updated to ensure that developers design and initiate confirmatory clinical trials at the time of Accelerated Approval to allow for clear post-marketing data development that is efficiently produced and will verify clinical benefit.

Despite the FDA's procedural advancements, the data available at the launch of AAP products leaves stakeholders with questions regarding the value these products will bring to patients. For payers and developers in particular, Value-Based Contracts (VBCs) can mitigate these uncertainties in the initial coverage decisions because Real-World Data (RWD), with agreed-upon value outcomes, will be collected and assessed. That data serves as the basis for the payment structure, satisfying stakeholders' need to know that they are treating patients with products that help them, and that the products are rewarded based on the value they bring. Because VBCs usually run for no more than 24 months, it is reasonable to assume that the VBC structure in a second iteration would change, according to what is learned about the products' value from the first VBC.

For this case study, we assert that the data developed from VBCs can support PVA deliberations and contribute to the regulatory totality of evidence, building early support for appropriate patient

The Accelerated Approval Program & recent updates

In 1992, the US FDA initiated an Accelerated Approval Program (AAP) to address concerns that new medicines for diseases without adequate therapies were not reaching patients quickly enough. Since that time, the FDA's Center for Drug Evaluation and Research (CDER) has approved 278 new medicines via the AAP¹. The pace of AAP approvals has increased over time, with a quarter of these approvals (70 drugs) granted between 2020-2021.

Through the AAP, medicines that have shown promise to advance care are allowed to go to market with data limited to surrogate endpoints, and an agreement that confirmatory trials would be conducted after market entry to confirm clinical benefit. The confirmatory trials have been a consistent feature of the AAP agreement between CDER and manufactures.

Unfortunately, 1/3 of all AAP-approved medicines (104 drugs) have not completed the confirmatory trials in the agreed upon timeframes. According to the Office of Inspector General report estimates, Medicare and Medicaid spent more than \$18 billion for AAP-approved drugs with incomplete confirmatory trials between 2018-2020².

There are many reasons why confirmatory trials are so difficult to complete, including limited incentives for patients to join the trials, insufficient resource allocation by manufacturers (or transfer of ownership of a drug), and insurer's interest in negotiating additional endpoints to be included in the confirmatory trials³. In response, the FDA has initiated specific changes to the AAP in December of 2022 under the Consolidated Appropriations Act, including:

1. A mandate that confirmatory trials are underway prior to AAP approval decisions.
2. A more streamlined process to take drugs off the market if clinical benefit is not proven.

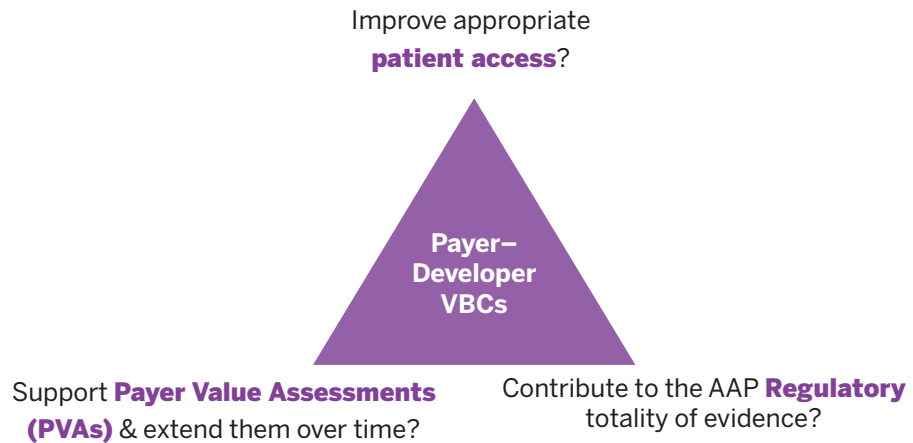
¹ U.S Dept. of Health and Human Services, Office of Inspector General, Data Snapshot. "Delays in Confirmatory Trials for Drug Applications Granted FDA's Accelerated Approval Raise Concerns" September 2022 OEI-01-21-00401, p.1.

² Ibid., p.5.

³ Kaltenboeck, A., et al, "Strengthening the Accelerated Approval Pathway: An Analysis of Potential Policy Reforms and Their Impact on Uncertainty, Access Innovation and Costs," Institute for Clinical and Economic Review White Paper, April 26, 2021. (Accessed online March 23, 2023), p.18-22.

¹ See FDA News Release, March 25, 2023, "FDA Issues Draft Guidance Aimed at Improving Oncology Clinical trials for Accelerated Approval," <https://www.fda.gov/news-events/press-announcements/fda-issues-draft-guidance-aimed-improving-oncology-clinical-trials-accelerated-approval>. Accessed Jun 6, 2023.

access to these new medicines. Particularly now, as the FDA guidelines for the AAP have become more defined, this case study can shed light on the complexity of data that VBCs can contribute and how that data might be used more broadly to support patient access.



The breakout group discussions for this case study are centered around three key questions exploring the following topics in more depth:

Question 1: Can VBC outcomes data improve appropriate patient access of Accelerated Approval medicines?

Astrorenoma is a life-threatening disease that is hard to diagnose early enough to save patients' kidneys. Astrotuminib has been granted an Accelerated Approval as an orphan drug to treat Astrorenoma, based on early trial data but responders and non-responders are difficult to differentiate prior to drug use. Those who do respond (30%) see dramatic improvement, with progression-free survival at 24 months. Patients facing this disease are eager for new treatments, but payers are understandably concerned that if they pay for Astrotuminib for all patients, knowing that not all will respond, the costs will outweigh the value provided.

We will examine whether VBCs can impact appropriate patient access during the gap between accelerated approval and confirmatory trial evidence review. The AAP authorizes access for small patient populations that have a high unmet need for treatment. Yet, these conditions themselves create challenges for developing a timely and robust data package. In this breakout group discussion, we will explore whether the data generated by VBCs can:

- Inform the use of AAP-approved products by understanding the outcomes in RW context.
- Address coverage and reimbursement uncertainty for patients outside the clinical inclusion/exclusion criteria, but within the labeled indication.
- Reduce Medicaid and legislative desire to restrict AAP-approved drug access.
- Improve patient care directly by using evidence in the care setting.

Question 2: Can VBC outcomes data support PVAs and extend them over time?

Astrotuminib will come to market when the data available is limited, and before confirmatory trials are complete. In general, the Payer Value Assessment process relies on the data available

from clinical trials. However, in this case, Astrotuminib will not have a robust data portfolio upon which the initial PVA review would be able to produce a long-lasting report on the product.

We will examine whether VBCs can generate outcomes data that could support subsequent PVA recommendations. In this breakout, we will explore how PVA approaches, outputs, and timing (real time and iterative) might change to incorporate the VBC data in the Astrotuminib case. In this breakout group discussion, we will explore how the data generated in VBCs can:

- Encourage methodological changes in the PVA process that a) recognize patient heterogeneity and b) shift from audit-based to prospective reviews.
- Encourage earlier PVA processes so that they can influence the endpoints of confirmatory trials and provide assessments that are more helpful to stakeholders.
- Prompt a shift to a system of more iterative PVA assessments that take place early, and more often, in response to new data generation.
- Explore how subsequent VBC rounds might evolve to address Payer Value Assessments.

Question 3: Can VBC outcomes data contribute to the AAP regulatory totality of evidence?

Astrotuminib will come to market with an indication that suggests improvement versus standard of care for patients suffering from Astrorenoma. In line with the updated process for AAP-approved products, the developer will have initiated a confirmatory trial as part of the approval process for this orphan cancer product. Therefore, the endpoints for the confirmatory trial will have been agreed upon at the time of launch. However, the confirmatory trial will take years to conduct and review. With shorter term horizons and an easily collected endpoint, VBCs will produce data about Astrotuminib performance in real-world settings.

We will examine whether VBCs using available clinical outcomes reporting can contribute to the totality of evidence, particularly in the case of AAP-approved medicines. In this breakout group discussion, we will explore how VBC-generated data can:

- Highlight the value of VBC-generated outcomes data.
- Enhance integrated evidence development plans by including VBC-generated outcomes data.
- Encourage patient-centric endpoint selection.
- Contribute to the data provided for label extension uses.

Challenges that value-based contracts address (elucidation & preliminary solutions)

Patient access

The Accelerated Approval Program (AAP) was initiated to enable early patient access to therapies addressing a serious unmet medical need. These products are coming to market early without the full evidence of clinical benefit, leading some payers to resist covering AAP-approved medicines, limiting patient access. As stated above, investigations have shown that the assumed benefit is

often left unproven, despite the high price tag for these medicines. A process originally put in place to expand patient access to care may in fact impede patient access because evidence of value is lacking.

The FDA has moved to ensure that the post-marketing confirmatory trials are underway at the time of granting Accelerated Approval and that there is a clear Program to take medicines off the market that do not prove clinical benefit. Yet patients don't want to wait, and they may not have to: It is possible that more controlled payment contracts—those structured to measure and reward value—will lessen the uncertainty around value earlier for payers, encouraging coverage for patients, and reimbursement for providers.

Topics for breakout discussions:

- In the short-term, the structure and use of a VBC could improve coverage for patients because payers would be more confident that they will be paying for a defined value benefit.
 - Could Astrotuminib VBC patient discontinuation outcomes data increase confidence regarding the coverage for patients meeting the FDA labeled indication but falling outside the supporting clinical trial inclusion and exclusion criteria, such as co-morbidities, age, severity, etc.?
- As VBC data becomes more broadly used, Astrotuminib VBC patient discontinuation outcomes data could refine care regimens within both labeled indication and clinical trial populations.
 - Could VBC data refine the patient populations treated as more outcomes are reported?
- VBCs have the potential to transform the infrastructure of patient outcomes reporting and the sharing of VBC-generated data.
 - What institutional or systemic changes would have to occur to support such a transformation? How could private payer VBC data be shared in the new system?
- In the mid-term, ongoing VBC data generation could be leveraged to balance clinical management with patient access.
 - With a VBC in place, could payers actually change utilization management, either with step therapy approaches or restrictions based on the RWD they obtain from the VBC?
- In a perpetual learning environment, second- and third-generation VBC data development could be managed to mitigate the patient burden related to reporting processes.
 - Could VBCs between developers and payers leverage patient-reported outcomes data?

Payer Value Assessment (PVA) Implications

While Health Technology Assessments are not a “fourth hurdle” to market in the US, Payer Value Assessments and Pharmacy & Therapeutic (P&T) committees combine to impact payer coverage decisions/patient access and pricing negotiations/decisions. For AAP-approved products where data is limited at launch, the PVA processes would benefit from additional RWD, especially where variations in response to a treatment are documented.

The data generated in VBCs can potentially reset the balance between uncertainty and access for AAP-approved medicines. The development and use of value evidence creates an opportunity to apply a real-world context to AAP-approved products. The VBC terms also ensure that patients have received the value that the VBC has measured and both parties are satisfied that payments reflect that value. VBCs can resolve uncertainty post facto, with ongoing data generation.

For this case study, our challenge is to consider how VBC outcomes data might impact the PVA process. If VBCs are generating data to confirm the value, what opportunity can be developed to incorporate VBC data into future PVA reviews? Are the value measures in a VBC more relevant to the patient experience than the evidence from confirmatory trials and the early trials that currently inform the PVA review? For example, are Progression-Free Survival (PFS) or Overall Survival (OS) measures as relevant for patient Quality of Life (QoL) as discontinuation might be (i.e., discontinuation identifies patients that cannot tolerate the medicine, thus more immediately measuring patient benefit)?

Topics for breakout discussions:

- As VBCs endeavor to clarify value, there would be less need to debate the uncertainty of the “projected value” and level of existing evidence for AAP-approved products, requiring a shift of PVA methods to focus on the outcome metrics. For example, personalized reimbursement would recognize patient heterogeneity, allowing for variation in the value assessment and in payments.
 - For Astrotuminib with VBCs using a patient discontinuation outcome metric, how might PVA processes connect to other stakeholders and their decisions?
- VBCs are structured to provide ongoing evidence, thus leading PVA processes into iterative assessment cycles as new evidence are compiled.
 - For Astrotuminib with VBCs using a patient discontinuation outcome metric, what might be the impacts on initial assessments, and then future adjustments?
- Payer Value Assessment departments would require procedural changes if they were to accept the ongoing generation of VBC data.
 - How might AAP-approved products shift how value is defined and measured?
 - Will PVAs be able to reconsider their own value assessment process and adapt?
 - Will PVA decision-makers have an impact on second- and third-generation VBC design?
- VBC data can benefit additional stakeholders, but the ability to navigate contract privacy concerns and the implications of more transparency with VBC data (e.g., sharing with the FDA for AAP-approved products) needs to be explored.
 - While the VBC structures have become more transparent, how would developers react to transparency re: outcomes? How might payers react?
 - How might VBC developers and payers embrace more transparency of their data?

Regulatory Totality of Evidence

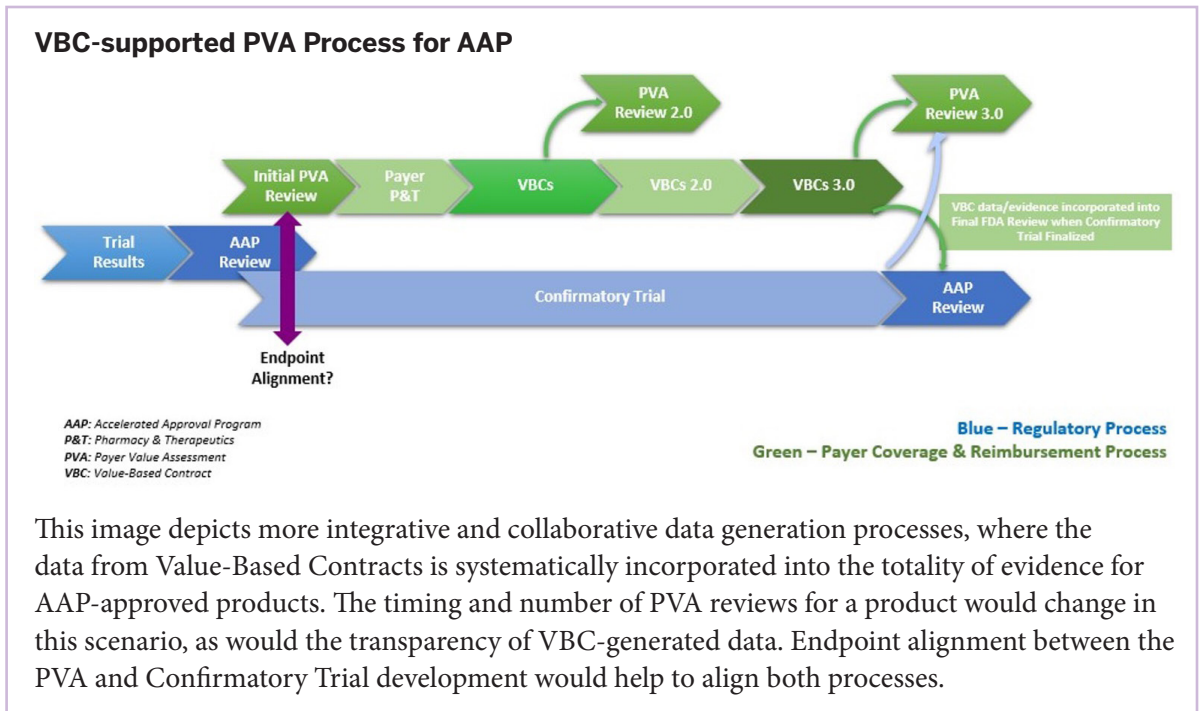
CMS and other payers have proposed to limit payments, restricting patient covered populations or delay access to AAP-approved medicines out of concern that the clinical benefit is unproven.

With the renewed focus on the need for evidence of value, there is an opportunity to reassess the data required to prove that a product can meet expected benefit thresholds for patients. Currently, the results of VBCs must be reported to the FDA, but the review of that data is not considered in the context of the broader totality of evidence that falls under regulatory responsibilities.

As AAP-approved products reach the market, VBCs in and of themselves encourage appropriate patient access for the population included in the VBC, because payers contract to pay for medicines when they live up to the contracted value assessment. VBCs also provide that data in an efficient, timely manner, albeit with privacy agreements in place related to contract terms and the patient data developed. Nonetheless, it is feasible to assert that VBC-generated data could be used to satisfy other data requirements, as part of a totality of evidence required for regulatory assessments. Can such uses of this data be explored, while upholding the utility of the VBC data generation process for its original purpose?

Topics for breakout discussions:

- For Astrotuminib with VBCs using a patient discontinuation outcome metric with associated claims information about the patients, what might be learned, if anything, that could contribute to “the totality of evidence”?
 - How would such structures differ between payer types (i.e., IDNs with internal visibility vs. smaller payers with timing delays)?
- Who might use Astrotuminib VBC discontinuation data and for what purpose? Assume that the VBC data will be available years prior to the confirmatory trial read-outs.
 - What stakeholders would have to be involved and in what capacity?
 - How can VBC-generated data satisfy their original contracted goals, while also contributing to the regulatory totality of evidence?
- VBC data can benefit additional stakeholders, but the ability to navigate contract privacy concerns and the implications of more transparency with VBC data (e.g., sharing with the FDA for AAP-approved products) needs to be explored.
 - While the VBC structures have become more transparent, how would developers react to transparency re: outcomes? How might payers react?
- VBC-generated outcomes data can be brought to regulatory evidence discussions but may require meta-analysis across VBC results.
 - What structural changes might be required to support multi-VBC, multi-institution studies?



Appendix: Value-Based Contracts review

Value-Based Contracts (VBCs) between payers and developers provide a structure where both parties agree on specific definitions of value and invest in methods to measure that value. Payments are tied to the specific health outcomes, ensuring that patient health is central to the contract terms. VBCs require tools in place to define and track health benefits (e.g., Electronic Health Records, claims data, patient-reported outcomes, etc.) that are efficient and effective so that the VBC is not cumbersome, nor a significant added expense.

Initiated in 2016, the NEWDIGS FoCUS consortium has investigated new, innovative financing and reimbursement models in the United States that will ensure patient access and establish sustainable financing solutions that work across stakeholder groups. Over the past 7 years, the FoCUS work has contributed to our understanding of how multiple stakeholders (payers, providers, patient advocacy organization, pharmaceutical developers, academics, and others) can reach new levels of collaboration and success when key dimensions of risk are addressed from multiple stakeholder perspectives.

While no one VBC can resolve all financing risks, FoCUS Design Lab workshops consolidated a list of the highest potential solutions. These precision financing solutions are utilized based upon a payer’s assessment of the specific therapy and their organizational needs. Table 1 below outlines 8 high potential solutions that can improve patient access and address financial sustainability, with a focus on the specific risks that are addressed with each tool (payment timing, performance, and actuarial risk).

In addition to analyzing current individual financing tools, the FoCUS program proposed a new service solution to payers who are not able to build internal capabilities to manage durable gene and cell therapies. The Orphan Reinsurer and Benefit Manager (ORBM) combines the risk-bear-

ing of reinsurers with the therapy contracting capabilities of pharmacy benefit managers, the provider network-building and medical management capabilities of insurers, and perhaps a specialty pharmacy distribution capability. This new service solution would be able to address performance, payment timing and actuarial risks, as well as executional risk. ORBM organizations can help facilitate access to durable, curative therapies by using precision financing solutions.

Table 1: FoCUS Workshops Precision Financing Solutions Summary

Precision Financing Solution	Performance Risk	Partial Risk Mitigation
Milestone-based Contracts	Upfront payments, developers obligated to pay refunds if patient performance milestones/outcomes are not met. Timing: <1 year	
Multi-year Milestone-based Contracts	Upfront payments, developers obligated to pay refunds if patient performance milestones/outcomes are not met. Timing: >1 year. Longer contracts fit better when a therapy’s value is demonstrated over a long time period. More complicated tracking procedures are required.	
Performance-based Annuities	Upfront payments for part of the price of therapy, with commitment to periodic payments once performance milestones/outcomes are met. Timing: >1 year.	Partially mitigates actuarial risk. Smooths payment timing
Warranty	A developer would provide an insurance product that reimburses payers for other drug /medical costs if a product does not provide expected outcomes. Coverage would be on a named patient basis. Timing: >1 year.	
Payment Timing		
Payment over Time/ Installment Financing	Payment for a treatment over multiple years, not in one upfront payment. Timing: requires payers to be able to sign contracts for periods >1 year.	Partially mitigates actuarial risk
Actuarial Risk		
Subscription	Provides a fixed fee for either a target level or unlimited supply of a treatment during a period of time, limiting actuarial uncertainty for the payer.	Manages total budgetary costs
Reinsurance/Stop Loss insurance	Agreements where insurance companies have insurance to reduce the impact of unexpected high costs for a patient or group of patients. Stop Loss insurance is a product that provides protection against unpredictable costs for a patient above a threshold. These products are multi-year contracts, in response to durable therapies.	
Risk Pools	Where federal or state programs cover insurance products in which a premium is set and paid for coverage of a defined treatment for a group, to create cost predictability	

**For more information on Precision Financing solutions:
Toolkit Overview: Precision Financing Solutions | NEWDIGS (tuftsmedicalcenter.org)**

For this AAP case study, the FoCUS work provides a strong foundation from which VBCs can be investigated for their contribution to medicines that reach the market via AAP. VBCs in this case study focus on those between payers and developers, where some of the challenges are the same: to ensure patient access to new medicines and to provide sustainable financial solutions. In addition, the AAP Case Study will also explore how VBCs can support PVA decisions and contribute to the regulatory totality of evidence.

With these objectives in mind, we will assume that VBCs can enhance the success of AAP-approved medicines. Our June 2023 Design Lab will dig deeper to explore what parameters of a VBC would be essential to meet the needs of stakeholders involved in AAP-approved products, noting that 1) AAP-approved medicines will no longer come to market without a confirmatory trial initiated at time of approval; and 2) Payers are not willing to pay for AAP-approved medicines that come to market with a high price tag and limited evidence.

Paying for Drugs that Work: The Accelerating Clinical Evidence Model

The Secretary has selected three new models for testing by the Innovation Center, including the Accelerating Clinical Evidence Model. The Model would adjust Medicare Part B payment amounts for Accelerated Approval Program (AAP) drugs to give manufacturers an incentive to expedite and complete confirmatory clinical trials. Working in consultation with FDA, CMS could consider various approaches to adjust payments to the provider for AAP drugs, seeking to balance incentives for developing novel treatments with potential harms of delayed confirmatory clinical trials. Any adjustments would be structured in a manner that attempts to avoid penalizing physicians or beneficiaries for choosing (or avoiding) an accelerated approval treatment¹. By incentivizing timely confirmatory trial completion, CMS could enable improved access to post-market safety and efficacy data.

Beneficiary Population: Medicare fee-for-service (FFS) beneficiaries. Model Participants: Mandatory participation for applicable Medicare Part B fee-for-service providers.

Test Question: Do targeted adjustments on payments for AAP drugs accelerate confirmatory trial completion, provide timely information on the safety and effectiveness of AAP drugs on the market, facilitate earlier withdrawals of AAP drugs when appropriate, and reduce Medicare spending on drugs that do not have confirmed clinical benefit?²

¹ <https://asgct.org/publications/news/february-2023/hhs-secretary-announces-cgt-access-model>. Accessed online May 18, 2023.

² <https://innovation.cms.gov/data-and-reports/2023/eo-rx-drug-cost-response-report-faqs>. Accessed Jun 6, 2023.

Resources

1. [Strengthening the Accelerated Approval Program ICER White Paper April 2021.pdf](#)
2. [HHS Secretary Responds to the President's Executive Order on Drug Prices | CMS](#)
3. [Lowering Prescription Drug Costs for Americans, Response to President Biden's Executive Order \(cms.gov\)](#)
4. [A Report in Response to the Executive Order on Lowering Prescription Drug Costs for Americans Frequently Asked Questions \(cms.gov\)](#)
5. <https://www.fiercehealthcare.com/payers/fdas-califf-calls-insurers-help-providers-participate-critical-clinical-drug-trials> (Accessed online March 23, 2023).