BIO
BIOTECHNOLOGY
INDUSTRY ORGANIZATION

November 19, 2010

BY ELECTRONIC DELIVERY

Bradford R. Lang
Public Health Analyst
Office of Pharmacy Affairs (OPA)
Heath Systems Bureau (HSB)
Health Resources and Services Administration (HRSA)
5600 Fishers Lane
Parklawn Building, Room 10C-03
Rockville, MD 20857

Re: Comments on the Civil Monetary Penalties

Dear Mr. Lang:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to respond to HRSA's September 20, 2010 advance notice of proposed rulemaking and request for comments ("ANPRM") seeking to obtain information and public comment on how to efficiently and effectively implement the civil monetary penalty ("CMP") authority provided by Section 7102(a) of the Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. 111-148. *See* 75 Fed. Reg. 57,230 (Sept. 20, 2010). BIO is the largest trade organization to serve and represent the biotechnology industry in the United States and around the globe. It represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO members are involved in the research and development of innovative healthcare, agricultural, industrial, and environmental biotechnology products. BIO supported passage of the Affordable Care Act.

BIO appreciates that HRSA is proceeding with care to develop standards for exercising the CMP authority extended to the agency in the Affordable Care Act. We believe that changes to the 340B Program of this significance require stakeholders to have an opportunity to fully review, analyze, and comment on any proposal to ensure that all perspectives are accounted for before any proposal is finalized. We proceed to address each of the topics on which HRSA is expressly seeking comment. Additionally, we have included in the appendix a letter that BIO previously sent to HRSA outlining a number of areas in which we seek additional guidance.

I. Existing Models

BIO agrees that the Department of Health and Human Services ("HHS") and other federal agencies have experience creating and implementing CMP provisions in a variety of

contexts, portions of which can provide useful guidance in designing and implementing CMPs in the 340B Program.

BIO has reviewed aspects of the CMP authority exercised by the HHS Office of Inspector General ("OIG") and Centers for Medicare and Medicaid Services ("CMS"), *see* 42 C.F.R. Parts 402, 1003, and 1005, as well as the CMP authority exercised by the Federal Aviation Administration ("FAA"), *see* 14 C.F.R. Part 13; the Department of Treasury ("Treasury"), *see* 31 C.F.R. Part 27; the Food and Drug Administration ("FDA"), *see* 21 C.F.R. Part 17; the Department of Agriculture, *see* 7 C.F.R. Part 1, Subparts H, L; and the Federal Deposit Insurance Corporation ("FDIC"), 12 C.F.R. Part 308, Subparts A, B, and H. We have also reviewed the HHS Office of Inspector ("OIG") reports *Deficiencies in Oversight of the 340B Drug Pricing Program* (October 2005) (OEI-05-02-00072) and *Review of 340B Prices* (July 2006) (OEI-05-02-00073), and Robert Fabrikant, *et al.*, *Health Care Fraud: Enforcement and Compliance* § 5.03 (2010 ed.).

The comments that follow refer to specific aspects of these various existing CMP regulations in making suggestions about how HRSA should structure CMP regulations for the 340B Program to ensure fairness and efficiency throughout the process.

II. Before Implementing Any CMP Procedures, HRSA Must First Adopt Standards and Processes Regarding the Ceiling Price Calculation, Covered Entity Identification, and True-Ups

The initial question for HRSA to address is *when* it should exercise the new CMP authority it received in the Affordable Care Act. The Affordable Care Act authorizes CMPs as a sanction for "knowingly and intentionally charg[ing] a covered entity a price for purchase that exceeds the maximum applicable price"—*i.e.*, knowing and intentional overcharges to covered entities. As a threshold matter, BIO believes HRSA should not invoke its CMP authority until the agency has taken steps to provide clarity on open issues regarding the calculation of the ceiling price and the identification of covered entities entitled to 340B prices. These steps include:

(1) developing and publishing, through a regulatory process that allows for public comment, the precise standards and methodology that manufacturers must use to calculate ceiling prices;

(2) establishing a single, universal, and standardized identification system through which manufacturers, distributors, and the Secretary can readily identify the covered entities to which the 340B ceiling price applies; and

(3) establishing procedures for manufacturers to issue credits and refunds to covered entities in the event of an overcharge or a subsequent rebate or discount that lowers the applicable ceiling price for the relevant quarter. One option that could facilitate this process is an arrangement to offer credits to covered entities though wholesalers.

Section 7102 of the Affordable Care Act, which requires the creation of the CMP process, also mandates the creation of these three standards and processes—and for good reason. If HRSA seeks to exercise CMP authority before it issues guidance to all interested parties specifying the written procedures for calculating the 340B price, the agency's "general lack of detailed procedures for calculating the 340B ceiling price" means that its CMP proceeding would be based on "unreliable data" and "could lead to inappropriate enforcement actions." HHS OIG, *Deficiencies in Oversight of the 340B Drug Pricing Program* at 12 (Oct. 2005) (OEI-05-02-0072). As the HHS OIG recognized, the government's calculation of the 340B ceiling price has faced problems with accuracy, *id.* at 11, and until those problems are resolved, HRSA cannot have confidence that it is fairly and appropriately invoking its CMP authority. *See also* HHS OIG, *Review of 340B Prices* at 18-19 (July 2006) (OEI-05-02-00073) (finding that 1,673 of the entity purchases in an analyzed sample appeared to be an overcharge based on HRSA data but were in reality a charge at or below the ceiling price once the correct pricing data was used; explaining that "[i]f HRSA had used its ceiling prices to assess the appropriateness of prices paid by 340B entities, it would have erroneously identified overpayments as transactions that were actually at or below the ceiling price, which could have led to inappropriate enforcement actions").

The information available to manufacturers for use in identifying participating covered entities has, historically, also been limited and at times inaccurate. The lack of an accurate database previously hindered manufacturers' ability to effectively identify entities eligible for the discount program. HHS OIG, *Deficiencies in Oversight of the 340B Drug Pricing Program*, *supra*, at 6. While OPA has made great strides in improving the database's accuracy, the absence of a single, universal, and standardized identifier still hampers manufacturer efforts to ensure covered entities get the discounts to which they are entitled. These hurdles must be resolved before HRSA can consider invoking CMP authority.

Finally, until there is a clear and mandatory procedure for a manufacturer to issue credits or refunds, as circumstances warrant, HRSA should not seek to assess a CMP against a manufacturer for failing to use currently non-existent mechanisms to true-up prices paid by covered entities. Standardization of this process will be an important step, given the high volume of true-ups and refunds that are likely to occur based on price changes flowing from routine restatements of average manufacturer price ("AMP") and best price ("BP") (which are calculated to seven decimal places and rounded to six) as well as the volume of products, covered entities, and manufacturers participating in the program.

III. Threshold Determination, Including Statute of Limitations

Once the above three sets of standards and processes have been implemented, BIO fully supports HRSA's adoption of a CMP process. BIO also agrees with OPA that its decision as to whether to initiate a CMP process should consider the amount by which a manufacturer has knowingly and intentionally overcharged a covered entity, the frequency of the conduct, and the manufacturer's compliance history. To be clear, however, BIO believes that such factors only become relevant once HRSA has concluded that knowing and intentional overcharges have occurred. Only once HRSA has reached that conclusion should those factors become relevant.

In such cases, BIO further suggests that HRSA consider the following additional factors when deciding whether to initiate a CMP proceeding: (1) whether an overcharge is *de minimus* (at a threshold to be proposed by HRSA through rulemaking, potentially based on either a fixed dollar amount or a percent of sales[1]); (2) whether any overcharge is offset by corresponding undercharges resulting from other restated ceiling prices during a one year time frame; (3) whether the manufacturer acted promptly to evaluate any alleged overcharge and correct it if an overcharge in fact occurred; (4) whether, when considered in proportion to the manufacturer's sales of all covered drugs to all covered entities, the occurrence rate for an overcharge is small; and (5) whether the legal basis for asserting that an overcharge occurred had previously been established by statute, regulation, or published agency guidance.

This last factor is critically important. BIO strongly believes that HRSA should not institute a CMP proceeding where the alleged overcharge involved circumstances not addressed by written and binding agency standards. In situations outside of those addressed through agency guidance or regulation, there can be no basis for HRSA to allege in a CMP proceeding that a manufacturer has engaged in a knowing and intentional overcharge—and only knowing and intentional overcharges permit HRSA to exercise its CMP authority. *See* Affordable Care Act, Section 7102. For example, HRSA has no regulations pertaining to situations in which the ceiling price is negative. While HRSA recommends that manufactures charge the entity a penny in such circumstances, "HRSA has not provided official guidance on this issue or updated its records to reflect this expectation." HHS OIG, *Deficiencies in Oversight of the 340B Drug Pricing Program, supra*, at 14. As the OIG itself has recognized, "[i]f HRSA uses data containing negative ceiling prices to determine if entities paid at or below 340 ceiling prices, the results will be skewed" and could result in "false positives that might cause HRSA to draw invalid conclusions about compliance with discount requirements." *Id.* at 14-15.

Finally, BIO requests that HRSA directly address one additional aspect of exercising CMP authority: the statute of limitations for such proceedings. Manufacturers have three years to restate a drug's AMP, and its BP in the case of an innovator product, during which time the ceiling price can correspondingly move upwards or downwards. *See* 42 C.F.R. § 447.510(b)(1). Clearly, routine restatements of AMP and BP will not meet the "knowingly and intentionally" standard that is required under the statute for imposition of a CMP and we believe that HRSA should clarify that this is the case. However, given that AMP and BP may change during that three year window, BIO recommends that HRSA set a four year statute of limitations, through rulemaking, for any CMP proceeding. Four years would balance HRSA's need for time to investigate with the burden on covered entities and manufacturers of extending the recordkeeping requirements beyond the three year period for restatement of AMP/BP. The four year limitations period would extend from the first day of the quarter on which a ceiling price at issue was in effect.

---

[1] BIO has proposed a 2% de minimus standard be applied in the restatement context. See Appendix hereto. We would hope that a de minimus standard in the CMP context would, at a minimum, meet and preferably exceed that standard given the enforcement context.

IV. Administrative Process Elements

BIO agrees that it is important for HRSA to articulate thoroughly in a subsequent notice of proposed rulemaking all of the details for any process HRSA proposes for administering its CMP authority.

Notice for Proposed Determinations. BIO suggests that, as in the CMS and OIG context of CMPs, HRSA's notice of intent to assess a CMP should include (1) a description of the facts and conduct demonstrating an overcharge; (2) an explanation as to why the stated violation justifies the CMP; (3) the amount of the proposed penalty; (4) any and all circumstances that were considered when determining the amount of the proposed penalty; (5) any aggravating and mitigating factors that HRSA considered; and (5) instructions for responding to the notice, including information about the recipient's right to a hearing, or any other procedure to contest the CMP, and the time within which the recipient must act to protect that right. If HRSA intends to propose that a failure to timely respond would permit HRSA to impose the proposed CMP and eliminate the right of appeal, the notice must make that clear as well. *See, e.g.*, 42 C.F.R. §§ 402.5, 402.7, 402.9; *see also, e.g.*, 12 C.F.R. § 308.18(b). The notice should be served in accordance with Rule 4 of the Federal Rules of Civil Procedure.

In providing a description of any alleged overcharge, the notice of intent should specify the ceiling price that HRSA has identified as the correct ceiling price and identify how HRSA reached that value, including stating the AMP, unit rebate amount ("URA"), and package size data that HRSA used in the calculation. It should also identify the covered entities subject to any alleged overcharge. Specifying the ceiling price and the covered entities involved is critical given the past problems in the government's calculation of the ceiling price and maintenance of an accurate covered entity database. *See* HHS OIG, *Deficiencies in Oversight of the 340B Drug Pricing Program, supra*, at 6 (noting that 38% of sampled entities listed as enrolled in the HRSA database were not participants in the 340B Program and that errors in the database hinder manufacturers' ability to effectively identify entities eligible for the discount program); *id.* at 11 (noting that the government's calculation of the 340B ceiling price was inaccurate 8% of the time because the government did not include the URA, which resulted in an overstated 340B ceiling price).

In addition, if the alleged overcharge involves sales of a drug to a covered entity through a distributor or wholesaler, as opposed to or in addition to sales directly from the manufacturer, the notice of intent should include HRSA's understanding as to why the alleged overcharge resulted from an overstated ceiling price as opposed to an error or additional charge made by the wholesaler or distributor. *See* HHS OIG, *Deficiencies in Oversight of the 340B Drug Pricing Program, supra*, at 4 (recognizing that "it is acceptable for wholesalers to charge covered entities 340B ceiling prices plus a distribution fee").

As in the Treasury CMP process, BIO also recommends that a recipient of a notice of intent to assess a CMP be provided 20 days to request an opportunity to review any documents or other evidence compiled or relied upon by the agency in determining to issue the notice, subject to privileges available under law. *See* 31 C.F.R. § 27.5(d)(4). If a recipient requests this

information, the time for responding should be stayed until 20 days after that information is made available to the recipient.

Procedural Process. BIO suggests that there should be six procedural steps in the CMP process: (1) a notice of intent to assess a CMP; (2) an opportunity to review the documents or evidence compiled or relied upon by the agency in determining to issue the notice; (3) an informal procedure to resolve the CMP; (4) a hearing; (5) an appeal within HHS to the Department Appeals Board ("DAB"); and (6) judicial review in the federal Courts of Appeals and the Supreme Court of the United States. All or some combination of these steps are included in the CMP processes articulated in regulations issued by OIG, CMS, the FAA, and the FDIC, among others. Each step, with citation to the relevant regulations, is discussed in more detail in the relevant section of these comments.

If HRSA provides recipients a right to review the documents or evidence on which the agency relied in issuing the notice of intent to assess a CMP, one additional option that HRSA should consider is providing for an automatic reduction of the CMP amount if the recipient, after reviewing those documents or evidence, waives its right to a hearing and consents to the CMP. There is precedent for this sort of reduction in CMP procedures. For example, under 42 C.F.R. § 488.436, a CMP is reduced by 35 percent if a long-term care facility waives its right to a hearing and agrees to pay a CMP proposed by CMS. A similar process could work well for the 340B Program. It would reduce the costs to HRSA to administer the CMPs and would provide an incentive for manufacturers not to contest the CMP in the presence of particularly strong or compelling evidence that the manufacturer knowingly and intentionally overcharged a covered entity.

BIO also requests that HRSA consider an informal resolution procedure similar to that used by FAA for situations in which a recipient does not agree with a CMP. In response to a notice of proposed penalty, the FAA regulations provide a recipient with an option to engage in an informal procedure before requesting a formal hearing. *See* 14 C.F.R. § 13.16(f). If a recipient opts for the informal procedures, the recipient can submit to the FAA written information, including documents and witness statements, demonstrating that there was no violation or that the amount of the penalty is not warranted, requesting a reduction of the proposed penalty, along with the reasons and documentation supporting a reduction, and request an informal conference to discuss the matter with the agency. *Id.* §§ 13.16(f)(2), 13.16(g). We understand that in the FAA context, parties invoke this informal procedure the vast majority of the time—and regularly resolve any proposed penalty through this mechanism, which is less costly and burdensome for the parties and the agency than a full-blown hearing.

Finally, the regulations should make clear that HRSA and a manufacturer can agree to settle or compromise a CMP proceeding without an admission of liability or wrongdoing, as often occurs in other settlement contexts. In such a settlement, no finding of liability will be made against the settling party.

Involvement of covered entities; notice to third parties and the public. BIO is not aware of any policy or program rational for providing notice of a proposed CMP to third parties or the

public or for involving covered entities in the process (other than through necessary third-party discovery or third-party subpoenas compelling testimony as discussed below). None of the other CMP processes that we reviewed permit third parties to play an active role in a CMP proceeding (again, outside of third-party discovery or third-party subpoenas). Especially given the privileged and confidential pricing data that are likely to be at the center of a CMP proceeding, it makes better sense to restrict the notice and involvement of outside parties to avoid any unauthorized disclosure of that information. The appropriate forum for involvement by covered entities is the separate and independent dispute resolution process, not the CMP process.

Additional Procedures in 42 C.F.R. § 1003. BIO recommends that HRSA make clear that if a case proceeds to a hearing, the consent of the officer(s) presiding over the hearing is not required for settlement of the CMP proceeding. *See* 42 C.F.R. § 1003.126. In addition, given the agency's burden to establish knowing and intentional overcharges in the 340B CMP process, BIO believes that the agency cannot use the sort of statistical sampling or extrapolation that is permitted in other limited HHS contexts. *See* 42 C.F.R. § 1003.133; 42 U.S.C. § 1395ddd(f)(3).

V. Hearing

BIO recommends that the agency provide a fair, impartial hearing as a matter of right. Civil penalty hearings, across agencies, typically take place before an administrative law judge ("ALJ") or presiding officer. If HRSA instead opts to propose a decision making body comprised of multiple individuals, BIO requests that any representation for covered entities be equally balanced with representation for manufacturers. An ALJ, or any other individual involved as part of a decision-making body, must be conversant with the requirements of the 340B Program and existing HRSA program guidance. To ensure that is the case, HRSA should request that the CMP proceedings be handled exclusively by a limited subset of ALJs, who then should be trained in the program's requirements. In the comments that follow below, BIO refers to the decision-making entity as the ALJ for simplicity.

Ex Parte Contacts. There should be no *ex parte* contacts at any stage of the proceeding. That includes any contact between the ALJ and any person connected with the proceeding from a manufacturer, covered entity, or the agency, including those connected as an advocate or in an investigative capacity. *See, e.g.*, 42 C.F.R. § 1005.5 ("No party or person (except employees of the ALJ's office) will communicate in any way with the ALJ on any matter at issue in a case, unless on notice and opportunity for all parties to participate."); 21 C.F.R. § 17.20 (same). A party should be permitted to file a motion requesting that the ALJ be disqualified from a proceeding, *see, e.g.*, 14 C.F.R. § 13.205(c), including for engaging in *ex parte* communications with HRSA, a manufacturer, or a covered entity.

Prehearing conferences. HRSA should consider authorizing prehearing conferences to permit the ALJ to discuss with the party and the agency, among other things, the necessity or desirability for a more definite statement of wrongdoing, a schedule for any needed discovery, including third-party discovery, and potential settlement of the case. *See* 42 C.F.R. § 1005.6; 21 C.F.R. § 17.21.

Discovery and subpoenas. Discovery is a critical administrative process element that should be addressed in any proposed rule. A manufacturer may need to obtain materials to defend itself at a hearing, including from non-parties to the CMP proceeding, such as wholesalers, distributors, and covered entities. Program guidance makes clear that manufacturers must make their drugs available through wholesalers, and that the use of wholesalers is for the convenience of both the manufacturers and the covered entities. *See* 59 Fed. Reg. 25110 (May 13, 1994). But unless a manufacturer has access to third-party discovery, it will not be able to ensure that it can obtain the necessary documents and testimony necessary to defend itself.

Numerous other CMP mechanisms provide for third-party discovery by authorizing the officer presiding over a hearing to issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence that relates to the matter under investigation. *See, e.g.*, 12 C.F.R. §§ 308.5(b)(2), 308.11(d), 308.26; 14 C.F.R. §§ 13.205(3), 13.220, 13.228; 21 C.F.R. §§ 17.19(a)(5), 17.27; 42 C.F.R. § 1005.9. HRSA should do the same. In addition, a party defending against a CMP should be able to move for an order compelling discovery if an individual or entity on whom discovery is served objects to providing full and complete discovery responses. *See* 42 C.F.R. § 1005.7.

Evidence. The hearing should not be bound by the Federal Rules of Evidence, although the ALJ should exclude evidence that is irrelevant, immaterial or privileged, that was part of a settlement offer, or where the probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues or considerations of undue delay or needless presentation of cumulative evidence. 21 C.F.R. § 17.39; 42 C.F.R. § 1005.17; *see also* 14 C.F.R. § 13.222(c) ("The fact that evidence submitted by a party is hearsay goes only to the weight of the evidence and does not affect its admissibility."); 12 C.F.R. § 308.36(3) ("Evidence that would be inadmissible under the Federal Rules of Evidence may not be deemed or ruled to be inadmissible in a proceeding conducted pursuant to this subpart if such evidence is relevant, material, reliable and not unduly repetitive."). Rebuttal witness and evidence should be permitted. *See* 42 C.F.R. § 1005.17.

Other Hearing Elements. BIO encourages HRSA to adopt other hearing process elements from the CMP provisions within HHS. These process elements permit attorney representation at a hearing, 42 C.F.R. § 1005.3; outline procedures for the exchange of witness lists, witness statements, and exhibits, *id.* § 1005.8; establish the parameters of a motions practice before the ALJ, *id.* § 1005.13; authorize cross-examination and exclusion of witnesses, *id.* § 1005.16; ensure an official record of the proceeding, *id.* § 1005.18; and authorize written testimony in addition to oral testimony, *id.* § 1005.16.

HRSA should bear the burden of proof on all issues other than affirmative defenses or mitigating circumstances, and the burden of proof should be a preponderance of the evidence as is generally applicable in civil matters. *Id.* § 1005.15; *see also, e.g.*, 14 C.F.R. § 13.224 (agency bears burden of proof); 21 C.F.R. § 17.33 (same). We also recommend post-hearing briefs and proposed findings of fact and conclusions of law, supported by citations to relevant authorities

and the relevant portions of the record. *See* 12 C.F.R. § 308.37; 21 C.F.R. § 17.43; 42 C.F.R. § 1005.19.

ALJ Authority. The ALJ should be authorized to affirm, increase, or decrease the amount of the CMP based solely on the record. 42 C.F.R. § 1005.20. When determining the amount of a civil penalty, the ALJ should be required to articulate in an opinion the reasons that support the penalty imposed, including discussing any circumstances that aggravate or mitigate the violation and any affirmative defenses. 21 C.F.R. §§ 17.34, 17.45. This information will be critical for any internal appeal and for judicial review. The regulations should also contain a catchall provision regarding aggravating and mitigating circumstances to make clear that the ALJ can consider any such circumstances in a given case, regardless of whether they are specifically identified in the regulation. *See* 42 C.F.R. § 1003.106; 42 C.F.R. § 402.11.

We recommend that the regulations specifically state that an ALJ is authorized to withhold from third parties or the public any record, evidence or testimony disclosing privileged information and/or confidential pricing data. *See, e.g.,* 14 C.F.R. § 13.266 ("The administrative law judge may order that any information in the record be withheld from public disclosure."); 12 C.F.R. § 308.5 (ALJ has authority "[t]o establish time, place and manner limitations on the attendance of the public and the media for any public hearing"). There should be specific procedures for filing under seal when the public filing of any document would disclose such information or be contrary to the public interest. HRSA could consider permitting redacted versions of such filings to be made public.

VI. Appeals Process

BIO recommends that HRSA include standards for both interlocutory appeals and appeals after an ALJ final decision in the CMP regulations.

Interlocutory appeals. A number of CMP mechanisms provide for interlocutory appeals in certain circumstances. For instance, the FDIC regulations permit interlocutory review if the ruling at issue involves a controlling question of law or policy as to which substantial grounds exist for a difference of opinion, immediate review may materially advance the ultimate termination of the proceeding, subsequent modification at the conclusion of the hearing would be inadequate, or subsequent modification would cause unusual delay or expense. 12 C.F.R. § 308.28(b). The FDA regulations provide for an interlocutory appeal if the officer presiding over a hearing "certifies on the record or in writing that immediate review is necessary to prevent exceptional delay, expense, or prejudice to any participant, or substantial harm to the public interest." 21 C.F.R. § 17.18(b). FDA also authorizes the filing of a brief on the interlocutory appeal issues. *Id.* § 17.18(c). *See also* 14 C.F.R. § 13.219 (FAA regulation addressing interlocutory appeals for cause and as of right).

BIO recommends that HRSA adopt the FDIC's interlocutory review standard. It simply makes sense, as well as encourages efficiency and helps to ensure fairness in hearings, to permit interlocutory review in situations presenting a controlling question of law or policy as to which substantial grounds exist for a difference of opinion. Neither the agency nor parties should bear

the costs of a full-fledged hearing where the ALJ agrees that the legal basis for the CMP itself or a particular ruling underlying the hearing is a novel question of law lacking a clear answer.

Appeal of Final Order Within HHS. The ALJ's ultimate decision about whether to assess a CMP and the size of that CMP should be appealable in all circumstances. The first level of appeal should be within HHS to the DAB and should be triggered by a notice of appeal, followed by a written brief. *See, e.g.*, 21 C.F.R. § 17.47. The ALJ's decision should include a written statement describing how and when to file a notice of appeal with the DAB. *See* 42 C.F.R. § 1005.20. The appeal should be a matter of right for which fact issues are reviewed under a substantial evidence standard and legal conclusions reviewed de novo. *See* 42 C.F.R. § 1005.21. In addition to affirming or reversing an ALJ decision, the DAB should be able to remand for consideration of additional evidence if new evidence has become available or there were reasonable grounds for failure to adduce such evidence in the hearing before the ALJ.

Filing a request for review with the DAB should automatically stay the ALJ decision, and once the DAB renders its decision, a party should be able to request for a stay pending judicial review. 42 C.F.R. § 1005.22; *see also* 12 C.F.R. § 308.41 (permitting stay of decision pending judicial review).

Judicial review. A party should be able to seek judicial review of the DAB's decision. *See, e.g.*, 42 C.F.R. § 402.21; 42 C.F.R. § 1003.127. That judicial review should occur in the United States Court of Appeals for the District of Columbia Circuit or the circuit in which the manufacturer resides or in which the alleged overcharge occurred. The Court of Appeals should have authority to affirm, modify, remand for further consideration, or set aside in whole or part, the DAB's decision. The Court may order that further evidence be taken before the ALJ upon a showing by any party that additional evidence is material and that there were reasonable grounds for failure to adduce such evidence in the hearing before the ALJ.

VII. Definitions

Instance. The Affordable Care Act limits a CMP to no more than $5,000 for "each instance" of knowingly and intentionally overcharging a covered entity. Because only knowing and intentional conduct can be subject to a CMP, the term "instance" should be defined to include actions within a manufacturer's control. Accordingly, the term "instance" should be defined to include (1) each incorrect ceiling price that actually results in an overcharge to a covered entity and (2) each incorrect determination by a manufacturer that a covered entity is not a covered entity entitled to the ceiling price that actually results in the covered entity purchasing products at higher than ceiling prices.

Defining "instance" in these two ways ensures that the number of "instances" flows from decisions within a manufacturer's control. As to the first prong, any overcharges in a given quarter that are based on in incorrectly calculated ceiling price will flow from the single calculation that the manufacturer made as to the ceiling price for the particular product. That calculation should be considered a single "instance." The number of "instances" should not be based on how many units of a product are purchased or how many covered entities make those

purchases. Those factors are outside the manufacturer's control. Similarly, under the second prong, an "instance" of overcharging also should include a manufacturer's incorrect determination that a customer is not a covered entity entitled to a correctly calculated ceiling price—also a determination within the manufacturer's control that may result in a covered entity being overcharged.

Finally, BIO strenuously objects to HRSA's suggestion that it would be authorized to treat a refusal to sell a covered outpatient drug as potentially actionable through the CMP process. First, CMPs are restricted to situations involving an overcharge, and a refusal to sell is not an overcharge. Second, even if a refusal to offer the ceiling price was considered to be an overcharge, a manufacturer will not have an obligation to offer covered drugs at the ceiling price until HRSA issues a new Provider Participation Agreement ("PPA") and manufacturers contractually obligate themselves to offer the ceiling price to covered entities by signing it. Until the Affordable Care Act was enacted, manufacturers had no obligation to offer their products to 340B covered entities. Nowhere in the 340B Program is there a mandate to offer products or a specific requirement that all, or any particular portion of, a 340B entity's request to purchase product be fulfilled. Consistent with the Program requirements, the PPA currently in effect only governs the price that manufacturers can charge covered entities for covered outpatient drugs.

In recognition of the current program requirements, Section 7102(b) of the Affordable Care Act amends the 340B Program to add a must-offer obligation through a new term to the Secretary's PPA: that "the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price." There can certainly be no CMP proceeding based on this new "must offer" provision until it is implemented through a new PPA or an amendment to manufacturers' existing PPA.

Knowingly and Intentionally. The ANPRM suggests that HRSA is considering permitting inferences of intentionality to be drawn from scenarios where, for example, one employee or agent of a manufacturer knows a customer is a covered entity and another employee or agent knows that customer is being charged more than the ceiling price, or where a manufacturer repeatedly miscalculates a ceiling price (which could result from numerous wholly *unintentional* circumstances, like a software problem). Permitting such inferences would significantly dilute the congressionally-mandated standard that a CMP could only issue when a manufacturer "knowingly and intentionally" overcharges a covered entity. As an initial matter, HRSA has not specified the sort of entity it might consider an "agent" of a manufacturer, which arguably could range from wholesalers to software vendors. The knowledge or intent of those entities independent from the knowledge or intent of the manufacturers themselves should have no bearing on whether the statutory standard is met.

Based on the above statements in the ANPRM, it appears that HRSA may be seeking to impermissibly redefine "knowingly" and "intentionally," words specifically chosen by Congress. Many civil fraud statutes use the term "knowingly" by itself, and most criminal statutes use "knowingly and willfully." But Congress chose an even higher, more exacting state of mind requirement, which clearly indicates that Congress intended this CMP remedy to be used only for very serious offenses. HRSA should not be permitted to redefine these terms to capture

lesser forms of misconduct. While Congress has at times defined "knowing," on its own, to require something less than actual knowledge, including "reckless disregard" or "deliberate ignorance"—for example, in the federal civil False Claims Act, 31 U.S.C. § 3729(b)(1)—here, the statute plainly requires more by referring only to conduct that is both knowing and intentional. Taken together, "knowingly and intentionally" should be defined to include only conduct undertaken with the specific intent to overcharge a customer that the manufacturer actually knows is a covered entity. The phrase cannot include, therefore, inadvertent, accidental, or negligent conduct, unrecognized error in computing the ceiling prices, conduct undertaken with the honest belief that the facts were otherwise, situations where there is a reasonable disagreement and no established law or agency guidance on point, or any other situation not presenting circumstances of deliberate misconduct.

VIII. Penalty Computation

In computing the penalty, the ANPRM proposes consideration of certain factors. BIO seeks clarification about certain of those criteria. The ANPRM refers to a manufacturer's "previous record of overcharging." So long as this factor only encompasses instances in which a manufacturer admits it overcharged a covered entity in the 340B Program or was adjudicated to have done so, BIO agrees that its consideration is appropriate. This factor cannot include instances of non-adjudicated allegations of overcharging, alleged instances of overcharging 340B covered entities that were dismissed or settled without an admission of wrongdoing, or alleged instances of overcharging outside the 340B Program. BIO also believes that the number of covered entities and the impact on patient access should be entitled to little, if any, weight in the analysis because these are not factors within a manufacturer's control.

BIO further recommends the inclusion of a number of additional factors in computing the penalty amount: (1) the nature and circumstances of the overcharge; (2) the degree of culpability of the entity against whom a CMP is proposed; (3) whether the manufacturer promptly took corrective steps after the error was discovered, such as developing and implementing a corrective action plan, reinforcing its internal compliance program, or taking disciplinary action against any employee who engaged in misconduct or failed to follow or utilize the entity's internal compliance program; (4) the materiality and total amount of any miscalculated ceiling price and resulting overcharge; and (5) whether the manufacturer self-reported the violation. Other CMP proceedings consider these factors, as well as a catchall factor permitting consideration of any other matter as justice may require. *See* 42 C.F.R. § 1003.106; 42 C.F.R. § 402.11.

IX. Payment of Penalty

BIO agrees that HRSA should establish methods for transferring any penalty assessed to the government. BIO also agrees that to the extent a penalty is not paid in a timely manner—not to be less than 60 days from the ultimate conclusion of any appeal or judicial review—HRSA could pursue a civil action to recover the amounts due.

BIO disagrees that interest should be available from the date of the overcharge. While interest should potentially be available for any credit or refund due to the overcharged entities,

interest on a civil penalty should be triggered by the filing of a notice of intent to assess a CMP—not from the overcharge itself. Given the routine restatements of AMP that are permitted and regularly occur during the three years following a manufacturer's initial AMP statement, it makes sense that interest should not be calculated until the ceiling price is finally adjusted and a CMP proceeding asserts that an overcharge occurred.

X. Integration of CMPs with Other Provisions in the Affordable Care Act

BIO reiterates that the CMP authority should not be exercised until HRSA has established procedures to verify ceiling prices, created a process for manufacturers to refund or credit overcharges, and provided a mechanism to confirm a covered entity's entitlement to the 340B ceiling prices. Those are necessary preliminary steps that must be taken to ensure that HRSA's CMP authority can be exercised in a fair, reasonable, and non-arbitrary manner that provides sufficient notice to manufacturers on key compliance principles. *See, supra*, 2-3.

Conclusion

BIO looks forward to working with HRSA over the coming months and years to implement the CMP authority. We hope that the agency finds this letter to be helpful as it begins this process. Please feel free to contact Laurel Todd at 202-962-9220 if you have any questions regarding any of the issues raised in these comments. Thank you for your attention to this very important matter.

Respectfully submitted,

/s/

Laurel Todd
Managing Director, Reimbursement and Health Policy

Sandra Dennis
Deputy General Counsel, Health

APPENDIX

September 3, 2010

BY ELECTRONIC DELIVERY

Commander Krista Pedley
Director
Health Resources and Services Administration (HRSA)
5600 Fishers Lane
Rockville, MD 20857

Re: Implementation of the Patient Protection and Affordable Care Act, as Amended by the Health Care and Education Reconciliation Act of 2010

Dear Commander Pedley:

The Biotechnology Industry Organization (BIO) is the largest trade organization to serve and represent the biotechnology industry in the United States and around the globe. BIO represents more than 1,200 biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO members are involved in the research and development of innovative healthcare, agricultural, industrial and environmental biotechnology products. Accordingly, we were pleased to support passage of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively, the Act).

Now that PPACA and HCERA have been enacted, we recognize HRSA has responsibility for implementing many of the Act's provisions relating to the 340B drug pricing program. We understand that HRSA is considering issuing a rulemaking to implement these requirements. BIO applauds HRSA for pursuing this approach, as we believe that changes of this significance should be implemented only through a notice-and-comment rulemaking process, allowing stakeholders to fully review, analyze, and comment on those proposals ensuring all perspectives are accounted for before any proposal is finalized.

In this regard, and to assist the agency in its implementation work, BIO would like to take this opportunity to bring to your attention a number of issues that we believe need to be addressed in any guidance or proposed rules HRSA issues related to sections 7101 and 7102 of PPACA, and section 2302 of HCERA, which make changes to section 340B of the Public Health Services Act. We also highlight ongoing issues relating to enforcement of the existing statutory prohibitions on duplicate discounts and diversion under the 340B statute.

I. Expansion of 340B Program and Retroactive Rebates

Section 7101(a) of PPACA amended the definition of a covered entity under section 340B to include new categories of hospitals. HRSA has implemented a rolling admission

process for these new entity types, beginning August 2, 2010 through September 30, 2010. Neither HRSA's July 28 webinar regarding this enrollment process nor the enrollment guidance provided on HRSA's website state that the new covered entity types are eligible for retroactive rebates back to January 1, 2010, the effective date of section 7101. By comparison, when HRSA issued its guidance regarding registration of children's hospitals pursuant to the Deficit Reduction Act of 2005 (DRA), its Final Notice expressly authorized those entities to request retroactive rebates and defined the process for doing so.[1] BIO interprets the absence of guidance to date regarding retroactive rebates for the section 7101 new entity types to mean that HRSA is not permitting those entities to seek such rebates and requests that HRSA confirm that is the case.

To the extent that HRSA will permit these newly eligible entities to seek retroactive rebates on covered outpatient drugs back to January 1, 2010, it is crucial that HRSA require the entity to demonstrate its eligibility for the entire period for which rebates are sought and also to certify its satisfaction of program requirements during that same period, consistent with OPA's previously defined approach for children's hospitals that seek retroactive rebates. BIO believes that HRSA should implement this same procedure with regard to retroactive rebates requested by the new covered entity hospital types, if such rebates are permitted, because manufacturers have experience in coordinating with covered entities regarding such requests. Consistent with this approach, HRSA also should limit the time period for covered entity requests for rebates to a period of 30 days post enrollment. Finally, BIO asks that HRSA include in its system for verifying the accuracy of information provided by covered entities, as discussed further below, a distinct identifier for those entities eligible for retroactive pricing and discounts.

II. Amendment to Pharmaceutical Pricing Agreement (PPA)

Section 7102(b) of PPACA amends section 340B to add two new requirements for the Secretary's PPA with the manufacturer. The first requirement is for manufacturer submission of ceiling price data to the Secretary and the second requirement is that "the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price." BIO asks that HRSA confirm that these new requirements will be implemented either through a new PPA or an amendment to manufacturers' existing PPA and that HRSA notify manufacturers regarding when HRSA expects to issue this new agreement or amendment.

As to the second, "must offer," requirement, we also request that HRSA confirm that manufacturers may use a reasonable allocation methodology, so long as that methodology does not discriminate based on a customer's 340B status. Where the FDA imposes requirements on the manufacturer regarding the distribution of a drug, such as Risk Evaluation and Mitigation Strategies, or REMS, and those FDA mandates limit a manufacturer's distribution avenues for particular products and/or impose compliance requirements on those entities that wish to dispense or administer a particular drug to a patient, HRSA should make clear that the manufacturer need not offer a product for sale to a covered entity unless and until the covered

[1] 74 Fed. Reg. 45206 (Sep. 1, 2009).

entity can qualify under those FDA-required standards. Finally, we request that should a manufacturer choose to seek guidance from the agency regarding implementation of such an allocation procedure, HRSA identify a point of contact to address such questions.

III. Program Integrity Changes to 340B Program

A. Ceiling Price Website

We understand that section 7102 requires the Secretary to develop a system to verify the accuracy of ceiling prices calculated by manufacturers and also to make 340B prices accessible to covered entities through an Internet website. BIO recommends that this website allow manufacturers to load their pricing data directly, similar to the Drug Data Reporting (DDR) system manufacturers currently use to report pricing and product data under the Medicaid drug rebate program, and that manufacturers be required to enter such data by the first day of the start of each quarter. The website also should include a flag to indicate to covered entities when the ceiling price for a particular drug has been updated, as discussed further below.

In implementing this provision, the Secretary is required to provide covered entities with access to these pricing data "in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized redisclosure." BIO is concerned that password protection alone is not sufficient to protect manufacturer data from unauthorized redisclosure, as required by the statute. We urge HRSA to implement additional safeguards to adequately protect against such redisclosure, including the establishment of penalties for covered entities that disclose ceiling price data. In developing these safeguards, we also ask that HRSA create procedures that address specific scenarios that are likely to arise, such as where a covered entity loses eligibility, or where an employee leaves one covered entity and becomes employed by another. HRSA's security procedures should address how it will manage passwords and control access to manufacturer data in such circumstances to ensure unauthorized disclosure does not occur.

B. True-Up of Ceiling Prices

Section 7102 requires the Secretary to establish procedures for manufacturers to issue appropriate refunds to covered entities in the event of an "overcharge," including where the overcharge results from a routine restatement of average manufacturer price (AMP) or Best Price (BP) data. BIO requests that HRSA confirm that any such procedures will apply prospectively only. BIO also strongly recommends that in establishing procedures for such refunds, HRSA include a materiality standard, a right to offset against undercharges, and a standardized process for issuing refunds, as discussed below. Finally, while BIO includes proposals below regarding how to operationalize the true-up and refund process, BIO strongly encourages HRSA to create a working group of stakeholders to further review and advise HRSA regarding the creation and implementation of such operational concerns.

1. The True-Up Requirement Should Apply Prospectively Only

Section 7102 requires HRSA to provide for the "establishment of procedures" and the "development of a mechanism" for the issuance of refunds to covered entities in the event of a change in a prior ceiling price. Although PPACA section 7101(e)(2) states that the amendments made by section 7102 shall be effective on January 1, 2010 and shall apply to drugs purchased after that date, it more specifically directs that a process must be established from appropriated funds so that manufacturers may make the refund payments. BIO believes, therefore, that the proper reading of the statute is that these processes, once created, will apply on a prospective basis only. We also recommend that these processes be reflected in the new PPA or PPA amendment, as discussed in Section II above. BIO also believes that this is the only workable approach from an operational perspective. The application of these processes, which are still undefined and will be complex to implement even on a prospective basis, will almost certainly present even greater if not insurmountable barriers if any attempt is made to apply them to prior periods. As should be apparent from the proposals discussed below, the implementation of the true-up and refund requirements will involve tremendous operational complexity for manufacturers of all sizes, as well as the entities who will benefit. Such complexities can be addressed and overcome when the parties have notice and time to develop and implement appropriate systems on a prospective basis. Application of such systems to prior periods, where the data and processes in place before were not designed to account for such requirements, will almost certainly result in errors and enormous administrative burdens on all parties involved.

2. HRSA Should Establish a Materiality Standard

Routine restatements of AMP and/or BP data have the potential to cause changes to prior ceiling prices that are material and where a refund to the covered entity would be appropriate under PPACA. However, BIO understands that such AMP and BP revisions (these figures are calculated to seven decimal places and rounded to six) are equally likely to result in ceiling price changes that are *de minimis*, such that only nominal refunds, whether issued by credit memo or check, would be due. Requiring manufacturers to issue such nominal refunds to each of the over 14,800 covered entities that may have purchased a drug at the prior ceiling price anytime there is a change to that price would be tremendously burdensome on manufacturers, OPA, covered entities, and wholesalers. BIO therefore urges HRSA establish a *de minimis* or materiality threshold for ceiling price changes that require refunds, such that the manufacturer would not be obligated to issue a refund where the restatement of AMP or BP for the quarter results in a decrease that is less than 2.0 percent of the original ceiling price paid by the covered entity. Where the change in the ceiling price exceeds this threshold, we further recommend that HRSA require refunds only where the total amount due the covered entity for all material ceiling price changes for that quarter across all products is at least $200.00. We note that the administrative cost to the manufacturer of issuing a check of any sort typically is approximately $100.00 and so is the appropriate materiality threshold for refunds.

Numerous federal standards, including those adopted by the Department of Health and Human Services, support the application of a materiality standard in different contexts where government funds are at issue. While the above proposed materiality standards would apply to

the payment of refunds to covered entities, and so would not involve refunds to the federal government itself, the government's own willingness to apply such standards to its own fiscal matters clearly supports the reasonableness of doing so as to covered entities as well. The standards we discuss below are the government's Cost Accounting Standards (CAS) as well as three materiality standards from the Department of Health and Human Services (HHS), all of which rely on a 5% materiality threshold – significantly higher than what BIO is requesting here.

The CAS are a set of accounting principles intended to improve uniformity and consistency in the measurement, assignment, and allocation of costs to government contracts. They apply to negotiated contracts and subcontracts in excess of $650,000, subject to certain exceptions.[2] Under CAS, the contractor's Administrative Contracting Officer (ACO) must determine whether CAS noncompliance or changes to the contractor's cost accounting practices results in increased costs to the Government. As part of that review, the ACO makes a determination of materiality of the cost impact. If the change or noncompliance is deemed to have an immaterial cost impact, then no contract adjustments are made.[3] The materiality standard is set forth at 48 C.F.R. § 9903.305:

> In determining whether amounts of cost are material or immaterial, the following criteria shall be considered where appropriate; no one criterion is necessarily determinative:
>
> > (a) The absolute dollar amount involved. The larger the dollar amount, the more likely that it will be material.
> >
> > (b) The amount of contract cost compared with the amount under consideration. The larger the proportion of the amount under consideration to contract cost, the more likely it is to be material.
> >
> > (c) The relationship between a cost item and a cost objective. Direct cost items, especially if the amounts are themselves part of a base for allocation of indirect costs, will normally have more impact than the same amount of indirect costs.
> >
> > (d) The impact on Government funding. Changes in accounting treatment will have more impact if they influence the distribution of costs between Government and non-Government cost objectives than if all cost objectives have Government financial support.

---

[2] There are exceptions to application of CAS for, among other things, contracts and subcontracts with small businesses, fixed-price contracts, and subcontracts for commercial items, etc. 48 CFR 9903.201-1,2.

[3] 48 C.F.R. § 30.602.

> (e) The cumulative impact of individually immaterial items. It is appropriate to consider whether such impacts:
>
> > (1) Tend to offset one another, or
> > (2) Tend to be in the same direction and hence to accumulate into a material amount.
>
> (f) The cost of administrative processing of the price adjustment modification shall be considered. If the cost to process exceeds the amount to be recovered, it is less likely the amount will be material.

We believe these factors, which weigh both the absolute and proportionate dollar amount involved as well as the costs of administrative processing, are equally applicable to and supportive of the creation of a materiality threshold for ceiling price revisions and covered entity refunds.

Within HHS, the Office of Inspector General (OIG) has adopted a five percent materiality threshold with regard to the Independent Review Organization (IRO) review of a manufacturer's reported average manufacturer prices (AMPs) and average sales prices (ASPs) pursuant to a Corporate Integrity Agreement (CIA) with the OIG. In at least three separate CIAs, the OIG has applied a threshold of "a net dollar error rate of 5% or greater" for purposes of the IRO's review.[4] Under this standard, if the Error Rate is lower than five percent, the data is not reviewed by the OIG at all.

Again with HHS, the National Institutes of Health has adopted a materiality standard in relation to cost accounting under federal grants, where charges to a grant for salaries and wages of persons working on the grant are based on the percentage of time the employee spends on the grant versus other institutional work the employee performs. For example, if the employee spends 50 percent of his/her time on the grant, then 50 percent of his/her salary can appropriately be charged to the grant. The rate at which a salary is charged to a grant typically is set at the

---

[4] Merck CIA, available at http://oig.hhs.gov/fraud/cia/cia_list.asp#b (Feb. 5, 2008) ("If any discovery sample defined in Section II.C.1 reveals a net dollar Error Rate of 5% or greater, Merck and the IRO shall hold an interim conference with the OIG to discuss the IRO's findings."); Bristol-Myers Squibb Company CIA, available at http://oig.hhs.gov/fraud/cia/cia_list.asp#b (Sep. 26, 2007) ("The IRO shall test a probe sample of 30 Transactions from each universe of Transactions Types for the selected quarter. If the IRO finds a net dollar error rate of 5% or more of the total sample size in any probe sample, BMS and the IRO shall hold an interim conference with the OIG to discuss the IRO's preliminary findings."); Aventis Inc. et al. CIA, available at http://oig.hhs.gov/fraud/cia/cia_list.asp#b (Aug. 29, 2007) ("The IRO shall test a probe sample of 30 Transactions from each universe of Transactions Types for the selected quarter. If the IRO finds a net dollar error rate of 5% or more of the total sample size in any probe sample, API and the IRO shall hold an interim conference with the OIG to discuss the IRO's preliminary findings.").

outset of the grant based on anticipated effort, before the work is performed, and then reviewed after a set period to verify the accuracy of the effort. If there is a "significant" change between the actual effort versus budgeted effort, an adjustment needs to be made.[5] There is no specific definition of "significant", but the NIH has adopted a general rule that a change of five percent or more of an employee's total effort would require an adjustment to the effort report (and accordingly, the amount chargeable to the grant).[6]

The Medicare program also applies a materiality standard with respect to the substitution of the average sales price (ASP) for purposes of setting Medicare reimbursement. Section 1847A(d)(3) of the Social Security Act permits the Secretary of HHS in setting reimbursement rates under Medicare Part B to disregard the ASP of a drug and substitute an alternative price as the basis for Part B reimbursement rates where an ASP exceeds the widely available market price (WAMP) or the AMP for the drug by an applicable threshold. Congress established an initial threshold of five percent through 2006, likely based on its own balancing of the savings generated by such price substitutions versus the burden imposed on both CMS and Medicare contractors by such substitutions. Although the Secretary has discretion under the statute to adjust the threshold for years after 2006, the Secretary has yet to do so.

These materiality criteria and standards make clear that the government itself, and HHS specifically, has recognized that the balancing of the dollars involved versus the burden of all parties is an appropriate consideration when determining refund obligations to the government. There is no reason why the same should not be true with respect to refund obligations to a covered entity. Based on the government's prior adoption of these factors, we believe the only question left for HRSA to consider is what the materiality standard should be. We believe our suggested thresholds are appropriate and reasonable, particularly given that HHS itself has adopted a higher 5% threshold in similar contexts.

3. HRSA Should Permit a Right of Offset

Where AMP and/or BP changes require changes to prior ceiling prices, we also urge HRSA to permit manufacturers to offset any overcharges due to retroactive decreases to ceiling prices by the amount of any undercharges made to the same covered entity that result from AMP and/or BP changes that cause ceiling prices to increase. The new statutory true-up requirement is intended to correct prior ceiling prices so that they accurately reflect any changes in the underlying pricing data. Those AMP and BP changes are as likely to move the ceiling price up as they are to move the price down. The new statutory language does not prohibit such upward adjustment to ceiling prices but rather specifies the need for "appropriate" credits and refunds. To ensure that ceiling price corrections fully reflect the actual underlying pricing data, we believe a fair approach would be to require manufacturers to true-up ceiling prices in both directions but allow manufacturers to offset upward adjustments in ceiling prices only up to the

---

[5] OMB Circular A-21, Cost Principles for Educational Institutions.

[6] Joe Ellis, Acting Director of NIH's Office of Extramural Research Administration, Effort Reporting: Total Professional Activity vs. Institutional Activity (Enclosure A) (undated).

amount of any credit that otherwise is due to an entity for downward adjustments to ceiling prices. Specifically, these offsets would be on an entity-wide and quarterly basis, so that any refunds owed to an entity for any (material) ceiling price decreases in a past quarter would be offset by undercharges to that same covered entity for (material) ceiling price increases in that same quarter. *In this way, covered entities would never be obligated to make affirmative supplemental payments in relation to prior purchases; only the amount of any credit otherwise due would be decreased.*[7]

While we believe this offset approach is fair in its own right, we also believe that any OPA policy that prohibits manufacturers from offsetting refunds to covered entities in this manner would violate the provisions of the 340B statute and PPA, which both specifically permit but do not require manufacturers to offer sub-ceiling prices. We understand HRSA may view AMP/BP revisions that would cause a ceiling price to increase as converting a previous price set at the ceiling price level into a voluntary sub-ceiling price that therefore cannot be adjusted. This position ignores actual manufacturer intent and practice in setting the original price. A good faith ceiling price offered by a manufacturer is not transformed into a voluntary sub-ceiling price merely based on later, unintended, and legally mandated changes to AMP and/or BP. The 340B statute[8] and PPA[9] both make clear that manufacturers are permitted, but not required, to offer sub-ceiling prices. A policy that does not permit manufacturers to upwardly reconcile ceiling prices due to AMP/BP changes would, we believe, act as a de facto sub-ceiling mandate and a violation of the statute and agreement terms. We also believe manufacturers are entitled to such offsets based on principles of common law restitution.

We understand that HRSA may believe that refund offsets due to upward adjustments to ceiling prices may be unfair because the covered entity relied on the original, lower, ceiling price when making a purchase decision. The argument, as we understand it, is that if the covered entity had been aware that the ceiling price at which it originally purchased a particular drug would be upwardly adjusted, the covered entity instead would have purchased any equivalent product that was available at a price lower than the restated ceiling price. To the extent this argument may have merit, it would be valid only in following limited circumstances

1. The drug at issue would have to be a multiple source covered outpatient drug, because only multiple source drugs can be interchangeable such that price alone could be (although is not necessarily) the determining purchase criterion, *and*
2. The alternative multiple source drug would have to have been available at a price that is both higher than the original ceiling price of the product the covered entity did purchase, but still lower than the restated price, because only a product with a price between the

[7] Upward adjustments to ceiling prices should be subject to the same *de minimis* threshold applicable to downward adjustments to ceiling prices.
[8] 42 U.S.C. § 256b.
[9] 58 Fed. Reg. 27293 (May 7, 1993) (requiring manufacturers to enter into a pricing agreement); Department of Health and Human Services, Pharmaceutical Pricing Agreement (PPA) at 8 (Feb. 8, 2006).

original and restated ceiling prices price could be viewed as more attractive based on price alone.

Given the limited circumstances in which this concern could have any merit, it cannot provide a basis for barring offsets for all covered outpatient drugs in all circumstances. In the case of BIO member products specifically, which generally are biologics and therefore not multiple source drugs, this argument is simply not applicable at all.

To address those limited situations in which these concerns may be applicable, BIO believes it would be appropriate for HRSA to permit the covered entity to demonstrate to the manufacturer that there was another, alternative multiple source product available at the time of the original purchase that was priced less than the restated price but more than the initial price. It is appropriate to require the covered entity to raise this issue because only the covered entity will have access to the ceiling prices of the alternative multiple source drugs – manufacturers will not have access to ceiling price data from other manufacturers. For the same reason, we ask that HRSA review and validate such claims to confirm that an alternative drug was in fact available at the lower price. Where the covered entity is able to make such a showing, as verified by HRSA, the manufacturer would be required to modify its offset of any refund to the entity by recalculating the undercharge based on the difference between the new, higher ceiling price and the price of the alternative multiple source product (rather than the original ceiling price). For example, assume that a covered entity purchased a unit of a multiple source covered outpatient drug at a ceiling price of $1.00, and that this price subsequently was revised to $1.10 as a result of an AMP/BP restatement. If the covered entity is able to demonstrate that an alternative product was available at the time of the purchase at a price of $1.05, the manufacturer would be permitted to offset any refunds to the covered entity only by the amount of $0.05 per unit, rather than $0.10 per unit.

4. HRSA Should Establish a Standardized Process for Issuing Refunds

Finally, BIO strongly recommends that HRSA establish a standardized process for manufacturer issuance of refunds to covered entities that minimizes the administrative burden for manufacturers, covered entities, wholesalers, and HRSA itself. The standardization of this process is important because of the high volume of true-ups and refunds that are likely to occur due to the volume of products, covered entities, and manufacturers participating in the program. For example, manufacturers could be required to update the manufacturer's prices on the OPA website (as discussed above) to reflect revisions to ceiling prices. In this way, the OPA website could provide a centralized notification system through which covered entities could learn of price changes and the potential availability of refunds, particularly if the OPA ceiling price website includes a "flag" that indicates prices that have been updated. Such an indicator may be particularly useful in light of the fact that manufacturers are obligated to correct their AMP and BP figures within three years of when those figures originally were due, and some manufacturers may make corrections multiple times during that period.[10]

[10] See 42 C.F.R. §447.510(b).

We further recommend that HRSA define the refund process to be one in which the manufacturers are responsible for calculating refund amounts due and issuing those refunds to covered entities via designated contact, such as through the issuance of credits to a specified wholesaler. Where the credit is not taken by the covered entity within one year of being issued and after reasonable follow-up by the manufacturer, including seeking HRSA's assistance as needed, we recommend that the manufacturer be permitted to cancel the credit. The manufacturer would be required to maintain documentation regarding the calculation of the refund due, which would have to be made available to the covered entity upon request, but would not otherwise be required to be affirmatively issued to the covered entity. The covered entity identification system that the Secretary is required to develop, as discussed further below, should include the identification of either the entity's designated wholesaler to which refund credits should be issued on the entity's behalf (preferably the wholesaler through which the entity purchased the product), or other contact for receipt of refunds. The covered entity would be responsible for keeping this information current as well as following up with the manufacturer, as needed, with questions regarding such credits. Finally, manufacturers should be given at least 90 days after the revision of any AMP/BP figures to calculate the resulting price changes and credits due before being obligated to update the prior pricing data, to provide sufficient time to ensure that the revised pricing and credits are accurate. Manufacturers should be permitted to seek an extension to this 90-day time period in extraordinary circumstances, such as where a particularly high volume of price changes, drugs, or covered entities are involved. We also recommend that HRSA's dispute resolution procedures, as discussed further in Section IV, specifically address disputes regarding these issues.

Historically, the 340B program has sought to share the administrative burdens of the program between the manufacturer and the covered entity and so the recommended process above does so as well. For example, for new covered outpatient drugs for which AMP and BP data are not yet available, the manufacturer must estimate the ceiling price in accordance with OPA guidance because there are no historic AMP or URA data with which to calculate the ceiling price.[11] The manufacturer must provide a refund *as requested by a covered entity* where the estimated ceiling price exceeds the actual ceiling price for that same quarter. As OPA explained in its Final Notice, the mechanism for retroactive pricing adjustment reflects "an attempt to evenly split the administrative burden of the process between the manufacturer and the entity. If an entity wishes a pricing adjustment, the dollar amount in question, one would expect, must be significant enough to balance the administrative burden involved in documenting and developing the request."[12] Consistent with this historic approach, BIO believes setting forth the streamlined, cooperative process for issuing credits described above will ensure that covered entities receive accurate refunds in the most rapid and efficient manner while also limiting the administrative burden on all parties involved.

[11] 60 Fed. Reg. 51488 (Oct. 2, 1995).
[12] Id.

We understand that the 340B Program's prime vendor may be particularly and uniquely suited to play a role in the development and administration of this process. While BIO welcomes the prime vendor's valuable input on these issues, and certainly believes the prime vendor should be a member of any workgroup, as proposed below, created to discuss implementation processes, BIO also believes it will continue to be important to give all parties – manufacturers and covered entities – the choice as to whether to partner with the prime vendor on these operational matters. As is currently the case in the 340B program, we believe HRSA should continue to encourage but not require program participants to work with the prime vendor as to any aspect of the 340B Program.

Finally, given the highly operational nature of the issues related to establishing a single standardized process for issuing refunds to covered entities in the event of a ceiling price change, BIO recommends that HRSA create a working group of stakeholders that includes covered entities, manufacturers, and wholesalers to collaborate on the implementation of this process and any related operational concerns that may arise. Only through such a group is HRSA sure to fully identify and consider the multitude of operational issues that will play a role in implementing this new statutory requirement.

C. Verification of Covered Entity Eligibility and Implementation of a Standard Identifier

Section 7102 obligates the Secretary to develop a procedure to enable and require covered entities to regularly update their eligibility information and for HRSA to verify the accuracy of that information. In validating covered entity eligibility, HRSA should not permit those entities that no longer meet the statutory definition of a covered entity to continue receiving discounts under the 340B program while they work towards eligibility during that period. The 340B statute expressly limits the manufacturer's obligation to provide the ceiling price to covered entities as defined by the statute and does not permit a "grace period" for those non-eligible entities seeking to re-qualify. BIO also requests that HRSA address whether its system for verifying covered entity eligibility will include auditing or spot-checks of the registration information provided by the covered entity to ensure that such information is accurate.

PPACA also requires the Secretary to establish "a single, universal, and standardized identification system by which each covered entity site can be identified" for purposes of facilitating ordering, purchasing and delivery of covered outpatient drugs as well as the processing of chargebacks. BIO recommends that HRSA use Health Industry Numbers (HINs) for this purpose, because these universal identification numbers are already used by many end-customers, wholesalers and manufacturers alike, including for identifying end-customers in chargeback-based sales. HRSA should continue to assign and use the 340B ID number as well for back-up identification, because not all entities have a HIN. If both identification numbers are listed for each covered entity on the OPA database, manufacturers will be better able to identify and validate covered entity eligibility for ceiling prices and ensure those discounts are provided

as appropriate. We ask that HRSA require that covered entities submit both identifiers to the wholesaler at all times.

IV. Administrative Dispute Resolution Regulations and Process for Imposition of Sanctions

PPACA requires the Secretary to promulgate regulations to establish and implement an administrative process for resolution of claims by covered entities and manufacturers, within 180 days of enactment. The Secretary also must establish a process for determining non-compliance by manufacturers and covered entities and for imposition of sanctions. In implementing these requirements, BIO urges HRSA to include in its proposed rule and process the following elements, to best protect the interests of all parties:

- The evidentiary standard (e.g., a preponderance of the evidence);
- Right to discovery and discovery procedures;
- Available remedies, if any, beyond those specified by the statute; and
- Confidentiality of the proceedings and the resolution.

V. Audits of Manufacturers and Wholesalers

Section 7102 of PPACA requires the Secretary to provide for "[s]elective auditing of manufactures and wholesalers." BIO requests that to the extent HRSA permits covered entities to conduct such audits, it apply the same standards that currently apply to audits by manufacturers under HRSA's existing audit guidelines.[13] These safeguards, including submission of an audit work plan documenting reasonable cause for the audit and retention of an independent auditor, will help to minimize the risk of disclosure of the manufacturer's confidential information as well as reduce the administrative burden on manufacturers.

VI. Audits of Covered Entities

The 340B statute permits the Secretary or a manufacturer to audit the records of the covered entity directly pertaining to the entity's compliance with the statute with respect to the manufacturer's covered outpatient drugs.[14] BIO requests that HRSA address whether the HHS Office of the Inspector General (OIG) will regularly audit participating covered entities for compliance with the requirements for eligibility and participation under the 340B program, as well as whether the OIG will audit a particular covered entity within a reasonable timeframe of a manufacturer's request. BIO believes that the OIG is best suited for such reviews because of its audit expertise and believes any such reviews should focus on covered entity eligibility, diversion, and duplicate discount compliance.

VII. Exemption for Drugs Designated as Orphan Drugs

[13] 61 Fed. Reg. 65406 (Dec. 12, 1996).
[14] 42 U.S.C. § 256b(a)(5)(C).

BIO understands that certain covered entities that previously were enrolled in the 340B program as disproportionate share hospitals may seek to re-enroll in the program as one of the new covered entity hospital types added by PPACA. We request that HRSA confirm our understanding that the exception to the ceiling price obligation for drugs that are designated as orphan drugs applies effective with the covered entity's change in designation, such that the manufacturer is no longer obligated to offer that drug at the 340B ceiling price to the covered entity.

Similarly, we ask that HRSA confirm that where a covered entity meets the requirements for more than one type of covered entity under 42 USC 256b(a)(4), the applicability of the exception for orphan drugs is determined based on the "Entity Type" of the covered entity that is making the purchase, as set forth in HRSA's covered entity database. For example, a manufacturer would not be obligated to offer the ceiling price on an orphan drug to a covered entity that is identified in HRSA's database as a children's hospital, regardless of whether that hospital may also qualify as an eligible hemophilia treatment center under the 340B statute.

Finally, we also ask HRSA to confirm that the orphan drug exception does not apply to purchases made by children's hospitals during the period prior to enactment of HCERA. Section 2302 of HCERA, which created the orphan drug exception, amended the 340B statute itself (as amended by PPACA). While certain of PPACA's amendments to the 340B statute have a stated effective date of January 1, 2010, this provision in HCERA has no stated effective date and so we believe the orphan drug exception is effective only as of HCERA's enactment. We ask HRSA to confirm that interpretation.

VIII. Enforcement of Prohibitions on Duplicate Discounts and Diversion

PPACA and HCERA expanded the Medicaid rebate program to Medicaid managed care organization (MCO) utilization, but simultaneously exempted from Medicaid rebates those covered outpatient drugs subject to discount under the 340B program. This exclusion is consistent with the existing prohibition on duplicate discounts on Medicaid fee-for-service utilization. BIO urges HRSA to implement standards that will provide Medicaid MCOs and state Medicaid programs with the information necessary to exclude such utilization from their rebate claims to manufacturers. Although HRSA has defined such standards with respect to Medicaid fee-for-service utilization, state Medicaid agencies have not always been diligent in ensuring that such 340B utilization is excluded from their rebate claims. Adopting an effective policy for enforcing the duplicate discount prohibition will only become more important as the number of Medicaid enrollees increases under the various other provisions of PPACA and HCERA. BIO urges HRSA to implement a policy to more stringently enforce this provision, including a mechanism for manufacturers to seek enforcement where needed, either on their own or through the Secretary.

BIO also asks that HRSA address the issue of diversion of drugs purchased at the 340B discount to individuals who are not patients of the covered entity, including any controls that

HRSA is developing to ensure compliance with the existing prohibition on such diversion. In connection with this effort, we urge HRSA to finalize its January 2007 Notice regarding the definition of a "patient" for purposes of the 340B program.[15] As HRSA stated in that Notice, it is possible that some covered entities may have interpreted the current definition of a "patient" too broadly, resulting in the potential for diversion of 340B-priced drugs.[16] BIO believes providing covered entities with the explicit guidance set forth in the January 2007 notice regarding the necessary relationship between the covered entity and the individual patient is critical to reducing the risk of diversion of drugs purchased under the 340B program.

In particular, the January 2007 notice reiterates guidance issued by HRSA more than ten years ago making clear that employees of a covered entity must meet the definition of patient in order to be considered "patients" of the covered entity:

> *Comment*: Employees of covered entities should be either specifically precluded or included as eligible patients to receive discounted drug products.
>
> *Response*: Any employee of a covered entity who meets the criteria of the definition of covered entity "patient" would be eligible to access 340B pricing.[17]

To the extent that covered entities have been extending 340B pricing to their non-patient employees, they have been doing so contrary to this long-standing, public declaration by HRSA that employees are not patients of the covered entity unless they meet the three prongs of the patient definition test. The January 2007 Notice explicitly incorporates this pre-existing standard and puts to rest the apparent misconception by covered entities that their employees can qualify as patients either by virtue of being employed by the covered entity or under some lesser standard than that required for non-employees.[18] BIO strongly supports finalizing this clarification in order to protect the integrity of the 340B program.

Finally, BIO believes that it is particularly important that HRSA address the procedures and controls it will use to limit diversion and duplicate discounts now as covered entities implement multiple contract pharmacy arrangements pursuant to HRSA's March 2010 Final Notice.[19] The participation of additional contract pharmacies may increase the risk that 340B-priced drugs are diverted to individuals who are not patients of the covered entity and that Medicaid rebates are sought on 340B discounted drugs. BIO urges HRSA to address these considerations as it continues to implement measures to enforce the statutory prohibitions on duplicate discounts and diversion.

---

[15] 72 Fed. Reg. 1543 (Jan. 12, 2007).
[16] Id. at 1544.
[17] See 61 Fed. Reg. 55156, 55157 (Oct. 24, 1996).
[18] See 72 Fed. Reg. at 1546.
[19] 75 Fed. Reg. 10272 (March 5, 2010).

IX. Applicability of Changes to Medicaid Rebate Formula

PPACA implemented a number of changes to the Medicaid rebate formula, effective for rebate periods beginning January 1, 2010, including an increase in the Medicaid base rebate, a change in the rebate calculation for a line extension of a single source or innovator multiple source drug that is an oral solid dosage form, and a cap on the total unit rebate amount for all single source and innovator multiple source drugs equal to 100% of the AMP. BIO requests that HRSA confirm that these changes to the Medicaid rebate formula do not impact the calculation of the 340B ceiling price until the third quarter 2010. This is consistent with long-standing HRSA guidance directing that manufacturers may calculate the ceiling price using Medicaid data for a period that is two quarters prior to the effective quarter of the ceiling price.[20] As HRSA has not issued any change to this guidance, we ask that HRSA confirm our understanding that the Medicaid rebate amounts calculated under the revised rebate formula must be reflected in the ceiling price calculation beginning with the third quarter 2010.

X. Conclusion

BIO looks forward to working with HRSA over the coming months and years to implement PPACA and HCERA. We hope that the agency finds this letter to be a helpful tool as it begins the process. Please feel free to contact Laurel Todd at (202) 962-9220 if you have any questions regarding any of the issues raised herein. Thank you for your attention to this very important matter.

Respectfully submitted,

/s/

Laurel Todd
Managing Director, Reimbursement and Health Policy

[20] See HRSA, Dear Manufacturer and Wholesaler Letter (Aug. 17, 1993); see also HRSA, Letter to Joel Bobula from Marsha Alvarez (Feb. 25, 1993); HRSA, Dear Manufacturer Letter (Apr. 15, 1993); HRSA, Dear Manufacturer and Wholesaler Letter (Feb. 1, 1995).