Alternative Approaches for Valuing Multi-Use Drugs in Medicare Negotiation

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Executive Summary

In 2026, the maximum fair prices (MFPs) for the first 10 selected drugs under the Medicare Drug Price Negotiation Program will go into effect. On January 17, 2025 the Centers for Medicare & Medicaid Services (CMS) announced the next 15 selected drugs that will have MFPs effective in 2027. In guidance, CMS has established the methodologies for selecting and negotiating these products for the 2026 and 2027 initial price applicability years. CMS's current approach for establishing a single MFP weights the utilization of different indications for a drug and its therapeutic alternative(s). However, this utilization-based weighting approach may undervalue newer indications and disincentivize manufacturer development of additional uses for a product, particularly later in a product's lifecycle.

This paper explores three potential alternative approaches that CMS could consider for setting MFPs across multi-indication products: weighting different product uses based on (1) Medicare prevalence, (2) clinical input, or (3) unmet patient needs. While not an exhaustive list of potential options, these approaches aim to balance incentives for continued innovation with the goals of improving patient access and addressing treatment gaps. As the program matures in the coming years and more drugs with varied uses are selected for negotiation, CMS's methodology for determining MFPs will play an increasingly critical role in shaping patient access, fostering innovation, and meeting the evolving needs of the Medicare population.

Background

The Inflation Reduction Act (IRA) established the Medicare Drug Price Negotiation Program, which enables CMS to select and negotiate MFPs for top spending drugs without generic or biosimilar competition. These drugs must have been approved for at least seven years for small-molecule drugs and at least 11 years for biologics at the time of selection. The MFPs for the first set of selected drugs will go into effect beginning in 2026.

The IRA outlines general parameters for selecting drugs for negotiation and setting MFPs but leaves the details of methodology and implementation to CMS. When defining eligible products for negotiation in program guidance, CMS has adopted a broad interpretation of the definition of a "qualifying single-source drug." Specifically, CMS aggregates across all dosage forms and strengths of approved drugs with the same active moiety/ingredient, including across different New Drug Applications or Biologics License Applications. This approach treats various uses of a drug that may be developed over the product's lifecycle as one product for negotiation purposes.

In 2024 guidance, the agency stated that its statutory directive is to aggregate across dosages and formulations in order to avoid "product hopping,"[1] but challenges can arise when products selected for negotiation have multiple uses across different disease areas and populations. Because a drug's eligibility for negotiation depends on time since its initial approval, the aggregation of drugs across multiple uses means that newer uses of the product may have been launched more recently or may still be in the research phase when the drug is selected for negotiation. How CMS considers multiple uses of a selected drug will therefore impact CMS's MFP negotiations and can have broader implications for manufacturer investment strategies and patient access.

Research into multiple product uses is common for chronic disease treatments, which are often important for meeting public health needs. Sodium-glucose co-transporters 2 (SGLT2s), which were among the selected drugs in the first round of IRA negotiation, are an example of products with multiple uses. SGLT2s had new indications approved as recently as the year they were selected for negotiation. Later indications in chronic disease treatments often build upon increased scientific understanding and may provide additional benefits for patients and address remaining unmet needs. For SGLT2s, early indications focused on physiologic-based measures like glucose control, while later uses focused on outcome-centered measures like end-stage kidney disease, cardiovascular death, and hospitalization. For SGLT2s, this evolution of uses has meant that the first indication was for a larger patient population with sizeable competition and, as a result, a lower price point. Later uses of these products focused on outcomes may support a price point higher than the initial indication, making the consideration of these new uses an important part of the negotiation process.

CMS's Current Methodology for Establishing MFPs and Potential Challenges for Drugs with Multiple Uses

As written, current CMS guidance requires a single MFP for a 30-day equivalent supply for each selected drug but has the discretion to determine how to arrive at the MFP. Under the current approach, CMS may weight therapeutic alternative utilization across indications or use the selected drug utilization to determine how each indication should be factored into the MFP. CMS's release of MFP explanations for the first set of selected drugs highlighted this utilization-based weighting approach. Specifically, CMS weights therapeutic alternatives to determine the starting point for each use. CMS then combines the prices across the uses by considering the utilization of the selected drugs and its therapeutic alternatives.

[1] The Federal Trade Commission defines "product hopping" as a strategy wherein manufacturers seekto shift demand from a brand name drug that faces generic competition to a newly patented and/or exclusivity protected drug (often through a newer version of the same drug) that does not face generic competition.

Because CMS aggregates drugs across multiple uses and sets a single MFP, this utilization-based approach may create challenges for drugs with multiple uses for several reasons:

- **Lower initial utilization:** The utilization-based approach may inadvertently undervalue newer indications with lower initial utilization, as peak drug utilization typically occurs several years post-launch.
- **Different pricing strategies and patient benefits for other product uses:** Later indications may provide additional benefits to patients or address unmet needs, which may warrant different pricing structures. As indicated in the SGLT2 example, this could be problematic for certain therapeutic areas, such as chronic disease treatments, where later indications may have a higher price point but may not have reached peak utilization.
- **Reduced incentives for development of new product uses:** While newer uses may provide additional benefits to patients or address unmet needs, undervaluing these newer uses through a utilization-based weighting approach may reduce incentives for manufacturers to pursue additional uses post-approval.

Potential Alternative Approaches for Establishing MFPs for Drugs with Multiple Uses

The IRA does not explicitly require CMS to weight indications by utilization. Therefore, CMS has opportunities to consider alternatives that more effectively recognize the patient impacts of different product uses and incentivize manufacturer development to bring new and expanded treatment options to patients. Example alternative indication weighting approaches that CMS could consider include:

- Relative prevalence in the Medicare population,
- Clinical input on each indication's relevance and importance to a selected drug, and
- Unaddressed patient needs among the current patient population.

These approaches, detailed below, are potential frameworks for CMS to consider when setting a single MFP for products with multiple uses. Because CMS has chosen to aggregate across product uses when considering qualifying drugs for negotiation, consideration of alternative approaches to indication weighting is important, as many drugs selected for negotiation are likely to have multiple uses. However, modifying the current methodology may not be necessary for all drugs, and CMS will need to determine when methodological adjustments are required. While there may not be a formulaic approach to determine when adjustments should occur, CMS will need to ensure consistent application of its approach across drugs.

Illustrative Example of Application of Different MFP Weighting Approaches

Below is an illustrative example of a selected drug that demonstrates the challenges with a utilization-based approach. This example also highlights how the three potential alternative

approaches may better account for other uses of the product. Table 1 provides the characteristics of the hypothetical drug and how CMS currently weights the drug with its utilization-based weighting approach. Weighting of the uses is illustrated in Table 2 under the current approach compared to the three alternative approaches. In some instances, CMS may identify multiple therapeutic alternatives within each indication, but CMS has not provided detailed information on its approach to weighting across multiple therapeutic alternatives within an indication.

In this illustrative drug example, current utilization across the three approved uses (Table 1) would match CMS's utilization-based weighting approach (Table 2). As a result, the more recently approved Use C would likely have a low impact on MFP as utilization is significantly low and well below its potential peak value (as measured by prevalence).

Table 1. Characteristics of Illustrative Selected Drug

	Approval Date	Current Utilization	Medicare Prevalence	Clinician Rating of Importance	Priority of Unmet Needs Addressed
Use A	2012	55%	15M	5	4
Use B	2015	40%	10M	5	4
Use C	2023	5%	10M	5	6

Table 2. Weighting of Illustrative Selected Drug Indications

	Current: Utilization-Based Approach	Alternative Approach 1: Medicare Specific Prevalence[1]	Alternative Approach 2: Clinical Input-Based Weighting[2]	Alternative Approach 3: Unaddressed Patient Needs[3]
Use A	55%	43%	33.3%	28.6%
Use B	40%	28.5%	33.3%	28.6%
Use C	5%	28.5%	33.3%	42.8%

1. Use A Weight = Use Prevalence ÷ [Use A Prevalence + Use B Prevalence + Use C Prevalence]
2. Use A Weight = Use A Clinician Rating ÷ [Use A Clinician Rating + Use B Clinician Rating + Use C Clinician Rating]
3. Use A Weight = Use A Unmet Need Rating ÷ [Use A Unmet Need Rating + Use B Unmet Need Rating + Use C Unmet Need Rating]

Three alternative approaches are explored below and compared to the current utilization-based weighting methodology.

Alternative Approach 1: Medicare-Specific Prevalence

Under the Medicare-specific prevalence approach, each use would be weighted by its Medicare prevalence relative to the total Medicare prevalence across therapeutic areas. CMS can access various data sources to implement this approach, including published literature with these prevalence estimates and data submitted by the public via the Negotiation Data Elements Information Collection Request (ICR).

Table 1 provides the Medicare-specific prevalences for the illustrative drug. Use A has the greatest prevalence, while Uses B and C have the same prevalence. Using this approach, the weighting of Use C increased significantly from the current utilization approach and is now weighted equally to Use B. Use A has the greatest weight due to it having the largest Medicare prevalence (Table 1, Approach 1). Use C is now weighted equally to Use B, whereas in the utilization-based approach, Use B was weighted more heavily.

This approach better aligns negotiation outcomes with the drug's impact on the disease burden in Medicare. By using a more stable metric like prevalence that is not dependent on the lifecycle of a particular treatment, additional uses of a product that are pursued later in a product's lifecycle or closer to negotiation eligibility would not be undervalued based on utilization. This approach would also help maintain incentives for manufacturers to pursue additional treatments later in a product's lifecycle that may benefit patients. However, a Medicare-specific prevalence approach may still under or overvalue indications to the extent that prevalence differs from peak utilization. This approach may also inadvertently undervalue less common conditions that present a high cost burden to the Medicare program.

Alternative Approach 2: Clinical Input-Based Weighting

Under this approach, each use would be weighted based on its relative importance (e.g., relevance and value) from a clinical perspective. The uses that clinicians view as more important would be given higher weight. In its simplest form, clinicians could rate each use on a scale of one to seven, where one represents no clinical improvement over the standard of care, four represents a significant improvement over the standard of care and seven represents a breakthrough compared to the standard of care. The ratio of each individual use's clinical importance to the sum of clinical importance across indications would be used to determine relative weighting. The approach could be implemented via a public forum (e.g., a roundtable), an independent survey of clinicians, integrated into the Clinician-Focused Input section of the ICR, or via other methods (e.g., targeted interviews) that engage clinicians and measure their perspective on each indication's importance.

Table 1 also provides clinician importance ratings for the illustrative drug example. All three indications receive a five rating (slightly above significant improvement over the standard of care). Because all three indications have equal clinical importance, they are weighted equally, and the relative importance of Use C in the negotiation process significantly increases (see Table 1, Approach 2). This approach would better align with clinical perspectives on the benefits of a product's different uses for patients. This ensures that the clinical perspective—rather than a variable, market-based metric (utilization)—plays a key role in shaping a product's MFP.

While CMS already requests feedback from clinicians on negotiated products, this approach may require additional resources due to the granularity of input needed to value clinical importance

appropriately. The level of engagement from the clinical audience would directly affect the accuracy of the ratings under this approach.

Alternative Approach 3: Unaddressed Patient Needs

Under this approach, each indication would be weighted based on current unaddressed patient needs in the population. Patient needs may include, but are not limited to, treatment availability, efficacy, convenience, acceptability, and side effects. Uses where current treatments are insufficient would be given a higher weighting. Patients, caregivers (where relevant), and clinicians could rate each use on a scale of one to seven, where one represents no unmet needs addressed by the therapy compared to the standard of care, four represents moderate priority unmet needs are addressed compared to the standard of care, and seven represents essential priority unmet needs are addressed compared to the standard of care. This approach could also be implemented using any of the techniques described in the clinical input-based weighting approach (public forums, interviews with clinicians, etc.).

Table 1 provides unmet ratings for the illustrative drug for patients, caregivers, and clinicians. At a rating of four, Uses A and B address moderate priority unmet needs, while a rating of six for the third indication (Use C) demonstrates that the drug addresses high-priority unmet needs. While Use C would receive the lowest weighting under the current utilization-based approach, it would be weighted most under this alternative approach due to its higher rating for addressing unmet patient needs.

Compared to the current utilization-based approach and other approaches, this approach puts patients at the forefront in weighting the benefit of different uses for a product. As a result, this approach would ensure that MFPs align with the interest of patients and provide the appropriate incentives for manufacturers to pursue additional product uses. However, this approach poses similar challenges as Alternative Approach 2 in collecting the granularity of clinician, patient, and caregiver input for accurate ratings.

Conclusion

The alternative approaches described above demonstrate how CMS may consider drugs with multiple indications in the negotiation process. The illustrative drug example detailed in this paper highlights how the current utilization-based approach presents challenges for drugs with multiple uses, especially those that treat chronic disease and may create disincentives for developers to pursue indications later in a product's lifecycle. With many of the selected 2026 and 2027 negotiated drugs treating chronic disease and having multiple uses, CMS's approach for weighting different uses will impact many common treatments used by Medicare beneficiaries. As the number of drugs selected for Medicare negotiation grows in future years, and as many of these drugs are likely to have multiple uses, it will become increasingly important that CMS's negotiation process creates the appropriate incentives that align the best interests of patients, manufacturers, and the federal government.

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