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Maryland Prescription Drug Affordability Board
Comments on Draft Cost-Review and UPL Documents for Ozempic
April 2026

AARP Maryland, which has about 850,000 members, congratulates the state's Prescription Drug Affordability Board (PDAB) on the three draft documents it released on April 22, 2026, regarding cost review and upper payment limits (UPLs) for Ozempic. They are thoroughly researched, balanced, clear, and justified in their conclusions and proposed actions.

Based on that and the very large and rapidly growing state and local government expenditures for Ozempic, AARP Maryland urges the prompt adoption of the draft Cost Review Study Report and draft UPL regulations for Ozempic. By doing that, the PDAB will position state and local governments to withstand the rapidly rising costs for this drug, which already accounts for 4.87 percent of their gross prescription drug spend in one instance. Moreover, the usage of this drug is likely to continue rising strongly since it is increasingly being prescribed "off label" by physicians for weight loss in addition to the FDA-approved uses for type 2 diabetes, cardiovascular disease (CVD) and chronic kidney disease (CKD).

The PDAB correctly made a unanimous prior preliminary determination that Ozempic has created an affordability challenge for the state health care system. The cost to the state and local government in Maryland, the PDAB found, is "disproportionate to the net cost paid by payors." And these costs also hit individual state and local government beneficiaries hard, with the impact likely to expand in the future, since the drug is considered the preferred GLP-1 option not only for type 2 diabetes but also for CVD and CKD.

The case for taking prompt action is strengthened further by FDA findings that Ozempic is no longer in a shortage situation. Moreover, the last of the drug's patents don't expire until December 2031 and June 2033, the PDAB noted. Therefore, no generic drugs that might exert downward pressure on Ozempic's price are on the near-term horizon.

Given this situation, the PDAB's draft UPL regulation on Ozempic is needed and appropriate. Under this draft, the UPL starting January 1, 2027, would be $274 for a 30-day supply. This cost is the same as the negotiated Medicare Fair Price, lending added credence to the suitability of the figure Maryland would use as its base when the UPL starts. And there would be annual inflation adjustments starting January 1, 2028, with the new rate then tied to the federal Consumer Price Index for 18 months before the UPL took effect.

For all these reasons, AARP Maryland praises the PDAB for the Draft Cost Review Study Report, the Calculations and Analyses Underpinning Potential UPL Values, and the draft UPL

regulations for Ozempic. AARP urges the prompt adoption of all these documents so that state and local governments in Maryland — and especially their beneficiaries — can begin receiving much-needed relief from the costs of this important drug.

PhRMA
RESEARCH • PROGRESS • HOPE

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By Electronic Submission

May 1, 2026

Maryland Prescription Drug Affordability Board
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Bowie, MD 20715
comments.pdab@maryland.gov

RE: Draft Regulation – New Regulation COMAR 14.01.07.02 (Upper Payment Limit); Ozempic: Calculations and Analyses Underpinning Potential UPL Values

Dear Members of the Maryland Prescription Drug Affordability Board:

The Pharmaceutical Research and Manufacturers of America ("PhRMA") is writing in response to the Maryland Prescription Drug Affordability Board's (the "PDAB's" or "Board's") request for written comments on its draft regulation regarding an Upper Payment Limit for Ozempic (COMAR § 14.01.07.02) ("Draft Regulation") and its Calculations and Analyses Underpinning Potential UPL Values for Ozempic ("Calculations and Analyses Document"").[1] PhRMA represents the country's leading innovative

[1] *See* Draft New Regulation – COMAR 14.01.07.02 (Upper Payment Limit), *available at* https://pdab.maryland.gov/Documents/regulations/2026/14.01.07.02.Propsed%20Ozmepic%20UPL%20Regs%204.22.26.pdf**;** Ozempic: Calculations and Analyses Underpinning Potential UPL Values, *available at* https://pdab.maryland.gov/Documents/Cost%20Review/2026/4.22.26%20OZEMPIC.Upper%20Payment%20Limit.Calculations%20and%20Analyses%20%281%29%20%281%29.pdf. In filing this comment letter, PhRMA reserves all rights to legal arguments with respect to the constitutionality of Md. Code, Health Gen. §§ 21-2C-01–16 (the "PDAB Statute"). PhRMA also incorporates by reference all comments, concerns, and objections that it has previously raised regarding the Board's implementation of the PDAB Statute. *See, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations – New Regulation COMAR 14.01.06 (Implementation and Monitoring of Upper Payment Limits); New Regulation – COMAR 14.01.07 (Upper Payment Limit) (Mar. 30, 2026); Letter from PhRMA to Board Regarding Draft Cost Review Study Reports for Comment (Mar. 30, 2026); Letter from PhRMA to Board Regarding UPL Amount and Methodology Documents (Mar. 4, 2026); Letter from PhRMA to Board Regarding Cost Review Study Process and Policy Review Process (Feb. 10, 2026); Letter from PhRMA to Board Regarding Proposed Rules – Amendments to COMAR § 14.01.01.01 (Definitions); New Regulation COMAR § 14.01.01.06 (Hearing Procedures); New Chapter COMAR § 14.01.05 (Policy Review, Final Action, Upper Payment Limits) (Feb. 10, 2025); Letter from PhRMA to Board Regarding Proposed Regulation – Amendments to COMAR § 14.01.04.05 (Cost Review Study Process) (Dec. 2, 2024); Letter from PhRMA to Board Regarding Draft Regulations – Amendments to COMAR § 14.01.01.01 (Definitions); New Regulation COMAR § 14.01.01.06 (Hearing Procedures); New Chapter - COMAR § 14.01.05 (Policy Review, Final Action, Upper Payment Limits) (Nov. 8, 2024); Letter from PhRMA to Board Regarding Plan of Action for Implementing the Process for Setting Upper Payment Limits – Draft Working Document (Aug. 26, 2024); Letter from PhRMA to Board Regarding Selected Drug List (July 16, 2024); Letter from PhRMA to Board Regarding Request For Information Draft Forms (July 12, 2024); Letter from PhRMA to Board Regarding List of Proposed Therapeutic Alternatives and Sample Dashboard (May 10, 2024); Letter from PhRMA to Board Regarding Cost Review Study Process (Apr. 24, 2024); Letter from PhRMA to Board Regarding Rules of Construction and Open Meetings Proposed Rule; Confidential, Trade-Secret, and Proprietary Information; Public Comment Procedures; and Cost Study Review Process (Oct. 23, 2023); Letter from PhRMA to Board Regarding Definitions; Rules of Construction and Open Meetings; Confidential, Trade- Secret, and Proprietary Information; and Cost Review Study Process (June 30, 2023); Letter from PhRMA to Board Regarding Confidential, Trade-Secret, and Proprietary Information Proposed Rule (May 4, 2023); Letter from PhRMA to Board Regarding Rules of Construction and Open Meetings Proposed Rule (May 4, 2023); Letter from PhRMA to Board Regarding Draft Regulations on Public Information Act (May 4, 2023); Letter from PhRMA to Board Regarding General Provisions; Fee Assessment, Exemption, Waiver, and Collection Amendments; and Cost Review Process (May 1, 2023); Letter from PhRMA to Board Regarding Cost Review: Additional Metrics for Identifying Potential Drugs Presentation (Sept. 12, 2022).

biopharmaceutical research companies, which are focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat, and cure disease. PhRMA member companies have invested more than $850 billion in the search for new treatments and cures over the last decade, supporting nearly five million jobs in the United States.

PhRMA has previously commented on various aspects of the Board's work to implement and carry out its responsibilities under the Maryland PDAB Statute ("PDAB Statute").[2] We have expressed our concerns in detail regarding the Board's process for setting upper payment limits ("UPLs") and its activities more broadly, and we encourage the Board to consider these previously submitted comments.[3] In addition, we provide below select comments and concerns with respect to the Draft Regulation and the Board's UPL-setting process in general.

I. Lack of Clear and Meaningful Standards for the UPL-Setting Process

PhRMA continues to have concerns regarding the lack of clear and meaningful standards governing the Board's UPL-setting process, including its process for reconsidering a UPL after it is set.[4]

A. Reconsideration of UPLs

- **Reconsideration of Maximum Fair Price ("MFP")-Based UPLs.** PhRMA remains concerned that the Board has proposed using the Medicare MFP as the UPL benchmark. A drug subject to an MFP may be subject to renegotiation under the Medicare Drug Negotiation Program ("MDPNP") or may cease to be subject to an MFP altogether, but the Board has not established clear and meaningful standards and processes for reconsideration of an MFP-based UPL in such circumstances. The Board has recently indicated that it intends to amend the regulations to allow for reconsideration of MFP-based UPLs if the MFP is renegotiated.[5] PhRMA urges the Board to provide for automatic UPL reconsideration if the corresponding MFP is renegotiated or the drug is no longer subject to an MFP.[6] PhRMA also urges the Board to address how it will monitor MFP changes and establish clear timelines for reconsidering UPLs and modifying or repealing accordingly.

- **Reconsideration of UPLs for Drugs in Shortage.** The PDAB Statute specifically authorizes the Board to "reconsider" a UPL if there is a shortage and prohibits it from applying a new UPL to a drug in "current shortage."[7] The Board's regulations also provide that "the Board shall reconsider" a UPL if it "becomes aware of a shortage . . . in the State."[8] However, as discussed

[2] *See* Md. Code, Health Gen. §§ 21-2C-01–16.
[3] *See* comments cited *supra* note 1.
[4] *See* Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 2-4; Letter from PhRMA to Board (Mar. 4, 2026) *supra* note 1 at 2-3; Letter from PhRMA to Board (Aug. 26, 2024) *supra* note 1 at 1-7.
[5] UPL Regulations: Implementation and Monitoring of Upper Payment Limits, PDAB Meeting Materials, Apr. 13, 2026 ("April 13 Meeting Materials") at 9, *available at* https://pdab.maryland.gov/Documents/meetings/2026/April%2013%2c%202026/2026.04.13.UPL%20Regulations-%20General%20Provisions.pdf.
[6] *See* Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 2.
[7] *See* Md. Code, Health Gen. § 21-2C-13(c)(1)-(2); *see also* COMAR § 14.01.05.09(A)(2); Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 2-3.
[8] COMAR § 14.01.05.09(A)(2); *see* Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 2-3.

in our previous comment letters, the regulations do not explain how the Board will monitor for shortages.[9] While the Board's regulations require it to "develop a program for monitoring the availability of any prescription drug product for which it sets a UPL," the Board has not yet developed such a program.[10] The Board should revise its regulations to specifically address how the Board will monitor for shortages and ensure timely UPL reconsideration if shortages arise.

B. Other Concerns with the UPL-Setting Process

The Board continues to lack clear and meaningful standards for other aspects of the UPL-setting process. PhRMA reintroduces the following, non-exhaustive examples and encourages the Board to review its previously submitted comments for further discussion.[11]

- **UPL Development.**[12] PhRMA remains concerned by the lack of clear standards and processes governing the development of proposed UPLs, including with respect to selecting information to consider, choosing UPL framework parameters and amounts, and determining the appropriateness of a UPL.[13] We urge the Board to establish meaningful standards to guide its actions and limit the risk of arbitrary decision-making.

- **Patient Access and Affordability.**[14] PhRMA is concerned that the Draft Regulation does not provide an adequate process for monitoring the impact of the proposed UPL on patient access and affordability. We request that the Board establish robust measures to monitor access and affordability factors, including benefit design.

- **Confidentiality.**[15] In its response to public comments on government entity reporting requirements, the Board indicated that it intends to "protect any sensitive information per COMAR 14.01.01.04 Confidential, Trade-Secret, and Proprietary Information."[16] PhRMA again asks the Board to address how it will safeguard confidential, proprietary, and trade secret information (as statutorily required) and amend its regulations to expressly protect such information disclosed to the Board.[17]

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[9] *See, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 2-3; Letter from PhRMA to Board (Feb. 10, 2025) *supra* note 1 at 3.

[10] COMAR § 14.01.05.08(B)(1); *see* COMAR § 14.01.05.08(B)(2) ("If monitoring discloses a shortage of the prescription drug product in the State, the Board may suspend or modify the UPL"); Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 3.

[11] *See, e.g.*, *See* Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1; Letter from PhRMA to Board (Mar. 4, 2026) *supra* note 1.

[12] *See, e.g.*, Letter from PhRMA to Board (Mar. 4, 2026) *supra* note 1 at 2-3; Letter from PhRMA to Board (Feb. 10, 2025) *supra* note 1 at 2-4.

[13] *See* COMAR § 14.01.05.02(B)(2); *see, e.g.*, Letter from PhRMA to Board (Mar. 4, 2026) *supra* note 1 at 2-3; Letter from PhRMA to Board (Feb. 10, 2025) *supra* note 1 at 2-4.

[14] *See* Draft COMAR § 14.01.07.02; *see also, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 3.

[15] *See, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 3-4.

[16] *See* April 13 Meeting Materials at 5.

[17] *See* Md. Code, Health Gen. § 21-2C-10(a)–(b) ("Only Board members and staff may access trade secrets and confidential and proprietary data and information ... that is not otherwise publicly available"; "all information and data" shall be "considered to be a trade secret and confidential and proprietary information" and "is not subject to disclosure under the Public Information Act" if it is obtained by the Board "and is not otherwise publicly available.").

- **Stakeholder Comment.**[18] To allow for meaningful feedback and participation, PhRMA again asks the Board to both post all documents subject to public comment on its website and distribute the same to stakeholders and distribution lists at least 14 days before the comment deadline.[19] The Board should explain how it will incorporate and address all feedback.[20]

II. Improper Characterization of Medicare Maximum Fair Prices ("MFPs") as "Negotiated"

The Calculations and Analyses Document misrepresents the MFP-setting process by describing MFPs as "negotiated."[21] Under the Inflation Reduction Act ("IRA") and Centers for Medicare & Medicaid Services ("CMS") implementing guidance, the process for establishing an MFP is far from a "negotiation," as that word is customarily used.[22] CMS has unilateral and virtually unconstrained discretion to set any price it wishes (below a statutory ceiling) and impose severe penalties on manufacturers that do not agree to CMS's prices or refuse to engage in the process. A manufacturer that does not agree to "negotiate" or does not agree to the MFP that CMS sets must withdraw *all* of its products from Medicare and Medicaid—which account for approximately 45 percent of nationwide retail prescription drug spending.[23] Manufacturers' only alternative is to accept an excise tax of up to 1,900 percent and, in some circumstances, civil monetary penalties. These penalties and taxes command acquiescence, not true negotiation.[24] Furthermore, CMS dictates MFP terms through a rigid, non-negotiable framework. Manufacturers must sign the agreement with CMS before knowing the final price, they cannot revise the terms, and they are denied legal recourse or transparency into CMS's decision-making process.[25]

III. MFP Is an Inherently Flawed Metric for State Use and Could Create Access Challenges for Patients

PhRMA remains concerned about the Board's use of MFPs as benchmarks for setting Maryland UPLs.[26] MFPs are specifically developed for the Medicare program and patient population under the statutory framework of the Inflation Reduction Act, but the Draft Regulation would apply these prices to an entirely different market and patient population. In doing so, the Board would be disregarding the unique market dynamics and affordability challenges that patients in Maryland may be facing.[27] As PhRMA has previously

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[18] *See, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 4; Letter from PhRMA to Board (Nov. 8, 2024) *supra* note 1 at 5-6.

[19] *See, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 4.

[20] *See, e.g.*, *id.*

[21] Calculations and Analyses Document at 1.

[22] *See, e.g.*, Decl. of P. Costello, *Nat'l Infusion Ctr. Ass'n v. Becerra*, No. 1:23-cv-00707-DII (W.D. Tex. Aug. 10, 2023), ECF No. 35-6 at ¶¶ 12-14, 20 (describing the MFP-setting process and indicating that, "[a]bsent a legal compulsion to do so, Amgen would not agree to these prices").

[23] Congressional Budget Office ("CBO"), Prescription Drugs: Spending, Use, and Prices (Jan. 2022), *available at* https://www.cbo.gov/publication/57050.

[24] In fact, the CBO score for the IRA presumes that the excise tax will not generate any revenue independent of its effects on drug pricing through imposition of the government's MFP. *See* CBO, Estimated Budgetary Effects of Public Law 117-169, to Provide for Reconciliation Pursuant to Title II of S. Con. Res. 14 at 5 (Sept. 7, 2022), *available at* https://www.cbo.gov/publication/58455.

[25] *See* Inflation Reduction Act of 2022, Pub. L. 117-168, §§ 11001(c), 11002(c) (lack of notice-and-comment rulemaking); 42 U.S.C. § 1320f–7, Social Security Act § 1198 (lack of judicial review).

[26] *See* Calculations and Analyses Document at 1-2; *see also e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 4-5; Letter from PhRMA to Board (Mar. 4, 2026) *supra* note 1 at 3-4; Letter from PhRMA to Board (Nov. 8, 2024) *supra* note 1 at 10.

[27] *See* Calculations and Analyses Document at 1-2.

expressed, MFP-based UPLs raise serious concerns for patient access, particularly if expanded to the commercial market.[28]

CMS sets its MFPs through the Medicare Drug Negotiation Program ("MDPNP"), but because the program is still at an early stage, many operational and legal issues remain unresolved. The MFPs for the initial set of drugs only recently went into effect. Although it will be years before the effects of MFPs on patient affordability and access are fully understood, recent evidence shows that out-of-pocket costs for Medicare patients have significantly increased and the number of patients benefiting from MFPs has remained relatively small. Avalere Health's analyses of 2025 and 2026 Part D plan formularies found Part D plans were tightening access to branded medicines, changes that could translate into fewer therapeutic alternatives within classes that contain drugs with an MFP.[29] Further, analyses of 2025 and 2026 Part D plan formularies found that Part D plans have increased utilization management, shifted tier placement, and limited access to drugs subject to an MFP.[30]

The downstream effects of the UPL on patient access are likely to be exacerbated by the use of MFPs in state populations. Using MFP as a benchmark is therefore premature, and PhRMA is concerned with the Board moving forward with an MFP-based UPL without fully understanding the patient impact from the MDPNP.[31]

Finally, the Draft Regulation is silent on the fundamental question of how UPLs will be effectuated. At the federal level, even CMS's complicated process has outstanding key issues not yet resolved, and the MFP applies only to Medicare—raising serious doubts about how Maryland will effectuate a UPL given that the U.S. pharmaceutical market and distribution strategies function nationally. In the case of the MFP, the federal government has designed a specific process for implementing the price for patients insured by Medicare—this system does not apply to other markets. This is a significant shortcoming that Maryland cannot disregard, because an unworkable approach could lead to access challenges for patients. Without understanding how UPLs will work in practice, the Board will not be able to meaningfully assess the impact on the supply chain and patients.

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On behalf of PhRMA and our member companies, thank you for consideration of our comments. Although PhRMA remains concerned about the Draft Regulation and the Calculations and Analyses Document, we continue to stand ready to be a constructive partner in this dialogue. Please contact Kristin Parde at Kparde@phrma.org with any questions.

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[28] *See, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 4-5; Letter from PhRMA to Board (Mar. 4, 2026) *supra* note 1 at 3-4; Letter from PhRMA to Board (Nov. 8, 2024) *supra* note 1 at 10.

[29] Avalere Health, 2025 Part D Formularies Shift to More Coinsurance and UM (Oct. 2024); Avalere Health, Part D Formulary Management Tightens in 2026 (Nov. 2025).

[30] Avalere Health, 2025 Part D Formularies Shift to More Coinsurance and UM (Oct. 2024; Avalere Health, Part D Formulary Management Tightens in 2026 (Nov. 2025). In addition, a 2025 physician survey by Avalere found that nearly all providers (92%) would be somewhat or very likely to stop stocking Part B drugs subject to an MFP. *See* Avalere Health, White Paper: Provider Survey on Part B Negotiation (Sept. 2025).

[31] *See, e.g.*, Letter from PhRMA to Board Regarding Draft Regulations (Mar. 30, 2026) *supra* note 1 at 4-5; Letter from PhRMA to Board (Mar. 4, 2026) *supra* note 1 at 3-4; Letter from PhRMA to Board (Nov. 8, 2024) *supra* note 1 at 10.

Sincerely,

Kristin Parde
Deputy Vice President, State Policy

Alexandra Hussey
Senior Director – Law

Value of Care Coalition

May 1, 2026

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

RE: Upper Payment Limit (UPL) Calculations and Analyses Underpinning Potential UPL Values for Ozempic

Dear Chair Mitchell and Members of the Maryland Prescription Drug Affordability Board,

On behalf of the Value of Care Coalition, we appreciate the opportunity to comment on the April 22, 2026 staff analysis, "Ozempic: Upper Payment Limit (UPL) Calculations and Analyses Underpinning Potential UPL Values" (v.1.0). Our comments address the analytical framework and conclusions, which raise several substantive concerns regarding the adequacy, completeness, and policy relevance of the proposed UPL approach.

First, the proposed UPL is anchored to the federal Medicare Maximum Fair Price (MFP) rather than a Maryland-specific assessment of affordability. The document presents no independent methodology grounded in state-level data and does not demonstrate how the selected benchmark reflects the costs, utilization patterns, or payer dynamics specific to Maryland. This concern is compounded by the fact that the applicable MFP does not take effect until CY2027. The analysis does not establish that the proposed UPL represents an appropriate or evidence-based price for this, or any, market.

Second, the document acknowledges that a UPL set at the MFP does not reflect all discounts, rebates, and price concessions — yet sets aside the Board's own net price data in favor of a benchmark designed for a federal market and a different population. This gap is compounded by market developments the document does not address: net prices for semaglutide have declined substantially, the federal government has already announced reduced pricing for Ozempic, and lower-cost direct-to-consumer options have entered the market. Anchoring a state UPL to a figure the document itself acknowledges is incomplete — and that does not reflect current market conditions — is not a sound basis for a health care policy.

Third, the document raises but does not resolve a fundamental implementation question: whether a single UPL is appropriate across the different entities it would govern. The analysis notes that payors and purchasers occupy different positions in the supply chain, and that pharmacy markups may or may not be appropriate depending on how a given entity acquires the drug — yet recommends no differentiated values and provides no analysis of how a uniform figure would function equitably across these contexts. These questions warrant resolution before a UPL determination is made.

Fourth, the document does not assess the proposed UPL's potential impact on patient affordability or access. It does not model changes in out-of-pocket costs, nor evaluate effects on formulary design, utilization management, or pharmacy participation. For Ozempic — an ongoing therapy for patients managing type 2 diabetes and related cardiovascular and renal conditions — this gap is consequential. Interruptions in therapy can worsen glycemic control, increase cardiovascular risk, and drive avoidable hospitalizations. Health plans have warned that UPLs can lead to higher deductibles, increased prior authorization, and formulary restrictions; independent pharmacies have raised concerns about their capacity to stock affected drugs. Without modeling these dynamics, the document does not demonstrate that the proposed UPL would achieve its intended goals of actually saving money for patients or the overall health care system.

These gaps suggest the current analysis does not provide a sufficiently robust foundation for establishing a UPL for Ozempic. The Coalition encourages the Board to address these limitations before advancing any determination, ensuring it is supported by complete data, Maryland-specific evidence, and a clear connection to patient affordability and access.

We appreciate the opportunity to provide comments and look forward to continued engagement on this important issue.

Sincerely,

Derek Flowers
Value of Care Coalition