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June 26, 2025

Submitted via email to: IRARebateandNegotiation@cms.hhs.gov

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
P.O. Box 8013
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RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Director Klomp:

The Massachusetts Biotechnology Council ("MassBio") appreciates this opportunity to submit comments on the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price ("MFP") in 2026, 2027, and 2028 (the "IPAY 2028 Draft Guidance").

MassBio represents the premier global life sciences and healthcare hub of Massachusetts, which has a vibrant biomedical research and development community that is a global leader for medical discovery and innovation. MassBio's 1,800+ member organizations are dedicated to preventing, treating, and curing diseases through transformative science and technology that brings value and hope to patients. MassBio's mission is to advance Massachusetts' leadership in the life sciences to grow the industry, add value to the healthcare system, and improve patient lives.

MassBio remains concerned about the impact the Medicare Drug Price Negotiation Program (the "Negotiation Program") will have on the future development of innovative and life-saving therapies, as well as on the world-leading small and emerging biotech companies based in Massachusetts. Given the potential impact on innovation and thus on vulnerable patient access to life-saving therapies, we continue to urge CMS to adopt a "do no harm" approach in implementing this program that errs on the side of mitigating against the potential disincentives created by the program's framework, and that allows the agency to make corrections as needed to preserve innovation.

In particular, with respect to the IPAY 2028 Draft Guidance, we urge CMS to:

- Explore opportunities to preserve incentives to develop innovative therapies;
- Expeditiously implement processes for MFP effectuation that facilitate manufacturer compliance without resulting in duplicate discounts; and
- Evaluate the impact of the IRA on the innovation ecosystem, particularly in Massachusetts.

I. CMS Should Explore Opportunities to Preserve Incentives to Develop Innovative New Therapies.

***Orphan Drugs*.** MassBio remains concerned that the narrow scope of the orphan drug exclusion creates a strong disincentive for developers to continue to develop new indications and formulations for existing orphan therapies.

Rare diseases, as defined by the FDA, are conditions that impact fewer than 200,000 patients nationwide, and are inherently under-researched, under-diagnosed, and under-treated. Although much progress has been made since the enactment of the Orphan Drug Act (ODA) 40 years ago, over 90 percent of known rare diseases still do not have therapies or treatments.

This scarcity in therapies is due to a variety of reasons, including the resource and time investment needed to generally design, develop and bring a drug to market,[1] as well as the low success rate of this process.[2] There are also plethora of challenges specific to developing drugs for rare diseases, as the low number of actual patient numbers for certain diseases makes it difficult to establish an adequately sized and diverse patient population for a clinical trial, as well as obtain the high-quality patient data necessary to evaluate clinical trial outcomes.

That said, there has fortunately been a recent surge in the development of drugs for rare disease populations,[3] with much of this development occurring in Massachusetts.[4] Today 40 percent of therapies in the pipeline are in rare disease. Furthermore, given the nature of rare diseases, therapies developed for a particular rare disease can often be the starting point in the translation of new scientific discoveries to clinical medicine.

However, the narrow scope of the orphan drug exclusion creates a strong disincentive to undertake these investments, even though the science is there and could benefit vulnerable populations. Furthermore, because of the limited scope of the exclusion, companies may be

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[1] It can take 10 to 15 years and $1-2B for a drug to be designed, developed and approved for use in patients. I.V. Hinkson, B. Madej, E.A. Stahlberg, *Accelerating therapeutics for opportunities in medicine: a paradigm shift in drug discovery*, Front Pharmacol, 11 (2020), p. 770.

[2] 90 percent of developed drugs are unsuccessful. H. Dowden & J. Munro, *Trends in clinical success rates and therapeutic focus*, Nat Rev Drug Discov, 18 (2019), pp. 495-496.

[3] L. J. Fermaglich & K. L. Miller, *A comprehensive study of the rare diseases and conditions targeted by orphan drug designations and approvals over the forty years of the Orphan Drug Act*. Orphanet J Rare Dis. (June 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10290406/.

[4] D. Seiffert, *Massachusetts owns the orphan drug market. Here's the proof,* Boston Business Journal (Nov. 9, 2015), https://www.bizjournals.com/boston/blog/bioflash/2015/11/massachusetts-owns-the-orphan-drug-market-here-s.html.

disincentivized from developing therapies for rare diseases to begin with, and to instead prioritize indications with larger patient populations from the outset.

For these reasons, we are concerned that CMS has not proposed any policies in the IPAY 2028 Draft Guidance to ensure that implementation of the Negotiation Program will not undermine orphan drug development. Notably, in the past CMS has stated that it would "consider[] whether there are additional actions the agency can take in its implementation of the Negotiation Program to best support orphan drug development."[5] However, the IPAY 2028 Draft Guidance is noticeably silent with respect to this important issue.

MassBio continues to urge CMS to implement the orphan drug exclusion in a way that promotes and is consistent with the underlying purposes and goals of the ODA: to create the necessary financial incentives to accelerate the development of rare disease drug development. For example, CMS should exercise its regulatory discretion to start the pre-negotiation period for orphan drugs upon loss of the orphan drug exclusion (i.e., when the product obtains approval for a new indication for a different disease or condition), rather than when the product was initially approved. In addition, once an orphan drug is selected for negotiation, CMS should ensure that its consideration of the statutory factors adequately values the benefit the therapy brings to patients with rare disease.

Pill Penalty. MassBio also remains concerned with the "pill penalty" inherent in the IRA, pursuant to which small molecule drugs may be subject to negotiation under the Program four years earlier than biological products. This unequal treatment will have serious consequences for vulnerable patients who rely on these drugs. Recent reports indicate that the pill penalty has resulted in a significant decline in R&D investment in small molecule medicines.[6] Furthermore, Medicare Part D plans have indicated that they plan to increase utilization management practices and patient cost-sharing for small molecule drugs selected for IPAY 2026.[7]

In the April 15, 2025 Executive Order "Lowering Drug Prices by Once Again Putting Americans First,"[8] the Trump Administration acknowledged this disparate treatment and its potential harm, and calls on HHS and Congress to "to modify the Medicare Drug Price Negotiation Program to align the treatment of small molecule prescription drugs with that of biological products, ending the distortion that undermines relative investment in small molecule prescription drugs…."

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[5] Medicare Drug Price Negotiation Program: Final Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027.

[6] D. G. Schulthess et al., *The Inflation Reduction Act's Impact Upon Early-Stage Venture Capital Investments*, Ther Innov Regul Sci (April 2025), https://link.springer.com/article/10.1007/s43441-025-00773-3.

[7] Magnolia Market Access, *Inflation Reduction Act Payer Insights Report* (Summer 2024), www.magnoliamarketaccess.com/wp-content/uploads/MMA_IRA-Payer-Insights-Survey4.0_Chartbook_2024.07.31.pdf.

[8] Exec. Order No. 14,273, 90 Fed. Reg. 16441 (April 18, 2025), https://www.govinfo.gov/content/pkg/FR-2025-04-18/pdf/2025-06837.pdf.

MassBio strongly supports legislative efforts to address this issue and welcomes the opportunity to work with the Administration and Congress to ensure swift passage.

II. CMS Should Establish Processes for MFP Effectuation that Facilitate Manufacturer Compliance Without Resulting in Duplicate Discounts.

MassBio appreciates CMS's efforts to support the effectuation of the MFP, including through the creation of the Medicare Transaction Facilitator (MTF). We are concerned, however, that CMS has yet to outline a specific proposal for MFP effectuation with respect to Medicare Part B. While CMS has proposed to adopt a similar effectuation approach as Part D, this approach overlooks the various ways in which Part B and Part D differ in materials ways. These include, for instance, the number of dispensing entities, the manner in which drugs are purchased and dispensed, and the unique coding and reimbursement systems across the two parts. We urge CMS to consider these factors and engage closely with a variety of stakeholders, including manufacturers, to develop a workable effectuation approach for Part B drugs.

We are similarly concerned that, even in the Part D context, elements of CMS's existing framework may impose undue burden on manufacturers or complicate manufacturers' ability to effectuate the MFP without resulting in duplicate discounts. We therefore urge CMS to take proactive steps to prevent duplicate discounts between the Negotiation Program and the 340B drug discount program.

The Negotiation Program statute exempts manufacturers from providing access to the MFP to covered entities when the 340B ceiling price is lower than the MFP for a given selected drug.[9] Although the statute requires manufacturers to provide access to the MFP if it is lower than the 340B ceiling price, this provision further requires that the MFP be offered in a "nonduplicated amount."[10] The proper implementation of this provision is necessary to ensure the proper functioning of the MFP as contemplated by Congress.

However, although IPAY 2026 is fast approaching, in the IPAY 2028 Draft Guidance, CMS has not proposed any specific policies in response to manufacturer concerns about preventing 340B duplicate discounts. CMS instead states that it "will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP." Instead, CMS states that it is "continuing to explore" the feasibility of incorporating 340B-related transactional data from 340B covered entities identifying such claims, including "considering ways to incorporate asynchronous 340B data into MTF processes in the future."

MassBio urges the prompt adoption of a framework that incorporates 340B-related transactional data into MTF processes. As we have stated in previous comment letters, a process that requires manufacturers to work out deduplication directly with covered entities, without any involvement

[9] SSA § 1193(d)(1).
[10] SSA § 1193(d)(2).

from CMS, is simply not realistic. As such, one approach CMS can take to actively implement the 340B nonduplication provision is to require covered entities to identify 340B claims at the point-of-sale using available 340B claims modifiers. CMS can also impose requirements on Part D plans regarding the types of claims that they may adjudicate. Specifically, CMS could designate the lack of a 340B claims modifier as a "defect" that prevents the claim from being a "clean claim" subject to the prompt payment standard.

We stress that it is critical that CMS expeditiously adopt such a framework governing the identification of 340B claims ahead of IPAY 2026. Manufacturers are required to submit their plans for implementing MFP by September 1, 2025, and clarity with respect to the identification of 340B claims is an essential component of this process.

III. CMS Should Evaluate the IRA's Impact on the Innovation Ecosystem in Massachusetts.

We continue to urge CMS to carefully examine the impact of the law in Massachusetts. In light of Massachusetts' unique role as the hub of companies directly engaged in research, development, and manufacturing of innovative products, Massachusetts will be a "canary in the coal mine" in terms of changes to the system, and will thus be a good test case to see how IRA implementation affects the biotech industry.

In early 2023, MassBio surveyed its membership regarding the IRA's immediate impacts, and member perspectives regarding certain regulatory and legislative policies that could mitigate those impacts. MassBio plans to continue to survey our membership and perform other data-driven approaches to monitor the impact of the law, and we hope to have the opportunity to be a resource for CMS as it begins to track the impact of the IRA.

Likewise, as CMS proceeds with implementation of the law, MassBio urges the agency to similarly prioritize building the necessary infrastructure to track the impact of the IRA on the innovation ecosystem. This will be vital given the long-standing relationship between innovation and increased access to life-saving therapies, and the need for the agency to "do no harm" in the ongoing implementation of this program. For instance, CMS could track the following metrics, using CMS's own data and certain data available from the FDA, to assess the IRA's impact over time:

- Number of new technology add-on payment applications for drugs and biologicals;
- Requests for pass-through status under the Hospital Outpatient Prospective Payment System;
- Number of new NDCs in average sales price (ASP) reporting data;
- Number of NDA/BLA submissions (tracking proportion of small-molecule vs. large molecule over time);
- Number of supplemental NDA/BLA submissions;
- Number of applications for orphan drug designation (ODD);

- Percent of products with an ODD that are approved by FDA;
- Number of applications for breakthrough therapy designation;
- Number of applications for fast-track designation; and
- Number of applications for regenerative medicine advanced therapy designation.

We further urge CMS to publicly report data to inform both the public and policymakers in Congress, and to establish a dynamic framework pursuant to which significant decreases in relevant metrics trigger reconsideration of the negotiation process implemented by the agency.

IV. Conclusion

MassBio thanks CMS for your consideration of our comments. Please don't hesitate to contact me at (617)-674-5148 or kendalle.oconnell@massbio.org if you have any questions or would like any additional information to consider our comments.

Best regards,

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