What happens when the MFN pharmaceutical policy goes into effect?

Examining the consequences on access to care for Medicare beneficiaries and on the viability of frontline community oncology practices

One perspective from a Cancer Care Pharmacist at a mid-sized cancer practice:

> *“There will be many patients that forgo treatment either because of lack of access or inability to pay.”*

> *“Our local [hospital] system is no where near capable of handling that volume. The economic impact would be huge. Billing issues, staffing issues, it would be a complete disaster.”*

In response to a question about what they would do if MFN went into effect:

> *"I would update my CV.”*

How the interim final MFN rule would work

Medicare will reimburse practices for the top 50 drugs (by aggregate 2019 Medicare Part B total allowed charges) based on a new formula, phased in over 4 years.*

Current model

ASP

+

4.3% × ASP

After sequestration

Formula imposing deep cuts on top 50 Part B reimbursement

% × ASP

+

% × MFN Price

+

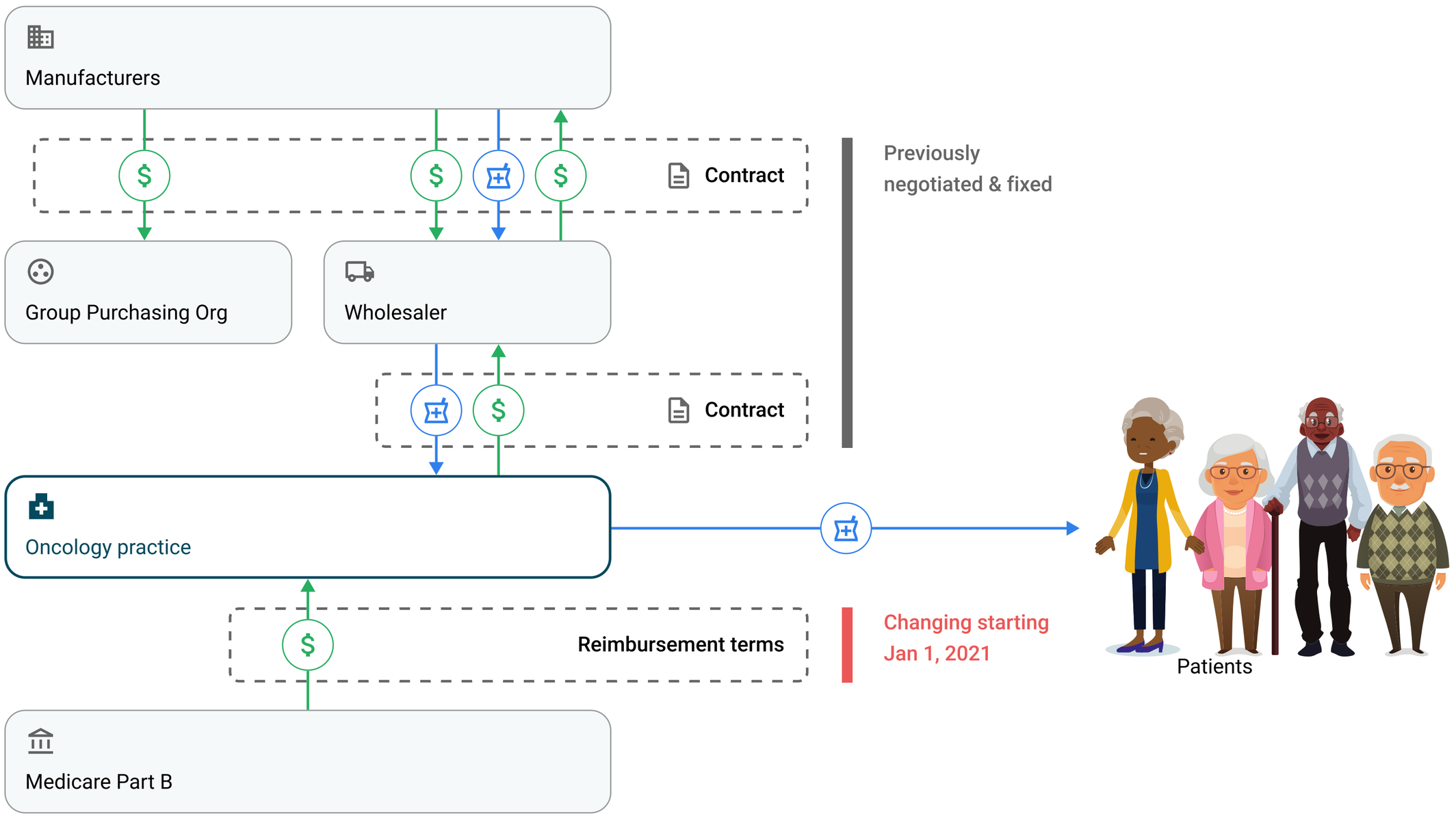
$148.73 flat payment per infusion

Billed as a separate CPT code

	2021	2022	2023	2024	2025	2026	2027
% × ASP	75%	50%	25%	0%	0%	0%	0%
% × MFN Price	25%	50%	75%	100%	100%	100%	100%

How cancer patients get vital Medicare Part B drugs

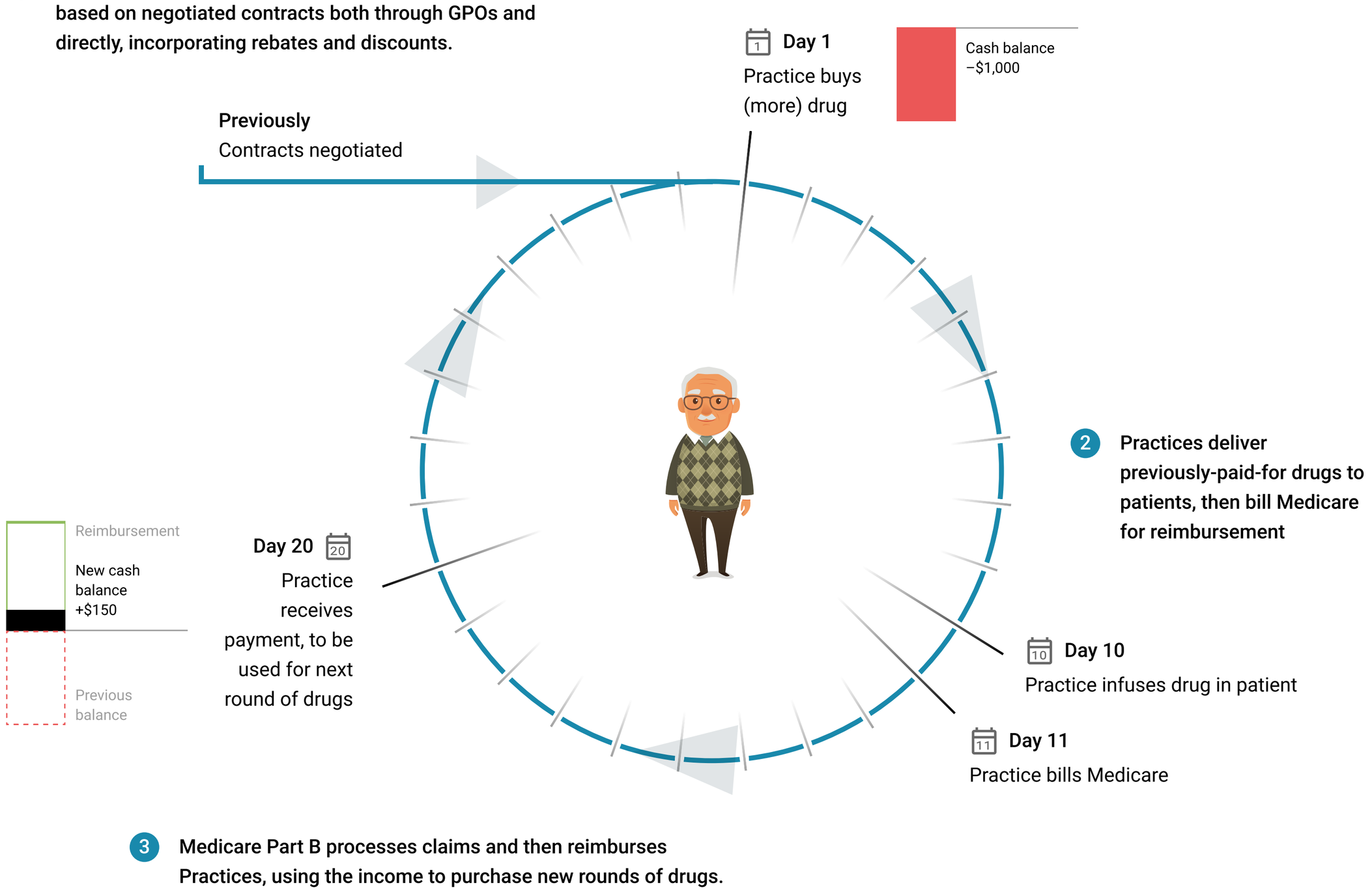
Due to the nature of drug delivery, changing reimbursement rates exerts pressure on practices.



*The Interim Final Rule was originally scheduled to go into effect on January 1, 2021, but has been delayed by a legal injunction.

Practices would immediately feel the impact of MFN due to the way they procure pharmaceuticals*

Given how timing works in the value chain, oncology practices pay up front to procure pharmaceuticals that are then in turn provided to patients. Reimbursement is only received afterwards. While oncology practices may be able to renegotiate contracts if the interim final rule goes into effect, no systems exist today that enable separately-contracted rates for patients with different types of insurance.



→ Key takeaway

If reimbursement is cut abruptly and significantly as planned under MFN, practices will come under significant financial duress, threatening their ability to provide care to patients and their overall financial viability. This is why Medicare's Actuary projects that under MFN a large share of Medicare patients will have no access to medicines or have their access disrupted.

Illustrating the impacts on different practices and patients

On the following pages, we'll demonstrate the impacts of the interim final MFN Rule on small, mid-sized, and large community oncology practices by examining individual patient cases.

*The Interim Final Rule was originally scheduled to go into effect on January 1, 2021, but has been delayed by a legal injunction.

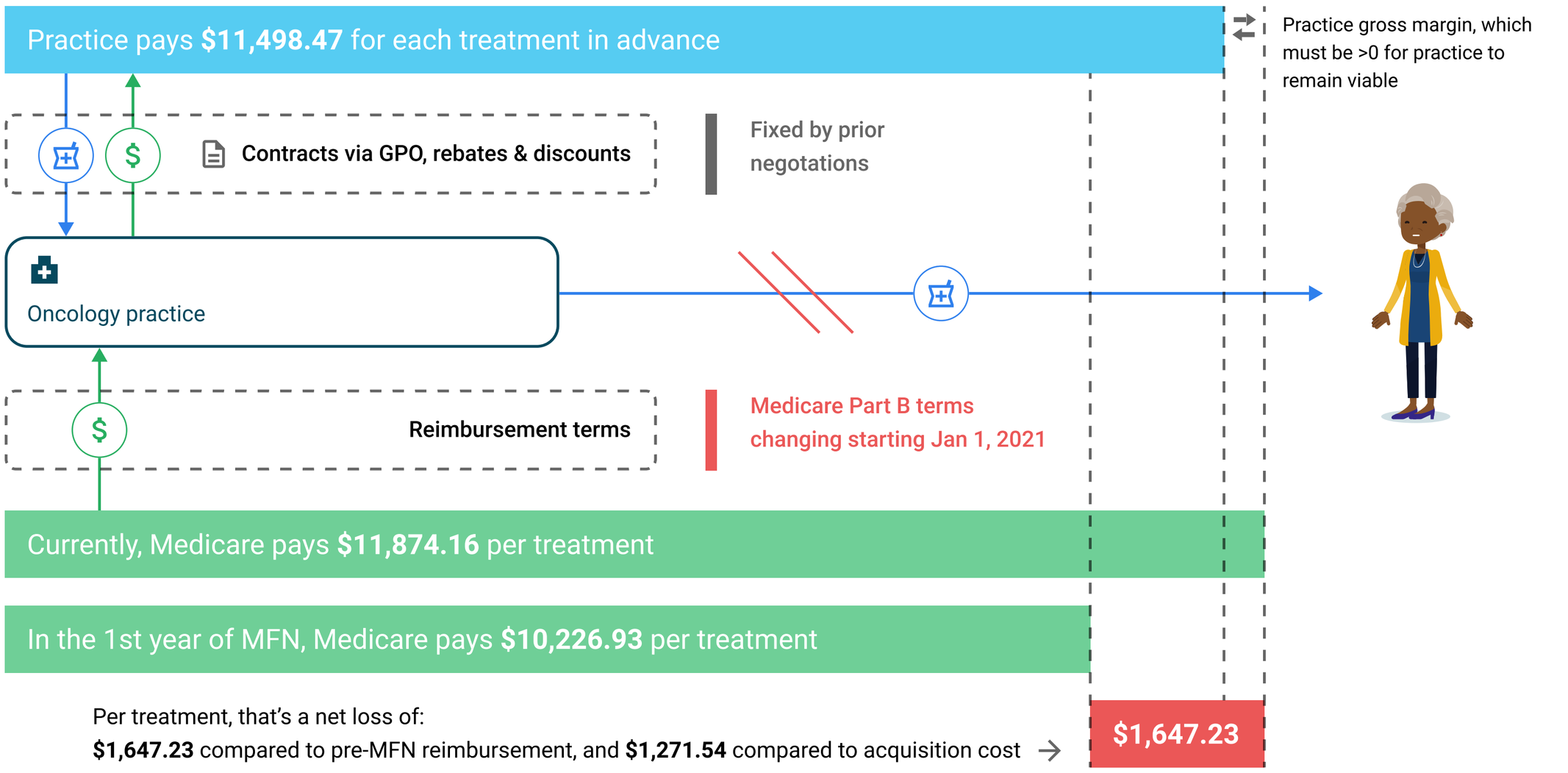
Meet Sonia

Sonia is 70 years old with HER-2 positive metastatic breast cancer. After a mastectomy, she begins treatment with trastuzumab, pertuzumab, and paclitaxel, based on the CLEOPATRA Phase III trial. In addition, the patient is found to be at high risk for spread of her cancer to the bone.

She receives IV pertuzumab, trastuzumab and paclitaxel every three weeks, in addition to denosumab for potential bone involvement. Without this treatment, her cancer would most likely spread, potentially in a rapid fashion.

Here's how Sonia's typical small, rural practice manages her care

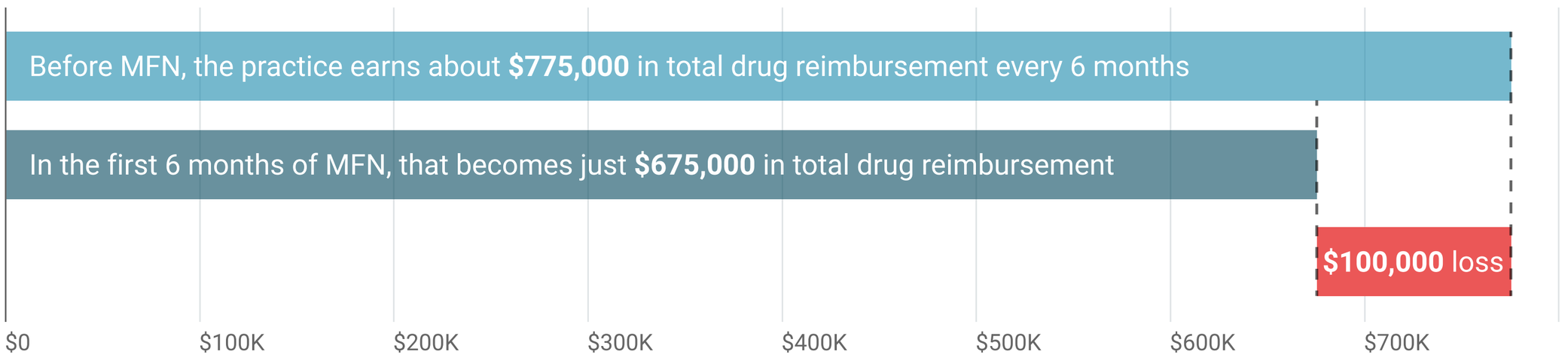
Given fixed drug purchasing contracts, changing reimbursement rates represents a potential threat to practice operability



To treat Sonia for another 6 months, the practice would lose $14,825.09, leading them to turn her away. Sonia would go without treatment, unsure where to find care.

In the 1st year of MFN compared to pre-MFN reimbursement levels. Losses would grow in later years.

It's not just Sonia. Here's the story across all breast cancer patients at this practice in the first 6 months of 2021.



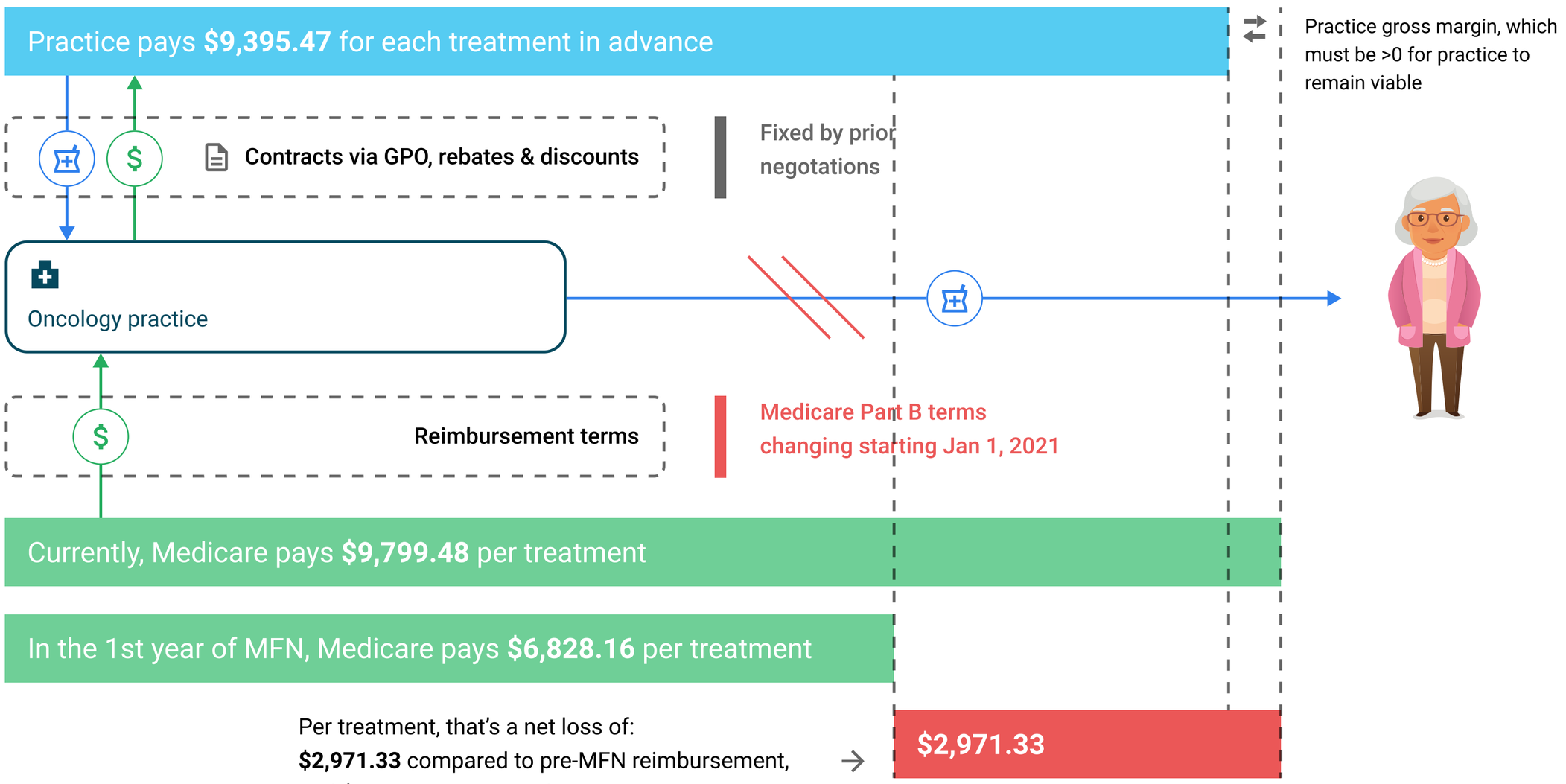
Meet Marianne

Marianne is 66 years old with advanced diffuse large B cell lymphoma, on a regimen of rituximab, cyclophosphamide, doxorubicin, vincristine and prednisone.

MFN causes the practice to lose money on the rituximab and determine that they can't afford to provide the treatment, instead offering the same regimen without the rituximab. This materially worsens her 3 year survival by 13% (from 70% with R-CHOP to ~57% with CHOP alone). Given her advanced disease and age, she warrants the use of pegfilgrastim on a preventative and supplementary basis.

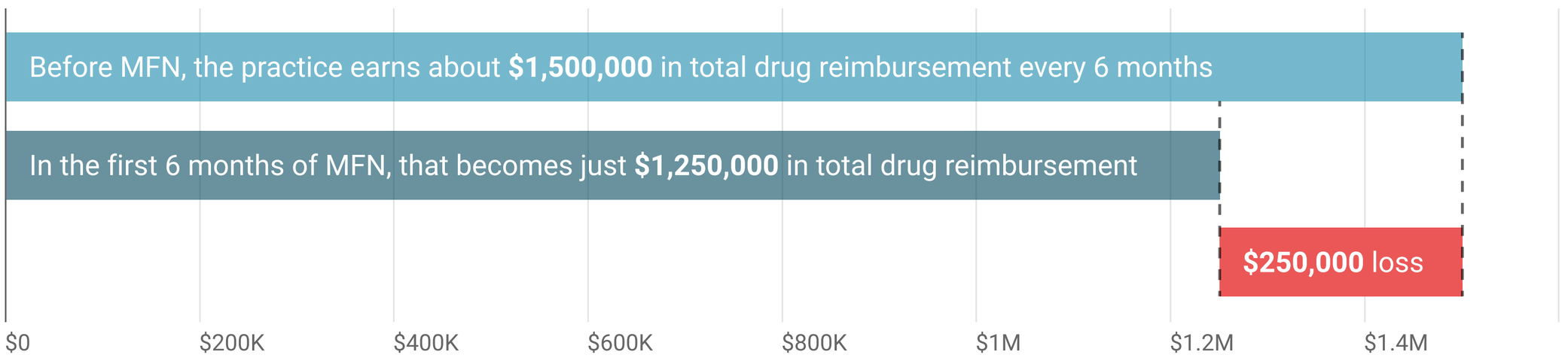
Here's how Marianne's typical mid-sized practice manages her care

Given fixed drug purchasing contracts, changing reimbursement rates represents a potential threat to practice operability



Over 6 months of Marianne's treatment, the practice would lose $17,827.95.
This might force a change in her treatment, or require her to look for care elsewhere.
In the 1st year of MFN compared to pre-MFN reimbursement levels. Losses would grow in later years.

It's not just Marianne. Here's the story across all lymphoma patients at this practice in the first 6 months of 2021.

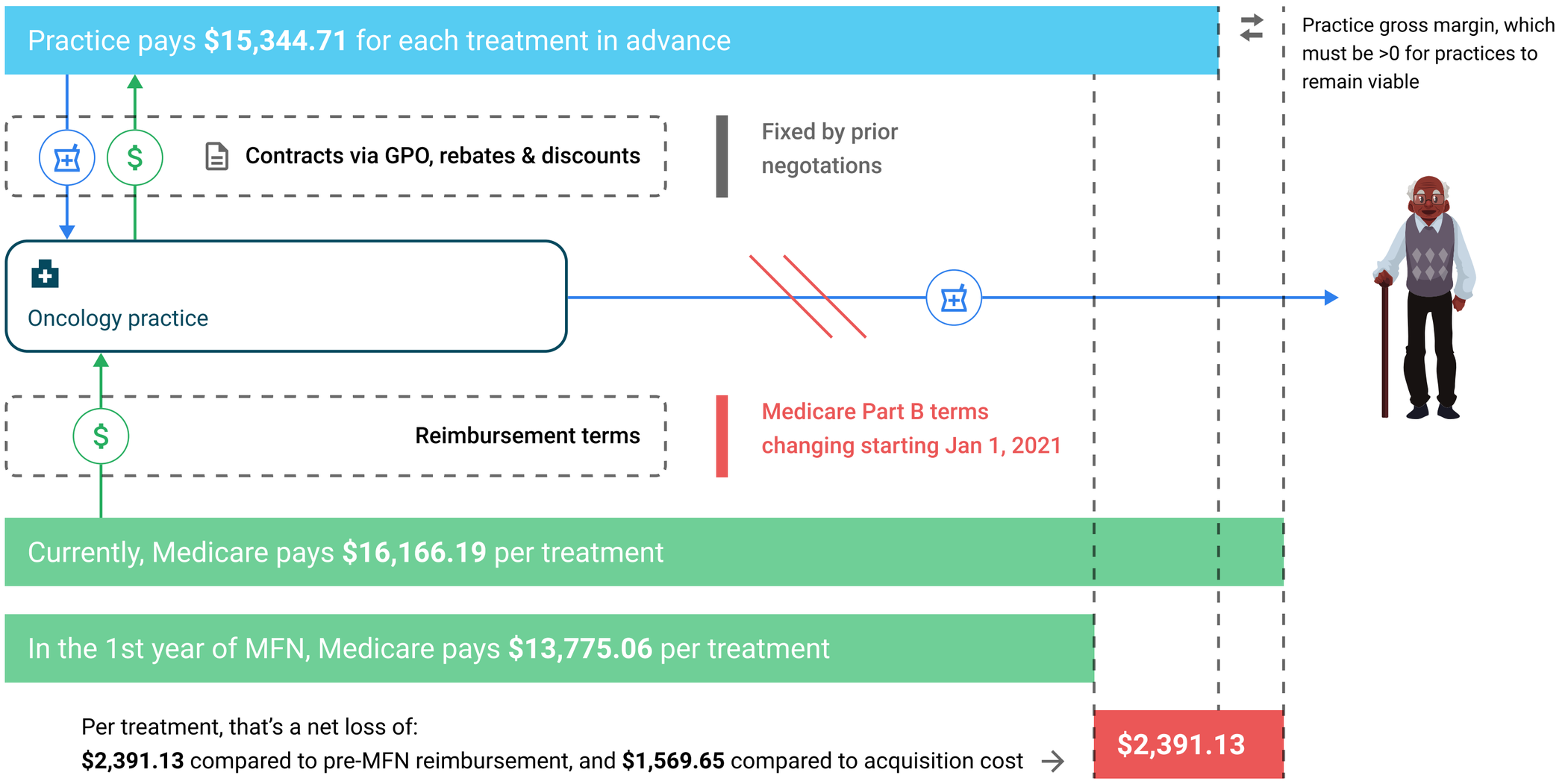


Meet Gerald

Gerald is 68 years old, with metastatic lung cancer. His oncologist has him on a regimen of carboplatin, pembrolizomab, and pemetrexed. They estimate that the patient's risk for a significant decrease in his white blood cell count is approximately 10–15%, which would then require the additional use of pegfilgrastim.

Here's how Gerald's typical large-sized practice manages his care

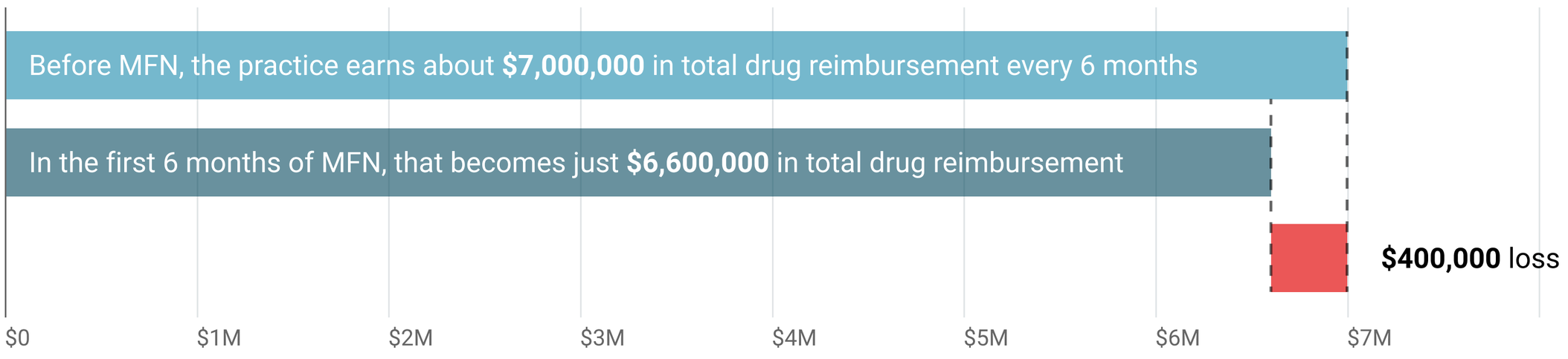
Given fixed drug purchasing contracts, changing reimbursement rates represents a potential threat to practice operability



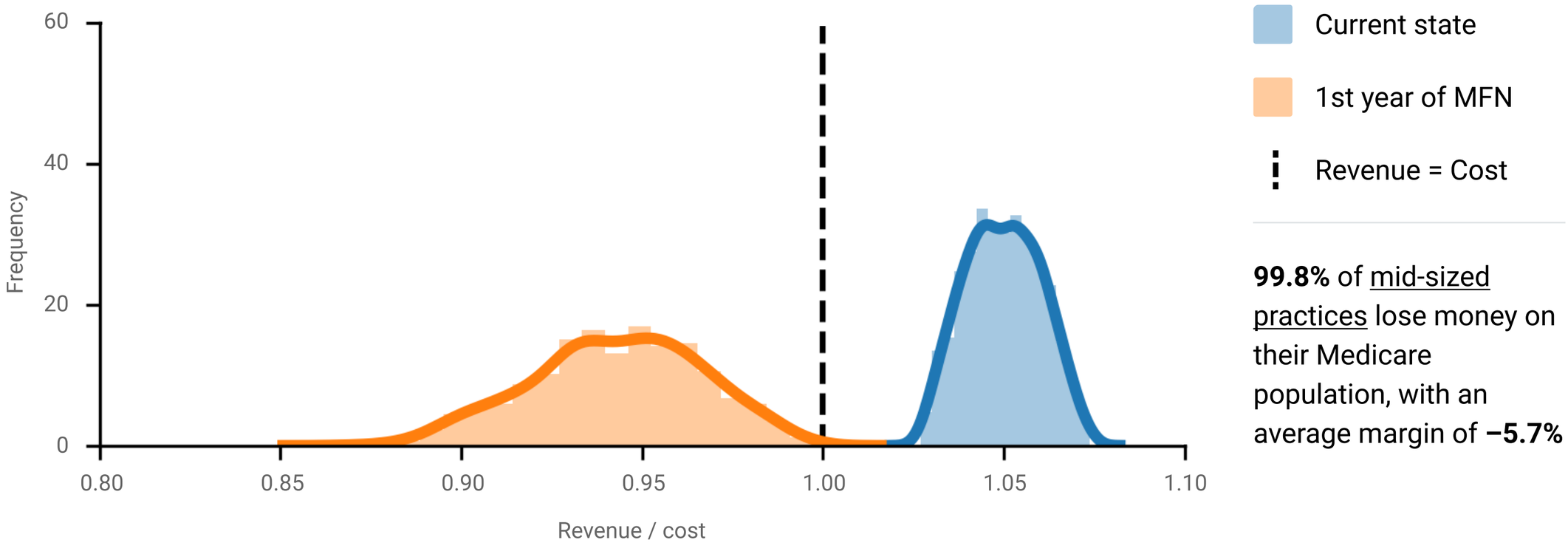
To treat Gerald for another 6 months, the practice would lose $21,520.18, leading them to turn him away. Gerald would go without treatment, unsure where to find care.

In the 1st year of MFN compared to pre-MFN reimbursement levels. Losses would grow in later years.

It's not just Gerald. Here's the story across all lung cancer patients at this practice in the first 6 months of 2021.

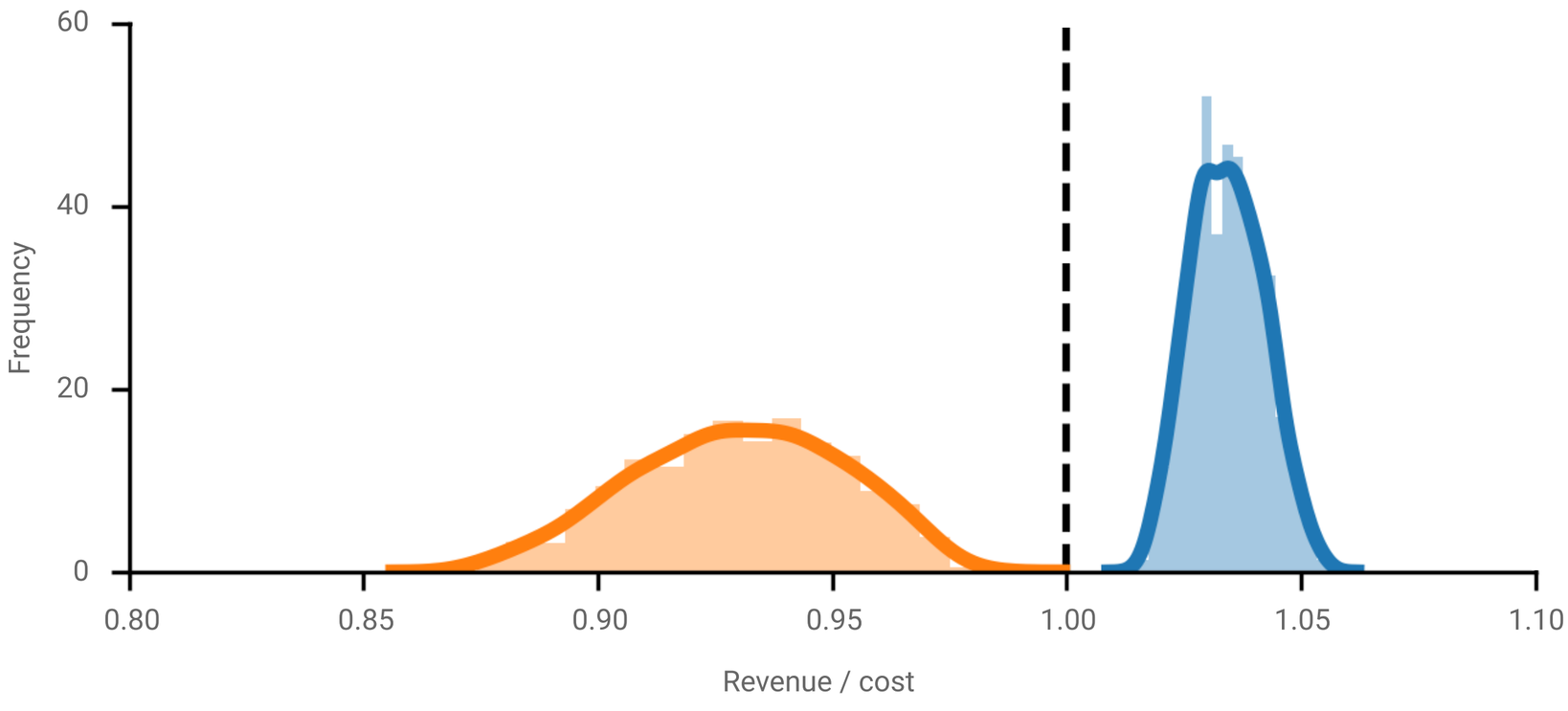


It’s not just breast cancer, lymphoma, and lung cancer. Here’s what it looks like across all cancers using 1,000 simulations of a mid-sized practice.

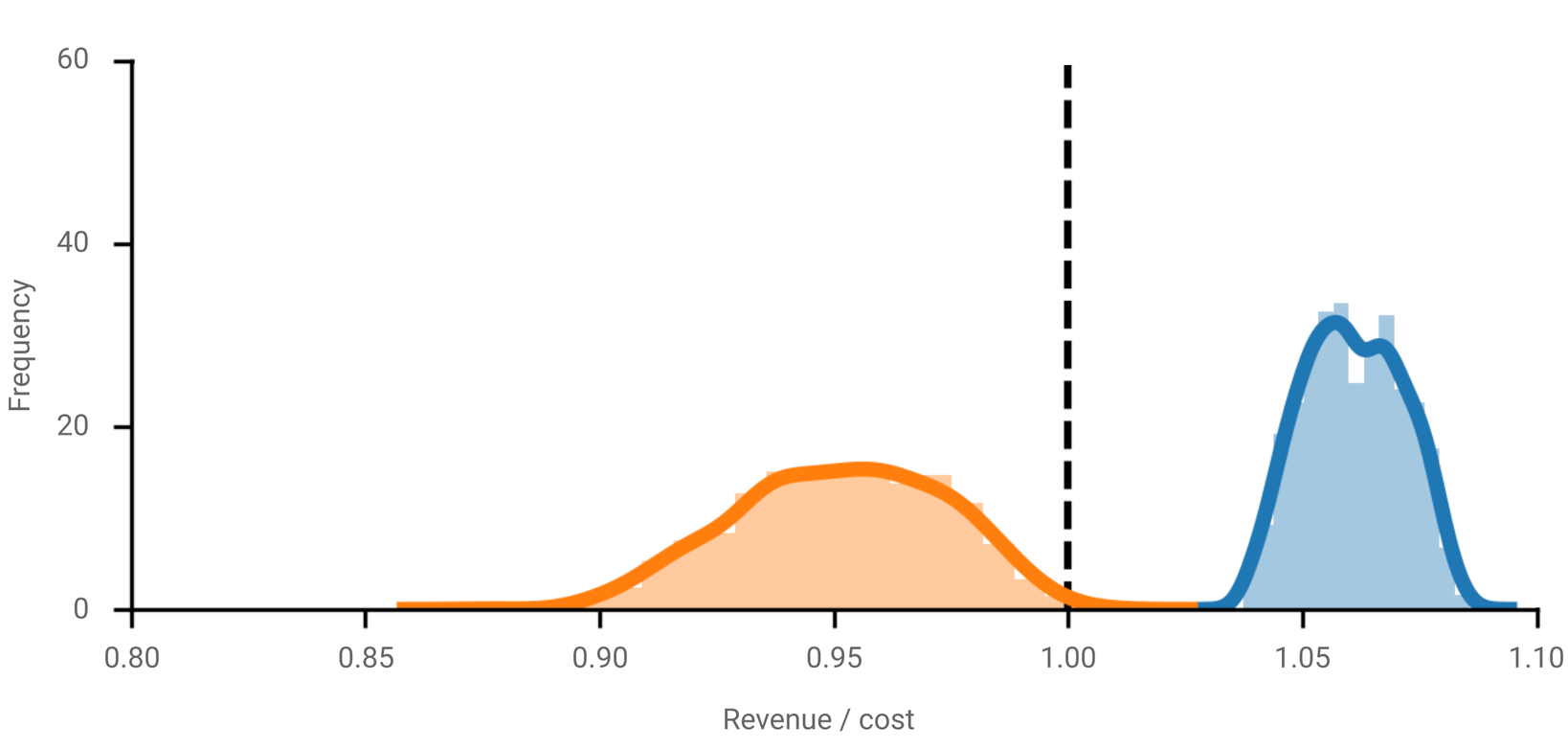


99.8% of mid-sized practices lose money on their Medicare population, with an average margin of **–5.7%**

And it’s not just mid-sized practices. Here are simulations of small and large practices, showing that almost every one will lose significant money on their Medicare population.



100% of small practices lose money on their Medicare population, with an average margin of **–7.05%**



99.2% of large practices lose money on their Medicare population, with an average margin of **–4.8%**

These analyses were based on simulations of standard-of-care treatment regimens used by a typical mix of Medicare patients receiving cancer treatment in each size practice. The reimbursements used to construct these estimates were the Q1 2021 MFN prices (75% ASP and 25% MFN).