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Underwater: Medicare Negotiated Prices For Part B Cancer Drugs Could Change Prescribing

by Cathy Kelly

Anticipation that reimbursement for significantly discounted Keytruda and Opdivo won't keep them afloat will influence treatment decisions by oncology providers, officials predict.

Medicare price negotiation for Part B oncology drugs will have ramifications across Medicare and commercial insurance markets because of the way that reimbursement works for physician-administered drugs, experts predicted at the Association of Value-Based Cancer Care educational summit on 18 October.

Practices are already thinking about shifting prescribing to a non-negotiated therapeutic equivalents or referring patients to hospitals for treatment if they lose too much money on reimbursement for drugs targeted by the government price setting process. In Medicare, providers are paid at the average sales price plus a 6% add-on fee (before budget sequestration) that is based on the price of the drug. That has set up a situation where providers may be financially reliant on higher cost drugs.

Physician administered drugs will face Medicare negotiated prices beginning in 2028 and two mega-blockbuster cancer medicines, *Merck & Co., Inc.*'s Keytruda and *Bristol Myers Squibb Company*'s Opdivo, are the first Part B candidates expected to be targeted.

Executives with two large oncology networks addressed how prescribing might change in the PD-1/PD-L1 checkpoint inhibitor class, which includes Keytruda and Opdivo, beginning in 2028. "For every drug – especially that we prefer … on our pathways – and as we think about things like therapeutic interchange, we look at the value of the drug and don't want to be underwater," Texas Oncology executive VP policy and strategic initiatives Debra Pratt explained.

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"If you're in a situation where you're underwater, it is not a practice that is sustainable that you can continue to prescribe something at scale," she continued. "So I think that picking the best value partner where you're not underwater is going to be a strategy that's really important." Texas Oncology is affiliated with US Oncology.

Tennessee Oncology executive chairman Jeff Patton agreed. If an alternative to Keytruda or Opdivo is endorsed by the National Comprehensive Cancer Network compendium, "that means that our peers say these drugs are therapeutically interchangeable, so why wouldn't we do it? We're not going to use an underwater drug. We can't [because] we can't stay in business." Patton is also CEO of OneOncology, which is affiliated with Tennessee Oncology.

Some PD-L1 inhibitor alternatives that might benefit from the situation include *Roche Holding AG*'s Tecentriq, *AstraZeneca PLC*'s Imfinzi and *Merck KGaA*'s Bavencio.

The situation could lead to prescribers making different decisions for Medicare beneficiaries than they do for commercially insured patients, the executives acknowledged.

"I hope it doesn't come to that," Pratt said. "We will always strive to give people effective therapy," but "it is possible that could be a different scenario for Medicare patients than it is for others."

She maintained "we really, as doctors, are agnostic to payers when we're making therapy choices for our patients. But I can imagine a scenario where if this sort of hijacks drug reimbursement substantially to where you have different options for Medicare beneficiaries and the commercial payers. I think that we'll do what we need to do to deliver the most effective therapy to folks that we can and have a sustainable business model."

Patton added that "my answer is the same as Debra's: I hope not, but we're willing to. ... If we're forced to differentiate, we'll provide different care to different sets of patients."

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Impact Of Medicare Negotiation On Prices In Commercial Insurance

Panelists also discussed whether Medicare price negotiation would impact prices and reimbursement in the commercial sector.

ADVI senior advisor Michael Kolodzej noted there will be some impact because under the Inflation Reduction Act, the "maximum fair price" determined by the Centers for Medicare and Medicaid Services for negotiated drugs will be incorporated into the calculation of average sales prices, which are used as the basis of Medicare Part B payments and also in reimbursement in commercial insurance.

"We've determined that the ASP is going to trend down because of the [maximum fair price], which will be about a third lower, something like that. ... It will trend down over time," Kolodzej said. ASPs are reported by manufacturers up to 30 days after the close of the previous quarter. As a result, there is a two-quarter lag between the time when sales reflected in the ASP occur and the time when those sales become the basis for payments.

Could Negotiation Increase Use Of 340B-Discounted Drugs?

Daniel Senior, senior VP market economics at Cencora (formerly *AmerisourceBergen Corporation*) suggested manufacturers of negotiated drugs might need to think about lowering prices in the commercial sector to match Medicare. For example, they may consider whether their product might be subject to 340B prices for patients that are referred to a hospital for treatment instead of their community practice.

"What the law says is that [340B eligible] practices, providers and pharmacies are all eligible for the lower of the maximum fair price or 340B" prices, so manufacturers are going to have to make a decision about, 'OK, if I don't lower the price [in the commercial sector] are more of those patients going to show up at the hospital under 340B,' which by the way is going to be a lower price almost all the time," Senior said.

The "reality is [manufacturers] are going to have to make decisions about whether reimbursement in the community setting is where they're better off [versus] patients ending up in the hospital because of this underwater scenario," he continued. However, "I also hope it doesn't come to that, there are plenty of rational actors between the payers, the manufacturers and the providers."