Most Favored Nation Model: An Overview

On November 20, the Administration announced its Most Favored Nation (MFN) Model, which will go into effect on January 1, 2021. This document outlines the basics on the Model and describes what actions NICA is taking to prevent this harmful policy from being rushed into effect.

What will happen to reimbursement?
For fifty drugs identified by CMS, the Model has two main goals:

1. Gradually replace the ASP with the MFN price; and
2. Replace the percentage-based add-on fee with a flat fee.

The MFN price is the lowest per-capita-GDP adjusted price of any country in a certain group of comparator countries. Comparator countries are OECD members with a per capita GDP greater than 60% of U.S. per capita GDP. For the first year, CMS has identified 22 countries that will be in the group based on these criteria. The Model will blend in the new MFN price over the first four years, as follows:

- Year 1 (2021): reimbursement will be a 75% ASP/25% MFN price blend
- Year 2 (2022): 50/50 blend of both prices
- Year 3 (2023): 25% ASP/75% MFN price
- Year 4 through the end of the demo: 100% MFN price

CMS provides illustrative MFN prices for the fifty drugs that are included in Year 1 based on 2019 data, but these are just examples. The agency will post the final/actual reimbursement rates on the Model website before January 1, but gave no specific date for that posting.

Additionally, the Model will replace the current 6% add-on fee with a flat fee of $148.73 per dose, to be updated over time to account for the effects of inflation. This change does not have a phase-in: it will become effective on January 1, 2021 for all covered drugs.
Administration codes are unaffected by the Model.

**Which drugs are included?** The Centers for Medicare and Medicaid Services (CMS) identified a list of fifty Part B fee-for-service drugs that will be included for the first year of the Model. This list includes many products used by infusion centers, such as drugs used to treat autoimmune, neurological, and gastrointestinal conditions. The full list is attached. CMS may add additional drugs in the future.

**Is my State included?** Yes: the Model is nationwide.

**When?** The Model begins on January 1, 2021, and lasts for seven years. As explained below, the Model will gradually replace the average sales price (ASP) with the MFN price over the first four years of the Model.

**Who will participate? Can I opt out?** Participation is mandatory. Your enrollment will occur automatically upon submission of a claim for one of the fifty included drugs. CMS includes a very limited financial hardship exemption, but this will not be available for the first year.

**What happens next?** As CMS has acknowledged, the MFN Model will lead to a loss of beneficiary access to several Part B drugs. This is unacceptable, particularly since people in need of these medicines represent some of Medicare’s most vulnerable beneficiaries. NICA is hard at work on several fronts to stop the rushed implementation of this harmful policy:

- **Administration:** To make sure our concerns are aired to all possible audiences, we will file a comment letter objecting to the rule before the end of the year. Because the comment period closes nearly a full month after the Model takes effect, however, it is clear that CMS is not interested in meaningful or actionable feedback from stakeholders.
- **Court system:** We have joined with several other plaintiffs to bring a lawsuit in challenging the Model on procedural and substantive grounds and to seek a preliminary injunction that would prevent the Model from going into effect on January 1.
- **Congress:** Finally, we have joined a broad coalition of Part B drug patients, providers, and other stakeholders who are actively urging Congress to delay implementation of the Model.
## TABLE 2: PERFORMANCE YEAR 1 MFN MODEL DRUG HCPCS CODES LIST WITH TOP BILLING SPECIALTIES

<table>
<thead>
<tr>
<th>Rank</th>
<th>List of HCPCS Codes</th>
<th>Short Description*</th>
<th>2019 Total Allowed Charges, after exclusions (in dollars)</th>
<th>1st Top Specialty</th>
<th>2nd Top Specialty</th>
<th>3rd Top Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>J0178</td>
<td>Aflibercept injection</td>
<td>$2,982,942,674</td>
<td>Ophthalmology</td>
<td>Ambulatory Surgical Center</td>
<td>Internal Medicine</td>
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<td>2</td>
<td>J9271</td>
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<td>Medical Oncology</td>
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<td>Medical Oncology</td>
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<td>4</td>
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<td>Internal Medicine</td>
<td>Rheumatology</td>
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<td>Internal Medicine</td>
<td>Rheumatology</td>
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<td>Internal Medicine</td>
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<td>Internal Medicine</td>
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<td>Medical Oncology</td>
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<td>31</td>
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<td>Internal Medicine</td>
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<td>32</td>
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<td>Gastroenterology</td>
<td>Dermatology</td>
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<td>Internal Medicine</td>
<td>Medical Oncology</td>
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<td>35</td>
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<td>Medical Oncology</td>
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<td>36</td>
<td>J9034</td>
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<td>Internal Medicine</td>
<td>Medical Oncology</td>
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<td>37</td>
<td>J9085</td>
<td>Epoetin alfa, non-esrd</td>
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<td>Hematology/Oncology</td>
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<td>38</td>
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<td>39</td>
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<td>40</td>
<td>J1439</td>
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<td>41</td>
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<td>Brentuximab vedotin inj</td>
<td>$162,519,904</td>
<td>Hematology/Oncology</td>
<td>Internal Medicine</td>
<td>Medical Oncology</td>
</tr>
<tr>
<td>Rank</td>
<td>List of HCPCS Codes</td>
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<td>------</td>
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<td>Medical Oncology</td>
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<td>43</td>
<td>J9354</td>
<td>Inj, ado-trastuzumab emt 1mg</td>
<td>$157,438,453</td>
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<td>Internal Medicine</td>
<td>Medical Oncology</td>
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<td>44</td>
<td>Q5111</td>
<td>Injection, udenca 0.5 mg</td>
<td>$155,483,502</td>
<td>Hematology/Oncology</td>
<td>Internal Medicine</td>
<td>Medical Oncology</td>
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<td>45</td>
<td>J7324</td>
<td>Orthovisc inj per dose</td>
<td>$152,408,630</td>
<td>Orthopedic Surgery</td>
<td>Physician Assistant</td>
<td>Sports Medicine</td>
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<td>J2785</td>
<td>Regadenoson injection</td>
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<td>Internal Medicine</td>
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<td>J0517</td>
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<td>Internal Medicine</td>
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</tbody>
</table>

Note: Ambulatory Surgical Center is included as a specialty to show drug utilization in this setting.

*The short description effective as of January 1, 2021.

Table 3 shows the distribution of total 2019 Medicare Part B allowed charges for the drugs identified in Table 2 by provider and supplier type to show the types of providers and suppliers that had claims for these separately payable Medicare Part B drugs in 2019. To assign claims to a provider or supplier type, we considered the type of MAC that processed the claim, type of bill, provider number, revenue center, line place of service code, and specialty of the health care practitioner associated with the drug claim line.