NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

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June 16, 2020

Todd Vasos
Chief Executive Officer
Dollar General Corp.
100 Mission Ridge
Goodlettsville, TN 37072

Subject: Blue Cross Blue Shield of Tennessee Specialty Pharmacy Mandate

Dear Mr. Vasos,

I represent the National Infusion Center Association (NICA), a nonprofit patient advocacy organization with a mission to protect, promote and expand patient access to infusion care. NICA is the unifying voice for office-based infusion providers, and we spend a great deal of our time and resources pushing back against harmful payer mandates that interfere with patients' abilities to receive infusions and other provider-administered therapies when and where they need them. Since it was announced last fall, NICA has called on Blue Cross Blue Shield of Tennessee (BCBST) to reverse a policy decision which, if enacted on July 1st as planned, will not only result in unhappy beneficiaries (i.e. your employees) but will also increase the healthcare costs of these patients. BCBST has indicated that they are simply unable to reverse this decision, as they are following the wishes of the employer sponsoring the health plan. We certainly appreciate that specialty medications are very expensive, and we understand the desire to reduce the cost of care for these patients. Insurers tout specialty pharmacy mandates as a means of cost savings, and I imagine this is how the idea was pitched to your team; BCBST has reported that this specialty pharmacy mandate is expected to reduce costs by 20%. While that sounds great on paper, I question whether they also informed you that this plan will force patients out of office-based infusion centers into hospitals where costs can be expected to double or even triple.[1]

Please find attached a letter NICA sent to BCBST leadership expressing our concerns; I encourage you to read it and share with your HR/Benefits team as it outlines the cause-and-effect relationship between specialty pharmacy mandates and increased cost liabilities in great detail. Ultimately, most infusion centers cannot treat patients whose health plans require the specialty pharmacy acquisition model as it increases administrative burden for both the practice and the patient, generates wasted drug (which you and your employees have already paid thousands of dollars for), and can cause delays and disruptions in treatment schedules[2]—all for reimbursement which does not allow the practice to cover its costs. The end result is that infusion centers will not be able to treat to your

[1] Magellan Rx Management. (2019). *Medical Pharmacy Trend Report*. Retrieved from https://www1.magellanrx.com/documents/2020/03/mrx-medical-pharmacy-trend-report-2019.pdf/
[2] American Society of Health System Pharmacists. (2016). *ASHP Specialty Pharmacy Resource Guide*. Retrieved from https://www.ashp.org/Specialty-Pharm-Guide-2015

employees under this health plan, and have been forced to begin transferring their care into the hospital setting, increasing the costs to you and your employees significantly. BCBST has responded to this concern publicly, stating "The only reason this would happen is if providers refuse to follow our new process and turn our members away," adding "Sadly, though, some providers are making this choice and forcing patients to find a new sites for care." [3] No provider wants to send his or her own patients away, or force them receive care elsewhere; this is evidenced by the very public outcry from numerous healthcare providers, medical societies and professional organizations about this policy. Providers do not want their patients infusing in hospitals any more than the patients themselves want to be there. As an infusion nurse myself, I would be remiss if I did not also mention the concerns associated with forcing immunocompromised patients into acute care settings. This is not the ideal care setting for these patients at any time, but it is especially concerning during a public health emergency when patients with a highly contagious infectious disease are also seeking treatment in those hospital settings. Infusion patients are exactly the group of individuals with complex, chronic illnesses that we are trying to keep out of hospitals right now, as they are at highest risk of severe COVID-19 disease should they become infected. We should be encouraging these patients to keep their disease well-managed by utilizing lower cost, high-quality care settings, but policies like this specialty pharmacy mandate are instead restricting access and creating barriers to care.

BCBST has characterized the pushback they have received regarding this policy as follows: "Some providers have just been upset they'll lose revenue." [4] Ignoring for a moment how deeply insulting this is to the healthcare providers who have devoted their lives to some of our nation's vulnerable patient populations, the statement is also simply inaccurate. BCBST is correct in their observation that providers are upset, however this policy would not result in *lost* revenue—under this policy, if providers continued treating these patients, it would result in a *negative profit margin*. If it were proposed that Dollar General must now sell products below cost (or even *at cost*), I expect you would find that policy to be untenable to say the least. BCBST is doing just that—requiring providers to treat patients at a loss and portraying their objection to do so as greed.

Regarding the increased costs associated with administration of specialty medications in hospital settings, you do not have to take us at our word. We would be happy to share some of the data, however you could also ask BCBST directly. Ask them to explain to you the rationale for their site of care management initiatives, in which they actively shift patients out of hospital settings into alternate sites of care (like physician offices). Ask them to provide their claims data for hospital outpatient claims and physician office claims for their top administrative codes—namely 96365/96366 and 96413/96415. Promises of a 20% drug savings are less appealing when the administration of that medication costs 200% more.[1] Most hospitals find the administrative burden

[3] Blue Cross Blue Shield of Tennessee. (2020). Setting the Record Straight about our Specialty Drug Program [Press release]. Retrieved from https://bcbstnews.com/pressreleases/setting-the-record-straight-about-our-specialty-drug-program/

[4] Blue Cross Blue Shield of Tennessee. (2020). Moving Forward with Flexibility: Q&A on our Specialty Pharmacy Changes [Press release]. Retrieved from https://bcbstworksforyou.com/bcbst-news-center-moving-forward-with-flexibility-qa-on-our-specialty-pharmacy-changes/

associated with specialty pharmacy acquisition to be too great to bear, and may not even accept these patients, hence the providers concerns about this policy creating access barriers.[2] The cost to manage these diseases is high; the costs when these diseases are undermanaged is much, *much* higher.

The bottom line is that utilization management strategies-- including specialty pharmacy mandates-- take a one-size-fits-all approach to cost containment, which simply doesn't work when caring for individuals with some of the most complex disease states associated with the highest economic burdens when undermanaged. When evaluating health plans for your employees, I hope you will consider that one-size-fits-all is not a viable approach for any other consumer industry, and it certainly isn't appropriate when the end product is a life and the cost of "not fitting" is paid with an employee's health and wellbeing. It is my hope that with complete information and real-world context, the Dollar General team will gain clarity on the best path forward for both your organization and your employees. I truly appreciate your time and attention in this matter, and I would be more than happy to make myself available for further discussion at your convenience.

Sincerely,

KAITEY MORGAN, RN, BSN, CRNI
DIRECTOR OF QUALITY & STANDARDS