February 6, 2020

Andrea D. Willis, MD
Senior Vice President and Chief Medical Officer
BlueCross BlueShield of Tennessee
6021 Brentwood Chase Drive
Brentwood, TN 37027

Dear Dr. Willis:

On behalf of the undersigned organizations and the thousands of physicians and health professionals we represent, we are writing to you regarding your decision to require providers to purchase specialty drug through the BlueCross BlueShield of Tennessee Preferred Specialty Pharmacy Network. We thank you for recognizing the ramifications of this policy by implementing a delay until July 1. However, our concerns about the ramifications of this policy on patient access to care are unchanged, and this delay will simply result in the patients' barriers to care being implemented on July 1, unless the policy is rescinded. We urge you to reconsider this change and also request the opportunity to speak with you further regarding our concerns. Further, we have and will continue to reach out to individual employers in Tennessee to ensure that they fully understand the ramifications of the plan they've been sold.

Through conversation with our members in Tennessee and surrounding states, we have confirmed that this policy change will negatively impact patients' access to critical treatments. Practices currently engaging in the buy-and-bill model operate under thin margins. If forced to obtain drugs from a specialty pharmacy, even these small margins will be erased. Drug administration fees alone will not cover practices' overhead costs associated with in-office administration such as rent, utilities, drug storage, insurance, and staff salaries. You surely recognize the offer of a "dispensing provider agreement", which allows for ongoing buy and bill procedures with reimbursement at your specialty pharmacy reimbursement rate, to be a hollow offer as our providers cannot acquire drugs at the price quoted by your PBM (which is artifactually lowered through opaque rebate policies which incent higher list prices and increase Magellan's profit). Similarly, the offer to join your specialty pharmacy provider network does nothing to address the unreimbursed administrative costs our providers will see. The predictable result of this policy will be a shift in site of care for your patients' infusions to a more expensive hospital outpatient setting, which may serve as a significant barrier to their access to treatment and will certainly serve as an inconvenience to them. Not only will treatment costs be higher in the hospital setting, but there will be a predictable minority of patients who, due to the inconvenience, the higher out of pocket cost, or simply fear of the unknown, will drop their treatments when transferred to this setting, and then their overall healthcare costs will predictably rise as their diseases flare. We are aware that a number of hospital facilities will, like our members, not accept white bagging policies, and in these communities, the patient will lose access to treatment all together.

As a reminder, there are numerous additive reasons our providers offering physician administered drugs would decline to administer specialty pharmacy acquired drugs. At the same time that infusion clinic operating margin is reduced by this policy, administrative overhead is increased due to the additional work required to coordinate the timing of drug ordering with individual patient scheduling, the potential need to prior authorize both the medication and the administration codes separately, and the expected increase in patient calls requesting assistance sorting out how to apply copay assistance funds prior to treatment, given the expected need for patients to pay the specialty pharmacy prior to drug shipment. Additional billing staff time will be needed to sort out which patients we are billing for drug, versus those we are not. There will be increased drug waste when using specialty pharmacy for infusible drugs compared to buy-and-bill process. When purchasing drugs for buy-and-bill administration, there is no direct patient assignment. If a patient has drugs ordered through specialty pharmacy and that patient is unable to use the medication for any reason (i.e. infection, change in medical history, or intolerance/ineffectiveness of medication) then the medication must be wasted as it is unethical and illegal to administer the medication to a different patient. Furthermore, any necessary change in dosing will force a delay of treatment. Even if it appears that a health plan is able to pay less for drugs through a specialty pharmacy, wasting medication for one infusion for one patient will certainly dwarf any savings created. Finally, we would raise the important medico-legal issue of drug provenance. How did the drug arrive at the specialty pharmacy, how can the infusing provider verify its supply chain, and what are the legal ramifications of infusing a drug with a compromised supply chain?

To the extent this policy is being pushed by your PBM, we urge you to recognize that you are alienating the vast majority of private GI, neurology, ophthalmology, rheumatology, urology clinics. The discussions we have had with individual patients in the last month have almost uniformly validated their understanding of the economic model we work under and recognition that this policy, if implemented, will push these patients' treatments out of our offices into the more expensive hospital setting. We can assure you that none of the patients we have spoken to have been sympathetic to this policy, when its full ramifications have been explained. As previously noted, we have and will continue to reach out to individual employers who may have signed onto this plan, as we are confident you sold them this policy without a transparent understanding of its ramifications.

We appreciate the concerns you may have regarding the price of biologics. However, we believe the current buy-and-bill model is the best option for infusible medications to ensure patient safety and continued access to these critical treatments. We would point to recent studies of Medicare patients showing price increases of buy and bill drugs in part D (managed by PBMs like yours) of 45%, due to higher drug costs driven by higher rebates, vs 21% in part B, where lower drug costs are incentivized. Providers offering physician-administered drugs are operating under a part B model, and we intend to educate your employer groups regarding the difference in cost incentives for this model vs the PBM model, where higher drug prices are incentivized. The numbers do not lie.

We would greatly appreciate the opportunity to speak to you further about this issue and our concerns. To arrange a mutually convenient time for a conference call, please contact Meredith Strozier, ACR Director of Practice Advocacy, at mstrozier@rheumatology.org or (404) 633-3777.

Sincerely,

American Academy of Ophthalmology
American Academy of Dermatology
American College of Rheumatology
American Gastroenterological Association
American Urological Association
Coalition of State Rheumatology Organizations
Alabama Society for Rheumatic Diseases
Tennessee Rheumatology Society

CC:
Natalie Tate, PharmD, MBA
Vice President, Pharmacy Management
BlueCross BlueShield of Tennessee