Healthe SYSTEMS
Transforming healthcare.

May 10, 2017

Chairman Dale L. Schultz
Industrial Commission of Arizona
800 W Washington St
Phoenix AZ 85007

Re: 2017/2018 PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE

Dear Chairman Schultz,

Please accept these comments in support of the Annual Physicians' and Pharmaceutical Fee Schedule development process. Healthesystems appreciates the opportunity to provide input on the proposed solutions under consideration this year. Our comments will center on Sections 5 and Section 4, and we have additional comments as it relates to the ongoing challenges associated with physician dispensing of medications to injured workers.

Section 5. Payment to treating providers who participate in healthcare, preferred provider organization, outcome based network, or specialty networks

Healthesystems is highly concerned about the language proposed in this section of the Staff Recommendations document, particularly the language which would disrupt a payers' ability to negotiate and contract for proprietary contract rates below the fee schedule. Contracts between private entities are regulated by contract law, and it is our experience that these types of contracts are entered into voluntarily by the parties. If the parties cannot agree on the terms of the contact, which generally do include a disclosure of rates and a dispute resolution process, then it is entirely up to the parties to decline participation in these types of arrangements.

If the Commission were to intervene in the manner to which networks, medical providers and payers contract for discounted services, this would have a chilling impact on competition for all payers in the state including public entities. Pharmacy networks, pharmacy benefit managers (PBMs) and even specialty networks who procure durable medical equipment and home health services would be adversely impacted; potentially unable to deliver the same level of value they do to providers and injured workers. These types of networks reduce the administrative burden and cost associated with provider credentialing. They also eliminate the frequent phone calls and faxes that would be otherwise required to obtain prescription drug authorizations, facilitate delivery of durable medical equipment and scheduling of home health services.

All of these value added services benefit the injured worker, provider and the payer by speeding the timeframe for treatment and simplifying the billing and payment process. It is our recommendation that the Commission withdraw the language proposed in Section 5 and consider assembling a stakeholder group to further study the issue. We do not see the proposed language as an equitable solution to the problem it seeks to resolve.

Section 4. Designation of Medi-Span as the Publication for Purposes of Determining Average Wholesale Price ("AWP")

Healthesystems continues to support the use of Medi-Span as the publication for determining Average Wholesale Price.

Proposal for Future Staff Recommendations

Finally, we recommend the Commission examine the ongoing prevalence of physician dispensing and specifically, its associated costs, risks and benefits to the system. It has been more than eight years since the last fee schedule change that addressed this issue. Since then, the Commission has adopted the ODG treatment guidelines for management of chronic pain and opioid use. In order to prospectively manage opioids and chronic pain medications more efficiently, it is strongly recommended the Commission require injured workers to obtain medications from a pharmacy rather than a physician dispenser. There are a number benefits to the injured worker and the payer in obtaining medications in a pharmacy setting.

Because pharmacies connect to the payer in real time, via online processing, payers are able to immediately assess whether a medication is recommended within the ODG chronic pain management guidelines. Pharmacies are also able to identify duplicative therapies, contraindications and drug recalls. These additional checks are generally not performed in the same manner when medications are dispensed from a physician's office.

Another benefit to the injured worker is that pharmacies are required by national standards to collect and transmit significantly more robust data about the medication and how it is to be used than a physician who dispenses the medication. For example, a pharmacy must indicate the days' supply data of the dispensed drug. This data is critical for the payer to determine adherence to the daily morphine equivalent dosage as recommended in the ODG chronic pain management guidelines. Physician dispensers are not required to send this same level of detailed data at the time the drug is dispensed, leaving payers with insufficient information to quickly measure the prescribers' adherence to the ODG guidelines.

In addition, there have been multiple studies published in recent years demonstrating pharmacy costs are much higher for identical medications, when dispensed from a physician's office versus a retail pharmacy. WCRI has reported on this and other cost drivers associated with physician dispensing in 2012 and 2016.[1] For these reasons, we recommend the Commission study this further and consider adopting language which would allow payers who contract for pharmacy services to notify injured workers that their medications for outpatient use must be obtained through the pharmacy network. <u>This does not mean that injured workers would be required to go to a particular pharmacy as chosen by the payer, they could choose from any pharmacy in the network</u>.

Most payers today contract with a PBM and these networks are usually connected to most neighborhood retail pharmacies and the big box and supermarket pharmacy chains. According to a 2015 WCRI study, three

[1] WCRI, Physician Dispensing in Workers' Compensation, July 2012, Dongchun Wang and WCRI, Physician Dispensing of Higher-Priced New Drug Strengths and Formulation, April 2016, Dongchun Wang, Vennela Thumula, Te-Chun Liu

states have similar regulatory requirements which permit the employer to direct pharmaceutical care to a pharmacy network; they are California, Minnesota and New York.[2] As a result, Minnesota and New York have minimal costs associated with physician dispensing. While California's system has permitted employer/carrier direction into a pharmacy network, there are a number of political and regional differences in this state that may cause some payers to underutilize this control.

Healthesystems would welcome the opportunity to work with Commission staff and other interested stakeholders on developing language to address the issues described in the Staff Recommendations as it pertains to networks. We also are eager to engage in policy discussions about physician dispensing in the coming year. Thank you for considering our input on these topics. Please contact me directly should you have any questions or comments on this information.

Sincerely,

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[2] WCRI Workers' Compensation Medical Cost Containment: A National Inventory, 2015, Ramona P. Tanabe April 1, 2015