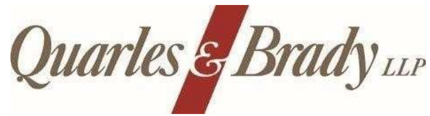

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July 22, 2021

VIA US MAIL AND E-MAIL

Industrial Commission of Arizona
c/o Charles Carpenter, Manager, Medical Resource Office
P.O. Box 19070
Phoenix, AZ 85005-9070

Dear Commissioners and Staff of the Industrial Commission of Arizona:

Please accept this letter as RX Development Associates, Inc. ("RXD") and ServRx, Inc.'s ("ServRx") public comments in regards to the Industrial Commissioner of Arizona's ("Commission") 2021-2022 Physicians' and Pharmaceutical Fee Schedule and corresponding Staff Proposal and Request for Public Comment. Both RXD and ServRx greatly appreciate the Commission's public comment process and thanks the Commission for its time and consideration.

By way of background, RXD is a full-service prescription management company for injured workers, and offers clients a retail pharmacy partnership and in office dispense programs nationwide. ServRx is a first-fill solution for processing Workers' Compensation pharmacy prescriptions; offering direct pharmacy services to injured workers throughout the United States.

RXD and ServRx oppose the Commission's proposal to adopt National Average Drug Acquisition Cost ("NADAC") as the primary basis for determining the reimbursement value for prescriptions instead of the existing average wholesale price ("AWP") driven benchmark.[1] RXD and ServRx respectfully believe that the Commission lacks the statutory authority to adopt NADAC at this time. This is because the use of NADAC has not been validated and accepted standard in the area of workers' compensation pharmaceutical reimbursement, as only California has adopted the standard. Additionally, drastically revising Arizona's reimbursement methodology to a still unproven structure that has only been spearheaded by California's Workers'

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[1] *See* Industrial Commission of Arizona, Staff Proposal and Request for Public Comment, 2021/2022 Arizona Physicians' and Pharmaceutical Fee Schedule, Exh. A, p. 18-19. *available at*: https://www.azica.gov/sites/default/files/media/2021%20Staff%20Proposal%20and%20Exhibit%20A.pdf
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Compensation System could inject uncertainty and instability into Arizona's effective and cost-efficient prescription drug program. Uncertainty and instability to Arizona's otherwise proven reimbursement model may, in turn, result in few participating providers and negatively impact injured worker access to quality care.

I. THE COMMISSION LACKS STATUTORY AUTHORITY TO ADOPT NADAC AS PART OF THE PHYSICIAN FEE SCHEDULE

The Commission is authorized by statute to consider the adoption of a fee schedule with provisions that involve specific prices, values or reimbursements for prescription drugs.[2] If the Commission considers the adoption of such fee schedule for prescription drugs, the Commission shall:

> . . . base the adoption on ***studies or practices that are validated and accepted in the industry***, including the applicability of formulas that use average wholesale price, plus a dispensing fee, and that have been made publicly available for at least one hundred eighty days before any hearing conducted by the commission.[3]

While A.R.S. § 23-908(C) directs the Commission to consider the applicability of using AWP as a benchmark, it does not require the adoption of AWP or any other benchmark methodology as part of the fee schedule. Rather, the primary and dispositive requirement for the adoption of a specific benchmark as part of the fee schedule is that the adoption be based on studies or practices that are validated and accepted in the industry.

For all of its discussion in recent years, NADAC is a relatively new pricing benchmark, having been adopted by CMS as an optional benchmark to satisfy Actual Acquisition Cost ("AAC") requirements starting in 2016. Despite arriving at the conclusion that NADAC "has become validated and accepted within the industry," the research supplied by Myers and Stauffer does not specify the actual rate by which NADAC has been adopted by state Medicaid programs or its adoption rate by private payors.[4] While NADAC is finding more applications with each passing year, to say that it is validated and accepted by the pharmaceutical reimbursement industry as a whole without further support is premature. As a result, any conclusion that NADAC is a widespread validated and acceptable standard is without support and any adoption of the same would be arbitrary and capricious.

More importantly, in the workers' compensation world that the Commission, the Arizona workers that it serves, and its stakeholders operate in, the use of NADAC is almost nonexistent.

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[2] A.R.S. § 23-908(C).
[3] *Id.* (emphasis added).
[4] *See* Myers and Stauffer, PHARMACEUTICAL REIMBURSEMENT: Review of Pricing Methodologies within Workers' Compensation White Paper, p. 13, December 21, 2020, *available at*: https://www.azica.gov/sites/default/files/media/Myers%20and%20Stauffer%202020%20White%20Paper.pdf (hereinafter "Myers and Stauffer White Paper").

As noted in Myers and Stauffer's White Paper, of the 37 states that set a defined pricing schedule, 34 states continue to use AWP as a benchmark. To date, only one state – California – has incorporated the NADAC benchmark into its workers' compensation pharmaceutical reimbursement methodology. Further, the Myers and Stauffer White Paper only points to one academic evaluation of California's Workers' Compensation System published in 2018. That evaluation concentrated on the percentage by which the various benchmarks (including NADAC) provided pricing on claims. Myers and Stauffer do not point to any qualitative study on the impact that NADAC has had on California's Workers' Compensation System, its providers, and most importantly, patient care.

Simply put, the NADAC benchmark is not a practice that is validated and accepted in the pharmaceutical reimbursement industry as a whole or as part of workers' compensation sector in particular. Adoption of the standard would run counter to the plain language and intent of A.R.S. § 23-908(C). As such, RXD and ServRx respectfully believe that the Commission lacks the statutory authority to incorporate NADAC into the 2021-2022 Physicians' and Pharmaceutical Fee Schedule at this time.

II. THE USE OF NADAC REQUIRES MORE STUDY AND ADOPTION BY PEER STATES

The Myers and Stauffer White Paper appears to suggest that NADAC needs to be adopted in order to control costs. In particular, Myers and Stauffer point to a 2020 National Council on Compensation Insurance ("NCCI") study showing that Arizona's cost per lost-time claim is approximate 145% of the national average. However, it is clear that prescription drug costs are not driving the cost disparity, as the data shows that only 9% of total payment of claims are attributable to prescription drugs compared to a national average of 8%. If anything, this figure suggests that Arizona is doing an excellent job in keeping prescription drug costs very close to the national average.

Moving away from AWP to NADAC is not just a matter of updating the Physicians' and Pharmaceutical Fee Schedule. Changes in benchmark and reimbursement methodology have real impacts on workers' compensation providers. The Myers and Stauffer White Paper says nothing of the impact that such a change may have on the providers tasked with caring for Arizona's injured workers and the sustainability of their practices. A drastic change in benchmark and reimbursement methodology such as the move from AWP to NADAC will negatively impact the economics for providers and could very well push many of them out of the workers' compensation sector. A large enough shift of prescription drug providers out of workers' compensation could result in lower quality care, less access, dramatically delay care to injured workers, and ultimately increase costs to Arizona's program.

Any change in Arizona's benchmark and reimbursement methodology must not only select practices that are validated and accepted by industry but also carefully study the impact on the ability for Arizonans to timely obtain prescription drugs and on the ability of providers to

effectively and economically deliver such care. To adopt NADAC now, when it has only been implemented at the workers' compensation level in California, would introduce uncertainty into Arizona's cost-efficient and effective prescription drug program.

This is the exact type of outcome that the language in A.R.S. § 23-908(C) is designed to prevent. By mandating that the Commission base the adoption of fee schedule components on studies or practices that are validated and accepted in the industry, the law requires the Commission to use carefully vetted methods. A benchmark that is only presently used in an unspecified number of Medicaid programs, with an unspecified number of private payors, and by California's Workers' Compensation System is not a validated and accepted industry practice.

We hope the Commission finds this perspective helpful. Please let us know if you have any questions. Again, RXD and ServRx appreciate the Commission's time and consideration of this matter.

Very truly yours,

Christopher T. Dang
Nicholas H. Meza

CTD:hlh