November 25, 2019

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 groups and the thousands of rheumatologists and rheumatology 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 as of January 1, 2020. We have serious concerns about the threat this change poses to patient access as well as the added administrative burden to practices. We urge you to reconsider this change and also request the opportunity to speak with you further regarding our concerns.

We are concerned 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. 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 will 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 rheumatic disease flares.

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. Given the appropriate concern about the cost of infusible biologics, it seems prudent to avoid increasing waste by moving away from the buy-and-bill process. 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?

In light of the issues mentioned above, which chiefly serve to increase administrative work for decreased revenue, as well as issues of drug provenance and liability, we anticipate a number of our members simply refusing to accept a "white bag" policy. To the extent that our members and or local hospitals do not accept this policy, patient access will suffer, and there will be a predictable rise in overall health care spending due to disease flares.

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 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 College of Rheumatology
Association of Women in Rheumatology
Coalition of State Rheumatology Organizations
Alabama Society for the Rheumatic Diseases
Arkansas Rheumatology Association
Georgia Society of Rheumatology
Kentuckiana Rheumatology Alliance
Midwest Rheumatology Association
Mississippi Arthritis and Rheumatism Society
North Carolina Rheumatology Association
Tennessee Rheumatology Society

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