Dear Mr. Weiske and Ms. Matthews:

The Pharmaceutical Care Management Association (PCMA) is submitting the following comments for consideration regarding the 11-12-14 draft of the Managed Care Plan Network Adequacy Model Act. PCMA is the national trade association representing America’s pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 216 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, and Medicare Part D.

PCMA would like to thank you for your hard work and dedication to accomplish such a significant task. We appreciate being able to be a part of the process and look forward to continuing to be involved in this subgroup’s work. Health carriers hire PBMs to manage pharmacy benefits on their behalf. As part of the management of these benefits, PBMs assemble networks of pharmacies so that the carrier’s members can fill prescriptions easily in multiple locations. Additionally, mail-service pharmacies provide carriers’ members with another option for convenient access to their medications through home delivery.

At the outset, it is important to note that pharmacy networks are distinctly different than doctor or hospital networks. Unlike doctors who have to limit the number patients they can treat at one time, pharmacies do not have such capacity limits as to how many patients they can serve. Patients also have multiple options for filling their prescriptions, including home delivery, whereas there are only certain doctors that are permitted to perform a particular surgery or provide a particular treatment. Such distinctions create challenges with the inclusion of “pharmacist” or “pharmacy” in the definition of “health care provider” or “provider.”

Generally, we believe that the term “pharmacist” is not the appropriate provider to be included in the definition. PBMs contract with pharmacies, not with individual pharmacists, for inclusion in the pharmacy network. If a PBM were required to include individual pharmacists, they would
have to contract with each and every pharmacist that worked for a particular pharmacy. Consumers rarely, if ever, choose a pharmacy because of the pharmacist working behind the counter. Rather, they choose a pharmacy, or pharmacy chain, that is available to fill their prescriptions. Including pharmacists, rather than pharmacies, in the adequacy standard would require plans to include tens of thousands of pharmacists and provide no benefit to a consumer attempting to locate an in-network pharmacy at which to get his prescription filled.

Specifically, a number of provisions throughout the Model Act would not be applicable to pharmacy networks with regard to the dispensing of drugs, thus the blanket inclusion of “pharmacy” within the definition of “health care provider” or “provider” would be problematic:

General Discussion – Sections 3 and 5(a)

There is some discussion in the General Note (at the end of Section 3) and the Drafting note (at the end of Section 5(a)) relating to tiered provider networks. In the case of pharmacy, there may be preferred pharmacies that a patient can go to for lower out-of-pocket costs but the patient always has the ability to go to any pharmacy in the network to fill a prescription. This is not an access issue – it’s a preference issue since the availability of consumers to access their pharmacy benefits or get their medications is not hindered. It is also a benefit design issue developed to provide cost savings under certain circumstances without impacting network availability or consumer choice.

Section 5 (Network Adequacy)

Additionally, Section 5 (Network Adequacy) notes a number of standards that can be demonstrated to show the sufficiency of the network. In the case of mail-service pharmacy and specialty pharmacy the concept of access is not geographically based. While patients with short-term, acute needs continue to use drugstores, patients with chronic conditions like high blood pressure also have the option to rely upon on mail-service pharmacies to save money and get prescriptions delivered directly to their homes. Trends in pharmaceutical development have also led to the creation of specialty pharmacies. Specialty pharmacies are distinct from traditional pharmacies in that they coordinate many aspects of patient care and disease management for patients on complex, high-cost drug therapies, often for rare and/or complex diseases. They efficiently deliver medications with special handling and storage or distribution requirements using sophisticated logistical techniques, such that one specialty pharmacy can serve the entire region or country. Specialty pharmacies also coordinate care with other clinicians and health care professionals to improve clinical and economic outcomes for patients and payers. Conventional pharmacies are not equipped to fulfill this range of needed services, so payers and benefit managers turn to the unique expertise of specialty pharmacies. Thus, the ability of mail-service and specialty pharmacies to provide needed medications through the convenience of home delivery meets the concept of network adequacy without the need for geographic proximity to a patient’s physical location.

There is also some discussion in the drafting note at the end of Section 5(B) about time and distance standards. The model act does not currently include this and we believe that it should
continue to not include such proscriptive standards. This is also another area that would not be applicable in the case of mail-service and specialty pharmacies which offer patients convenient access to their medications regardless of geographic location. Access to pharmacies is very different from access to doctor and hospitals. The Model Act, in its current form, was not drafted with these differences in mind.

Section 6(L) Continuity of Care

Section 6(L)(2)(b) requires the continuance of treatment until the treatment is completed or for up to 90 days when a provider’s contract is terminated without cause. This type of mandate is not appropriate and doesn’t make sense in the context of pharmacy. If a pharmacy is terminated from a network, the patient still maintains the ability to get a prescription from any other pharmacy in the network. Unlike individual physician practices, we are unaware of any pharmacies not accepting new patients’ prescriptions due to their current volume of business. From the pharmacy benefit perspective, the main concern is that a patient continues to have access to their medications, not a particular pharmacy. This is again much different than a patient’s access to a particular doctor or hospital for on-going medical treatment.

Similarly, in Section 6(L)(3) relating to the continuance of treatment for a patient and reimbursement to the provider in “special circumstance” cases, such requirements don’t make sense in the context of pharmacy. There is again no access issue – it’s a matter of preference since the ability of patients to get their medications is not hindered in such cases. When a pharmacy is terminated from a network, changing pharmacies may be an inconvenience to the patient, but it is not a life threatening event or a major disruption of care since the patient can get the medication from any other pharmacy in the network or by mail service.

We urge the Subgroup not to include pharmacies in these standards. However, if the Subgroup should move forward with the inclusion of pharmacy, PCMA requests that, at a minimum, exceptions for pharmacy be included as needed in the areas discussed above. In light of the fact that the model was drafted to address doctor and hospital networks, further analysis of the Model Act from the pharmacy perspective and extensive stakeholder input would be required.

Sincerely,

Jessica S. Mazer, Esq.
Assistant Vice President, State Affairs