Providence
Health Plan
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthPlan.com

January 2, 2026 Submitted via CSIPublicComment@mt.gov

Commissioner James Brown, State Auditor
Montana Commission of Securities and Insurance
840 Helena Avenue
Helena, MT 59601

Attn: Trevor Graff, Government Affairs Director

RE: Providence Health Plan's Comment on Potential House Bill 740 Rulemaking

Providence Health Plan (Providence) appreciates the Commissioner's request for comment on House Bill 740, regarding pharmacy audit, reimbursement, and prohibited practices. Providence is a registered pharmacy benefit manager in Montana. In addition to pharmacy benefit services, Providence offers commercial, Medicare Advantage, and Medicaid benefits, operating in Oregon, Washington, and California. Further, Providence Health Plan is part of the Providence Health System, a faith-based, not-for-profit network of hospitals, physicians, clinics, home health, and affiliated services operating across seven states. This diverse family of organizations employ 120,000 people who serve in 52 hospitals, and include more than 900 clinics, senior services, home health, hospice, PACE, housing, and many other health and educational services. Driven by a belief that health is a human right, Providence Health System is committed to understanding and responding to the needs of the many communities it serves, and to providing high-quality, equitable health care for all.

Driven by this mission, Providence Health Plan provides pharmacy benefits under an administrative fee model, where a transparent, predictable fee covers our services, such as processing claims, network management, and formulary management. We pass through rebates, disclosing the amount and source of the funds. We also provide access to our MAC lists, pricing detail, and audit rights.

In building a pharmacy network for our members, we seek to ensure that our members have choice and can maintain continuity of care, regardless of where they live. We support policy measures, such as HB 740, that are intended to strengthen independent and rural pharmacies. We recognize that in rural communities, pharmacy operating costs are often higher, and resources are more limited. For this reason, we operate with a rural rate structure that helps to sustain pharmacy access in underserved areas. HB 740 provides a meaningful pathway to protect independent pharmacies from market pressures that could limit consumer access.

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Providence provides the following response to questions posed by the Commissioner of Securities and Insurance (CSI).

1. Does the definition of independent pharmacy outlined in House Bill 740 require additional regulatory clarification? Does the definition create the unintended inclusion of other pharmacy business models outside of similar independent or community pharmacies? Does the current definition for pharmacy benefit managers require further clarification? If so, what considerations should be made for clarity in administrative rules?

Yes. Providence requests additional clarification from CSI regarding the definition of "independent pharmacy," including specification regarding ownership, operation, affiliation with a PBM, and tax filing status such as for-profit, not-for-profit, or publicly traded.

In addition, Providence requests that CSI publish a regularly updated list of independent pharmacies in the state. After passage of HB 470, Providence sent an attestation to all in-network Montana pharmacies, requesting self-identification if "independent" under the statutory definition. Pharmacies that returned a signed attestation identifying as independent were set up in the Providence Pharmacy Network with reimbursement consistent with House Bill 740. However, to ensure ongoing claim reimbursement accuracy and reduce administrative burden for pharmacies and PBMs, Providence requests that CSI publish a regularly updated list of independent pharmacies operating in Montana in a downloadable file format.

2. How should "third-party payer" be further clarified in administrative rule, especially regarding self-insured employer arrangements, discount plans, and non-traditional payers?

Clarification in rule distinguishing PBMs from third-party payers—particularly in the context of self-insured employer plans, discount arrangements, or other non-traditional payment models—would be helpful to avoid misapplication of statutory requirements.

3. Are there specific, objective criteria or documentation that could be required to verify a pharmacy's status as "independent" under House Bill 740, e.g. attestation forms, accreditation records, ownership documentation, affiliation disclosures? Would periodic re-certification be helpful to ensure continued compliance?

In order to ensure accurate and thorough application of the provisions of HB 740, PHP recommends that CSI maintain and publish a monthly or quarterly updated list of independent pharmacies, with annual recertification by pharmacies. Making this information available in a standardized electronic file format would reduce duplication,

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ensure consistency across PBMs, and improve claim accuracy without imposing additional reporting obligations on pharmacies.

4. House Bill 740 mandates a minimum reimbursement floor for independent pharmacies. Is further clarity required in the form of administrative rule to define the methodology, calculation or process to update that floor? What source should the agency use when considering the Wholesale Acquisition Cost?

Regarding minimum professional dispensing fees, Providence would prefer that CSI annually publish the updated minimum dispensing fee amount prior to January 1 of each year. A centrally published value would eliminate confusion and ensure uniform application across PBMs and payers.

House Bill 740 currently specifies that the minimum dispensing fee is subject to annual inflationary adjustment based on the Consumer Price Index (CPI-U), as published by the U.S. Bureau of Labor Statistics. Publishing the calculated annual amount would provide operational clarity without requiring additional rulemaking. i.e. IHS MOU rate is published annually.

Providence currently uses Medi-Span as its pricing source for Wholesale Acquisition Cost (WAC), as this is the pricing compendium available within Providence's systems for both AWP and WAC data.

5. The use of maximum allowable cost (MAC) pricing and reference lists is contemplated in §33-22-172. Are there additional MAC list considerations that are not addressed in this section, such as retention and availability of MAC list & reference pricing history, additional specificity regarding accessibility of such lists, concerns regarding use of more than one MAC list or reference pricing tool, or other aspects of MAC/reference pricing?

Existing statutory requirements provide sufficient guidance and flexibility for operational compliance. Additional rulemaking related to MAC list retention, accessibility, or reference pricing history is not necessary.

6. What provisions, if any, should be established in rule for reimbursement audits and recoupments? From the perspective of pharmacy benefit managers and third-party payers, what clarifications in rule would help facilitate consistent application of the new fee and audit prohibitions in House Bill 740?

Providence supports reasonable guardrails around reimbursement audits and recoupments that ensure consistency, transparency, and fairness for all parties. Administrative rules should clarify:

- Permissible audit timeframes, including clear look-back periods, to avoid retroactive application of new reimbursement standards.
- Clear definitions of what constitutes clerical or technical errors versus fraud, waste, or abuse, consistent with existing Montana statute.
- Explicit allowance for recoupments resulting from duplicate claims, incorrect NDC submission, quantity discrepancies, or eligibility errors.
- Standardized notice and appeal timelines for pharmacies prior to recoupment.

Clear guidance would help PBMs operationalize the audit provisions in House Bill 740 consistently while minimizing administrative burden and disputes with pharmacies.

7. What additional reporting requirements, if any, should PBMs, payers, or pharmacies have under the rules? Should the rules contemplate a required timeframe for advance notice of contract changes? How should any reporting requirement of the pharmacies or PBMs treat proprietary information that may be protected data?

Any reporting contemplated in rule should:

- Be limited to information necessary for regulatory oversight.
- Avoid disclosure of proprietary pricing methodologies, contract terms, or reimbursement algorithms.
- Protect confidential and trade secret information from public disclosure.

Advance notice requirements for contract changes should align with existing contractual notice provisions and avoid duplicative or conflicting obligations. Information exchanged between pharmacies and PBMs should remain confidential and exempt from public records disclosure.

8. The bill adds provisions limiting the PBM's ability to add drugs to a Maximum Allowable Cost list if they are temporarily unavailable. What length of time should constitute temporary and what source of data should the agency use in enforcing the lists?

The definition of shortage could mean different things to pharmacies or PBMs, as some shortages may be regionally impacted. Nevertheless, Providence reviews drugs weekly that are obsolete, temporarily unavailable, or listed on a drug shortage list for our Maximum Allowable Cost (MAC) list. We do not support a requirement that would insist on PBMs removing shortage drugs from a MAC list and then adding them back when they are more readily available. The requirement would not only increase Providence's workload but could also be confusing to the impacted pharmacies and could result in a lower reimbursement. This is especially the case when only a few manufacturers of a particular GCN are unavailable but the entire GCN is not unavailable. For drugs on a

shortage list, Providence may give a MAC rate increase to ensure a fairer market rate for the drug.

Providence leaves obsolete NDCs on the MAC schedule for approximately one year to enable pharmacies to use up their stock and reduce waste. If drug has not expired, we want these drugs to be available, as needed. Nevertheless, if the drug is temporarily unavailable and, on the list, the pharmacy does not have to dispense.

Additionally, there is no accurate way for claims processing to identify drugs on a shortage list with our claims processor, SS&C, or NCPDP.

9. Are there existing arrangements with independent pharmacies that are jeopardized by any provisions of House Bill 740? Please indicate whether these arrangements could be addressed by rulemaking within the provisions of House Bill 740 or whether future legislative action is needed.

Section 6(9) of HB 740 requires pharmacy benefit managers to apply the same utilization review, fees, copayments or cost-sharing, days' supply allowance, and other conditions across all network pharmacies, including mail-order and affiliated pharmacies. While this provision promotes consistency, we interpret it to mean that independent pharmacies cannot offer enhanced benefits, such as waiving cost-sharing, which might otherwise encourage patients to use these pharmacies. This limitation could unintentionally reduce flexibility for independent pharmacies to differentiate themselves and attract members, even when doing so would improve access and may improve adherence. We recommend that CSI provide an interpretation of Section 6(9) that is consistent with the intent of the legislation.

10. What role will pharmacies/beneficiaries have in filing complaints or initiating investigations under the rule?

Providence supports a clear, standardized complaint process administered by CSI. Administrative rules should:

- Require pharmacies and beneficiaries to exhaust reasonable internal dispute or appeal processes prior to initiating a regulatory complaint.
- Establish clear documentation standards for complaints submitted to the agency.
- Provide defined timelines for agency review and response.

11. Should the rules specify periodic review or audit of compliance by the agency?

Periodic compliance reviews by the agency may be appropriate; however, such reviews should be:

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- Risk-based and targeted, rather than routine or duplicative.
- Focused on systemic compliance issues rather than individual claim-level disputes.
- Coordinated with existing regulatory oversight activities to avoid redundant audits.

Clear parameters around scope and frequency would help ensure effective oversight without excessive administrative burden.

12. Are the any further considerations that the agency should consider in drafting rules for House Bill 740?

Providence kindly requests CSI provide sufficient implementation timelines when new rules are finalized to allow PBMs and pharmacies to update systems and processes. Further, guidance documents or FAQs are helpful to support consistent interpretation and compliance across stakeholders.

Providence appreciates the opportunity to comment on potential rulemaking for HB 740. Please direct any questions regarding our comment to Tara Harrison, Government Affairs Director, Tara.Harrison@Providence.org.

Sincerely,
Tara Harrison
Government Affairs Director
Providence Health Plan