



Summary of Express Scripts' Comments on Medicare NPRM (CMS-4182-P)

In November, CMS issued a notice of proposed rulemaking for Contract Year 2019 for the Medicare prescription drug benefit. Express joins PCMA, AHIP, ERIC and others with general support and serious concerns about the proposed rule.

Any Willing Pharmacy

We urge CMS not to pursue changing current definitions of pharmacies within the Any Willing Pharmacy context or otherwise. Modifying standards only to broaden pharmacy access to Part D beneficiaries (who already enjoy access to pharmacy networks exceeding the strict TRICARE minimum standards) risks considerable harm to the very patients that proponents of such changes claim they seek to assist. Pharmacy fraud remains a prevalent concern to plans and CMS should review this data before further consideration of this policy change. This proposal hampers Part D plan sponsors' ability to negotiate lower prescription prices for beneficiaries. This policy will result in increased federal government spending.

Application of Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale

We strongly urge CMS not to proceed with any future rulemaking that *mandates* plan sponsors include a minimum percentage of manufacturer or pharmacy price concessions at the retail POS across *all* plan offerings. Requiring rebates at point of sale in Part D would significantly increase program costs by \$82.1 billion over the next ten years, increase beneficiary premiums by \$28.3 billion, and provide a nearly \$30 billion windfall to drug makers. These are CMS' own estimates.

While we share CMS' interest in creating value for beneficiaries and lowering out of pocket costs, what is contemplated in the RFI will have far reaching impacts.

- We suggest CMS only further consider these issues through pilot projects to test these changes to the design of prescription drug benefits.
- Mandating plans share a minimum percentage of negotiated price concessions will not present a consistent advantage to all beneficiaries. Since not all drugs have rebates, beneficiaries utilizing those drugs will pay a higher premium without recognizing any POS savings.
- The current approach of reporting rebates as DIR does not prevent transparency. As CMS is fully aware, reported DIR is taken into consideration in future bids, meaning actual negotiated rebates are eventually realized and taken into consideration in the bid development.
- Mandating POS rebates adds negotiating leverage for drug manufacturers with plan sponsors, because it will be easier to "reverse engineer" drug pricing rebates offered by other drug makers.

Part D Prescriber Preclusion List

We appreciate and support CMS' new approach that disposes of the previous provider enrollment policy. It is disappointing, however, to see provisional fills remain in the new proposal; we believe this requirement is no longer necessary and will be confusing to members while adding needless complexity to the benefit. We recommend CMS finalize the policy after removing the provisional fill requirement.

Medicare Advantage and Part D Prescription Drug Plan Quality Rating System:

Express Scripts is generally supportive. Specifically:

- Annual Flu Vaccine Metric: We suggest CMS instead use medical and prescription claims data as they are both more holistic and reliable information sources from which to conduct assessments.
- SNP Star Reporting Level: We suggest CMS investigate developing an alternative solution for the SNP population in addition to the current CAI adjustment.
- PDP Contract Star Reporting Level: We urge CMS to continue reporting Star Ratings at the contract level and not the plan level. Plan level reporting would produce inaccurate results.

- **Measure Weighting:** We cautions against increasing the relative weighting of CAHPS measures within the Star Rating and recommends keeping the current 1.5x multiplier.
- **Data Integrity:** We respectfully request that CMS publicly share all simulated data testing the scaled reduction approach.

Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes

We enthusiastically support CMS' efforts to provide Part D sponsors with greater flexibility to make mid-year formulary changes, and urge adoption in the final rule. The availability of new generic drugs affords plan sponsors the opportunity to safely and effectively save/stretch drug spending for beneficiaries and CMS without sacrificing the quality of care provided is a positive development.

Revisions to Timing and Method of Disclosures (Electronic Communications)

We enthusiastically support changes that promote electronic communication and recommend CMS adopt them in the final rule.

Implementation of the Comprehensive Addiction and Recovery Act (CARA) Provisions:

We find CMS' proposal to implement CARA provisions to be both reasonable and practical interpretations of the statute. We do, however, caution that questions remain as to how plan sponsors are to treat members who challenge their lock-in designation. We urge CMS provide plan sponsors significant latitude in operating their respective programs. Other recommendations include:

- We recommend that CMS not finalize the exemption for LTC beneficiaries
- We urge CMS to withdraw their proposed 6 month delay preventing lock-in of a beneficiary identified as being at-risk of abusing opioids.
- We recommends that CMS not adopt its proposal to treat pharmacies with multiple locations as a single pharmacy.

Submission of Bids and Related Information

ESI appreciates CMS' proposed change giving plan sponsors flexibility to submit enhanced bid submissions that do not reflect the substantial differences relative to any of its other enhanced bid submissions as previously required. We encourage CMS to formally adopt it in the final rule.

Exceptions Process

- We support exempting the specialty tier from cost-sharing and suggest that, for purposes of clear beneficiary communication and operational simplification, the specialty tier not be included among factors used for tiering exception considerations involving other medications.
- CMS should consider introducing zero-dollar cost-share tiers, which are designed to promote the use of generics for conditions that are targeted for specialized care management the potentially substantial benefits of this approach would not be realized and both CMS and plans would be exposed to unnecessary expenses that undermine the tier's purpose and effectiveness.
- We support using the existence of a therapeutic alternative on a lower tier as a criterion for granting a tiering exception request and propose the following definition be used to describe it—a drug with:
 - FDA approval for the same indication;
 - Is an appropriate treatment based on current compendia and treatment guidelines;
 - Has the same therapeutic classification; and
 - Is delivered via the same route of administration.
- We recommend CMS revise Chapter 18 to reflect this guidance and provide updated examples that provide clarity plans and auditors need to assure compliant implementation and execution.

Activities that Improve Healthcare Quality:

While we enthusiastically support this proposed change, ESI respectfully requests CMS provide updated, detailed MLR methodology reporting instructions and/or guidance documentation to aid in preparing the simplified reporting data points in line with how it had been compiled for the more detailed reporting template.