AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: MassHealth Section 1115 Demonstration Amendment Request

Dear Administrator Verma:

On behalf of the American Medical Association (AMA) and our physician and student members, thank you for the opportunity to comment on the MassHealth Section 1115 Demonstration Amendment request.

The AMA believes everyone deserves quality health care. As physicians, we regularly confront the effects of lack of access to adequate care and know that Medicaid is an important—and often the only—source of consistent care for low-income individuals. The AMA encourages policymakers at all levels of government to focus their efforts on working together to identify realistic coverage options. Further, the AMA has long recognized the benefit of allowing states to experiment with new models for covering low-income residents and supports efforts by states to develop and test different Medicaid models that best meet the needs and priorities of their low-income adult populations. While encouraging state flexibility, the AMA also acknowledges the need for safeguards to protect low-income patients and emphatically supports Medicaid's role as an indispensable safety net for the most vulnerable patients. We share Massachusetts' commitment to a sustainable Medicaid program and to maintaining recent coverage gains; however, we are concerned that some elements of the proposal may decrease access to affordable coverage and jeopardize the health and welfare of low-income patients.

We also understand the significant fiscal challenges MassHealth and all Medicaid programs face, but are concerned that many of the changes proposed in the waiver amendment are merely cost-shifting, not cost-saving mechanisms. While initial savings may be realized from policies that restrict access to certain health care services and medications, the long-term impact will manifest elsewhere in the health care system as treatments are interrupted or delayed until conditions worsen, practices spend resources on mounting administrative burdens, and patients seek treatment in emergency departments rather than primary care practices. We advise against pursuit of short-term savings in ways that will exasperate existing problems in the health care system and put patient health at risk.

Alignment with commercial plans

The stated objective of the MassHealth amendment to align Medicaid policies with commercial plans is laudable to the extent that such alignment will reduce churning and ensure continuity of care for patients. Reducing the interruptions caused by churning is an important step to ensuring patients receive appropriate, continuous care in the most appropriate setting, and we applaud MassHealth for taking steps to improve transitions. However, we caution against alignment with commercial policies without scrutiny of those policies' merit and appropriateness in the Medicaid program.

In particular, the waiver amendment notes that many of the proposed new policies are essential to curb Medicaid crowd-out of commercial insurance. As the proposal states, the portion of residents insured by commercial plans in Massachusetts has decreased in recent years, while MassHealth has experienced a corresponding increase in enrollment. The state concludes that, to address this phenomenon, Medicaid policies should more closely mirror those employed in the commercial market. We disagree. While certain commercial market features may be beneficial for the Medicaid population, declining commercial enrollment in favor of Medicaid coverage should be viewed skeptically, with an eye toward addressing the inadequacies in the commercial market that cause consumers to seek other coverage options, rather than scaling those same flawed policies to new populations. If private coverage is not working for the general population—who, in general, enjoy greater access to resources to help navigate the complexities of health insurance—it is a mistake to assume those same features would be beneficial to the Medicaid population.

Access to medications

We are particularly concerned about the waiver proposals to adopt a commercial-style closed formulary with minimum coverage of just one drug per therapeutic class, a limited specialty pharmacy network, and an exclusion policy toward new drugs. The AMA is a strong advocate of addressing health care costs, especially pharmaceutical costs, but implementation of programs that have the impact of impeding patient access to medically necessary care is not an appropriate or effective way to achieve that goal. Together, we believe these proposals will impose unnecessary barriers to needed medications and encroach on the patient-physician relationship. Clinical decisions about the appropriate course of treatment should be made by a physician and patient together, based on the patient's best interest, not by program administrators focused more intently on cost than care. The AMA understands the need for managing limited budgets, but we are greatly concerned that if a drug works for the "vast majority," decisions will be made that could result in harm to other patients.

At a minimum, these proposals should not be approved without robust safeguards and a prompt, effective means for granting exceptions based on individual medical need. That exceptions process, moreover, should not impede patients' immediate access to medications and other treatments the physician determines are medically necessary. While we are encouraged that MassHealth emphasized its commitment to ensuring access to medically necessary medications through use of an exceptions process, the exceptions process described lacks important detail, including what happens to the patient's care while the exceptions process runs its course. In addition, we are concerned with ambiguity of the factors listed to guide whether a medication has "limited or inadequate clinical efficacy." For example, an older medication that is taken four times per day might not have more than an incremental clinical effect compared to a newer medication taken once per day, but the newer medication might spur increased adherence. We ask that the Centers for Medicare & Medicaid Services (CMS) require much greater

specificity to ensure Medicaid patients will have access to the medications they need on a timely basis, and that the analysis used to exclude medications is guided by more diverse factors than currently listed.

Further, MassHealth's intention to rely on an exceptions process similar to the existing prior authorization process for non-preferred drugs or off-label indications is not without problems. As currently employed in commercial markets, utilization management programs can create significant barriers to care by delaying the start or continuation of necessary treatment, which may in turn negatively affect patient health outcomes. Indeed, 90 percent of physician practices report that administrative burdens result in care delays, and 80 percent report they are sometimes, often, or always required to repeat prior authorization for prescription medications when a patient is stabilized on a treatment for a chronic condition, interrupting an effective course of care. These administrative hassles interrupt care and jeopardize patient health.

In addition, the very manual, time-consuming processes used for exceptions also burden providers and divert valuable resources away from direct patient care. In fact, physicians report that their practices spend over 16 hours on average each week on prior authorizations of prescriptions and medical services, even though the vast majority are ultimately approved. Many practices resort to employing a full-time staff member with the sole responsibility of navigating insurer administrative policies. If CMS approves these proposals to narrow access to pharmaceuticals, physician practices will face even more administrative burdens—a consequence that may disincent physician practices from seeing Medicaid patients in the first place.

Provider networks

We are concerned about Massachusetts' proposal to adopt narrow networks, a feature that has caused considerable complications in commercial markets, for patients enrolled in the MassHealth Primary Care Clinician (PCC) plan. While the AMA recognizes the need to incentivize enrollment in Accountable Care Organizations (ACO), such promotion should not be to the detriment of patients that opt to remain enrolled in the PCC plan. Often, patients choose the PCC plan because they have complex health care needs that cannot be accommodated in other plans or because their preferred providers are not participating in the ACO or managed care network. It is important for these patients to maintain existing relationships with their treating physicians. At a minimum, CMS should require MassHealth to implement safeguards to preserve existing physician-patient relationships with newly out-of-network providers.

Further, we do not agree that promotion of the ACO model is worth trading important network adequacy patient protections. Ensuring active, meaningful provider networks must be a priority for policymakers at all levels. Over the past several years there has been a significant narrowing and tiering of provider networks, often resulting in the exclusion of physicians who care for vulnerable patients from networks or accessible tiers. As physicians, we are concerned that these limited networks are compromising patients' access to quality care. In the context of Medicaid, this compromise is exacerbated because of the lower physician participation rate in Medicaid. We urge CMS to not waive network adequacy requirements and the freedom of choice provisions that preclude narrow networks.

Similarly, the waiver amendment proposes to eliminate its existing Medicaid cost sharing wrap when any enrollee in the premium assistance program for employer-sponsored insurance (ESI) receives care from any provider that is not enrolled as a MassHealth provider. This proposal fails to account for the likelihood that a patient's ESI plan network will not overlap with the network of MassHealth-enrolled

providers. As a result, a patient enrolled in ESI may, in practice, have access to an exceedingly narrow network of providers that accept both the ESI plan and MassHealth or be forced to forgo needed cost-sharing assistance in order to access care. We urge CMS to dispense with this proposal absent safeguards to ensure all Medicaid enrollees, including those that receive premium assistance for ESI, have access to an adequate network of providers.

Health Connector coverage

The AMA advocates for use of subsidized private health insurance coverage over public sector expansions as a means of providing coverage to the uninsured and, in particular, supports allowing Medicaid beneficiaries to purchase private health insurance coverage with income-adjusted subsidies. Such state efforts should meet or exceed projected coverage levels while maintaining or improving upon established levels of quality of care and maximizing patient choice of physicians and private health plans.

While encouraging state flexibility, the AMA also acknowledges the need for safeguards to protect beneficiaries. It is imperative that policymakers are cognizant of the different needs of low-income patients from those in higher income brackets. While it is true, as the waiver amendment points out, that non-disabled adults are the most economically mobile group among Medicaid members and are more likely to be employed and to enroll in commercial coverage, these statements discount the important characteristics that make Medicaid patients unique. Medicaid patients are more likely to suffer from chronic disease, mental illness and substance use disorders, and to have lower socioeconomic status, poorer nutrition, and fewer community and family resources than other populations. For these reasons, Medicaid benefits have historically been more generous than those available in the private market because the state and federal governments have rightly recognized that addressing low-income patients' specific needs is imperative to improving health outcomes. We encourage CMS to require MassHealth to provide wrap-around benefits for all services provided under the state plan, as has been required in other states that have provided premium assistance for commercial plans.

In addition, the AMA advocates that private coverage for Medicaid-eligible individuals must include minimal or no cost-sharing obligations. As has long been known since the RAND Health Insurance Experiment conducted 40 years ago, low-income individuals are more sensitive to increases in cost sharing and, as a result, are more likely to forgo needed care and suffer adverse health outcomes when faced with higher medical costs. ConnectorCare is a valuable program for low-income patients as it offers more affordable coverage than what is available in the Marketplace with the federal premium tax credits and cost-sharing reductions. However, ConnectorCare coverage is costlier to patients than MassHealth coverage. According to the waiver proposal, Medicaid patients transferred to ConnectorCare will have out-of-pocket costs up to $1,250 for an individual and $2,500 for families. Too many patients living just above poverty will find these costs prohibitive and delay or forgo care. We urge CMS to require a five percent cap on out-of-pocket expenses for all individuals with incomes up to 133 percent of the federal poverty line.

Institutions for mental disease

Finally, we strongly support Massachusetts' plan to expand access to residential services provided in an institution for mental disease (IMD). While strides continue to be made to increase the number of physicians and other providers who can care for patients with mental illness and substance use disorders (SUD) in the outpatient setting, the existing limit on the size of inpatient facilities continues to hamper access to treatment in those settings. Moreover, at the same time that beds in freestanding psychiatric

facilities and psychiatric units in general hospitals have declined in the past several years, the toll of the ongoing opioid epidemic has continued to result in unacceptable numbers of overdoses and death. While this is not a magic bullet, and does not take the place of more needed investment in community-based treatment resources and access to all forms of medication assisted treatment for SUD, it is a step in the right direction. The AMA applauds Massachusetts and CMS for your efforts to make access to treatment services available to millions of individuals for whom treatment was previously out of reach.

Thank you for the opportunity to comment on the MassHealth Section 1115 Demonstration Amendment request. Please contact Margaret Garikes, Vice President of Federal Affairs, with any questions at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD

cc: Massachusetts Medical Society