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Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston MA 02108

By email to kaela.konefal@state.ma.us

Re: Comments for Demonstration Amendment

Dear Assistant Secretary Tsai,

These comments are submitted by the Massachusetts Law Reform Institute on behalf of our low income clients who rely on MassHealth for access to medical care. Unlike most major amendments to the 1115 waiver, the changes proposed on July 20, 2017 will primarily restrict eligibility and services and shift costs to members and for this reason we strongly oppose such changes. We understand the financial challenges facing the MassHealth program, however many of these proposals, such as the ESI "gate" and the transfer of parents and caretaker relatives to MassHealth CarePlus from MassHealth Standard will not produce significant savings. For still other proposals, such as the reduction in the MassHealth wrap, there appear to be no savings estimates. Instead, for many proposals the rationale is "alignment with commercial insurance" with no evidence showing why such alignment is worthwhile. Where there is room for savings such as by leveraging employer contributions for the costs of coverage through premium assistance, or negotiating supplemental pharmacy rebates, the agency has not made the case that it needs the sweeping waiver of basic Medicaid protections that it seeks. The proposal as a whole does not meet the criteria for an 1115 waiver, and we urge EOHHS to rethink it.

I. Aligning coverage for non-disabled adults with commercial plans does not promote the objectives of the Medicaid Act

Section 1115 demonstrations are premised on "promoting the objectives" of the Medicaid Act.[1] The objectives of Medicaid are to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services and to furnish rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.[2] Increasing out of pocket costs and decreasing the scope of benefits for low income individuals to better align their coverage with commercial insurance does not promote the objectives of Medicaid. Medicaid exists to compensate for the limitations of

[1] 42 U.S.C.§ 1315a
[2] 42 U.S.C. § 1396-1.

commercial insurance for low income individuals not to replicate those limitations. Reducing MassHealth eligibility and services will also reduce state spending. However, courts have ruled that saving dollars cannot be the basis for a demonstration.[3]

A. Medicaid beneficiaries are not similarly situated to individuals who are commercially insured

The rationale for many of the proposals in the 1115 waiver is to align the coverage of current Medicaid beneficiaries with commercial insurance. Commercial insurance coverage differs from Medicaid coverage in many ways including charging higher premiums and cost sharing, covering fewer benefits, providing fewer consumer protections and paying providers more. The 1115 proposal seeks to align coverage of current Medicaid beneficiaries with commercial insurance by either disqualifying those with potential access to commercial insurance from MassHealth or providing MassHealth beneficiaries with fewer benefits, fewer provider choices and increased out of pocket costs.

EOHHS's premise is that non-disabled adults on MassHealth are similarly situated to commercially insured adults. But this is simply not true. First and foremost, non-disabled adults under 133% of the poverty level are much poorer than commercially insured adults. Even if it were true that non-disabled adult MassHealth members have greater potential than other MassHealth beneficiaries for higher incomes in the future, they don't have higher incomes now. Now, as a condition of qualifying for MassHealth, their incomes are under 133% of poverty or $16,040 for one person in 2017. The median income in Massachusetts in 2015 was $ 70,628.[4]

Given the high cost of living in Massachusetts, individuals with income under 133% of poverty are often unable to pay for their basic needs and have no disposable income available to pay for health care. Many of the unique features of Medicaid, such as affordability protections and the assurance of transportation, are a direct consequence of this income disparity. Medicaid's premium and cost-sharing limitations for those under 150% of the poverty level are supported by decades of research showing how even modest premiums and cost sharing applied to the poor and near poor lead to steep enrollment declines and reduced access to medically necessary care.[5] Similarly, research shows transportation is a greater access barrier for low income Medicaid beneficiaries than for the commercially insured. [6]

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[3] Newton–Nations v. Betlach, 660 F.3d 370, 381 (9th Cir. 2011) (citing Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994).

[4] American Community Survey, 1-year estimate

[5] Artiga, S. et al, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, http://www.kff.org/medicaid/issuebrief/the-effects-of-premiums-and-cost-sharing-on-low-incomepopulations-updated-review-of-research-findings/

[6] P. Cheung, J. Wiler, and et. al., National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries, Annals of Emergency Medicine (July 2012), Retrieved from http://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext
S. Syed, B. Gerber, and L Sharp, Traveling Towards Disease: Transportation Barriers to Health Care Access, Journal of Community Health (Oct. 2013). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215
U.S. Government Accountability Office, Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage (Jan 2016). Retrieved from http://www.gao.gov/assets/680/674674.pdf

Further, poverty and health are inter-related. "A significant body of literature has demonstrated that Medicaid beneficiaries are distinct from those covered by ESI…on a host of demographic, socioeconomic, and health status dimensions."[7] Compared to privately insured adults, Medicaid beneficiaries have more health limitations, higher prevalence of chronic conditions, non-chronic conditions, mental illness or substance abuse, and other conditions such as asthma, diabetes, heart disease, hypertension, back conditions, bronchitis/respiratory conditions, and gastrointestinal conditions.[8]

Even among adults who do not meet the Social Security definition of disability, Medicaid beneficiaries have complex and chronic care needs. A recent study by the Kaiser Family Foundation found that 35% of adult Medicaid enrollees who were *not* receiving disability benefits and did not have a job reported illness or disability as their primary reason for not working.[9] Further, individuals for whom alcoholism or addiction is a contributing factor to a determination of disability are not considered disabled under rules applicable to Social Security Disability, SSI and MassHealth's Disability Determination Unit.[10]

Medicaid is far better designed than commercial insurance to meet the health needs of the poor. For example, among non-elderly adults with mental illness, those with Medicaid are more likely than those with private insurance to receive treatment.[11]

Low income, even among workers, is linked with other differences compared to higher income workers. Low income workers under 250% FPL are more likely to be young, people of color, and female and to have lower levels of educational attainment compared to higher-income workers.[12] These differences are more pronounced for workers living below poverty. Further, a larger share of low-income workers are members of families with dependent children than higher income workers, and are far more likely to be single parents compared to higher income workers.[13]

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[7] Coughlin, Teresa A., Sharon K. Long, Lisa Clemans-Cope and Dean Resnick, What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults, May 2013 , Kaiser Family Foundation, http://www.kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/

[8] Op. cit.

[9] Garfield, Rachel, Robin Rudowitz and Anthony Damico, Understanding the Intersection of Medicaid and Work, February 2017, Issue Brief (Kaiser Family Foundation) Figure 4. http://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

[10] Social Security Administration, Program Operations Manual, Section DI 90070.050 Adjudicating a Claim Involving Drug Addiction or Alcoholism (DAA) ("We do not consider a claimant disabled if drug addiction or alcoholism (DAA) is a contributing factor material to the determination that the claimant is disabled)." https://secure.ssa.gov/poms.nsf/lnx/0490070050

[11] Facilitating Access to Mental Health Services, Fact Sheet, June 2017, Kaiser Family Foundation, http://files.kff.org/attachment/Fact-Sheet-Facilitating-Access-to-Mental-Health-Services-A-Look-at-Medicaid-Private-Insurance-and-the-Uninsured

[12] Williamson, Alanna, Larisa Antonisse, Jennifer Tolbert, Rachel Garfield and Anthony Damico, ACA Coverage Expansions and Low-Income Workers, Issue Brief, June 2016, Kaiser Family Foundation, http://www.kff.org/medicaid/issue-brief/aca-coverage-expansions-and-low-income-workers/

[13] Op cit. Figure 1

A recent report by the Center for Health Information and Analysis(CHIA) shows that workers at lower wage firms have lower offer, eligibility and take up rates and face higher purchasing costs and cost-sharing on their employer plans than their counterparts in higher wage firms.[14] This is consistent with national studies that low income workers are less likely to have employer sponsored insurance for many reasons including being more likely to work in agriculture and service sectors or for small employers who are less likely to offer coverage or more likely to be part-time workers ineligible for employer coverage.[15]

B. For many adults, lowering the MassHealth income level will decrease continuity of coverage and increase churn

Besides the obvious disadvantages of reduced benefits and higher costs, the one and only asserted advantage of alignment with commercial insurance –increased continuity and reduced churn—will at best be true for only some, and not true for many others. It is true that if the Connector has a wider income range, more individuals will be able to remain in the same MCOs if their income goes up albeit with higher premiums and copays. However, such individuals will lose Medicaid's continuity of care protections for the working poor. Working parents whose income goes over 133% FPL can now remain in MassHealth for 12 months under Transitional Medicaid. Also, working parents with income up to 300% FPL whose employers offer family coverage may be eligible for Family Assistance Premium Assistance in MassHealth compared to losing all assistance in ConnectorCare.

Further, narrowing the income range in MassHealth will result in those from 100-133% FPL whose incomes fluctuate *down* below 100% FPL moving from ConnectorCare to MassHealth rather than remaining in MassHealth. Data on income fluctuations show that fluctuations in both directions are common at income levels below 150% FPL.[16] In addition, the initial transition of 140,000 members from MassHealth to ConnectorCare in 2019 will be highly disruptive. In 2019, MassHealth members under 133% FPL may be in one of 17 ACOs, but in ConnectorCare there will be only one affordable MCO available to them. Further, to have an affordable MCO, ConnectorCare members may have to change carriers annually to remain in the lowest cost MCO. Similarly, adults under 133 % FPL disqualified from MassHealth based on access to ESI will have more coverage disruptions if their income or family size drops or the ESI offerings change making ESI unaffordable, than if they had remained eligible for MassHealth secondary coverage.

II. Lowering income eligibility for non-disabled adults to 100% of the federal poverty level will reduce coverage and access to care

The state proposes to lower eligibility for non-disabled adults to 100 percent from 133 percent of the federal poverty level, beginning January 1, 2019, resulting in an estimated 100,000 parents/caretakers and 40,000 childless adults losing MassHealth some of whom would regain

[14] CHIA Research Brief, The Benefits Divide: Workers at Lower-Wage Firms and Employer-Sponsored Insurance in Massachusetts, August 2017, http://www.chiamass.gov/assets/docs/r/pubs/17/mes-research-brief-august-2017.pdf
[15] Op cit Figure 3
[16] Sommers, Benjamin D., and Sara Rosenbaum, Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges, Health Affairs 30, No. 2 (2011): 228-236, doi: 10.1377/hlthaff.2010.1000, Exhibit 4.

coverage in ConnectorCare. We oppose this proposal. It will not further the goal of achieving near universal coverage. On the contrary, this request will lead to loss of coverage for individuals who are not eligible for ConnectorCare, and for those who may be eligible but who will not be able to successfully enroll. This conclusion is based on our experience here in Massachusetts with the eligible but unenrolled in ConnectorCare and experience in other states that rolled back Medicaid income standards in 2014.

Further, for those who do succeed in enrolling in ConnectorCare, they will have fewer benefits, significantly higher copays, fewer affordable plan choices and will lose a host of special Medicaid protections designed to meet the needs of very low income people. They will lose out on the opportunity to benefit from new Accountable Care Organizations that we are told will transform MassHealth, and the ACOs in turn will lose a significant share of their expected enrollees. Finally, it is far from clear that CMS would approve a partial Medicaid expansion with an enhanced match for the 260,0000 expansion adults remaining in CarePlus. Without the enhanced match the Medicaid rollback will increase state spending.

A. Many of the 140,000 losing MassHealth will not be able to successfully transition to ConnectorCare

ConnectorCare has eligibility rules that MassHealth does not that will bar some individuals from qualifying for ConnectorCare. We have not seen any analysis from EOHHS estimating the number of people unable to transition or a plan for addressing the problem. The August 2017 EOHHS presentation indicates that "medically frail" individuals will be able to retain MassHealth eligibility. However, the 1115 proposal does not include a provision retaining Medicaid coverage for the medically frail or for any other adults who do not qualify for ConnectorCare on the basis of rules not applicable in Medicaid at the 100-133% income level.

1. Some MassHealth members are not eligible for ConnectorCare

Among the groups who now qualify for MassHealth but will not qualify under Connector rules are:

- Individuals offered employer sponsored insurance (ESI) that will cost less than 9.56% (2018) of family income for self only coverage and the spouse of such an individual regardless of the added cost of coverage for a spouse.
    - In addition to the high percentage, the problem is that the definition of "affordable"—for both an individual employee and a family—is based on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan. This is particularly problematic for low-income families, who pay a much higher share of their income to purchase ESI coverage than higher-income families. We note that the Connector is not contemplating waiver of the so-called "family glitch" in its proposed 1332 document.
- Veterans enrolled in the VA Health System but otherwise uninsured
    - The VA Health System is considered other coverage that disqualifies these veterans from ConnectorCare
- Married couples living apart who file taxes as married filing separately.

    - Married couples filing separately are not eligible for ConnectorCare (unless the reason for not filing jointly is domestic violence or abandonment and the whereabouts of the spouse is unknown).
    - If a married couple files jointly, the income of both spouses will be counted in determining eligibility even if they live apart and are financially independent
- "Dreamers" (Deferred Action Childhood Arrivals or DACA)
    - DACA is not an eligible immigration status for Connector, but it is eligible for state-funded MassHealth Family Assistance

2. Many MassHealth members eligible for ConnectorCare are unlikely to successfully enroll

Other individuals may not be barred from ConnectorCare but will find it difficult to navigate the greater complexity of the ConnectorCare eligibility and enrollment system. We know this both from the experience in Massachusetts and the experience of other states that rolled back Medicaid eligibility for adults in January 2014.

Some otherwise eligible individuals may not qualify because they are confused by the tax-filing rules. This will include individuals who are not now required to file taxes, such as early retirees with taxable Social Security below the filing threshold. If they indicate on the application that they do not file taxes they will be unable to qualify for Connector Care.

There are also a large group of people who do not understand the additional steps required to affirmatively enroll in a ConnectorCare plan and the deadlines for doing so. People found eligible for ConnectorCare must either enroll during the "open enrollment period" or within 60 days of being determined eligible for ConnectorCare outside of open enrollment. If they fail to enroll by the deadline, in most cases, they will be unable to enroll until the following year.

While there is a special enrollment period for people eligible for ConnectorCare who missed open enrollment, there is still a deadline to enroll that if missed will foreclose enrollment for the balance of the calendar year. In the former Commonwealth Care program, eligible individuals were never foreclosed from reapplying and enrolling regardless of the time of year or whether they were previously found eligible and failed to enroll. Similarly, in MassHealth there is no open enrollment period or special enrollment periods, and coverage is not dependent on applicants taking the second step of enrolling in an MCO. MassHealth members are eligible and covered right away and if they are required to enroll in managed care and fail to do so, MassHealth will automatically enroll them.

Information we obtained from the Health Connector for July 14, 2017 shows that in Plan Type 2A, (100-150% FPL), over 40% of those found eligible for ConnectorCare were unenrolled. Some of these individuals may still be within their 60 day window to enroll, but most will be unable to enroll in ConnectorCare until 2018. If 40% of 140,000 former MassHealth members similarly miss ConnectorCare enrollment deadlines, an additional 56,000 may be uninsured.

Table 1. ConnectorCare PT 1 & 2A Eligible Counts: 7/14/17		
Population	**Plan Type 1 (0-100% FPL)**	**Plan Type 2A (100-150% FPL)**
PT1 and 2A Eligible Unenrolled	9,606	19,924
PT 1 and 2 A Enrolled	15,021	29,082
PT1 and 2A Eligible	24,627	49,006

Another pitfall in ConnectorCare that has no equivalent in MassHealth is that anyone eligible for a plan with no premium contribution who does not switch to the new lowest cost plan at next year's open enrollment will be assessed a premium and terminated if the premiums are not paid. This not only disrupts continuity of coverage for those who switch, but ends coverage altogether for some who fail to switch. For example, this year, roughly 3,000 members with no premium in December 2016 who did not switch to the new lowest cost plan for 2017 were terminated for nonpayment of premiums on March 31, 2017.

The likelihood that many beneficiaries who lose Medicaid coverage would not successfully make the transition to private coverage, even if they are eligible for subsidized coverage, is also borne out by the experience of other states. Experience from other states such as Wisconsin, Connecticut and Rhode Island shows that even when efforts are made to assure a smooth transition, people get lost in the shuffle. In Rhode Island despite considerable efforts, 1,271 parents of the 6,574 (or 19 percent) who lost Medicaid when the state rolled back eligibility (on the theory that they could get premium tax credits) never applied for a premium tax credit.[17] During the first round of a similar parent eligibility rollback in Connecticut only one in four parents losing Medicaid coverage enrolled in a QHP.[18] In Wisconsin only one-third of those losing Medicaid coverage purchased QHPs although the state had predicted that 90 percent would.[19]

Finally, even adults who are eligible and successfully navigate the more complex rules required to enroll in ConnectorCare are more likely to experience gaps in coverage and medical debt for services incurred during gap periods than MassHealth beneficiaries. There is a built in gap period for new applicants who are eligible for ConnectorCare because eligibility and coverage are separate steps and coverage is only prospective on the first of the month after plan selection. In MassHealth, on the other hand, eligibility and coverage both are retroactive to 10 days prior to the date of application. Retroactive eligibility is one of the ways that Medicaid is better at protecting the poor and near poor from medical debt than commercial insurance.

[17] Kate Lewandowski, "Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned," https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?1439834245

[18] Langer, S. et al. *Husky Program Coverage for Parents: Most Families Will Feel the Full Impact of Income Eligiblity Cut Later ln 2016* http://www.ctvoices.org/sites/default/files/h16HUSKYIncomeEligibilityCut.pdf

[19] "One-third who lost BadgerCare coverage bought plans on federal marketplace," *Journal Sentinel*, July 16, 2014. http://archive.jsonline.com/business/almost-19000-badgercare-plus-recipients-enrolled-inobamacare-b99312352z1-267339331.html

B. ConnectorCare offers fewer affordable premium choices, fewer benefits and charges higher copays than MassHealth

1. Fewer affordable premium choices

There are no premium charges for the 140,000 adults between 100-133% FPL in MassHealth regardless of their choice of managed care plan, and in 2018 they will have additional choices for Accountable Care Organizations (ACOs) with no premium contribution. In 2018 the Connector plans to offer only one MCO with no premium contribution for those with income under 150% of poverty. Those choosing an MCO other than the lowest cost MCO will be charged a premium, regardless of income. In 2017, monthly premiums were as high as 17% of income for individuals or up to 25% of income for couples to remain in an MCO other than the lowest cost MCO.[20]

2. Fewer benefits

In addition, ConnectorCare plans do not cover entire categories of health services available in MassHealth such as dental services, non-emergency transportation or long term services and supports. Further, even if a broad category of services are covered such as pharmacy benefits or inpatient and outpatient mental health and substance use disorder services, ConnectorCare does not offer a comparable amount, duration or scope of benefits compared to MassHealth.

For example, in the area of behavioral health and substance use disorder services, MassHealth offers a scope of diversionary behavioral health services with no equivalent in ConnectorCare plans, and has just added coverage for more substance use recovery services across the continuum of care including transitional support services and residential rehabilitation services. Further, ConnectorCare plans charge Plan Type 2A members (including those from 100-133% FPL) a $50 copayment for inpatient services presumably including inpatient detoxification and $10 copayments for mental health and substance use outpatient visits. Importantly, individuals for whom alcoholism or addiction is a contributing factor to a determination of disability will not be able to regain access to more comprehensive and affordable MassHealth services by establishing a disability.[21]

3. Higher copays

ConnectorCare Plan Type 2A also has substantially higher copays than MassHealth such as: $10 for an office visit, $50 for the ER, and drug costs of $10-$40 up to a $500 annual drug maximum compared to MassHealth copays of $3.65 for most drugs and $3 for an inpatient visit. The maximum out of pocket cost-sharing in ConnectorCare Plan Type 2A ($1250 for an individual or $2500 for a couple) as a percent of income represents up to 10% of income for an individual and 15% of income for couples at 100% FPL; and up to 7.7% of income for an individual and 11.5% of income for couples at 133% FPL.

Another important Medicaid protection for the poor and near poor that does not exist in ConnectorCare is the Medicaid rule that providers cannot refuse services based on a MassHealth

[20] ConnectorCare offers at least one no-premium option for the lowest cost MCO for people with income up to 150% of poverty in Plan Types 1 and 2A, but charges premiums for other MCO choices. The percentage shown here is for people at 100% FPL choosing a higher cost MCO currently offered through the ConnectorCare Plan Type 2A.
[21] See footnote 10

members' inability to pay the copayment on the date of service.[22] This does not protect MassHealth members from medical debt, but it does protect them from denial of services.

Given the high cost of living in Massachusetts, families under 133% of poverty have insufficient income to meet their basic needs without taking into account the added cost of health services. See the table below which shows the basic cost of living in Massachusetts for different family configurations compared to various income levels as a percent of poverty.

The research literature is clear that even small copayments negatively affect access to care for the poor:

> Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services. Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.[23]

Table 2. Comparison of MA Cost of Living with 150%-300% FPL

	Required Annual Income for Average Cost of Living in MA[24]	**150% FPL**	**200% FPL**	**300% FPL**
Family Size 2				
1 Adult 1 Child	$ 47,842	$24,360	$32,480	$48,720
Family Size 3				
2 Adults (1 Working) 1 Child	$ 41,648	$30,630	$40,840	$61,260
2 Adults 1 Child	$ 52,960			
1 Adult 2 Children	$ 56,527			
Family Size 4				
2 Adults (1 Working) 2 Children	$ 46,535	$36,900	$49,200	$73,800
2 Adults 2 Children	$ 61,694			
1 Adult 3 Children	$ 69,933			

[22] 130 CMR § 506.017

[23] Artiga, S. et al, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, http://www.kff.org/medicaid/issuebrief/the-effects-of-premiums-and-cost-sharing-on-low-incomepopulations-updated-review-of-research-findings/

[24] From the MIT Living Wage Calculator (living costs are shown here minus estimated medical costs), http://livingwage.mit.edu/states/25

C. MassHealth has legal protections to assure affordability and other consumer protections and work incentives that ConnectorCare does not

Federal Medicaid rules prohibit premium charges for individuals under 150% of poverty and limit copayments to nominal amounts. The authorizing statute for the former Commonwealth Care program created Medicaid-like protections for the poor: no premiums, copayments no higher than MassHealth, comprehensive benefits including dental and basic due process rights.[25] Individuals enrolled in the current ConnectorCare program have far fewer protections. The Affordable Care Act sets out the basic parameters of coverage, and state law authorizes added state premium and cost sharing subsidies but provides no other direction to the Connector board.[26] Over time, "affordable" MCO choices have become fewer and fewer. In 2018, the Connector will offer only one affordable MCO. Unlike Medicaid, ConnectorCare has no legal requirement to offer coverage at no cost to those under 150% of poverty.

The Connector also lacks other Medicaid protections specifically designed for the poor and near poor. For example, Medicaid is an important work support. Programs like Transitional Medical Assistance enable low income families with children to remain on Medicaid for 12 months if they have earnings that now exceed Medicaid financial income limits. There is no equivalent to these programs and a host of other Medicaid-specific features designed to meet the needs of the poor and near poor in ConnectorCare. ConnectorCare is based on a commercial insurance model and provides coverage to people with income up to three times the poverty level --$36,180 for one person in 2018 compared to $12,060 to $16,040 for someone between 100% and 133% of the poverty level.

D. The MassHealth ACO program will not have the opportunity to achieve savings and better health for 140,000 members

Another negative feature of the proposed transition is that these 140,000 adults would be removed from MassHealth just as the program is moving into delivery system reform designed to improve quality and control costs starting in early 2018 and to begin to address the social determinants of health. Accountable Care Organizations will need stable and expanded enrollment to succeed. Keeping this population in MassHealth will give ACOs the chance to achieve savings by addressing the underlying cost drivers and to produce better health outcomes for its members.

E. A partial expansion may jeopardize the enhanced matching rate

The shift in coverage for those from 100-133% FPL, only possible because of a drafting error in the ACA, will result in higher costs to the federal government.[27] It is far from clear that the federal government will approve an enhanced match for a partial expansion to 100% FPL. If Massachusetts forfeits the 90 percent enhanced matching rate for expansion adults, 260,000 of whom have income at or under 100% of poverty, it will offset any state savings for 100,000 parents at 100-133% FPL and result in a net increase in state spending. CMS guidance issued in

[25] Section 45, Chapter 58, St. 2006 (enacting G.L. c. 118H, §6)
[26] G.L. c. 176Q, §3
[27] Dylan Scott, Why one little waiver could be a big deal for Medicaid, August 10, 2017, Vox, https://www.vox.com/policy-and-politics/2017/8/10/16127264/voxcare-waiver-really-big-deal-medicaid

December 2012 states that enhanced matching funds are not available for a partial expansion.[28] This was the experience of Wisconsin which was unable to obtain an enhanced match for expanding to adults up to 100% FPL. In March 2017, CMS wrote to Governors promising support for rolling back many Medicaid protections, but notably did not invite requests for partial Medicaid expansions. Arkansas is the first state to request a partial expansion with an enhanced match from the new CMS administration; its request is pending. However, all states that expanded Medicaid and are now responsible for 10% of costs would benefit financially from a partial expansion to 100% FPL, and more can be expected to follow suit if CMS allow partial expansions. Given the potentially large added costs to the federal government of assuming the costs for subsidized coverage for those from 100-133% FPL, it seems highly doubtful that this approach for shifting costs to the federal government will succeed.

III. The ESI Lock-Out, even if it disqualifies only 5,000 people, does not promote the objective of the Medicaid Act

The proposed 1115 amendments seek authorization for the MassHealth agency to deny or terminate MassHealth eligibility for non-disabled adults who have access to affordable employer sponsored health insurance (ESI) as defined by the agency. Because these are individuals with income under 133% of the federal poverty level (FPL), few will be able to afford private commercial insurance, and we fear most of these individuals will become uninsured.

A. The proposed affordability test does not capture the costs of ESI

The 1115 proposal indicates that ESI will be considered affordable for those under 133% FPL if the employee share of the premium does not exceed 5% of income. More recently, at the August listening session, the agency said that ESI would not be considered affordable unless the deductible combined with the employee share of the premium were under 5% of income. Five percent of income is the upper limit for premiums and *all forms* of cost-sharing for those over 150% of poverty to pay for Medicaid coverage. However, even the if out of pocket maximums in ESI were added to the 5% of income calculation, it would not capture the higher costs of ESI because the proposal does not include any standards for the scope of ESI coverage.

If the ESI lock out were to be limited to ESI that met the Connector's standards for minimum creditable coverage, it still would not be comparable to MassHealth. Such coverage could exclude durable medical equipment, rehabilitative therapy (PT, OT, SLT), home health, short-term skilled nursing facility care, dental and hospice.[29] Further, even if benefits are covered in ESI, the amount, duration and scope of benefits may be severely limited compared to Medicaid coverage. In the area of mental health and substance use disorder services in particular, commercial coverage does not equal MassHealth. For adults under 133% FPL (or under 100% FPL if the income standard is lowered), these uncovered services impose additional costs and additional costs restrict access to care compared to comprehensive Medicaid coverage.

[28] Centers for Medicare & Medicaid Services, "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid," (December 10, 2012), https://www.medicaid.gov/federal-policyguidance/downloads/FAQ-12-10-2012-Exchanges.pdf

[29] 956 CMR 5.03(1)

B. In Medicaid and the Massachusetts individual mandate, no premium contribution for someone under 150% FPL is affordable.

Federal Medicaid law and MassHealth regulations, as well as the Connector's affordability scale for both ConnectorCare premiums and for the individual mandate, recognize that NO premium contribution is affordable for individuals and families with income under 150% of the poverty level. The individual mandate standard was developed by the Connector pursuant to Chapter 58 with broad public participation and has stood the test of time.

C. Massachusetts families under 133% FPL have insufficient income to meet basic living costs without the added costs of health insurance premiums.

Under the proposal, a low-income parent with two children and income under $20,420 per year, $1702 per month (100% of poverty for a household of three) offered ESI at a monthly premium of $85 (5% of income) for individual coverage will no longer be eligible for MassHealth. The costs of coinsurance, copays and uncovered services will add hundreds more to the cost of ESI. At income levels under 133% of poverty, families cannot afford all the added costs of ESI after meeting their basic living costs. See, Table 2 above.

In particular, the high cost of housing in states like Massachusetts is not captured by the national federal poverty level standards. In Massachusetts, rent at 40% of median for a two-bedroom apartment is $1,424. In order to afford this level of rent and utilities — without paying more than 30% of income on housing — a household must earn $4,747 monthly or $56,967 annually.[30] At $1702 per month, rent for that two- bedroom is 84% of income. The waiting list for section 8 subsidized housing in Massachusetts is over 100,000 names long.

Not surprisingly, ample research documents how price sensitive poor and near poor families are to premium costs:

> Premiums serve as a barrier to obtaining and maintaining coverage among low-income individuals. These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.[31]

The administration says the purpose of its proposal is to "promote the uptake of employer sponsored insurance." However, the more likely result is that families will have to forego insurance coverage in order to pay the rent or keep food on the table.

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[30] National Low Income Housing Coalition, Out of Reach 2017 : the High Cost of Housing, p. 116 http://nlihc.org/sites/default/files/oor/OOR_2017.pdf

[31] Kaiser Family Foundation, **June 2017 | Issue Brief ,** The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings, http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

D. This is not a return to the way it was under chapter 58: MassHealth has always supported working poor parents

The ESI lock out will affect low income families with children who from 1997 until today have been able to rely on MassHealth as a work support. Under long standing MassHealth rules, there is no ESI lock out. Instead, if ESI is cost effective, families are required to participate in Premium Assistance which reimburses premium costs and cost sharing and provides services, like dental, that might not be in the employer plan. If a working parents on MassHealth no longer meet the family income standard, they are entitled to a further 12 months of transitional medical assistance as a work incentive. In addition, if working parents have access to family coverage from ESI, Family Assistance Premium Assistance may help reduce the ESI premium cost until family income exceeds 300% of poverty. These programs help families to work their way out of poverty without the abrupt "cliff effects" in other benefit programs. The ESI lock-out undermines a successful and important support for working families.

An ESI "gate" did exist in the Commonwealth Care program for people not eligible for MassHeatlh with income up to 300% of poverty, and today there is an ESI "gate" under the ACA for eligibility for Premium Tax Credits for individuals with income up to 400% of poverty. However, this kind of control is rarely found in programs with income levels at poverty or near poverty.

E. An improved Premium Assistance program is a better way to promote ESI

We support increased participation in MassHealth Premium Assistance as the best way to leverage employer contributions and reduce state spending while also assuring that low income workers have affordable and comprehensive coverage. According to EOHHS, MassHealth was providing coverage to about 200,000 more working people in 2015 than in 2011. However, to the best of our knowledge there has been no commensurate increase in Premium Assistance. On the contrary, according to the August presentation at the listening session, over 150,000 individuals lost MassHealth between June 2016 and June 2017 partly as a result of enforcing Premium Assistance. We presume this means individuals lost coverage, at least temporarily, for failing to return information regarding available ESI or failing to enroll in ESI when directed to do so. This kind of process-driven churning harms eligible members, destabilizes health plans, and wastes the time of MassHealth workers. It makes far more sense for EOHHS to improve the Premium Assistance program than to divert its limited time and resources to denying MassHealth coverage to the working poor.

IV. MassHealth Limited coverage is not waivable and provides important benefits

Lawfully present immigrants who do not meet the stricter immigrant eligibility rules of MassHealth are eligible for both ConnectorCare and MassHealth Limited. The proposal seeks a waiver to terminate MassHealth Limited for these individuals. Section 1903(v) of the Social Security Act requires states to provide emergency Medicaid. The Secretary's waiver authority is limited to Section 1902, therefore emergency Medicaid is not subject to the Secretary's waiver authority. In any event, terminating emergency Medicaid is not a good policy.

MassHealth Limited covers only emergency care which is redundant for those also enrolled in ConnectorCare, but since MassHealth is payer of last resort, this redundancy should impose no costs on MassHealth. MassHealth Limited is not redundant during the temporary period before ConnectorCare enrollment begins and the retroactive period10 days prior to application. Currently, if individuals do not enroll in ConnectorCare, their HSN ends but Limited is at least available to reimburse hospitals for ER services. Without HSN or MassHealth Limited, hospitals and community health centers will incur more uncompensated care costs, the state will have foregone federal revenue, and consumers will incur more medical debt. Terminating Limited is particularly unfair since individuals eligible for ConnectorCare who miss the enrollment deadline will in most cases be unable to enroll until the following year –a confusing situation for many people but particularly for recent immigrants and those not proficient in English. A better way to encourage enrollment into ConnectorCare than cutting off MassHealth Limited would be to create a Special Enrollment Period for MassHealth Limited members coupled with increased outreach on an ongoing basis.

V. 230,000 low income parents and caretaker relatives will have fewer benefits in MassHealth CarePlus than MassHealth Standard

The 1115 amendments also propose a shift of 230,000 parents and caretaker relatives with income under the newly lowered 100% FPL limit to MassHealth Care Plus, an Alternative Benefit Program authorized only for expansion adults that has fewer benefits than MassHealth Standard. CarePlus does not include long term services and supports or non-emergency medical transportation. Reducing benefits for parents and caretaker relatives does not promote the objectives of the Medicaid Act. Further, reducing benefits available to parents and caretaker relative in January 2002 violates state law.[32]

The proposal justifies the benefit reduction as better aligning with commercial insurance and promoting continuity and reducing churn. It is surely true that commercial insurance does not typically cover NEMT or LTSS. However, it is mystifying how aligning Medicaid with commercial insurance by eliminating NEMT and LTSS will promote continuity and reduce churn. Does EOHHS believe that MassHealth members under 133% of poverty who forego commercial insurance at an employee premium cost of $143 per month for single coverage will instead choose to enroll if the MassHealth coverage available to them at no added premium cost no longer covers NEMT or LTSS (which the employer coverage also fails to cover)?[33]

The Medicaid program has required coverage of NEMT for a reason, studies have shown that it improves health outcomes and in some cases reduces costs.[34] The state's rationale for eliminating

[32] G.L. c. 118E § 53.
[33] $143 per month is the average employee share of cost for single coverage among lower wage firms. See footnote 14, Ex. 9.
[34] P. Hughes-Cromwick and R. Wallace, et al., Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation, Transit Cooperative Research Program (Oct. 2005), http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

NEMT is to better align CarePlus with commercial insurance. However, transportation is a greater access barrier for low income Medicaid beneficiaries than for the commercially insured.[35] EOHHS has supplied no information about how many of the 230,000 parents use NEMT. In our experience, few MassHealth members are aware of the benefit. It is not described in the member booklet or on the MassHealth website. Most of those who use the benefit learn of it through their doctors who must obtain prior authorization in order for their patients without access to transportation to obtain a ride to health services. According to MassHealth, only 4% of CarePlus members use NEMT for other than SUD services. Eliminating NEMT cannot be a significant savings. Nor can the delay in providing LTSS until such time as the parents and caretakers who need LTSS succeed in establishing medical frailty or disability account for significant savings.

VI. Reducing the Premium Assistance wrap does not promote the objectives of the Medicaid Act

The 1115 proposal seeks to reduce MassHealth benefits for non-disabled adults receiving premium assistance for the costs of commercial coverage and to reduce cost-sharing assistance for students required to enroll in student health plans. We oppose reductions in the MassHealth wrap that will result in individuals in premium assistance arrangements being afforded fewer beneficiary protections than all other MassHealth enrollees.

Reduced benefits

The rationale for restricting the benefit wrap is that the process used to verify that the scope of commercial coverage meets a basic benefit level is sufficient to assure adequate coverage.[36] However, the definition of a basic benefit level does not consider the amount, duration and scope of benefits. For example, if ESI covers only 10 rehabilitative therapy visits and 20 visits are both medically necessary and covered by MassHealth, under the proposal, the added visits will not be covered. It is fundamentally unfair that non-disabled adults will be denied medically necessary care available to similarly situated MassHealth members without access to ESI. If ESI imposes unreasonable medical necessity criteria, rather than deny a member a covered service, MassHealth can enforce its subrogation rights against the insurer. Similarly, rather than deny services in those cases where ESI has appropriately denied prior authorization on medical necessity grounds, MassHealth can design a system to trigger its own prior authorization process to determine MassHealth medical necessity criteria are satisfied prior to payment. Denying coverage altogether is unfair and furthers no purpose other than reducing state spending.

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[35] P. Cheung, J. Wiler, and et. al., National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries, Annals of Emergency Medicine (July 2012), Retrieved from http://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext
S. Syed, B. Gerber, and L Sharp, Traveling Towards Disease: Transportation Barriers to Health Care Access, Journal of Community Health (Oct. 2013). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215
U.S. Government Accountability Office, Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage (Jan 2016). Retrieved from http://www.gao.gov/assets/680/674674.pdf

[36] Commercial insurance must satisfy a "basic benefit level" defined as equivalent to the Connector's "minimum creditable coverage" standard. 130 CMR 501.01 (definition of basic benefit level cross-referencing to 956 CMR 5.03(1)(a). The current review also requires coverage for certain additional benefits: DME, Home Health, Early Intervention, Medical Nutrition Therapy, and Hospice.

Increased cost sharing

Currently, for all adults except students and Medicare recipients, MassHealth secondary coverage pays for cost-sharing in excess of Medicaid limits only if the provider bills MassHealth for the excess cost sharing amount. This essentially limits most MassHealth beneficiaries to seeing providers who participate in both the commercial plan and in MassHealth. This policy eliminates one of the few advantages of commercial insurance compared to MassHealth, the participation of independent practitioners such as dentists and psychiatrists who may be in short supply in MassHealth. Further in the field of mental health, MassHealth fee for service has a very narrow network of independent providers. Fee for service essentially allows no independent licensed mental health professionals, other than psychiatrists, to bill for therapy services as independent providers.[37] Psychologists for example, can participate in MassHealth only for purposes of testing, and not for the provision of therapy services. Thus limiting the ability of providers who do not otherwise participate in MassHealth to bill for cost sharing, unfairly shifts costs to members.

When CMS approved the state plan amendment to provide premium assistance for student health insurance plans (SHIP) in the individual market on November 18, 2016, it required the state to reimburse students for any out of pocket cost sharing in excess of Medicaid amounts while the state evaluated "the overlap of providers participating in both Medicaid and group/individual health insurance plans to ensure that the network is adequate to meet the health needs of premium assistance beneficiaries." If the networks are adequate, the State was then to submit a freedom of choice waiver in order to continue SHIP premium assistance beyond a Dec. 31, 2017 sunset date.

The state is now seeking a freedom of choice waiver to deny students and other individuals enrolled in premium assistance the same cost sharing protections provided to all other Medicaid enrollees without having conducted any evaluation of the overlap of providers in student health plans and other commercial insurance with participating providers in MassHealth fee for service. Without such an evaluation, the state has no basis for seeking a waiver.

VII. The proposed pharmacy restrictions do not promote the objectives of the Medicaid Act

A. A closed drug formulary is not needed to obtain supplemental rebates and will reduce access to necessary medication

We oppose the MassHealth proposal to create a closed formulary. Currently, MassHealth is required to cover any drug for which the manufacturer participates in the federal Medicaid rebate program. The current open formulary guarantees patients access to the highest standard of care available and allows physicians to prescribe the course of treatment they and their patients believe is most appropriate. A closed formulary would restrict the drugs MassHealth covers, with as few as one drug available per therapeutic class. We believe this proposed restriction

[37] Other entities such as mental health centers and outpatient hospitals can bill MassHealth fee for service for the services of licensed mental health professionals in their employ, and the MassHealth MCOs and the Partnership do include independent licensed mental health professionals in their networks.

unduly restricts physicians' exercise of clinical judgment based on their treatment experience with individual patients who often have complex medical conditions. If implemented, this proposal could seriously undermine patients' health and thereby defeats the purpose of the Medicaid Act.

The rationale given for this proposal is that a closed formulary will enhance the leverage EOHHS has in negotiating rebates with pharmaceutical companies by favoring highly discounted drugs over more expensive alternatives. Currently, all fifty States and the District of Columbia cover prescription drugs under the Medicaid Drug Rebate Program, which is authorized by Section 1927 of the Social Security Act. States may choose to layer individually negotiated supplemental rebates over the federal Medicaid drug rebates. States leverage their ability to subject certain drugs within classes to prior authorization using Preferred Drug List (PDL) status to drive deeper discounts from manufacturers looking for a competitive edge. As of December 2015, 47 states and the District of Columbia operate single and/or multi-state supplemental rebate arrangements. Only Hawaii, New Jersey, New Mexico and South Dakota do not have supplemental rebates in place; Arizona and Massachusetts began collecting supplemental rebates for the first time in 2015.[38] According to the Medicaid and CHIP Payment and Access Commission, the Medicaid Drug Rebate Program reduces gross spending on affected prescription drugs by almost half.[39] Given the extraordinary success nationally of drug rebate programs, we fail to see why Massachusetts needs the added leverage of restricted formulary access to successfully negotiate substantial discounts through rebates in its pharmacy program.

In fact, recent MassHealth history involving Hepatitis C (HCV) demonstrates the effectiveness of state negotiations in reducing the cost of treatment through rebate agreements without closing the formulary to other HCV drugs[40] Here unnecessary and punitive prior authorization restrictions were removed from MCOs' treatment protocols which limited access to those patients with existing severe and untreatable liver impairment, and further limited access to patients without a sufficient period of drug and alcohol sobriety, extended HCV treatment to all MassHealth patients under an open access policy.

Unlike several of the changes proposed elsewhere in this 1115 Waiver Amendment Request, this proposed formulary restriction would apply to all MassHealth members, including people living with disabilities, medical frailty, HIV, and breast and cervical cancer, as well as children, and seniors. Prescription drugs are a lifeline for people living with chronic and complex conditions, and further restrictions on access to medications will only serve as a barrier to obtaining the treatment regimens that are most appropriate for these individuals. People with complex medical

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[38] Vernon K. Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, Laura Snyder & Elizabeth Hinton. (2015, October). "Medicaid Reforms to Expand Coverage, Contain Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." Kaiser Family Foundation and the National Association of Medicaid Directors. http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years2015-and-2016/

[39] Chris Park. (2015, October). "Trends in Medicaid Spending for Prescription Drugs." Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2015/10/Trends-in-Medicaid-Spending-for-Prescription-Drugs.pdf

[40] https://www.bostonglobe.com/metro/2016/06/30/masshealth-pay-for-hepatitis-drugs-for-all-infected-members/DhQNZCf9WDZH5CM41V4vgI/story.html.

conditions are often treated for multiple ailments, requiring further balancing of patient histories and drug interactions to arrive at patient specific treatment plans.

This proposal is particularly concerning for continued access to HIV and HCV medications. Physicians choose which drugs to prescribe their HIV and HCV patients based on a wide range of factors, including co-occurring illnesses, medical history, and previous treatment tolerance[41] It is important to note that HIV and HCV drug regimens are not interchangeable. HIV and HCV are complex diseases and treatment options must take into account several individualized medical factors as well as concerns regarding a patient's medication adherence. Before initiating treatment, physicians must consider drug interactions, coexisting conditions, and side effect profiles. Recent advances in HIV treatment have allowed for some patients to reduce their dauntingly complex bill burden by taking a single dose of combined HIV antiretroviral treatment. This greatly improves patients' adherence to treatment, reducing overall treatment costs and reducing further infections.[42] While these single dose HIV medications are sometimes more expensive than the older multi-drug combination therapies, they greatly simply patient adherence and are mostly highly tolerated medications with few side effects. Therefore, it is important that doctors are able to provide treatment based on patients' needs, not on availability in MassHealth driven solely by cost savings concerns.

Implementing an exceptions process to a closed formulary through which an individual can attempt to access coverage for a drug not on the formulary would also fall far short of ensuring that people with a complex medical condition and their providers can access the appropriate treatment regimen. This is true because of the uncompensated cost to providers of going through the exceptions process, because this coverage is not guaranteed, and because the process of obtaining this coverage is often opaque.[43] Given these concerns, we urge MassHealth to consider alternative strategies to lower prescription drug spending that will not adversely impact beneficiaries' access to medically necessary medications.

If Massachusetts does proceed with a limited formulary, we recommend that at a minimum it adopt the patient protections afforded Medicare Part D patients in their selection of a pharmacy plan with a closed formulary. Specifically, we ask that the formulary adhere to the guidelines set forth in the Medicare Prescription Drug Benefit Manual – Chapter 6 Part D Drugs and Formulary Requirements. See Section 30.2 which requires that two drugs per category or class be made available in a given formulary – not the single drug proposed by the formulary restrictions of the MassHealth proposed 1115 waiver.

We further would recommend that the rule set forth in the Medicare Prescription Drug Manual at Section 30.2.5 "Protected Classes" be adopted. This rule states that "Part D sponsor formularies

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[41] *See generally Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*, DEPARTMENT OF HEALTH AND HUMAN SERVICES, https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf; *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*, American Association for the Study of Liver Diseases and the Infectious Diseases Society of America, http://www.hcvguidelines.org/.

[42] http://www.aidsmap.com/Single-tablet-regimen-improves-antiretroviral-adherence-and-reduces-hospitalisation/page/2763722/

[43] *See* James L. Raper et al., *Uncompensated Medical Provider Costs Associated with Prior Authorization for Prescription Medications*, 51 CLINICAL INFECTIOUS DISEASES 718, 720 (2010).

must include all or substantially all drugs in the immunosuppressant (for prophylaxis of organ transplant rejection) antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes."

B. A Selective Specialty Pharmacy Network for PCC and Fee-for-Service Will Restrict Access for the Homeless and other Vulnerable Populations

We are concerned that the proposal to limit the choice of pharmacy to specialty pharmacies for members receiving care through the fee-for-service and the primary care clinician (PCC) plan may have the unintended effect of imposing unnecessary barriers to obtaining lifesaving specialty medications. While specialty pharmacies can provide care coordination benefits to those that prefer them, they often present physical access problems for those experiencing homelessness and people in transient living situations. This is especially true where no brick-and-mortar locations are readily accessible and members are forced to receive their medications in the mail. These individuals in particular may not be able to receive medications consistently in the mail, creating gaps in treatment and increasing the likelihood that members will not be able to adhere to their treatment regimens.[44] For many individuals, having medications delivered to their home or workplace where co-workers, neighbors, and other residents may discover their health conditions or medication needs could result in serious harm and social alienation, especially given the significant stigma still associated with HIV and HCV.

Provider and community health workers' experiences with MassHealth MCOs utilizing specialty pharmacies to dispense HCV medications demonstrate how mail order dispensing is inappropriate for members with unstable living situations. While patients may designate providers or other representatives to accept deliveries on their behalf, the process is often complicated, burdensome, and difficult to navigate. Specialty pharmacies do not allow a patient's community service provider to order medications on their behalf, instead forcing the patient to make each phone call. For many, this is simply impractical. Medication orders are often lost or cancelled due to patients' frequent changes of addresses and phone numbers.

Given these concerns, we urge you to ensure that members covered in the fee-for-service program and the PCC plan continue to have access to their medications through brick-and-mortar pharmacy locations and are not forced to receive them through mail order. This enhanced choice of pharmacy is particularly important for people living with complex medical needs, as these individuals frequently choose the PCC plan instead of enrolling with an MCO.

VIII Narrowing provider networks, limiting MCO choices, and increasing cost-sharing do not further the objectives of the Medicaid Act

A. Restricting the provider network in the PCC Plan is not necessary to promote ACO enrollment and will harm individuals with disabilities

In 2016, the state initially sought to reduce benefits in the PCC Plan in order to encourage individuals required to enroll in managed care to not select the PCC Plan. Almost all stakeholders who commented on this aspect of the proposal objected to it, particularly people

[44] Wayne Turner & Shyaam Subramanian, *Essential Health Benefits Prescription Drug Standard,* Nat'l Health Law Program, http://www.healthlaw.org/publications/browse-all-publications/ehb-prescription-drug-standard-mail-order-pharmacies#.VYimyGAse_d.

with disabilities. The state withdrew the reduced benefit proposal but did obtain authorization for a "carrot" rather than a "stick" enrollment incentive: Charging lower copayments in ACOs and MCOs compared to the nominal copayment amounts in the PCC Plan. MassHealth now seeks to use another stick: Reducing the provider networks in the PCC Plan. The rationale purports to be delivery system reform, but the agency has not sought any similar incentives to discourage members from enrolling in MCOs whose providers are not in ACOs.

As we wrote in our comments on the earlier 1115 proposal seeking to reduce benefits in the PCC Plan, the agency has presented no evidence that the PCC Plan provide poorer quality care than the MCOs, and none of the evidence in the public record substantiates such a claim. Further, with the massive delivery system change in store for 900,000 members whose primary care clinicians have joined ACOs, this is a terrible time for disrupting the PCC Plan which disproportionately serves people with disabilities. Finally, as we said in our 2016 comments, the PCC Plan provides an opportunity to evaluate the effect of different delivery systems and actually learn something from the DSRI demonstration which is after all the purpose of the 1115 statute.

B. Insufficient information has been provided to assess the proposal to restrict MCO choices in certain parts of the state

The proposal to restrict MCO choices based on limited available primary care physicians in certain areas of the state is being made in anticipation of new ACO and MCO networks. The MCO contracts are still in procurement and we have not been able to obtain enough information to assess the effects of this proposal.

C. Applying cost sharing limits on an annual basis will undermine the purpose of such limits

The state seeks to apply the cost sharing out of pocket limit on an annual rather than a monthly or quarterly basis as a matter of administrative convenience. Administrative convenience is not a sufficient basis for an 1115 waiver. It is far more likely that individuals will benefit from a monthly (or even a quarterly) out of pocket limit than an annual one. Presumably that is why a monthly or quarterly limit is required, and that is why we oppose an annual limit.

D. The premium schedule for those over 150% FPL should be progressive based on income at both the low and high end of the income range

The CommonHealth program for people with disabilities charges premiums on a sliding scale with no upper income limit. The agency plans to convert all of its premium charges to a percentage based system and seeks a waiver to exceed the 5% limit for CommonHealth members with income over 5% of poverty. In the August listening session the state said it would not exceed the highest percentage of affordability set by the Connector for purposes of the state individual mandate which in 2018 will be 8.05%. This is a reasonable upper limit for the CommonHealth program.

However, it is important that any premium schedule be progressive based on income. A premium range that starts at 3% of income for people at 150% of poverty and rises to 8.05% of income for those with income over 400% of income is starting out too high. We recommend starting the premium schedule at a much lower percentage than 3% of income and also capping the size of premium increases by a reasonable amount to avoid steep increases in premiums and a likely drop off of enrollment. The presentations related to the current 1115 proposals were also our first opportunity to see the proposed copayment schedule. With respect to copayments, we recommend sub-caps for certain services or other ways to address what may be burdensome amounts for both members and providers particularly for some specialty services and outpatient therapy services.With regard to both the planned changes in the premium and the copayment schedule planned for 2019, we request an opportunity for a more detailed discussion with the MassHealth agency.

Thank you for the opportunity to comment. We look forward to having additional opportunities to meet with EOHHS and Office of Medicaid staff to strengthen and improve the MassHealth program without harming the vulnerable beneficiaries for whom it provides such important and essential services.

Yours truly,

Vicky Pulos and Neil Cronin