AIMED ALLIANCE
Alliance for the Adoption of Innovations in Medicine

October 20, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Verma:

The Alliance for the Adoption of Innovations in Medicine (Aimed Alliance) is a tax-exempt, not-for-profit organization that works to improve access to quality health care and preserve the practitioner-patient relationship. We are writing to comment on the Massachusetts' Medicaid Section 1115 Demonstration Amendment Request and respectfully ask the Centers for Medicare and Medicaid Services (CMS) to deny the state's proposal to adopt a commercial-style closed formulary for its MassHealth program.

In its amendment request, Massachusetts seeks to further align coverage with commercial plans and make other changes to make MassHealth more sustainable. Among other things, Massachusetts has proposed the adoption of a commercial-style closed drug formulary to manage growing drug costs and enable MassHealth to negotiate more favorable rebate agreements with manufacturers. Massachusetts cites to commercial pharmacy benefit managers' adoption of closed formularies, whereby they can exclude drugs from the formularies and replace them with less expensive, medically equivalent drugs. Aimed Alliance understands Massachusetts' need to contain rising prescription drug costs. However, proposals to address rising costs should not include policies that could interfere with the practitioner-patient relationship and adversely impact patient care.

Switching a stable patient's medication for nonmedical reasons (e.g., in response to formulary changes) can lead to unintended consequences, including adverse health events and an increase in emergency department visits.[1] In addition, physicians, pharmacists, and health care administrators have reported that switching treatments for nonmedical reasons can increase side effects or unforeseen effects, administrative costs, and downstream costs to plans.[2] In other words, such cost-motivated changes to stable patients' medication interfere with the practitioner-

[1] *See* Tricia Johnson, "Medicaid Prescription Formulary Restrictions and Arthritis Treatment Costs," Am. J. of Public Health, 2008 July; 98(7): 133-1305, doi: 10.2105/AJPH.2007.118113. *See also* Motheral, B.R., "The Effect of a Closed Formulary on Prescription Drug Use and Costs, Inquiry, 1999-00 Winter;36(4):481-91.

[2] *E.g.*, D.T. Rubin, et al., P354 Analysis of Outcomes After Non-Medical Switching of Anti-Tumor Necrosis Factor Agents, EUR. CROHN'S & COLITIS ORGANISATION (2015), https://www.ecco-ibd.eu/index.php/publications/congress-abstract-s/abstracts-2015/item/p354-analysis-of-outcomes-after-non-medical-switching-of-anti-tumor-necrosis-factor-agents.html. Bryan R. Cote & Elizabeth A. Petersen, Impact of Therapeutic Switching in Long-Term Care, 14 AM. J. MANAGED CARE SP23 (2008).

patient relationship, disrupt patients' course of care, increase health care utilization, and, as a result, raise related health care costs.[3]

As such, Aimed Alliance recommends that Massachusetts consider alternative approaches to address rising drug costs. One possible approach is to increase copayments for beneficiaries with incomes above 150 percent of the federal poverty level (FPL) to the maximum amount permitted by federal law. Federal law allows Medicaid programs to charge eligible beneficiaries with incomes above 150 percent of the FPL a copayment of up to four dollars for preferred drugs, and up to 20 percent of the cost Medicaid pays for non-preferred drugs.[4]

Currently, copayments for pharmacy services covered under MassHealth, which include both first-time prescriptions and refills, are $1 for certain covered generic drugs and over-the-counter drugs mainly used for diabetes, high blood pressure, and high cholesterol; and $3.65 for each prescription and refill for all other generic, brand-name, and over-the-counter drugs covered by MassHealth.[5] Raising the copayment for beneficiaries above 150 percent of the FPL would offset a portion of prescription drug costs. It would also empower beneficiaries to choose their medications based on cost-benefit analyses that they conduct in consultation with their health care providers.

Consumers must understand what they are paying for and feel the impact of its cost in order to value their health care and moderate their consumption. Providing incentives for individuals with incomes above 150 percent of the FPL to control their own health care costs may effectively reduce MassHealth's overall drug expenditures.

Aimed Alliance's approach to patient care will reduce overall costs and yield fewer undesirable outcomes than adopting a closed formulary. Therefore, we urge CMS to deny Massachusetts' request to adopt a closed drug formulary, and to encourage Massachusetts to explore alternative solutions that will not significantly interfere with the practitioner-patient relationship and quality of care. Thank you for considering our comments on this matter.

Sincerely,

Nellie Wild
Senior Policy Advisor

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[3] *Id.*
[4] Medicaid.Gov, Cost Sharing Out of Pocket Costs, *available at* https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html
[5] 130 CMR 506.014: MassHealth: Financial Requirements, Copayments Required by MassHealth