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July 6, 2021

Ms. Shalanda Young
Acting Director
Office of Management and Budget
725 17th St. NW
Washington, D.C. 20503

Re: Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government

Dear Acting Director Young:

The Academy of Managed Care Pharmacy (AMCP) thanks the Office of Management and Budget (OMB) for the opportunity to provide comments in response to its request for information (RFI) period titled "*Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government*" published on May 5, 2021, and to leverage our members' expertise in offering feedback on this RFI.

AMCP is the professional association leading the way to help patients get the medications they need at a cost they can afford. AMCP's diverse membership of pharmacists, physicians, nurses, biopharmaceutical professionals, and other stakeholders leverage their specialized expertise in clinical evidence and pharmacoeconomics to optimize medication benefit design and population health management and help patients access cost-effective and safe medications and other drug therapies. AMCP members improve the lives of nearly 300 million Americans served by private and public health plans including Medicare and Medicaid, pharmacy benefit management firms, and emerging care models.

AMCP's mission is to improve Americans' health by ensuring they have access to high-quality, cost-effective medications and other therapies. With this mission, we have a moral imperative to dismantle systemic and structural racism that has resulted in significant disparities in health status and access to quality care. AMCP has joined other pharmacy associations in committing to take action to ensure the care provided by pharmacists upholds the highest standards. These actions include, but are not limited to:

- Working together to provide opportunities to address health care disparities and strengthen affected communities.

- Providing pharmacist, student pharmacist, and pharmacy technician education on social injustices and systematic challenges impacting health care.
- Delivering strategies that focus on change through communications, partnerships, and solutions to address health care disparities.
- Continuing dialogue among pharmacy organizations and stakeholders to identify and implement change.

We recognize that these are broad goals, and, as such, they are only the beginning. As part of AMCP's strategic priority pillar to address health disparities, we work to translate these goals into specific, long-term actions that improve patient outcomes and ensure that we are collectively accountable for health equity among all Americans, including Black Americans, indigenous people, and people of color.

To begin this work, AMCP held a Partnership Forum titled "Racial Health Disparities: A Closer Look at Benefit Design," which brought together more than 40 experts representing payers, pharmacy benefit managers, integrated delivery systems, health economists, patient advocates, academicians, biopharmaceutical manufacturers, and other key stakeholders within managed care. At the event, these stakeholders worked to identify potential structural issues in the current prescription drug formulary and benefit design processes and proposed viable solutions to reduce racial health disparities. Several key principles emerged from the discussion, including the need to acknowledge that structural racism exists, that managed care pharmacy needs to integrate proactive solutions to improve equity which begins with education and training throughout health care organizations, and that patients must be viewed holistically with an understanding of the compounding effect of social determinants of health.[1] Moving forward, AMCP commits to incorporating the outcomes of this forum into our strategic priorities in order to identify the role managed care pharmacy can play in recognizing and reducing racial health disparities, and to review and updateour current policies to reflect the need for change in the practice of managed care pharmacy and in public policy to address racial health disparities.

Information and Key Questions: Barrier and Burden Reduction
Are there specific requirements or processes (e.g. in-person visits, frequency of recertification of eligibility) that have been shown in rigorous research to cause program drop-off or churn by underserved individuals and communities? Similarly, is there rigorous evidence available that certain requirements or processes have little actual effect on program integrity?

AMCP Response

Continuous Medicaid Enrollment

[1] https://www.amcp.org/sites/default/files/2021-04/AMCP%20PF%20ExecSumm%200421_6.pdf

In the multi-payer US health care system, an individual may transition through various types of health insurance coverage or become uninsured because of a change in their employment and/or eligibility status. A disruption in health insurance coverage can negatively impact access to care, patient outcomes, and medication adherence, as well as put vulnerable populations at financial risk.

Coverage churn is particularly common in the Medicaid program, and typically signals that an individual is cycling through periods of being uninsured, resulting in interruptions in access to care. Reasons for Medicaid churn are varied but include administrative burdens such as increased paperwork and frequent eligibility checks, income fluctuations that are common for individuals with low incomes, and changes in eligibility for varying coverage categories (i.e. aging out of Medicaid children's coverage, women losing eligibility 60 days post-pregnancy etc.).[2] Studies have shown that increased eligibility checks and burdensome renewal processes have led to declining Medicaid enrollment and increased coverage churn in several states.[3] Additional research has demonstrated that low-income individuals experiencing income volatility and the resulting loss of Medicaid eligibility do not transition to other forms of insurance, such as marketplace or employer-sponsored coverage, and instead become uninsured.[4] Studies have also shown that minority populations are the most likely to experience income volatility each year.[5]

Importantly to AMCP, studies have shown that Medicaid churn leads to lower medication adherence and skipped prescription drug doses.[6,7] Increased medication adherence has resulted in better patient outcomes and reductions in total health care spending.[8] In order to reduce insurance churn and its subsequent impact on patients, **AMCP supports continuous 12-month eligibility for Medicaid and reducing the administrative burdens that contribute to churn**. The Centers for Medicare and Medicaid Services (CMS) should work with Congress to extend the continuous coverage provision of the 2020 Families First Coronavirus Response Act and approve any continuous coverage waivers for adults that are submitted by states, such as those approved for Montana and New York. CMS should encourage and work with states to reduce the frequency of eligibility checks and to reduce the amount of paperwork and supporting documentation that must be continually provided for Medicaid enrollment. Doing so will help address disparities in health coverage and access that can lead to improved health outcomes.

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[2] https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by

[3] https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/

[4] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00378

[5] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security

[6] Health Affairs 35, No. 10 (2016): 1816–1824

[7] Banerjee et al. BMC Health Services Research 2010, 10:195 http://www.biomedcentral.com/1472-6963/10/195

[8] https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.1087?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

States currently have the option to provide 12-month coverage through Children's Medicaid and the Children's Health Insurance Program (CHIP), with 23 states implementing continuous coverage in Children's Medicaid and 25 in CHIP.[9] Studies have shown that the longer children were enrolled in Medicaid, the lower their Medicaid expenditures and that continuously enrolled children receive more routine preventive care, which improves health and lowers costs per enrollee. Overall, state Medicaid expenditures increased modestly, and evidence indicates that increased benefit costs are offset by decreased administrative costs due to lower rates of churn.[10] Additionally, analysis of the Montana Medicaid waiver implementing continuous Medicaid enrollment for adults found that it resulted in a substantial expansion of health coverage and an increase in the use of preventive care.[11] These results demonstrate that continuous Medicaid enrollment can produce positive health effects with modest budget impact.

Medicare Part D Low Income Subsidy Enrollment

The Medicare Part D program offers premium and cost-sharing assistance to qualified low-income beneficiaries through the program's Low-Income Subsidy (LIS). Enrollees who qualify for full Medicaid benefits (dual eligibles), enrollees in Medicare Savings Programs, and individuals receiving Supplemental Security Income (SSI) are automatically enrolled in the LIS program. Other eligible beneficiaries must apply to receive the LIS either through the Social Security Administration (SSA) or through their state Medicaid program. Eligibility for the LIS, either for full or partial subsidies, is based on an enrollee's income and other assets, which must be below specified levels. For full LIS enrollees, the federal government pays the monthly Part D premium, deductibles, and expenses in the Part D coverage gap. LIS enrollees also pay lower, statutorily set copayments for formulary drugs. The goal of these lower out-of-pocket costs for LIS enrollees is to increase access to needed prescription medications and to support medication adherence by lowering the cost barrier.

Medicare Part D enrollment generally is high, though research has shown that minority enrollment, in particular Hispanic enrollment, is significantly lower than in the white population. A study found that Hispanic beneficiaries are 35% less likely than non-Hispanic whites to have Part D coverage and further, that this disparity is driven in part by those individuals eligible for the LIS program but not automatically enrolled.[12] Beyond this racial disparity, enrollment of LIS-eligible beneficiaries who are not automatically enrolled is low overall, with some evidence that enrollment rates for this population are as low as only 30%.[13] In order to address the disparities in Part D coverage, **CMS should address barriers to LIS enrollment for eligible beneficiaries by making the enrollment process simpler and engaging in targeted outreach to enroll more eligible beneficiaries. CMS**

[9] https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html

[10] https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0362

[11] https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf

[12] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0671

[13] https://journals.sagepub.com/doi/pdf/10.5034/inquiryjrnl_49.03.04

should also consider utilizing available data sources such as SSA records, tax records, or enrollment data from other federal programs for low-income individuals to identify LIS-eligible, but not enrolled, Part D beneficiaries.

AMCP appreciates the opportunity to comment on the RFI titled "*Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government.*" We are committed to be being a valuable resource to CMS for improving access to prescription drugs at lower costs and reducing costs in the health care system for Medicare beneficiaries. If you have any questions regarding AMCP's comments or would like further information, please contact me at 703-684-2600 or scantrell@amcp.org.

Sincerely,

Susan A. Cantrell. RPh, CAE
Chief Executive Officer