Wisconsin Medical Society

May 19, 2017

Mr. Michael Heifetz
Medicaid Director Wisconsin Department of Health Services
Division of Medicaid Services
1 West Wilson Street, Room 350, P.O. Box 309
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RE: Comments on Wisconsin Department of Health Services Proposed 1115 BadgerCare Waiver Application

The Wisconsin Medical Society (Society), representing more than 12,500 members across the state, has long desired that all Wisconsin citizens have access to high-quality and affordable care and has worked to help improve Wisconsin patients' health. We remain committed to these ideals as Wisconsin continues to be a national leader at the forefront of the changing health care landscape.

As that national leader, we are proud that Wisconsin historically has had one of the more expansive and well-run Medicaid programs. This is evidenced by Wisconsin's high quality of care and low per-patient costs. The high levels of access and care that Medicaid patients receive in Wisconsin are a testament to the quality of our physicians and the commitment of our elected leaders to foster vibrant safety net programs such as Medicaid. The Society looks forward to a continued partnership with the State to ensure these trends and outcomes continue.

The Society, and the Wisconsin Chapter of the American College of Emergency Physicians (WACEP) and the Wisconsin Psychiatric Association (WPA) appreciate this opportunity to share specific thoughts on the BadgerCare Reform Demonstration Waiver the Wisconsin Department of Health Services (DHS) intends to submit to the Centers for Medicare and Medicaid Services next week:

Monthly premiums
We appreciate the Governor's and DHS's efforts to encourage patients to be active, engaged in, and cognizant of the cost of their health care. That stated, the Waiver's proposal to charge premiums for the Childless Adult (CLA) population could present several challenges. First, the proposed premium structure – a sliding scale based on income – appears to be administratively cumbersome. While the premiums themselves are low relative to other insurance programs the administrative costs necessary to collect the premiums far exceed the revenue that would be brought in to the program. The premiums could also have the unintended effect of discouraging enrollment in Medicaid and increasing the number of uninsured in the State. For these reasons, we suggest an alternative whereby there is a single flat premium, as opposed to a sliding scale, for members closer to 100 percent of the FPL, while members closer to 0 percent of the FPL are

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exempt from the premium.

Second, the Waiver is silent on how the premiums would be collected. Medicaid patients are consistently cycling on and off coverage as their economic situations change. This "churning" of Medicaid patients already necessitates a complex system and administrative infrastructure. Adding the collection of premiums will only further burden an already stressed administrative system. Further, the Waiver does not specify how the Department of Health Services will collect premiums for members without access to a bank account or a pre-paid credit card. However, we do appreciate the fact that the Waiver will allow third-party payers to make premium payments on a member's behalf.

Third, the Waiver does not specify how and when a member would be terminated for eligibility for non-payment of premiums. States like Indiana which charge premiums under their HIP 2.0 Medicaid expansion of the Affordable Care Act terminate patients after 60 days. We believe there should be an explicit mention of how long patients can be delinquent on premium payments before they are terminated. Further, patients should be allowed to re-enroll if they make partial payments of past due premiums.

Healthy Behavior Incentives

We broadly support the State's efforts to increase the use of screenings and preventive services. Research and studies demonstrate that participation in health screenings can improve the life of the patient by addressing health factors before they become more serious conditions, while lowering the overall costs of care in the long run. Our concerns are not that the State is conducting screenings, but how they are being used, and who is providing the patient with information. We also have reservations about the Waiver's charging a copay to patients who the utilize the emergency room.

We believe the use of health screenings should be used as an incentive, and not as a de facto disincentive. Utilizing the results of health screenings to charge different premiums to CLA Medicaid members discriminates against members who participate in "risky behaviors." Building from this position we believe screenings should be conducted by licensed medical professionals to ensure that members who exhibit risky behavior can receive sound and evidence-based advice and information. These discussions are most productive when a medical professional and a patient can have an honest discussion on the steps necessary to improve a patient's health.

We encourage the State's efforts on patient education regarding the correct use of medical facilities. However, we find that charging a copay for use of the emergency room is misplaced. We agree that if patients utilize emergency rooms in an improper manner they should be counselled and educated after the fact. Charging a copay at the first visit is unnecessarily burdensome on the patient, in that it may deter those who believe they have true emergencies from seeking emergent care, contradicting the prudent layperson standard. Furthermore, we urge DHS to obtain a more complete analysis of the effect on health outcomes of other states' use of copays for use of the emergency department. We suggest that if the state insists on charging copays that they only do so for repeat visits and not the initial use of emergency room services. The state should also incorporate a series of exemptions (e.g. distance from a health center, triage care, or hospitalization), like those employed in Arizona and Indiana. Further, depending on when the copay is applied, it should be applied as a facility fee rather than a provider fee as

providers do not have the appropriate systems in place to collect copays while treating patients. Consequently, we also suggest that physicians not be the ones responsible for educating patients on proper use of the emergency room. Physicians – particularly in an emergency room setting – are already overburdened and this is a task that should be assigned elsewhere.

Drug Testing

Continuing with our support for conducting health screens, we support the Waiver's stated goal of increasing the level and quantity of support for helping Medicaid members with substance use disorders. However, we note the Waiver's lack of specificity on how the tests will be conducted and how that information will be stored. The Waiver is unclear on who will be maintaining the security of the test results. This presents significant HIPAA concerns as to how this sensitive information will be handled, stored, and referenced in the future.

Contingent with a positive drug test, we disagree with the Waiver's insistence that members complete a treatment program as a condition of eligibility. Sensitive information regarding the improper use of licit or illicit substances is best discussed between a patient and their physician. It is through open discussion that the patient and physician can address any substance use issues confronting the patient. Arbitrarily forcing members to undergo treatment they are unwilling to accept can have the opposite effect of helping a patient address addiction and substance use issues. Rather, it may exacerbate their behavior which could have larger and more serious health costs and impacts. We support the State's efforts for at-risk members to receive treatment and counseling for addiction; we would prefer that the State make more resources available to implement treatment programs, which would allow physicians and patients to determine the best course of treatment.

We are also concerned about drug testing being used as a condition for Medicaid eligibility. Drug testing is not a condition of eligibility for many insurance plans in either the private sector or in any federally administered marketplaces. If the stated goal of the Waiver is to bring Medicaid benefits and programs more in line with those of private and commercial insurance, this represents a significant deviation from current eligibility practices. We would prefer the State instead pursue drug treatment programs and policies that provide incentives for proactive behavior rather than punishments for risky behavior.

Limits on Length of Medicaid Eligibility

Our position on health system reform advocates for equal access to quality and affordable coverage, but also for a ban on lifetime caps for insurance. By instituting a 48-month limit on Medicaid eligibility the State is implementing a de facto cap on insurance. We appreciate the State's efforts to encourage Medicaid patients to seek and obtain work, and to reward them for that work by creating an exemption for the length of eligibility. We also appreciate the list of exemptions that the State has considered for people who are unable to work due to disability or diagnosed mental conditions. However, we would encourage the State to reconsider its stance on having a 48-month limit, or alternatively reduce the 80-hour per month threshold.

Residential Treatment Coverage

We support the State's initiative to expand access for residential substance use disorder treatment. We believe that residential treatment for substance use disorder should be voluntary and based on either physician-patient discussions or as part of a diversion program.

Conclusion

We appreciate the efforts the State is taking to improve its Medicaid program – particularly its emphasis on expanding treatment for substance use disorders and access for mental and behavioral health services. We are concerned about the implementation of premium payments and drug testing for the childless adult population and the potential it could have for discouraging enrollment and coverage. We look forward to working with the State to address these concerns and improving the quality of care for Medicaid patients.

Sincerely,

Wisconsin Medical Society

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