WISCONSIN HOSPITAL ASSOCIATION, INC.

July 14, 2017

TO: Seema Verma, Administrator, Centers for Medicare & Medicaid Services

FROM: Eric Borgerding, President & CEO, Wisconsin Hospital Association

RE: State of Wisconsin BadgerCare Reform Demonstration Project; Coverage of Adults without Dependent Children with Income at or below 100% FPL; Draft 1115 Demonstration Waiver Amendment Application

The Wisconsin Hospital Association is a statewide nonprofit association with a membership of more than 130 Wisconsin hospital and health systems. In every corner of the state, our members are the foundation of the health care safety net, each day caring for thousands of low-income and uninsured people. Because of this, hospitals are in a unique position to identify both the positive and negative aspects of our current Medicaid program, and bear the implications, positive or negative, of its reforms. It is from this perspective that WHA offers comments on Wisconsin's pending Section 1115 application.

A long held principle of WHA is that personal responsibility and prudent use of health care services must be a priority. We believe we must champion incentives for employees, employers, and all participants to improve and maintain good health and encourage the more efficient use of health care services. At the same time, Wisconsin's hospitals and health systems are the safety net, providing care and services for all who come to their doors. Championing personal responsibility must be balanced with a recognition of the circumstances of the most vulnerable in our society.

We applaud the Administration for your ongoing commitment to helping people achieve success. We believe some of the proposals included in the Section 1115 Waiver draft, such as the use of health risk assessments, and waiving the IMD exclusion are positive. We have concerns about the implementation of others and unintended consequences of these provisions as drafted. From our members' viewpoint on the front lines of providing care, we hope you will consider these comments offered to help improve upon the proposal in the interests of our patients and members of our communities.

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Funding for the Childless Adult Demonstration Population

We encourage CMS to provide enhanced federal funding for the demonstration population.

From a policy perspective, the state's intent as expressed in the waiver amendment proposal aligns with federal policy priorities. However, we are concerned that the additional services and costs of operationalizing these program changes could have implications for the state's budget that are not reflected in the traditional match rate. We encourage CMS to ensure the financial sustainability of the program with additional federal support. This additional support will help Wisconsin meet the stated goals of the waiver amendment, including the addition of residential treatment for substance use disorders.

The President's first Executive Order of his Administration called for the Department of Health and Human Services to do everything it could to alleviate the ACA's burden on individuals and states. In the AHCA bill as passed by the House, Congress shows its support for state efforts for reforms with a 5 percent match increase around work requirements. Wisconsin's proposal looks to go well beyond work requirements, and this Congressional support offers a solid foundation to seek enhanced match.

Further, Wisconsin took a unique path to providing coverage for childless adults with income below the poverty line. In doing so, the previous federal administration determined that Wisconsin's 'partial expansion' was ineligible for enhanced federal matching funds, even though Wisconsin clearly expanded coverage and has added about 130,000 childless adults to the Medicaid program under the Wisconsin model for coverage. Medicaid is a safety net and in Wisconsin all who have income below 100% FPL, those who are "in poverty", are covered by the program.

Wisconsin's approach has required an investment by the state which has significantly benefitted the federal Medicaid program but which has been inequitable because the previous federal Administration's interpretation of the ACA provisions were inflexible in meeting state objectives. The AHCA as passed by the House and the draft BCRA now being considered by Congress include provisions that attempt to recognize these inequities, but do not go far enough in recognizing a model like Wisconsin's. With the principle of equity in mind, we encourage CMS to consider and approve an enhanced match for the demonstration population.

Wisconsin has been a model in avoiding gaps in coverage and could be a flagship state among those that want to focus adult coverage in Medicaid on people living in poverty with income below 100% FPL. Wisconsin can continue to serve that leadership role, but there needs to be equity in federal support. Other states are stepping forward with requests to look more like the current Wisconsin demonstration. The Arkansas legislature recently directed the state to seek a modification to their 1115 waiver program to reduce the income threshold for Medicaid eligibility from 133% FPL down to 100%, just as Wisconsin has done.. As states seek flexibility for their programs, including as expansion states seek ways to reform their programs and reduce costs for their Medicaid programs, the principle that Medicaid should be a safety net for all in poverty can resonate if states are assured of enhanced funding.

Imposing Copayments on Emergency Department Utilization

The draft waiver includes copayments for emergency department (ED) utilization. Hospital emergency rooms are vital to the overall health care system, and provide a critical need for patients. Given the costs for emergency room services, it is understandable to seek ways to incent care in the most appropriate setting. However, we have several concerns about the proposal as drafted and offer the following comments and considerations.

- The waiver amendment proposal as drafted appears to apply to *all* emergency room use. As a result, this could discourage individuals from seeking care in the emergency room when it is appropriate and reasonable for the situation. Much utilization of the emergency department is indeed clinically appropriate for the situation, is reasonable by a prudent layperson standard, or occurs when alternative means of care – primary care or urgent care - is unavailable.
    - *We encourage CMS to clarify that any copayments would be limited to non-emergent use of the emergency department and would not apply when primary care or urgent care is unavailable (such as during evening hours).*

- We estimate that the proposal, as drafted and based on all ED utilization would result in the imposition of $5.2 million worth of copayments. The proposal indicates that providers will be required to collect these copayments. We oppose having providers collect these copayments. We also strongly oppose any initiative to reduce provider reimbursement in advance of collecting these copayments. Given the population is in poverty with income below 100% FPL, it is highly likely most of these copayments will remain uncollected. As a result, imposing a copayment will essentially result in a provider rate cut, increasing our Medicaid shortfall even more. The Department is proposing to collect premiums (instead of the managed care organization collecting the premiums). We believe the state's Department of Health Services (DHS) should also collect the copayments.
    - *Rather than require that providers collect copayments, the Department of Health Services should collect the copayments from Medicaid enrollees.*

- We know from experience that ED utilization is dependent on many factors. ED utilization is very much connected to whether a person has chronic conditions and is in need of more health care services overall, and linked to individuals who have mental health conditions.
    - *We recommend adding exemptions to the copayment requirement for individuals with certain clinical conditions, including mental health conditions, so that individuals with a primary or secondary diagnosis of these conditions would be exempt from paying the copayment.*

- The experience of our members demonstrates that implementing intensive ED transition care coordination programs targeted at the highest utilizers of the emergency room is effective at connecting patients to the appropriate care setting and reducing ED utilization significantly. These kinds of care management activities are currently not reimbursed by the Medicaid program. A better and more effective means of reducing ED utilization, educating patients about appropriate use of the ED and improving overall health would be to fund these care coordination programs. We would be happy to work with you to provide additional data and information on these programs.
    - *We recommend that CMS support and fund care management activities of providers so that they can implement care coordination models that result in reduced emergency department utilization.*

Premiums

The proposal requires enrollees with income between 50% and 100% FPL to pay premiums.. Hospitals and health systems understand the philosophical intent for patients to be responsible for a premium, as would be expected under private insurance. However, we are also concerned that any

premium payment requirement on people who have income below poverty, no matter how small, will impose a challenge for recipients.

- It is reasonable to expect that recipients in poverty will not have the means to pay the premium. The ramification is that the recipient will be disenrolled from Medicaid for six months. This is a significant consequence for failure to pay a small premium. We encourage CMS to look to other states that have imposed premiums such as Arkansas. Arkansas imposes premiums on individuals above the poverty line and failure to pay results in a debt to the state, not disenrollment from the program.
    - *We encourage CMS and DHS to seek alternative ramifications for not paying the premium rather than disenrollment.*

- WHA's members are the health care safety net. Individuals who fail to pay their premium and are disenrolled will still seek care at their doors and our members will continue to serve them. Unfortunately, this will mean higher uncompensated care.

- We appreciate that DHS recognizes that third parties may want to assist individuals in paying for these premiums. We encourage CMS to allow these third party payments without restriction. That being said, even though we are supportive of third party premium payments, this does place another new cost on providers.

- We encourage DHS to provide information about the number of current Medicaid recipients for whom proposed for premium payments would apply, and seek data on the extent to which their income fluctuates. Anecdotally, we understand income at this level could fluctuate monthly as individuals with hourly wages may work several hours one month, but fewer hours the next. We encourage CMS and DHS to seek a simplified reporting of income and calculation of the premium amount. For example, will people have to report even small changes in income? How will providers be notified of eligibility?
    - *If premiums are imposed, we encourage DHS to simplify administration and collection.*

- An added consideration is whether there is a grace period for failure to pay the premium, and how long that grace period will be. We suggest a longer grace period, particularly in the early years of the premium payment implementation.
    - *The waiver proposal should identify the grace period for paying premiums, with a longer grace period for the first few years of implementation.*

Eligibility Time Limit; Work Requirement

The proposed waiver establishes a 48 month limit on BadgerCare eligibility for childless adults ages 19-49. This limit is linked to compliance with a work or job training requirement. That the Governor's budget includes funding and resources to help implement programs to assist individuals in meeting this requirement is positive.

- We appreciate the recognition in the waiver application that some individuals will not be able to participate in work and therefore will be exempt from the requirement.
    - *We also encourage CMS to consider whether other medical reasons might qualify for an exemption from the work requirement. Examples could include individuals undergoing cancer treatment, an organ transplant, or other medical condition that might be a barrier to an individual seeking work*

- We note that the "manager's amendment" to the American Health Care Act as passed by the House identified possible activities that would count toward meeting a work requirement, including community service.
    - *We encourage CMS to add community service to its list of acceptable activities that may count toward the work requirement.*

- We are concerned that recipients may lose coverage for not meeting the work requirement, and will have no other options for coverage. We appreciate that the time period on the loss of coverage is limited to six months per 48 month period.
    - *We encourage CMS and DHS over the course of the four years after implementation of this policy to assess how well it is working and to track recipients so that more intense assistance may be offered in the last 12 months before anyone is disenrolled as a result of this policy.*

Health Risk Assessment and Healthy Behaviors

We appreciate the Administration's emphasis on health risk assessments and believe such assessments are positive practices that can lead to better health outcomes.

- The waiver amendment draft does not indicate who would administer the HRA, and how the HRA information would be shared and be used to develop care plans.
    - *We encourage the Department to work with managed care organizations and providers to ensure appropriate and timely use of the HRA to meet patient needs.*

- Medicaid recipients should not be penalized if they try but are unable to obtain the health risk assessment in a timely manner.
    - *We encourage CMS and DHS to consider circumstances that would allow an individual to be exempt from the requirement – for example, if the recipient tried to schedule an appointment to get an HRA but was unable to secure an appointment for several months.*

- Some employers use positive incentives to encourage employees to complete their health risk assessment.
    - *We encourage the Department to evaluate the completion rate of the HRAs, and consider if the incentive (a 50% reduction in the premium amount) is sufficient to incent participation.*

Drug Screening & Testing

While Wisconsin has made gains in the past several years in expanding substance abuse treatment resources, considerable additional investments will be necessary to address the treatment needs of the childless adult population. WHA will continue to partner with and support the state's efforts to combat substance abuse and increase access to and availability of substance abuse treatment for individuals suffering from addiction.

- With respect to the waiver provisions for drug screening, testing and treatment, it is important to recognize that individuals with substance use disorders often have co-occurring mental health issues, and individuals with behavioral health disorders are more likely to have one or more co-occurring medical conditions. We are concerned about the ramifications of prohibiting coverage for those who refuse drug treatment. This could result in high risk patients becoming uninsured,

while these patients will still have significant health needs, and will continue to seek services likely in the emergency room.

- *We ask CMS and DHS to instead consider incentives for screening, drug testing and seeking drug treatment rather than program ineligibility.*

- We appreciate the recognition by the Department of the critical shortages of substance abuse treatment options, reflecting the ongoing concerns across the state regarding access to these services. We are concerned about individuals who are screened and test positive who cannot get treatment.
  - *Prior to screening, we ask CMS and DHS to consider the availability of treatment programs in the area and forgo screening if drug treatment is not available.*
  - *We also recommend that CMS and DHS work to increase the availability of Medicaid-certified behavioral health providers by increasing Medicaid reimbursement for providers of behavioral health and substance abuse treatment.*

IMD Exclusion

- Under the draft amendment, DHS proposes waiving the current exclusions for IMD services. This is an important step toward expanding access to care. WHA supports this part of the waiver amendment. However, we are concerned that the language of the proposal could result in a narrow interpretation of the exclusion.
  - *We encourage CMS to clarify that the IMD exclusion is applicable to all levels of residential care, to substance use, and to mental health inpatient treatment.*

Summary

Thank you for considering our comments on the draft waiver amendment. If you have any questions, please feel free to contact me.

Sincerely,

/s/

Eric Borgerding
President/CEO