July 10, 2017

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: ABC for Health, Inc.'s comment on Wisconsin's Section 1115 Demonstration Waiver on BadgerCare Plus

Dear Administrator Verma,

Thank you for the opportunity to provide comment on the Section 1115 Waiver Request submitted to you by the State of Wisconsin Department of Health Services titled, "BadgerCare Plus Reform Demonstration project Waiver Amendment."

Advocacy and Benefits Counseling for Health, Inc. (ABC for Health) has a unique perspective on working with low-income, health disparity populations access both health care and coverage in Wisconsin. Founded in 1994, ABC for Health helps families and individuals across Wisconsin gain access to health care benefits and services. ABC for Health's mission is to provide consumers and providers with information, advocacy tools, legal services, and expert support they need to secure health care coverage and services. ABC for Health works to translate individual case experiences into local strategies as well as system level reforms through our statewide HealthWatch Wisconsin project and serves as a catalyst in the development of local HealthWatch Coalitions to promote community efforts and community voices directed at health care coverage and access concerns for children and families.

Please take into consideration the following:

Monthly Premium Requirement

The premiums Wisconsin seeks to impose on Childless Adults enrolled in BadgerCare Plus create unnecessary administrative hoops and hurdles that impede access to health coverage and care for otherwise eligible individuals – in this case, our lowest income and most vulnerable adults.

Wisconsin's Legislative Fiscal Bureau[1] has questioned whether state Medicaid programs can charge premiums for individuals with household income under 150%. Generally, the practice is prohibited or limited to Medicaid expansions states, as provided under the Affordable Care Act. States like Indiana, for example, have increased flexibility for premiums because of their Medicaid Expansion.

[1] Paper #354, Budget Paper "BadgerCare Plus Coverage for Childless Adults" 4, available at: https://docs.legis.wisconsin.gov/misc/lfb/budget/2015_17_biennial_budget/102_budget_papers/354_health_services_badgercare_plus_coverage_for_childless_adults.pdf

It is ironic that the State requests the very flexibility available under the Affordable Care Act that Wisconsin so vehemently opposed.

The Wisconsin Legislative Fiscal Bureau noted in 2015, "It is likely that some childless adults enrolled in or eligible for BadgerCare Plus would not pay the required premium" and will therefore lose coverage. Research on the issues confirms those expected results. The UW Population Health Institute found that childless adults who have not previously owed a premium were more likely to exit coverage when a premium was required.[2] In fact, the state counts on that fact. Under its waiver proposal, Wisconsin projects that enrollment will "decrease from 150,050 beneficiaries in CY 2016 to 146,407 in CY 2018," which seems like an under-count of people terminated or dropped from the program.[3] But Wisconsin's own cost estimates show the inefficiency in the waiver, as it projects costs to *increase* from $825 million in CY 2016 to over $1 billion in CY 2018 while losing enrollees.

Just as significant is who will be cut from BadgerCare Plus coverage. The premium requirement "would adversely affect very low income people who often lack checking accounts or credit cards. For many of those adults, it would be easier for them to go back to the ranks of the uninsured and rely on emergency rooms as their fallback source of health care, which will cost all of us much more in the long run."[4]

Data out of Indiana released in May 2017 shows the impact of charging premiums for Medicaid.[5] Indiana now attaches premiums to some Medicaid Expansion populations. Penalty for nonpayment is not a prohibition on coverage, but instead enrollment in a more limited benefit program. Unlike Indiana, Wisconsin would charge premiums for childless adults *below* the poverty line, and the consequence for nonpayment is loss of benefits. Indiana's experiment confirms that charging premiums as a requirement for Medicaid benefits is counterproductive. Not only does charging premiums lead to fewer people seeking benefits and ultimately a greater number of uninsured, but they often go unpaid from those who do seek benefits under these plans. 55% of Indianans who became eligible for Medicaid in the first 22 months after expansion in 2015 either missed their first

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[2] Evaluation of BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults Executive Summary Report 2014, available at: https://uwphi.pophealth.wisc.edu/publications/other/badgercare-2012-waiver-evaluation-executive-summary.pdf

[3] BadgerCare Plus has not had over 150,000 childless adults enrolled in coverage since May 2015. As of May 2017, there were 144,938 childless adults enrolled in BadgerCare Plus, having lost over 1,400 from March to April, and an additional 1,040 from April to May, most likely due to being lost at time of renewal. Available at: https://www.forwardhealth.wi.gov/WIPortal/StaticContent/Member/caseloads/481-caseload/statewide/statewide.htm

[4] DHS Proposes New Impediments to BadgerCare Participation, WCCF Blog, available at: http://www.wccf.org/dhs-proposes-new-impediments-badgercare-participation/

[5] More than half of Indiana's alternative Medicaid recipients didn't make payment required for top service, Indy Star, available at: http://www.indystar.com/story/news/politics/2017/05/08/more-than-half-indianas-alternative-medicaid-recipients-didnt-make-required-monthly-payment/101445840/

payment or missed one while on the program.[6] Another 90% fell into a lower tier plan in order to avoid paying higher premiums, potentially being denied dental and vision benefits.[7] 14% never enrolled in the program.[8] In addition, the cost of administering the two-tiered system has been noted as particularly high by the insurance companies that administer Medicaid in the state.[9]

We oppose the use of premiums. They stand as a barrier to the most vulnerable, homeless or housing insecure, and those struggling to meet basic needs, even when working. "People with Medicaid have trouble affording even modest premiums, and find themselves subject to penalties that can impede access to necessary care."[10] Additionally, no Section 1115 waivers approved by the Centers for Medicare and Medicaid Services to date for *any* Medicaid population include premiums as a condition of eligibility or coverage lock-outs for non-payment for those *under* 100% FPL.

Time Limit on Medicaid Eligibility & Work Requirement

The Waiver Request is hardly an improvement, but rather seeks punitive changes that affect adults, many of whom are sick or suffering chronic health conditions that may not *yet* meet the level of a disability determination. For some individuals, BadgerCare Plus coverage provides the opportunity to create or update a medical record, to help support a future finding of disability that may include an opportunity to work, like available with the Medicaid Purchase Plan (MAPP).

Creating obstacles to care violates the letter and spirit of 1115 waivers to demonstrate program improvement to support better care and services for enrollees. Above all else, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of major health and welfare programs, including certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The authority is provided at the Secretary's discretion for demonstration projects that the Secretary determines promote Medicaid program objectives. This waiver request is neither a demonstration project nor a plan to promote Medicaid program objectives.

To add a time limit to BadgerCare Plus is to remove the entitlement altogether. As the Wisconsin Legislative Fiscal Bureau warned in 2015, "No state has gained federal approval to broadly limit the length of time individuals may receive Medicaid benefits. As Medicaid is administered as an entitlement, it appears unlikely that the administration would gain federal approval for this provision."[11] In fact, the Centers for Medicare and Medicaid Services have not approved state waiver requests to require that Medicaid beneficiaries work as a condition of eligibility, on the basis that such a provision would not further the program's purposes of promoting health coverage and access.

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[6] *Id*.
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] Charging Medicaid Premiums Hurts Patients and State Budgets, Families USA, available at: http://familiesusa.org/medicaid-expansion-waivers-states#/
[11] *Supra* note 1 at 4.

Instead, Wisconsin's proposal creates the greater likelihood that people will not get needed health services. For example, its punitive approach to emergency room care and increased cost sharing is both misguided and unfair. Terminating people from health care coverage after 48 months for not working is myopic policymaking at its worst. Such actions will promote increased use of emergency rooms and treatment that will increase uncompensated care for hospital guided by EMTALA requirements.[12]

Moreover, as you *should* know, some programs require waiting periods before benefits begin. The proposal to eliminate BadgerCare Plus coverage could affect people in required waiting periods imposed by other administrative roadblocks. Terminating coverage also demonstrates a lack of understanding of the health conditions in the community. The American Cancer Society has warned that terminating eligibility would be detrimental to cancer patients.[13] And consider other patients who have moved from diagnosis through treatment – they may not be able to meet a work requirement. The effects of an illness, if not rising to the level of a disability, includes for some, a continued regimen of prescriptions, long-term side effects, and a risk of recurrence. Four years does not fit the scope of care.

We oppose work requirements – because they do not work. We need look no further than the failed work requirement in Wisconsin's own FoodShare program. Two years ago, Governor Scott Walker introduced new work requirements as a condition of receiving FoodShare benefits. The rule called for "able-bodied adults without children at home" to be employed to keep their FoodShare. If they could not secure employment within 3 months, the benefits end. In his new state budget, Walker wants to expand work requirements to adults with children in the home. He would need federal approval to do so. Gov. Walker, in a December interview with the Wisconsin State Journal said, "Most of those people went out and got jobs, I believe... Human nature is we all need a nudge for things."[14] In fact, 21,000 of FoodShare beneficiaries gained employment as of January 2017, per the State Journal.[15] However, Walker failed to mention that 64,000 FoodShare recipients were kicked off their food benefits because they were either not looking for or could not find gainful employment.[16] That is as if the entire city of Eau Claire, WI were kicked off the program. The irony for many is that low-income workers, many of whom are participating in the job training programs

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[12] Emergency Medical Treatment & Labor Act (EMTALA) ensures public access to emergency services regardless of ability to pay. Available at: https://www.cms.gov/regulations-and-guidance/legislation/emtala/

[13] Cancer Patient Concerned About BadgerCare Plus Changes, WKOW (2015), available at: http://www.wkow.com/story/29142769/2015/05/Saturday/cancer-patient-concerned-about-badgercare-plus-changes

[14] Wisconsin State Journal, "21K employed through FoodShare jobs program, 64K lost benefits" available at: http://host.madison.com/wsj/news/local/govt-and-politics/k-employed-through-foodshare-jobs-program-k-lost-benefits/article_cb37feed-43f5-5d77-9677-db447f030dbf.html

[15] *Id.*

[16] *Id.*

connected to FoodShare in 2015 are making less than $12 an hour. This means that despite full employment, they are still eligible for FoodShare.

The National Health Law Program published an issue brief called "Medicaid Work Requirements-Not a Healthy Choice"[17] on March 21. In the brief, authors describe how work requirements run counter to the purpose of Medicaid, saying, "work requirements applied to health coverage get it exactly backwards." They argue, and we agree, it is an additional and "counterproductive condition on eligibility," and simply a barrier to coverage and the "pathway to health" that Medicaid coverage represents. The brief points to research that demonstrates that 8 in 10 adults in Medicaid are already working.[18] Moreover, the research reminds us that just because someone on Medicaid is not legally considered disabled, they may still live with chronic and possibly disabling conditions that preclude them from working. There is a classic and profound misunderstanding of the people enrolled in Medicaid by lawmakers and policy leaders proposing work requirements. Finally, the brief points to research by the Center on Budget and Policy Priorities that found work requirements are ineffective, including a startling finding: The large majority of individuals subject to work requirements remained poor, and some became poorer.[19]

Emergency Room Copayments

Wisconsin is proposing the addition of copays for Wisconsin's lowest income adults every time they use the emergency room as an "incentive" to use health care services in a way that is "mindful of health care value." The waiver request continues, "Members will be educated on seeking preventive services and other care at the appropriate setting," but does not specify who will be doing the educating, other than presuming that the instance of the copay itself is the lesson.

The state continues, "They will also understand the direct cost of health care services, which will drive responsible health care decision-making." Suggesting that an $8 copay will help patients understand "direct costs" is a fallacy perpetuated on stereotype, suggesting that it must be the uneducated, unsophisticated adults who are enrolled in BadgerCare Plus and warrant "schooling" on health care economics and financing, especially at the most critical times when emergency services are needed. The state provides no other support for how a copayment will achieve its educational objectives, nor does it distinguish emergent from non-emergent use of the emergency room.

The paternalistic policy language puts the burden on hospitals to collect the copay, yet says hospitals can't refuse treatment for nonpayment of the copay. It does not prohibit collection or revenue cycle management strategies to recoup from the low-income consumer. The proposal does not incentivize

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[17] Medicaid Work Requirements-Not a Healthy Choice, National Health Law Program, available at: http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirements-not-a-healthy-choice#.WN1C62e1vRZ

[18] *Id.*

[19] Work Requirements Don't Cut Poverty, Evidence Shows, Center on Budget and Policy Priorities, available at: http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows

care or coverage – it instead cuts the one lifeline to care for many individuals. In the end, it is one more disincentive to enroll in BadgerCare Plus and one more obstacle to care. Individuals could rationally deem it more appropriate to join the ranks of the uninsured and use the emergency room as their care, socializing and redistributing the cost of their care to everyone else while adding to Wisconsin's uncompensated care.

Even more, as CLASP reminds you,[20] CMS lacks the authority to change the rules on ER copays under a Section 1115 waiver. Waivers of cost-sharing provisions are under the purview of Section 1916(f) waivers, which the state has not requested, and only in such cases where care was deemed non-emergent AND other sources of outpatient care were demonstrated to have been available.[21] None such criteria were established nor met in this waiver request.

Substance Abuse Identification

Drug testing has been determined to be expensive, ineffective, and illegal. It harkens back to the 1980s and 1990's get tough "war on drugs" rhetoric, piece of a larger, outdated trend of asserting that moral depravity and the lack of "personal responsibility" are at the root of social problems, rather than understanding the systemic causes of poverty, homelessness, and racism.[22] As Rep. John Nygren and Lt. Governor Rebecca Kleefisch wrote as Co-chairs on the Governor's Task Force on Opioid Abuse in their report to Gov. Scott Walker titled "Combating Opioid Abuse," "We're not talking about the 'Just Say No' campaign of the 80's and 90's. Now it's heroin, meth, and prescription drugs….As the drugs on the street have changed, our policy and policing frameworks *must* catch up to the shifting trends."[23] Kleefisch and Nygren recommend adding more doctors in Wisconsin focused on prevention, treatment, and management of addiction as well as recovery specialists and support to help patients transition from hospital to home after a drug-related incident. Recommendations include creating treatment alternative programs, regional pilot programs, counseling, and county-based or private post-treatment care, and making opioid antagonists like Narcan available over the counter.[24] The body of literature and research has proven the ineffectiveness of excluding those identified as "substance abusers" from public benefits, should they refuse testing or treatment.[25] To do so would also undermine the very legislation put in place to help combat opioid abuse in Wisconsin, and take us back to the failed policies of the 1980s.

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[20] CLASP Comments on the Draft 1115 Demonstration Waiver Amendment Application, available at: https://public.medicaid.gov/gf2.ti/af/328098/41093/PDF/-/CLASP_Wisconsin_1115_Waiver_Comments_to_CMS_FINAL.pdf

[21] See: https://www.ssa.gov/OP_Home/ssact/title19/1916.htm

[22] Craig Reinarman and Harry G. Levine, The Crack Attack: Demon Drugs and Social Justice 1997; Diana Gordon, Drugs, Race and the "Dangerous Classes (1994)

[23] Combatting Opioid Abuse: A Report to Governor Scott Walker, available at: https://hope.wi.gov/Documents/ReportOnCombatingOpioidAbuse.pdf

[24] *Id* at 4-6.

[25] See, e.g., "The Sham of Drug Testing for Benefits," available at: https://www.forbes.com/sites/judystone/2015/02/17/the-sham-of-drug-testing-walker-scott-and-political-

The government-sponsored act of identifying an individual as a substance abuser raises constitutional questions. The Center for Law and Social Policy, Inc. reminds us of the legal history behind suspicion-less testing – found repeatedly to be a violation of the Fourth Amendment, constituting a search without basis.[26] The US Sixth Circuit Court of Appeals determined Michigan's 1999 requirement of drug testing in the Family Independence Program unconstitutional.[27] Florida's 2011 law requiring drug testing of TANF applicants was determined to be an "unreasonable search" by the US Eleventh Circuit Court of Appeals.[28] In the few months Florida conducted testing, extremely few recipients were determined to be abusing substances, consistent with previous research that found only a small share of welfare recipients experience substance abuse disorders, while the state realized no savings in its program administration, as operating costs far exceed the fiscal savings from denying benefits. In fact, the testing ended up costing the state over $1 million.

The State may argue they have "reason" to purse testing, based on answers to a brief questionnaire[29] in which particular answers demonstrate suspicion for a follow-up drug test. This hardly cures the constitutional violation of an unreasonable search. Additionally, the state's policy and practice would violate the Americans with Disabilities Act, ethical principles, and applicants' rights.[30] The Americans with Disabilities Act (ADA) and the Rehabilitation Act protects individuals with disabilities, including individuals with substance abuse disorders, and protects them as they seek equal access to social service agencies and programs. To impose a drug test on this protected class would be to violate Part I of the ADA. Part II of the ADA requires that public entities not discriminate against persons with disabilities, imposing a duty on the government to make public benefits systems equally accessible for disabled and non-disabled individuals. A disability itself cannot prevent an individual from accessing the benefits to which they are entitled.

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pandering/#29ccee9b59be; "Michigan's Drug-Testing Welfare Program Has Yielded Zero Positive Results," available at: https://www.theguardian.com/us-news/2016/jun/21/michigan-welfare-drug-testing-program; and "No Savings are Found From Welfare Drug Tests," available at: http://www.nytimes.com/2012/04/18/us/no-savings-found-in-florida-welfare-drug-tests.html

[26] Matt Lewis and Elizabeth Kenefick, "TANF Policy Brief: Random Drug Testing of TANF Recipients is Costly, Ineffective and Hurts Families," CLASP, http://www.clasp.org/admin/site/publications/files/520.pdf

[27] Marchwinski v. Howard, 319 F.3d 258 (6th Cir. 2003)

[28] Lebron v. Sec. of the Fla. Dep't of Children and Families, 772 F.3d 1352 (11th Cir. 2014)

[29] An additional question arises as to the accuracy of tests or screens: Corporations and agencies that produce screening tools themselves admit no screening measure is 100% accurate, nor does it include clinical diagnosis standards. https://www.sassi.com/customer-support/clinical-support/screening-issues/

[30] See, for example, SASSI Institute which has stated, with emphasis, on its website "To use the SASSI to discriminate against individuals, such as disqualifying job applicants or to deny public assistance, violates the purpose of the SASSI and is a violation of the Americans with Disabilities Act." Available at: https://www.sassi.com/customer-support/clinical-support/screening-issues/

While the state may argue that within the ADA the category of individual "current drug users" are excluded from the definition of "disabled individuals,"[31] the illegality of this wavier comes from the fact that the state would be testing potentially ***all*** childless adults, including both protected and unprotected individuals, not yet aware who fits the ADA definition. The state has argued that testing all childless adults will help them "find" the substance abusers. To do so would violate the rights of protected classes.

When seen in light of the research on how poverty exacerbates the harms of drug use, the exclusion of drug users from public benefits or protection is more serious. Consider the overreach the testing would allow. Testing for substance abuse could potentially reveal additional, private and protected health information about a patient, whether it be pregnancy, genetic condition/predisposition, presence of lawful prescription medication, or other medical need. Mandating the sharing of such personal health information should not be a requirement to obtain basic, necessary health coverage.

It is widely acknowledged that adequate substance abuse treatment capacity does not exist in all counties or for all services. Many areas report a lack of detoxification treatment centers and providers able to offer medication-assisted treatment. Local officials have called the gap between people who want or need drug treatment and the amount of treatment available to be a "significant gap."[32] The situation is worse in rural Wisconsin, where there is a lack of specialized knowledge. As Nygren and Kleefisch advised the Governor, "Wisconsin faces a shortage of workers focused on health care delivery generally and substance abuse services in particular." They encouraged health care providers, universities, and employers to seek grant funding for projects to help fill professional shortages. "The workforce shortage to provide these services is real, especially in our rural areas."[33] These services are especially important for treating addiction to heroin and opiate-based prescription pain relief medications. Heroin and other opiates combined are the most common substance for

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[31] 42 U.S.C. § 12102 - U.S. Code - Unannotated Title 42. The Public Health and Welfare § 12102. Definition of disability, available at: http://codes.findlaw.com/us/title-42-the-public-health-and-welfare/42-usc-sect-12102.html#sthash.hCmjzosY.dpuf

[32] More Potent Street Drugs, Lack of Treatment Help Stoke Dane County Heroin Deaths, Wisconsin State Journal, 2016, available at: http://host.madison.com/wsj/news/local/crime-and-courts/more-potent-street-drugs-lack-of-treatment-help-stoke-dane/article_026b8e2c-7094-5e6a-b24d-9a2edc1544a4.html

[33] *Supra* note 23 at 10. Yet, Nygren and Kleefisch say their concern is finding the people who need help, and suggest the Governor's order to DHS to seek federal permission to drug test in FoodShare is the way to identify those who need help "before it's too late." These recommendations run contrary to the message of treatment and prevention the rest of the Report highlights. To achieve gains in prevention, individuals must have access to preventive services, treatment and recovery. The attempt to drug test FoodShare recipients failed when the courts tossed Wisconsin's legal attempt to force approval. Available at: http://www.jsonline.com/story/news/politics/2017/01/11/official-food-stamp-drug-tests-would-violate-federal-law/96438832/

which people are receiving treatment. The Waiver fails to address anything related to capacity for treatment.[34]

The state is seeking to join a trend in drug policy, which prioritizes monitoring, and punishment (in the form of denying coverage for "noncompliance") over treatment. Resources are being used toward the establishment of testing and monitoring contracts but not enough to the establishment of treatment programs themselves. "Since we already have waiting lists of people who need and want drug treatment, spending scarce state dollars on new screening and treatment requirements will add to the waiting lists and divert resources from more effective solutions."[35] The punitive measures deviate from the supportive goals the state Department of Health Services should be achieving, given modern research and evidence on the nature of addiction.

The state's testing policies raise more dangerous concerns. Is this a policy meant to be more of a political spectacle, one where facts are irrelevant, in order to perpetuate an ideology? Are the "problems" of substance abuse being attributed to our lowest income, minority individuals, those under 100% FPL, in fact meant to identify a "drug problem" with the poor? This capitalizes on the antipathy of ideological audiences[36], who resent using "tax money for public assistance."[37] Instead, eliminating drug users from public benefits (should they refuse testing or treatment) is, at best, if attractive at all, would only seem so in the short term. It does nothing to address the underlying drug problems, exacerbating the harms of drug use to the individual and his community.

The exact opposite approach of what this waiver suggests would be more effective: instead of conditioning care and coverage on being "drug free," instead improve the ability of childless adults to find treatment and basic income support. Increase health coverage to more individuals. Make treatment widely accessible. Eliminate administrative hoops and hurdles standing in the way of

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[34] Consider Wisconsin's failed experiment in restricting Hepatitis C patients from Medicaid treatment. Wisconsin's overly strict policy requires testing/monitoring sobriety before Medicaid-covered treatment may be delivered. Wisconsin's instance of Hepatitis C has increase 450% since 2011 is among the worst in the nation, with twice the national average of Hepatitis C infections. Available at: https://www.dhs.wisconsin.gov/publications/p00440-2015.pdf. This, too, runs counter to treatment guidelines and recommendations from the Centers for Medicare and Medicaid Services warning states against imposing conditions for coverage that unreasonably restrict access. It raises legal concerns due to being contrary to statutory requirements of federal law that requires state Medicaid programs to pay for all medically necessary treatments. As CDC research links increased instance of Hepatitis C to increasing injection drug use with opioids, the state would be wise to broaden access to coverage and care, not institute additional hoops and hurdles in the path of connecting to coverage and care.

[35] *Supra* note 4

[36] William N. Elwood, Rhetoric in the War on Drugs: The Triumphs and Tragedies of Public Relations 34 (1994)

[37] Similarly, identify poverty with crime – and disproportionally blame minorities.

accessing coverage and care. The result will be an improvement in health outcomes and a reduction in drug use.[38]

Healthy Behaviors Incentives

The healthy behavior incentives contained in this waiver request will be difficult to enforce and even more difficult to maintain constitutionally. The waiver proposes to reduce premiums for people who do not engage in certain "risky" behaviors, with the goals of encouraging healthy lifestyles, improving "accountability," and lowering healthcare costs. The request lists the following as "risky" behaviors: alcohol consumption, body weight, illicit drug use, tobacco use, and seatbelt use, to be measured by a "health risk assessment" that measures risk "according to national health organization standards." This proposition is vague and as such, impractical. Which national health organizations and which standards?

Additionally, the proposed healthy behavior incentive will certainly puncture privacy protections, requiring significant disclosure regarding one's habits, health history, and physical or mental/ behavioral health state, as addressed above. The waiver weakens current privacy protections while not delivering evidence-based proof of positive results. The effects of "healthy behavior" programs in Medicaid have not been extensively studied, and where evaluated, have mixed results.[39]

Wisconsin is not "demonstrating" anything[40] – it can and should learn from what states like Indiana, Iowa and Michigan have experienced in their "healthy behavior" programs. "Their complicated provisions required *extensive* administrative resources and beneficiary education to implement."[41]

In Wisconsin, the results are clear. Wisconsin conducted six "pilot projects" from 2008 to 2010 under then Governor Doyle, with different incentives targeted to different populations.[42] Rewards were supposed to encourage enrollment and promote desired healthy behavior activities – but no causal link could be proven. In fact, enrollees reported that information through classes and materials – strategies that used only a strong education component – were just as helpful in motivating them to change behavior as incentives.[43] Past evaluations did not measure "return on investment," and participating health plans noted they did not accurately gauge the extensive staff time needed for

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[38] *Supra* note 22 at 205.
[39] The Use of Healthy Behavior Incentives in Medicaid, MACPAC, 2016, Available at https://www.macpac.gov/wp-content/uploads/2016/08/The-Use-of-Healthy-Behavior-Incentives-in-Medicaid.pdf
[40] As required in 42 U.S.C. § 1315(a) (codification of section 1115).
[41] Proposed Medicaid Section 1115 Waivers in Maine and Wisconsin, The Henry J. Kaiser Family Foundation, available at: http://kff.org/medicaid/issue-brief/proposed-medicaid-section-1115-waivers-in-maine-and-wisconsin/
[42] Do Incentives Work for Medicaid Members? A Study of Six Pilot Projects, Wisconsin Department of Health Services (2013), available at: https://www.dhs.wisconsin.gov/publications/p0/p00499.pdf
[43] *Supra* note 29

implementation. They ended up devoting extensive *additional* resources while not achieving the program goals.[44]

In fact, **none** of the six funded pilot projects in Wisconsin reached a health outcome goal.[45] Such failed past pilot projects are evidence of how this proposal runs contrary to the requirements of Section 1115 demonstrative project, and therefore is not an appropriate waiver request, as it is neither experimental, a demonstration, or pilot project that will likely promote the goals of the Medicaid Act. We already know from six pilot projects that we can pass on risk assessments. That experiment did not work.

Most concerning, these "risky" behavior assessments promise to create an unconstitutional disparate impact among demographic groups. Many of these behaviors vary among genders, cultures, races, and ethnicities for various sociological reasons.[46] They also can be discriminating based on health condition or diagnosis. For example, body weight can be dramatically impacted by factors such as diagnosis or medication regimen.[47] To charge a higher premium for a condition outside of one's control is punitive and discriminatory. The waiver request proposes a system that has the potential to provide lower premiums for certain groups and higher premiums for others, under the guise of a healthy behavior incentive. This disparity will reinforce and potentially widen the dramatic economic and racial gaps that already exist.[48]

Residential Treatment

Your waiver suggests the state will make residential treatment available for those testing positive for drug use (assuming they consented to testing and fully participate in treatment recommendations). We remind you that effective enforcement of the Mental Health Parity and Addition Equity Act of 2014's mandate would require all Medicaid managed care organizations to provide needed services. Simply enforce the existing requirements that all of Wisconsin's BadgerCare and Medicaid HMOs cover all mental health and substance abuse services, including residential treatment, to exactly the same extent that they are required to cover services like physical rehabilitation therapy in a skilled nursing facility. You can enforce MHPAEA and make residential treatment readily available to **every** individual in need, regardless of age or source of health insurance, especially as we are in the

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[44] *Id.*
[45] *Supra* note 42.
[46] See: "Tobacco-Related Disparities," available at: https://www.cdc.gov/tobacco/disparities/index.htm; CDC's "Health Disparities in Obesity" fact sheet, available at: https://www.cdc.gov/minorityhealth/chdir/2011/factsheets/obesity.pdf; and "Minority Health and Health Disparities," available at: https://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/diversity-health-disparities.
[47] See *Wide Effect: Drugs that Promote Weight Gain* by Christina Johnson, available at: https://health.ucsd.edu/news/features/Pages/2015-03-03-weight-gain-and-medications.aspx
[48] See *Wealth inequality has widened among racial, ethnic lines since end of great recession*, available at: http://www.pewresearch.org/fact-tank/2014/12/12/racial-wealth-gaps-great-recession/

midst of a national opioid epidemic. We already have the tools available to eliminate barriers to effective mental health care and substance abuse treatment.

Wisconsin has relied on its original BadgerCare Plus waiver to include Childless Adults instead of accepting federal funding for a full Medicaid Expansion for its Childless Adult population. In so doing, Wisconsin also restricted access to parents on BadgerCare Plus to 100% FPL, instead of a Medicaid Expansion threshold of 138% FPL. By limiting BadgerCare Plus access, Wisconsin policy choice leaves low-income populations vulnerable to marketplace fluctuations and lost coverage. In the event of dramatic, and predicted, marketplace failures or fluctuations in Wisconsin, thousands of people between 100-138% FPL could lose important health coverage. Extending Medicaid to these populations (up to 138%) would be a wise, proactive step to help avoid tens of thousands of people in Wisconsin losing coverage.

Wisconsin should stop restricting coverage and leaving the taxpayers holding the bill and should accept federal Medicaid Expansion money to cover both childless adults and parents at the intended 138% FPL.

Increasing Wisconsin's Uncompensated Care

Finally, consider the cost of adding a substantial number of these childless adults to the ranks of the uninsured. In Wisconsin, uncompensated care in hospitals was at $900 million in 2015, down from over $1.5 billion in 2013, largely in part to the rapid connection of adults to coverage, either BadgerCare Plus of the Marketplace. When more people have access to coverage, hospitals see fewer uninsured patients, write off fewer bills, bringing their uncompensated care costs down. Uncompensated care costs impact everyone! When hospitals spend more on charity care or lose money to bad debt, they increase costs to everyone else to make up for losses.

Wisconsin notes that its baseline costs will be adjusted to account for program elements such as the financial impact of collecting premiums and higher emergency department copays and time-limited eligibility, which may include costs related to job training. As CMS requires Section 1115 waivers to be budget neutral to the federal government, Wisconsin will need to cover the administrative costs out of *taxpayer* pockets.

Accessibility and Transparency of Process

Wisconsin can improve its process for public testimony and comment. First, there were only two public hearings held on this waiver, one in southeastern Wisconsin (Milwaukee, WI) and one in central Wisconsin (Wausau, WI). The hearing in Wausau was conducted during business hours (from 11am until 2pm), meaning some working individuals would have a difficult time participating. For those wishing to participate in the public hearing remotely, the state invited people to "join" the public hearing via phone, in which complicated instructions were delivered on how to dial in. Once on the phone, separate complicated instructions on how to call into a separate number and enter a passcode to then leave a voicemail message comment were stated verbally twice at the start of the hearing. Joining the hearing late would mean missing the call-

in/comment instructions. Second, individuals were restricted to 2 minutes of comments, hardly time to cover concerns or praise on all elements of the waiver.

Marlia Mattke, Assistant Administrator of Wisconsin's Division of Health Care Access and Accountability as moderator for the public hearings stated, "The comments that are compiled today and throughout the public comment process will be included in the final waiver application that is submitted to the federal government."[49] That statement proved to be incorrect. The Department did not make the comments compiled through the comment process available, nor did they include them with the waiver submitted to CMS. Instead, the state created a meager 8-page summary of public comments, which largely misrepresented the voice of the people of Wisconsin.

Scott Bauer of the Associated Press[50] acquired the public comments after filing an open records request. It showed that of the 1,050 public comments received only five supported the waiver in full.

Additionally, the state withheld the names of the people commenting. "The Associated Press used an open records request to obtain the emails, form letters from advocacy groups, voicemails and testimony submitted to the department over a 30-day public comment period, from April 19 to May 19. The documents included more than 1,000 comments on Walker's plan, but nearly all of the names of the people commenting were withheld."[51]

The state refined its waiver request after the comment period closed. The modifications Wisconsin made were *slight* modifications to the original waiver, and as minimal a response they could give after cherry picking through the comments. We presume the 1,045 public comments opposing the waiver were more critical, especially on areas of work requirements, termination of benefits, drug testing, and the charges they seek to impose on emergency room.

For example, in the summary of waiver comments presented to CMS, the waiver drug-testing requirement was summarized by the state centering almost entirely on the 6-month prohibition on returning to coverage after refusing a test. We believe this to be cherry-picking from the public comment, mis-representing the actual comments received on this issue. We expect that the

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[49] As stated during the public hearing, available in archived webcast, stated at minute 9:59: https://livestream.com/accounts/14059632/events/7313758

[50] AP Exclusive: Records Show Scant Support for Walker's Plan, US News, June 20, 2017 available at: https://www.usnews.com/news/best-states/wisconsin/articles/2017-06-20/ap-exclusive-records-show-scant-support-for-walkers-plan

[51] Wisconsin DHS withholds names of Medicaid waiver commenters, AP, June 20, 2017, available at: https://apnews.com/03277bf0afca49149dfa3a689965bb6f

state received numerous comments (including our own) reminding them of the constitutional & privacy concerns of drug testing Medicaid recipients.

The actions of the Department certainly obstruct an open, transparent discussion, subverting the point of a public hearing and comment period. In the future, we would hope for a more transparent reporting of the public comments, especially when the stakes are so high.

Conclusion

In Wisconsin, about 1.2 million people rely on BadgerCare and Medicaid programs to provide essential, affordable, and effective health care services. And the impact of these programs reaches thousands more--our friends, neighbors, grandparents, colleagues, and health care providers large and small in every county of Wisconsin.

Once again, Wisconsin has released a proposal that radically restructures and limits benefits to several thousand adults and creates a complicated maze of an eligibility system. In a proposal driven by ideology, the state hopes to direct more people to the "free market" system of health care. Sadly, this promotes a "team of me" approach for Wisconsin with smaller risk puddles, high costs, and poorer benefits. Instead, Wisconsin – and CMS - should be looking to expand public-private partnerships coverage options like BadgerCare Plus that promoted large scale pooling and discounted care due to purchasing power and economic efficiencies. The state should consider promoting pooling and spreading risk, creating financial leverage, and promoting consumer protection and health plan accountability.

These cuts also affect friends, neighbors, grandparents, and insured populations that will likely see increased costs. The large pool of BadgerCare and Medicaid recipients provides cost effective coverage that lowers the number of uninsured and keeps people out of expensive, inefficient, and often uncompensated emergency room care. Most people realize that uncompensated care costs do not disappear but rather show up in the form of increased health care costs. Health care providers redistribute unpaid medical bills to small business, people with insurance, and other hospital patients.

Sincerely,

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