AMA
AMERICAN MEDICAL ASSOCIATION

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May 18, 2017

Secretary Linda Seemeyer
Wisconsin Department of Health Services
P.O. Box 309
Madison, WI 53707-0309

Re: BadgerCare Reform Demonstration Waiver

Dear Secretary Seemeyer:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am pleased to submit comments on the BadgerCare Reform Demonstration Waiver Amendment to the Wisconsin Department of Health Services (DHS) Division of Medicaid Services. Recognizing that many of the provisions included in the waiver amendment were predetermined by the Wisconsin legislature in 2015, we intend to limit our comments to those provisions over which DHS has exercised discretion.

The AMA believes everyone deserves quality health care. As physicians, we regularly confront the effects of lack of access to adequate care and know that Medicaid is an important—and often the only—source of consistent care for low income individuals. The AMA encourages policymakers at all levels of government to focus their efforts on working together to identify realistic coverage options. Further, the AMA has long recognized the benefit of allowing states to experiment with new models for covering low-income residents and supports efforts by states to develop and test different Medicaid models that best meet the needs and priorities of their low income adult populations. While encouraging state flexibility, the AMA also acknowledges the need for safeguards to protect low income patients and emphatically supports Medicaid's role as an indispensable safety net for the most vulnerable patients. We are concerned that some elements of the BadgerCare Reform Demonstration may jeopardize the health and welfare of Medicaid enrollees.

Premiums

We urge DHS to ease the requirements regarding payment of premiums. In particular, we are concerned that enrollees who fail to make premium payments on time will be disenrolled from the Medicaid program and barred from reenrolling for six months. This punitive lock-out period will increase the number of uninsured residents in Wisconsin and increase the burden of uncompensated care on the health care system. Furthermore, the policy fails to take into account the harsh reality faced by those living in poverty. For these vulnerable patients, income can be unpredictable, and withdrawing the security provided by Medicaid disadvantages patients at the very time when they need it most. At a minimum, DHS should consider providing a hardship exemption, permitting reenrollment after partial repayment and granting a 90-day grace period during which Medicaid benefits are still provided.

We are also concerned that the premium requirements will be too administratively complex for those enduring hardship. While we understand the state's interest in promoting personal responsibility among the Medicaid population, we urge you to implement a premium structure that will not be overly burdensome on enrollees. As we have learned from the experiences of other states, administratively complicated program requirements result in patient churn and disrupt the important continuity and coordination of patient care. We suggest DHS set one premium rate and exempt enrollees with incomes significantly below the poverty line and simplify the process for premium payment so that those with low financial and health care literacy do not fall behind.

Emergency department utilization

The AMA appreciates the attention given to overuse of the emergency department (ED). In addition to driving up health care costs, avoidable use of the ED leads to overcrowding that strains the capacity of the ED medical staff to care for true medical emergencies. We point out, however, that the waiver proposal does not specify that graduated co-pays will be imposed *only* for non-emergency use of the ED. We ask you to clarify that BadgerCare will not seek co-pays for appropriate use of the ED. To discourage Medicaid patients from seeking emergency care when necessary puts beneficiaries at risk of harm or even death.

Further, imposition of financial penalties should not be the only method employed to encourage Medicaid beneficiaries to seek care in an appropriate setting. We urge you to consider and address the underlying reason why Medicaid patients seek care in the emergency department–the difficultly many face in accessing an adequate network of Medicaid-participating primary care providers. While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, ample research has demonstrated that low reimbursement rates can significantly affect a physician's ability to accept Medicaid patients into his or her practice. In Wisconsin, on average, Medicaid's reimbursement rates are only 71 percent of Medicare rates. Rates are even lower for primary care physicians–just 57 percent of Medicare. Without adequate payment, physicians may not have the financial capacity to continue participating in the program, and, in turn, beneficiaries are likely to face barriers to care, resulting in more frequent emergency department visits as a last resort. Setting adequate Medicaid reimbursement rates is an essential element in any effort to reduce avoidable ED utilization.

Healthy behavior incentives

The AMA concurs with DHS that Medicaid patients should be active and engaged participants in managing their health. We also appreciate that healthy behavior incentives may decrease the cost of medical care to the tax-paying public. We want to emphasize, however, that risk assessments and behavior incentives should be part of an integrated approach to encouraging the adoption of healthy lifestyles, involving coordinated efforts by physicians and other health care providers. Incentives should be one piece of an ongoing risk-reduction and behavior change program to encourage and support long-term changes in habits and behaviors, rather than simply a means to reduce cost sharing. To that end, screenings should be conducted by licensed medical professionals so that enrollees who exhibit risky behavior can receive medically appropriate and evidence-based advice, information and assistance they need to make positive behavior modifications. Efforts should be made to ensure that other DHS policies, resources, and activities support and facilitate participation in healthy behaviors.

We are also concerned about the extent to which information disclosed in the health risk assessment will be protected by DHS. Confidentiality of program participants and their private health information must be maintained in order to ensure beneficiaries are forthcoming both in the health risk assessment and with their health care provider when seeking care after enrollment. In particular, we urge DHS to establish safeguards and set strict standards governing the acquisition, storage, and usage of an applicant's information regarding risky behaviors. So that individuals are not discouraged from applying for coverage altogether, DHS must guard against the perception and fear applicants may have that the information they disclose will be used against them by, for example, law enforcement or employers.

Drug testing and treatment

As a threshold issue, screening for substance use disorders (SUD) is an important element of identifying those who would benefit from treatment. The end goal of increasing access to SUD treatment is positive, but DHS must take care to ensure implementation of the program protects and prioritizes patients' interests.

We are concerned that DHS has placed too much faith in drug testing. There is a lack of evidence to support drug testing as a dispositive means to accurately identify those who would benefit from treatment. It is also important to recognize that drug test results are not infallible, and reliance on drug testing fails to account for the variability in tests, the difficulty in proper interpretation, and the tremendous cost associated with blanket testing. Focusing on appropriate screening and non-punitive measures to identify individuals for treatment would be much more beneficial and medically appropriate.

Moreover, while we recognize that DHS was directed by the Wisconsin legislature to implement a drug screening and testing program, we are troubled that DHS has gone beyond its legislative directive to require, as a condition of eligibility, that applicants who test positive for drug use undergo a drug treatment program. We believe, as a matter of medical ethics, that patients have the right to make decisions about accepting or refusing any recommended medical intervention and to have those decisions respected. Patients with SUD may be coerced into treatment if their enrollment in Medicaid and the accompanying receipt of needed medical care is at stake. This, we believe, runs counter to the principles of informed consent to medical treatment that are fundamental in both ethics and law. We strongly urge you to dispense with this requirement. Instead, DHS should refer patients to addiction and treatment services based on medical necessity and diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders as determined by a physician.

Further, we are concerned that the waiver does not specify what "completion" of a drug treatment program will entail. A SUD is a chronic, relapsing medical disease that does not conform to a definitive "cure" as would, for example, a broken arm or leg. That is why we urge that, if DHS pursues this policy, it must delegate to a treating physician the authority to determine the appropriate plan of care, in coordination with the patient him/herself, to ensure that the care meets patient needs and respects patient preferences to the greatest extent possible. Treatment should meet the American Society of Addiction Medicine criteria of medical necessity for services and the Patient Placement Criteria including withdrawal management, short-term inpatient and residential treatment, partial hospitalization, intensive outpatient treatment, outpatient treatment including Medication Assisted Treatment, and long-term recovery supports. This includes how DHS expects to ensure a comprehensive team of health care professionals to provide the medical, psycho-social, behavioral and other critical components essential to successful and meaningful SUD treatment and long-term recovery.

Finally, we consider DHS' plans to expand access to residential services provided in an institution for mental disease (IMD) a positive development. It is important to note, however, that coverage does not equate with access and loosening the restriction on IMD services will not automatically result in a robust network of providers. Reimbursement must be sufficient to attract providers of high quality care, and DHS must minimize administrative barriers, such as prior authorization, that too often limit access to treatment options.

Implementation and evaluation

We appreciate that DHS has allocated one year from the date of federal approval to implement the BadgerCare Reform Demonstration Waiver. During that time, we encourage DHS to seek and incorporate ongoing feedback from the physician community. We also encourage DHS to develop a transparent process for monitoring and evaluating access to care under the program and to include such information in the waiver evaluation submitted to the federal government. In particular, we ask that DHS carefully monitor the impact of the health risk assessment, drug screening activities, and work requirement for unintended consequences that obstruct access to care.

We thank you for the opportunity to provide our input on the BadgerCare Reform Demonstration Waiver. If you have any questions, please contact Annalia Michelman, JD, Senior Legislative Attorney, Advocacy Resource Center, at annalia.michelman@ama-assn.org or (312) 464-4788.

Sincerely,

James L. Madara, MD

cc: Wisconsin Medical Society