Mental Health America of Wisconsin

May 18, 2017
Wisconsin Department of Health Services
Secretary Linda Seemeyer
P.O. Box 309
Madison, WI 53707-0309

Dear Secretary Seemeyer:

Mental Health America of Wisconsin (MHA) is submitting these comments on the proposed waiver of Medicaid regulations for the BadgerCare Childless Adult Waiver.

Our comments in this testimony will focus on the impact of the BadgerCare Childless Adult Waiver Amendment on people with mental illnesses because they are our constituency. That focus should not be interpreted as approving, supporting or endorsing anything in this waiver that applies to the larger population of low-income people who must rely on Medicaid for their healthcare and who may be harmed by this proposal.

MHA is primarily concerned about how the proposed waiver would impact access to mental health and substance abuse services. In general we know that Medicaid is the single largest payer of mental health services in the country. We also know from the Mental Health and Substance Use Needs Assessment produced by the Department of Health Services in 2013 that almost half of individuals who receive mental health services are funded, at least in part, by Medicaid. A significant number of these individuals access Medicaid through the BadgerCare Childless Adult Waiver. Although some may be potentially eligible for Medicaid by virtue of a disability, obtaining a disability determination can be a difficult process, requiring extensive medical documentation. Many individuals with significant mental illness and/or other chronic disabling conditions, including those who have experienced homelessness, have not had consistent access to healthcare over the years, and have difficulty providing the needed documentation for a disability determination.

Additionally, those individuals who receive publicly supported services are especially dependent upon Medicaid. Enrollment in BadgerCare has provided opportunities for access to county administered benefits such as Comprehensive Community Services (CCS) which supports recovery for people with mental illness and substance use disorders. It is important to note that Medicaid provides services that are not generally covered by private insurance, such as these psychosocial rehabilitation services, so continued and ongoing access to Medicaid and the unique long term supports it provides is vital for Wisconsinites with mental illnesses. Of course, access to Medicaid as a funding stream for these services also has a significant impact on the ability of counties to provide the services. The expansion of CCS through Governor Walker's 2013 budget significantly reduced disparities across counties in access to these services.

General Comments

We understand that the DHS was working in response to directions from the Wisconsin Legislature. We appreciate your efforts to take into consideration how the waiver could impact specific sub-groups, such as those with mental illnesses. There are many thoughtful accommodations, such as the exemptions from the work requirements.

The waiver requires the DHS to address costs to implement. Since that is not spelled out in the current application we can only express our concern about whether the costs for collecting premiums, conducting

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drug screening and testing and other elements of the waiver are reasonable and will satisfy the cost neutrality requirements of the waiver. Unfortunately these calculations do not take into account costs to the members, some of which we address below.

MHA has a strong ethic around stakeholder inclusion in policy making and implementation. There are many aspects of the proposed program that would benefit from a broadly constituted stakeholder advisory group, which would include individuals who are or could be members of the population served by the waiver. We urge the DHS to create such a group if the waiver goes forward.

Finally, we note that in many ways the population of people with substance use disorders is treated differently than people with mental illnesses in the waiver despite the fact that both disorders are recognized medical conditions. We are concerned that there are inaccurate assumptions about the population that comprises those eligible for the BadgerCare Childless Adult program as it relates to substance use disorders and current work behaviors that are reflected in the waiver request and that could negatively impact the access of this population to treatment. Given that Social Security, many years ago, changed the ability of these individuals to get disability—and the Medicaid coverage associated with it—access to services for this population has been significantly improved by the Childless Adult program. Given the epidemic of opioid abuse we are concerned that elements of the waiver could negatively impact access to substance abuse treatment despite the waivers stated intent of supporting such treatment.

Premiums and Cost-Sharing

MHA opposes the imposition of premiums on this population because premiums for individuals at very low incomes result in loss of coverage.

- Part of DHS' rationale for premiums is that "preventive care service utilization is expected to increase as members seek to utilize appropriate health care services." However, the BadgerCare Plus Core Plan saw outpatient visits increase 29 percent and inpatient hospitalizations decline 59 percent when there were no premiums. However, when enforceable premiums were imposed on adults above 138 percent of the federal poverty line in 2012, over two-thirds of adults in this group left the program within six months, and one in five lost coverage due to failure to pay.[1] It is more likely that these individuals who left the program then used more emergency room care as access to outpatient care was reduced.

- A new report about Indiana's Medicaid waiver program finds that nearly 57,189 people missed a payment and either lost coverage or never fully enrolled because of it, between February 2015 and November 2016. That's close to three out of 10 eligible Hoosiers earning above the poverty line who either tried to enroll or did enroll[2].

- A review of premium use in Michigan, Iowa and Indiana indicates that "Premiums are unaffordable for those who are subject to them, causing some enrollees to accumulate debt or be dropped from the program".[3]

[1] Alexandra Gates and Robin Rudowitz, "Wisconsin's BadgerCare Program and the ACA," Kaiser Family Foundation, February 2014.

[2] http://sideeffectspublicmedia.org/post/complicated-rules-are-hindering-access-indiana-s-medicaid-program-experts-say?utm_content=buffer48735&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

[3] Callow, Andrea. "Charging Medicaid Premiums Hurts patients and State Budgets." Families USA. familiesusa.org /product/charging-medicaid-premiums-hurts-patients-and-state-budgets. April 2016.

These reports suggest that 20-30% of enrollees will lose coverage. However the table on p. 16 of the draft waiver application shows only a modest reduction in enrollees, which is at odds with what we would expect based on the experiences documented above. Given this the DHS might want to explain their rationale for these projections.

Additionally, many recipients will have logistical problems paying premiums.

- In addition to their limited budget, many are without a bank account, credit card, or other means to easily pay monthly premiums. An *FDIC National Survey of Unbanked and Underbanked Households*, published in October 2014, found that 7.7% of US households were "unbanked" in 2013, and an additional 20% were underbanked. Minority households had less access: among Black households 20% were unbanked" and 33% underbanked; and data for Hispanic households indicated that 17.9% were unbanked and 28.5% were underbanked.[4]

- The lack of access to a bank account creates significant barriers to conducting basic financial transactions such as paying monthly premiums. Studies have shown that Medicaid participants have trouble affording even modest premiums, and that premiums can impede access to necessary care, and increase use of emergency rooms and uncompensated care.[5]

The DHS needs to identify how such individuals will pay their premiums.

MHA recommends that co-payments for emergency department (ED) use should not change from current levels.

- Indiana is currently the only state to receive CMS approval for special cost-sharing waiver authority to implement a copayment for Medicaid beneficiaries, and it's for people who use the ED for non-emergent purposes. Wisconsin's amendment goes beyond Indiana's policy to impose cost-sharing on all ED use for this population which could deter beneficiaries from seeking necessary emergency care and have a detrimental effect on their health.

Access to an emergency room is an important part of the continuum of care and therefore not always inappropriate. The lack of access to timely outpatient services for mental health care is a significant issue in many areas of Wisconsin—as the DHS' Medicaid Fee for Service Access Study made clear—and sometimes makes the emergency department the only access point, even if this is a less than desirable situation. Medicaid recipients should not bear the cost for these access issues. An individual who chooses not to utilize emergency departments due to costs may end up in more costly settings such as inpatient or correctional.

Work Requirement

MHA supports the exemptions to the work requirement, which includes individuals with mental illnesses.

[4] Susan Burhouse, Karyen Chu, Ryan Goodstein, Joyce Northwood, Yazmin Osaki, Dhruv Sharma. "2013 FDIC National Survey of Unbanked and Underbanked Household." https://www.fdic.gov/householdsurvey/2013/index.html. October 2014

[5] Callow, Andrea. "Charging Medicaid Premiums Hurts patients and State Budgets." Families USA. familiesusa.org /product/charging-medicaid-premiums-hurts-patients-and-state-budgets. April 2016.

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We also recommend the addition of language to the waiver to explicitly exempt these same groups from the 48-month limit. This seems to be implied but the application does not explicitly state that a participant who is exempt from the work requirement will not accrue time towards the 48-month limit.

We also have a concern that people participating in AODA treatment programs are exempt from the work requirement but not those who might be seeking such treatment but who are unable to receive it due to lack of available programs. As with mental health services, access to AODA treatment services is very poor in many parts of the state. Elements of this waiver will attempt to address this but are unlikely to result in significant improvements over the short term.

MHA notes that available data about this population calls into question whether a problem currently exists that the waiver is trying to address. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.[6] Based on this data it would appear that virtually all current enrollees would either meet the work requirement or one of the exemptions.

Drug Testing

MHA supports screening for alcohol and drug use as a key part of preventive care and within the context of the client/provider relationship. MHA has been supportive of efforts such as Screening, Brief Intervention and Referral to Treatment which seek to accomplish the same goals as this proposed waiver component. However, in the context of the health care relationship such screening and intervention does not carry the same legal and punitive risks for individuals.

<u>However, MHA opposes the drug screening and testing requirements in the waiver because we are concerned they would likely deter some people from seeking coverage and would not be the best use of funds.</u>

- The legal consequences of a positive drug test outside of the patient/provider relationship might deter individuals from getting needed health care. Or it might cause individuals to simply lie on the screening tool, undermining the purpose of the screening.

- The process itself can be experienced as invasive and burdensome and may require taking time off work and finding transportation for a separate trip to the Medicaid office.

- An assessment of seven state programs that drug-test applicants for TANF found that they've identified very few drug users: in fact, TANF applicants have lower rates of drug use than the general population.[7]

Moreover, Wisconsin admits that treatment may not even be available given the current demand for treatment, which undercuts its rationale for requiring testing. Given that there is currently a shortage of

[6] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[7] Bryce Covert, "What 7 States Discovered After Spending More Than $1 Million Drug Testing Welfare Recipients," Think Progress, February 2015.

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substance use disorder treatment and prevention programs, and waitlists of people in need of treatment, it would be more impactful to use these funds to develop provider capacity.

Waiver of IMD Exclusion for Inpatient Substance Use Disorder Treatment

MHA supports this narrowly targeted waiver of the IMD exclusion which would allow Medicaid coverage for 22-64 year olds only for inpatient substance use disorder treatment up to 90 days. There is currently a lack of capacity for residential treatment for substance user disorders, and in many areas of the state there are waiting lists for such treatment. As many people with mental illnesses have a co-occurring substance use disorder, enhanced access to substance use disorder treatment will positively impact the ability to address mental health concerns.

However, MHA believes that the State must continue to invest in resources in the community to ensure access to services in the least restrictive environment and that services in these facilities must be subject to the Uniform Placement Criteria to ensure they are necessary and appropriate and the least restrictive setting in which services can be provided. Recognizing the historical concern about warehousing of people with mental illnesses that the IMD exclusion addresses it is important that this waiver does not open the door to more extensive use of longer term institutionalization.

Healthy Behavior Incentives

While MHA opposes the premium structure, as noted above, if it is implemented we note that many individuals with mental illnesses will be in the category of individuals for whom the condition is beyond their control. This is especially true with regard to weight gain that is associated with some psychiatric medications. Smoking cessation, while important for people with mental illnesses as with anyone else, is also challenging for this group. Individuals with mental illnesses who continue to smoke should not be prohibited from the premium reduction unless specialized programs are offered.

MHA further offers the following:

- We support the healthy behaviors this element of the waiver seeks to increase.
- We promote programs that are strength-based, and integrated.
- We note that people with mental illnesses want to live healthy lives.
- We suggest that people meeting the requirements of the waiver be exempt from premiums.
- Since this element is modeled after similar incentives in some commercial or self-insured plans, we also recommending including incentives such as health club benefits to support healthy behaviors.
- As noted under our general comments, stakeholders need to be involved in determining how this will be implemented (e.g, if you are taking people's word for it, are they potentially subject to Medicaid fraud?).

Thank you for your consideration of our comments.

Sincerely,

Shel Gross
Director of Public Policy