July 14, 2017

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Request to Amend Wisconsin's § 1115 BadgerCare Project

Dear Sir/Madam:

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals. We appreciate the opportunity to comment on Wisconsin's request to amend its BadgerCare Demonstration Project.

We support Wisconsin's decision to accept federal funds to cover low-income adults through Medicaid. However, NHeLP recommends that HHS not approve the BadgerCare amendments. The amendment application is fundamentally flawed, both procedurally and substantively, and would be harmful to low-income people who need Medicaid coverage to obtain health care.

Procedural defects

Wisconsin's proposal amends a § 1115 demonstration approved by HHS to operate from December 30, 2014 through December 31, 2018. Wisconsin proposes to implement the amendments contained in the application more than one year after it receives approval from the Secretary.[1] Thus, at best, Wisconsin will have only a few months to implement its proposals with significant provisions of the demonstration, including the 48-month time limit on eligibility, well outside the BadgerCare demonstration expiration. The projected timeline is insufficient to implement the proposed demonstration and only makes logical sense if it is assumed that the Secretary will approve an application to renew the demonstration, which is not an appropriate basis for approving the amendment now before the Secretary.

[1] *See* Implementation, BadgerCare Reform Demonstration Project, Section 1115 Demonstration Waiver Amendment Application at § 3.5 (June 7, 2017)(hereinafter "Application").

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Accordingly, HHS should withdraw its June 15, 2017 Letter of Completeness and require the State to propose amendments with time frames that are consistent with a demonstration project, as required by § 1115.

HHS authority and § 1115

To be approved pursuant to § 1115, Wisconsin's amendment must:

- propose an "experiment[], pilot or demonstration;"
- waive only provisions of 42 U.S.C. § 1396a;
- be likely to promote the objectives of the Medicaid Act; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[2]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are too poor to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.[3] As explained below, Wisconsin's proposals to impose a premium-or-lock-out requirement, emergency room copayments, work requirements, time limits on eligibility, drug testing, and IMD expansion cannot be approved because, separately and together, they are inconsistent with the provisions of § 1115.

Premium-lock-out requirements

Wisconsin seeks to impose monthly premiums for persons between 51-100% FPL. Individuals who fail to pay the premiums will be terminated from the program, locked out for six months, and must pay all unpaid premiums prior to reenrolling.[4] Individuals whose answers to a risk assessment reveal no risky behaviors will pay a reduced premium, while others are subject to increased premiums.[5]

The premium-lock-out request is not experimental, will not promote Medicaid's objectives, and it ignores § 1115's requirement that experiments be approved only to the extent and for the period needed to carry out the experiment. Wisconsin has *already* implemented a § 1115 waiver with a premium requirement, and the results demonstrated that the premiums were not consistent with the objectives of the Medicaid program.[6] Wisconsin implemented premiums for BadgerCare adult enrollees at higher income levels (<133% FPL) in 2012 and found significant declines in enrollment across all effected eligibility categories.[7] These results simply added to the findings from more than 40-years'

[2] 42 U.S.C. § 1315(a).
[3] See 42 U.S.C. § 1396-1.
[4] Application, § 3.4.1 Monthly Premium.
[5] Application, § 3.4.2 Healthy Behavior Incentives.
[6] CMS, Waiver Authority, Badger Care (No. 11-W-00125/5) (Apr. 27, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/BadgerCare/wi-badgercare-amend-appvl-4272012.pdf.
[7] Univ. of Wisconsin, Population Health Inst., *Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2012 Waiver Provisions TECHNICAL & SCIENTIFIC REPORT,* Table C3 Exits among BadgerCare Plus members required to pay premiums within first year of July 2012 policy change, by Eligibility group and FPL band (Dec. 8, 2014); https://uwphi.pophealth.wisc.edu/publications/other/badgercare-2012-waiver-evaluation-final.pdf.

of well-known and redundant research into the effects of premiums on low-income individuals, namely that premiums cause low-income individuals to lose health care coverage, and they increase expenditures when sick but uninsured individuals delay care until they need emergency, urgent, and/or acute care.[8] Most recently, the Kaiser Family Foundation reviewed the research from 65 studies and concluded that premiums create significant barriers to low-income people obtaining Medicaid coverage, with those living below the poverty level particularly affected because they are most likely to become uninsured and to have great health care needs.[9]

Wisconsin's request to impose the premium-lock-out program also cannot be approved because § 1115 only authorizes the Secretary to waive requirements of 42 U.S.C. § 1396a. The statutory authorizations for premiums are contained in independent, free-standing requirements set forth at 42 U.S.C. §§ 1396o, 1396o-1. While these statutes provide states with a great deal of flexibility to impose premiums and cost sharing, they prohibit imposing premiums on persons with incomes below 150% FPL. The Secretary should deny this request because he does not have the authority to grant it under § 1115.

Tethered to the improper premiums, the lock out request should also be denied. In addition to the problems noted above, lock outs will, with certainty, harm individuals who need coverage but cannot afford to pay their past debts. Lock outs blatantly contradict the basic purpose of Medicaid, to provide medical assistance, and the well-established best practice of encouraging continuity of care in health coverage. We note they will also harm Wisconsin's provider infrastructure, as providers will continue to treat uninsured patients and face high uncompensated care costs. The lock out is not likely to promote Medicaid's objectives as is required for a § 1115 waiver.

Finally, there is nothing new or experimental with Wisconsin's proposal to impose heavier premiums based on health risk assessments. Such measures have been extensively studied. For example, a study in *Health Affairs* found that smokers in states with a surcharge had a lower take-up of available insurance coverage than their non-smoking counterparts.[10] If smokers forgo health care due to the inability to pay an increased premium, they will miss out on more than just tobacco cessation services; they also will not get the care that could detect a tobacco-related cancer at an early stage or treat a tobacco-caused illness, such as COPD.

Wisconsin takes the wrong approach by doubling the premiums of individuals who fail to "manage" health risk behaviors, rather than providing them with access to treatment and other interventions. In conclusion, the premium-lock-out request should be denied because it does not meet the requirements of § 1115.

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[8] *See*, *e.g.*, Samantha Artiga et al., KAISER FAM. FOUND., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/; David Machledt & Jane Perkins, NAT. HEALTH LAW PROGRAM, *Medicaid Premiums & Cost Sharing and Premiums* (March 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

[9] Kaiser Fam. Found., *supra* n. 8.

[10] Abigail Friedman et al., "Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation," *Health Affairs*, July 2016, http://content.healthaffairs.org/content/35/7/1176.abstract.

Emergency department copayments

In its Application overview, Wisconsin seeks to impose a "graduated copay" for emergency department (ED) use.[11] In the body of the application, Wisconsin proposes to impose a flat $8 copay for each use of the ED (*i.e.*, emergency or non-emergency).[12] These copayments do not meet the requirements of § 1115.

The copayments are not experimental, and they are not likely to promote the objectives of the Medicaid Act. The research cited in the above section on premiums also discusses research regarding copayments and similar charges and is incorporated by reference here.[13] In short, over 40-years' of research has demonstrated that these proposed copayments are harmful to low-income people, causing them to forego needed care.

The copayments also conflict with non-waivable provisions of the Medicaid Act regarding copayments. In provisions located outside of § 1396a, the Medicaid Act provides states with flexibility to establish copayments, but it also includes beneficiary protections.[14] Among these are limits on the copayment amount and requirements that emergency room cost sharing be tied only to *non-emergency* services furnished to an individual in the hospital ED, *only if* the following conditions are met: (1) the individual has an actually available and accessible alternative to the ED for the service, and the hospital informs the individual, after conducting the EMTALA screen, of the copayment and the name and location of alternative service providers, along with a referral.[15] These protections are not built into this waiver, and, therefore, it should be denied.

Work requirements

Wisconsin seeks to impose a work requirement on individuals enrolled in BadgerCare.[16] If an individual does not meet the requirement for a given month, the month will count toward a 48-month limit on Medicaid eligibility, discussed below. The stated purpose of the work requirement is "to encourage members to seek work and reach self-sufficiency."[17]

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Wisconsin to condition Medicaid eligibility on compliance with work activities (and, thus, has never done so). Work requirements are an illegal condition of eligibility beyond the Medicaid eligibility criteria clearly enumerated in federal law. Medicaid is a medical assistance program, and although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical

[11] Application, § 3.2 Demonstration Project Overview.
[12] Application, § 3.4.2.1 Copays for Emergency Department Utilization.
[13] See, *e.g.*, David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013); Karoline Mortenson, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 HEALTH AFFAIRS 1643 (2010).
[14] *See* 42 U.S.C. §§ 1396o, 1396o-1.
[15] *Id*. § 1396o-1(e).
[16] Application, § 3.4.4.1 Employment and Training.
[17] Application, § 6.0 Evaluation Design.

assistance to all individuals who qualify under federal law. As courts have held, additional eligibility requirements are illegal.[18]

Section 1115 cannot be used to short circuit the Medicaid protections, because there is no basis for finding that work search requirements are likely to assist in promoting the objectives of the Medicaid Act.[19] As noted earlier, the purpose of Medicaid is to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services and to furnish "rehabilitation and other services to help [such individuals] attain or retain capability for independence or self-care.[20] Conditioning Medicaid eligibility on completion of a work requirement gets it exactly backwards by blocking access to care and services that help individuals attain and retain independence or self-care and, as a result, be able to work. Research confirms that *Medicaid coverage allows individuals to obtain and maintain employment*. For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage has made it easier to continue working. Among enrollees who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.[21]

The work requirement will be particularly counterproductive for the many individuals with chronic conditions that affect their ability work, but do not qualify them for disability benefits. A recent study by the Kaiser Family Foundation found that 35% of adult Medicaid enrollees who were not receiving disability benefits and did not have a job reported illness or disability as their primary reason for not working.[22] While the amendment indicates that the work requirement will not apply to beneficiaries who are diagnosed with a mental illness or who are physically or mentally unable to work, the evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be – often due to verification requirements–and are more likely than other individuals to lose benefits.[23]

Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical and mental health issues are disproportionately

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[18] See, *e.g.*, *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children did were not getting immunizations, check-ups, or were missing school because regulation was inconsistent with Medicaid and TANF statutes); *see also Dalton v. Little Rock Family Planning Services*, 516 U.S. 474, 478 (1996) (holding state coverage of abortion services needed to be consistent with federal provisions setting forth the circumstance for that coverage).

[19] By contrast, as far back as the 1970s, states obtained section 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, http://aspe.hhs.gov.hsp/isp/waiver2/waivers.htm.

[20] 42 U.S.C. § 1396-1.

[21] Ohio Dep't of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, (2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[22] Rachel Garfield, Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[23] *See, e.g.*, Andrew J. Cherlin et. al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 Soc. Serv. Rev. 387, 398 (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health").

likely to be sanctioned for not completing the work requirement.[24] Such individuals may not understand what is required of them, or may find it difficult to complete the necessary paperwork or to travel to appointments to be assessed for an exemption.

Evidence from the Supplemental Nutrition Assistance Program (SNAP) is particularly relevant, as the BadgerCare work requirement is modeled on work requirement in the Wisconsin Food Share Employment and Training (FSET) program. Researchers have expressed concern that states might incorrectly determine that many of the nearly 20% of all SNAP participants who have a disability, but do not receive disability benefits, are subject to the work requirement.[25] One study from Franklin County, Ohio found that one-third of individuals referred to a SNAP employment and training program in order to keep their benefits reported a physical or mental limitation, and 25% of these individuals indicated that the condition limited their daily activities. Additionally, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.[26]

Because conditioning Medicaid eligibility on completion of the work requirement will disqualify individuals with chronic and disabling conditions, the requirement implicates the civil rights protections contained in the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.[27] These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they not be waived under § 1115 or under any other authority of the Secretary.[28]

In addition, extensive research reveals that a mandatory work requirement does not effectively increase self-sufficiency. Studies of cash assistance programs have already established that a work requirement does little to increase stable, long-term employment and does not decrease poverty.[29] In fact, work requirements have had the reverse effect leading to an increase in extreme poverty in some areas of the country, as individuals who do not secure employment lose their eligibility for cash assistance.[30]

Again, evidence from Wisconsin's FSET program is instructive. Between April 1, 2015 and March 31, 2017, only approximately 18,299 FSET participants gained employment. This number includes both the Food Share recipients who are required to participate in the program and voluntary enrollees.[31] Over the same time period, the work requirement and time limit for childless adults caused more than three times the number of participants–over

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[24] *See, e.g.*, Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004) (Departmental Paper University of Pennsylvania School of Social Policy and Practice), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.
[25] Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities,* 4, 14 (2014).
[26] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.
[27] 42 U.S.C. § 12312; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (prohibiting recipients of federal funds from discriminating on the basis of disability).
[28] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).
[29] LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't' Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. Pol'y Analysis & Management 231, 234 (2016).
[30] *Id*.
[31] *FoodShare Employment and Training (FSET) Program Cumulative Data*, Wisc. Dep't of Health Servs. (May 5, 2017), https://www.dhs.wisconsin.gov/initiatives/fset-cumulative.htm.

70,000 individuals–to lose access to critical food assistance.[32] In addition, the largest FSET provider in the state has faced criticism from the U.S. Department of Agriculture for its failure to help participants secure long-term, stable jobs.[33]

In the amendment application, Wisconsin notes that 58% of FSET participants do not meet the work requirement and assumes that the percentage will be the same among BadgerCare enrollees who are subject to the work requirement.

A far more productive approach would be to connect BadgerCare enrollees to properly-resourced voluntary employment programs. Studies show that these voluntary employment programs increase employment and income among low-income individuals. For example, a rigorous evaluation of Jobs Plus, a voluntary employment program for public housing residents, found that the program produced substantial and sustained gains in earnings when fully implemented.[34] The state also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.

In summary, the work requirement stands Medicaid's purpose on its head by creating barriers to coverage and the pathway to health that the coverage represents. The end result of this policy will likely be fewer people with Medicaid coverage and more uninsured people delaying treatment and later seeking uncompensated care in hospitals and federally qualified health centers. There will be more gaps in coverage, meaning more expensive treatment when eligibility is eventually regained. Hospitals and community health centers will suffer financially as they are expected to treat more people with chronic or acute illness with less funding. For these and other reasons, HHS has consistently denied states' requests to impose a work requirement on individuals who are seeking medical assistance through the Medicaid program.

Finally, we note that most individuals who will be subject to the requirement are already working and do not need additional "encouragement" to obtain or maintain employment.[35]

Time limit on eligibility

Wisconsin proposes to impose a 48-month limit on BadgerCare eligibility for adults, after which enrollees will be terminated from the program for six months.[36] According to the State, the time limit will help contain health care costs.[37] However, these time-limits will harm individuals who need coverage and, thus, contradict the basic purpose of Medicaid to provide medical assistance. We note that time limits will also harm Wisconsin's provider

[32] *Id.*
[33] *See, e.g.*, Letter from Tim English, Regional Admin., U.S. Dep't of Agriculture, Food & Nutrition Serv., to Linda Seemeyer, Sec'y, Wisc. Dep't of Health Servs. (October 19, 2016).
[34] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.
[35] Rachel Garfield, Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (finding that almost 80% of adults who are enrolled in Medicaid but do not receive SSI live in families with at least one worker, and almost 60% are working themselves).
[36] Application, § 3.4.4 Time Limit on Medicaid Eligibility.
[37] *Id.*

infrastructure, as providers will continue to treat uninsured patients. To our knowledge, such a time-limit on eligibility has never been allowed by HHS.

Time limits applied to medical assistance are by nature arbitrary and capricious. Many individuals face serious or chronic health challenges that impede their ability to work, even if they may not technically qualify as disabled or medically frail. Medicaid offers dependable and affordable coverage that supports their ability to generate income (full-time or part-time) and may prevent them from otherwise becoming fully destitute. Such individuals are also more likely to have lower incomes over an extended period of time (and thus be impacted by this proposed policy). Conditioning eligibility on an arbitrary cumulative time limit would likely have a disproportionate impact on such individuals and, as a result, may violate the Americans with Disabilities Act and § 504 of the Rehabilitation Act—provisions that the Secretary is not authorized to waive as part of a § 1115 experiment.

Finally, we note that there is no corollary for time-limiting medical coverage in the Marketplace or in commercial health insurance, which both serve a higher income population with fewer health care needs. Therefore, such time limits are not even consistent with Wisconsin's stated objective to "Design a medical assistance program that aligns with commercial health insurance design to support members' transition from public to commercial health care coverage."[38]

Mandatory drug testing and coerced treatment

Wisconsin seeks permission to impose mandatory drug screening, testing, and treatment as a condition of eligibility for medical assistance.[39] BadgerCare applicants would undergo mandatory screening for current and prior use of controlled substances. Individuals whose screening "indicate[s] possible abuse" of a controlled substance would be required to undergo drug testing. Those testing positive, and who cannot provide evidence of a valid prescription, would be required to undergo treatment for Substance Use Disorder (SUD).

Those who refuse screening, testing, or treatment are denied enrollment in Medicaid. At its foundation, the proposed program is predicated upon using Medicaid eligibility and access to health care services as an external motivator to coerce beneficiaries into participation in SUD treatment programs—an approach of questionable legality and one that is not supported by the standards of care.

To begin with, this request should be denied because there is nothing experimental about mandatory drug testing and treatment. Congress has expressly allowed drug testing in some other public benefit programs (but not Medicaid), and these programs have been thoroughly studied. As Wisconsin acknowledges in its amendment application, *"[E]vidence supports that members are much more likely to complete treatment when they enter it voluntarily rather than as a condition of eligibility* […]."[40] In addition, the proposal conflicts with Medicaid's purpose by barring individuals who do not comply with the testing protocol not only from medical assistance to treat the SUD but from all medical assistance treatment and services they may need. Given the importance of medical assistance, the compelled

[38] Application, § 3.1 Project Objectives.
[39] Application, § 3.4.5 Substance Abuse Identification and Treatment.
[40] *Id*. (emphasis added).

screening and testing protocol implicates protections guaranteed by the Fourth and Fifth Amendments to the U.S. Constitution, which of course, cannot be waived by the Secretary.

HHS should also reject Wisconsin's request to impose mandatory drug testing and treatment as a condition of Medicaid eligibility because the proposal does not reflect the standard of care for SUD treatment. This unprecedented proposal for coerced treatment as a condition Medicaid eligibility would interfere with the doctor-patient relationship, create barriers to and deter use of health services,[41] and contribute to stigmatization of persons with SUD, driving people with significant health needs away from care. Taken together, these consequences make this proposal inconsistent with Medicaid's objective of providing medical assistance to low-income people.

Wisconsin's proposal does not align with the standard of care for SUD treatment because it coerces participation by making Medicaid eligibility contingent upon participation in SUD treatment. Research overwhelmingly finds that a patient's internal motivation and readiness to participate in a SUD treatment program are predictive of better treatment outcomes, including treatment retention and completion outcomes.[42] By contrast, patients who lack internal motivation and readiness to participate in treatment but who experience high levels of external motivation, such as legal consequences, the threat of withdrawn access to services, or coercion from family, friends, and health care providers, are less likely to complete treatment programs and have long term success.

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[41] Research has established that compulsory drug testing deters people from seeking care. *E.g.*, Werb, D. et al, *The effectiveness of compulsory drug treatment: A systematic review*, International Journal of Drug Policy , Volume 28 , 1 – 9 (Feb. 2016), http://www.ijdp.org/article/S0955-3959(15)00358-8/fulltext., Am. Soc'y of Addiction Med., *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* 42 (2015), https://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline; Am. Cong. of Obst. & Gyn., *Committee Opin.* (May 2012), www.acog.org (last visited June 30, 2017); Am. Cong. of Obst. & Gyn., Toolkit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction 5, https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf ("Imposing mandatory urine testing within the Medicaid program disproportionately burdens low-income communities and communities of color and exacerbates the consequences of false positive results by jeopardizing women's access to health care.").

[42] *See*, *e.g.*, D. Longshore & C. Teruya*, Treatment motivation in drug users: a theory-based analysis,* 81 Drug & Alcohol Dependence 179, 183-186 (2005) (noting readiness to participate in treatment predicted treatment retention and resistance to participation in treatment predicted drug use, particularly for individuals whose treatment referral was coercive); Allan Zeldman, Richard M. Ryan, & Kevin Fiscella, *Motivation, Autonomy Support, and Entity Beliefs: Their Role in Methadone Maintenance Treatment*, 23 J. of Soc. & Clin. Psy. 675, 692 (2004) *("*These findings suggest that external motivation, unless accompanied by high levels of internal motivation, may impede the achievement of positive treatment outcomes."); Karen A. Urbanoski*, Coerced addiction treatment: Client perspectives and the implications of their neglect*, 7 Harm Reduc. J. 1, 6 (2010) ("There is evidence that initially beneficial outcomes of legally mandated treatment do not persist after the threat of sanctions is lifted."); Rabia Bilici, et al, *Motivation for treatment in patients with substance use disorder: personal volunteering versus legal/familial enforcement*, 10 Neuropsychiatric Disease & Treatment 1599, 1602-03 (2014) ("Our results suggest that the circumstances of admission may affect levels of motivation for treatment and that motivation may be higher in patients undergoing treatment voluntarily"); *see also* Sharon M. Kelly et al, *Predictors of methadone treatment retention from a multi-site study: A survival analysis*, 117 Drug & Alcohol Dependence 170 (2011); Alexandre B. Laudet & Virginia Stanick, *Predictors of motivation for abstinence at the end of outpatient substance abuse treatment*, 38 Journal of Substance Abuse Treatment 317 (2010); D. Dwayne Simpson et al., *Drug abuse treatment retention and process effects on follow-up outcomes*, 47 Drug & Alcohol Dependence 227 (1997); Richard M. Ryan et al., Robert W. Plant, & Stephanie O'Malley, *Initial Motivations for Alcohol Treatment: Relations with Patient Characteristics, Treatment Involvement, and Dropout*, 20 Addictive Behaviors 279 (1995).

Wisconsin's proposed protocol for drug testing also raises concern because it relies on drug test results as the determining factor for whether or not a patient will be required to participate in a treatment program. This does not align with the standard of care. The American Society of Addiction Medicine (ASAM), a professional organization with over 4,300 members and a leader in the development of professional and clinical standards, recently published a guide on the "Appropriate Use of Drug Testing in Clinical Addiction Medicine." The organization strongly emphasizes that drug test results should not be over-interpreted. For example, a positive test result is not sufficient evidence for a SUD diagnosis nor does a negative test result necessarily indicate that the patient does not have SUD.[43] In other words, drug testing has inherent limitations and cannot be relied upon as the sole measure of a patient's substance use.[44] The American Medical Association's (AMA) policy on drug testing corroborates this position.[45]

Doctors, working with patients, are best equipped to decide when, where, and how to treat someone for any medical condition, including SUD. The policy of withholding access to Medicaid until an applicant agrees to treatment interferes with this doctor-patient relationship and jeopardizes the health of individuals who may need care for other medical conditions but who are not yet ready to participate in a SUD treatment program. This barrier to care would be especially harmful for people living with multiple medical conditions, such as mental health, HIV, and cancer, who need higher levels of care. Deciding which medical condition should be treated first is best left to the judgment of a medical professional, not an arbitrary, one-size-fits-all condition of eligibility.

This proposal will have a disparate impact on people with chronic and disabling conditions, including mental illness, thus implicating a violation of Title II of the ADA. As noted above, the Secretary cannot waive the ADA.[46] To give just one example, the screen is to detect current and prior drug use; however, the ADA prohibits discrimination against individuals with disabilities who previously used illegal drugs.

Finally, even if the State could implement the testing as a cost saving measure, information gathered on similar drug testing requirements implemented in several states' TANF programs shows it will not achieve that goal. In 2016, the Center for Law and Social Policy collected information from 13 states that had made drug screening and testing an eligibility condition for TANF. (In contrast with Medicaid, Congress has authorized drug testing in TANF, a federal assistance program that does not include health care.) In states that had implemented the policies, few applicants had been identified as likely to have SUD and even fewer tested positive for recent substance use.[47] In 2012, Florida implemented a short-lived drug testing requirement for cash assistance applicants. Florida tested 4,086 applicants over a four-month period, during which only 2.6% of applicants failed the drug

[43] American Society of Addition Medicine, *Appropriate Use of Drug Testing in Clinical Addiction Medicine* (April 2017), at 11-12, https://www.asam.org/quality-practice/guidelines-and-consensus-documents/drug-testing.
[44] *Id.* at 12.
[45] American Medical Association, *Drug Abuse: Drug Testing* H-95.985 (2016), https://policysearch.ama-assn.org/policyfinder.
[46] *See* 42 U.S.C. § 12312.
[47] Randi Hall, Center for Law and Social Policy, *Drug Testing and Public Assistance* (Oct. 2016), http://www.clasp.org/resources-and-publications.

test. The drug testing requirement cost the state an extra $45,780 in just a four-month period and identified very few individuals with potential SUD.[48]

Wisconsin's proposed drug screening and testing requirement does not align with the standard of care for SUD treatment, would create barriers to care that could negatively impact the health of the state's Medicaid population, and is not a cost-effective use of limited state funds. It does not achieve an experimental purpose and is inconsistent with Medicaid's objectives. Its compulsory nature implicates constitutional violations, and it may also violate the ADA. HHS has no authority to approve any waiver that includes the proposed drug screening, testing, and treatment requirement.

IMD exclusion

Wisconsin seeks HHS permission to waive a long-standing statutory requirement that prohibits the use of federal Medicaid funds to provide care or services in an institution for mental diseases.[49] The waiver would allow Wisconsin to provide in-patient SUD treatment for up to 90 days at residential treatment facilities of more than 16 beds to the entire Wisconsin Medicaid population, and not just childless adults.[50] HHS has no authority to waive the IMD exclusion through § 1115. Section 1115 may only be used to waive requirements of 42 U.S.C. § 1396a. The IMD exclusion is set forth at § 1396d(a)(29)(B).

While there is a need for short-term crisis services, the IMD exclusion has provided an incentive for states and managed care plans to use IMDs on as limited a basis as possible. The trend has been to develop smaller, more community-based facilities that do not qualify as IMDs. They are often more patient-centered, and because they are likely to be spread throughout the state, usually allow an individual to keep closer ties with their family and community supports, which, of course, are requirements of the ADA.

Conclusion

In summary, while NHeLP supports the use of § 1115 to implement experiments that the provision authorizes, we strongly object to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. As demonstrated above, the Wisconsin application contains numerous provisions that are inconsistent with the standards of section 1115 and with other provisions of law. We appreciate your consideration of our comments. If you have questions about these comments, please contact Wayne Turner (turner@healthlaw.org) or Jane Perkins (perkins@healthlaw.org).

Respectfully submitted,

Jane Perkins
Legal Director

[48] *Id.*
[49] Application, § 3.4.5.1 Addressing Substance Abuse in Wisconsin.
[50] *Id.*