May 19, 2017

Michael Heifetz, Medicaid Director
Wisconsin Department of Health Services
P.O. Box 309
Madison, WI 53707-0309
Submitted to: Wisconsin1115CLAWaiver@dhs.wisconsin.gov

RE: BadgerCare Reform Demonstration Waiver Proposal – UnitedHealthcare Community Plan Comments

UnitedHealthcare Community Plan of Wisconsin appreciates the opportunity offered by the Wisconsin Department of Health Services (DHS) to provide feedback on the state's proposed amendment to its current 1115 Demonstration Waiver, known as the BadgerCare Reform Demonstration.

We support the state's goal to leverage private sector health care models to drive better quality care at a sustainable cost for the childless adult population (CLA). Wisconsin has previously demonstrated its innovative approach to providing access to health coverage for Wisconsinites who meet the CLA criteria in implementing the initial BadgerCare Reform Demonstration in 2014. Wisconsin is now well-positioned to build on those efforts to create a new system of care focused on promoting accountability, self-sufficiency, and healthy behaviors for the CLA population.

As an experienced Health Management Organization (HMO), UnitedHealthcare Community Plan is serving 166,000 members in the Wisconsin Medicaid program today. Through our national footprint, UnitedHealthcare Community & State serves approximately 5.8 million members across 24 states, including 13 managed long term care programs, two Financial Alignment Demonstrations, and Duals Special Needs Plans (DSNP) in 16 states. As an enterprise, UnitedHealthcare has extensive experience serving individuals in the commercial health insurance market, leveraging hallmarks of private sector insurance design, including health behavior incentives, health risk assessments, and premium collections, that Wisconsin is interested in implementing in the BadgerCare Reform program.

Rooted in our experience in both the Medicaid and commercial markets, our enclosed comments focus on program design elements we recommend that DHS consider as the state develops the details of the BadgerCare Reform program.

We believe these comments will assist the state in achieving its goals of a sustainable program that makes use of private sector models to promote healthy behavior.

Our comments are organized by three primary considerations:

- Ensuring Continuity of Care;
- Defining the Role of the State vs. HMOs; and
- Incentivizing Healthy Behaviors

The design of the BadgerCare Reform program is ambitious and will require a significant amount of new processes to be developed by the state, HMOs, and providers to administer. The program design will also require investment in ensuring the readiness of the state IT and infrastructure to support the new levels of communication and data sharing that will be necessary to support program goals.

Ensuring Continuity of Care

Wisconsin's proposed BadgerCare Reform proposal is focused on driving greater levels of consumer engagement and responsibility in health care consumption among CLA members. One of the primary avenues the proposal emphasizes an increased level of engagement is by tying completion of certain requirements to Medicaid benefits.

Under the proposal, members can maintain their coverage if they meet specific work requirements, successfully meet their premium obligations, and complete their health risk assessment (HRA) and drug screen/test if-required.

If a member does not complete certain requirements outlined in the proposal, they will lose access to their Medicaid benefits for a six-month period. During these six-month periods, the state provides avenues for members to complete their requirements and regain coverage at any time.

The tactic to limit access to benefits for six-months at a time could prove a strong incentive for members to complete their requirements and meet premium obligations. However, such an approach could negatively impact continuity of care for members in the CLA group, driving up overall health care costs for the population.

Research has shown that continuity of care, particularly among the Medicaid population, is critical to keeping individuals healthy and maintaining health care costs. According to the Kaiser Family Foundation, interruptions in Medicaid coverage can lead to greater emergency department (ED) use as well as significant increases in hospitalization for conditions that can be managed on an ambulatory basis.[1]

Focusing just on health care cost, studies have shown that the average monthly medical expenditure for an adult enrolled in Medicaid for 12 months is about two-thirds the level of a person enrolled for just six months, and half the level of a person enrolled for just one month.[2]

While Wisconsin's coverage suspension is limited to six months, research has shown that even short-term losses of coverage can have significant impact. Studies in California and Oregon of low-income

[1] Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence". August 2013. Available at: http://kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/

[2] The George Washington University Department of Health Policy, "IMPROVING MEDICAID'S CONTINUITY OF COVERAGE AND QUALITY OF CARE." July 2009. Available at: https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_66898AB4-5056-9D20-3D5FC0235271FE99.pdf

adults who lost their Medicaid coverage for short periods found significant declines in basic measures of access, such as unmet health care and medication needs, and likelihood of a recent primary care visit, as well as significant declines in health status.[3]

Additionally, maintaining continuity of care is critical to the success of Wisconsin's Medicaid HMOs in managing individuals effectively. When a member has a gap in coverage, the HMO is no longer able to manage the services the individual is accessing or provide them care management or coordination that could help them make the most efficient and cost-effective choices for their care. Additionally, HMOs will no longer have access to clinical data that could inform care needs and/or interventions that can prevent the onset of chronic conditions.

To maintain the level of continuity of care that Wisconsin experiences today, we recommend that in lieu of limiting access to all Medicaid benefits for six months that Wisconsin instead deploy a tiered benefit system, similar to the structure of the Healthy Indiana Plan 2.0 (HIP 2.0) launched in 2014.

Under HIP 2.0, qualifying individuals at or below 100% federal poverty level (analogous to the Wisconsin CLA population) who meet specified requirements receive access to a benefit package that includes the state's standard Medicaid package plus additional coverage including vision. In the event requirements are not met, individuals in this group lose access to this benefit package and instead receive a "skinnier" package of Medicaid benefits. These individuals maintain basic coverage and enrollment with their HMO, therefore reaping the benefits of continuity of coverage. However, this structure also provides incentive for members to meet their obligations to maintain more robust benefits.

Wisconsin could also alternatively consider a hardship exemption for members who are engaged in their health care but for personal reasons are not able to meet all requirements to maintain their coverage. States that have begun implementing premium requirements for Medicaid, such as Arizona and Michigan, have leveraged hardship exemptions. Hardship exemptions allow the continuity of care while the member addresses their challenges with meeting requirements.

Additionally, we recommend that the state consider the need for notice and education to members regarding the status of their payments, as well as the length of the grace period, in order to help members maintain continuity of coverage. Under the HIP 2.0 program in Indiana, for example, members are allowed 60 days to make a late payment before their coverage status changes. Implementing a grace period, coupled with appropriate member communication and education, will help maintain continuity of coverage, while providing members the opportunity to make a payment in the event they were unaware one was due but intend to maintain coverage.

[3] Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence". August 2013. Available at: http://kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/

UnitedHealthcare Community Plan

Defining the Role of the State vs. HMOs

Implementing the reforms outlined in the BadgerCare Reform proposal will require significant new operational and administrative processes for both the state and the HMOs. As these new processes will be critical to the overall success of BadgerCare Reform, we recommend that DHS carefully consider the roles for both the state and the HMOs in the administration of the program. The proposal as it is currently written does not provide significant detail on how these responsibilities will be managed. Based on our experience, we offer the following recommendations for outlining the roles of the state and the HMOS:

Pre-enrollment processes

We recommend that any new administrative or operational processes related to the BadgerCare Reform program that must occur before an individual is deemed eligible and enrolled in coverage be conducted by the state. Under the current proposal, the drug screening and testing and health risk assessment (HRA) processes would fall into this category. Taking such an approach would allow the state to maintain eligibility determination decisions and streamline the drug screen and testing and HRA processes by keeping them centralized at the state level.

Information collected via the drug screens and on the HRA, including those regarding healthy behaviors, should be shared with the HMOs with which an individual enrolls to inform care management strategies.

Post-enrollment processes

Time limit on Medicaid eligibility + Employment and training: The proposed requirements on time limits for coverage will require significant efforts to educate members on the program changes as well as close coordination with how members' employment and training status is tracked.

As the ultimate determination for eligibility for the program lies with the state, we recommend that the state maintain the official record of when a member's 48-month count begins and ends. Wisconsin should consider clearly defining when coverage officially begins – such as upon first premium payment.

As a part of this effort, we recommend that the state alert the HMO when a member is nearing the end of their eligibility window (recommendation is 6 months prior) so that the HMO can leverage their communications to alert the member that their coverage is coming to an end and provide education regarding the opportunity to re-enroll after 6 months or in the event of an eligibility category change.

Members who meet specified employment and training requirements will not accrue time against their 48-month limit during the time they are working. As eligibility determinations are a state responsibility, we recommend that the state leverage the existing FoodShare Employment and Training (FSET) infrastructure to track whether members are meeting their required employment and training requirements to maintain eligibility. Information as to whether members are meeting these requirements should be shared with the HMOs regularly and HMOs should be alerted in a timely fashion

if members fail to meet these requirements and whether a member will lose coverage due to their employment status change.

Implementation of this provision will significantly increase the volume of individuals accessing FSET employment supports. To ensure members have access to appropriate employment and training opportunities as well as that tracking and reporting regarding member employment status is properly maintained, we encourage the state to assess, test, and confirm readiness of the existing infrastructure to meet the increased demand it will need to support.

Premium calculation and collection + Co-pays: The state and the HMOs will need to work hand-in-glove to ensure that premium –related information is actively maintained and communicated effectively between the state and the HMOs.

We recommend that upon enrollment and annual renewal, which are conducted by the state, that the state determine the appropriate premium level for the member based on their household income, completion of the HRA and their self-reported healthy behavior activity. However, for the ongoing collection of premium payments we recommend that the state leverage the infrastructure of the HMOs. The state and the HMOs will need to work together to ensure timely and accurate information exchange regarding income level and required premiums, as the HMOs do not collect this information today.

Additionally, we recommend that Wisconsin leverage the capabilities of the HMOs to manage and track member co-pays for ED use. As the proposed design increases member co-pays based on ED utilization within given timeframe, the level of co-pay responsibility must be based in claims history and communicated to the provider. HMOs and providers will need to establish channels and protocols for sharing required co-pay levels and whether those obligations are met by the member. The co-pay requirements will likely increase providers' administrative burden. To help limit that burden and ensure program success, providers will require tested capabilities and seamless access to member information from both the state and the HMOs. We recommend that the state consider a single portal in which providers can access member co-pay obligations across all HMOs, rather than each HMO deploying their own technology, which is the current model in Indiana that has proven problematic for the state's program.

Under the proposal third parties such as employers or non-profits would be allowed to pay the premium on behalf of members. We recommend that Wisconsin reconsider this provision due to the potential that this activity would increase the likelihood of individuals enrolling in the program once they become sick, negatively impacting the risk pool managed by the HMOs. Due to a similar concern in the Individual market, in December 2016 the Centers for Medicare and Medicaid Services (CMS) issued an Interim Final Rule barring renal dialysis facilities from making premium payments for individuals on plan offered

in the Marketplace without (1) disclosing to the insurer that a third-party payment will be made, and (2) obtaining assurance from the insurer that third-party payments will be accepted.[4]

It is unlikely that reconsidering third party premium payments would impact a significant number of CLA enrollees. In an evaluation of Indiana HIP 2.0 program, which does allow third parties to pay member premiums on their behalf, The Lewin Group found that only 1.5% of participating members had at least one premium paid on their behalf by a third party.[5]

Incentivizing Healthy Behaviors

Under the current BadgerCare Reform proposal members would be incentivized to avoid or actively manage risky health behavior with a 50% premium reduction. Wisconsin's approach is unique among recent new Medicaid Demonstration Waiver programs that include healthy behavior incentives. States including Indiana, Michigan, and Arizona focus instead on incentivizing members to complete wellness activities and preventive care.

In our commercial market experience, we have found programs that incentivize healthy behaviors, rather than incentivize moving away from unhealthy behaviors, to be most effective. For example, in a recent sample of our commercial incentive programs that encourage healthy behaviors, our members were 2.6 times more likely to experience weight loss greater than 10%.

We have also learned through our commercial experience that member education is critical to the effectiveness of the incentive program. To ensure they are fully capable of meeting the healthy behavior incentive, members need to fully understand the reward they will receive if they comply appropriately.

Additionally, the reward needs to be commensurate with level of required effort to drive desired behavior change. To that end, we encourage Wisconsin to consider a tiered approach to healthy behavior incentives rather than a singular premium reduction approach. Under the proposed model, members that do not engage in health risk behaviors at all as well as those that do engage in, but are actively managing, such behaviors receive the same level of premium reduction (50%). However, in most cases, managing health risk behaviors takes significantly more effort than not engaging in such behaviors. Given this, Wisconsin could, for example, consider a structure in which those managing health risk behaviors receives a 50% premium reduction while members that are not engaging in such behaviors receive a smaller reduction upon completion of the HRA, but receive additional premium reductions reach a full 50% reduction for engaging in wellness-promoting behavior.

Overall, our commercial market experience has also taught us that implementing healthy behavior incentives is a matter of testing and learning. We evaluate the effectiveness of our incentive programs

[4] Note that this Interim Rule is not currently enforced as a federal court in Texas granted a preliminary injunction as the court found that CMS bypassed—without good cause—notice and comment periods required under the Administrative Procedures Act. http://www.lexology.com/library/detail.aspx?g=ed48921c-6d25-465d-a016-0b01529e2740.

[5] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

each year and make changes based on that evaluation for the following year. As Wisconsin's proposed approach is unique, we recommend that the state leverage a "test and learn" type of mindset in the design of healthy behavior incentives. Wisconsin should evaluate the effectiveness of the state's healthy behavior incentive approach following Year 1 of the program and determine how the incentives can be adjusted or the approach changed for Year 2 to meet the state's overall goals of a healthy CLA population.

If any additional information or insights would be helpful, we would be happy to discuss further.
Sincerely,

Ellen Sexton
Chief Executive Officer
UnitedHealthcare Community Plan of Wisconsin
(414) 443-4309
ellen_r_sexton@uhc.com