Wisconsin's Medicaid & BadgerCare Plus Health Coverage

CMS § 1115 Waiver Provisions For 2019–2023

FINAL EVALUATION REPORT

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ABBREVIATIONS AND TERMS

BRFSS	Behavioral Risk Factor Surveillance System
CARES	Wisconsin Medicaid's Eligibility and Enrollment System
CLA	Childless Adults: Non-elderly adults without dependent children who are eligible for Wisconsin's BadgerCare program
CMS	U.S. Centers for Medicare and Medicaid Services
DHS	Wisconsin Department of Health Services
DiD	Difference-in-Differences analysis method
ED	Emergency Department
FHS	Wisconsin Family Health Survey
FPL	Federal Poverty Level
HNA	Health Needs Assessment
IMD	Institutions for Mental Disease
IRP	University of Wisconsin–Madison Institute for Research on Poverty: Independent evaluators for Wisconsin's Medicaid waiver
MOUD	Medications for Opioid Use Disorder
MODRN	Medicaid Outcomes Distributed Research Network
NCQA	National Council on Quality Assurance
OUD	Opioid Use Disorder
PHE	Public Health Emergency
SUD	Substance Use Disorder
TNQ	Treatment Needs Questionnaire
WHIO*	Wisconsin Health Information Organization

*Data for this report was provided by the Wisconsin Health Information Organization (WHIO). The WHIO information is copyrighted and requires a license for its use.

"Members" terminology:
We generally refer to individuals enrolled in Wisconsin Medicaid as "members" in the text unless drawing comparisons where that term would not be fitting. The alternative terms enrollees and beneficiaries were used in the original evaluation design report, evaluation questions and hypotheses, and the name of the primary data collection survey instrument. We have retained these usages.

EXECUTIVE SUMMARY

Summary of the Demonstration

The BadgerCare Reform demonstration was originally approved by the Centers for Medicare and Medicaid Services (CMS) on December 30, 2013. On October 31, 2018, the CMS approved its extension through December 31, 2023. In the extension, the CMS renewed one provision and approved several amendments that created new provisions for the Wisconsin DHS to implement. The renewed and new provisions as approved in 2018 are described below followed by a summary of their operational status as of the end of the current waiver period.

Health Care Coverage for Childless Adults (CLAs). Health care coverage for non-elderly adults without dependent children with family incomes of up to 100% of the federal poverty level. This provision has been in effect without disruption since its introduction in April 2014.

Community Engagement. Required most childless adult members ages 19 to 49 to participate in 80 hours of community engagement activities per month as a condition of continued Medicaid eligibility. CMS withdrew approval of this provision on April 6, 2021, prior to implementation.

Health Assessment Linked to Eligibility and Premiums. Required completion of a health risk assessment as a condition of eligibility for CLA members and provided an opportunity for reduced premiums based on the health risks and healthy behaviors reported on the health risk and needs assessments. This provision was suspended in March 2020 prior to full implementation and remained suspended through the close of the waiver period. Authority for this provision was formally withdrawn by CMS at the end of the waiver period on 12/31/2023.

Premiums, Lock-Out Periods, and Emergency Department (ED) Copayments. Premiums for CLA members with incomes greater than 50% and up to 100% FPL as a condition of enrollment; a period of non-eligibility for up to 6 months for failure to pay the required premium; and on-ramps to reactivate coverage during the non-eligibility period. An $8 copayment for non-emergency use of the emergency department. The premium and lock-out period components of this provision were suspended in March 2020 (retroactive to their January 2020 implementation) and then authority was formally withdrawn by CMS at the end of the waiver period on 12/31/2023. The emergency department copayments were implemented in November 2020 and remained in effect at the close of the waiver period.

Expansion of Coverage for Substance Use Disorder (SUD) Treatment Services. Expanded coverage for substance use disorders including a residential treatment benefit and for existing Medicaid-covered services when provided in an institution for mental disease including medically supervised withdrawal management, inpatient services, and medication-assisted treatment. This provision was implemented in February 2021 and remained in effect at the close of the waiver period.

Implications of the COVID-19 Pandemic for Interpretation of Results

The original evaluation design (**Attachment 1**) was revised to mitigate the confounding effects of the pandemic on the causal relationships between the provisions implemented during the

pandemic and their intended outcomes[1]. These provisions include the ED copayment policy and the expansion of coverage for SUD treatment services. However, the severity of the pandemic impacts on health and health care utilization are unlikely to be fully addressed by these methods. As such, we recommend caution in the interpretation of the results for the ED copayment and the SUD waiver provisions and note specifics in the corresponding sections.

Principal Results and Recommendations

In collaboration with the Wisconsin DHS and in accordance with CMS technical guidance[2], the evaluator defined the evaluation questions to assess the effectiveness of each provision in achieving its programmatic goals. At the request of CMS and the Wisconsin DHS, the Final Report only includes evaluation results for the provisions that were in effect at the close of the waiver period.

Health Care Coverage for Childless Adults. The Medicaid program goals of this provision are to improve health outcomes and reduce unnecessary services in the member population and to create a program that is sustainable and available to those who need it most. This evaluation sought to determine if the expansion of benefits to childless adults had the following effects: a reduction in the state's uninsured rate, an increase in access to medical care for CLAs, and a reduction in the provision of uncompensated care by hospitals. Findings include:

- The uninsured rate in Wisconsin declined significantly after the 2014 CLA coverage expansion. Insurance gains for CLAs from the CLA expansion put their overall insurance coverage rates on par with rates for parents. These gains have been maintained since the initial waiver period.

- The reduction in uninsurance within Wisconsin following the CLA expansion was greater than the reduction in non-expansion states over the same period and less than the size of the decline in Affordable Care Act (ACA) Medicaid expansion states.

- There was an overall trend in improvement in access to care for CLAs but no systematic evidence of a differential change compared to Medicaid expansion or non-expansion states.

- Declines in uncompensated care among Wisconsin hospitals were similar to declines in ACA Medicaid expansion states, while non-expansion states saw continued increases in hospital uncompensated care. The reductions in uncompensated care in Wisconsin associated with the 2014 CLA expansion persisted through the current waiver period.

In summary, the CLA expansion of Medicaid that Wisconsin adopted in 2014 was effective at expanding insurance coverage statewide. This translated to substantial reductions in the need for hospitals to provide charity care. Overall, the results suggest that this demonstration waiver provision has been largely successful in achieving its goals of coverage availability to those who need it most and sustainability. Continuation of the CLA waiver is recommended due to its

[1]Implications of COVID-19 for Section 1115 Demonstration Evaluations: Considerations for States and Evaluators. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-covid19-implications.pdf.

[2]Evaluation Design Guidance for Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance and Substance Use Disorders. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-1115-eval-guide.pdf.

benefits and satisfaction of the program goals. Ongoing attention to access measures is recommended to ensure that members can use their benefits in ways that improve their health. Strategies to replicate the strengths of the waiver might include additional targeted outreach to focus on reaching populations with higher health needs, as demonstrated by Wisconsin's success in targeting childless adults below the poverty line.

Emergency Department (ED) Copayments. The Medicaid program goal for the ED copayment policy is to ensure that CLA members use ED and related services appropriately to facilitate the provision of suitable levels of care. This evaluation addressed three main questions: 1) Did the imposition of a co-payment for non-emergency use of the ED reduce the number of non-emergency visits to the ED among CLAs? 2) Are hospitals consistent in how they define non-emergent use of the emergency department? and 3) Are hospitals consistent in how they implement the ED co-payment policy? Findings include:

- Awareness of ED copayment policy was low among CLA members, did not substantially grow over time, and did not differ from awareness among parents and caretakers, for whom it did not apply.

- Compared to a control group of parents and caretakers, there was no evidence that CLAs experienced a relative decline in non-emergent visits after implementation of the copayment policy.

- Evidence of consistent, effective implementation of the ED copayment was not apparent. Few hospitals directly billed for claims that had associated ED copayments. Within-hospital analysis did not show evidence of change in the ratio of non-emergent to emergent visits for CLAs compared to parents and caretakers after copayment policy implementation.

Overall, there is no evidence that the ED copayment policy supported the Medicaid policy goal of targeting appropriate use of medical services, although available evidence does not suggest it reduced access for members. Value-based insurance design, such as that focused on structuring copayments in a way that most effectively encourages efficient use of care, is worthy of continued testing in Medicaid. Continued, careful attention to communication about the ED copayment policy and its implications for members coupled with strategies to encourage reliance on urgent care settings rather than EDs for non-emergent conditions are recommended to support the goals of this waiver provision.

Expansion of Coverage for Substance Use Disorder Treatment Services. The Medicaid program goal associated with this provision of the waiver is to reduce the incidence of drug overdose deaths by improving access to the full continuum of SUD treatment. The evaluation assessed the effects of this provision on four major outcomes: the supply of SUD providers, members' use of newly covered services, members' use of existing covered SUD services, and the rate of overdose deaths among Medicaid members.

- There was no evidence of an increase in SUD provider availability, defined as providers newly delivering SUD services, after implementation of the demonstration waiver relative to a comparison group of non-SUD providers.

- Most members with self-reported problematic substance use were not aware of the residential SUD benefit though the fraction reporting awareness grew from 2020 to 2024.

- Claims for residential SUD treatment use increased for Wisconsin Medicaid members after the introduction of the new benefit although a cross-state comparison of admissions to residential treatment offered no evidence of a differential change in the rate of admissions in Wisconsin relative to states without a Medicaid residential SUD benefit.

- Based on a comparison of Wisconsin Medicaid and commercially insured adults, there was no evidence of a relative increase in the use of existing covered SUD services among Medicaid adults after implementation of the waiver.

- All-cause and overdose-specific mortality increased among Medicaid members relative to a comparison population of non-Medicaid Wisconsin adults after implementation of the demonstration waiver compared to the baseline period.

Overall, the residential SUD treatment, as implemented in the context of the COVID-19 pandemic, was not associated with meaningful changes in Medicaid members' SUD-related health care use or overdose mortality risk relative to comparison groups. However, recently published research demonstrates the positive effects of a Medicaid residential treatment benefit on access to residential SUD care suggesting that the benefit can support the program goal[3]. Continuation of this waiver provision is recommended. Strategies to strengthen the residential SUD treatment waiver provision might include targeted messaging to members whose health care history suggests a persistent or severe addiction disorder to improve awareness, and the use of a real-time inventory of residential SUD treatment beds available for Wisconsin Medicaid members to facilitate referrals and optimal allocation of resources.

[3]Bass B, Urada D, Khurana D, Boustead A, Joshi V. (2023) The Effect of the Drug Medical Organized Delivery System 1115 Demonstration Waiver on Substance Use Disorder Treatment Access: Evidence from California. Drug and Alcohol Dependence. 246(109847).

WAIVER DEMONSTRATION BACKGROUND

BadgerCare is Wisconsin's combined Medicaid and Children's Health Insurance Program (CHIP) for low-income families and for childless adults (CLAs). The BadgerCare Reform demonstration was originally approved by the Centers for Medicare and Medicaid Services (CMS) on December 30, 2013. On October 31, 2018, the CMS approved its extension through December 31, 2023. In the extension, the CMS renewed one provision and approved several amendments that created new provisions for the Wisconsin DHS to implement. The renewed provision provides authority for the state to provide most Medicaid state plan benefits to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including 100% of the federal poverty level through expenditure authority under section 1115(a)(2) of the Act. This provision remained in effect without disruption beginning with its introduction in April 2014 to the present.

While the BadgerCare Reform Demonstration impacts all adult, full-benefit Medicaid members, most provisions focus specifically on non-disabled, childless adult members. All provisions are described below as they were included in the approved demonstration for 2019–2023. The new provisions were implemented throughout the calendar years 2019–2021. However, the operational status of some provisions changed over time as a consequence of the COVID-19 pandemic and declaration of the public health emergency (PHE), on March 18, 2020. The timing of these changes and status of each original and new provision as of the end of the waiver period, December 31, 2023, are summarized in **Table 1.1**.

Waiver Provisions That Impact Childless Adult Members

CLA Health Care Coverage. Originally approved for the 2014–2018 BadgerCare Demonstration, this provision provides health care coverage to non-elderly CLAs with family incomes of up to 100% of the federal poverty level (FPL). The Wisconsin DHS primary goal is to improve health outcomes of members and reduce unnecessary services. The state anticipated that establishing an eligibility income limit at 100% FPL, rather than implementing a full ACA-authorized Medicaid expansion, was "creating a program that is sustainable" and "available to those who need it most."

Community Engagement. An amendment to the original demonstration, this provision required most of the CLA members ages 19 to 49 to participate in 80 hours of community engagement activities per month, such as employment, job skills training, or community service as a condition of continued Medicaid eligibility. Failure to comply with the requirement for 48 cumulative months would result in disenrollment from the demonstration and the individual would be locked out of re-enrollment for six months. After completing the six-month lockout period, the individual would be eligible to reapply for coverage in the childless adult demonstration population, if otherwise still eligible.

Health Assessment Linked to Eligibility and Premiums. This provision, new in the 2019–2023 demonstration, introduced a Treatment Needs Questionnaire (TNQ) and Health Needs Assessment (HNA) also referred to as the BadgerCare Plus Health Survey. The TNQ includes one question for the member about whether drug use has caused any problems and if they are willing to get help. If yes, the TNQ was designed to initiate a quick referral for substance use assessment and services. The HNA survey assesses health risk and protective behaviors. If

members engaged in health protective behaviors or were attempting to manage their health risk behaviors, their survey responses would trigger potential reduction in their premiums.

Premiums and Lock-Out Periods. Premiums for CLAs ages 19 to 64 with incomes from 50% to 100% of the FPL were also added to 2019–2023 waiver demonstration. Those CLAs who are subject to the premium requirement but do not make such payments would, at the time of annual renewal, be terminated from Medicaid enrollment and placed in a lock-out period of non-eligibility for up to six months. However, the member was to be permitted to reenroll at any time prior to the end of the six-month period if they pay all owed premiums, or if their situation changed such that they would no longer be subject to a premium requirement. The Wisconsin DHS anticipated that cost-sharing implemented through the premiums would provide members with coverage more like commercial coverage and thus aid their eventual transition from Medicaid.

Emergency Department Copayments. Another addition to the waiver demonstration in 2019–2023 was a requirement for an $8 copayment for non-emergent use of a hospital emergency department (ED) for CLAs. The hospital provider was responsible for using a "prudent layperson" standard in the determination of whether a CLA had an emergency medical condition. Prior to providing non-emergency services subject to the copayment, hospitals had to provide a medical screening, inform the member of the potential cost sharing, and provide a referral to an alternative provider who could provide services with a lesser or no-cost share. The goal of the policy is to educate CLAs on the appropriate uses of the ED and other levels of care, deter future avoidable ED visits, and reduce ED Medicaid costs.

Waiver Provisions That Impact All Full-Benefit, Adult Medicaid Members

Expansion of Coverage for Substance Use Disorder Treatment. Included as an amendment to the waiver provision for 2019–2023, this provision of the waiver modifies the benefit package for substance use disorder (SUD) treatment for all full-benefit adult Medicaid members. The Wisconsin DHS identifies this waiver provision as part of a comprehensive statewide strategy to combat substance use disorders and drug overdose by broadening the available continuum of care and increasing access to services.

Specifically, the demonstration waiver authorizes federal funding for treatment provided to members in Institutions for Mental Disease (IMD), allowing Wisconsin Medicaid to make two significant programmatic changes: 1) establish a residential treatment benefit for SUD; and 2) cover existing Medicaid services when they are provided in an IMD including medically supervised withdrawal management, inpatient services, and medication-assisted treatment (MAT).

Additionally, this provision includes several new or revised policies to support the implementation and quality of these newly covered services. These policies cover:

- updated licensure/certification requirements for providers;
- placement criteria consistent with American Society of Addiction Medicine (ASAM);
- utilization management for the residential treatment benefit;
- residential treatment provider qualifications that align with national standards; and
- a requirement that residential treatment facilities offer MAT.

Table 1.1: Provision Implementation Changes During the 2019–2023 Waiver Period and Operational Status as of 12/31/2023

Waiver Provision	Current Status & History of Changes
CLA Health Care Coverage	Effective
	Coverage was established in the 2014–2018 waiver period and extended through the 2019–2023 waiver period.
Community Engagement	Approval Withdrawn
	Member communication was initiated in November 2019 through February 2020 for a 2/1/20 start date. The provision was then suspended at the onset of the public health emergency in mid-March 2020. CMS withdrew approval for the community engagement provision on 4/6/21.
Health Assessment Linked to Eligibility and Premiums	Suspended
	The health assessments were added to enrollment process 2/1/20. The provision was suspended at the onset of the public health emergency in mid-March 2020. The Health Needs Assessment (HNA) and the Treatment Needs Questionnaire (TNQ) were maintained as optional only in the DHS Access system. Following the close of the waiver period, both health assessments were formally discontinued by CMS on 1/1/24.
Premiums and Lock-Out Periods	Suspended
	Member communication regarding premiums and lock-out periods was initiated in November 2019 through February 2020. The provision was suspended at the onset of the public health emergency in mid-March 2020. Following the close of the waiver period, this provision was formally discontinued by CMS on 1/1/24.
Emergency Department Copayments	Effective
	The original implementation date for ED copayments was 2/1/20. DHS announced in December 2019 that all copayments would be suspended 1/1/20–6/30/20. After an announcement that 7/1/20 was the new start date for ED copayments, DHS later changed the implementation date to 11/2/20. ED copayments collected between 7/1/20–11/1/20 were refunded.
Expansion of Coverage for Substance Use Disorder Treatment	Effective
	The original implementation date was 2/1/20. DHS announced a delay in the implementation of this provision on 1/24/20. The provision was implemented on 2/1/21.

Adaptation of the Evaluation to Demonstration Changes

The evaluation design was altered to address the implementation changes described in **Table 1.1** as well as the potential effects of the COVID-19 pandemic and policies associated with it (e.g., maintenance of enrollment) on evaluation outcomes. The evaluation team substantially revised the original evaluation design plan in consultation with the Wisconsin DHS and the

CMS. The final plan was approved in September 2021. The revisions included dropping the evaluation questions and hypotheses for the Community Engagement provision because it had been withdrawn in April 2021. For provisions remaining in effect or in suspension as of September 2021, revisions included greater flexibility in modeling time, the exclusion of a pandemic period from the baseline or pre-period, and dropping selected analytical strategies requiring the assumption of a stable pre-trend in outcomes which was no longer tenable. Complete details, including a comparison of the original and revised analyses for each question can be found in the Evaluation Design Plan (**Attachment 1**).

Two of the provisions that were placed in suspension during the 2019–2023 waiver were never restarted and were officially withdrawn in January 2024: health assessment linked to eligibility and premiums; and premiums and lock-out periods. Throughout the waiver demonstration period, the evaluation team implemented components of the evaluation design for these provisions for the few months that they were active, and where possible, made projections of the provisions' potential effects had they been implemented. Prior reports to the Wisconsin DHS and the CMS included preliminary analyses for these provisions. At the request of CMS and the Wisconsin DHS, these provisions have been excluded from the final report.

EVALUATION QUESTIONS AND HYPOTHESES

The Wisconsin DHS contracted with the University of Wisconsin–Madison Institute for Research on Poverty (IRP) to conduct the evaluation of the Wisconsin BadgerCare Reform Demonstration. The IRP research team has written evaluation reports for the BadgerCare Reform Demonstration project annually since 2020 for the 2019–2023 demonstration period. The final Interim Report required by CMS described results for approximately the first half of the demonstration period and was submitted April 2023 after incorporating CMS feedback. This report represents the final Summative Evaluation Report for the entire waiver period required by CMS.

The final Summative Evaluation Report expands upon findings in earlier reports in its scope and comprehensiveness. The report is comprehensive in its coverage of results for all active demonstration provisions and their associated hypotheses and research questions, and in its use of data that extends, in most cases, through the end of the waiver period.

Goals, Outcomes, and Questions for Childless Adults Coverage Expansion

Figure 1.1 below displays the driver diagram for the CLA coverage expansion. In the logic of the driver diagram, the immediate outcomes are necessary mechanisms or conditions to achieve the secondary outcomes which in turn contribute directly to realizing the overall goal of the CLA coverage expansion: to improve health outcomes and reduce unnecessary services for the Medicaid population. In addition, by establishing an eligibility income limit at 100% of the FPL, rather than implementing a full ACA-authorized Medicaid expansion, the State of Wisconsin focused on "creating a program that is sustainable" and "available to those who need it most."

In April 2014, Wisconsin initiated a CMS-approved 1115 Demonstration Waiver that allowed federal Medicaid matching funds for providing health care coverage for childless adults between the ages of 19 and 64 years old who have income at or below 100% FPL. The childless adult population receives the standard benefit plan, which is the same benefit plan that covers parents, caregivers, and children.

The immediate expected outcome from the CLA coverage expansion is to increase health insurance coverage for the childless adult population and thereby decrease the overall uninsured rate across the state. Secondarily, greater insurance coverage among CLAs is anticipated to increase their use of health care and to reduce the volume of uncompensated care that Wisconsin hospitals provide as uninsurance among CLAs declines. In **Table 1.2** below, the complete list of hypotheses and research questions from the final Evaluation Design Report to evaluate these outcomes are described.

Figure 1.1. Driver Diagram for the Childless Adults Coverage Expansion

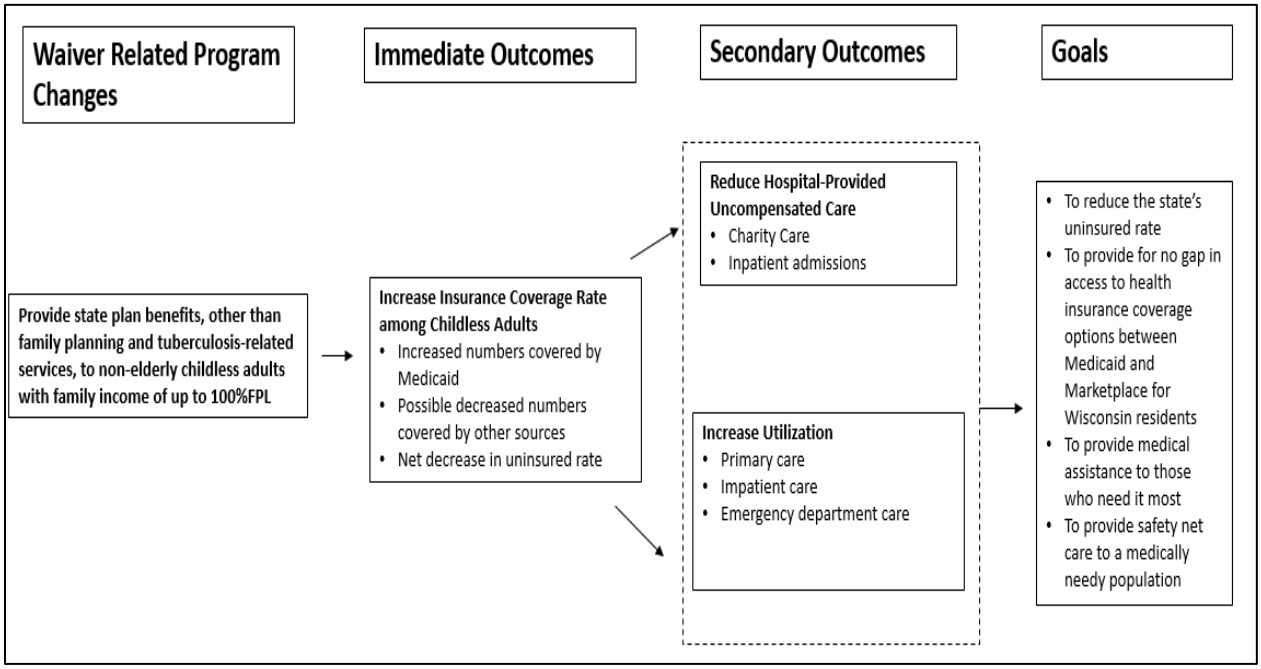


Table 1.2: Hypotheses and Questions for Childless Adults Coverage Provision

Hypothesis 1.1. The expansion of benefits to non-elderly childless adults (CLAs) will reduce the state's uninsured rate.

Primary Research Question 1.1: Did the expansion of benefits to CLAs reduce the state's uninsured rate?

Q 1.1a. What are the trends in Wisconsin's adult uninsured rate and uninsured rate among CLAs?

Q 1.1b. How much did the change in the number of CLAs due to the Medicaid expansion contribute to the overall change in the adult uninsured rate in Wisconsin?

Hypothesis 1.2. The expansion of benefits to CLAs will lead to increased access to medical care among poor CLAs.

Primary Research Question 1.2: How did the CLA expansion affect the use of health care services?

Q 1.2a. Did the expansion of benefits to CLAs increase the use of primary care among poor CLAs in Wisconsin?

Q 1.2b. What are the short- and long-term effects of eligibility and coverage policies, including maintenance of eligibility, on Medicaid health service expenditures?

Hypothesis 1.3. By expanding the safety net, the expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals.

Primary Research Question 1.3. Did the expansion of benefits to CLAs reduce the provision of uncompensated care (charity care plus bad debt) among Wisconsin acute care hospitals?

Q 1.3a. What are the trends in the provision of uncompensated care among Wisconsin hospitals and did it change along with the expansion of benefits to CLAs?

Q 1.3b. Did hospitals in areas with greater reductions in the number of uninsured CLAs experience differential changes in uncompensated care?

Hypothesis 1.4. Additional requirements of the current demonstration may increase administrative costs.

Primary Research Question 1. 4. What are the administrative costs incurred by the state and counties to implement and operate the demonstration?

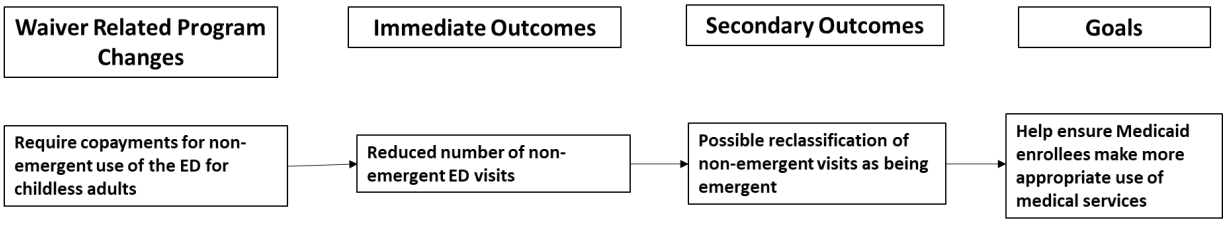
Q 1.4a What are the administrative costs incurred by the state to implement and operate the demonstration?

Q 1.4b How did county income maintenance staff workloads change around implementation of the current demonstration?

Goals, Outcomes, and Questions for the Emergency Department Co-Payment

The driver diagram in **Figure 1.2** displays how the ED copayment policy is designed to achieve its outcomes. In the logic of the driver diagram, the immediate outcomes are necessary mechanisms or conditions to achieve the secondary outcomes which in turn contribute directly to realizing the overall Medicaid program goal of the ED copayment policy: To ensure that CLA Medicaid members use ED and related services appropriately to facilitate the provision of the appropriate level of care.

Figure 1.2: Driver Diagram for the Emergency Department Co-Payment Requirements



For CLAs, an $8 copayment for non-emergent use of the hospital ED was implemented November 2, 2020. The provider is responsible for using a “prudent layperson” standard in the determination of whether a member has an emergency medical condition. Prior to providing non-emergency services subject to the copayment, hospitals must provide a medical screening, inform the member of the potential cost sharing, and provide the name and location of an alternative provider who could provide services with a lesser or no cost share, including a referral. Providers cannot refuse treatment for nonpayment, but were given flexibility on collecting the copayment based on burden. Wisc. Stat. 49.45(18) states that “providers are required to make a reasonable attempt at collecting the copayment from the member unless the provider determines that the cost of collecting the copayment is more than the amount the provider would collect.”

The provider screening for an emergent need and $8 copayment are designed to educate the CLA member on the appropriate use of the ED and reduce future non-emergent uses of the ED as an immediate outcome. Secondarily, another goal of the policy is to provide CLA members experience with a coverage copayment policy that more closely aligns with commercial coverage policies and hypothetically may increase readiness to transition to commercial coverage.

In **Table 1.3** below, the complete list of hypotheses and research questions from the final Evaluation Design Report to evaluate these outcomes are described. Hypotheses 3.6 and 3.7 are worded similarly. Hypothesis 3.6 is intended to evaluate the implementation process such as whether and how the hospitals are applying the copayments. Hypothesis 3.7 is intended to evaluate the impact on patient visit rates across hospitals.

Table 1.3: Hypotheses and Questions for the Emergency Department Co-Payment Provision

Hypothesis 3.5. The imposition of a co-payment for non-emergent use of the emergency department will lead to more appropriate uses of medical care among CLAs enrolled in Medicaid.

Primary Research Question 3.5: Did the imposition of a co-payment for non-emergent use of the emergency department reduce the number of non-emergency visits to the emergency department among CLAs enrolled in Medicaid?

Q 3.5a. What was the number of non-emergent visits to the emergency department among CLAs prior to the imposition of copayments?

Q 3.5b. What was the total number of emergency department visits among CLAs prior to the imposition of copayments?

Q 3.5c. How did the numbers of emergency department visits and non-emergent visits change among CLAs after the imposition of copayments?

Q 3.5d. How did the use of primary care change among CLAs after the imposition of copayments for non-emergent visits to the emergency department?

Q 3.5e. Do beneficiaries with co-payment requirements understand their payment obligations?

Hypothesis 3.6. Hospitals vary in how they implement the required co-payment for non-emergency use of the ED.

Primary Research Question 3.6: Are hospitals consistent in how they define non-emergent use of the emergency department, as necessary to apply the associated Medicaid co-payment policy?

Q 3.6a. Do hospitals understand the policy requiring a co-payment for non-emergent use of the emergency department?

Hypothesis 3.7. Hospitals are implementing the policy requiring a co-payment for non-emergent use of the emergency department in a consistent manner.

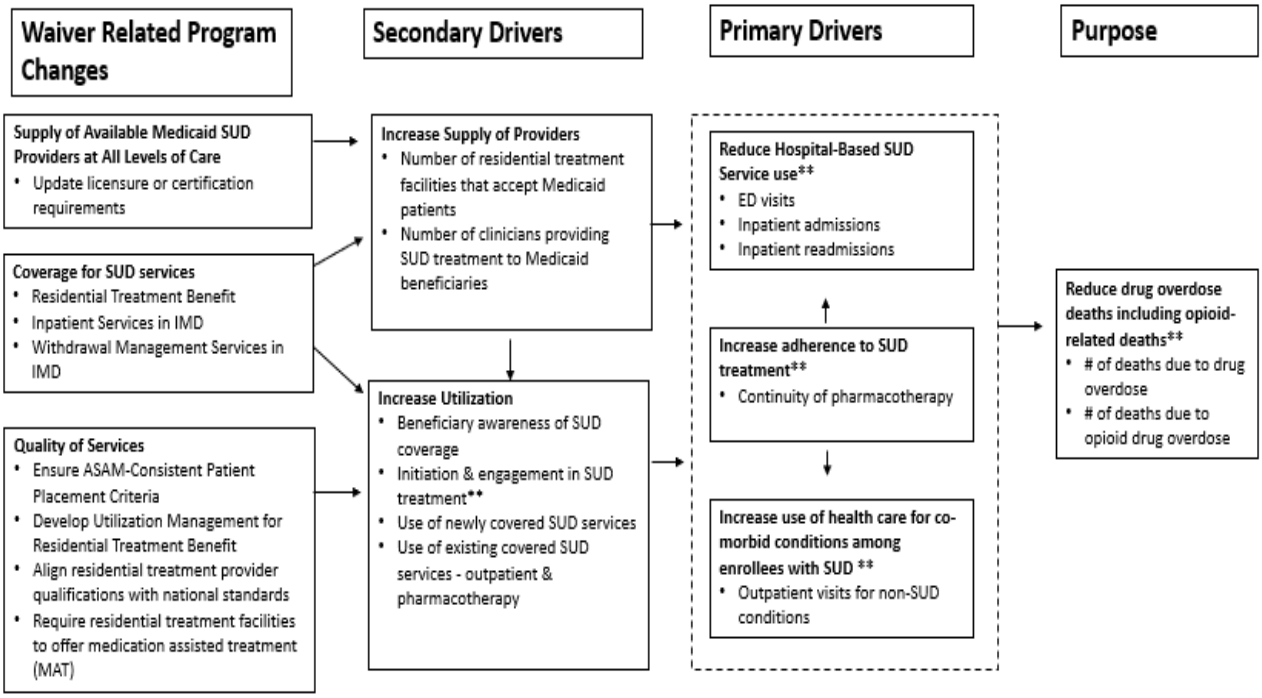
Primary Research Question 3.7: Are hospitals consistent in how they are implementing the policy requiring a co-payment for non-emergent use of the emergency department?

Q 3.7a. Is the definition of non-emergent ED visits consistently applied across hospitals?

Goals, Outcomes, and Questions for Substance Use Disorder Treatment Coverage Expansion

Figure 1.3 below displays the driver diagram for the SUD coverage expansion. In the logic of the driver diagram, secondary drivers are mechanisms or conditions that are necessary to achieve the primary drivers which subsequently contribute directly to realizing the overall purpose of the demonstration waiver: to reduce drug overdose deaths in the Medicaid population.

Figure 1.3: Driver Diagram for the Coverage Expansion of Substance Use Disorder Treatment



The provision to expand coverage for SUD treatment services took effect on February 1, 2021. Specific programmatic changes that the Wisconsin Medicaid program implemented under the SUD demonstration waiver fall into three functional categories: supply of Medicaid SUD providers at all levels of care; coverage for SUD services; and quality of SUD services. These changes were designed to impact the rate of drug overdose deaths through a sequence of mechanisms. Most directly, the programmatic changes aimed to increase the supply of SUD providers that accept and treat Medicaid members, and to increase Medicaid members' use of SUD treatment services.

Such effects on these secondary drivers then had the potential to influence the primary drivers: members' health care needs and preferences, and their capacity to seek care that is suited to their needs. For example, increased access to SUD providers and increased use of SUD services may reduce symptoms of SUD, increase the likelihood of recovery, increase engagement in health care, and foster knowledge and awareness of treatment needs. These changes may thus enable members to remain in SUD treatment, reduce hospital-based SUD service use, and/or address previously ignored physical and mental health co-morbidities. Improvements in outcomes considered primary drivers then have the potential to influence the waiver's overall goal of reducing drug overdose deaths among Medicaid members.

In **Table 1.4** below, the complete list of hypotheses and research questions in the final adapted Evaluation Design Report are described.

Table 1.4: Hypotheses and Questions for Coverage Expansion of Substance Use Disorder Treatment

Consistent with the CMS guidance for the evaluation of SUD waivers, the evaluation design is organized around evaluation questions with specific hypotheses following each question. In addition, Q4.5 has no accompanying hypotheses per CMS guidance.

Question 4.1. Does the SUD demonstration waiver increase the supply of SUD providers for Medicaid enrollees?

H 4.1a. The SUD demonstration waiver will increase the supply of SUD providers that accept and/or treat Medicaid enrollees.

Question 4.2. Does the SUD demonstration waiver increase access to, and use of, newly covered SUD services for Medicaid enrollees?

H 4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time.

H 4.2b. The SUD demonstration waiver will increase use of SUD treatment in IMD settings including residential treatment, impatient treatment, medically supervised withdrawal services and MAT for opioid use disorder.

H 4.2c. The SUD demonstration waiver will increase initiation and engagement in SUD treatment.

Question 4.3. Does the SUD demonstration waiver change Medicaid enrollees' use of existing covered SUD services?

H 4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services, including in-person and telehealth, and pharmacotherapy treatment provided outside IMD settings.

H 4.3b. The SUD demonstration waiver will reduce use of hospital-based SUD services, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H 4.3c. The SUD demonstration waiver will increase access to health care for co-morbid physical and mental health conditions among enrollees with a SUD, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H 4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

Question 4.4. Does the SUD demonstration waiver reduce the rate of drug overdose deaths among Medicaid enrollees including opioid-related deaths?

H 4.4a. The SUD demonstration waiver will reduce the rate of drug overdose deaths among Medicaid beneficiaries, including opioid-related overdose deaths, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

Question 4.5. What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?

METHODOLOGY

The evaluation of the demonstration waiver used both primary and secondary data as described below. The specific sources used to evaluate each waiver provision are noted in the relevant sections.

Primary Data

During the course of this waiver demonstration, the evaluation team fielded Medicaid Beneficiary Surveys in 2020, 2022, and 2024. The 2020 and 2024 surveys were designed to support a comparison of evaluation outcomes across all provisions from the baseline or early waiver period to a post-implementation period. The 2020 and 2024 surveys are the primary survey data analyzed in this final report. A smaller 2022 survey included a subset of measures from these more comprehensive instruments, with the primary goal to obtain a mid-point assessment of members' experiences with the implementation of the provisions. Additionally, the team conducted in-depth interviews with a subgroup of respondents to the 2022 survey; these interviews focused specifically on the ED copayment waiver provision.

The instruments, methodology, and complete findings from the 2020 and 2022 surveys and the 2022 in-depth interviews have been previously reported to Wisconsin DHS in annual progress reports and the Interim Evaluation Report. In the Final Report, the 2024 survey instrument and complete results are provided in **Attachment 2** and **Attachment 3**, respectively. The 2024 methodology is described below with reference to the 2020 survey methodology to facilitate interpretation of the comparisons made throughout this report between findings from the two surveys.

Each survey was a cross-sectional survey of individuals currently or previously enrolled in the BadgerCare program. In 2020, survey sampling was conducted by the UW Survey Center (UWSC); the National Opinion Research Center (NORC) at the University of Chicago led the survey design and fielded the survey. In 2024, UWSC supported all aspects of the survey data collection. In both rounds, the survey covered topics relevant to the waiver evaluation and, more generally, tracked self-reported health care access and member experiences.

Survey Domains

The surveys addressed the following common topics:

- Health insurance coverage status - past year and current
- Medicaid eligibility and enrollment changes
- Health care needs, access, and use
- Health status and health behaviors
- Experiences with Medicaid unwinding (2024 only)
- Awareness of waiver provisions
- Member demographic characteristics

Questions were developed using items from previous national surveys, Wisconsin surveys of Medicaid members, and other state surveys of Medicaid members. Specific surveys include the

Behavioral Risk Factor and Surveillance System,[4] the Urban Institute Health Reforming Monitoring Survey,[5] Kaiser Family Foundation Health Tracking Polls,[6] the National Health Interview Survey,[7] the Michigan waiver's survey of Medicaid members,[8] and the Oregon Health Insurance Experiment.[9]

Sampling

The surveys used a multi-stage sampling plan, developed around priority groups shown in **Table 1.5.** CLA's are the primary target population in the waiver and comprise sample groups A-B. Group A's income level is 0–49% of the FPL and Group B's income level is between 50–100% of the FPL. Group C included individuals with a diagnosis of a substance use disorder in the past year. Both surveys also included a subgroup of individuals who had been enrolled as CLAs during the preceding year but disenrolled from that coverage (Group D). These individuals helped us to examine the outcomes of people who may have experienced challenges with reenrollment or lost coverage due to other programmatic changes. Group E are parents or caretakers enrolled in Medicaid who serve as a comparison group to CLAs.

The sample for both surveys was drawn from the Medicaid enrollment data identifying the population of BadgerCare members based on eligibility group, enrollment status, and diagnosis of substance use disorder (for sampling Group C). Group C was selected using enrollment data linked to claims data that included indicators for people with any claims showing an International Classification of Diseases Tenth Revision (ICD-10) diagnosis code of a substance use disorder over a recent 12-month period. Group C members could also be eligible if they had a hospital or ED visit related to a substance use disorder in the prior 12 months within the Medicaid claims.

The sample was augmented to include an oversample of Spanish-speaking members who identified Spanish as their preferred first language. These individuals received a Spanish-translated self-administered questionnaire and were contacted by a Spanish-speaking interviewer if they participated in the phone survey.

The overall sample drawn was 15,750 individuals in 2020 and 8,500 individuals in 2024. The sample sizes for each group were designed to provide adequate statistical power to make comparisons across survey groups to answer the study hypotheses.

[4]Behavioral Risk Factor Surveillance System. https://www.cdc.gov/brfss/index.html

[5]Urban Institute HRMS. https://hrms.urban.org/

[6]Kaiser Family Foundation Tracking Poll. https://www.kff.org/polling/

[7]National Health Interview Survey. https://www.cdc.gov/nchs/nhis/index.htm

[8]Healthy Michigan Voices Survey. https://ihpi.umich.edu/featured-work/healthy-michigan-plan-evaluation/healthy-michigan-voices-survey

[9]Oregon Health Insurance Experiment – Documents. https://www.nber.org/programs-projects/projects-and-centers/oregon-health-insurance-experiment/oregon-health-insurance-experiment-documents

Table 1.5: Survey Samples for the 2020 and 2024 Beneficiary Surveys

Group	Composition	English Language Samples		Spanish Language Over-Samples		Total Samples	
		2020	2024	2020	2024	2020	2024
A	Childless adults with incomes 0–49% FPL	2,135	1,620	107	80	2,242	1,700
B	Childless adults with incomes 50–100% FPL	2,300	1,620	115	80	2,415	1,700
C	Adults who have a probable substance use disorder	2,994	1,620	150	80	3,144	1,700
D	Childless adults who were disenrolled from Medicaid	2,375	1,620	119	80	2,494	1,700
E	A comparison group of parents and caretakers enrolled in Medicaid	2,993	1,620	149	80	3,142	1,700
Total Sample		12,797	8,100	640	400	13,437	8,500

Note: In the 2020 survey, another group without a history of employment was sampled which brought the total sample size to 15,750. The group was included to evaluate a community engagement/work requirement, but this provision was withdrawn by CMS.

Approach to Grouping Survey Sample

In the results presented in this report, we generally present individuals as members of the groups from which they were sampled using the Medicaid data. However, to create the disenrolled Group E, a second group identification step is used. Individuals who responded to the survey about their enrollment status differently than their enrollment status in the Medicaid data were re-assigned to another group. CLAs in Groups A or B identified in the Medicaid data as enrolled in Medicaid, but who self-identified on the survey as disenrolled from Medicaid were reassigned to the disenrolled Group D. Alternatively, CLAs identified in the Medicaid data as disenrolled for Group D, but who self-reported being enrolled in Medicaid on the survey, were reassigned to Group A or B as enrolled CLAs. We also exclude individuals from the oversampled SUD group from the primary set of results about coverage and ED copayments. For the hypotheses related to SUD, we include individuals from all groups (including group C) if they self-report experiencing problems related to drugs or alcohol that would potentially make them eligible for SUD treatment.

Fielding

The fielding procedures in 2020 and 2024 included both mail and phone survey components. However, several differences also existed in the fielding procedures, so separate descriptions of each are provided.

In 2020, individuals were mailed a $2 pre-incentive payment and were encouraged to complete a web survey online by clicking a link and entering a unique code. This was followed by two rounds in which individuals were mailed the self-administered questionnaire (SAQ) along with an envelope addressed to NORC to return the survey. For the phone survey, there were up to six attempted contacts. Individuals who stated that they did not want to take the survey (i.e., “hard refusals”) were removed from the call-back schedule. When NORC encountered disconnected or invalid lines, it used a proprietary database to search for other contact information (e.g., using contact information harvested by credit reporting agencies). Beginning in December 2020, interviewees were offered $5 to complete the survey. Given the challenging

circumstances under the COVID-19 pandemic at this time, the survey response incentive was increased to $20 from January 14 through February 4, 2021, and finally increased to $30 until the close of data collection on February 25, 2021.

In 2024, individuals were sent a $5 pre-incentive payment and were sent the survey twice in the mail, but there was no option to complete on a web survey. Individuals who did not respond to the mailed survey were contacted by trained interviewers from the UWSC. The UWSC also used a tracing center to locate individuals with incomplete or out-of-date contact information. The UWSC attempted to contact respondents up to five times and, as in 2020, stopped if they encountered a firm refusal.

Table 1.6 shows the data collection timelines for each survey.

Table 1.6: Survey Data Collection Timeline

Fielding Procedure Steps	2020 Survey	2024 Survey
Contact 1: Mail invitation to web survey	10/5/2020	N/A
Contact 2: Mail questionnaire	10/19/2020	2/16/2024
Contact 3: Second mailing of questionnaire	10/26/2020	3/18/2024
Contact 4: Initiate telephone follow-up calling	12/1/2020	4/16/2024
Close survey data collection	1/25/2021	8/16/2024
Survey data delivery	**3/22/2021**	**9/9/2024**

Survey Completion

For the 2020 survey, a total of 2,799 surveys were completed. By mode, 1,117 (39.9%) surveys were completed by self-administered mail questionnaire, 874 (31.2%) were completed by phone, and 804 were completed on the web (28.7%). Among all 15,750 sampled individuals, 3,782 individuals (24% of cases) either lacked a phone number or had an invalid phone number (e.g., disconnected or wrong number).

For the 2024 survey, a total of 1,922 surveys were completed. By mode, 1,371 (71.3%) surveys were completed by self-administered mail questionnaire and 551 (28.7%) by phone. Among all sampled cases 2,380 were ineligible due to invalid or missing phone numbers.

The American Association for Public Opinion Research (AAPOR) provides formulas for calculating response rates. The AAPOR formula used takes all completed cases and divides it by the total sample minus the ineligible cases as displayed in **Table 1.7**.

Table 1.7: 2020 and 2024 Response Rates

Survey Year	Sample Size	Ineligible Respondents	Completed Surveys	Response Rate
2020	15,750	3,782	2,799	23.4%
2024	8,500	2,380	1,922	31.4%

Data Processing

The NORC in 2020 and the UWSC in 2024 applied quality control and logic checks to the data prior to delivering the final data set to UW analysts. Data were harmonized across modes of the survey. Responses that did not follow the survey skip patterns (particularly for mail surveys) were recoded. For example, if an individual responded “no” for a stem question, their responses were removed from follow-up questions that depended on an initial “yes” response.

Because the number of individuals eligible to respond to each question differed by question, the UW team defined an eligible denominator for each question that excluded logical skips and individuals who responded “don’t know” or were otherwise a non-response. In limited cases where “don’t know” was considered an informative answer, these individuals were included in the denominator. We note these choices in table notes and track the eligible denominators for each question.

Weighting

Weights were raked to match the age, sex, and group distributions of the sampling frames as a post-stratification adjustment. Post-stratification adjustment changes the sampling weights so that the distribution of select demographic characteristics among respondents matches the distribution of those characteristics in the population from which samples were drawn.

Secondary Data

American Community Survey. The American Community Survey (ACS), a nationally representative survey conducted by the U.S. Census Bureau, contains state-level geographic identifiers. It is a source of population estimates, demographics, and health insurance coverage sources including Medicaid coverage, private group, and non-group

Behavioral Risk Factor Surveillance System (BRFSS). Run by the Centers for Disease Control and Prevention, the BRFSS is a set of state-level surveys that collect data from all 50 states and the District of Columbia on the health and health behaviors of U.S. residents. The survey also collects information on employment and health insurance coverage, though not the source of that coverage. The data are available at the state level and with roughly a two-year lag.

CARES. Wisconsin CARES is the state’s online eligibility and enrollment portal for public benefits, including Medicaid, TANF, and FoodShare (SNAP). We use data from CARES to attain longitudinal administrative data pertaining to enrollment. Demographic information includes age, sex, educational attainment, county of residence, income, and income sources. CARES data also include reason codes associated with disenrollment.

Current Population Survey. The Current Population Survey (CPS), sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS), is the primary source of labor-force statistics for the U.S. population.

Hospital Cost Reports. These reports are submitted annually to CMS by all acute care and critical access hospitals. Data on uncompensated care (UCC) are reported in Worksheet S-10 of Form CMS-2552-10, which was first used beginning in May 2010. UCC is the sum of two reported items: the cost of charity care provided to uninsured patients (line 23 column 1) and the cost of non-Medicare bad-debt expense (line 29).

Medicaid Enrollment, Claims, and Encounter Data. We obtained enrollment, claims and encounter data from the Wisconsin DHS. These data files contain detailed information on eligibility, diagnoses, procedure, billing codes, and paid amount for care delivered via fee-for-service and managed care.

Multi-Payer Claims Database. The Wisconsin Health Information Organization, known as WHIO, is private-sector-operated, voluntary, multi-payer claims database. WHIO includes Medicaid along with commercial insurance covering most of Wisconsin's population. It excludes Medicare fee-for-service, self-funded employers whose third-party administrators do not submit claims, and individuals insured by national or border state companies (e.g., HealthPartners, Aetna, and Cigna). The WHIO data include a claims file and a member enrollment file, which permits identification of unique individuals' enrollment in health insurance over time regardless of whether members incur claims. WHIO does not release identifiable data, so these data are not linked to Medicaid administrative data.

National Survey of Substance Abuse Treatment Services (N-SSATS) and *National Substance Use and Mental Health Services Survey (N-SUMHSS)*. The Substance Abuse and Mental Health Services Administration (SAMHSA) conducts these annual surveys to gather a census of facilities nationwide providing substance abuse treatment and to collect data on the characteristics of the populations served, available services, and sources of payment accepted. The N-SSATS and N-SUMHSS are publicly available datasets. Data for calendar years 2017–2022 were available and used for this evaluation. The SAMHSA replaced the N-SSATs with the N-SUMHSS in 2021.

Small Area Health Insurance Estimates (SAHIE). The SAHIE program was created to develop model-based estimates of health insurance coverage for counties and states. SAHIE data can be used to analyze geographic variation in health insurance coverage, as well as disparities in coverage by race/ethnicity, sex, age, and income levels that reflect thresholds for state and federal assistance programs.

Treatment Episode Data Set – Admission (TEDS-A). The TEDS-A is a national dataset complied by the SAMHSA that includes substance abuse treatment admission-level data for facilities receiving state funds or federal block-grant funds to provide alcohol and/or drug treatment services. The dataset is structured at the admission-level and includes characteristics of each admission including patient demographics, dates of admission, services received, and the state in which facility is located. This dataset is published approximately two-years after the close of the calendar year (e.g., May 2019 for the 2017 dataset). Data for calendar years 2017–2021 were available and used for this evaluation.

Wisconsin Death Records. We obtained mortality data for working age adults in Wisconsin from 2017 through 2022 from the Wisconsin Department of Health Services and merged them with Medicaid enrollment data to identify deaths among Medicaid members and non-Medicaid enrollees.

Wisconsin Family Health Survey (FHS). The Wisconsin Family Health Survey is an annual statewide random-sample telephone survey of all household residents. This survey includes topics such as health insurance coverage, health status, health problems, and use of health care services.

In early 2025, as the final report was being completed, we were made aware of an error in construction of the historical Medicaid claims extract files by the data vendor. The timing meant

that we had time to assess potential impact, but not to redo all analyses and writing. After conducting a comprehensive review of corrected data extract files from the data vendor, we determined that this error resulted in certain claims (and claims-related eligibility) being excluded for cases not active at the time of the monthly ongoing data delivery. This error did not affect the CARES eligibility files but does affect related claims. We examined missingness by eligibility category and over time and found missingness concentrated in the disability population; the number of affected individuals ranged from 0.001% to 0.007% of the study population. There is some minor missingness in the claims files as a result which varies from 0.02% to 0.085% of total monthly visits during the period examined in the data. In order to cause bias in estimates, missingness would need to be correlated with treatment measures which we saw no evidence of. Due to the small scale of the missingness, any potential bias is likely to be minimal.

Provision 1 Methodology: Coverage for CLAs

Evaluation Design

The CLA coverage provision was implemented in 2014. Our overall approach to evaluation was to use interrupted time series and difference-in-differences models to understand the causal effects of the expansion and test whether effects differed in the 2019–2023 period compared to earlier periods. We also used panel data models based on matched border counties. Analysis of administrative costs was descriptive.

Table 1.8 below offers a summary of the evaluation design elements, followed by more detailed descriptions of the design components.

Table 1.8: Provision 1 Summary of Hypotheses, Questions, Data Sources, and Analytic Approaches for Evaluation of the Expansion of Medicaid Benefits to CLAs

Comparison Strategy	Outcome Measures	Data Sources	Analytic Approach
Hypothesis 1.1: The expansion of benefits to CLAs will reduce the state's uninsured rate. *Primary Research Question 1.1: Did the expansion of benefits to CLAs reduce the state's uninsured rate?* *Question 1.1a: What are the trends in Wisconsin's adult uninsured rate and uninsured rate among CLAs?*			
CLAs prior to expansion	No source of insurance coverage	American Community Survey (ACS)	Interrupted time series (ITS).
	Covered by Medicaid/BadgerCare		
	Covered by private insurance	Family Health Survey (FHS)	
	Other public coverage		
Question 1.1b: How much did the change in the number of CLAs due to the Medicaid expansion contribute to the overall change in the adult uninsured rate in Wisconsin?			
CLAs in other states	No source of insurance coverage	American Community Survey (ACS)	Difference-in-differences (DiD).
	Covered by Medicaid/BadgerCare		
	Covered by private insurance	Behavioral Risk Factor Surveillance System (BRFSS)	
	Other public coverage		
Adults in counties that neighbor Wisconsin	No source of insurance coverage	Small Area Health Insurance Estimates (SAHIE)	Panel data models based on geographically contiguous and matched border counties.
Hypothesis 1.2. The expansion of benefits to CLAs will lead to increased access to medical care among poor CLAs. *Primary Research Question 1.2: How did the CLA expansion affect the use of health care services?* *Question 1.2a: Did the CLA expansion increase the use of medical care among low-income CLAs in Wisconsin?*			
CLAs in other states	Doctor visits	Behavioral Risk Factor Surveillance System (BRFSS)	Difference-in-differences (DiD).
	Dentist visits		
	Health care access	Family Health Survey (FHS)	
Parents and caregivers in Wisconsin	Self-reported utilization and access to care	Survey of beneficiaries	
Question 1.2b: What are the short- and long-term effects of eligibility and coverage policies on Medicaid health service expenditures?			
Parents and caregivers in Wisconsin	Total Medicaid-paid health care expenditures	State Medicaid claims	Difference-in-differences (DiD)
	Per-person Medicaid-paid health care expenditures		

Comparison Strategy	Outcome Measures	Data Sources	Analytic Approach
Hypothesis 1.3. By expanding the safety net, the expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals. *Primary Research Question 1.3: Did the CLA expansion reduce the provision of uncompensated care among Wisconsin acute care hospitals?* *Question 1.3a. What are the trends in the provision of uncompensated care among Wisconsin hospitals and did it change along with the expansion of benefits to CLAs?*			
Hospitals prior to CLA expansion	Dollar amount of charity care provision Dollar amount of bad debt	CMS Hospital Cost Reports	Interrupted time series (ITS) using data prior to 2020.
Question 1.3b. Did hospitals in areas with greater reductions in the number of uninsured CLAs experience differential changes in uncompensated care?			
Hospitals in other states	Dollar amount of charity care provision Dollar amount of bad debt	CMS Hospital Cost Reports	Difference-in-differences (DiD) for causal analyses rely on data prior to 2020. Descriptive analysis of 2020 forward are included.
Hospitals in neighboring geographic areas	Dollar amount of charity care provision Dollar amount of bad debt	CMS Hospital Cost Reports	Panel data models based on geographically contiguous and matched border areas. Causal analyses before 2020 and descriptive analyses from 2020 forward are used.
Hypothesis 1.4. Additional requirements of the demonstration may increase administrative costs. *Primary Research Question 1.4: What are the administrative costs incurred by the state and counties to implement and operate the demonstration?* *Q1.4a What are the administrative costs incurred by the state to implement and operate the demonstration?*			
N/A	Administrative costs associated with demonstration startup Ongoing administrative costs of demonstration operations	DHS-provided estimates of contract costs, staff-time equivalents, and other costs	Descriptive analysis of administrative costs over time
Q1.4b How did county income maintenance staff workloads change around implementation of the current demonstration?			
N/A	County administrative costs	County workload reporting data	Descriptive analysis of administrative costs over time

Target and Comparison Populations

The target population was CLAs that received Medicaid health care coverage during the 2019–2023 demonstration period in Wisconsin. The comparison group populations varied depending on the research question as described below. The states included in the Medicaid expansion comparison group includes Minnesota, Michigan, and Illinois. The group of states included in the Medicaid non-expansion comparison group includes Florida, Texas, and North Carolina. A state's Medicaid expansion status was defined based on the presence or absence of an ACA Medicaid expansion during the study period. Because Wisconsin's CLA expansion is unique, comparing to both types of states provides full context for the results.

Q 1.1. "Did the CLA expansion reduce the state's uninsured rate?": To examine changes in uninsured rate trends, CLAs in years prior to the current 2019–2023 demonstration period were a comparison group including CLAs before CLA expansion began in 2014. The second comparison group was CLAs from other states including states that fully expanded Medicaid to 138% of the FPL and states that did not expand. The third comparison group was adults in counties that border Wisconsin.

Q 1.2. "How did the CLA expansion affect the use of health care services?": Two groups were compared to CLAs on measures of health care utilization and access including parents and caregivers with BadgerCare coverage. The second comparison group included CLAs in Medicaid expansion and non-expansion states. For 1.2b, an examination of the expansion's effects on health service expenditures, we adapted the evaluation design. Specifically, the planned external comparison group was to be constructed from the H-CUP State Inpatient Databases. However, it was not possible to reliably identify CLAs in these data, so there is no external comparison group for 1.2b and we instead compared to parents and caretakers with BadgerCare.

Q 1.3. "Did the CLA expansion reduce the provision of uncompensated care among Wisconsin acute care hospitals?": The provision of uncompensated care in all Wisconsin hospitals was compared to hospitals in Wisconsin prior to the CLA expansion, hospitals in the Medicaid expansion and non-expansion states, and hospitals in geographic areas in other states bordering Wisconsin.

Q 1.4. "What are the administrative costs incurred by the state and counties to implement and operate the demonstration?": Descriptive analyses only of administrative costs over time were conducted without a comparison group.

Evaluation Period

The primary focus of analyses included data from the 2019–2023 demonstration period. Data from earlier periods were also analyzed to provide context to the changes that occurred during the demonstration period. Trend analyses of changes in uninsured rates include the previous 2014–2018 demonstration period and the 2009–2013 period prior to the CLA coverage expansion. Changes in healthcare utilization for CLAs included the 2012–2018 period. Changes in uncompensated care included data describing the prior period from 2010–2018. Effects may differ across these time periods, which we allowed for in the analyses.

Data Sources and Outcome Measures

Data sources and outcome measures for the evaluation of the eligibility expansion are summarized for each below. The *Secondary Data* section of the report provides a complete description of each data source for the entire demonstration evaluation.

In Question 1.1, health insurance outcomes from the ACS, FHS, and BRFSS were defined as binary measures. The ACS asks its respondents whether a person is currently covered by any of the listed types of health insurance. Thus, the ACS measures health insurance for the Wisconsin population based on how/whether people are insured at the point-in-time that they answered the survey during the year of collection. Individuals can report more than one source of health insurance coverage at the time of the survey, so the sum of the sources of coverage will not total 100%. The FHS asks whether the individual was covered at any time during the last 12 months. We also reported health insurance coverage from the BRFSS overall and by income. Because the BRFSS reports income in eight categories and because these categories do not align with the FPL thresholds used to determine Medicaid eligibility, we followed a procedure suggested by the State Health Access Data Assistance Center and defined income as a percent of FPL for each respondent using the lowest income level in the category, creating a "lower bound" measure. Thus, the income measures reported should be considered rough approximates.

In the BRFSS, individuals were asked: "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, or Indian Health Service?" This variable was constructed as a binary variable equal to 1 if the individual responded "Yes" and 0 if they responded "No." "Don't know/not sure" or "Refused" responses were coded as missing. The SAHIE analysis outcome was the county-level uninsurance rate.

For Question 1.2a, examining changes in CLA use of health care, data from the BRFSS were used to analyze trends in access to care coverage among Wisconsin adults. We examined the following outcomes:

- **Cost as a barrier to care**: Individuals were asked, "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" This variable was constructed as a binary variable equal to 1 if the individual responded "No" and was coded as 0 if the individual responded "Yes."

- **Have personal doctor**: Individuals were asked, "Do you have one person you think of as your personal doctor or health care provider?" This variable was constructed as a binary variable equal to 1 if the individual responded "Yes" and 0 if they responded "No." "Don't know/not sure" or "Refused" responses were coded as missing.

- **Routine checkup**: Individuals were asked, "About how long has it been since you last visited a doctor for a routine checkup? [A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.]" This variable was constructed as a binary variable equal to 1 if the individual responded "Within past year (anytime less than 12 months ago)" and was coded as 0 if the individual responded "Within past 2 years (1 year but less than 2 years ago)" or "Within past 5 years (2 years but less than 5 years ago)" or "5 or more years ago" or "Never." "Don't know/not sure" or "Refused" responses were coded as missing.

- **HIV test**: Individuals were asked, “Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation. Include testing fluid from your mouth.” “Yes” responses were coded as 1 and “No” responses as 0. “Don’t know/not sure” or “Refused” responses were coded as missing.

- **Pneumonia shot**: Individuals were asked, “Have you ever had a pneumonia shot also known as a pneumococcal vaccine?” Those who responded “Yes” were coded as 1, those who responded “No” were coded as 0, and those who responded “Don’t know/not sure” or “Refused” were coded as missing.

- **Flu shot**: Individuals were asked, “During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose? (A new flu shot came out in 2011 that injects vaccine into the skin with a very small needle. It is called Fluzone Intradermal vaccine. This is also considered a flu shot.)” Those who responded “Yes” were coded as 1, those who responded “No” were coded as 0, and those who responded “Don’t know/not sure” or “Refused” were coded as missing.

- **Last dental visit**: Individuals were asked, “Including all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists, how long has it been since you last visited a dentist or a dental clinic for any reason?” This variable was constructed as a categorical variable equal to 1 if the individual responded “Within the past year (anytime less than 12 months ago),” and 0 otherwise. “Don’t know/not sure” or “Refused” responses were coded as missing.

The Wisconsin Family Health Survey (FHS) from 2012 through 2022 was also used to examine trends in access to care coverage among Wisconsin adults aged 18–64. The report presents data on evenly spaced years: 2012, 2015, 2018, 2022. Access to care in 2021 may have been affected by the COVID-19 Public Health Emergency.

We examined the following outcomes from the FHS:

- **Has a usual place of care**: Individuals were asked “Is there one particular clinic, health center, doctor’s office or other place that you yourself usually go to if you are sick or need advice about your health?” This variable was constructed as a binary variable equal to 0 if the individual responded “no” and was coded as 1 if the individual responded “yes.”

- **Had a checkup in the past 12 months**: Individuals were asked “About how long has it been since you visited a doctor for a routine physical exam?” This variable was constructed as a binary variable equal to 1 if the individual indicated that such a visit occurred in the past 12 months and 0 otherwise.

- **Hospitalized in the past 12 months**: Individuals were asked “In the past 12 months, who in your household has stayed overnight in a hospital?” This variable was constructed as a binary variable equal to 1 if the individual responded that they themselves stayed overnight in a hospital and 0 otherwise.

- **ER visit in the past 12 months**: Individuals were asked “In the past 12 months, who in your household has been treated at a hospital emergency room?” This variable was constructed as a binary variable equal to 1 if the individual responded that they themselves were treated in an ER and 0 otherwise.

- **Dentist visit in the past 12 months**: Individuals were asked "About how long has it been since you visited a dentist?" This variable was constructed as a binary variable equal to 1 if the individual indicated that such a visit occurred in the past 12 months and 0 otherwise.

- **Could not get needed care**: Individuals were asked, "During the last 12 months, was there any time when you needed medical care or surgery but did not get it?" Those who responded "Yes" were coded as 1, those who responded "No" were coded as 0.

While most of these measures clearly indicate access to care—such as "has a usual place of care," "checkup in past 12 months," "dentist visit in past 12 months," and "could not get needed care in past 12 months"—other measures are more nuanced. For example, being hospitalized in past 12 months could indicate access to needed care or could indicate lack of access to primary care resulting in an avoidable hospitalization. Similarly, ER visits could indicate appropriate access to care or could result from not having access to primary care.

Medicaid expenditure outcomes in Question 1.2b were constructed using the Medicaid claims and encounter data and reflect the sum of allowed amounts across all medical categories (including pharmacy).

For Question 1.3 examining possible reductions in the provision of uncompensated care among Wisconsin acute care hospitals, data were drawn from CMS Hospital Cost Reports. These reports are submitted to CMS annually by all acute-care and critical access hospitals (CAHs). Data on UCC are reported in Worksheet S-10 of Form CMS-2552-10, which was first used beginning in May 2010. While all hospitals receiving Medicaid reimbursement complete CMS-2552-10, only acute care hospitals and CAHs complete worksheet S-10 and we include both types of hospitals in all analyses. Extracted from these reports, at the hospital-level, were measures of charity care and bad debt which we totaled to uncompensated care. In particular, these measures were constructed as:

- **Charity Care**: Charity care (or financial assistance) consists of services for which hospitals neither received, nor expected to receive, payment because they had determined the patient's inability to pay.

- **Bad Debt**: Bad debt consists of services for which hospitals anticipated but did not receive payment.

- **Uncompensated Care**: Uncompensated care is the sum of charity care and bad debt. In practice, hospitals have difficulty distinguishing between charity care and bad debt.

The analysis compared trends in uncompensated care among Wisconsin hospitals located in border counties with adjacent border-county hospitals in Michigan, Minnesota, Iowa, and Illinois. Each border county was matched with multiple neighbors and each match represents a unique and fixed pair in the statistical analysis. Thus, we examined whether there was a trend in the difference in hospital uncompensated care between, for example, Burnett County, Wisconsin and Pine County, Minnesota. **Table 1.9** lists the set of Wisconsin counties and matched border counties. Our definition of acute care hospitals included critical access hospitals and excluded long-term stay and specialty hospitals.

For Question 1.4a examining the state administrative costs of the demonstration waiver, the Wisconsin State DHS provided data from administrative systems describing annual full-time

equivalents (FTEs) and salary costs for staff who worked on the demonstration provisions. Annual contractor costs were also collected from DHS including costs for adapting the application and renewal system to allow applicants to take the health assessment surveys and members to make premium payments. Other contractor data described the cost to adapt other Medicaid administrative data systems including the Medicaid claims and encounter systems.

Table 1.9: Matched State Border Counties for Uncompensated Care and SAHIE Analyses

Wisconsin Border Counties	Counties from Bordering States
Burnett County	Pine County, MN
Burnett County	Chisago County, MN
Crawford County	Clayton County, IA
Crawford County	Allamakee County, IA
Douglas County	Carlton County, MN
Douglas County	Pine County, MN
Douglas County	St. Louis County, MN
Grant County	Dubuque County, IA
Grant County	Jo Daviess County, IL
Grant County	Clayton County, IA
Green County	Winnebago County, IL
Green County	Stephenson County, IL
Kenosha County	Allegan County, MI
Kenosha County	McHenry County, IL
Kenosha County	Lake County, IL
La Crosse County	Winona County, MN
Lafayette County	Stephenson County, IL
Lafayette County	Jo Daviess County, IL
Marinette County	Dickinson County, MI
Pepin County	Wabasha County, MN
Pepin County	Goodhue County, MN
Pierce County	Washington County, MN
Pierce County	Goodhue County, MN
Pierce County	Dakota County, MN
Polk County	Washington County, MN
Polk County	Chisago County, MN
Rock County	Winnebago County, IL
St. Croix County	Washington County, MN
Trempealeau County	Winona County, MN
Vernon County	Allamakee County, IA
Vilas County	Iron County, MI
Vilas County	Gogebic County, MI
Walworth County	McHenry County, IL

A data gap prevented the analysis of local administrative costs for Question 1.4b. Local, county income maintenance staff workloads were planned to be assessed for changes related to the implementation of the demonstration. While the initial evaluation design planned to access a data source at the Wisconsin DHS, no such data was found on county income maintenance workloads specific to the CLA demonstration for the 2019–2023 waiver period.

Analytic Methods

Three analytic approaches were used to evaluate the CLA coverage provision including interrupted time series (ITS), difference-in-differences (DiD), and panel data models based on geographically contiguous and matched counties. Detailed descriptions of these analytic techniques can be found in the Evaluation Design Report (**Attachment 1**). Each of the primary research questions were addressed as follows:

Question 1.1. Did the CLA expansion reduce the state's uninsured rate? Interrupted time series (ITS) analyses were used to determine whether the CLA expansion reduced the fraction of CLAs without health insurance. Additional outcomes examined included sources of insurance coverage including Medicaid/BadgerCare, private insurance, and other sources of public coverage such as Medicare. Using difference-in-differences (DiD) modeling, changes in coverage for CLAs in Wisconsin were compared with changes in CLAs in other states that did not expand Medicaid, as well as with the change in states that fully expanded Medicaid. This analysis also examined changes in sources of coverage (Medicaid/BadgerCare, private, other public). Data sources include ACS, FHS, and BRFSS. ACS analyses excluded 2020 due to changes to the survey processes related to the public health emergency impacting data quality.

Adults in counties that border Wisconsin were compared with adults in Wisconsin by geographically matching border counties in Wisconsin to their contiguous border counties in neighboring states and by estimating panel data models using the SAHIE. Since all of Wisconsin's neighboring states (except Iowa) implemented a full ACA Medicaid expansion, the CLA expansion was effectively compared to a full Medicaid expansion in this analysis.

Question 1.2. Did the CLA expansion increase the use of medical care among poor CLAs in Wisconsin? One analysis compared Wisconsin CLAs and parents and caregivers using DiD with the Wisconsin Family Health Survey data. A second analysis of the BRFSS data compared CLAs in Wisconsin with CLAs in other states using DiD. We undertook a similar comparison between parents and caregivers versus CLAs enrolled in Medicaid by taking advantage of the historical data available in the Wisconsin Medicaid Beneficiary Survey using DiD. A final analysis of expenditures was conducted with Wisconsin Medicaid data comparing CLAs and parents and caregivers using descriptive trends and DiD techniques.

Question 1.3. Did the CLA expansion reduce the provision of uncompensated care among Wisconsin acute care hospitals? ITS, DiD, and panel data models were used for analyses on hospitals in geographically matched areas to determine the impact of the CLA expansion on the provision of charity care and on bad debt by hospitals using hospital cost-report data.

Question 1.4. What are the administrative costs incurred by the state to implement and operate the demonstration? Descriptive analyses of DHS administrative data were used to analyze the administrative costs to implement demonstration policies typically incurred in the years prior to and including 2019, the initial year of the demonstration. Analyses also examined ongoing operational costs through the end of the demonstration period in 2023. Implementation of some provisions was delayed and/or extended due to the COVID PHE and, thus, the analysis

timeframe for both implementation and operations costs varies depending on the provision. Analyses distinguish State DHS costs versus contractor costs.

Methodological Limitations

Because the CLA expansion was implemented at a single time statewide and without randomized controls, the evaluation relied on quasi-experimental methods. The state reduced eligibility for parents from 200% FPL to 100% FPL simultaneous to the childless adult expansion, complicating interpretation of results for outcomes that cannot be limited to childless adults. An additional limitation when using parents and caretakers as a control group is that parents and caretakers tend to be healthier than CLAs, and may have different trends in their health and health care utilization that change over time in ways that are not captured by the statistical modeling. Unlike some other provisions in the 2019–2023 demonstration waiver, CLA coverage continued through the COVID-19 pandemic period and thus the evaluation design was minimally impacted. Evaluation of the CLA coverage's impact on the uninsured rate, health care utilization, and uncompensated acute hospital care all use a pre-post design to examine change after the 2019–2023 demonstration waiver period began. However, the evaluation does not rely on post-2020 data for causal inference due to the impact of the COVID pandemic period. The evaluation of this provision could have excluded the 2020 period and retained the use of ITS methods. However, because trends in the waiver population during the pandemic period and beyond are of interest to understand the remaining waiver provisions, we also included a description of these trends, allowing for heterogeneity over time, when feasible.

Provision 3 Methodology: ED Copayments for CLAs

Evaluation Design

Emergency department (ED) copayments were newly implemented during this waiver period, in November 2020. The evaluation design for the ED copayment provision for CLAs focused on their implementation and the causal impact of the ED copayments between 2020–2023 after the policy was implemented. The impact on ED visits in this period was analyzed relative to ED visit trends for CLAs in 2016–2019 prior to the ED copayment policy in DiD analyses. ED visits for Medicaid-enrolled parents and caregivers as well as commercially-insured adults were also analyzed for comparison. These same two comparison groups were used to analyze the relative effect of ED copayment policies on the use of primary care services. We included models that exclude the pandemic period, defined as March 2020–March 2021, to avoid COVID-related disruptions in the baseline. When examining members' and hospitals' understanding of the ED copayment policy, we used descriptive analyses of member survey data in 2020, 2022, and 2024. To measure the consistency of hospital implementation of the policy, our approach was to use hospital-level descriptive analyses and DiD models.

Table 1.10 summarizes elements of the evaluation design with further descriptions of the design components.

Table 1.10: Provision 3: Summary of Hypotheses, Questions, Data Sources, and Analytic Approaches for Evaluation of Emergency Department Copayment Requirements for CLAs

Comparison Strategy	Outcome Measures	Data Sources	Analytic Approach
Hypothesis 3.5: The imposition of a copayment for non-emergent use of the emergency department will lead to more appropriate uses of medical care among CLAs enrolled in Medicaid.			
Primary research question 3.5: Did the imposition of a copayment for non-emergent use of the emergency department reduce the number of non-emergency visits to the emergency department among CLAs enrolled in Medicaid?			
Question 3.5a: What was the number of non-emergent visits to the emergency department among CLAs prior to the imposition of copayments?			
No comparison strategy is required	Number of non-emergent ED visits	CARES and WI Medicaid Claims and Encounter Data	Descriptive
Question 3.5b: What was the total number of emergency department visits among CLAs prior to the imposition of copayments?			
No comparison strategy is required	Total number of ED visits	CARES and WI Medicaid Claims and Encounter Data	Descriptive
Question 3.5c: How did the numbers of emergency department visits and non-emergent visits change among CLAs after the imposition of copayments?			
CLAs enrolled prior to introduction of ED copayments	Total number and number of non-emergent ED visits	CARES and WI Medicaid Claims and Encounter Data	DiD
Parents and caregiver adults	Total number and number of non-emergent ED visits	CARES and WI Medicaid Claims and Encounter Data	DiD
Commercially insured adults	Total number and number of non-emergent ED visits	WHIO	DiD
Question 3.5d: How did the use of primary care change among CLAs after the imposition of copayments for non-emergent visits to the emergency department?			
Parents and caregiver adults	Total number and number of primary care visits	CARES and WI Medicaid Claims and Encounter Data	DiD
Commercially insured adults	Total number and number of primary care visits	WHIO	DiD
Question 3.5e: Do beneficiaries with copayment requirements understand their payment obligations?			
No comparison strategy is required	Knowledge and understanding of payment obligations	Beneficiary survey	Descriptive
Hypothesis 3.6: Hospitals vary in how they implement the required copayment for non-emergency use of the ED.			
Primary research question 3.6: Are hospitals consistent in how they are defining non-emergent use of the emergency department, as necessary to apply the associated Medicaid copayment policy?			
Question 3.6a. Do hospitals understand the policy requiring a copayment for non-emergent use of the emergency department?			
No comparison strategy is required	Understanding of copayment requirements	Beneficiary survey and interviews	Descriptive

Comparison Strategy	Outcome Measures	Data Sources	Analytic Approach
Hypothesis 3.7. Hospitals implement the policy requiring a copayment for non-emergent use of the emergency department in a consistent manner.			
Primary research question 3.7: Are hospitals consistent in how they are implementing the policy requiring a copayment for non-emergent use of the emergency department?			
Question 3.7a: Is the definition of non-emergent ED visits consistently applied across hospitals?			
CLAs subject to copayments	Hospital-level measure of the ratio of visits for which copayments assessed, relative to the number of non-emergent visits measured using the Billings (2000) probabilistic method	CARES and WI Medicaid Claims and Encounter Data	Descriptive
Parents and caregiver adults	Hospital-level measure of the ratio of non-emergent to total ED visits	CARES and WI Medicaid Claims and Encounter Data	DiD

Target and Comparison Populations

The target population for the evaluation of ED copayment policy included CLAs in the Wisconsin Medicaid program during the 2020–2023 policy implementation period. For Question 3.5 examining the effect of the ED copayment policy on ED visits, three comparison groups were used. First, ED visits for CLAs enrolled in Medicaid prior to the imposition of ED copayments for non-emergent use were analyzed. Second, ED visits for parents and caregivers in Wisconsin who were enrolled in Medicaid were comparatively analyzed. Third, ED visits for adults enrolled in commercial insurance in Wisconsin were comparatively analyzed.

For Questions 3.5.e and 3.6 examining understanding of the ED copayment policy, no comparison group analyses were necessary since these questions apply only to CLAs.

Two comparison groups were used for Question 3.7 examining the consistency with which hospitals implemented the ED copayment policy. CLAs enrolled in Medicaid prior to the imposition of the policy and parents and caregivers enrolled in Medicaid during the ED policy period were used as comparison groups.

Evaluation Period

The evaluation period includes the years 2016 through 2023, which includes a pre-period before copayments begin, through the end of the evaluation period, with exceptions for analyses of commercially insured which begin in 2017 due to a data limitation and hospital-level analyses which begin in 2018 to maintain a time-consistent set of hospitals in operation.

When the Medicaid Beneficiary Survey data are analyzed, the final survey conducted in 2024 provides a point-in-time assessment of members' experiences at the end of the waiver period. When changes are analyzed with the survey data, data from the first survey conducted in 2020 just before the SUD provision was implemented are used as a baseline.

Data Sources and Outcome Measures

The data sources and outcome measures for the evaluation of the ED copayment policy are summarized for each below. The Secondary Data section of the report provides a complete description of each data source for the entire demonstration evaluation.

Medicaid enrollment, claims, and encounter data were the sources for identifying CLAs and their ED visits. Non-emergent ED visits subject to the copayment policy were measured using a probabilistic method developed for claims data.[10] We note that this measure of non-emergent visits was created as a way to use administrative records to measure population ED use, not as a way to triage patients or classify them for reimbursement purposes or to assess appropriateness of ED utilization, which may depend on factors not available for measurement in the administrative data. This measure allows us to create a time-consistent definition of the broader set of visits most likely to be impacted by the copayment policy. To identify primary care utilization, we have included any visits with one of the "definite" codes ("320" for geriatrics; "316" for family practice; "271" and "318" for general practice; and "92" for nurse practitioner family practice) which is a slightly narrower definition than within the Medicaid claims. As part of our

[10]Billings John, Nina Parikh, Tod Mijanovich. Emergency Department Use: The New York Story. New York (NY): Commonwealth Fund; 2000 Nov. (Issue Brief). https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2000_nov_emergency_room_use__the_new_york_story_billings_nystory_pdf.pdf

measure development process, we verified that results were robust to a broader definition of primary care.

The research team conducted three Medicaid Beneficiary Surveys in 2020, 2022, and 2024 that included questions about the ED copayment policy. Survey questions were used to examine Question 3.5.e provide measures of awareness of the ED copayment policy, its deterrent effect on use of the ED, and the financial burden of the copayment. The complete set of 2024 survey results are available in **Attachment 3**.

Hospital focus groups were proposed in the Evaluation Design Report to evaluate Question 3.6 about hospitals' awareness and definition of the copayment policy. However, in consultation with Wisconsin DHS, it was decided that the burdens faced by hospitals such as staff shortages due to the COVID-19 pandemic necessitated dropping the additional burden that focus groups would have imposed on hospitals. Instead, focused member surveys and member interviews, alongside administrative data, served as data sources to understand how hospitals varied in their implementation of ED copayments. These reflect member experiences of implementation.

In Question 3.7, the hospital-level measure of the ratio of visits for which copayments were assessed relative to the number of non-emergent visits was not feasible as an outcome because copayments were so infrequently assessed. Instead, we analyzed Medicaid claims and encounter data for this measure descriptively during the 2020–2023 policy implementation period and assessed the hospital-level measure of the ratio of non-emergent to total ED visits using a DiD approach using 2018–2023 data as planned.

Analytic Methods

We addressed the primary research questions as follows:

Question 3.5. Did the imposition of a copayment for non-emergent visits to the emergency department reduce the number these visits among CLAs enrolled in Medicaid? Using the comparison group of parents and caregivers enrolled in Wisconsin Medicaid, DiD models comparing outcomes among CLAS relative to parents before versus after the implementation of copayments were estimated for non-emergent and total ED visits. Similar DiD models were also estimated for non-emergent and total ED visits using the comparison group of commercially insured adults in Wisconsin. We also provided descriptive analyses of the survey data including comparisons of CLAs and parents in the 2024 survey and changes in CLA responses from the 2020 baseline to the 2024 endline survey. In each year, we tested for differences across the two groups using two-sided t-tests (or chi-squared tests for response options with more than two levels). We also tested for differences adjusted by age, race, Hispanic ethnicity, and gender in a logistic (or multinomial logistic, as appropriate) regression.

Question 3.6. Are hospitals consistent in how they are defining non-emergent use of the emergency department, as necessary to apply the associated Medicaid copayment policy? Descriptive analysis of the 2022 interim beneficiary survey and interviews, focusing on ED visits and copayments, was performed.

Question 3.7. Are hospitals consistent in how they are implementing the policy requiring a copayment for non-emergent use of the emergency department? We employed a descriptive analysis of the extent of variation across hospitals in whether they collect copayments and differences among hospitals that did and did not charge copayments. Non-emergent visits were measured using the probabilistic method developed for claims data described above. Our

hospital-level measures of non-emergent visits sum the probabilities that visits are non-emergent by hospital, eligibility group, and month. We also used DiD analysis to determine whether ED visits at the hospital level changed for CLAs following the imposition of the copayment requirement relative to a comparison group of parents and caregivers enrolled in Wisconsin Medicaid.

Methodological Limitations

Several major limitations were relevant to studying ED copayments. First, the implementation sequence of the ED copayments, which first began on July 1, 2020, but was then retroactively eliminated and again implemented November 2, 2020, means that it is somewhat unclear what to expect about member response. The second major limitation is the simultaneity of occurrence of the implementation with the COVID-19 pandemic. Our models that leave out the pandemic period defined as March 2020 to March 2021 also leave out the intermediate implementation period and so may address both concerns. However, the severity of pandemic impacts on health care utilization requires cautious interpretation of observed outcomes and is unlikely to be fully addressed by this method; we are uncertain whether isolating the demonstration effects is fully feasible. An additional limitation of both the parents and caregivers and commercially insured adults as control groups is that they tend to be healthier than CLAs, and may have different trends in their health and health care utilization that change over time in ways that are not captured by the statistical modeling. Finally, the COVID-19 pandemic also limited our ability to conduct focus groups and obtain direct data on policy implementation from hospitals.

Provision 4 Methodology: Substance Use Disorder Treatment Coverage Expansion

Evaluation Design

Evaluation of Provision 4 was designed to identify the effects of a new residential SUD treatment benefit on SUD-related health care access, health care use more generally, and overdose mortality by comparing these outcomes before and after the benefit's implementation in February 2021.

Descriptive analyses were used to summarize and compare outcome trends and point-in-time outcomes within and, when available, across groups. DiD was the analytic approach used to address the primary non-descriptive research questions for evaluation of SUD waiver provision. Our primary models excluded the pandemic period for DiD analyses to avoid COVID-related disruptions in the baseline period. For completeness, models that include the pandemic period within the pre-implementation period are also shown.

A summary of the elements of the evaluation design are described in **Table 1.11** followed by further descriptions of the design components. The format of the table conforms to the specific CMS guidance for the evaluation of SUD waiver demonstrations and differs from table formats in prior sections. Consistent with the CMS guidance, the evaluation was organized around evaluation questions with specific hypotheses following each question, in contrast to Provisions 1 and 3.

Table 1.11: Provision 4: Summary of Questions, Hypotheses, Data Sources, and Analytic Approaches for Evaluation of the SUD Demonstration Waiver

Driver	Measure Description [steward]	Numerator	Denominator	Data Source	Comparison Group(s)	Analytical Approach
Q4.1 Does the SUD demonstration waiver increase the supply of SUD providers for Medicaid enrollees?						
H4.1a. The SUD demonstration waiver will increase the supply of SUD providers that accept and/or treat Medicaid enrollees.						
Secondary Driver (Increase Supply of Providers)	Number of residential treatment facilities that accept Medicaid patients [n/a]	Facility reports willingness to accept Medicaid patients	Federal, state, and local government and private residential treatment facilities that provide substance abuse treatment services	National Survey of Substance Abuse Treatment Facilities	All treatment facilities in Wisconsin and in selected comparison states for the measurement period	Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Modified selection criteria of comparison states to include state-level COVID-19 outcomes. Interpretation of DiD findings include discussion of the potential residual confounding effects of the pandemic.
Secondary Driver (Increase Supply of Providers)	Proportion of Medicaid clinicians that provide treatment for SUD [n/a]	Number of clinicians that provide one or more services with an SUD diagnosis in any category of service (i.e., outpatient, inpatient, emergency department) in the measurement period	Number of active clinicians that provide any outpatient, inpatient, IMD, or emergency department service to one or more adult Medicaid enrollees in the measurement period.	WI Medicaid claims and encounter	Clinicians who provided any service to one or more adult Medicaid enrollee during the three years before SUD waiver implementation, and clinicians who provided any service to one or more adult Medicaid enrollee during the three years after SUD waiver implementation.	ITS analysis dropped as it would be strongly confounded by COVID disruptions. Implement a DiD in which we compare the change in # of clinicians that provide one or more services with an SUD diagnosis, to the change in # of clinicians who provide one or more services with a diabetes diagnosis. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.
Q4.2 Does the SUD demonstration waiver increase access to, and use of, newly covered SUD services for Medicaid enrollees?						
H4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time						
Secondary Driver (Increase Utilization)	Awareness of Medicaid coverage for SUD services [n/a]	Beneficiary Survey	Beneficiary Survey	Beneficiary Survey	Cross-sectional sample of enrollees at two post-implementation time points	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analysis compares pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.

Driver	Measure Description [steward]	Numerator	Denominator	Data Source	Comparison Group(s)	Analytical Approach
H4.2b. The SUD demonstration waiver will increase use of SUD treatment in IMD settings including residential treatment, inpatient treatment, medically supervised withdrawal services and MAT for opioid use disorder.						
Secondary Driver (Increase Utilization)	Any use of SUD treatment in IMD setting and volume of use, overall and by service type [n/a]	Any SUD treatment use overall and by service type; quantity of SUD treatment services received by service type.	All admissions during the measurement period from treatment facilities that receive state funds or federal block grant funds to provide alcohol and/or drug treatment services	Treatment Episode Dataset - Admissions	Admissions to drug treatment facilities in WI and a set of comparison states for three years before and two years after implementation of the SUD demonstration waiver in WI.	Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Modified selection criteria of comparison states to include state-level COVID-19 outcomes. Interpretation of DiD findings include discussion of the potential residual confounding effects of the pandemic.
H4.2c. The SUD demonstration waiver will increase initiation and engagement in SUD treatment.						
Secondary Driver (Increase Utilization)	Initiation and engagement of alcohol and other drug dependence treatment [NCQA-IET]	Initiation- # of enrollees who initiated treatment w/in 14 days of the index episode. Engagement- # of enrollees who initiated treatment & had >=2 additional services with a diagnosis of AOD w/in 30 days of initiation visit	Enrollees with a new diagnosis of AOD received between 1/1–11/15 of the measurement year, and continuous enrollment 60 days before new diagnosis and 44 days post.	WI all-payer claims database (DiD analysis); Medicaid claims and encounter (validation analysis)	For DiD: Non-elderly adults enrolled in Medicaid and non-elderly adults enrolled in private insurance during the three years before and/or after implementation of the waiver.	ITS analysis dropped as it will be strongly confounded by COVID disruptions. Implemented descriptive trend analysis with Medicaid data to validate all-payer data. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.
Q4.3 Does the SUD demonstration waiver change Medicaid enrollees' use of existing covered SUD services?						
H4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services, including in-person and telehealth, and pharmacotherapy treatment provided outside of IMD settings.						
Secondary Driver (Increase Utilization)	Any outpatient visit for SUD treatment, and volume of outpatient visits for SUD treatment. [MODRN]	Any, and # of non-emergency department, outpatient claims with a SUD diagnosis and of an OUD diagnosis. Outpatient visits include in-person and telehealth visits.	All member-months observed for target population and comparison group during the measurement period	Same as H4.2c	Same as H4.2c	ITS analysis dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.

Driver	Measure Description [steward]	Numerator	Denominator	Data Source	Comparison Group(s)	Analytical Approach
Secondary Driver (Increase Utilization)	Any medication assisted treatment for opioid use disorder [MODRN]	Any claim for buprenorphine, naltrexone (oral), injectable naltrexone, buprenorphine/Naloxone or a HCPCs code for buprenorphine or buprenorphine/ naloxone, methadone administration, or naltrexone	All member-months observed for enrollees with at least one encounter with a diagnosis of OUD in inpatient, outpatient and professional claims during the measurement period	Same as H4.2c	Same as H4.2c	ITS analysis dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.
Secondary Driver (Increase Utilization)	Any outpatient visit for SUD treatment; any prescription medication treatment for SUD [n/a]	Beneficiary Survey	Beneficiary Survey	Beneficiary Survey	Cross-sectional sample of enrollees at two post-implementation time points	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analysis compare pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.
H4.3b. The SUD demonstration waiver will reduce use of hospital-based services, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.						
Primary Driver (Reduce Hospital-Based SUD Service Use)	Any emergency department visit with a SUD-diagnosis, and volume of emergency department visits with an SUD diagnosis [MODRN]	Any, and # of ED visits with a SUD diagnosis of any kind; any and # of ED visits with an OUD diagnosis	All member-months observed for target population and comparison group during the measurement period	Same as H4.2c	Same as H4.2c	Descriptive analyses are unchanged. The ITS analysis is dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.
	Any hospitalization with a SUD diagnosis, and number of hospitalizations with a SUD diagnosis [MODRN]	Any, and # of hospitalizations with a SUD diagnosis of any kind; any, and # of hospitalizations with an OUD diagnosis	All member-months observed for target population and comparison group during the measurement period	Same as H4.2c	Same as H4.2c	Descriptive analyses are unchanged. The ITS analysis is dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.

Driver	Measure Description [steward]	Numerator	Denominator	Data Source	Comparison Group(s)	Analytical Approach
Primary Driver (Reduce Hospital-Based SUD Service Use)	Any, and volume of readmissions within 30-days following hospitalization for a SUD diagnosis [n/a]	Any, and # of readmissions to the hospital within 30-days for an SUD diagnosis of any kind; any and # of readmissions to the hospital within 30-days for an OUD diagnosis	Hospital discharges with a diagnosis of SUD in the measurement period among enrollees with continuous enrollment for a least 31 days post-hospitalization.	Same as H4.2c	Same as H4.2c	Descriptive analyses are unchanged. The ITS analysis is dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.
	Any emergency department visit for a SUD; any hospitalization for a SUD [n/a]	Beneficiary Survey	Beneficiary Survey	Beneficiary Survey	Cross-sectional sample of enrollees at two post-implementation time points	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analyses compare pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.
H4.3c The SUD demonstration waiver will increase use of health care for co-morbid physical and mental health conditions among enrollees with a SUD, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.						
Primary Driver (Increase Use of Health Care for Co-Morbid Conditions)	Any outpatient visit for a non-SUD diagnosis; Quantity of outpatient visits for a non-SUD diagnosis [n/a]. Outpatient visit includes in-person and telehealth visits.	Any, and # of non-emergency department, outpatient claim with a non-SUD diagnosis; any, and # of non-emergency department outpatient claims with a non-SUD diagnosis	All member-months observed for target population and comparison group members with at least one inpatient, outpatient, emergency department or IMD claim with an SUD diagnosis	Same as H4.2c	Same as H4.2c	Descriptive analyses are unchanged. The ITS analysis is dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.
Primary Driver (Increase Use of Health Care for Co-Morbid Conditions)	Health status and chronic conditions; access and use of general medical care; Substance use and SUD; access and use of drug Tx; knowledge/ understanding of waiver provisions	Beneficiary Survey	Beneficiary Survey	Survey	Cross-sectional sample of enrollees at two post-implementation time points	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analysis compares pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.

Driver	Measure Description [steward]	Numerator	Denominator	Data Source	Comparison Group(s)	Analytical Approach
H4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.						
Primary Driver (Increase adherence to SUD treatment)	Continuity of pharmacotherapy for OUD [NQF 3175, MODRN]	Enrollees who have at least a) 90 days, and b) 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than 7 days.	Enrollees that meet Inclusion criteria: individuals with a diagnosis of OUD in inpatient, outpatient or professional claims at any time during the measurement period; and at least one claim for an oral OUD medication during the measurement period received with at least 180 days before the end of the final calendar year of the measurement period; and continuously enrolled for at least 6 months after the month with the first OUD medication claim in the measurement period with no gap in that enrollment.	Same as H4.2c	Same as H4.2c	Descriptive analyses are unchanged. The ITS analysis is dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.
Q4.4 Does the SUD demonstration waiver reduce the rate of drug overdose deaths among Medicaid enrollees including opioid-related deaths? **H4.4a. The SUD demonstration waiver will reduce the rate of drug overdose deaths among Medicaid beneficiaries, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.**						
Purpose (Reduce drug overdose deaths including opioid-related deaths)	Rate of drug overdose death, and opioid-related drug overdose death [WIDHS - Technical Notes Annual Death Report, 2017, P-01170-19]	# of deaths due to any type of drug overdose; # of deaths due to opioid drug overdose	Medicaid non-elderly adult population for the measurement period; Estimated Wisconsin non-elderly adult population not enrolled in Medicaid for the measurement period; Estimated Wisconsin non-elderly population in the measurement period.	WI Death Records; Census Estimates; Medicaid Enrollment	For DD: Wisconsin non-elderly adult population not enrolled in Medicaid during the measurement period	Descriptive analyses are unchanged. The ITS analysis is dropped as it will be strongly confounded by COVID disruptions. Excluded 2020 from the baseline period for DiD models to avoid COVID-19 related effects on outcomes during the baseline. Interpretation of DiD findings include discussion of the potential confounding effects of the pandemic.

Driver	Measure Description [steward]	Numerator	Denominator	Data Source	Comparison Group(s)	Analytical Approach
Q4.5 What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?						
	Total health care costs; SUD and non-SUD costs; category-specific costs (e.g., inpatient, pharmacy, outpatient non-ED, outpatient ED, long-term care). [CMS SUD Evaluation Design TA Attachment A]	Medicaid amount paid for each outcome noted.	All member-months observed during the measurement period for the target population.	Medicaid claims and encounter data.	Non-elderly adult Medicaid beneficiaries enrolled during the 3 years before and/or after waiver implementation.	Descriptive analyses are unchanged. The ITS analysis is dropped as it will be strongly confounded by COVID disruptions.

Note: MODRN refers to the Medicaid Outcomes Distributed Research Network's Opioid Use Disorder workgroup. https://www.academyhealth.org/MODRN

Target and Comparison Populations

Multiple populations were used for the Provision 4 analyses depending on the research hypotheses and available data sources. These included two separately constructed member cohorts. The first, the Medicaid cohort, included individuals ages 21–64 with at least one month of Medicaid enrollment during the evaluation period (2017–2023) in any of the following eligibility categories: parents/caretakers, childless adults, pregnant women, income extension and disabled. The second, the WHIO Cohort, was constructed from the state's voluntary, multi-payer claims database and included individuals ages 21–64 with full benefit Medicaid or commercial insurance.

For Question 4.1 we examined changes in the availability of providers who deliver substance use treatment for Medicaid members. We did this both among residential SUD treatment providers nationwide and among a broadly defined set of Wisconsin Medicaid providers that includes individuals, clinics, and hospitals. For analyses of changes in the supply of SUD residential treatment facilities, the target and comparison populations, respectively included all residential SUD treatment facilities that participated in the National Survey of Substance Abuse Treatment Services (N-SSATS: 2017–2020) and the National Substance Use and Mental Health Services Survey (N-SUMHSS: 2021–2022) in Wisconsin and the comparison states. The comparison group included all 16 states that did not implement a SUD waiver during the study period: Alabama, Arizona, Arkansas, Florida, Georgia, Hawaii, Iowa, Mississippi, Missouri, Nevada, New York, North Dakota, South Carolina, South Dakota, Texas, and Wyoming. For this analysis, an SUD residential treatment facility was defined as a facility that has 18 or more beds allocated to SUD treatment.

For the Wisconsin Medicaid provider analysis, we constructed the study population from all providers who had at least one claim for an outpatient, inpatient, or emergency department (ED) service for the Medicaid cohort. The target population was providers that newly delivered an SUD-related service, and the comparison population was providers that newly delivered a diabetes-related service. This comparison population was plausibly unaffected by the change in SUD treatment coverage but would likely have been affected by state- and Medicaid-wide factors that influence Medicaid members' use of health care. Among providers newly delivering care for the condition of interest, we differentiated those with zero claims in the prior year for *any* service ("New Medicaid Providers" and those with claims in the prior year for conditions other than the condition of interest ("Established Medicaid Providers"). This distinction made it possible to observe the source of a potential change in supply, the addition of newly active providers in Medicaid or the addition of SUD or diabetes service delivery among existing providers.

To describe potential changes in member awareness of the new residential benefit (H4.2a), problematic substance use, and self-reported health and health care use (H4.3a, H4.3b, H4.3c), we compared the 2020 and 2024 Medicaid Beneficiary Survey respondents. The study population to assess problematic substance use included all survey respondents. All other analyses were conducted among only those who reported problematic substance use.

To examine the potential increase in the use of SUD treatment in IMD settings (H4.2b), Wisconsin SUD specialty treatment facilities served as the target group and the comparison group included facilities in the 18 states that did not have a Medicaid IMD waiver for SUD treatment in place between 2017–2021 that submitted data to the TEDS-A: Alaska, Arizona, Arkansas, Connecticut, Florida, Georgia, Hawaii, Iowa, Mississippi, Missouri, Montana, Nevada, New York, North Dakota, South Carolina, South Dakota, Texas, and Wyoming. Comparison

group composition was constant over the study period with one exception. In 2020, North Dakota did not submit data to TEDS. For H4.2c examining changes in initiation and engagement with SUD services, the Medicaid and commercially-insured adults within the WHIO cohort were the target and comparison groups, respectively.

For hypotheses under Question 4.3 examining the change in claims-based measures of health care, the Medicaid population and commercially-insured adults within the WHIO cohort were the target and comparison groups, respectively.

For Question 4.4 examining the changes in drug overdose deaths, the target population included all persons aged 18–64 with at least one month of Medicaid enrollment between January 1, 2017, and December 31, 2022. The comparison population included all persons in Wisconsin aged 18–64 with no enrollment in Wisconsin Medicaid over the same period.

The Medicaid cohort served as the study population for Q4.5, an examination of trends in Medicaid expenditures. There was no comparison group specified for this question.

Evaluation Period

The primary evaluation for this provision included a maximum of three years preceding its implementation, 2017–2019, and a maximum of 35 months post-implementation, 2/2021–12/2023. In some cases, noted below, the post-implementation period included the full calendar year of 2021 including January when the benefit was not operative. Most analyses of the waiver's impact on claims-based measures of health care use and expenditures encompassed the maximum evaluation period (H4.1a, H4.2c, H4.3, Q5). For a subset of hypotheses, the duration of the study period varied based on data availability at the time of report preparation

Specifically, the publicly available survey data used to address the residential treatment facility-related hypotheses (4.1a) and individual use of residential treatment (4.2b) were only available through 2022 and 2021 respectively. Anomalies in the prescription medication data for commercially insured adults in the WHIO cohort before March 2019 limited the duration of the pre-period for questions that rely on these data (H4.3a and H4.3d). Wisconsin death record data, used for Q4.4, were available through 2022. For analyses reliant upon the Medicaid Beneficiary Surveys (H4.2a, H4.3a-c), data from the 2020 Medicaid Beneficiary Survey conducted before implementation of the residential SUD treatment benefit were used as a baseline. The 2024 survey data provided a point-in-time assessment of members' experiences at the end of the waiver period.

Data Sources and Outcome Measures

The data sources and outcome measures for the evaluation of the SUD demonstration waiver are summarized for each hypothesis below. The Secondary Data section of the report provides a complete description of each data source for the entire demonstration evaluation.

H4.1a. The SUD demonstration waiver will increase the supply of SUD providers that accept and/or treat Medicaid enrollees.

Two publicly available data sources were used to examine the availability of residential SUD treatment providers nationwide: the N-SSATS (2017–2020) and the N-SUMHSS, which replaced the N-SSATS in 2021.The primary outcome measure was a binary variable indicating

whether the facility did or did not accept Medicaid as a source of payment. A facility was defined as any type of facility that had 18 or more beds allocated to SUD treatment.

The Wisconsin Medicaid claims and encounter data were used to assess changes in the supply of providers delivering SUD care more generally. The primary outcome was the rate of new providers per month per 1,000 Medicaid members. To identify the numerator for this measure, we identified all new providers with at least one outpatient, inpatient, or ED claim for SUD and all providers with at least one such claim for diabetes. We defined the provider newly delivering care for the condition in year, T, if they had no claim for that condition in the prior year, T-1. Within each year, we allocated the initial claim observed for the provider to the month in which the service was delivered. The denominator was constant across months, within year; it was based upon the annual count of members in the Medicaid cohort.

H4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time.

We compared awareness of the new residential treatment benefit among respondents before and after implementation of the benefit using the 2020 and 2024 Medicaid Beneficiary Surveys. The outcome measure was a binary variable set to a value of 1 if the respondent reported that their insurance plan covered residential treatment for alcohol or drugs.

H4.2b. The SUD demonstration waiver will increase use of SUD treatment in IMD settings.

The Treatment Episode Data Set – Admissions (TEDS-A) was used to measure SUD treatment in IMD settings in Wisconsin and comparison states; it is the only publicly available source for specialty SUD treatment admissions nationwide. We assessed two outcomes defined as rates per 100,000 individuals ages 21–64 in the state-year: the rate of admissions to a residential treatment setting; and the rate of admissions in which medication for opioid use disorder (MOUD) was part of the treatment plan. The numerators for these measures were obtained from the TEDS-A. The Current Population Survey sponsored by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics was the source of the denominators in each state-year.

Additionally, the Wisconsin Medicaid enrollment, claims and encounter data were used to plot within-state trends in the number of unique members that received residential SUD treatment by eligibility category. Consistent with Forward Health 2020-42, residential SUD treatment was defined by the presence of a claim with procedure code H00018 and revenue code 1002, and a modifier code of TF or TG.

H4.2c. The SUD demonstration waiver will increase initiation and engagement in SUD treatment.

The WHIO was used as the data source for this hypothesis. We implemented the Medicaid Outcome Distributed Research Network's (MODRN) measure of initiation and engagement in alcohol and drug dependence treatment. It is an adaptation of the pre-2022 version of the National Council on Quality Assurance's (NCQA) initiation and engagement in alcohol and drug treatment measure. Medication treatment was added to the NCQA measure for measurement year 2022 as an eligible treatment for the initiation and engagement measure. Because this study period largely precedes that change, we implemented an adaptation of the prior version that excludes medication treatment. Additional adaptations from NCQA specifications include the definition of the population of interest, the study's Medicaid cohort as defined above, and an intake period of March 1–November 15 rather than January 1–November 15 for 2017 to

establish a negative diagnosis history within the study years. The index episode was an individual's first qualifying claim with an SUD diagnosis in the calendar year following a 60-day period without an SUD diagnosis, and continuous enrollment 2 months before and 1 month after the index episode. Initiation was defined as receipt of treatment within 14 days of the index episode. Engagement was defined as at least two additional services (beyond initiation) with an SUD diagnosis within 30 days of initiation. The denominator for both measures was the index episode.

H4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services and pharmacotherapy treatment provided outside IMD settings.

H4.3b. The SUD demonstration waiver will reduce use of hospital-based SUD services, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H4.3c. The SUD demonstration waiver will increase access to health care for co-morbid physical and mental health conditions among enrollees with a SUD, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

We examined changes in use of existing covered services for claims-based outcomes from the WHIO. To identify SUD- and OUD-related health care use, we required a diagnosis of SUD or OUD in any position on the claim. We used procedure codes and admission and discharge dates to identify outpatient visits, emergency department visits, and inpatient stays. SUD-related care is defined as a claim with an ICD-10 diagnosis code of any of the following substances: alcohol; opioids; cannabis; sedative, hypnotic, or anxiolytic; cocaine; other stimulant; hallucinogen; inhalant; and other psychoactive substance. Non-SUD related care is defined as claims lacking any of the previously listed SUD diagnosis codes.

We constructed monthly and annual binary and count variables for any outpatient visit with a diagnosis of SUD, a diagnosis of opioid use disorder (OUD), and a non-SUD diagnosis (H4.3a, H4.3c). We constructed a binary measure to assess receipt of medication treatment for opioid use disorder within the calendar year. Medications for opioid use disorder include naltrexone, buprenorphine, and methadone (H4.3a).

For hospital-based care including emergency department and inpatient stays, we constructed monthly and annual binary and count variables to capture total visits and visits for any SUD diagnosis and with a diagnosis of OUD. Additionally, we constructed a binary measure of all-cause hospital readmission within 30 days of a SUD-related hospitalization (H4.3b).

Our measure of adherence to SUD treatment was continuity of pharmacotherapy for OUD (H4.3d). We adapted the continuity of pharmacotherapy measure from National Quality Forum measure #3175 for use in the Medicaid population following specifications developed by the

MODRN Network.[11] We created two binary measures to assess 90-day and 180-day continuous pharmacotherapy for MOUD.

In addition to claims data, self-reported outcomes were assessed from the 2020 and 2024 Medicaid Beneficiary Surveys. The key study measures included an indicator of problematic substance use, having a usual source of care, use of outpatient, emergency department or hospital services, and self-reported health status (H4.3a, H4.3b, H4.3c).

H4.4a. The SUD demonstration waiver will reduce the rate of drug overdose deaths among Medicaid beneficiaries, including opioid-related overdose deaths, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

We obtained mortality data for working age adults in Wisconsin from 2017 through 2022 from the Wisconsin Department of Health Services and merged them with Medicaid enrollment data to identify deaths among Medicaid members and non-Medicaid enrollees. The primary outcome measures were 12-month death rates per 100,000 adults including all-cause, overdose, and opioid-overdose deaths. We used cause of death codes from Wisconsin DHS and ICD-10 to identify overdose (X40 - X44, X60-64, X85, Y10-14) and opioid overdose (transax1-13 code, T401-T404). To calculate the death rate for each month, we divided the monthly death counts for each group by their respective population's size in the month.

To obtain the numerator for the Medicaid population, we first identified all members enrolled in any given month and then summed deaths occurring among those individuals over the following 12 months. For example, to count Medicaid deaths for individuals enrolled in January 2021, we summed all deaths occurring in February 2021 through January 2022. To count non-Medicaid or comparison population deaths, we calculated a 12-month death count for all individuals not enrolled in Medicaid during the reference month. For example, to count non-Medicaid deaths in January 2021, we counted all deaths from February 2021 through January 2022 among individuals not enrolled in Medicaid in January 2021.

The denominator for the Medicaid population was the count of members in the Medicaid enrollment data for the month. The denominator for the comparison group was the annual population of non-elderly adults in Wisconsin from the American Community Survey minus the Medicaid population for that month. This approach to defining the denominator for the comparison group assumes a stable monthly population within the year.

Question 4.5. What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?

Expenditure data from the Medicaid claims and encounter data from 2017–2023 were used to calculate the average annual expenditures per member in 2023 dollars by applying the Wisconsin Medicaid fee-for-service fee schedule to all encounter and fee-for-service claims. The outcomes included total and SUD-related expenditures overall and by category: outpatient, emergency department, inpatient, prescription medications, and SUD residential treatment. To identify SUD-related expenditures, we followed the definition for SUD care described in H4.3.

[11]Donohue JM, Jarlenski MP, Kim JY, Tang L, Ahrens K, Allen L, Austin A, Barnes AJ, Burns M, Chang CH, Clark S, Cole E, Crane D, Cunningham P, Idala D, Junker S, Lanier P, Mauk R, McDuffie MJ, Mohamoud S, Pauly N, Sheets L, Talbert J, Zivin K, Gordon AJ, Kennedy S. Use of Medications for Treatment of Opioid Use Disorder among US Medicaid Enrollees in 11 states, 2014-2018. Journal of the American Medical Association. 2021;326(2):154-164. doi:10.1001/jama.2021.7374.

Analytic Methods

We addressed the research questions and hypotheses as follows.

H4.1a. The SUD demonstration waiver will increase the supply of SUD providers that accept and/or treat Medicaid enrollees.

We used a DiD approach to compare the average change in the likelihood that a residential SUD treatment facility in Wisconsin accepted Medicaid as a payer after implementation of the waiver (2021–2022) relative to the pre-period (2017–2019), to the analogous change among facilities in the comparison group. The unit of analysis for the regression model was the facility-year. We clustered standard errors at the state to account for multiple observations within states across years. Regression models include variables to adjust for facility ownership status and state-level policy and demographic characteristics. Consistent with pre-specified analyses, the primary model excluded the year 2020 from the pre-period to mitigate the potential confounding effects of the COVID-19 pandemic. Results that included 2020 in the pre-period are shown for completeness.

To assess a potential change in the supply of providers delivering SUD care more generally, we used a DiD design to compare the change in the rate of new providers for SUD relative to diabetes care following implementation of the residential treatment benefit relative to the prior period. The unit of analysis for the regression model was the month-year. The key terms included were a binary measure to indicate provider type (SUD=1; Diabetes=0), an indicator for the post-implementation period (2021–2023), and an interaction term between the provider type and post-period. The pre-period was 2018–2019 rather than 2017–2019 because construction of the outcome required a one-year look-back period. Calendar year 2020 was omitted to mitigate the potential confounding effects of the COVID-19 pandemic. Adjusted models included the proportion of the population that was eligible for Medicaid as childless adults. Descriptive analyses included a graphical summary of the outcome trends as well as the trend in all providers with an SUD or diabetes-related claim for context.

H4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time.

A cross-sectional, pre-post analysis was implemented to compare the percentage of respondents that reported awareness of the new residential treatment benefit in the Medicaid Beneficiary Survey of 2024 relative to the 2020 survey. All analyses were weighted to adjust for the sample design and non-response.

H4.2b. The SUD demonstration waiver will increase use of SUD treatment in IMD settings.

To test the effect of the SUD demonstration waiver on the use of SUD treatment in IMD settings, we implemented a DiD design to compare the change in admissions to a residential treatment facility within Wisconsin before (2017–2019) versus after implementation of the benefit (2021) relative to the comparison group. To adjust for potential time-varying differences between Wisconsin and comparison states in characteristics that may be related to the outcomes, we constructed state-year control variables. These variables included age, sex, race, ethnicity, foreign-born, veteran status, and educational achievement. Additionally, we conducted descriptive analyses to compare the outcomes and state characteristics across Wisconsin and the comparison group of states. In a within-state descriptive analysis, we summarized trends

over time in the number of unique members with a claim of residential SUD treatment by eligibility category.

H4.2c. The SUD demonstration waiver will increase initiation and engagement in SUD treatment.

Using a DiD design, we compared the likelihood of initiation and engagement among Medicaid members before versus after implementation of the residential treatment benefit to the comparison group of commercially insured adults. The unit of analysis was the index episode for the initiation outcome and the initiation episode for the engagement outcome. Few individual characteristics are present in the WHIO data. As such, models included age and sex as control variables. The pandemic period is defined as March 2020 – January 2021, the start of the PHE through the month preceding benefit implementation and was excluded from the primary models. Results including the pandemic period are shown for completeness. Additionally, we conducted descriptive analyses to summarize the percentage of the observed episodes followed by initiation or engagement in each group.

H4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services and pharmacotherapy treatment provided outside IMD settings.

H4.3b. The SUD demonstration waiver will reduce use of hospital-based SUD services, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H4.3c. The SUD demonstration waiver will increase access to health care for co-morbid physical and mental health conditions among enrollees with a SUD, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

We implemented a DiD design to compare the use of existing covered SUD services among Medicaid members relative to the commercially insured comparison group before and after implementation of the new benefit. For H4.3a-c, the unit of analysis was the insurance group-period (e.g., Medicaid-Jan2017, Commercial-Jan2017, etc.). These aggregate models were weighted by the population size for each insurance-group-period. Control variables included mean age and proportion male for the insurance group-period. For H4.3d, the unit of analysis was the MOUD episode and control variables included age and sex. For all H4.3 regression models, the post-period begins with the first month of the benefit's availability through the end of the waiver period, February 2021 – December 2023. The pandemic period was defined as March 2020 – January 2021 which includes the start of the PHE through the month preceding benefit implementation. The pre-period (excluding the pandemic) was defined as January 2017 – December 2019 for outpatient, ED and inpatient outcomes. For medication-related outcomes, the pre-period (excluding the pandemic) was defined as March 2019 – December 2019 because of prescription data anomalies observed for the commercially insured population before March 2019. Results including the pandemic period are shown for completeness.

We additionally implemented a series of robustness checks using alternative model specifications for the DiD analysis including a fixed, continuously enrolled panel of both Medicaid members and commercial beneficiaries, beginning the pre-period at different times,

and using person-month as the unit of analysis for H4.3a-H4.3c. None of these alternative analyses made a qualitative or major quantitative difference in the results, and for brevity we do not include them in this report

A cross-sectional, pre-post analysis was implemented using the 2020 and 2024 member surveys to test for the equivalence of self-reported problematic substance use, SUD and general health care use, and health status before and after implementation of the residential treatment benefit.

H4.4a. The SUD demonstration waiver will reduce the rate of drug overdose deaths among Medicaid beneficiaries, including opioid-related overdose deaths, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

We calculated age-adjusted monthly death rates for the Wisconsin Medicaid and comparison population residents. We used a DiD design to compare the change in death rate for the Medicaid and comparison populations before and after implementation of the SUD demonstration waiver. The pre-period included 2017–2019; the post-period included 2021–2022. We omitted 2020 from our primary models to mitigate the potential confounding effects of the COVID-19 pandemic. Given anticipated compositional shifts in the Medicaid population due to coverage changes resulting from the COVID-19 pandemic, we also examined trends in the Medicaid population count over time.

Question 4.5. What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?

We used the Consumer Price Index to inflate all dollars to 2023 values and implemented descriptive analyses to summarize real annual Medicaid expenditures by service category overall and for SUD-related services.

Methodological Limitations

Two methodological limitations were common across all the research questions for the SUD provision of the demonstration. The first is the onset and persistence of the COVID-19 pandemic before and through the initial implementation of the new benefit, and its impacts on health care use, health and the health care workforce. Relatedly, the Medicaid maintenance of enrollment policy, implemented in response to the COVID-19 pandemic, altered the size and composition of the study populations in ways that may plausibly affect evaluation outcomes. Our DiD models excluded the early pandemic period and so may address this limitation but the magnitude of pandemic-related impacts on health care use, health, the health care workforce and insurance enrollment requires cautious interpretation of the outcomes and was unlikely to be addressed by this method. We are uncertain whether isolating the new waiver's effects is fully feasible.

The second limitation that was common across all research questions was the lack of a within-state Medicaid comparison group because all adults were subject to the new SUD residential treatment benefit at the same time. The evaluation design included the use of a commercially insured comparison group (H4.2, H4.3) and a non-Medicaid Wisconsin comparison population (Q4.4) to mitigate possible confounding secular events and trends. However, unobserved time-varying differences between the Medicaid and comparison groups may introduce residual confounding. No comparison population was available for descriptive analyses of change over

time in member self-reported benefit awareness (H4.2a), problematic substance use, health care use, and health (H4.3a-c).

Additional unique limitations existed for specific analyses. For H4.1a assessing the supply of SUD residential treatment facilities, the N-SSATS was the planned data source, but was replaced by SAMHSA in 2021 with a new survey named the N-SUMHHS. The SAMHSA advises against comparisons between data collected in the N-SSATS and the N-SUMHSS because of changes in the survey design. The period for our analysis is 2017–2022, thus requiring data from both surveys. We presented these pre-specified analyses to comply with the evaluation design report and caution that the results should not be interpreted causally because of the change in data source. Additionally, the facility-level measure of Medicaid acceptance does not fully capture treatment capacity as bed availability may change within existing facilities.

Three limitations apply specifically to the analysis of the second component of H4.1a, assessing changes in the supply of SUD providers more generally. First, our measure of supply focused specifically on providers who were newly delivering SUD or diabetes services; it did not capture potential changes in the volume of SUD or diabetes services delivered by established providers. Second, we were not able to adjust fully for changes in population composition over time that may have differentially affected demand for SUD and diabetes services because of multicollinearity between these measures and the outcome. Third, the comparison group—diabetes providers—is a plausible counterfactual, conditional on two assumptions: 1) expanded coverage for SUD treatment does not influence the supply of diabetes' providers in Medicaid, and 2) absent the benefit's introduction, the monthly rate of new providers for diabetes and for SUD would have trended in parallel. While visual assessment of the outcome trends pre-benefit implementation suggests that this assumption is plausible, it is not testable.

There is one limitation specific to the analysis of the waiver's impact on residential treatment use (H4.2b). Although the benefit was implemented in February 2021, we have less than one year of post-implementation due to lagged availability of the data. As such, we are unable to observe any longer-run or delayed effects.

For Question 4.4 examining overdose deaths among the Medicaid population, the DiD design produces causal estimates conditional on the assumption that the outcomes across the groups would have trended in parallel in the absence of any benefit change. The non-parallel pre-trends in the outcomes that we observed in this analysis casts doubt on the plausibility of that assumption.

PROVISION 1 RESULTS: CHILDLESS ADULT COVERAGE EXPANSION

Waiver Provision 1 provides health care coverage to non-elderly adults without dependent children with family income of up to 100% of the federal poverty level (FPL). Evaluation hypotheses and questions for this provision focus on the following Medicaid program goal: To improve health outcomes and reduce unnecessary services. The state's waiver proposal also explained that establishing an eligibility income limit at 100% FPL, rather than implementing a full ACA-authorized Medicaid expansion, is "creating a program that is sustainable" and "available to those who need it most."

The final evaluation results for the 2019–2023 BadgerCare Reform demonstration period for the CLA coverage expansion are presented below sequentially in the order of the hypotheses and questions listed earlier in the report. This section focuses on results and conclusions with limited methodology information but full descriptions of the evaluation design and methodology can be found in **Attachment 1**. The CLA coverage expansion remained fully intact during the COVID public health emergency (PHE) so results for all evaluation questions are included unless otherwise noted.

Hypothesis 1.1: The expansion of benefits to CLAs will reduce the state's uninsured rate.

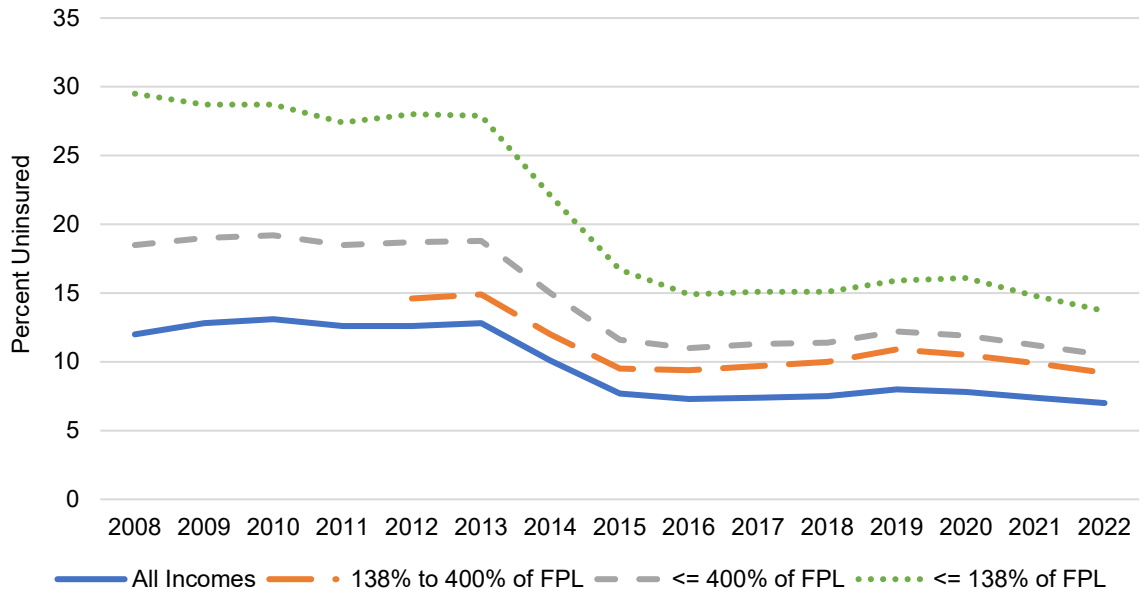
Primary Research Question 1.1: Did the expansion of benefits to CLAs reduce the state's uninsured rate?

Question 1.1a: What are the trends in Wisconsin's uninsured rate among adults?

Data for this analysis are drawn from three sources: the U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE), the American Community Survey (ACS), and the Wisconsin Family Health Survey (FHS). The SAHIE does not provide income as a percentage of the federal poverty level (FPL) at Wisconsin's Medicaid adult eligibility income limit of 100% of FPL. Instead, SAHIE provides income relative to poverty at select thresholds.

Figure 2.1 displays the trends, using the SAHIE in Wisconsin's adult (ages 18–64) uninsured rate from 2008 to 2022 by income group. Prior to 2014, the average uninsured rate was 12.7%. For adults at or below 138% of FPL, it was 28.4%; for those at or below 400% of FPL, it was 18.8%; and for those between 138%–400% of FPL, it was 14.8%. Across all income categories, a drop in the uninsured rate is evident compared to this baseline during both the initial and current waiver period. Between 2014 and 2018, the uninsured rate for all income groups decreased 4.7 percentage points to 8.0%, a 37% drop. For adults at or below 138% of FPL, the uninsured rate decreased 11.6 percentage points to 16.8%, a 41% drop; for those at or below 400% of the FPL, it had decreased 6.7 percentage points to 12.1%, a 36% drop; and for those between 138%–400% of FPL, it had decreased 4.7 percentage points to 10.1%, a 32% drop. In both absolute and relative terms, the largest drops in uninsured rates occurred among adults below 138% of FPL who were most affected by the benefit expansion to CLAs. These reductions in uninsured rates were steady or slightly larger from 2019–2022, with overall uninsurance at 7.6%; 15.1% uninsurance for those at or below 138% of FPL; 11.5% uninsurance for those at or below 400% of FPL; and 10.1% for those at 138%–400% of FPL.

Figure 2.1. Trends in Wisconsin's Adult Uninsured Rate



Notes: The SAHIE program models health insurance coverage by combining survey data from several sources with administrative data. The goal is to provide reliable estimates for small geographies; it does not allow separate estimates for adults with and without dependent children. The displayed income groups are not mutually exclusive.

Based on data from the American Community Survey (ACS) from 2009 through 2023, we similarly document the trends in current insurance coverage among Wisconsin adults aged 19–64. In contrast to SAHIE, the ACS allows for examining adults at Wisconsin's Medicaid adult eligibility income limit. The ACS has been measuring health insurance on a consistent basis since 2009, which enables an analysis of trends in health insurance coverage and the sources of health insurance coverage prior to and following Wisconsin's 2014 establishment of a Medicaid adult eligibility income limit at 100% FPL. As previously noted, this limit represented an expansion of the eligibility income limit for CLAs, but a contraction in the eligibility income limit, from 200% FPL, for parents and caretakers.

Table 2.1 reports the portion of CLAs and of parents with any source of insurance coverage in selected years from 2009 to 2023. From 2009 to 2013, roughly 85.5% of CLAs in Wisconsin had some source of insurance. In 2014, the first year of the expansion in the income eligibility limit for Medicaid to 100%, this percentage increased 4 percentage points to 89.5% and continued to increase in years thereafter. Between 2013 and 2023, the percentage of CLAs with any source of health insurance coverage increased by 7.8 percentage points. Medicaid coverage also increased among CLAs during this period. From 2009 to 2013, roughly 8% of CLAs received coverage from Medicaid. In 2014, this percentage increased by more than 2 percentage points, to 9.5%, and continued to increase through 2023 at which time the percent receiving Medicaid coverage was 12.6%. Between 2013 and 2023, the percentage of CLAs with Medicaid coverage increased by 4.7 percentage points. Approximately 60% of the increase in health insurance coverage among CLAs in Wisconsin between 2013 and 2023 can be attributed to increases in Medicaid coverage.

Table 2.1. Rates of Insurance Coverage, Adults Aged 19–64 in Wisconsin, by Type of Insurance

	2009	2013	2014	2019	2023	Percentage Point Change 2013–2023
Childless Adults						
Any coverage	**85.4%**	**85.5%**	**89.5%**	**91.8%**	**93.3%**	**7.8**
Medicaid	7.1%	7.9%	9.5%	11.8%	12.6%	4.7
Employer	70.0%	67.4%	68.5%	69.8%	70.2%	2.8
Individual	10.3%	11.3%	12.3%	11.9%	13.7%	2.5
Other Public	6.5%	7.5%	7.8%	6.9%	6.1%	-1.4
Parents						
Any coverage	**89.0%**	**89.0%**	**89.5%**	**91.1%**	**92.9%**	**3.9**
Medicaid	18.1%	19.9%	18.3%	14.4%	18.8%	-1.1
Employer	67.8%	65.6%	66.1%	71.5%	70.9%	5.3
Individual	6.4%	6.1%	8.4%	7.4%	8.1%	1.9
Other Public	3.1%	4.0%	3.8%	4.0%	4.2%	0.2
All Adults						
Any coverage	**86.9%**	**86.9%**	**89.5%**	**91.5%**	**93.2%**	**6.3**
Medicaid	11.5%	12.5%	12.9%	12.7%	14.8%	2.4
Employer	69.1%	66.7%	67.6%	70.4%	70.5%	3.7
Individual	8.7%	9.3%	10.8%	10.3%	11.7%	2.4
Other Public	5.2%	6.2%	6.3%	5.8%	5.4%	-0.7

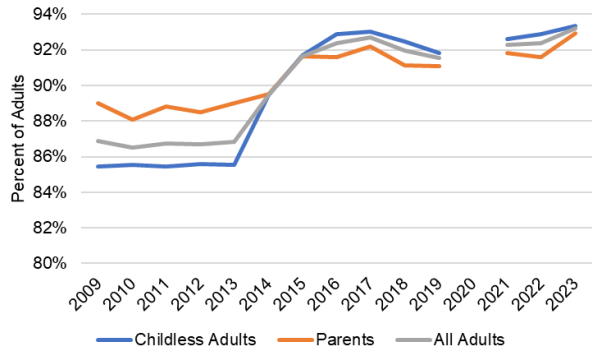
Source: American Community Survey, 2009-2023, U.S. Census Bureau.
Note: Other government insurance refers to Medicare, military/veterans coverage, and Indian Health Service coverage.

Among parents, health insurance coverage also increased between 2013 and 2023 but by less—3.9 percentage points—than for CLAs. The percentage of parents with Medicaid coverage decreased steadily between 2014 and 2019 but increased between 2019 and 2023. Between 2013 and 2023, the percentage of parents with Medicaid coverage decreased slightly by 1.1 percentage points. Overall, health insurance coverage increased among parents over this period because both employer-sponsored coverage and individual coverage increased by 5.3 and 1.9 percentage points respectively.

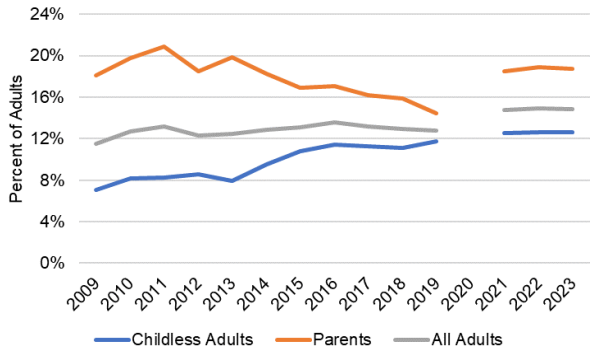
Figure 2.2 displays the trends in any sources of coverage and in Medicaid coverage among parents and CLAs in Wisconsin from 2009 to 2023 using the ACS data.

Figure 2.2. Percent of Wisconsin Adults with Insurance Coverage

Panel A. Trends in Percent of Wisconsin Adults with Insurance Coverage



Panel B. Trends in Percent of Wisconsin Adults with Medicaid Coverage

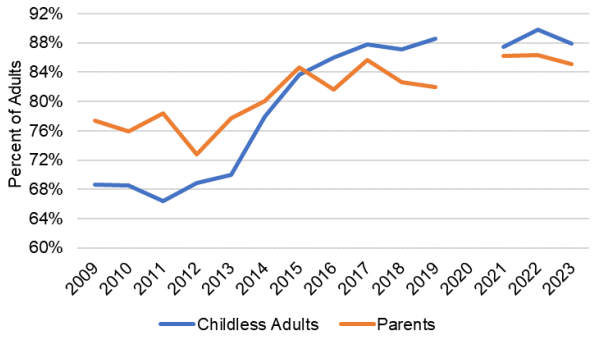


Using data from the ACS, we calculate trends in health insurance coverage among adults in Wisconsin by FPL. In the ACS, as noted previously, health insurance coverage is measured at the point-in-time when the survey was administered. By contrast, income is measured over the 12 months prior to when the survey was administered, so the survey measure does not necessarily reflect the income used for program eligibility. For this reason, we include analyses of higher income groups.

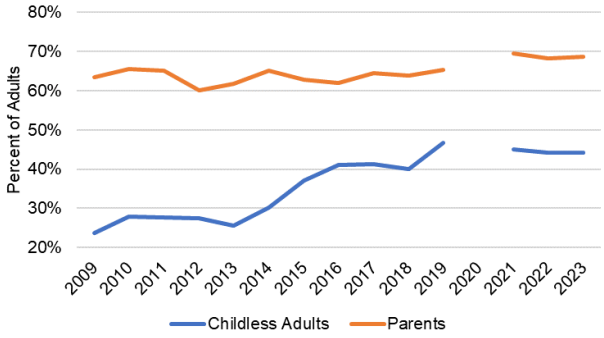
CLAs with incomes less than the FPL experienced very large increases in insurance coverage over the 2009 to 2023 period as the result of the expansion in Medicaid eligibility (**Figure 2.3)**. From 2013 to 2023, the percentage of low-income CLAs with any source of insurance coverage increased by 17.9 percentage points and the percentage with Medicaid coverage increased by 18.6 percentage points. Since 2015, Medicaid has become the largest source of insurance coverage for low-income CLAs in Wisconsin with 44.3% receiving Medicaid in 2023. Among parents with low incomes, by comparison, the percent with any source of insurance coverage increased by 7.4 percentage points and Medicaid coverage increased by 6.9 percentage points to 68.7% in 2023.

Figure 2.3. Percent of Wisconsin Adults with Insurance Coverage, <100% FPL

Panel A. Trends in Percent of Wisconsin Adults with Insurance Coverage, <100% FPL



Panel B. Trends in Percent of Wisconsin Adults with Medicaid Coverage, <100% FPL



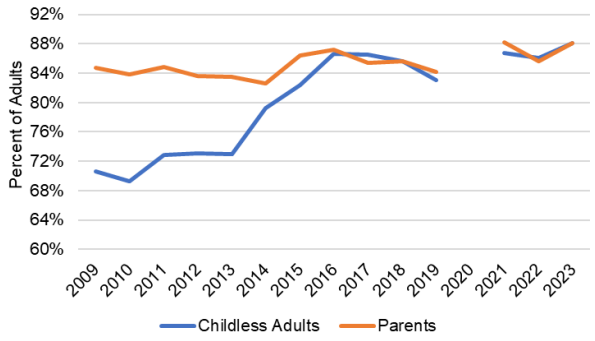
Among Wisconsin CLAs with incomes between 100 and 250% of FPL, health insurance coverage increased by 15.2 percentage points between 2013 and 2023, again primarily due to increases in Medicaid coverage, which increased by 10.5 percentage points (**Figure 2.4)**. Among Wisconsin parents with incomes between 100 and 250% of FPL, health insurance coverage increased by 4.6 percentage points between 2013 and 2023. The percentage with Medicaid coverage decreased by 6.4 percentage points between 2013 and 2019, but then increased by 10.5 percentage points between 2019 and 2023. Private insurance coverage (both employer-based and individual coverage) also increased between 2013 and 2023.

Wisconsin CLAs with incomes between 250 and 500% of FPL had a 5 percentage point increase in health insurance coverage between 2013 and 2023 (**Figure 2.5)**. This increase was largely due to expanded Medicaid coverage, which increased by 3.8 percentage points over this period. Health insurance coverage among Wisconsin parents with incomes between 250 and 500% FPL was largely flat between 2013 and 2023. There was a 2.7 percentage point increase in Medicaid coverage over this period, but this increase did not lead to increases in overall coverage.

Small increases occurred in health insurance coverage among both CLAs and parents in Wisconsin with incomes greater than 500% FPL, with coverage among CLAs increasing by 0.4 percentage point and coverage among parents increasing by 3.3 percentage points. **(Figure 2.6)**

Figure 2.4. Percent of Wisconsin Adults with Insurance Coverage, 100–250% FPL

Panel A. Trends in Percent of Wisconsin Adults with Insurance Coverage, 100–250% FPL



Panel B. Trends in Percent of Wisconsin Adults with Medicaid Coverage, 100–250% FPL

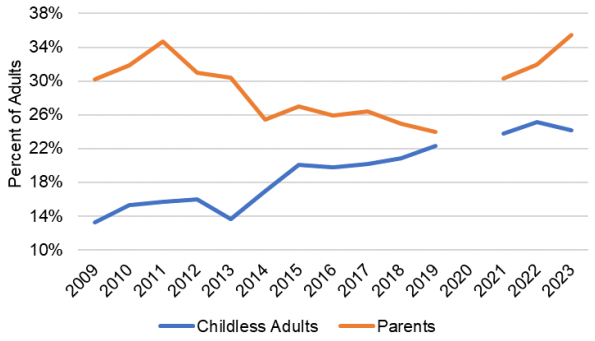
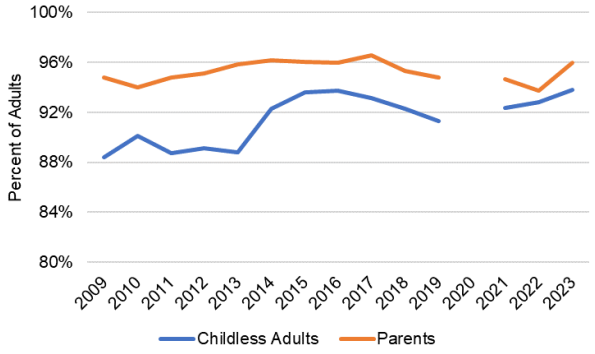


Figure 2.5. Percent of Wisconsin Adults with Insurance Coverage, 250–500% FPL

Panel A. Trends in Percent of Wisconsin Adults with Insurance Coverage, 250–500% FPL



Panel B. Trends in Percent of Wisconsin Adults with Medicaid Coverage, 250–500% FPL

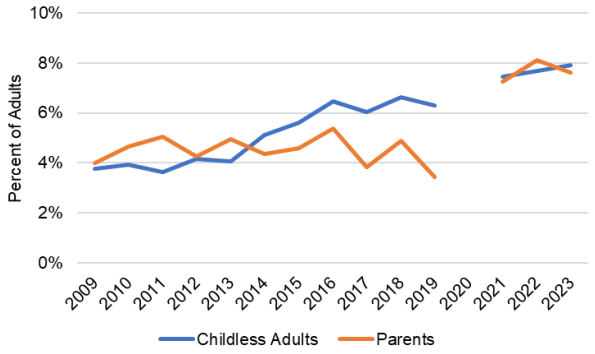
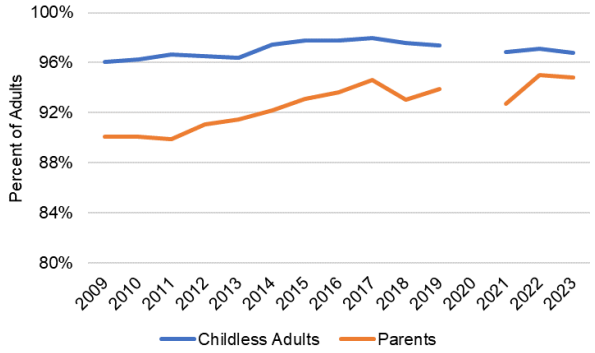
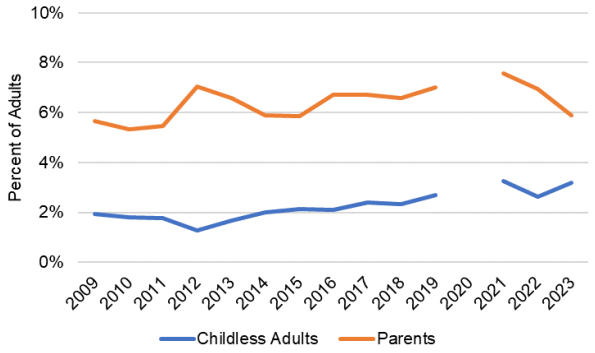


Figure 2.6. Percent of Wisconsin Adults with Insurance Coverage, >500% FPL

Panel A. Trends in Percent of Wisconsin Adults with Insurance Coverage, >500% FPL



Panel B. Trends in Percent of Wisconsin Adults with Medicaid Coverage, >500% FPL



We estimate the change in trends for health insurance coverage in Wisconsin using interrupted time series from 2009–2023 with a break in 2014. Calendar year 2020 was excluded. We estimate these models for all adults aged 19 to 64, as well as for CLAs and parents. The results of the models are reported in **Table 2.2**.

Table 2.2. Interrupted Time Series Estimates of Insurance Coverage among Adults in Wisconsin

	All Adults		Childless Adults		Parents	
	Any Coverage	Medicaid	Any Coverage	Medicaid	Any Coverage	Medicaid
Time	0.0001	0.0015	0.0003*	0.0020	0.0004	0.0023
	(0.0005)	(0.0018)	(0.0001)	(0.0019)	(0.0014)	(0.0027)
2014	0.0402*	0.0029	0.0528*	0.0153*	0.0189*	-0.0200
	(0.0099)	(0.0054)	(0.0105)	(0.0075)	(0.0096)	(0.0098)
Time x 2014	0.0031	-0.0020	0.0038	0.0014	0.0015	-0.0089*
	(0.0030)	(0.0019)	(0.0033)	(0.0023)	(0.0030)	(0.0029)
Constant	0.8671*	0.1214*	0.8545*	0.0762*	0.8860*	0.1895*
	(0.0017)	(0.0055)	(0.0003)	(0.0046)	(0.0044)	(0.0079)

Source: Authors' analysis of 1-Year ACS Data from 2009–2023 (2020 excluded).
Note: * Indicates statistical significance at 5% level or less. Newey-West standard errors are reported in parentheses.

All adults show a discontinuous increase in the fraction with insurance coverage in 2014, but no statistically significant change in the coverage trend after 2014. Among all adults, there was neither a statistically significant change in the fraction with Medicaid coverage in 2014 nor a significant change in the coverage trend after 2014 (**Figure 2.7**).

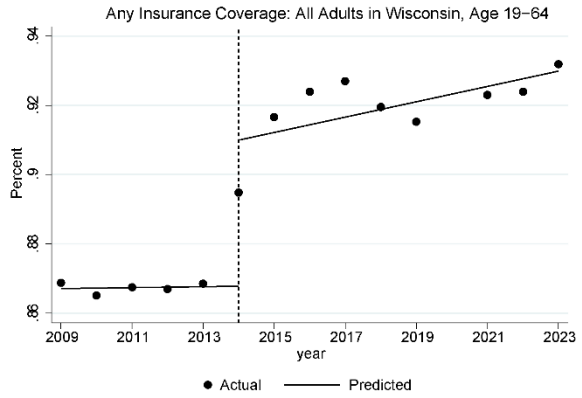
CLAs show a statistically significant discontinuous increase in both the fraction with insurance coverage and the fraction with Medicaid coverage in 2014, but do not show a statistically significant change in the trends in overall coverage or in Medicaid coverage after 2014 (**Figure 2.8**).

Parents show a discontinuous increase in the fraction with any source of insurance coverage in 2014, but do not show a statistically significant change in the trend after 2014. However, among parents there was a statistically significant discontinuous decrease in the trend in Medicaid coverage after 2014 (**Figure 2.9**).

These results show that the changes in overall coverage rates and in Medicaid coverage rates were evident in the data quickly following the policy changes (including, but not restricted to, the changes in the income eligibility limits for adults). As the trends in coverage post-2014 were not statistically different from the trends prior to 2014—with the exception of Medicaid coverage among parents—these results suggest that the main effects of the policy changes on insurance coverage occurred immediately and have trended similarly afterward.

Figure 2.7 Any Insurance Coverage and Medicaid Coverage: All Adults in Wisconsin, Age 19–64

Panel A.



Panel B.

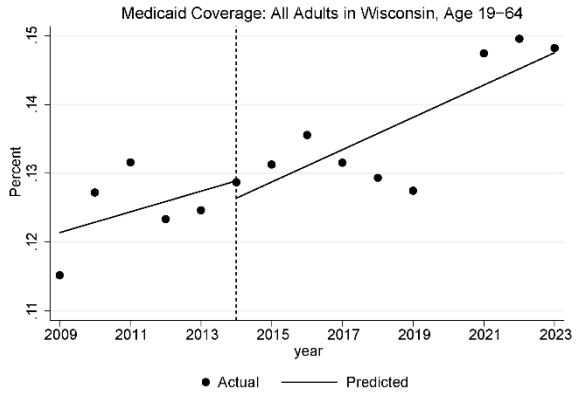
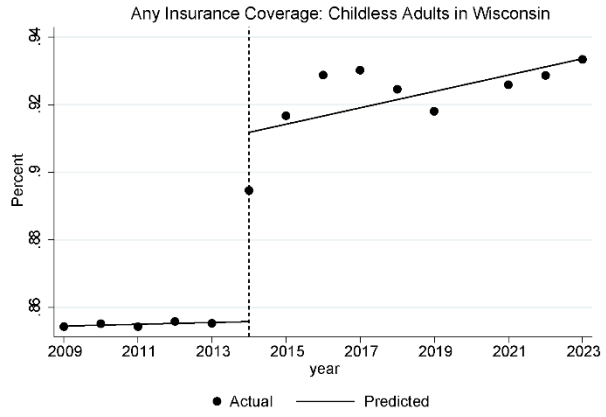


Figure 2.8. Any Insurance Coverage and Medicaid Coverage: CLAs

Panel A.



Panel B.

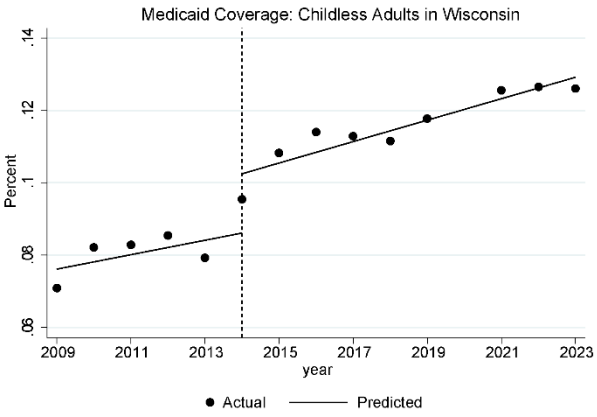
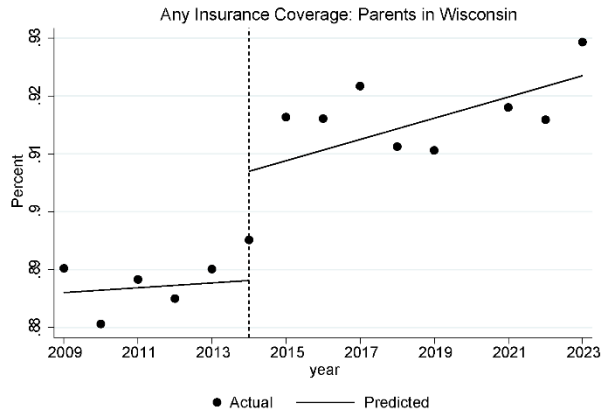
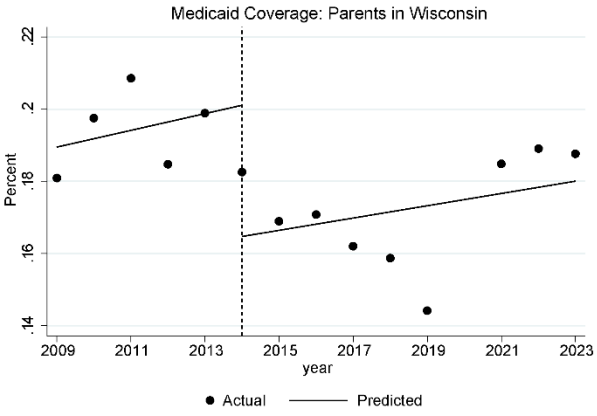


Figure 2.9. Any Insurance Coverage and Medicaid Coverage: Parents in Wisconsin

Panel A.



Panel B.



Based on data from the Wisconsin Family Health Survey, **Table 2.3** reports the percent of CLAs and of parents with any source of insurance coverage in select years from 2012 to 2022. In 2012, roughly 88.7% of CLAs in Wisconsin has some source of insurance. In 2014, the first year of the expansion in the income eligibility limit for Medicaid to 100%, this percentage increased 5 percentage points to 94.3% and continued to increase in years thereafter. Between 2012 and 2022, the percentage of CLAs with any source of health insurance coverage increased by 7.9 percentage points. Medicaid coverage also increased among CLAs during this period by 4.4%. In 2012, roughly 8% of CLAs received coverage from Medicaid. In 2014, this percentage increased by 2 percentage points, to 10%, and continued to increase through 2018 at which time the percent receiving Medicaid coverage was 14.7% before declining slightly in 2022 to 12.7%.

The gains in coverage for the CLA population are highlighted by trends in the parent comparison group. While 93% of parents had insurance coverage in 2012 compared to 88.7% of CLAs, the gains in coverage for CLAs brought their coverage level even with parents in 2022 at about 96.6% in both groups. Much of this change was driven by changes in Medicaid coverage where the percentage of CLAs increased by 4.4 percentage points and the percentage of parents decreased by 8.4 percentage points.

Overall, these results show large declines in uninsurance and increases in insurance rates in Wisconsin since 2014. The results suggest that gains for CLAs in 2014 from the CLA expansion put their overall insurance coverage rates on par with rates for parents. These gains have been maintained since the initial waiver period.

Table 2.3. Rates of Insurance Coverage, Adults Aged 19–64 in Wisconsin, by Type of Insurance

	2012	2014	2016	2018	2022	Percentage Point Change, 2012–2022
Childless Adults						
Any coverage	88.7%	94.3%	95.8%	94.8%	96.6%	7.9
Medicaid	8.2%	10.0%	12.4%	14.7%	12.7%	4.4
Employer	68.2%	67.9%	66.7%	64.9%	69.7%	1.5
Individual	9.2%	7.1%	14.8%	12.1%	15.6%	6.3
Other Public	13.2%	13.2%	12.7%	16.1%	11.9%	-1.2
Parents						
Any coverage	93.1%	94.0%	96.2%	96.1%	96.7%	3.6
Medicaid	21.2%	15.4%	15.2%	17.0%	12.9%	-8.4
Employer	66.3%	71.2%	71.4%	72.2%	74.6%	8.3
Individual	2.7%	3.3%	9.7%	6.4%	7.1%	4.4
Other Public	6.6%	6.7%	4.7%	7.7%	6.3%	-0.3

Source: Wisconsin Family Health Survey.

Question 1.1b: How much did the change in the number of CLAs due to the Medicaid expansion contribute to the overall change in the adult uninsured rate in Wisconsin?

The landscape for insurance coverage changed in 2014 in other states because of the implementation of the Affordable Care Act's insurance provisions, including both the expansion of Medicaid to 138% of FPL, in states that elected to expand Medicaid, and establishment of health insurance Marketplaces with premium and cost-sharing subsidies available to individuals with family incomes as low as 100% FPL.

To describe the impact of Wisconsin's CLA expansion in comparison to what happened nationally, we compare trends in Wisconsin with two sets of states using a differences-in-differences analysis. The first comparison group is a set of states that border Wisconsin and that expanded Medicaid: Minnesota, Michigan, and Illinois. The second comparison group is a set of states that did not expand Medicaid during the study period: Texas, Florida, and North Carolina. These results are summarized in **Table 2.4** and depicted in **Figure 2.10**-**2.12**.

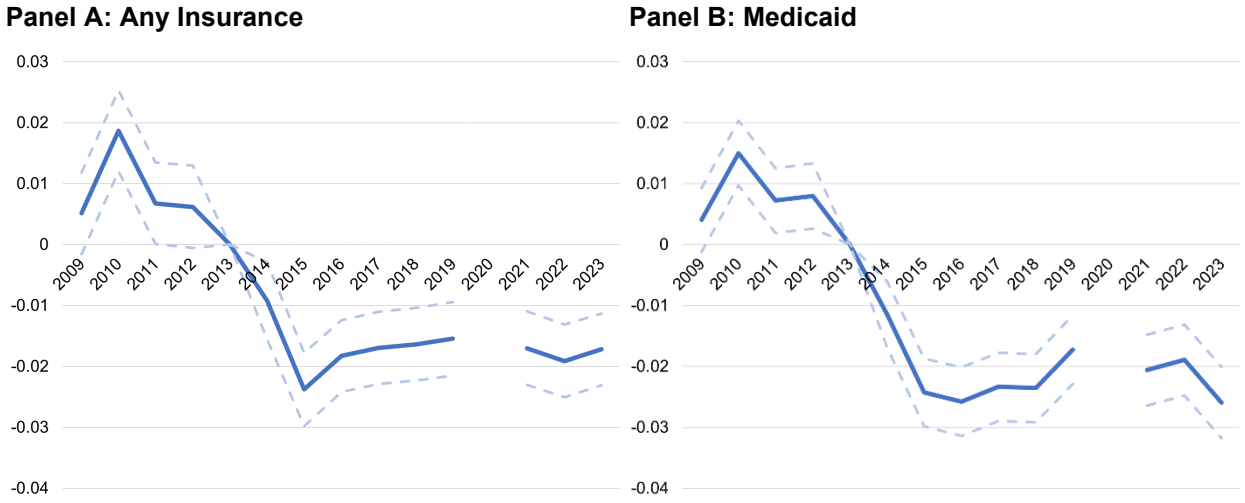
Both rates of health insurance coverage and of Medicaid coverage in Wisconsin decreased relative to those rates in Medicaid expansion states, Minnesota, Michigan, and Illinois, among both parents and CLAs. (Since coverage was increasing in all states, a relative decline means that coverage in Wisconsin increased by less than in those states, while a relative increase would mean that coverage in Wisconsin increased by more). These relative declines were statistically significant. Compared to these expansion states, the coverage gains in Wisconsin were smaller. As shown in the last two columns of **Table 2.4,** there were no differences for CLAs in the initial waiver period relative to the current waiver period compared to expansion states. For parents, there was a larger relative difference in any coverage and smaller difference in Medicaid coverage which drove an overall difference in these measures in the current waiver period relative to the initial waiver period.

Table 2.4. DiD Estimates of Rates of Insurance Coverage Among Adults Aged 19–64 in Wisconsin, by Type of Insurance

	2014	2015	2016	2017	2018	2019	2021	2022	2023	Difference (2019–2023) - (2014–2018)	*p* value
Wisconsin vs. Neighboring Medicaid Expansion States (Minnesota, Michigan, and Illinois)											
Childless Adults											
Any coverage	-0.93%	-2.38%	-1.83%	-1.70%	-1.64%	-1.55%	-1.70%	-1.91%	-1.72%	0.00	0.850
Medicaid	-1.15%	-2.43%	-2.58%	-2.33%	-2.36%	-1.72%	-2.06%	-1.89%	-2.59%	0.00	0.485
Parents											
Any coverage	-2.21%	-3.59%	-3.91%	-3.53%	-4.17%	-3.14%	-3.93%	-5.51%	-7.00%	-0.01	<0.000
Medicaid	-2.43%	-5.09%	-5.64%	-5.15%	-4.88%	-5.35%	-4.08%	-1.62%	-1.71%	0.02	<0.000
All Adults											
Any coverage	-1.39%	-2.83%	-2.60%	-2.37%	-2.58%	-2.13%	-2.51%	-3.34%	-3.83%	-0.01	<0.000
Medicaid	-1.64%	-3.47%	-3.69%	-3.43%	-3.29%	-3.12%	-2.80%	-1.62%	-2.23%	0.01	<0.000
Wisconsin vs. Large States that Did Not Initially Expand Medicaid (Texas, Florida, and North Carolina)											
Childless Adults											
Any coverage	-0.37%	-1.52%	-0.66%	-0.13%	0.06%	0.00%	0.63%	-0.44%	-0.38%	0.00	<0.000
Medicaid	0.79%	1.79%	2.18%	2.17%	2.18%	2.68%	3.47%	3.39%	3.09%	0.01	<0.000
Parents											
Any coverage	-3.31%	-4.05%	-4.47%	-3.73%	-3.79%	-2.95%	-3.09%	-5.20%	-6.91%	-0.01	<0.000
Medicaid	-1.63%	-2.47%	-2.39%	-2.70%	-2.53%	-3.14%	-2.16%	1.10%	0.61%	0.02	<0.000
All Adults											
Any coverage	-1.50%	-2.48%	-2.15%	-1.53%	-1.44%	-1.22%	-0.82%	-2.39%	-3.09%	0.00	0.957
Medicaid	-0.17%	0.14%	0.42%	0.28%	0.39%	0.44%	1.28%	2.61%	2.16%	0.01	<0.000

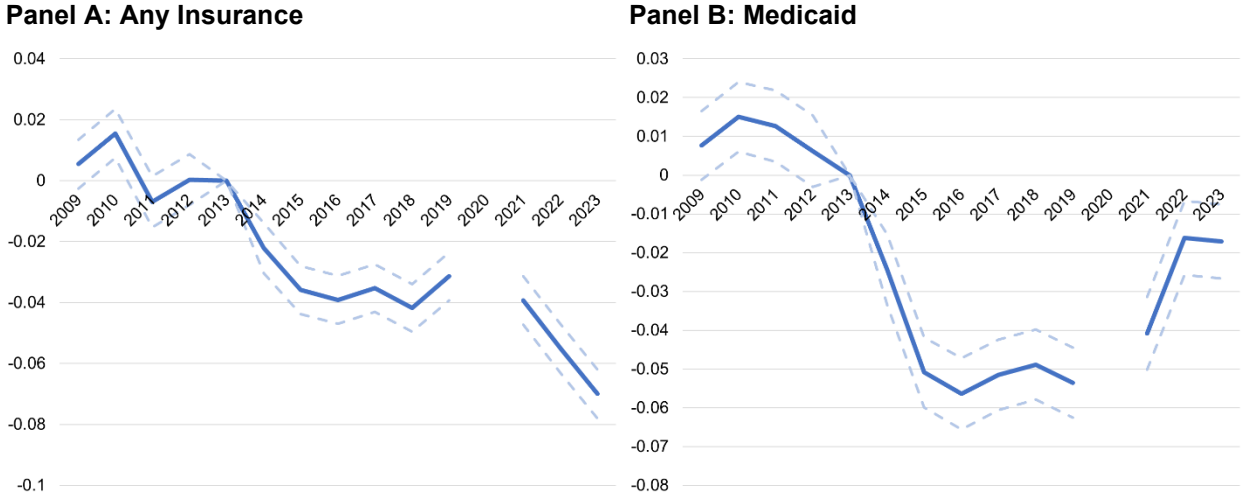
Source: Authors analysis of the 1-Year American Community Survey, 2009–2019, U.S. Census Bureau. Notes: Table shows DiD estimates comparing Wisconsin to indicated states in the time period indicated in the column relative to the baseline period (2009-2013); last two columns show the difference in the 2019-2023 waiver period compared to 2014-2018 and p-value for hypothesis test of difference from zero.

Figure 2.10. Percent of Wisconsin CLAs with Insurance Relative to States that Expanded Medicaid, by Type of Insurance



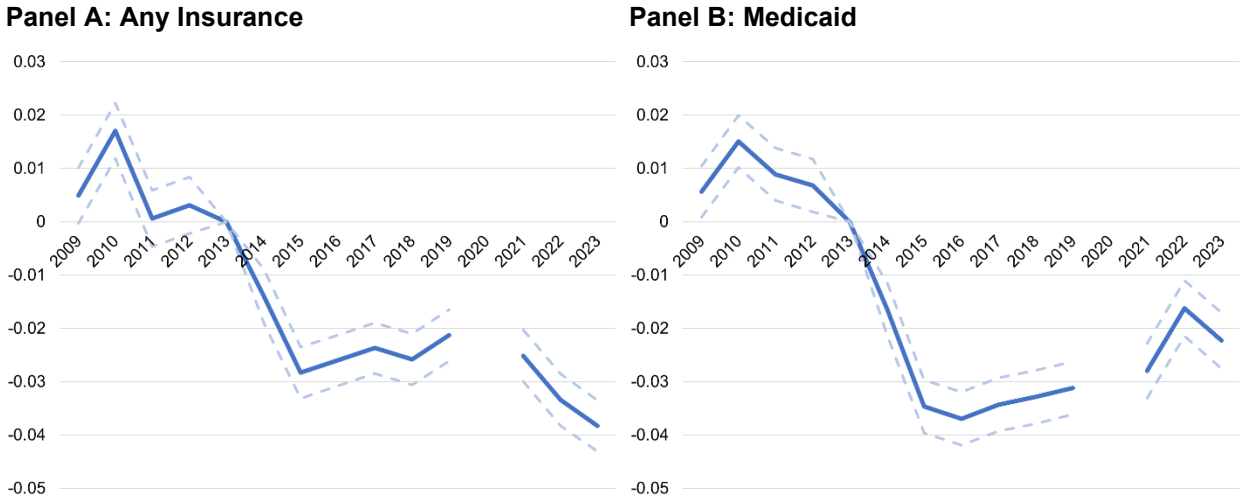
Source: Authors' analysis of 1-Year ACS, 2009–2023 (2020 excluded).
Notes: Results of a differences-in-differences analysis comparing Wisconsin with Minnesota, Michigan, and Illinois. Dashed lines represent 95% CI. 2013 is reference year.

Figure 2.11. Percent of Wisconsin Parents with Insurance Relative to States that Expanded Medicaid, by Type of Insurance



Source: Authors' analysis of 1-Year ACS, 2009–2023 (2020 excluded).
Notes: Results of a differences-in-differences analysis comparing Wisconsin with Minnesota, Michigan, and Illinois. Dashed lines represent 95% CI. 2013 is reference year.

Figure 2.12. Percent of Wisconsin Adults with Insurance Relative to States that Expanded Medicaid, by Type of Insurance



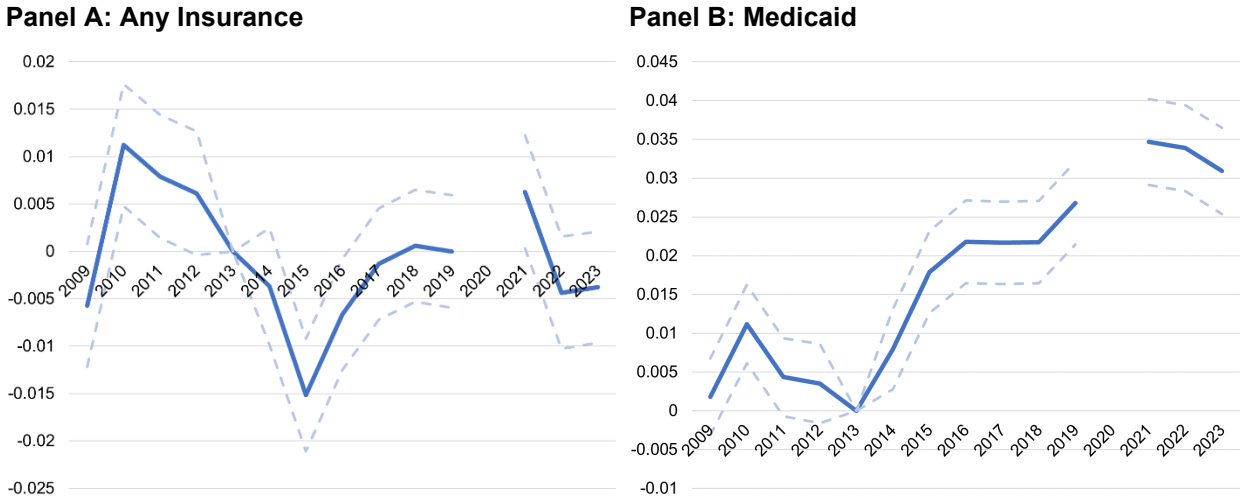
Source: Authors' analysis of 1-Year ACS, 2009–2023 (2020 excluded).
Notes: Results of a differences-in differences analysis comparing Wisconsin with Minnesota, Michigan, and Illinois. Dashed lines represent 95% CI. 2013 is reference year.

The results comparing trends in Wisconsin with those in states that did not initially expand Medicaid are presented in **Figure 2.13** through **Figure 2.15**. Among CLAs, overall rates of health insurance coverage in Wisconsin relative to Texas, Florida, and North Carolina, were roughly unchanged over the 2009 to 2023 period. Rates of Medicaid coverage among CLAs in Wisconsin increased substantially relative to rates in Texas, Florida, and North Carolina and this increase is statistically significant.

Among parents in Wisconsin, rates of overall health insurance coverage decreased relative to Texas, Florida, and North Carolina, and these declines are statistically significant. Rates of Medicaid coverage declined among parents in Wisconsin relative to Texas, Florida, and North Carolina between 2014 and 2019, but did not differ in the 2021–2023 period.

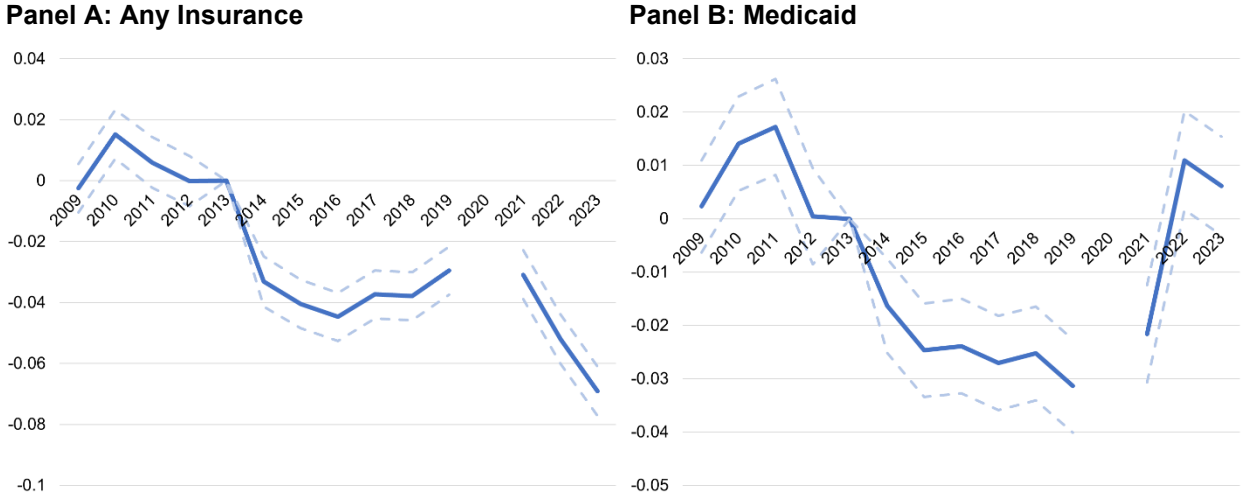
Among all adults, insurance coverage rates declined in Wisconsin relative to Texas, Florida, and North Carolina, driven by declines among parents, while Medicaid coverage rates increased, driven by increases among CLAs. As shown in the last two columns of **Table 2.4**, there were larger relative gains in Medicaid and uninsurance in the current waiver period for CLAs compared to the selected non-expansion states. For parents there was a downward trend in overall coverage in the current waiver period and an upward trend relative to the non-expansion states; overall the gains dominated.

Figure 2.13. Percent of Wisconsin CLAs with Insurance Relative to Medicaid Non-Expansion States, by Type of Insurance



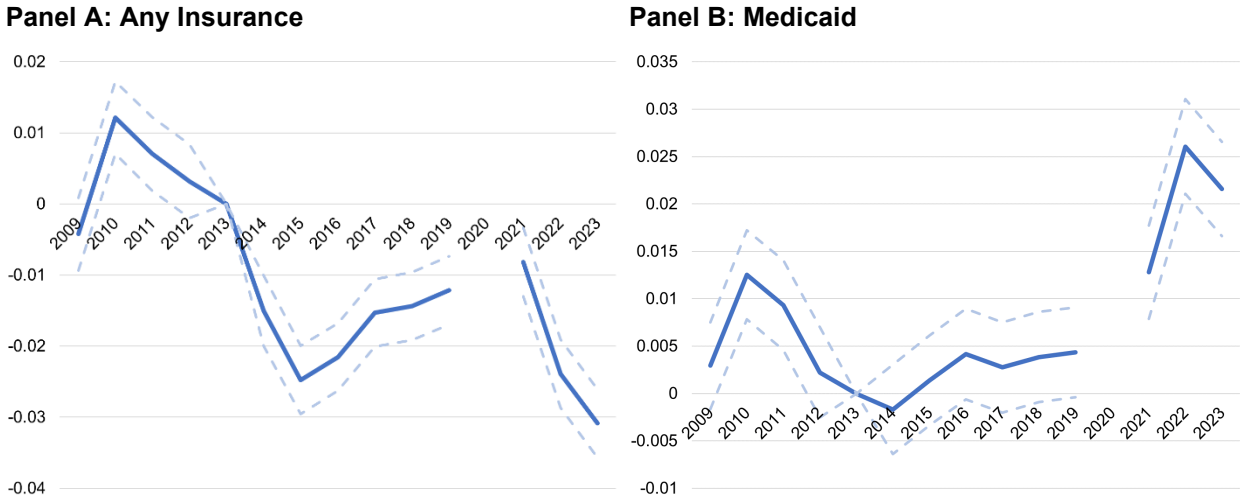
Source: Authors' analysis of 1-Year ACS, 2009–2023 (2020 excluded).
Notes: Results of a differences-in-differences analysis comparing Wisconsin with Texas, Florida, and North Carolina. Dashed lines represent 95% CI. Reference year is 2013.

Figure 2.14. Percent of Wisconsin Parents with Insurance Relative to Medicaid Non-Expansion States, by Type of Insurance



Source: Authors' analysis of 1-Year ACS, 2009–2023 (2020 excluded).
Notes: Results of a differences-in-differences analysis comparing Wisconsin with Texas, Florida, and North Carolina. Dashed lines represent 95% CI. Reference year is 2013.

Figure 2.15. Percent of Wisconsin Adults with Insurance Relative to Medicaid Non-Expansion States, by Type of Insurance



Source: Authors' analysis of 1-Year ACS, 2009–2023 (2020 excluded).
Notes: Results of a differences-in-differences analysis comparing Wisconsin with Texas, Florida, and North Carolina. Dashed lines represent 95% CI. Reference year is 2013.

We also provide an analysis of health care coverage as reported in the Behavioral Risk Factor Surveillance System (BRFSS). Coverage rates in the BRFSS among Wisconsin CLAs showed substantial increases from 2013–2022. **Table 2.5** shows that the fraction of all CLAs with coverage increased from 87% to 94%; for those with the lowest incomes, the gains were the largest, increasing from 68% to 93%. A difference-in-differences (DiD) comparison of the selected groups of expansion and non-expansion states to Wisconsin are included in **Table 2.5**. These analyses compare CLAs in Wisconsin to select groups of expansion (Minnesota, Michigan, and Illinois) or non-expansion (Texas, Florida, and North Carolina) states. The results do not suggest major differences in coverage between Wisconsin and other states in overall coverage outcomes for CLAs. The point estimates are not statistically different from zero with the exception of all income levels relative to non-expansion states, where Wisconsin CLAs were slightly less likely to be covered. However, the result is not driven by the lower-income groups most likely to be impacted by Medicaid coverage expansion for whom we see positive though not statistically significant coefficients. When we tested for differences across the waiver eras (2019 on compared to 2014–2018), we did not find any differences with the exception of a relative increase in coverage in Wisconsin for CLAs in the 100–200% of FPL range compared to expansion states during the current waiver period.

Table 2.5. DiD Analyses of Any Health Care Coverage, BRFSS

	All Incomes		<100% FPL		100–200% FPL	
	Relative to Expansion States	Relative to Non-Expansion States	Relative to Expansion States	Relative to Non-Expansion States	Relative to Expansion States	Relative to Non-Expansion States
Coefficient	-0.0140	-0.0123*	-0.0815	0.00950	-0.00723	0.00186
(Standard Error)	(0.00661)	(0.00200)	(0.0351)	(0.00499)	(0.00353)	(0.00622)
Baseline Rate (WI 2013)	.87		.68		.73	
Endline Rate (WI 2022)	.94		.93		.88	

Notes: Table reports coefficient of DiD analysis of Wisconsin compared to selected expansion and non-expansion states. This analysis is weighted and controls for age, education, employment, marital status, household size, gender, and race. * Indicates statistical significance at 5% level or less. Excludes 2020.

Finally, we examine effects on the uninsurance rate by comparing to a set of matched border counties using data from the SAHIE. Overall trends for Wisconsin were presented in **Figure 1**. **Table 2.6** presents the results of a DiD analysis using matched border counties to understand how declines in overall uninsurance rates compared to other geographically similar places. Coefficients in the table represent the difference in the Wisconsin counties and matched border counties compared to the baseline period (prior to 2014), and the table includes the *p* values of the results of a test for the difference in the coefficient in 2014–2018 compared to 2019 forward. Because of the way the SAHIE is constructed, it is not as subject to concerns about survey data collection and so we include 2020 in the analysis.

Table 2.6. DiD Analyses of Uninsurance Rate, SAHIE

	All Incomes	<138% FPL	138%FPL–400% FPL	<400% FPL
Wisconsin, 2014–2018 Period	1.45*	3.57*	1.73*	2.52*
(Standard Error)	(.365)	(.991)	(.320)	(.413)
Wisconsin, 2019–2022 Period	.94*	3.24*	1.29*	1.99*
(Standard Error)	(.446)	(1.218)	(.455)	(.632)
p value of test for difference	0.0031	0.5324	0.0362	0.1288

Notes: Table reports coefficient of DiD analysis of border counties in Wisconsin compared to matched border counties in nearby states (IL, IA, MN, and MI). * Indicates statistical significance at 5% level or less.

The results of this analysis suggest that Wisconsin counties' uninsurance rate was consistently higher relative to the comparison border counties (all of which were in Medicaid expansion states) both in the early and current waiver period. For example, results suggest that uninsurance was 1.45 percentage points higher in Wisconsin relative to comparison states after 2014 across all income groups. The coefficient is consistently lower in the 2019–2022 period, suggesting a relative reduction in the difference, although formal tests for differences were only statistically different from zero for individuals with incomes at 138–400% of FPL and for the overall group including all incomes. Overall, reductions in uninsurance rates in Wisconsin were more limited than in the comparison border locations with some evidence of the gap closing after 2019.

Hypothesis 1.2: The expansion of benefits to CLAs will lead to increased access to medical care among low-income CLAs.

Question 1.2a: Did the CLA expansion of benefits increase the use of health care among low-income CLAs in Wisconsin?

Table 2.7 reports measures of access to care for CLAs and parents aged 18–64 in various years from 2012 to 2022 based on data from the Wisconsin Family Health Survey. Among CLAs in Wisconsin, all measures improved between 2012 and 2018, and then most worsened between 2018 and 2022. In 2012, 92.9% of CLAs had a usual place of care, increasing to 94.4% in 2018 and then decreasing to 93.1% in 2022. A small percent (5.2%) of CLAs could not get needed care in 2012 and this percentage decreased to 3.4% in 2018 before increasing to 5.0% in 2022. Hospitalizations and ED visits show a similar pattern, increasing from 2012 to 2018 before decreasing afterward.

Similar patterns are seen among parents, with improvements in access in most measures between 2012 and 2018 and worsening in access between 2018 and 2022. Overall, for both CLAs and parents in Wisconsin, access to care improved between 2012 and 2018. However, most of these gains were erased between 2018 and 2022; these trends are most likely explained by the impacts of COVID on healthcare system access rather than any impacts from the waiver. We assess this further by comparing the 2012-2022 difference in access among CLAs to that among parents. The last column in Panel C of **Table 2.7** shows the difference in access to care over time between parents and CLAs. Relative to parents, CLAs had relative gains in the likelihood of a usual place for care, no difference in the likelihood of a checkup, declines in hospitalization rates, a small increase in ER visits, a small decrease in dental visits, and were more likely to report not getting needed care. **Figures 2.16 and 2.17** display trends in the percent of CLAs and parents with a checkup in the past 12 months and not getting needed care from 2012 to 2022.

Table 2.7: Access to Care Among All Adults

	2012	2014	2016	2018	2022	Percentage Point Change 2012–2022
Panel A: CLAs						
Has Usual Place of Care	92.9%	92.2%	93.1%	94.4%	93.1%	0.2
Checkup in Past 12 Months	68.5%	67.0%	65.4%	71.3%	71.8%	3.3
Hospitalized in Past 12 Months	8.8%	7.0%	10.1%	9.7%	7.2%	-1.6
ER Visit in Past 12 Months	17.0%	15.0%	16.5%	20.1%	18.5%	1.4
Dentist Visit in Past 12 Months	72.2%	68.1%	71.2%	75.6%	71.5%	-0.7
Could Not Get Needed Care in Past 12 Months	5.2%	3.8%	3.3%	3.4%	5.0%	-0.2
Panel B: Parents						
Has Usual Place of Care	96.0%	95.6%	95.9%	96.2%	94.7%	-1.3
Checkup in Past 12 Months	65.9%	66.4%	66.8%	68.7%	69.2%	3.3
Hospitalized in Past 12 Months	4.0%	6.0%	6.8%	6.8%	4.6%	0.6
ER Visit in Past 12 Months	16.2%	16.3%	13.8%	17.8%	17.4%	1.3
Dentist Visit in Past 12 Months	76.4%	73.4%	76.0%	81.5%	76.4%	0.0
Could Not Get Needed Care in Past 12 Months	3.6%	2.3%	3.3%	3.2%	1.8%	-1.8
Panel C: Between Group Difference (Panel A – Panel B)						
Has Usual Place of Care	-3.1%	-3.4%	-2.8%	-1.8%	-1.6%	1.5
Checkup in Past 12 Months	2.7%	0.7%	-1.4%	2.6%	2.6%	0.0
Hospitalized in Past 12 Months	4.8%	1.0%	3.4%	2.9%	2.6%	-2.2
ER Visit in Past 12 Months	0.9%	-1.3%	2.7%	2.3%	1.0%	0.2
Dentist Visit in Past 12 Months	-4.3%	-5.3%	-4.8%	-5.9%	-4.9%	-0.6
Could Not Get Needed Care in Past 12 Months	1.6%	1.5%	0.1%	0.2%	3.2%	1.6

Figure 2.16: Trends in Checkups for All Adults

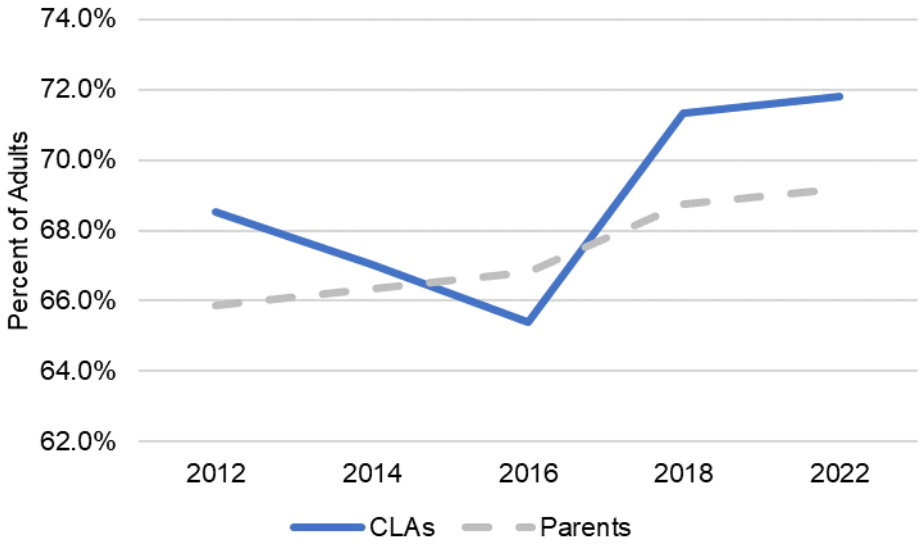


Figure 2.17: Trends in Not Getting Needed Care for All Adults

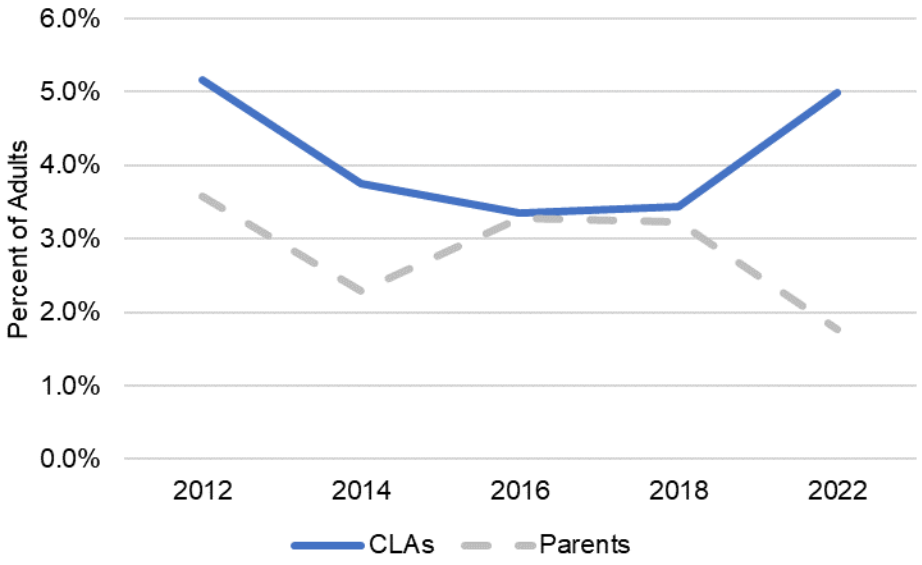


Table 2.8 reports measures of access to care for CLAs and parents within incomes less than the FPL. Among low-income CLAs in Wisconsin, most measures improved between 2012 and 2018, and then worsened between 2018 and 2022. One exception is the percent that could not get needed care, which increased from 6.8% in 2012 to 8.1% in 2018 but then increased further to 12.9% in 2022 (**Figures 2.18** and **2.19**). Among low-income parents, the percentage with a usual place of care and who had a checkup in the past 12 months was roughly constant between 2012 and 2018, but then fell by 2022. The percentage with a hospitalization and the percentage with a dentist visit increased between 2012 and 2018, and then fell between 2018 and 2022. The percentage of low-income parents with an ER visit remained mostly consistent

from 2012 to 2022, while the percentage who could not get needed care fell from 6.9% in 2012 to 5.0% in 2022. When comparing the changes over time for CLAs to parents, in Panel C, low-income CLAs were overall more likely to have a usual place of care and had relative increases in all types of health care utilization, but also were more likely to report they could not get all needed care.

Table 2.8: Access to Care Among Adults with Incomes <100% of FPL

	2012	2014	2016	2018	2022	Percentage Point Change, 2012–2022
Panel A: CLAs						
Has Usual Place of Care	89.1%	95.2%	92.1%	94.9%	93.7%	4.6
Checkup in Past 12 Months	69.1%	63.5%	63.3%	71.6%	60.2%	-8.9
Hospitalized in Past 12 Months	17.3%	13.4%	25.9%	16.9%	18.2%	0.9
ER Visit in Past 12 Months	34.0%	31.3%	38.8%	34.0%	45.5%	11.6
Dentist Visit in Past 12 Months	42.6%	41.0%	45.8%	57.8%	49.1%	6.4
Could Not Get Needed Care in Past 12 Months	6.8%	15.6%	10.8%	8.1%	12.9%	6.1
Panel B: Parents						
Has Usual Place of Care	94.9%	94.9%	92.3%	94.3%	92.8%	-2.1
Checkup in Past 12 Months	70.3%	72.7%	72.7%	70.7%	61.0%	-9.3
Hospitalized in Past 12 Months	6.1%	8.9%	16.3%	13.8%	6.5%	0.4
ER Visit in Past 12 Months	29.9%	29.4%	27.9%	27.0%	29.5%	-0.4
Dentist Visit in Past 12 Months	55.0%	54.0%	57.1%	62.6%	51.6%	-3.4
Could Not Get Needed Care in Past 12 Months	6.9%	8.4%	9.4%	2.7%	5.0%	-1.9
Panel C: Between Group Difference (Panel A – Panel B)						
Has Usual Place of Care	-5.8%	0.3%	-0.3%	0.7%	0.9%	6.8
Checkup in Past 12 Months	-1.2%	-9.2%	-9.4%	0.8%	-0.8%	0.4
Hospitalized in Past 12 Months	11.2%	4.5%	9.5%	3.1%	11.7%	0.5
ER Visit in Past 12 Months	4.1%	1.9%	10.9%	7.0%	16.0%	11.9
Dentist Visit in Past 12 Months	-12.3%	-13.0%	-11.3%	-4.7%	-2.5%	9.8
Could Not Get Needed Care in Past 12 Months	-0.1%	7.2%	1.3%	5.3%	7.9%	8.0

Figure 2.18: Trends in Checkups for Adults with Incomes <100% of FPL

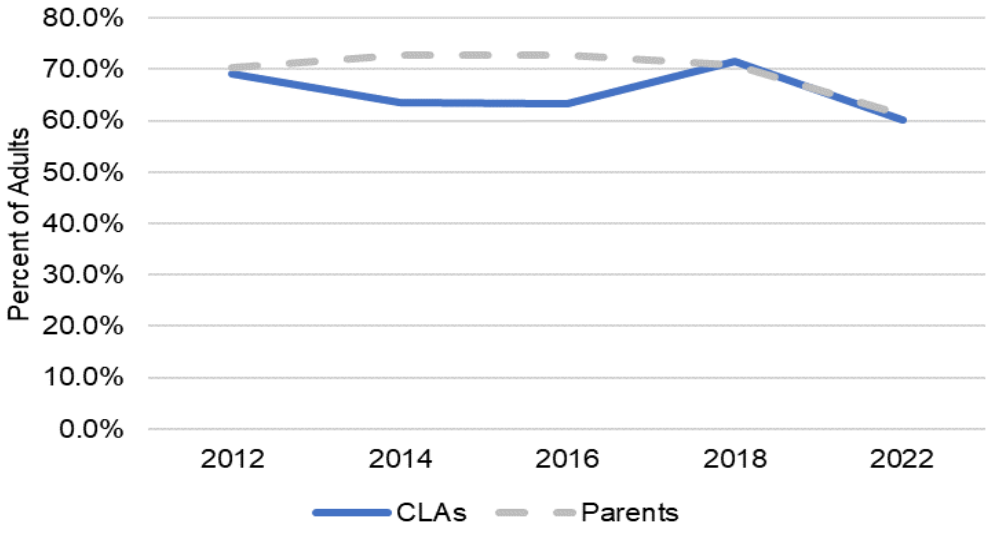


Figure 2.19: Trends in Not Getting Needed Care for Adults with Incomes <100% of FPL

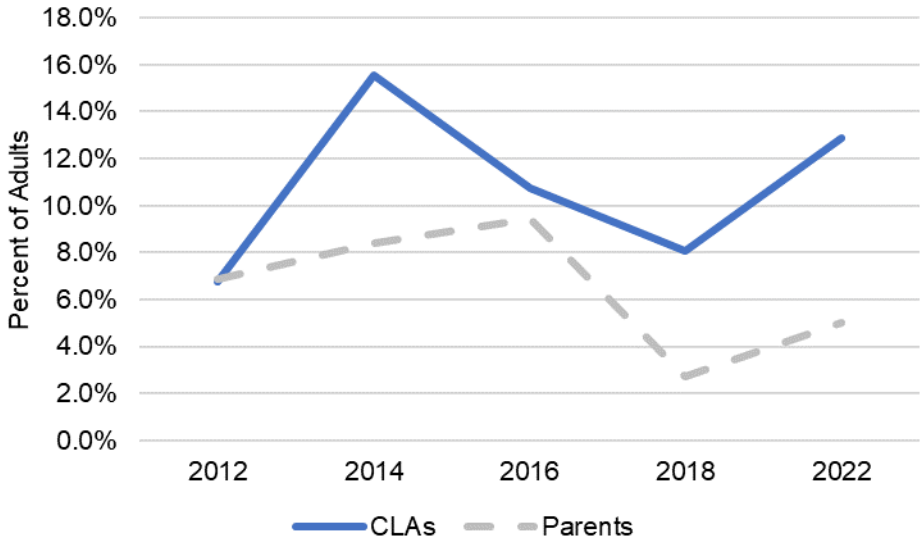


Table 2.9 reports these measures of access to care for CLAs and parents within incomes between 100 and 200% of the FPL. Among CLAs in this income range, all measures improved or were roughly flat between 2012 and 2022 except access to dental care which decreased by 6.5 percentage points. Among parents with incomes between 100 and 200% of the FPL, some measures improved while others worsened. For example, the percent receiving a checkup in the past 12 months decreased from 66.4% in 2012 to 64.4% in 2022 and the percent that could not get needed care decreased from 5.0% in 2012 to 1.8% in 2022 (**Figures 2.20** and **2.21**). When comparing the changes over time for CLAs to parents, in the last column of Panel C, CLAs in this income group were overall more likely to have a usual place of care and had relative increases in all types of health care utilization, and had a larger decline in their likelihood to report they could not get all needed care.

Overall, many indicators of access to care in the FHS trended down during the waiver period, but not necessarily more so for parents than for CLAs, suggesting these changes were more about broader health care access issues associated with the pandemic.

Table 2.9: Access to Care Among Adults with Incomes 100–200% of FPL

	2012	2014	2016	2018	2022	Percentage Point Change, 2012–2022
Panel A: CLAs						
Has Usual Place of Care	88.3%	92.2%	90.6%	90.1%	91.7%	3.4
Checkup in Past 12 Months	60.7%	61.3%	62.4%	67.7%	65.9%	5.2
Hospitalized in Past 12 Months	10.8%	9.8%	13.8%	13.9%	11.4%	0.6
ER Visit in Past 12 Months	19.9%	22.5%	24.2%	33.8%	34.7%	14.8
Dentist Visit in Past 12 Months	59.3%	49.2%	53.7%	56.8%	52.8%	-6.5
Could Not Get Needed Care in Past 12 Months	13.0%	10.4%	8.1%	6.4%	8.3%	-4.7
Panel B: Parents						
Has Usual Place of Care	96.2%	94.4%	94.7%	93.7%	92.6%	-3.7
Checkup in Past 12 Months	66.4%	69.8%	62.3%	68.5%	64.4%	-2.0
Hospitalized in Past 12 Months	3.9%	7.3%	8.2%	9.6%	2.8%	-1.1
ER Visit in Past 12 Months	19.2%	21.1%	13.8%	26.1%	20.5%	1.4
Dentist Visit in Past 12 Months	64.4%	57.7%	65.0%	70.6%	53.0%	-11.4
Could Not Get Needed Care in Past 12 Months	5.0%	2.1%	3.4%	10.5%	1.8%	-3.2
Panel C: Between Group Difference (Panel A – Panel B)						
Has Usual Place of Care	-8.0%	-2.1%	-4.0%	-3.6%	-0.9%	7.1
Checkup in Past 12 Months	-5.7%	-8.4%	0.1%	-0.8%	1.5%	7.2
Hospitalized in Past 12 Months	6.9%	2.5%	5.6%	4.3%	8.6%	1.7
ER Visit in Past 12 Months	0.7%	1.5%	10.3%	7.7%	14.1%	13.4
Dentist Visit in Past 12 Months	-5.1%	-8.5%	-11.4%	-13.8%	-0.1%	4.9
Could Not Get Needed Care in Past 12 Months	8.0%	8.3%	4.8%	-4.1%	6.4%	-1.6

Figure 2.20: Trends in Checkups for Adults with Incomes 100–200% of FPL

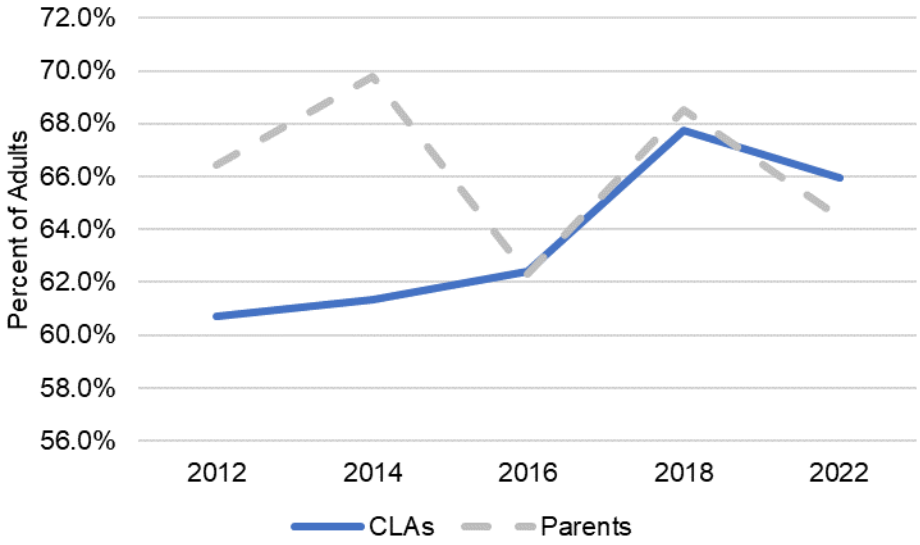
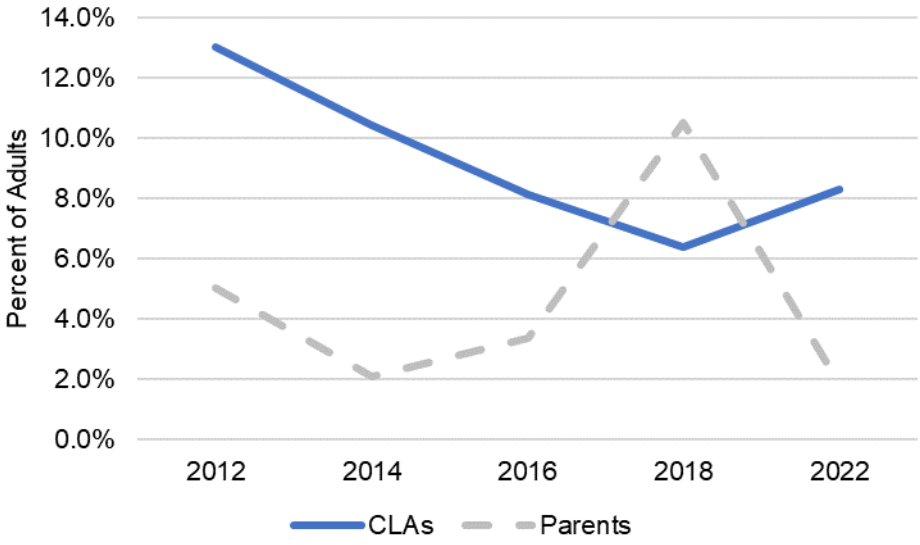


Figure 2.21: Trends in Not Getting Needed Care for Adults with Incomes 100–200% of FPL



We also provide an analysis of access to care and preventive health care use using data from the BRFSS collected from 2013 to 2022. Average rates in 2013 and 2022 and DiD comparison of CLAs in the selected groups of expansion and non-expansion states to Wisconsin are included in **Table 2.10**, where the post period is defined as the two waiver periods, 2014–2018 and 2019–2022. Models exclude survey year 2020 from the analysis. Measures of access to care in Panel A showed consistent improvement among CLAs from 2013 to 2022, with reductions in the proportion reporting cost as a barrier to care from 27% to 15% among those

with incomes <100% of FPL and increases in the proportion reporting having a personal doctor from 66% to 79%. These trends were evident across both income groups in the table, but most pronounced for the lowest income. In comparing to CLAs in other states, minimal differences were evident in Wisconsin compared to either expansion or non-expansion states. Relative to non-expansion states, CLAs in Wisconsin were more likely to report cost as a barrier to care in 2014-2018, and those with incomes <100% of FPL were less likely to report cost as a barrier to care in the current waiver period. Relative to both expansion and non-expansion states, CLAs 100-200% of FPL were less likely to report having a personal doctor in 2014-2018 and more likely, compared to non-expansion states, in the current waiver period. When testing whether these results differed in the current waiver period compared to the prior waiver period, results were significantly lower compared to non-expansion states for those <100% FPL for the cost as a barrier to care outcome after 2019, and significantly higher for the 100–200% FPL group relative to non-expansion states for the personal doctor outcome, both suggesting potential improvements relative to non-expansion states in the 2019 period.

Panel B of Table 2.10 shows the results of analysis of preventive care outcomes. Improvements and/or maintenance of gains are evident from 2013-2022 among CLAs in Wisconsin across all outcomes in the lowest income (<100% of FPL) group with the exception of HIV testing, which showed a downward trend from 50% to 41%. The results of the difference-in-differences analyses comparing CLAs in Wisconsin to CLAs in expansion and non-expansion states almost universally suggest relative declines in the fraction reporting a routine checkup within the last year in the 2014-2018 period which are not found in the 2019-2022 period. Similarly, CLAs in Wisconsin were comparatively less likely to report ever having an HIV test for almost all comparison states and income groups in the 2014-2018 period, but differences were not apparent in the 2019-2022 period.

The proportion reporting pneumonia shots in any income group relative to baseline levels in comparison expansion states was relatively higher in Wisconsin in 2014-2018, but lower compared to both groups of states in the 100-200% of FPL group. Consistent improvements in the 2019-2022 period among CLAs in Wisconsin were seen in for each income group for pneumonia compared to non-expansion states, and among CLAs from 100-200% of FPL compared to expansion states. CLAs in all income groups in Wisconsin were less likely than baseline to have a flu shot in the last 12 months compared to expansion states, but were more likely compared to non-expansion states in the 2019-2022 period. For the dental visits outcome, CLAs in Wisconsin were relatively more likely to have had a dental visit than CLAs in expansion and non-expansion states within 100-200% of FPL and more likely compared to those in non-expansion states for the <100% FPL group. However, no differences were found in the All Incomes group in the 2014-2018 period. In the 2019-2022 period, there was evidence of a relative decline in dental care among CLAs with <100% of FPL compared to expansion states and a relative improvement among CLAs with <100% of FPL compared to non-expansion states.

Overall, these analyses from the BRFSS suggest improvements in measures of relative access to care in the 2019-2022 period for CLAs in Wisconsin, and do not suggest that changes to access to care were systematically larger or smaller than in expansion states or non-expansion states.

Table 2.10. DiD Analyses of Access to & Preventive Care, BRFSS

	All Incomes		<100% FPL		100–200% FPL	
	Relative to Expansion States	Relative to Non-Expansion States	Relative to Expansion States	Relative to Non-Expansion States	Relative to Expansion States	Relative to Non-Expansion States
Panel A: Access to Care						
Cost is a barrier to care						
2014-2018	0.00163	0.0104*	0.0219	0.00909	-0.0279	-0.0132
(Standard Error)	(0.00435)	(0.00229)	(0.0156)	(0.0114)	(0.0136)	(0.00603)
2019-2023	-0.00411	-0.0134	0.0163	-0.0516*	-0.00915	-0.0237
(Standard Error)	(0.0125)	(0.00994)	(0.0130)	(0.0108)	(0.0256)	(0.0191)
Baseline Rate (WI 2013)	.12		.27		.22	
Endline Rate (WI 2022)	.10		.15		.15	
Have personal doctor						
2014-2018	-0.00639	0.000731	-0.0422	-0.00776	-0.0585*	-0.0540*
(Standard Error)	(0.00429)	(0.00902)	(0.0189)	(0.00928)	(0.00916)	(0.00511)
2019-2023	0.0156	0.000969	0.0144	0.000476	0.0433	0.0236*
(Standard Error)	(0.0145)	(0.00663)	(0.0243)	(0.00778)	(0.0421)	(0.00562)
Baseline Rate (WI 2013)	.77		.66		.70	
Endline Rate (WI 2022)	.81		.79		.76	
Panel B: Preventive Care						
Routine checkup in past 12-months						
2014-2018	-0.0351*	-0.0212	-0.106*	-0.0692*	-0.0738*	-0.0719*
(Standard Error)	(0.00769)	(0.00934)	(0.0124)	(0.0124)	(0.0166)	(0.0111)
2019-2023	-0.00721	0.00294	-0.00131	0.0104	0.0119*	0.0212
(Standard Error)	(0.0121)	(0.00652)	(0.00739)	(0.00656)	(0.00255)	(0.0121)
Baseline Rate (WI 2013)	.65		.58		.64	
Endline Rate (WI 2022)	.69		.71		.64	
Ever received HIV test						
2014-2018	-0.0362*	-0.0373*	-0.0977*	-0.0801*	-0.0419	-0.0461*
(Standard Error)	(0.00341)	(0.00162)	(0.0104)	(0.0149)	(0.0152)	(0.0143)
2019-2023	0.00771	0.0200	-0.0506	-0.0385	-0.00492	-0.0176
(Standard Error)	(0.00472)	(0.00655)	(0.0210)	(0.0218)	(0.00449)	(0.0146)
Baseline Rate (WI 2013)	.31		.50		.31	
Endline Rate (WI 2022)	.30		.41		.34	
Ever received pneumonia shot						
2014-2018	0.00420*	0.00959	-0.00164	-0.0148	-0.0430*	-0.0238*
(Standard Error)	(0.000621)	(0.00750)	(0.0126)	(0.0206)	(0.00905)	(0.00613)
2019-2023	0.0114	0.0162*	0.0263	0.0480*	0.0876*	0.0728*
(Standard Error)	(0.00832)	(0.00369)	(0.00867)	(0.0113)	(0.0178)	(0.00357)
Baseline Rate (WI 2013)	.22		.24		.32	
Endline Rate (WI 2022)	.23		.31		.27	
Received flu shot in past 12 months						
2014-2018	-0.00839*	-0.0165	-0.0131	-0.00159	-0.00304	-0.0177
(Standard Error)	(0.00205)	(0.00600)	(0.0325)	(0.0149)	(0.0172)	(0.0102)
2019-2023	0.0309	0.0769*	0.0175	0.0343	0.0386*	0.0780*
(Standard Error)	(0.0102)	(0.00569)	(0.0133)	(0.0137)	(0.00968)	(0.00823)
Baseline Rate (WI 2013)	.33		.25		.31	
Endline Rate (WI 2022)	.42		.37		.37	
Dental visit in past 12 months						
2014-2018	0.00351	0.00218	0.00480	0.0456*	0.0712*	0.0386*
(Standard Error)	(0.00789)	(0.0109)	(0.0232)	(0.0110)	(0.0126)	(0.00521)
2019-2023	-0.0214	-0.0114	-0.0235*	0.0172*	-0.00257	0.0359
(Standard Error)	(0.00716)	(0.00624)	(0.00233)	(0.00368)	(0.0252)	(0.0246)
Baseline Rate (WI 2013)	.77		.46		.51	
Endline Rate (WI 2022)	.66		.48		.54	

Notes: Expansion states include Minnesota, Michigan, and Illinois, and non-expansion states include Florida, North Carolina, and Texas. This analysis is weighted and controls for age, education, employment, marital status, household size, gender, and race. * Indicates statistical significance at 5% level or less. Dental visits only asked in even years. Excludes 2020.

Finally, we report the results of the access to care and utilization of care measures from the 2020 and 2024 Medicaid Beneficiary Surveys. **Table 2.11** provides a weighted comparison of results for CLAs and parents and shows a test for differences in changes over time within CLAs as well as a DiD analysis of the change in outcomes for CLAs compared to parents from 2020 to 2024.

Just over 90% of CLAs reported a place they usually go for health care, with no difference over time and a very similar fraction for parents, with no relative difference over time. More than 80% of CLAs reported getting all the health care they needed in the last 12 months in both 2020 and 2024, with no difference over time; there was a decline in the proportion reporting they had among parents, resulting in a relative increase in this measure for CLAs that was statistically significant (p = .02). The fraction reporting getting all the prescription medications needed declined dramatically from 2020 to 2024, from 93.8% to 78.9% among CLAs (p<.001); however, a similar decline among parents was also observed and there was no relative difference in the measure for CLAs compared to parents.

The proportion of CLAs reporting a dental visit in the past 12 months was 41.6% in 2020 and 45.3% in 2024 and the difference was not statistically different from zero (p = .191). Similar fractions of parents reported dental visits and there was no measurable relative difference over time. The fraction reporting visiting a doctor's office at least once was 78.5% in 2020 and 84.9% in 2024, an increase that was statistically significant (p = .004); however, parents saw a similar relative increase and the DiD estimate was not statistically different from zero (p = .896). The proportion of CLAs reporting telephone or video visit options declined slightly from 54.7% to 49.3% (p = .059). Although there was a smaller decline among parents, the relative decline was not statistically different from zero (p = .451). Finally, the proportion of CLAs reporting an overnight hospital stay was 10.4% in 2020 and 13.6% in 2024, an increase that was not statistically different from zero (p = .092). A similar increase for parents meant that the relative difference was also not statistically different from zero (p = .915).

Overall, the Medicaid Beneficiary Survey measures of access to and utilization of care by CLAs do not suggest any substantive changes over the current waiver period relative to parents.

Table 2.11. 2020 and 2024 Medicaid Beneficiary Survey, Access and Utilization for CLAs vs. Parents

	CLA					Parents				
	2020		2024		2020 vs 2024	2020		2024		
	N	%	N	%	*p* value	N	%	N	%	DiD [*p* value]
Is there a place you usually go for your health care?	1,285	90.1%	807	90.4%	0.856	390	88.5%	292	89.9%	-0.011 [0.756]
In the last 12 months, did you get all the health care you needed?	1,193	83.9%	749	82.8%	0.571	403	91.2%	264	80.7%	0.094 [0.021]
In the last 12 months, did you get all the prescription medications you needed?	1,009	93.8%	715	78.9%	<0.001	321	90.6%	247	75.6%	0.0004 [0.993]
Dentist visit in past 12 months	594	41.6%	412	45.3%	0.191	192	43.4%	154	46.8%	0.002 [0.964]
In the last 12 months, about how many times did you visit a doctor's office? ("1 or more times" responses reported)	1,110	78.5%	769	84.9%	0.004	372	83.8%	296	89.7%	0.005 [0.896]
Do your health providers offer telephone or video visits as options?	780	54.7%	438	49.3%	0.059	278	62.6%	194	61.2%	-0.040 [0.451]
Did you stay in hospital overnight in last 12 months?	149	10.4%	124	13.6%	0.092	50	11.3%	47	14.1%	0.004 [0.915]

Note: Only "Yes" responses reported in table unless otherwise noted.

Question 1.2b. What are the short- and long-term effects of eligibility and coverage policies on Medicaid health service expenditures?

This analysis uses state Medicaid claims to display trends in per-person Medicaid-paid health expenditures from January 2012 through December 2023. **Figure 2.22** displays average per-person per month overall expenditures, including pharmacy claims, as monthly averages for parents and for CLAs.

These data have been winsorized at the 99th percentile to address outlier expenditures and are not inflation-adjusted. Pre-expansion average expenditures for CLAs were $541 per month and were higher than for parents ($391); however, the population of CLAs enrolled at that point was very small and selected (from a prior limited CLA program). Following the expansion to all CLAs in April 2014 (and contraction to 100% FPL among parents) average CLA expenditures trended upward beginning in 2015 before declining dramatically in early 2020 and remaining flat through 2022. Toward the end of 2023, per capita expenditures among CLAs were again trending up. Per capita expenditures for parents exhibited an overall upward trend during this period with the exception of early 2020. Average expenditures between April 2014–December 2018 were$ 635 for CLAs and $455 for parents, and between December 2019 and December 2023 were $710 for CLAs and $550 for parents.

Figure 2.22: Overall Trends in Per-Person Per Month Medicaid-Paid Health Care Expenditures

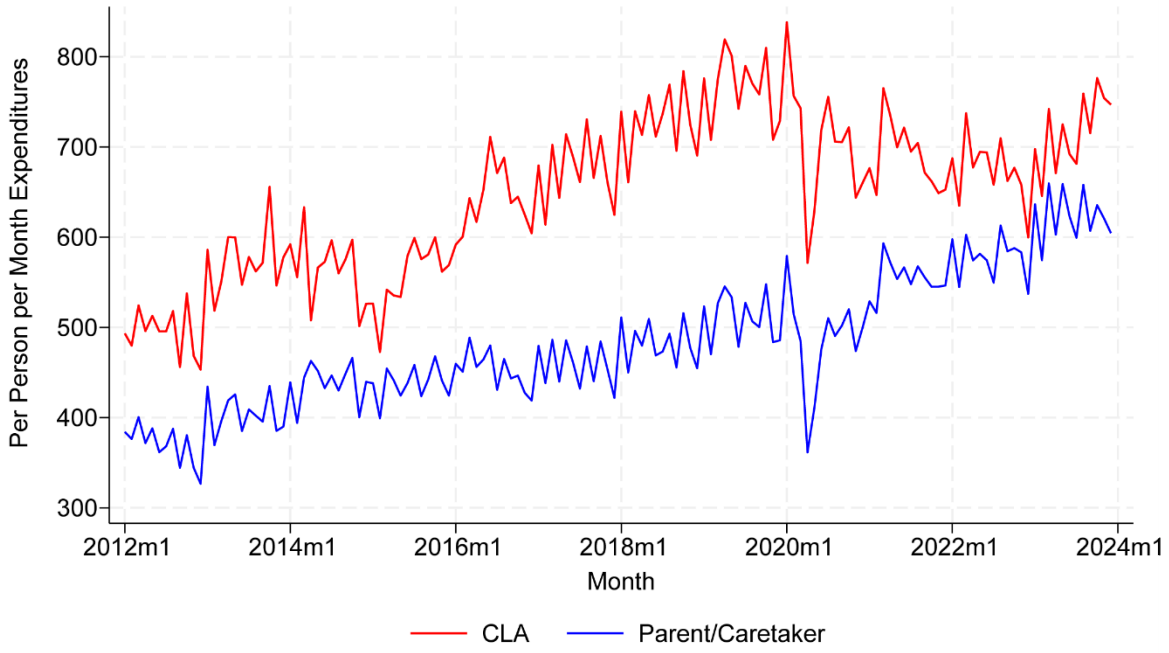


Figure 2.23 provides an overview of the distribution of per-person Medicaid expenditures for CLAs at the median 50th, 70th, and 90th percentiles. These percentiles reflect the population enrolled at the time and the data were winsorized at the 99th percentile to address outlier expenditure amounts. The distribution trends over time for the 50th and 70th percentile groups appear consistent while the distribution trend for the 90th percentile group trends slightly upward. The figure suggests that the noted upward trends in average expenditures is driven by increases for individuals with high expenditures rather than an upward shift in expenditures for everyone.

Figure 2.23: Trends in CLA Per-Person Medicaid Expenditures, Percentiles

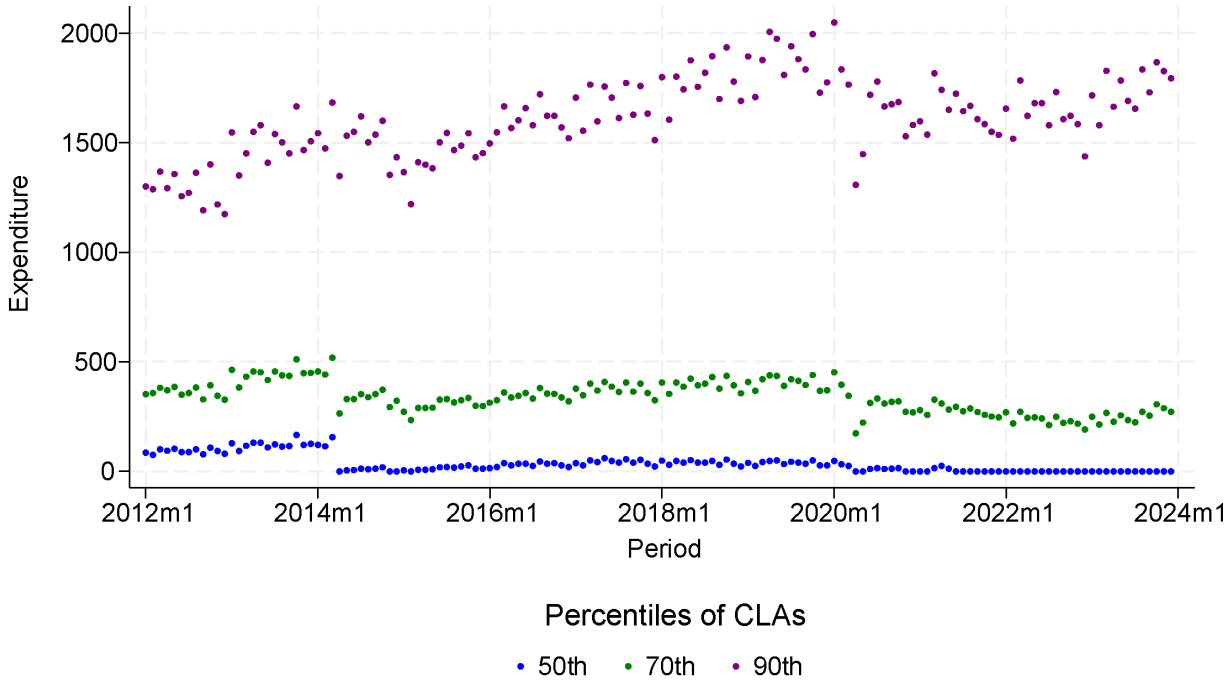


Figure 2.24 shows trends in total Medicaid-paid expenditures. This figure reflects both the number of individuals enrolled and their spending; the large increase in total expenditures for CLAs from March 2014 to April 2014 reflects the new enrollment of the expansion population. For CLAs, total expenditures grew significantly over this period, reflecting a combination of enrollment growth and the per capita increases in expenditures described above. For parents, total expenditures trended slightly down or were flat from 2014 through early 2020, in contrast with the growth in per capita expenditures, reflecting that enrollment was trending down as well. After 2014, note that most of the increase in total expenditures by group was driven by increased enrollment after 2020 for both groups.

Figure 2.24: Trends in Medicaid-Paid Expenditures by Eligibility Group

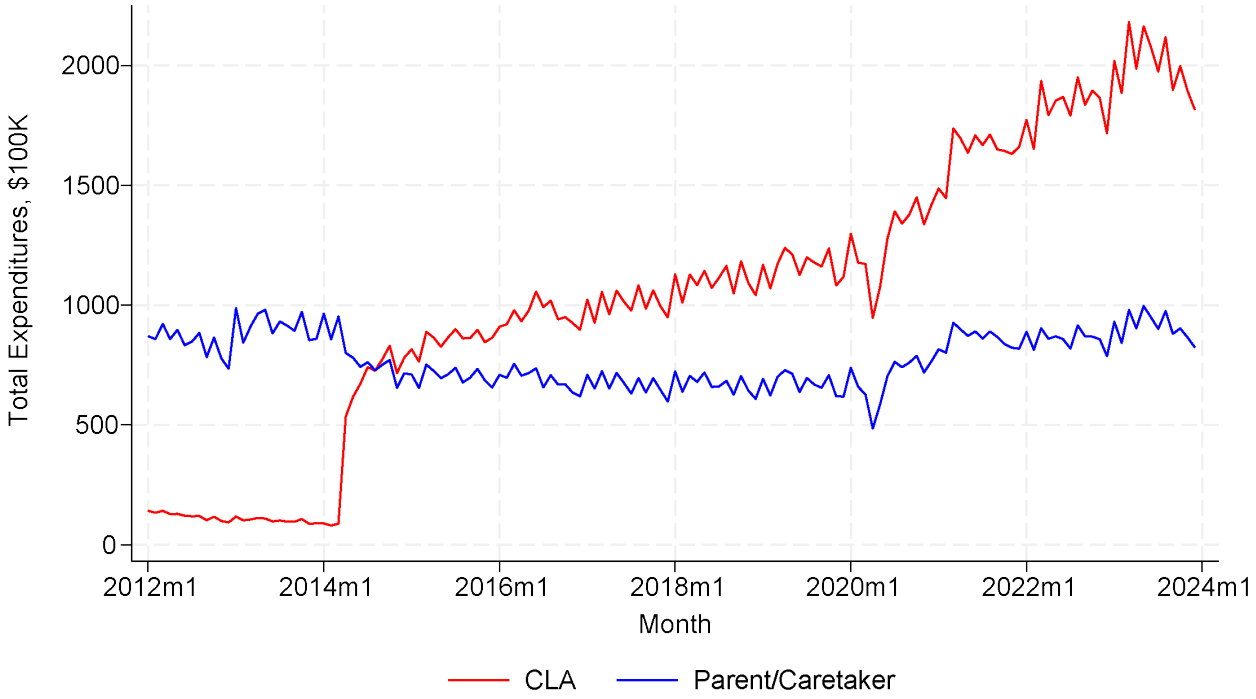


Table 2.12 shows the results of a DiD analysis comparing total and per capita expenditures among CLAs to parents before and after April 2014, including a separate indicator for the waiver period. The coefficients of interest are the interactions of the CLA variable with the two waiver periods, which show the relative change for CLAs compared to parents during that time compared to before April 2014. We also include the F-statistic and *p* value of a test for a difference in the relative change for CLAs in the first versus second waiver period.

For total expenditures, the relative change for CLAs was a large increase compared to parents in the first waiver period (959 $100K) and an even larger increase in the second waiver period (1,550 $100K); the difference between these periods was statistically different from zero ($p<0.001$). Because the total expenditure trends were quite different for the two groups pre-2014, the absolute level of the change should not be interpreted causally, but the test of the two waiver periods compared to one another showing an increase is still relevant.

The per capita expenditures trends among the two groups were more similar, better supporting a causal interpretation. No relative increase in per capita expenditures was measurable for CLAs compared to parents after April 2014, and a test for the differences in the two waiver periods was not statistically significant indicating no change in that conclusion in the current waiver period ($p = .18$). In estimates not shown, we excluded the COVID-19 period from the analysis, and no qualitatively different conclusions were suggested.

Overall, these analyses of trends in expenditure show that both overall and per capita, CLAs are more expensive to cover than parents, and that these differences in per capita expenditures have remained about the same across the waiver periods, though overall Medicaid expenditures for CLAs have increased more rapidly. The absolute difference in per capita expenditures likely reflects the older age distribution of CLAs, while the relative increases in total expenditures likely reflect increases in the population of CLAs enrolled over time.

Table 2.12. DiD Analyses of Total and Per Capita Expenditures – CLAs vs. Parents

	Total Expenditures ($100K)	Per Capita Expenditures
April 2014–December 2018	-175.51*	67.09*
	(-3.68)	(5.14)
January 2019–December 2023	-80.86	163.34*
	(-1.70)	(12.52)
CLA	-768.70*	147.68*
	(-13.49)	(9.47)
CLA*April 2014–December 2018	959.17*	31.33
	(14.22)	(1.70)
CLA*January 2019–December 2023	1549.87*	12.53
	(22.98)	(0.68)
F-Statistic	134.29	1.82
p value	<0.001	0.18
N	288	288

Notes: t-statistics in parentheses. F-statistic and *p* value reflect test of difference in CLA*April 2014–December 2018 – CLA*January 2019–December 2023. * Indicates statistically significant at 5% level or higher.

Hypothesis 1.3. By expanding the safety net, the expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals.

Primary Research Question 1.3. Did the expansion of benefits to CLAs reduce the provision of uncompensated care (charity care plus bad debt) among Wisconsin acute care hospitals?

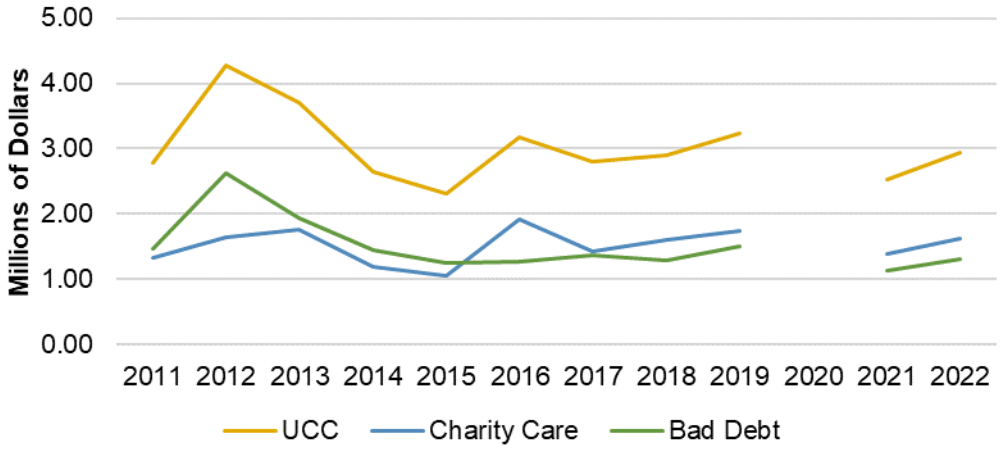
Question 1.3a. What are the trends in the provision of uncompensated care among Wisconsin hospitals and did it change along with the expansion of benefits to CLAs?

First, we report the trends in uncompensated care, charity care, and bad debt in fiscal years 2011 through 2022 for all hospitals in Wisconsin (**Figure 2.25, Panel A**). Uncompensated care (UCC) is the sum of charity care and bad debt. After peaking in 2012, Wisconsin hospitals reported declines in UCC, charity care, and bad debt in 2013 and 2014. The total amount of uncompensated care provided was relatively constant thereafter. UCC values are reported in **Table 2.13**.

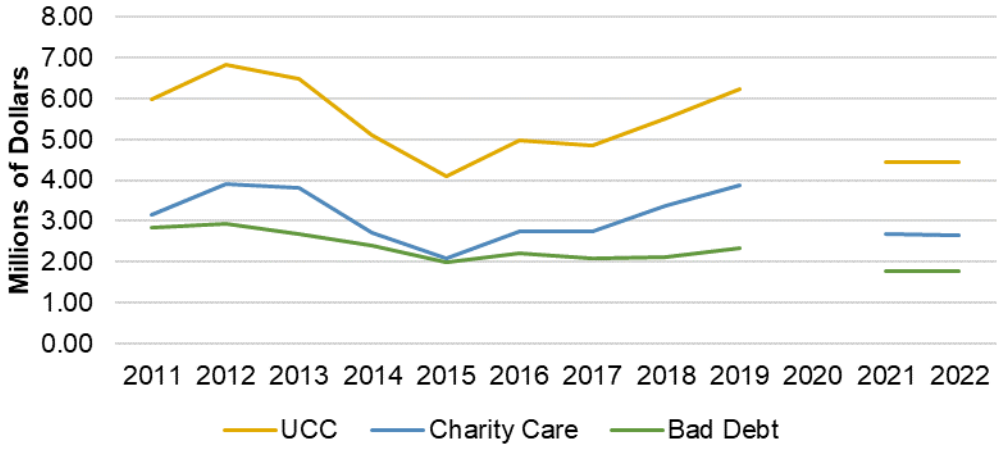
Panel B displays the trends in UCC, charity care, and bad debt in fiscal years 2011 through 2022 for hospitals in Michigan, Minnesota, and Illinois, which are the Medicaid expansion states we use as comparators for Wisconsin. As with Wisconsin, UCC peaked in 2012 and either declined or was constant thereafter.

Panel C displays the trends in UCC, charity care, and bad debt in fiscal years 2011 through 2022 for hospitals in Texas, Florida, and North Carolina, which are the Medicaid non-expansion states we use as comparators for Wisconsin. Unlike for expansion states or Wisconsin, UCC trended upwards for the entire period and at a steeper rate. (Note that the scale in Panel C is different from those in Panels A and B.)

Figure 2.25. Trends in Uncompensated Care, by Study Population (Millions of $)
Panel A: Wisconsin



Panel B: Comparison Expansion States - Michigan, Minnesota, Illinois



Panel C: Comparison Non-Expansion States - Texas, Florida, North Carolina

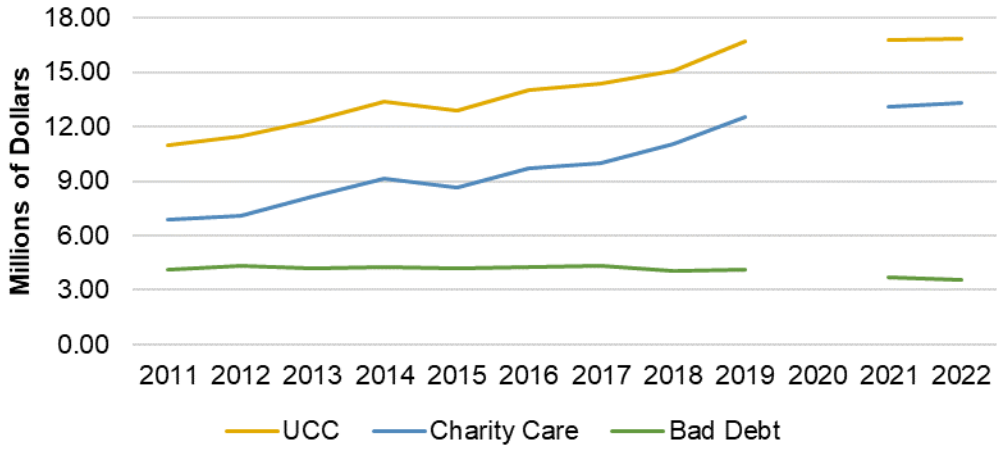


Table 2.13: Provision of Uncompensated Care in Wisconsin versus Comparison States, by Type of Care (Millions of $)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Wisconsin												
UCC	2.78	4.27	3.70	2.64	2.31	3.18	2.80	2.91	3.24		2.53	2.94
Charity Care	1.32	1.65	1.76	1.20	1.06	1.91	1.43	1.61	1.74		1.40	1.63
Bad Debt	1.46	2.62	1.94	1.44	1.25	1.27	1.37	1.30	1.50		1.14	1.31
Expansion States (MI, MN, IL)												
UCC	5.99	6.83	6.49	5.11	4.09	4.99	4.84	5.52	6.22		4.45	4.43
Charity Care	3.16	3.91	3.81	2.72	2.10	2.76	2.74	3.39	3.88		2.67	2.67
Bad Debt	2.83	2.92	2.68	2.40	1.99	2.23	2.10	2.13	2.34		1.78	1.77
Non-Expansion States (TX, FL, NC)												
UCC	10.97	11.46	12.33	13.40	12.86	14.03	14.35	15.10	16.69		16.80	16.84
Charity Care	6.85	7.09	8.16	9.16	8.65	9.74	10.00	11.08	12.55		13.07	13.29
Bad Debt	**4.12**	**4.37**	**4.18**	**4.24**	**4.21**	**4.29**	**4.35**	**4.02**	**4.14**		**3.73**	**3.55**

Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Note: Millions of current-year dollars.

We estimate the change in the trends in uncompensated care in Wisconsin and comparison states using interrupted time series with a break in 2014. **Table 2.14** displays results of the models.

Table 2.14: Interrupted Time Series Estimates of Uncompensated Care

	Wisconsin	MI, MN, IL	TX, FL, NC
Uncompensated Care			
Time	0.4569	0.2526	0.6832*
	(0.3048)	(0.1742)	(0.0557)
2014	-1.7849*	-1.9655*	0.0356
	(0.7368)	(0.5563)	(0.3693)
Time x 2014	-0.4283	-0.2579	-0.1439
	(0.3079)	(0.1960)	(0.0938)
Constant	3.1266*	6.1850*	10.9030*
	(0.4656)	(0.2661)	(0.0851)
Charity Care			
Time	0.2186*	0.3295*	0.6534*
	(0.0329)	(0.1251)	(0.1209)
2014	-0.6657*	-1.6142*	-0.0785
	(0.2233)	(0.4006)	(0.4644)
Time x 2014	-0.1788*	-0.2776	-0.0273
	(0.0485)	(0.1423)	(0.1403)
Constant	1.3591*	3.2969*	6.7133*
	(0.0502)	(0.1911)	(0.1847)
Bad Debt			
Time	0.2383	-0.0769	0.0297
	(0.2719)	(0.0491)	(0.0652)
2014	-1.1192	-0.3513	0.1141
	(0.6311)	(0.1604)	(0.1822)
Time x 2014	-0.2495	0.0197	-0.1166
	(0.2724)	(0.0543)	(0.0687)
Constant	1.7675*	2.8882*	4.1897*
	(0.4153)	(0.0750)	(0.0996)

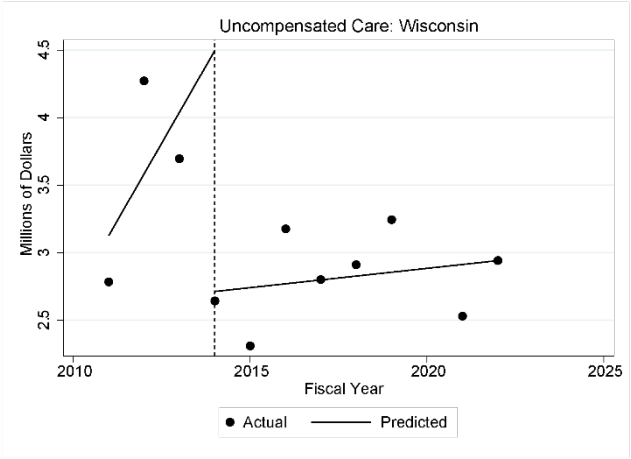
Note: * Indicates statistically significant at 5% level or higher. Newey-West standard errors are reported in parentheses.

In **Figure 2.26** Panels A and B, UCC in both Wisconsin and the Medicaid-expansion comparison states show a sizable discontinuous decrease in 2014; in other words, a drop in level (*p* value for intercept break 0.05 and 0.02, respectively). However, we observe no statistically significant change in the trend of UCC after 2014 ($p = 0.36$ and $p = 0.96$, respectively). Among the comparison states that did not expand Medicaid, however, there is neither a statistically significant change in the level of or the trend in UCC in 2014. These results are demonstrated in Panel C.

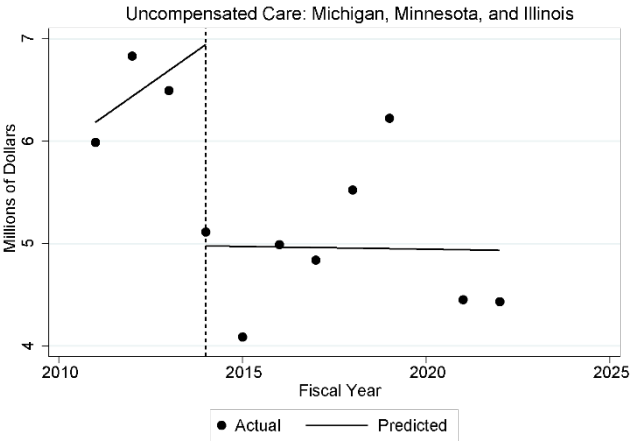
Overall, these results suggest that Wisconsin hospitals experienced large reductions in uncompensated care in 2014, as did the hospitals in states that fully expanded Medicaid, while non-expansion states did not see such a reduction.

Figure 2.26. Interrupted Time Series Estimates of Uncompensated Care

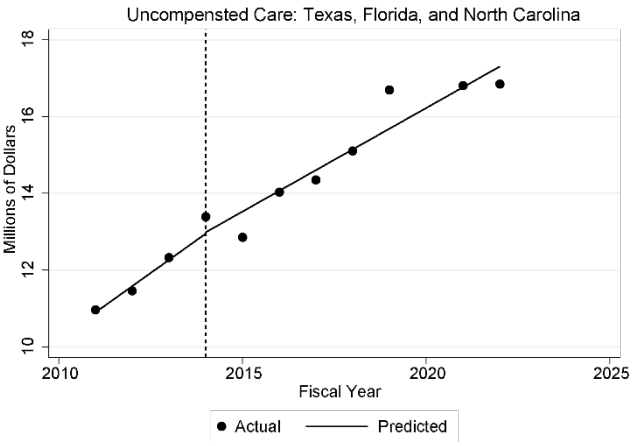
Panel A: Wisconsin



Panel B: Michigan, Minnesota, and Illinois



Panel C: Texas, Florida, and North Carolina



Question 1.3b. Did hospitals in areas with greater reductions in the number of uninsured CLAs experience differential changes in uncompensated care?

To further describe the impact of Wisconsin's health insurance income eligibility provision on UCC, we compare trends in Wisconsin to those in the comparison expansion and non-expansion states using a DiD analysis with hospital fixed effects.

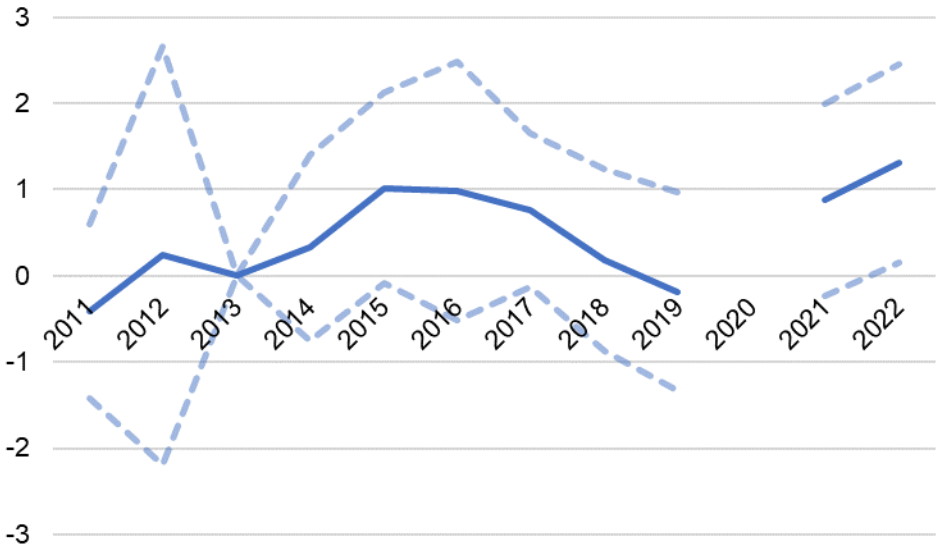
The results comparing trends in average levels of UCC, charity care, and bad debt among hospitals in Wisconsin with hospitals in states that expanded Medicaid are presented in **Figure 2.27** through **Figure 2.29**. In each figure, the values plotted on the bold line represents the average difference in UCC for each hospital in Wisconsin between a given year and 2013, relative to the same difference among the hospitals in the comparison states. The dashed lines represent the 95% confidence intervals around these estimates.

Average levels of UCC were not statistically different between Wisconsin and Minnesota, Michigan, and Illinois either before or following 2014, demonstrating that patterns were similar among Wisconsin hospitals and hospitals in expansion states. UCC levels were similar between hospitals in Wisconsin and Texas, Florida, and North Carolina prior to 2014. However, following 2014, UCC levels were statistically significantly lower among hospitals in Wisconsin.

Similarly, there was no statistical difference in UCC, charity care, and bad debt between Wisconsin hospitals and hospitals in expansion states between the 2014–2018 and the 2019–2022 periods. However, there was a statistically meaningful decrease in both overall UCC and charity care in Wisconsin relative to states that initially did not expand Medicaid between the 2014–2018 and the 2019–2022 periods.

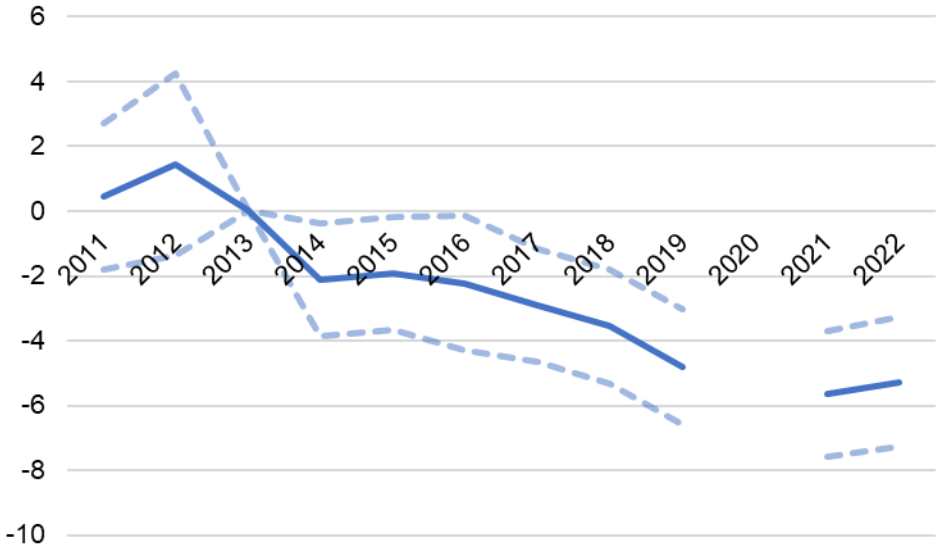
Figure 2.27: Trends in Hospital Uncompensated Care in Wisconsin Relative to Comparison States

Panel A: Wisconsin vs. Comparison Expansion States: MN, MI, IL



Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Notes: Results of a DiD analysis comparing Wisconsin with Minnesota, Michigan, and Illinois. Dashed lines represent 95% CI. Reference year is 2013.

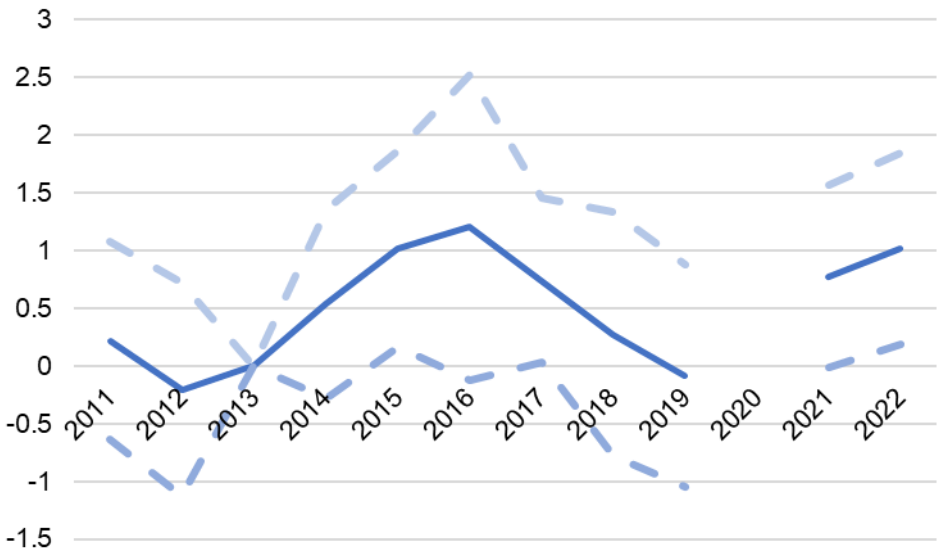
Panel B: Wisconsin vs. Comparison Non-Expansion States: TX, FL, SC



Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Notes: Results of a DiD analysis comparing Wisconsin with Texas, Florida, and North Carolina. Dashed lines represent 95% CI. Reference year is 2013.

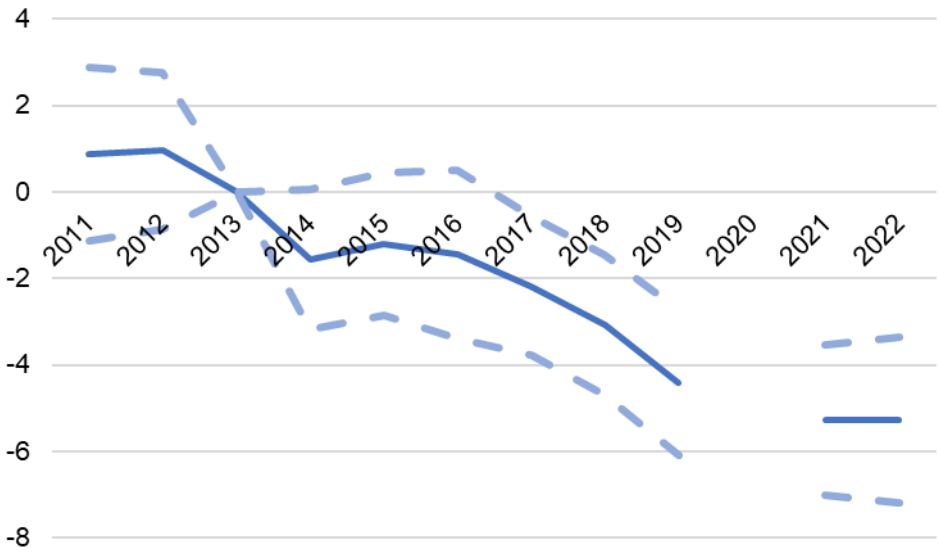
Figure 2.28: Trends in Hospital Charity Care in Wisconsin Relative to Comparison States

Panel A: Comparison Expansion States: MN, MI, IL



Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Notes: Results of a DiD analysis comparing Wisconsin with Minnesota, Michigan, and Illinois. Dashed lines represent 95% CI. Reference year is 2013.

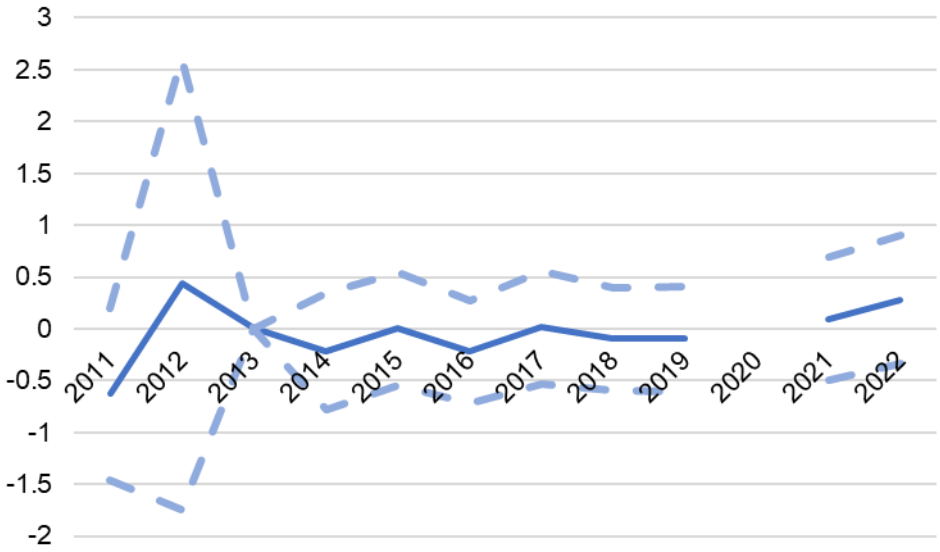
Panel B: Comparison Non-Expansion States: TX, FL, NC



Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Notes: Results of a DiD analysis comparing Wisconsin with Texas, Florida, and South Carolina. Dashed lines represent 95% CI. Reference year is 2013.

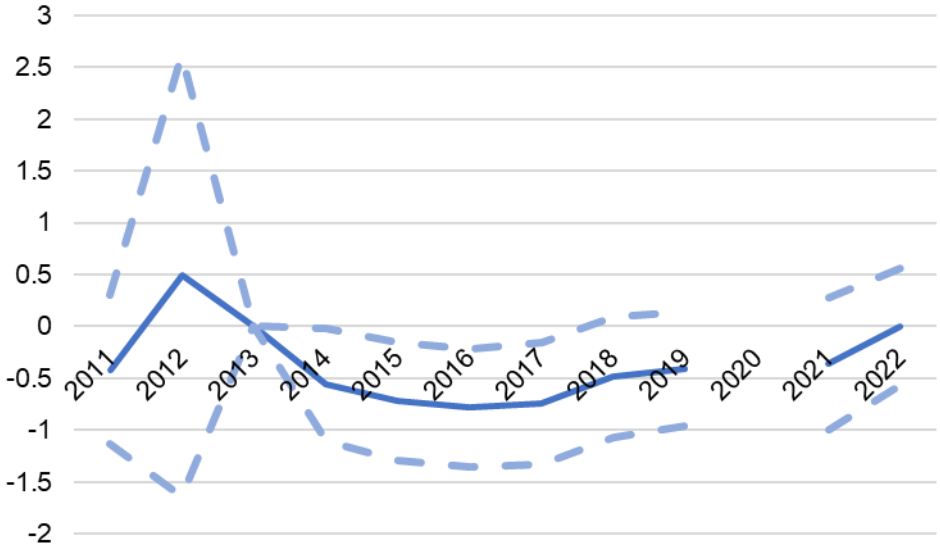
Figure 2.29: Trends in Hospital Bad Debt in Wisconsin Relative to Comparison States

Panel A Comparison Expansion States: MN, MI, IL



Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Notes: Results of a DiD analysis comparing Wisconsin with Minnesota, Michigan, and Illinois. Dashed lines represent 95% CI. Reference year is 2013.

Panel B Comparison Non-Expansion States: TX, FL, NC

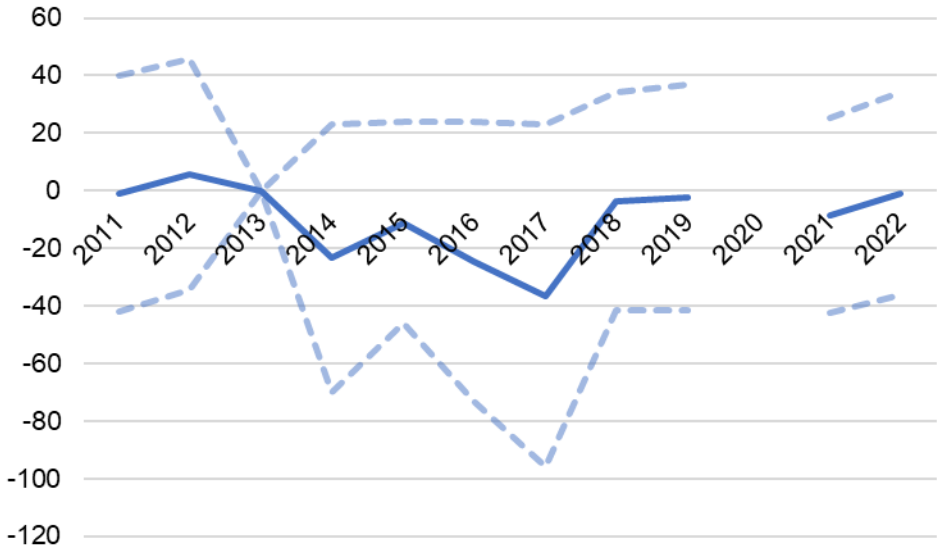


Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Notes: Results of a DiD analysis comparing Wisconsin with Texas, Florida, North Carolina. Dashed lines represent 95% CI. Reference year is 2013.

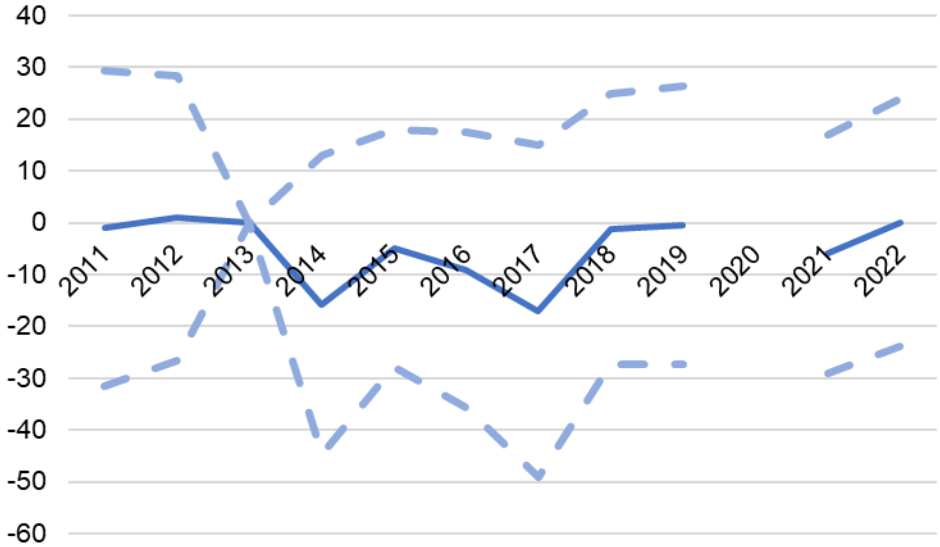
We find no statistically meaningful differences between the UCC, charity care, or bad debt provided by Wisconsin hospitals and that provided by comparison hospitals in bordering states, which were largely expansion states (**Figure 2.30, Panels A-C**). Moreover, there was no statistically meaningful change in these differences between the 2014–2018 and 2019–2022 periods. The solid line represents the difference in hospital UCC, charity care, or bad debt between Wisconsin hospitals and comparison hospitals in bordering states. The dashed lines represent 95% confidence intervals.

Figure 2.30: Differences in Hospital Uncompensated Care (in millions of $): Wisconsin Hospitals versus Geographically Matched Hospitals in Border Counties

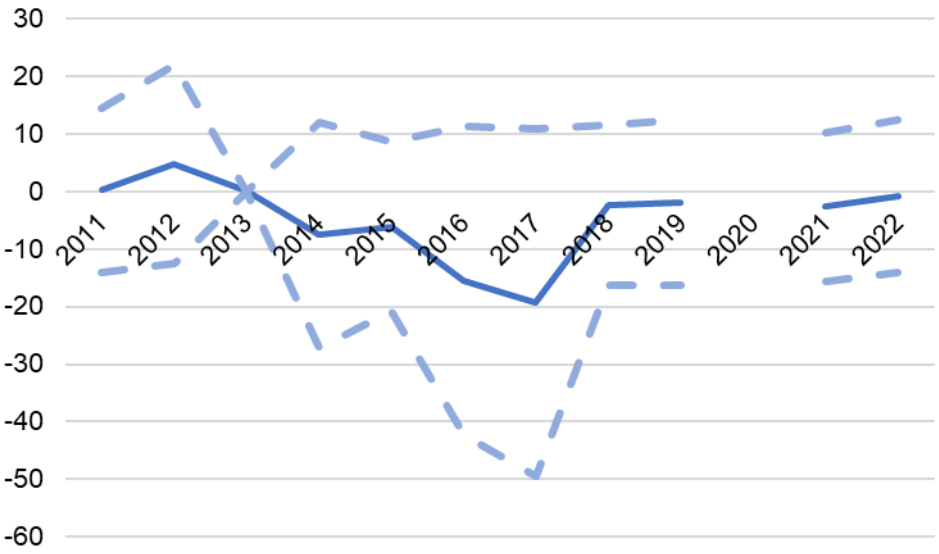
Panel A: Uncompensated Care



Panel B: Charity Care



Panel C: Bad Debt



Source: Authors' analysis of CMS Hospital Cost Reports (2020 excluded).
Notes: Results of a DiD analysis comparing border counties in Wisconsin with border counties in neighboring states. Dashed lines represent 95% CI. Reference year is 2013.

Overall, these results suggest that hospitals in Wisconsin experienced reductions in uncompensated care that were similar to those experienced by expansion states, while non-expansion states saw continued increases in uncompensated care. Reductions in uncompensated care in Wisconsin associated with the CLA expansion were sustained through the current waiver period.

Hypothesis 1.4: Additional requirements of the current demonstration may increase administrative costs.

Primary Research Question 1.4: What are the administrative costs incurred by the state and counties to implement and operate the demonstration?

Question 1.4a: What are the administrative costs incurred by the state to implement and operate the demonstration?

The BadgerCare demonstration waiver has a few provisions that are expected to reduce costs to the Wisconsin Medicaid program. The provision of health care coverage to CLAs is expected to reduce uncompensated care by hospitals. ED copayments are expected to reduce unnecessary uses of the ED and their associated costs. An overall assessment of the demonstration's impact on Medicaid costs would include such potential cost savings, but would also consider increased costs including the costs to administer the demonstration. Although the evaluation design does not include a full cost-benefit analysis, descriptive analyses are provided to begin to understand the administrative costs of the demonstration. While the research question is organized under Provision 1 in the evaluation design, the analysis of administrative costs covers all provisions of the demonstration.

Through a review of Wisconsin DHS administrative records, data were collected distinguishing the initial (2019) costs to implement the demonstration versus costs to operate and maintain the demonstration. When applicable, the distinction highlights the early administrative costs to implement the demonstration which are sometimes higher per year than ongoing operational costs. However, due to the COVID PHE, the implementation of some provisions was delayed and/or extended. Thus, the period of implementation costs is not always limited to the first year of the demonstration in 2019 or the immediate years just prior to demonstration period. Similarly, with the suspension of some provisions due to the COVID PHE, the period of operational costs varies by provision and is not applicable in some cases. The type of administrative costs assessed include both DHS staff and contractor costs for oversight, planning, and operations to implement and support the policies and procedures of the demonstration.

Wisconsin DHS Oversight

To facilitate the implementation of the demonstration, the Wisconsin DHS established the BadgerCare Reform Steering Committee. The committee provided general oversight of the implementation and guided the process from 2019–2021. After the SUD residential treatment benefit was implemented in 2021 and the demonstration's adjustments to the COVID PHE were established, the committee disbanded as the demonstration entered an operational mode. The committee involved a variety of personnel including 5% or less of the Medicaid Director, Deputy Director, and two Deputy Administrators. A full-time Policy Initiatives Advisor with direct responsibility for the implementation of the demonstration was also a key member. Ten different Health Care Program/Services Managers with responsibilities for different provisions within the demonstration also contributed 20–30% FTE each to the committee's oversight function. The committee's responsibility was to oversee the implementation process once it began in November 2019 through December 2021. The total DHS staff costs totaled $744,373 over these 26 months.

Provision 1 – CLA Health Care Coverage

For the CLA health care coverage provision which was implemented in 2014, no implementation costs are applicable for the 2019–2023 demonstration period. After the initial coverage policy was set and Medicaid eligibility and claims data systems were programmed to accommodate the CLA coverage provision, no specific operational costs were attributable in the current demonstration period either.

Provision 2 – Health Needs Assessments

The health needs assessments included two surveys that were designed and released in February 2020 before being immediately suspended in March due to the COVID PHE. The surveys were designed to be completed by new members during the application process to determine if any healthy behaviors warranted premium reductions or if substance use needs warranted an early referral for substance use assessment and services. DHS staff time to design the surveys, implement the policy linkages to premium reductions, perform fiscal analyses, establish networks for the referral process for SU services, and manage related contractor work began in November 2019 and totaled $34,083, $225,992, and $230,526 in 2019, 2020, and 2021 respectively. The work was completed primarily by partial FTEs for Health Care Program/Service Managers and Program and Policy Analysts, and also included consultation from the Medicaid Chief Medical Officer. The total combined cost for implementing Provision 2 was $490,601.

The health assessments were never re-activated after their suspension in March 2020. The surveys remained available for new members to complete, but they were optional and unlinked to the premium reductions which were also suspended. Thus, after initial implementation activities, there were no significant activities or costs to maintain the surveys.

Provision 3 – ED Copayments, Premiums, and Lock-out Periods

Similar to the health assessments, only implementation costs are available for the premiums and lock-out periods due to their indefinite suspension in March 2020 due to the COVID PHE. DHS's contractor, Gainwell Technologies, LLC, manages Wisconsin's Medicaid Management Information System. Gainwell contractor costs to implement the premium and lock-out period requirements and remove them after their suspension extended from July 2019 through June 2021 included a total cost of $295,019. Information technology contractor, Deloitte, costs to remove the premium functionality from Medicaid data systems were $6,489. Overall costs for the premium and lock-out period provisions were $301,508.

The implementation of the ED copayments was delayed to November 2020. The operational costs were assessed from the onset of these provisions through the end of 2023 when the demonstration period ended. Gainwell's costs to incorporate ED copayment requirements into the Medicaid eligibility and enrollment data system was incurred from July 2019 through June 2021 at a total cost of $100,205. Partial FTE's for five Health Care Program/Service Managers, Program and Policy Analysts, and IT Business Analysts from DHS began managing the implementation of the ED copayment requirement in November 2019 at a cost of $19,697 in 2019 before full annual costs of $130,605 and $133,228 were incurred respectively in 2020 and 2021. The total implementation cost for Provision 3 was $685,243. Ongoing operational costs in 2022–2023 and are not included as operations became automated and dedicated staff time was minimal.

Provision 4 – Expansion of SUD Treatment

After an original implementation date of February 2020, the implementation of the SUD treatment expansion provision was delayed until February 2021. Implementation costs are assessed through 2021 and operational costs are assessed in 2022-23. Administrative costs included the implementation of the new SUD residential treatment benefit in IMD settings, but also included broader DHS efforts to increase the accessibility of services and quality of services through the expanded use of evidence-based practices. Partial FTEs of seven different DHS staff were dedicated from November 2019 through 2021 on the implementation of this provision including time from Health Care Program/Service Managers, Budget and Policy Analysts, and a Therapies Consultant at a total cost of $409,226. The ongoing operational costs required reduced effort from four DHS staff at a total cost of $79,171.

Implementation efforts from the Gainwell and Deloitte contractors in adapting multiple Medicaid administrative data systems for the expansion of SUD treatment cost $1,216,458 from 2020–21. Combined contractor operational costs totaled $161,873 in the 2022-23 period.

In summary, the total state implementation costs for the 2019–2023 BadgerCare reform demonstration waiver across all provisions were $3,545,901 and the total operational costs were $241,044. Approximately 22% of implementation costs were due to temporary implementation, suspension, and removal of the HNA and premium provisions and the costs of ED co-pay implementation were approximately 11% of the total. The SUD waiver was approximately half of costs, mainly due to the need to adapt data systems. The cost analyses

may be helpful informing a more comprehensive cost-benefit analysis as a next step or being used as a benchmark informing the implementation of similar future demonstrations. The impact of the COVID PHE, however, imposes several limitations. With the suspension of multiple provisions, the ongoing operational cost figures were minimized and underestimate the operational costs for a fully-implemented demonstration of this type. The implementation cost figures offer a more accurate representation as all demonstration provisions were implemented before, or shortly after, the onset of the COVID PHE. However, the implementation cost figures also include some costs incurred to suspend or adapt provisions to the COVID PHE that could have inflated figures.

Q1.4b How did county income maintenance staff workloads change around implementation of the current demonstration?

A data gap prevented the analysis of local administrative costs for Question 1.4b. Local county and tribal income maintenance staff workloads were planned to be assessed for changes related to the implementation of the demonstration. While the initial evaluation design planned to access a data source at the Wisconsin DHS, no such data was found on county income maintenance workloads specific to the CLA demonstration for the 2019–2023 waiver period.

Conclusions

The program goal associated with this provision is focused on improving health outcomes and reducing unnecessary services in the member population, and to create a program that is sustainable and available to "those who need it most." The state has successfully implemented the coverage expansion to childless adults and sustained it since 2014. Our within-state analyses from several complementary sources of survey data on health insurance coverage indicate that the changes in BadgerCare eligibility in 2014 led to immediate increases in Medicaid coverage among CLAs. Insurance coverage from any source increased over this time period for CLAs, driven by Medicaid coverage. During the current waiver period through 2023, there were further increases in Medicaid coverage, likely due to the continuous coverage policies that were implemented during the public health emergency.

In comparison to states that expanded Medicaid through the ACA in 2014, gains in both insurance coverage and Medicaid coverage were smaller after 2014 among Wisconsin CLAs and parents. Medicaid coverage among Wisconsin CLAs increased beginning in 2014 relative to states that did not initially expand Medicaid, but evidence did not suggest these gains extended to increases in insurance coverage overall compared to the non-expansion states. Overall, and based on a number of different data sources, the analysis shows that Wisconsin's CLA expansion yielded changes in insurance coverage that fell between the magnitudes of change observed in typical Medicaid expansion states and non-expansion states.

We did not find strong evidence of differences in measures of population access to care or in use of preventative care for childless adults in Wisconsin relative to either expansion or non-expansion states. There were improvements in measures of relative access to care in the 2019-2022 period for CLAs in Wisconsin. A limitation of the BRFSS analysis is that the insurance coverage gains found in other data sources were not as evident in the BRFSS, which may mean that the BRFSS analysis is not capturing the affected population well. When health systems are close to capacity, access can be challenging to change, and challenges to the healthcare system during the COVID-19 pandemic may have dampened any potential impacts.

The expansion population had significantly higher per-person average health care expenditures than the traditional adult coverage group (parents and caretakers), particularly in the months immediately following expansion. This suggests that they may have had higher health needs and suggests that targeting of the program to childless adults below the poverty line may have been successful at reaching “those who need it most” in the sense of health needs.

Hospitals in Wisconsin saw reductions in their provision of uncompensated care, driven by reductions in charity care that were no different than the reductions experienced by hospitals in states that expanded Medicaid. These reductions are in contrast to the increases in uncompensated care and charity care experienced by hospitals in states that did not expand Medicaid. This suggests that the CLA expansion in Wisconsin was similar to a full Medicaid expansion from the hospital perspective and shows that Wisconsin lowered the burden to hospitals of providing uncompensated care. As uncompensated care can be a burden not only for hospitals but also for those who received the care, this finding also supports the goal of targeting the program towards “those who need it most.” The differences in average health care expenditures between the expansion coverage group and the traditional adult group may help explain why there were such large declines in uncompensated care compared to non-expansion states – individuals with the lowest incomes and greatest health needs may have been differentially likely to enroll in Medicaid. Depending on the underlying sources of uncompensated care dollars, these benefits may have spilled over to local governments and taxpayers, although analyses were not designed to test for this specifically.

In summary, the CLA coverage expansion that Wisconsin adopted in 2014 was effective at increasing coverage, if less effective at expanding coverage than the full expansions implemented in the comparison states. This translated to substantial reductions in the need for hospitals to provide charity care. Overall, the results suggest the demonstration waiver has been largely successful in achieving its goals of sustainability and coverage availability to those who need it most.

Policy Implications

Wisconsin’s unique CLA expansion makes it not only the lone state that has not participated in a full Medicaid expansion, but also the only state in which there is no coverage gap between Medicaid and Marketplace subsidy eligibility. The results on insurance coverage clearly demonstrate that the partial expansion did improve insurance coverage and that Wisconsin looks more similar to a full Medicaid expansion state in terms of gains to individual insurance coverage and reductions in hospital uncompensated care than a state that did not expand Medicaid. This finding is echoed in other research which also shows that CLAs who were enrolled in the expansion were unlikely to be previously privately insured, suggesting that the policy was well targeted towards the uninsured.[12] The overall literature on Medicaid expansion

[12]Dague, Laura, Marguerite Burns, and Donna Friedsam. "The Line Between Medicaid and Marketplace: Coverage Effects from Wisconsin's Partial Expansion." Journal of Health Politics, Policy And Law, 47, no. 3 (2022): 293-318.

also supports these findings of increased insurance coverage[13,14] and decreased hospitals uncompensated care[15,16,17] associated with eligibility expansions for low income individuals.

Another implication is that there may be limited practical difference from an insurance coverage perspective in expansions to 100% vs. 138% FPL. Other states that have not adopted ACA Medicaid expansion might benefit from the ability to implement a policy like Wisconsin's and might be more willing to do so should waivers allowing the enhanced federal match for such programs be permitted, resulting in the overall coverage mix of lower income adults to be more heavily weighted towards subsidized private coverage rather than Medicaid. Other states might wish to re-structure their existing programs. Some studies suggest substitution of Marketplace coverage for Medicaid could increase uninsurance and out-of-pocket expenses.[18,19] But, compared to a state not adopting any expansion, this middle ground may be a mechanism to insure those who need comprehensive health coverage the most.

Lessons Learned and Recommendations

The net result of Wisconsin's CLA expansion was an overall increase in health insurance coverage rates. The resulting increase in Medicaid coverage rates were between those of expansion and non-expansion states, with clear benefits in decreased need for provision of hospital uncompensated care. The strength of the CLA expansion waiver provision is its middle ground approach to coverage that takes advantage of the Medicaid program as well as relying on individual choice to enroll in federally subsidized private Marketplace plans. Continuation of the CLA waiver is recommended due to its benefits and satisfaction of the program goals. Ongoing attention to access measures is recommended to ensure that members are able to use their benefits in ways that improve health outcomes.

Strategies to replicate the strengths of the waiver might include additional targeted outreach to focus on reaching populations with higher health needs, as demonstrated by Wisconsin's success in targeting childless adults below the poverty line. If take-up of Marketplace plans is lower than for Medicaid, despite generous subsidies, relying on partial expansion might result in additional uninsurance among those near poverty, compared to full Medicaid expansion. To address potential concerns about knowledge of and access to Marketplace coverage or transitions between Medicaid and Marketplace coverage, such as ensuring that members are aware that subsidies are available should their income increase above the Medicaid eligibility threshold, future initiatives could examine how often such transitions are successful. When

[13]Mazurenko, Olena, Casey P. Balio, Rajender Agarwal, Aaron E. Carroll, and Nir Menachemi. "The Effects of Medicaid Expansion under the ACA: a Systematic Review." Health Affairs 37, no. 6 (2018): 944-950.

[14]Miller, Sarah, and Laura R. Wherry. "Health and Access to Care During the First 2 Years of the ACA Medicaid Expansions." New England Journal of Medicine 376, no. 10 (2017): 947-956.

[15]Nikpay, Sayeh, Thomas Buchmueller, Helen Levy, and Simone R. Singh. "The Relationship Between Uncompensated Care and Hospital Financial Position: Implications of the ACA Medicaid Expansion for Hospital Operating Margins." Journal of Health Care Finance 43, no. 2 (2016): 72-89.

[16]Dranove, David, Craig Garthwaite, and Christopher Ody. "Uncompensated Care Decreased at Hospitals in Medicaid Expansion States But Not at Hospitals in Nonexpansion States." Health Affairs 35, no. 8 (2016): 1471-1479.

[17]Rhodes, Jordan H., Thomas C. Buchmueller, Helen G. Levy, and Sayeh S. Nikpay. "Heterogeneous Effects of the ACA Medicaid Expansion on Hospital Financial Outcomes." Contemporary Economic Policy 38, no. 1 (2020): 81-93.

[18]Allen, Heidi, Sarah H. Gordon, Dennis Lee, Aditi Bhanja, and Benjamin D. Sommers. 2021. "Comparison of Utilization, Costs, and Quality of Medicaid vs Subsidized Private Health Insurance for Low-Income Adults." JAMA Network Open 4, no. 1: e2032669-e2032669. doi:10.1001/jamanetworkopen.2020.32669.

[19]Blavin, Frederic, Michael Karpman, Genevieve M. Kenney, and Benjamin D. Sommers. 2018. "Medicaid Versus Marketplace Coverage For Near-Poor Adults: Effects On Out-Of-Pocket Spending And Coverage." Health Affairs 37, no. 2: 299-307. https://doi.org/10.1377/hlthaff.2017.1166.

transition problems are identified, communications about renewals that include clear and individualized information about likely Marketplace eligibility could be examined to test for how they can improve transition rates and/or reduce uninsurance for those likely to lose coverage or who are denied.

PROVISION 3 RESULTS: EMERGENCY DEPARTMENT COPAYMENTS

Provision 3 was to implement two cost-sharing components:

1) *Premiums for CLA members with income 50–100% FPL*. Premiums went into effect February 1, 2020, but were retroactively suspended due to the maintenance of eligibility policy under the PHE, and remained suspended throughout the waiver period, until permission for premiums was withdrawn by CMS. In short, the premiums were never fully implemented. Although some analyses were completed to help contextualize this provision including some previously reported in the Interim and Annual Reports, the CMS and DHS asked the evaluation team to exclude evaluation hypotheses and questions related to the premium provisions from the final report. The original plan can be seen in the design report.

2) *Copayment for non-emergent use of the hospital emergency department (ED) of $8 for CLA members*. Providers cannot refuse treatment for non-payment. This part of the provision has been in place since November 2, 2020. The Provision 3 results are focused on the hypothesis and research questions related to this policy.

The Medicaid program goal associated with this provision is to provide members with coverage that more closely aligns with commercial coverage, promote participant engagement and readiness to transition to commercial coverage, and to ensure appropriate use of medical services.

Hypothesis 3.5: The imposition of a copayment for non-emergent use of the ED will lead to more appropriate uses of medical care among CLAs enrolled in Medicaid.

Primary Research Question 3.5: Did the imposition of a copayment for non-emergent use of the ED reduce the number of non-emergent visits to the ED among CLAs enrolled in Medicaid?

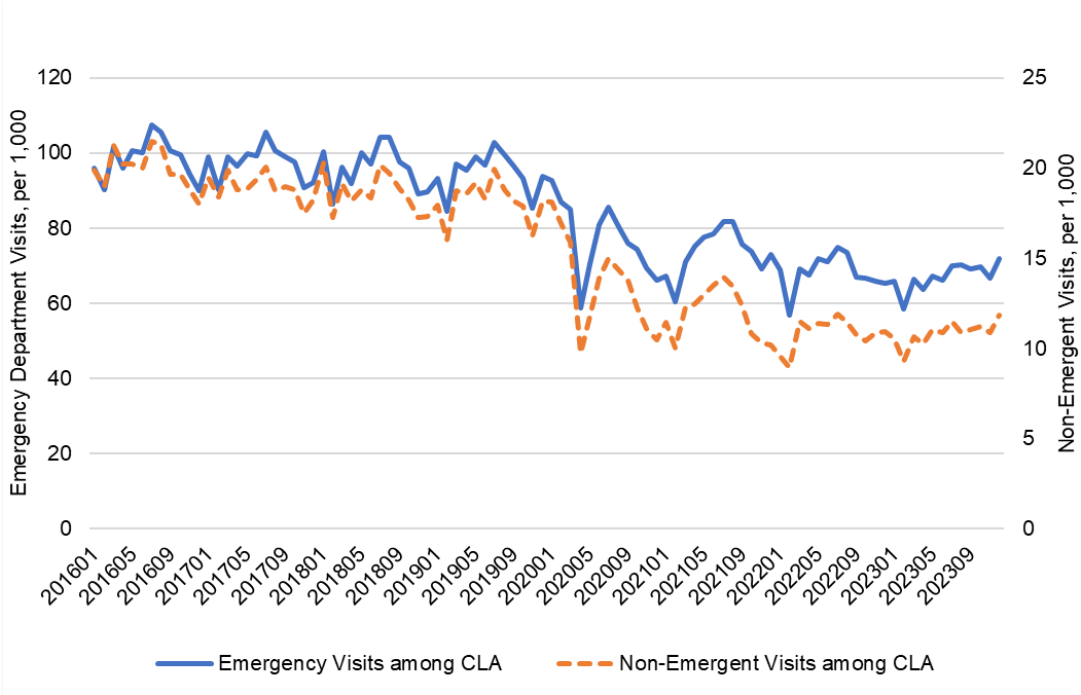
Question 3.5a: What was the number of non-emergent visits to the ED among CLAs prior to the imposition of copayments?

Analysis of Question 3.5a is purely descriptive and the relevant data are contained in **Figure 3.1**. The figure shows total emergency visits and among those, the total number of non-emergent visits per thousand members by month using the Medicaid claims data. Total visits are on the left axis and non-emergent visits are on the right axis. The definition of non-emergent is based on the Billings algorithm which assigns probabilities to ED visits based on the claim's codes.[20] We note that this measure of non-emergent visits was created for using claims records to measure population-level outcomes, not as a way to triage patients or classify them for reimbursement purposes or to assess appropriateness of utilization, which may depend on factors not available for measurement in the administrative data. The two series trend quite similarly over time (note again the differing scales; the average ratio of non-emergent to all emergency visits is 0.18). Non-emergent visits from July 2019 to November 2019 averaged 18 per thousand per month, and from July 2019 to November 2020 averaged 15 per thousand per month. The ratio of non-emergent to total visits was relatively consistent across time until April 2020, when it suddenly dropped, slowly recovered, and trended down again until it remained

[20]Billings John, Nina Parikh, Tod Mijanovich. Emergency Department Use: The New York Story. New York (NY): Commonwealth Fund; 2000 Nov. (Issue Brief). https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2000_nov_emergency_room_use__the_new_york_story_billings_nystory_pdf.pdf.

roughly steady through 2023. No sudden disproportionate change in non-emergent visits is evident beginning in November 2020. Rather, continuation of a downward trend in both overall and non-emergent visits that began in July is evident. These trends are very similar for other visit types in the Billings algorithm and for the probability of any visit (not shown).

Figure 3.1: Total Emergency and Non-Emergent Visits among CLAs per Thousand, 2016–2023



Question 3.5b. What was the total number of ED visits among CLAs prior to the imposition of copayments?

Figure 3.2 includes the total number of ED visits per month among CLAs from January 2016 to December 2023 using the Medicaid claims data. From July 2019 to November 2019, the CLA population averaged 96 visits per thousand per month, while from July 2019 to November 2020 they averaged 85 visits per thousand per month. As with non-emergent visits, no sudden change in emergent visits is evident beginning November 2020. Rather, continuation of a downward trend in both overall and non-emergent visits that began in July is evident.

Question 3.5c: How did the numbers of ED visits and non-emergent visits change among CLAs after the imposition of copayments?

To answer this question, we examine DiD models comparing CLAs to parents before and after the imposition of copayments using the Medicaid claims data, and we compare Medicaid-enrolled non-elderly adults to commercially-enrolled non-elderly adults before and after the imposition of copayments using the WHIO claims data. We scale results to average visits per thousand per month by group and provide robust standard errors.

Figure 3.2 shows total ED visits per person per month for parents and caretakers relative to CLAs from January 2016 to December 2023 using the Medicaid claims data, and **Figure 3.3** shows total non-emergent visits per person per month for parents and caretakers relative to CLAs for the same time period also using the Medicaid claims data.

Figure 3.2: ED Visits among Parents and CLAs, per Thousand, 2016–2023

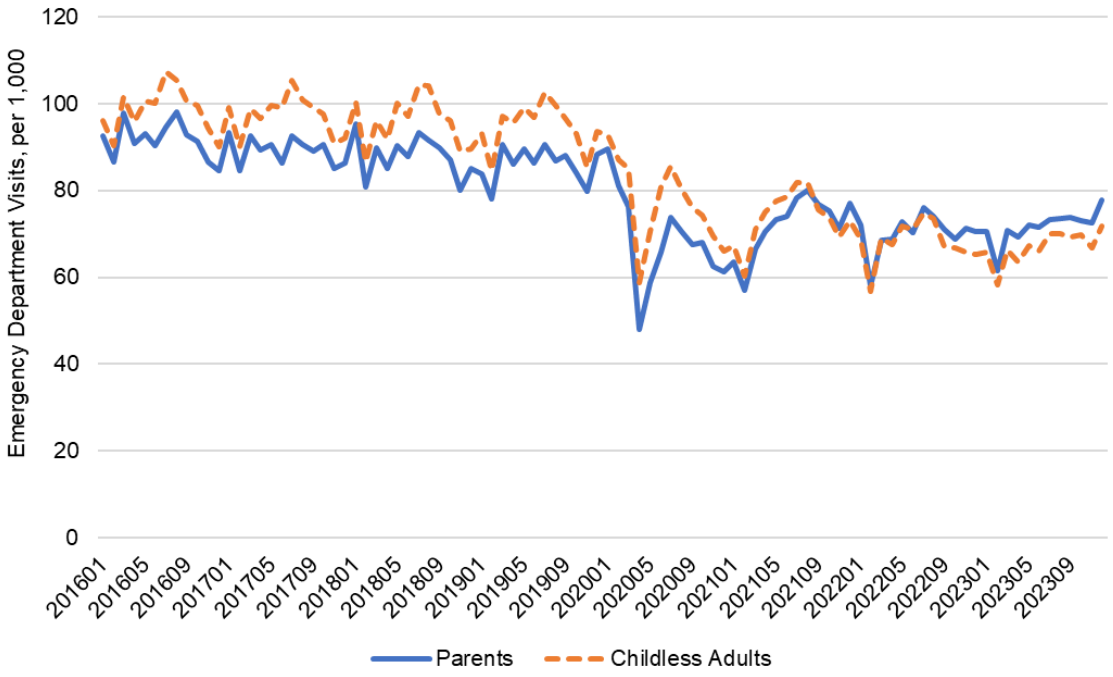


Figure 3.3: Medicaid Non-Emergent ED Visits among Parents and CLAs, per Thousand, 2016–2023

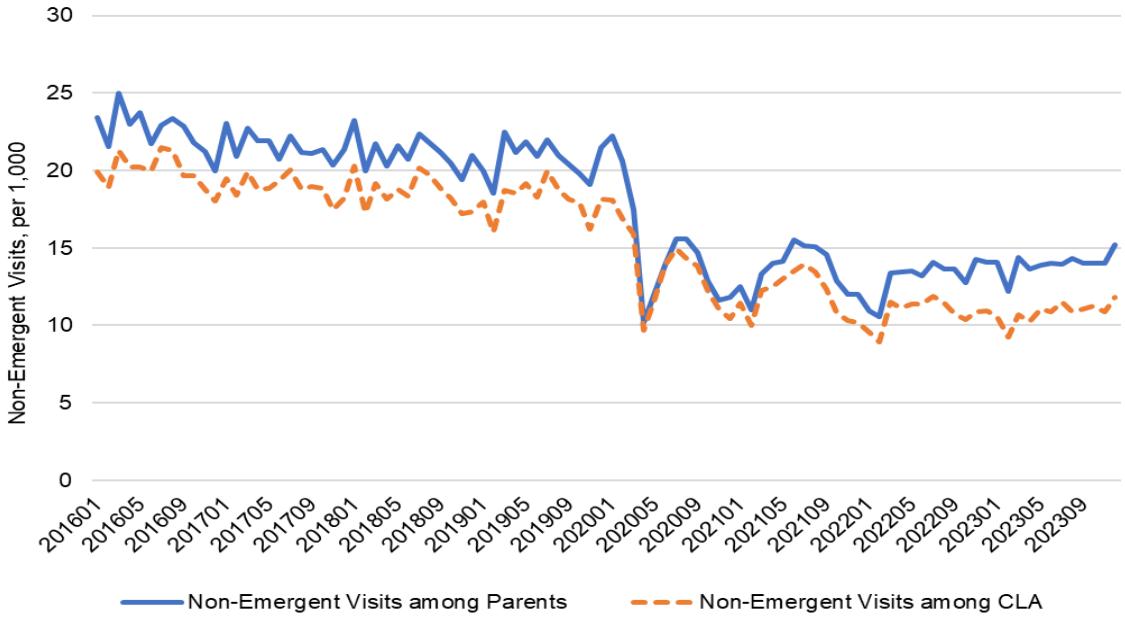


Table 3.1 is a DiD analysis of the two groups before and after November 2020 in the Medicaid claims data. Two models are estimated; one includes all months and the other excludes March 2020 to March 2021 due to the pandemic and implementation changes. Parallel trends do seem to be evident in the pre-implementation period for the two groups. However, some limitations apply for these analyses. First, continuous coverage was implemented in March 2020 and may have impacted enrollment in the two groups differentially. Second, COVID itself may have impacted the two groups differentially. For these reasons, we suggest caution in interpreting all results causally. For all ED visits, the DiD coefficient is negative, meaning that relative to parents, CLAs experienced a decline in visits after November 2020 relative to before. This is true both in the model that includes all months and in the model that excludes the pandemic period. The relative size of the effect suggests that visits among CLAs declined by approximately 10%. For non-emergent visits, there is no evidence that CLAs experienced a relative decline as the coefficient is positive. Instead, the models suggest that CLAs experienced a small relative increase in non-emergent visits compared to parents following the implementation of the ED copayment. The coefficient is statistically significant at the 5% level in both models and suggests a small relative increase in non-emergent visits of approximately 1% relative to baseline.

Table 3.1: DiD Analysis of ED and Non-Emergent ED Visits Before and After Imposition of Copayments – CLAs vs. Parents

	Model 1 (Includes all Months)	Model 2 (Excludes Pandemic Period)
Total Monthly ED Visits per 1,000 Members		
Coefficient	-9.00	-10.04
Robust Standard Error	(0.247)	(0.270)
p value	0.000	0.000
Baseline Average Monthly Visits per 1,000 CLA Members	93.18	96.36
Monthly Non-Emergent ED Visits per 1,000 Members		
Coefficient	0.24	0.20
Robust Standard Error	(0.084)	(0.092)
p value	0.005	0.029
Baseline Average Monthly Visits per 1,000 CLA Members	17.97	18.85

We also analyzed these outcomes in the WHIO data, comparing Medicaid non-elderly adults to commercially-insured non-elderly adults. WHIO data do not permit differentiation between parents and CLAs and are only available beginning in 2017. Trends in total ED visits among commercially-insured adults and Medicaid members from January 2017 to December 2022 are shown in **Figure 3.4**, and trends in non-emergent visits are shown in **Figure 3.5**. We assessed trends in overall Medicaid claims data compared to the WHIO Medicaid claims which showed that the WHIO data track the Medicaid claims well, although the level of visits is different since we cannot observe eligibility category and remove populations who might be eligible due to pregnancy or disability. However, there are differential trends in the pre-implementation period among commercial enrollees compared to Medicaid members within the WHIO data, which reduces confidence in the validity of difference-in-differences analysis. We report the results as pre-specified but suggest caution in interpreting them causally.

Figure 3.4: ED Visits per Month, Commercial vs. Medicaid Non-Elderly Adults, 2017–2022

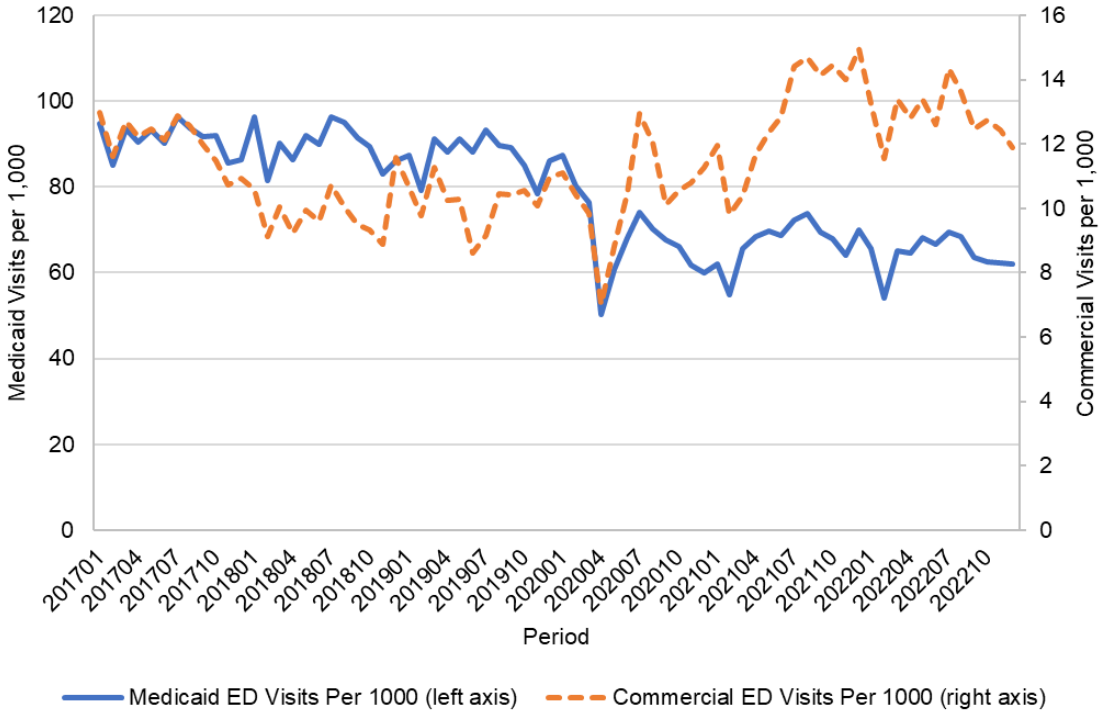


Figure 3.5: Non-Emergent ED Visits per Month, Commercial vs. Medicaid Non-Elderly Adults, 2017–2022

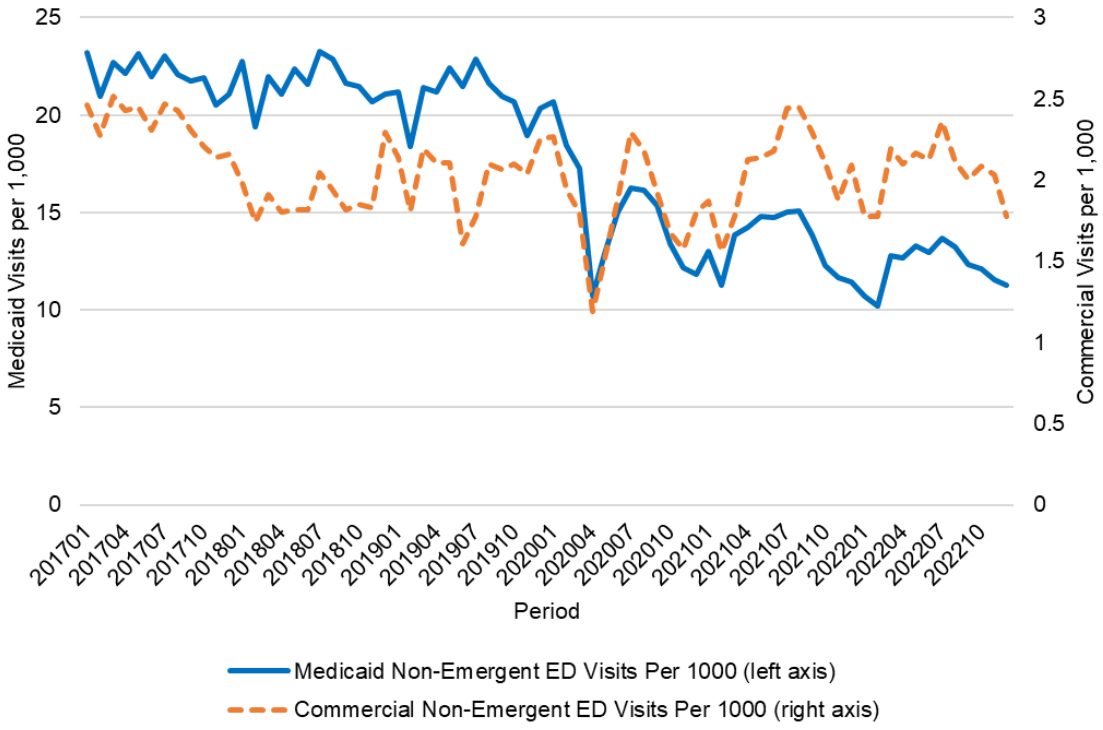


Table 3.2: DiD Analysis of All ED Visits and Non-Emergent ED Visits Before and After Imposition of Copayments – Medicaid vs. Commercial

	Model 1 (Includes all Months)	Model 2 (Excludes Pandemic Period)
Total Monthly ED Visits per 1,000 Members		
Coefficient	-11.0	-14.2
Robust Standard Error	(0.2)	(0.3)
p value	< 0.001	< 0.001
Baseline Average Visits per 1,000 CLA Members	89.1	85.2
Monthly Non-Emergent ED Visits per 1,000 Members		
Coefficient	-5.2	-7.1
Robust Standard Error	(0.1)	(0.1)
p value	< 0.001	< 0.001
Baseline Average Visits per 1,000 CLA Members	21.5	20.3

The results of the DiD analysis presented in **Table 3.2** compare non-elderly adult Medicaid members to non-elderly adult commercial enrollees before and after the introduction of copayments using WHIO data. Model 1 includes all months in the study period and Model 2 excludes the pandemic period defined as March 2020 to March 2021. Results of the analysis suggest a decline in both total ED visits and non-emergent ED visits among Medicaid members compared to commercial enrollees following the implementation of copayments for non-emergent use of the emergency room. A potential confounding cause is the changing composition of the Medicaid-enrolled population over time due to continuous coverage resulting in a healthier Medicaid population that used the ED less on average.

We examined the robustness of these results to various alternative specifications, including limiting to those 50+ who are more likely to be CLAs in Medicaid than parents. The analysis used a fixed, continuously-enrolled panel of both Medicaid members and commercial enrollees, inclusion and exclusion of controls for age, sex, county, calendar month and year, individual fixed effects, and beginning the pre-period at different times. We also examined the probability of visits instead of the actual number of visits. None of these alternative analyses made a qualitative or major quantitative difference in the results, and for brevity we do not include them in this report. A triple difference specification that compares older to younger members (since CLAs are a disproportionate number of the older Medicaid members) found instead a small positive coefficient for both any ED visits and non-emergent ED visits. This finding is more consistent with the findings from the Medicaid claims data on non-emergent visits, but not consistent with the finding from Medicaid claims on all visits.

Question 3.5d: How did the use of primary care change among CLAs after the imposition of copayments for non-emergent visits to the ED?

To answer this question, we examine DiD models comparing CLAs to parents before and after the imposition of copayments using the Medicaid claims data, and we compare Medicaid-

enrolled non-elderly adults to commercially-enrolled non-elderly adults before and after the imposition of copayments using the WHIO claims data.

We define primary care in the analysis of Medicaid claims if the outpatient provider has a specialty of general practice, family practice, pediatrics, internal medicine or geriatrics. **Figure 3.6** shows total primary care visits per 1,000 persons per month for parents and caretakers relative to CLAs from January 2016 to December 2023 using the Medicaid claims data. **Table 3.3** is a DiD analysis of the two groups before and after November 2020. Two models are estimated; one includes all months and the other excludes March 2020 to March 2021 due to the pandemic and implementation changes. The results of the analysis suggest a relative decline in primary care among CLAs relative to parents following implementation of the ED copays.

Figure 3.6: Primary Care Visits among Medicaid Parents and CLAs, per Thousand per Month, 2016–2023

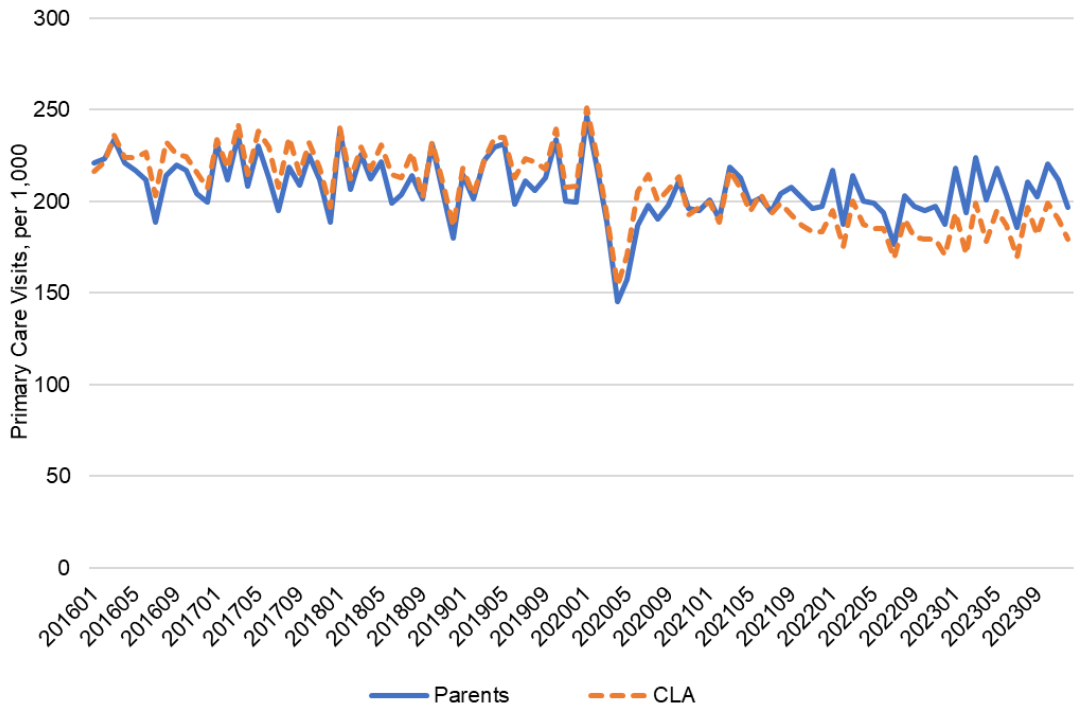


Table 3.3: DiD Analysis of Primary Care Visits Before and After Imposition of Copayments – CLAs vs. Parents

	Model 1 (Includes all Months)	Model 2 (Excludes Pandemic Period)
Monthly Primary Care Visits per 1,000 Members		
Coefficient	-20.5	-22.1
Robust Standard Error	(0.39)	(0.42)
p value	<0.001	<0.001
Baseline Average Visits per 1,000 CLA Members	217.4	221.5

We next present the results of a similar analysis using the WHIO data comparing Medicaid adults to commercially enrolled adults. **Figure 3.7** shows the trends in primary care visits per 1,000 enrollees for commercial enrollees compared to Medicaid members. There is some evidence of differential trends leading up to the implementation, particularly beginning in 2019, when primary care visits increase for commercial beneficiaries in contrast with the overall downward trend in primary care visits among Medicaid members, so we suggest caution in interpretation. **Table 3.4** shows the results of a difference-in-differences analysis that compares these two groups before and after the implementation of the ED copays. Results suggest a relative decline in primary care among Medicaid members compared to commercial enrollees following implementation of the ED copays. This result is consistent with the results of the within-Medicaid analysis in **Table 3.3**.

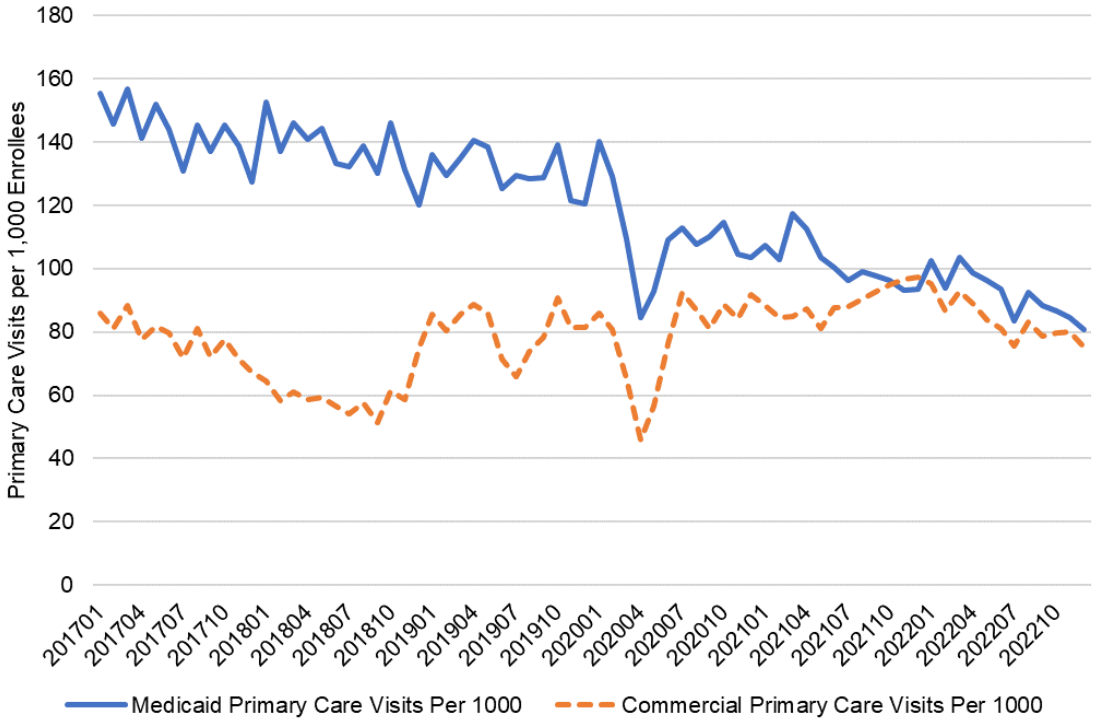
Overall, these results do not suggest that ED copayments redirected health care use to the primary care setting, although they are subject to the caveats discussed. Given the findings around copayment implementation and member awareness elsewhere in the report, the most likely explanation is not that ED copayments caused decreases in primary care use, but that other utilization trends related to COVID and continuous coverage differentially impacted the treatment and control groups.

We examined the robustness of these results to various alternative specifications, including limiting to those 50+ who are more likely to be CLAs in Medicaid than parents. The analysis used a fixed, continuously-enrolled panel of both Medicaid members and commercial enrollees, inclusion and exclusion of controls for age, sex, county, calendar month and year, individual fixed effects, and beginning the pre-period at different times. We also examined the probability of visits instead of the actual number of visits and a more expansive definition of primary care. None of these alternative analyses made a qualitative or major quantitative difference in the results, and for brevity we do not include them in this report.

Table 3.4: DiD Analysis of Primary Care Visits Before and After Imposition of Copayments – Medicaid vs. Commercial

	Model 1 (Includes all Months)	Model 2 (Excludes Pandemic Period)
Monthly Primary Care Visits per 1,000 Enrollees		
Coefficient	-28.1	-32.3
Robust Standard Error	(0.5)	(0.1)
p value	<0.001	<0.001
Baseline Average Visits (CLA) per 1,000 CLA Members	137.2	131.6

Figure 3.7: Primary Care Visits Per 1000 Enrollees, Medicaid vs. Commercial, 2017–2022



Question 3.5e: Do beneficiaries with copayment requirements understand their payment obligations?

To understand this better, we provide data from the 2020, 2022, and 2024 BadgerCare Surveys. Most respondents in 2020 were surveyed during a time when copayments were in place. We show responses for CLAs compared to parents. For brevity, we have excluded the 2020 and 2022 comparisons of demographics between parents and CLAs, which tend to be stable; 2020 demographic summaries were included in the Interim Evaluation Report and 2022 are included in the 2023 Annual Report. We provide a summary of the characteristics of these groups from the 2024 survey in **Table 3.5**.

Table 3.6 provides a comparison of parents and CLA responses relevant to member health care access and awareness of copayment policy for the 2024 survey. **Table 3.7** compares CLA responses in these domains from the 2020, 2022, and 2024 surveys. All responses are weighted.

Table 3.5 indicates that there are some demographic differences in CLA respondents relative to parents. CLAs are much more likely to be male (51.2% vs. 18.3%, $p<0.01$), and have an older age distribution ($p<0.01$). Race and ethnicity composition were similar in the 2024 survey groups, as was the distribution of educational attainment. Their income distribution is also lower ($p<0.01$). CLAs are less likely to report not being currently employed ($p<0.01$), and less likely to receive SNAP benefits (52.5% vs. 60.8%, $p=0.051$) and TANF benefits (1.5% vs. 6.9%, $p<0.01$). CLAs are also much less likely to report having children under 19, as would be expected (13.6% vs. 94.6%, $p<0.01$).

Table 3.5: Characteristics of CLAs and Parents, 2024 BadgerCare Survey

	CLAs	Parents	*p* value
Gender			
Male	51.2%	18.3%	<0.001
Female	47.1%	80.8%	
Other	1.7%	0.8%	
Age			
18–29	23.4%	14.7%	<0.001
30–39	20.7%	39.0%	
40–49	15.3%	36.9%	
50–59	22.5%	8.2%	
60–64	16.2%	0.4%	
Age 65 or Older	1.8%	0.8%	
Race			
White	59.7%	59.3%	0.843
Black	18.9%	18.6%	
Asian	2.5%	2.3%	
Native American	2.4%	3.9%	
Native Hawaiian	0.1%	0.3%	
Other	16.3%	15.6%	
Hispanic, Latino, or Spanish Origin			
Yes	14.9%	18.3%	0.383
No	85.1%	81.7%	
Education			
Less Than High School Diploma	14.8%	10.9%	0.329
High School Diploma or General Education Development or GED Certificate	38.7%	36.2%	
Vocational Training or 2-Year Degree	12.0%	12.7%	
Some College but No Degree	19.2%	25.4%	
A 4-Year College Degree or More	15.3%	14.8%	
Employment			
Yes, Employed by Someone Else	39.4%	30.1%	<0.001
Yes, Self-Employed	10.2%	18.5%	
Not Currently Employed	42.6%	49.8%	
Retired	7.8%	1.7%	
Hours Worked Per Week			
Less Than 20 Hours Per Week	30.6%	25.3%	0.190
20 To 29 Hours Per Week	23.2%	17.6%	
30 Or More Hours Per Week	46.3%	57.1%	
Total Annual Household Income			
Less Than $5,000	26.1%	30.7%	<0.001
$5,000–$14,999	34.9%	19.5%	
$15,000–$29,999	23.6%	19.8%	
$30,000 Or Higher	15.5%	30.0%	
Past 12 Months Household Receive Foodshare or SNAP			
Yes	52.5%	60.8%	0.051
No	47.5%	39.2%	
Past 12 Months Household Receive Wisconsin Temporary Assistance for Needy Families Program			
Yes	1.5%	6.9%	<0.001
No	98.5%	93.1%	
Under 19 In Household			
Yes	13.6%	94.6%	<0.001
No	86.4%	5.4%	
Under 19 Outside Household Who You Financially Support			
Yes	7.6%	13.0%	0.046
No	92.4%	87.0%	

Table 3.6 examines member awareness of copayment policies and use of the emergency room in the 2024 survey.

When asked to indicate what they believed to be the copayment policy regarding ED visits, the distribution of responses was not different for CLAs compared to parents (p = 0.309), and baseline awareness was low. For example, 81.3% reported they "never need to pay a co-pay" (compared to 86.1% of parents), 11.5% reported the correct policy (compared to 6.4% of parents), and 7.2% reported they "always need to pay a co-pay." There were no differences in the fraction who said they were too worried about the copayment and avoided the ED (8.9% of CLA versus 8.4% of parents). Similarly low proportions reported needing to borrow money or skip paying other bills to pay premiums or copayments (6.7% of CLAs and 7.4% of parents).

In terms of overall awareness of health care coverage, there were no major differences between parents and CLAs in terms of their agreement with understanding letters about their coverage. There was a difference in the fraction agreeing that they understood which payments were required; only 20.9% of CLAs reported strongly agreeing while 30.9% of parents did so, and the distributions were statistically different (p = 0.02). There were no statistically measurable differences in CLAs and parents in terms of understanding who is eligible for coverage or understanding how changes might affect them, although for both measures CLAs had a lower fraction reporting strong agreement (24.2% versus 34.0% for understanding who is eligible; 21.3% vs. 27.6% for understanding how changes might affect them).

Emergency department utilization was not statistically different between CLAs and parents; 55.5% of CLAs reported 0 visits in the last 12 months, 38.1% reported 1–3 times, and 6.4% reported 4+ times. When those who responded they had visited the ED were asked about their last visit, 30.5% of CLAs reported they didn't have another place to go, 32.5% reported they went to the ED because their health provider advised them to, 72.6% reported the problem was too serious for the doctor's office; none of these responses were statistically different from parents. A total of 26.8% of CLAs (29.5% of parents) agreed that they get most of their care at the ED, while 45.9% of CLAs indicated they had some other reason for visiting the emergency room; these measures were also not statistically different from responses among parents. We also asked about monetary-related access issues, but did not see differences between CLAs and parents in the proportion who reported problems paying medical bills (13.9% of CLAs vs. 17.4% of parents, p = 0.252) or reporting that medical services refused to treat them due to money owed (1.9% of CLAs vs. 2.4% of parents, p = 0.714).

These results do not broadly suggest major differences in care-seeking or access among CLAs relative to parents.

Table 3.6: Awareness of Copayment Policies and Use of ED, 2024 BadgerCare Survey

	CLAs	Parents	*p* value
Last 12 Months, How Many Times Go To An Emergency Room To Get Care For Yourself			
0 Times	55.5%	51.5%	0.102
1–3 Times	38.1%	37.4%	
4 or More Times	6.4%	11.2%	
Which Co-pay Rule Is True For Visits To The Emergency Room			
You Never Need To Pay A Co-Pay	81.3%	86.1%	0.309
You Only Need To Pay A Co-Pay For Care That The Doctor Determines Was Not	11.5%	6.5%	
You Always Need To Pay A Co-Pay	7.2%	7.4%	
Last 12 Months: Ever Been So Worried About A Co-Pay Not Gone To The Emergency Room			
Yes	8.9%	8.4%	0.853
No	91.1%	91.6%	
Last 12 Months: Had To Borrow Money, Skip Paying Other Bills In Order To Pay Premiums Or Co-pay			
Yes	6.7%	7.4%	0.798
No	93.3%	92.6%	
Last 12 Months: Have Problems Paying Any Medical Bills			
Yes	13.9%	17.4%	0.252
No	86.1%	82.6%	
Last 12 Months: Medical Service Refused To Treat You Because You Owed Money			
Yes	1.9%	2.4%	0.714
No	98.1%	97.6%	
Awareness About Health Care Coverage			
Understand The Letters About Health Care Coverage From Medicaid			
Strongly Agree	27.0%	32.6%	0.399
Agree	59.6%	53.1%	
Disagree	8.6%	10.4%	
Strongly Disagree	3.2%	3.3%	
Not Applicable	1.7%	0.5%	
Understand What Payments Are Required			
Strongly Agree	20.9%	30.9%	0.022
Agree	58.7%	55.3%	
Disagree	12.7%	6.7%	
Strongly Disagree	2.9%	4.1%	
Not Applicable	4.9%	3.1%	
Understand Who Is Eligible For Health Care Coverage Using Medicaid			
Strongly Agree	24.2%	34.0%	0.199
Agree	60.7%	52.1%	
Disagree	10.4%	10.0%	
Strongly Disagree	3.7%	3.3%	
Not Applicable	1.0%	0.6%	
Understand How Changes To Health Coverage Through Medicaid Might Affect You			
Strongly Agree	21.3%	27.6%	0.332
Agree	53.9%	51.9%	
Disagree	19.0%	15.1%	
Strongly Disagree	4.9%	5.1%	
Not Applicable	1.0%	0.3%	
Which of These Apply to Last Emergency Room Visit			
Did Not Have Another Place To Go For Care			
Yes	30.5%	41.6%	0.108
No	69.5%	58.4%	

	CLAs	Parents	*p* value
Health Provider Advised You To Go			
Yes	35.2%	44.2%	0.192
No	64.8%	55.8%	
Problem Was Too Serious For The Doctor's Office			
Yes	72.6%	72.8%	0.973
No	27.4%	27.2%	
Get Most Of Your Care At The Emergency Room			
Yes	26.8%	29.5%	0.709
No	73.2%	70.5%	
Some Other Reason			
Yes	45.9%	44.1%	0.803
No	54.1%	55.9%	

Table 3.7 compares responses among CLAs in the 2020 baseline, 2022 interim, and 2024 final BadgerCare surveys with respect to the emergency care and awareness domains. The 2022 interim survey was relatively small and did not ask precisely the same questions. We include the 2022 results in the table for completeness, but focus on testing for differences in the 2020 and 2024 responses. Because the copayment policy had been in place for more than 3 years in 2024, we would expect increased awareness of the policy in 2024 compared to the baseline survey.

When asked about which copayment rule was true for visits to the ED, we saw no change in the distribution of responses between 2020 and 2024 ($p = 0.064$), and if anything, a slight decline in correct responses. For example, 76.2% of respondents reported "you never need to pay a co-pay" in 2020, 73.1% in 2022, and 81.3% in 2024, while just 12.6% indicated the correct response ("you only need to co-pay for care that the doctor determines was not an emergency") in 2020, 10% in 2022, and 11.5% in 2024. This does not indicate a shift in understanding consistent with increased knowledge of or experience with the policy. There was a slight increase in the proportion indicating they were so worried about a copayment that they did not go to the emergency room, with 5.9% of baseline respondents indicating yes, 11.2% of 2022 respondents, and 8.9% of 2024 respondents ($p = 0.048$); however, this may reflect changes in the larger economy rather than concerns about the ED copayment policy specifically. There was no change in the fraction reporting they needed to borrow money or skip other bills to pay their premiums or copayments (6.3% in 2020 vs. 6.7% in 2024, $p = 0.814$). When asked if they had ever paid a copayment for services by Medicaid, 34.3% of baseline respondents said yes while 37.1% of 2024 respondents did so, although this increase was not statistically different from zero ($p = 0.295$).

Awareness categories in 2024 were collapsed to indicate agreement or disagreement to be consistent with the baseline survey, with 2022 interim survey responses "somewhat," "very," and "extremely" classified as agreement, and "not at all" or "a little" classified as disagreement. When asked about understanding the letters from the State DHS about their Medicaid health care coverage, agreement was consistently broad (87.2% in 2020, 81.8% in 2022, and 88.0% in 2024) and unchanged over time ($p = 0.683$). There was also no change in reported understanding of what payments are required (84.9% in 2020, 76.4% in 2022, and 83.7% in 2024, $p = 0.573$). There was a slight decline in reported awareness of who is eligible for coverage (89.3% in 2020, 78.4% in 2022, 85.8% in 2024, $p = .51$) which was on the margin of being statistically different from zero at the 5% level. There was no measurable difference in reported understanding how programmatic changes might affect them (73.8% in 2020, 61.7% in 2022, and 75.9% in 2024, $p = .424$).

Table 3.7: CLA Awareness of Copayment Policies and Coverage Satisfaction, 2020, 2022, and 2024 BadgerCare Surveys

	2020	2022	2024	*p* value (2020 vs. 2024)
Last 12 Months, How Many Times Go To An Emergency Room To Get Care For Yourself				
0 Times	67.2%	68.8%	55.5%	0.001
1–3 Times	28.2%	26.0%	38.1%	
4 Or More Times	4.6%	5.2%	6.4%	
Which Co-Pay Rule Is True For Visits To The Emergency Room				
You Never Need To Pay A Co-Pay	76.2%	73.10%	81.3%	0.064
You Only Need To Pay A Co-Pay For Care That The Doctor Determines Was Not	12.6%	10.00%	11.5%	
You Always Need To Pay A Co-Pay	11.1%	16.90%	7.2%	
Last 12 Months: Ever Been So Worried About A Co-Pay Not Gone To The Emergency Room				
Yes	5.9%	11.20%	8.9%	0.048
No	94.1%	88.80%	91.1%	
Last 12 Months: Had To Borrow Money, Skip Paying Other Bills In Order To Pay Premiums or Copay				
Yes	6.3%	-	6.7%	0.814
No	93.7%	-	93.3%	
Did You /Your Family Ever Pay Co-Pay For Services By Medicaid/BadgerCare In Last 12 Months?				
Yes	34.3%	-	37.1%	0.295
No	65.7%	-	62.9%	
Last 12 Months: Have Problems Paying Any Medical Bills				
Yes	15.1%	-	13.9%	0.56
No	84.9%	-	86.1%	
Last 12 Months: Medical Service Refused To Treat You Because You Owed Money				
Yes	1.6%	-	1.9%	0.741
No	98.4%	-	98.1%	
Awareness About Health Care Coverage				
Understand The Letters About Health Care Coverage From Medicaid				
Agree	87.2%	81.8%	88.0%	0.683
Disagree	12.8%	18.2%	12.0%	
Understand What Payments Are Required				
Agree	84.9%	76.4%	83.7%	0.573
Disagree	15.1%	23.6%	16.3%	
Understand Who Is Eligible For Health Care Coverage Using Medicaid				
Agree	89.3%	78.4%	85.8%	0.051
Disagree	10.7%	21.6%	14.2%	
Understand How Changes To Health Coverage Through Medicaid Might Affect You				
Agree	73.8%	61.7%	75.9%	0.424
Disagree	26.2%	38.3%	24.1%	

	2020	2022	2024	*p* value (2020 vs. 2024)
Which Of These Apply To Last Emergency Room Visit				
Did Not Have Another Place To Go For Care				
Yes	14.6%	25.0%	30.5%	<0.001
No	85.4%	75.0%	69.5%	
Health Provider Advised You To Go				
Yes	11.5%	25.0%	35.2%	<0.001
No	88.5%	75.0%	64.8%	
Problem Was Too Serious For The Doctor's Office				
Yes	41.0%	65.0%	72.6%	<0.001
No	59.0%	35.0%	27.4%	
Get Most Of Your Care At The Emergency Room				
Yes	4.0%	6.7%	26.8%	<0.001
No	96.0%	93.3%	73.2%	
Some Other Reason				
Yes	29.4%	73.3%	45.9%	0.001
No	70.6%	26.7%	54.1%	

An increase in the proportion reporting using the ED was evident (p = 0.001). In 2020, 67.2% reported 0 times, 28.2% reported 1–3 times, and 4.6% reported 4+ times, while in 2024, 55.5% reported 0 times, 38.1% reported 1–3 times, and 6.4% reported 4+ times. This is not surprising and likely reflects that the 2020 survey was fielded during the COVID-19 pandemic when utilization of all healthcare services was quite low. When those who responded they had visited the ED were asked about their last visit, a larger fraction (30.5% vs. 14.6%, p<0.001) of CLAs reported they didn't have another place to go for care. More frequently, CLAs reported that a health provider had advised them to go, and this increased over time (11.5% in 2020 vs. 35.2% in 2024, p<0.001). A much larger fraction reported that the problem was too serious for the doctor's office in 2024 than 2020 (41.0% vs 72.6%, p<0.001), which may reflect that some used the ED as a source of COVID-19 testing in 2020. A relatively large fraction of CLAs reported in 2024 that they got most of their care at the ED compared to 2020 (26.8% vs. 4.0%, p<0.001). Finally, while 45.9% of CLAs in 2024 indicated they had some other reason for visiting the emergency room, a smaller fraction did so in 2020 (29.4%, p = 0.001). These survey responses suggest that concerns about access to other care may increasingly explain ED utilization among CLAs that use the ED, keeping in mind the 2020 baseline survey took place during an unusual period. Consistently low fractions reported having problems paying any medical bills or that medical services had refused to treat them because they owed money across the years, and these proportions did not change between 2020 and 2024.

Overall, the survey responses among CLAs did not suggest either increased reported awareness or behavior consistent with awareness of the ED copayment policy.

Finally, in the 2022 interim survey we asked some questions to get a sense of member perceptions of what did and did not constitute appropriate ED visits usage and compared CLAs to parents. These results are reported in **Table 3.8**. We first asked among those who had used the ED if they had ever been told they were not experiencing an emergency. There was no statistical difference (p = 0.224) in the fraction of CLAs who said yes (9.1%) compared to parents (16.1%).

In addition, in order to assess whether members' perceptions of the prudent layperson standard for the ED copayment might align with member guidance from DHS on the subject, we asked about perceptions of whether individuals should go to the ED under different circumstances, including two circumstances which are generally recommended (cannot breathe or severely short of breath; suspected heart attack/stroke) and two circumstances which are not (cough, fever, or sore throat; burned themselves but not severely). Most members thought that someone probably or definitely should go to the ED if they couldn't breathe or were severely short of breath (97.2% of CLAs). Most members also thought someone should probably or definitely go if they thought they were having a heart attack or stroke (98.1% of CLAs). However, there was more mixed opinions on the scenarios that were less likely to fit the prudent layperson standard for ED use; 30.6% of CLAs thought someone should definitely or probably go to the ED for cough, fever, or sore throat, and 33.4% definitely or probably for a burn that was not severe. Being unsure may capture concerns about judgement and severity, and many more reported being unsure for these categories, but a significant portion still reported that the person should probably or definitely go. These perceptions were not measurably different between parents and CLAs.

Table 3.8: Perceptions of Appropriate ED Visits, 2022 Interim Survey

	CLAs (N= 195)	Parents (N= 163)	Adjusted *p* value
Indicators of Appropriateness			
Told that they were not experiencing an emergency	9.1%	16.1%	0.224
Appropriate reasons for ED use*			
Cannot breathe or have shortness of breath	97.2%	98.7%	0.384
Having a heart attack or stroke	98.1%	99.0%	0.318
Has a cough, fever, or sore throat	30.6%	35.0%	0.713
Burned themselves, but not severely	33.4%	38.2%	0.550

* Survey question scale was "Definitely no, Probably no, Not sure, Probably yes, Definitely yes." Percentages reported include "Probably yes" and "Definitely yes."

Hypothesis 3.6: Hospitals vary in how they implement the required copayment for non-emergency use of the ED.

Question 3.6a: Do hospitals understand the policy requiring a copayment for non-emergent use of the ED?

The Design Report proposed that we hold hospital focus groups to evaluate this hypothesis. Given the challenges faced by hospitals due to the COVID-19 pandemic, including ongoing staff shortages, we decided not to pursue this method after consultation with DHS. Instead, we pivoted to use the interim survey and its qualitative data collection to inform this hypothesis and associated research question. Without direct input from hospitals, beneficiary input was the best alternative. Although beneficiaries do not have direct knowledge of hospitals' understanding of the policy, their experience with hospitals' implementation of the policy serves as a proxy.

Qualitative interviews were conducted with a sample of 24 members about the ED copayment policy in 2022. A full report on the interview results and the interview questionnaire are included in **Attachment 4**. Here, we offer an overview focused on understanding the possible hospital variations in implementation of the required copayment for non-emergency use of the ED.

Interviewed respondents varied across the age spectrum and the majority (21/24) self-identified as white, with three respondents self-identifying as Black. Of self-identified gender, half reported male, and half female. Respondents were from around the state, with 17 different counties represented; Milwaukee (5/24) and Dane (3/24) were the only counties with more than 3 respondents. Both rural and urban counties were represented. A majority (16/24) reported living with other adults or children, and the majority (15/24) reported currently working. All respondents except one reported still being covered by BadgerCare, with one reporting she had recently left the program.

Most (19/24) reported at least one chronic health problem requiring ongoing medical attention, with responses varying and the single most frequent being a mental health disorder (7/24). As noted, all respondents had visited an ED at least once for their own care in the last 12 months. Almost all indicated they had primary care access (23/24) and usage (18/24), as well as urgent care access (19/24), and only 3 reported that it was difficult to obtain appointments. A large proportion knew which ED they would choose (20/24) if they needed it, and most of those that did not know which ED to choose had recently moved. Previous experience, convenience of location, and good opinion of care were the most frequently reported reasons for choosing that

ED. Access or availability, including the only option open at the time, and perceived severity were the most frequent reasons indicated for choosing the ED over other locations.

Most were satisfied with their ED experience. Although two indicated that the staff did not consider their visit an emergency, with one specifying that they had been told to self-treat a mental health problem, no respondents had ever been required to pay ED copayments by BadgerCare. None indicated awareness of recent changes to BadgerCare's coverage of emergency care, and none thought that BadgerCare members currently had to pay for any ED services, with the exception of one who recalled being told about an ED copayment policy for non-emergent visits.

Members generally reported that their own use of the ED was merited. However, many (17/24) agreed that other people sometimes use the ED inappropriately and most (21/24) thought that an $8 copayment was a reasonable and affordable amount relative to the value. Some agreed that the copayment might deter non-emergent use. At the same time, 19/24 reported that it would be difficult for members themselves to know whether a health problem was an emergency, and all reported that an $8 fee would not change whether they themselves went to the ED.

Overall, these interview results do not indicate that there is widespread knowledge of or experience with ED copayments.

Hypothesis 3.7: Hospitals implement the policy requiring a copayment for non-emergent use of the ED in a consistent manner.

Primary research question 3.7: Are hospitals consistent in how they are implementing the policy requiring a copayment for non-emergent use of the ED?

Question 3.7a: Is the definition of non-emergent ED visits consistently applied across hospitals?

To study this question, we examined the Medicaid claims and encounter data. We identified all ED visit claims for parents and CLAs from January 1, 2018, to March 31, 2022. In the administrative data, we are unable to directly observe the provider's decision-making process or their application of the prudent layperson standard that hospitals have been directed to use (as defined in 42 C.F.R. § 438.114). Instead, we provide two measures of non-emergent visits over time: one that identifies visits that were likely subject to the copayment requirement with respect to the provider's application of the standard (generally referred to as "possible ED copayment visits"); and one that assigns visits algorithmically, allowing non-emergent visits to be measured consistently over time, and represents a broader set of visits than those specifically subject to or targeted by the copayment policy (generally referred to as non-emergent visits).

The first measure identifies the set of visits that were billed subject to the copayment requirement. We identified a total of 24 possible ED copayment visits over the 21 months from July 2020 to March 2022 which were billed according to the state's Medicaid billing requirements ([modifier ("U1"), procedure codes (99281:99285, revenue codes (450:459)]) and the visits took place at eight different facilities. Fifteen of them took place after November 1, 2020. Of these, only four indicated a charge of $8 in the copayment field constituting two different facilities. All had facility descriptions as either General Acute Care Hospitals (7) or Rehabilitation Units (1). Between April 2022 and December 2023, we identified seven additional visits billed under these specifications; none had an $8 charge in the copayment field. We identified an additional nine visits billed to CLAs with an $8 copayment charge between April

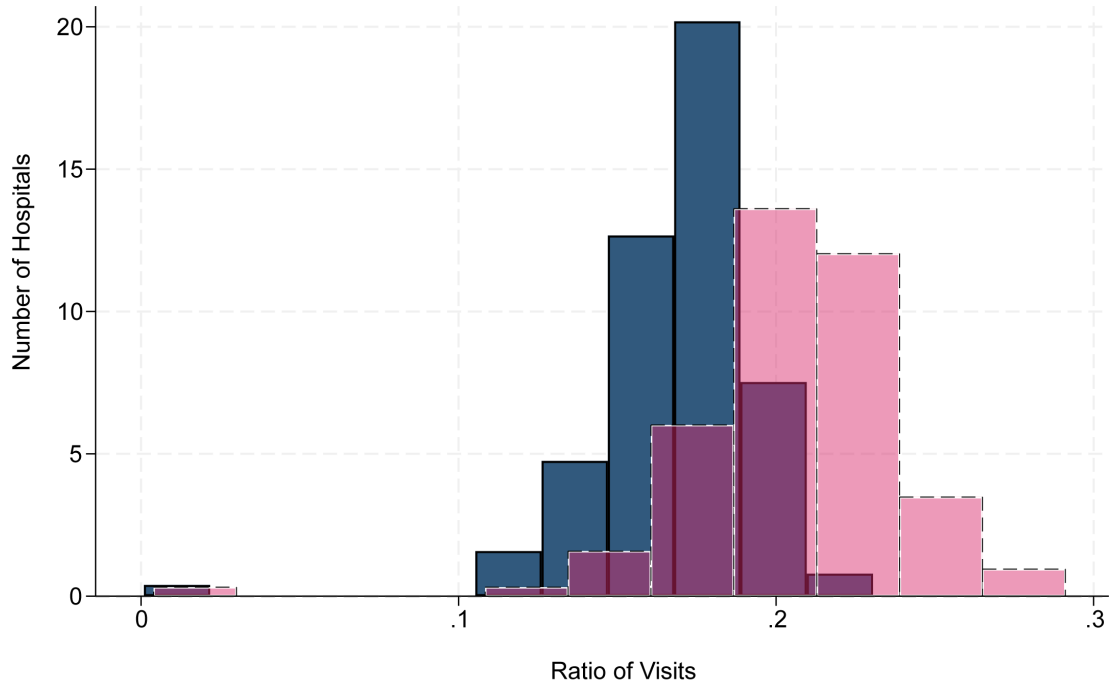
2022 and December 2023, by three different General Acute Care Hospitals in the same system. In total, this constitutes 31 total visits identified as possible ED copayment visits after the policy was in effect. The few hospitals that ever charged them served a larger than average number of Medicaid patients overall.

Our assessment was that it would not be meaningful to report the ratio of visits for which copayments were assessed to the overall number of non-emergent visits at the hospital level, as planned, as it would be effectively zero for almost all facilities. Instead, we note some differences among hospitals that did and did not charge copayments and describe hospital-level differences in total and non-emergent visit rates for CLA and parent members over time.

In what follows, we restrict attention to facilities billing for emergency visits that are in-state and had greater than 100 total visits from January 2018 to December 2019. There were 121 separate hospitals that fit the description of billing for at least one visit during the study period. The observation level is the facility-month-eligibility group and for an observation to be included in the analysis, at least one visit must have been billed per group per period (necessary to construct the ratio of non-emergent to total visits). This creates an unbalanced panel of hospital-eligibility groups.

In **Figure 3.8**, we plot a histogram of the ratio of non-emergent visits to total visits for each hospital in the pre-period (January 2018–October 2020; transparent red) compared to in the post-period (November 2020–December 2023; dark blue). There was a clear downward shift in the distribution of this ratio. For example, prior to the imposition of ED copayments, the average ratio was 0.21, and after it was 0.17. Much of this decrease in the share of a hospital's visits that were non-emergent was likely due to changes in health care use from the COVID-19 pandemic.

Figure 3.8: Histogram of Hospital-Level Non-Emergent to Total Visits Ratios Before and After ED Copayments



Notes: Figure shows histogram of hospital average ratio of non-emergent to total visits from January 2018 to October 2020 (transparent red) and November 2020 to December 2023 (blue).

We estimated difference-in-differences models in **Table 3.9** for total visits and the visit ratio, comparing these outcomes for parents versus CLA eligibility groups at the hospital-month level before and after November 2020, conditional on eligibility group, post period, hospital, and calendar month fixed effects. We include two models, one that includes all months from January 2018 through December 2023 and one that excludes March 2020–March 2021. These should be thought of as comparing the within-hospital change in visits for CLAs compared to parents after the introduction of ED copayments. Although there was an absolute increase in visits at the hospital level—likely reflecting increased total enrollment associated with continuous coverage—and a decline in the ratio of non-emergent visits to total visits for CLAs, neither model shows any evidence of a decline in visits or the ratio of non-emergent to emergent visits compared to the control group of parents. If anything, the DiD coefficient suggests that CLAs experienced a relative increase in both total visits and the ratio of non-emergent to all visits when compared to parents.

Table 3.9: DiD Analysis of Hospital-Level Visits Before and After Imposition of Copayments – CLAs vs. Parents

	Model 1 (Includes all months)	Model 2 (Excludes pandemic period)
Ratio of Non-Emergent to Total ED Visits		
Coefficient	0.0129	0.0135
Robust Standard Error	(0.0026)	(0.0029)
p value	<0.001	<0.001
Baseline Monthly Average (CLA)	0.188	0.194
Post-Implementation Monthly Average	0.160	0.159
Total ED Visits		
Coefficient	23.73	27.96
Robust Standard Error	(1.266)	(1.433)
p value	<0.001	<0.001
Baseline Monthly Average (CLA)	68	66
Post-Implementation Monthly Average	92	95

Notes: Models include hospital and calendar month fixed effects; 121 total hospitals are included in the hospital-month analysis with data from January 2018–December 2023.

In summary, these findings suggest that few hospitals directly billed for claims that had associated ED copayments, and that within-hospital differences in the ED visits of CLAs compared to parents that would support consistent implementation of the ED copayment policy were not evident.

Conclusions

The Medicaid program goal associated with this provision is to provide members with coverage that more closely aligns with commercial coverage, promote participant engagement and readiness to transition to commercial coverage, and to ensure appropriate use of medical services. Most hypotheses associated with the ED copayment were centered around the appropriate use of medical services.

The first key question associated with understanding the effectiveness of the ED copayment surrounds member awareness. If the imposition of a copayment for non-emergent use of the ED is expected to lead to more appropriate uses of medical care (Hypothesis 3.5), the target population of CLAs must have some awareness of the policy. The member survey results indicate that beliefs about the copayment policy regarding ED visits were not different for the CLAs compared to parents and baseline awareness of the policy was low. There were also no important or statistically measurable differences in the fraction who said they were too worried about the copayment and avoided the ED. In addition, when comparing the baseline 2020 survey to the 2024 survey results, after which many CLAs could have had the opportunity to experience the policy, the distribution of awareness is highly similar. This means that there is no evidence that awareness of the policy increased over time. Overall awareness of understanding letters from the program was relatively high in both surveys (85%+). Because member awareness is an important component of the goal of engagement and is necessary for the behavioral change associated with a shift in ED use to more appropriate emergent uses, these results would suggest members are unlikely to have been responsive to the policy. These findings are consistent with findings in the interim report from the baseline survey that although similar proportions of parent and CLA members were told they were not experiencing an emergency in their ED visit, CLAs and parents were no more likely to report they needed to pay a copayment for care the doctor determined wasn't an emergency. This broadly suggests that members are not aware of their copayment obligations, which means that the ED copayment policy is unlikely to be serving as an effective deterrent for avoidable ED use.

Responses to questions about what qualifies as a need to go to the ED suggest that member perceptions of need may differ from the prudent layperson standard and examples used in state communications about the ED copayment. The prudent layperson standard may be confusing for members. Member responses about understanding communication and policies were mixed and were lowest with respect to understanding how program changes might affect them.

Qualitative interview results also did not indicate evidence of widespread knowledge of ED copayments, suggesting there would not be a reason to expect a deterrent effect of the copayments. Member perceptions of the $8 amount were generally that it was affordable, would be worth it, and would not change their decision-making process. They additionally thought it was hard for patients to identify emergencies, further suggesting that while it may not be particularly harmful to members, it might not be an effective deterrent even if there were more widespread knowledge.

Testing the impact of the policy with models that used parents as a control group within the Medicaid data and alternatively used commercial enrollees as a control group within the all-payer claims encountered the practical difficulty of the large impact the COVID-19 pandemic on both health care utilization and Medicaid enrollment. If the pandemic impacted these groups differently, then measured differences in outcomes could be due simply to different responses to the pandemic and related policies itself. This concern is supported by different trends in utilization particularly between commercial enrollees and Medicaid members. The findings from the within-Wisconsin Medicaid comparisons, which we believe are the most credible, suggest an overall relative decline in ED visits by CLAs and a very small relative increase in the total number of non-emergent visits by CLAs compared to parents. The non-emergent ED visits declined for both groups after the ED copayment policy was implemented, but they declined more for parents. The conclusion this would support is that the copayment policy may have discouraged overall utilization but not necessarily targeted non-emergent utilization as measured. The findings from the comparisons to commercial enrollees were that Medicaid members' use of the ED declined overall and declined in greater proportion for non-emergent

visits following the implementation of copayments for ED visits, compared to commercial enrollees. This would support a conclusion that the ED copayment did successfully encourage more appropriate use of services. However, trends illustrated in the outcomes for the two groups suggest that commercial enrollees may not be a good control group for Medicaid members during this period and point towards caution in interpreting the results of these models as causal impacts of the copayment policy.

To understand these findings further we studied how members were experiencing the copayment policy by understanding their individual experiences and how ED care varies by hospital. Nothing in the member interviews suggests that members are experiencing a standardized implementation of a screening process at the different hospital EDs that they have used, and while two indicated they had been told by staff that they should have received treatment elsewhere, they did not report being told to pay a copayment or being referred elsewhere directly. This leads to the conclusion that members are not consistently experiencing the ED copayments.

After November 2020, the copayment requirement was in effect, but there is no evidence of widespread charging of copayments. We identified fewer than 40 potential visits where the $8 copayment was charged, at a small subset of facilities. If the declines in visits suggested by the comparisons to parents and commercial enrollees were driven by copayments, we would expect that members would demonstrate greater understanding of the policy and that it would be billed more frequently. This does not suggest consistent application of the standard across hospitals.

We cannot directly determine the explanation for these findings from our data. One possibility is that there may have been very few visits that hospitals would define as non-emergent using the prudent layperson standard published in the provider guideline; while the Billings algorithm suggested approximately 1 in 5 visits may have been non-emergent, it is an imperfect measure of visit urgency particularly from a prospective perspective as reasons for seeking care can differ greatly from eventual diagnoses in claims, with 40% of non-emergent claims found to have urgent initial reasons for visit.[21] A second possibility is that if the copayments cost more to collect than would result in revenue, hospitals may not have attempted to collect it. Per Wisc. Stat. 49.45(18), “providers are required to make a reasonable attempt at collecting the copayment from the member unless the provider determines that the cost of collecting the copayment is more than the amount the provider would collect.” This condition may apply for the case of the $8 copayment. Third, it is also possible that visits potentially subject to copayments were diverted to other facilities as there is a requirement to inform the member of the copayment. In our analysis of visit rates by eligibility group, we found no evidence of a decline in either total ED visits or the ratio of non-emergent to total visits, and we found declines in the utilization of primary care. When we asked members in the interviews, none reported being referred elsewhere, so we do not believe the evidence supports this explanation; however, this evidence is subject to the caveats described above.

Policy Implications

Our overall assessment is that the ED copayment policy as implemented does not support the Medicaid policy goal of targeting appropriate use of medical services, but also was not harmful for members, largely because it does not seem to have had any measurable aggregate effect. Drawing implications for current state and federal Medicaid policy is difficult because of the

[21]Giannouchos, Theodoros V., Benjamin Ukert, and Brad Wright. “Concordance in Medical Urgency Classification of Discharge Diagnoses and Reasons for Visit.” *JAMA Network Open* 7, No. 1 (2024): e2350522-e2350522.

challenges described in the evaluation, including the simultaneity of the COVID-19 pandemic. We do not have confidence in the internal validity of our analyses for causal inference or generalizability of the empirical findings.

Evidence to date from other sources on ED copayments is somewhat mixed. While Medicaid members can be quite responsive to copayments, they may not always differentiate between non-emergent and emergent needs and instead reduce utilization across the board. Similarly, when insurance coverage expands, utilization of the emergency room increases for both emergent and non-emergent reasons.[22,23,24,25,26] It is unclear in this case how much fidelity in implementation existed, possibly because the copayments were too small to be worthwhile relative to their complexity, which required not only an assessment using the prudent layperson standard but also specific referral to another facility. Hospitals may have perceived this as not worth their time, not to mention the decline in revenue from not serving the patient could have been an additional deterrent. In addition, some managed care plans explicitly exempted their members from the policy, evidently not perceiving it as worthwhile to implement. If this is the explanation, a different approach to enforcement might be considered. A larger copayment would also more likely be effective, but because members may struggle to differentiate non-emergent from emergent utilization, it may not achieve the goal in a targeted way. The state could re-evaluate implementation of the copayment policy in all hospitals and increase efforts to standardize implementation, possibly piloting in a smaller number of hospitals to identify specific implementation barriers.

Member awareness of the policy was low and often incorrect. This may have been because they were not experiencing the policy, but also may suggest that additional or more effective communication about the policy might have facilitated success. However, if member experience did not align with communications, it is unlikely that communications alone would be effective.

Results in the full report on the qualitative member interviews (**Attachment 4**) expand on members' perceptions of their care in EDs and may present ideas for further opportunities to improve the quality of care in EDs for Medicaid members.

Lessons Learned and Recommendations

Continued careful attention to communication about changes in policy that are consistent with best practice in language use and individualization may help ensure that members understand the policy's implications for them so that it may have the desired effects. For example, survey data using similar wording to official communications suggested some inconsistency across members among which types of care did and did not require immediate attention in the ED

[22]Mortensen K. 2010. Copayments did not reduce Medicaid enrollees' nonemergency use of emergency departments. *Health Affairs* 29: 1643–1650.

[23]Selby JV, Fireman BH, Swain BE. 1996. Effect of a copayment on use of the emergency department in a health maintenance organization. *New England Journal of Medicine* 334: 635–642.

[24]Sabik, Lindsay M., and Sabina Ohri Gandhi. "Copayments and emergency department use among adult Medicaid enrollees." *Health Economics* 25, No. 5 (2016): 529–542.

[25]Siddiqui, Mona, Eric T. Roberts, and Craig E. Pollack. "The effect of emergency department copayments for Medicaid beneficiaries following the Deficit Reduction Act of 2005." *JAMA internal medicine* 175, No. 3 (2015): 393–398.

[26]Taubman, Sarah L., Heidi L. Allen, Bill J. Wright, Katherine Baicker, and Amy N. Finkelstein. "Medicaid increases emergency-department use: evidence from Oregon's Health Insurance Experiment." *Science* 343, No. 6168 (2014): 263–268.

setting. Individualization has been shown to be effective in other contexts.[27] Targeted messaging based on past history of non-emergent use, if feasible, could also be considered.

Pilot studies that test different implementations and/or focus groups to identify barriers to provider participation in policy initiatives could offer avenues to improve implementation fidelity.

A strength of the waiver was that it did not seem to harm member access to care; based on interview data, members did not perceive the $8 copayment as too high or unaffordable. There is a potential trade-off between potential harms of a higher copayment and the likelihood of the copayment reducing non-emergent utilization. Future initiatives might focus on higher stakes and/or how to increase awareness of or actual access to outside ED options for the types of non-emergent care targeted by the policy, including perhaps additional signaling to members or explicit alternatives to consider under specific conditions.

Value-based insurance design, such as that focused on structuring copayments in a way that most effectively encourages efficient use of care, is worthy of continued testing in Medicaid.[28] Value-based insurance design can be effective in helping patients target utilization of scarce health care resources, although emergency care offers some special challenges including provider payment incentives and requirements under federal law.[29] Some of the specific rules associated with this policy, likely designed to ensure that members had continued access to care if they were turned away from the ED, may have increased complexity and reduced compliance by MCOs and hospitals, highlighting the potential importance of partnering with health care organizations in designing policies that will be feasible to implement. Members may also not make optimal decisions when they do not understand the parameters they face.[30] Prior work has shown that acuity issues are similar across insurance types, but access issues are more common for Medicaid patients, potentially driving differences in non-emergent utilization of EDs, and likely motivating the referral requirement in this policy.[31] Other approaches to increase access which may be more feasible to implement include such ideas as offering higher rates in non-emergent (primary care) settings for off-hours appointments, encouraging reliance on urgent care settings rather than EDs, which have been shown to decrease non-emergent use of the ED in private insurance settings,[32] or incentivizing use of a nurse call triage line.[33]

[27]Head, Katharine J., Seth M. Noar, Nicholas T. Iannarino, and Nancy Grant Harrington. “Efficacy of text messaging-based interventions for health promotion: a meta-analysis.” *Social Science & Medicine,* 97 (2013): 41–48.

[28]Chernew, Michael E., Allison B. Rosen, and A. Mark Fendrick. “Value-Based Insurance Design: By abandoning the archaic principle that all services must cost the same for all patients, we can move to a high-value health system.” *Health Affairs* 26, No. Suppl2 (2007): w195–w203.

[29]Farmer, Steven A., and N. Adam Brown. “Value-based approaches for emergency care in a new era.” *Annals of Emergency Medicine* 69, no. 6 (2017): 684–686.

[30]Loewenstein, George, Joelle Y. Friedman, Barbara McGill, Sarah Ahmad, Suzanne Linck, Stacey Sinkula, John Beshears et al. “Consumers’ misunderstanding of health insurance.” *Journal of Health Economics* 32, No. 5 (2013): 850–862.

[31]Capp, Roberta, Sean P. Rooks, Jennifer L. Wiler, Richard D. Zane, and Adit A. Ginde. “National study of health insurance type and reasons for emergency department use.” *Journal of General Internal Medicine,* 29, (2014): 621–627.

[32]Allen, Lindsay, Janet R. Cummings, and Jason Hockenberry. *Urgent care centers and the demand for non-emergent emergency department visits*. No. w25428. National Bureau of Economic Research, 2019.

[33]Alqatari, M., S. R. Morgan, A. Chang, and J. M. Pines. “Non-Emergency Department Interventions to Reduce Emergency Department Utilization: A Systematic Review.” *Annals of Emergency Medicine* 60, No. 4 (2012): S155.

PROVISION 4 RESULTS: EXPANSION OF COVERAGE FOR SUBSTANCE USE DISORDER TREATMENT

The Medicaid program goal associated with this provision of the waiver is to reduce the incidence of drug overdose deaths by improving access to the full continuum of substance use disorder (SUD) treatment. This provision modifies the benefit package for SUD treatment for all full-benefit Medicaid members. Specifically, the demonstration waiver authorizes federal funding for treatment provided to members in Institutions for Mental Disease (IMD), allowing Wisconsin Medicaid to make two significant programmatic changes: 1) establish a residential treatment benefit for SUD; and 2) cover existing Medicaid services when they are provided in an IMD including medically supervised withdrawal management, inpatient services, and medication-assisted treatment (MAT).

There are two main study cohorts for the evaluation of Provision 4. The Medicaid Cohort was constructed from Wisconsin Medicaid enrollment data (**Table 4.1** and **Figure 4.1**). The WHIO Cohort was constructed from the state's voluntary, multi-payer claims database and includes Medicaid and commercially insured adults (**Table 4.2**).

Table 4.1 and **Figure 4.1** summarize the growth and change in composition of the Medicaid member population over the evaluation period from 2017–2023. Member population growth coincides with the onset of the PHE and introduction of maintenance of enrollment policy; the decline beginning in 2023 is due to the policy's unwinding. Although Medicaid eligibility category is not observable in the WHIO data, these trends in Medicaid population size are also apparent (**Table 4.2**).

Figure 4.1. Medicaid Cohort: Enrollment Trends by Eligibility Category, 2017–2023

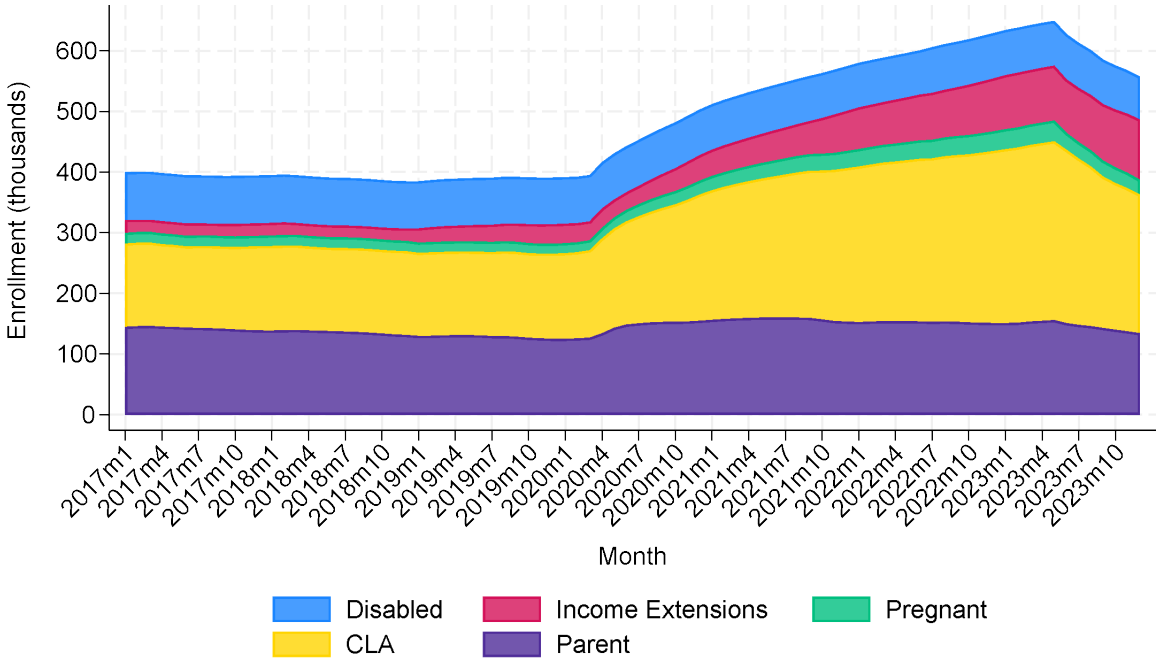


Table 4.1. Characteristics of Medicaid Cohort, 2017–2023

	2017	2018	2019	2020	2021	2022	2023
N=unique subjects	524,865	514,033	506,267	535,933	601,810	657,329	713,390
Average # months enrolled	9.10	9.10	9.20	10.00	10.90	11.00	10.30
Eligibility Group, %							
Childless Adults	38.2%	38.8%	39.5%	41.7%	44.4%	45.6%	46.4%
Parents & Caretakers	35.2%	34.4%	32.3%	31.8%	28.9%	25.3%	23.8%
Pregnant Women	5.5%	5.6%	5.5%	5.0%	5.2%	5.3%	5.5%
Income Extension	4.6%	4.6%	6.1%	6.3%	8.3%	11.8%	13.2%
Disabled	16.4%	16.6%	16.6%	15.2%	13.1%	12.0%	11.2%
Age Group, %							
21–25	16.6%	16.1%	15.7%	15.6%	15.9%	15.7%	15.6%
26–34	30.1%	30.2%	30.0%	30.0%	29.8%	29.6%	29.2%
35–44	22.5%	23.0%	23.6%	24.1%	24.5%	25.0%	25.5%
45–54	17.5%	17.0%	16.5%	16.1%	15.7%	15.6%	15.7%
55–64	13.3%	13.8%	14.2%	14.2%	14.1%	14.1%	14.0%
Gender, %							
Female	58.5%	58.4%	58.2%	57.6%	57.0%	56.7%	56.4%
Male	41.5%	41.6%	41.8%	42.4%	43.0%	43.3%	43.6%
Race, %							
Asian	3.1%	3.1%	3.1%	3.2%	3.3%	3.4%	3.4%
Black	19.4%	19.8%	20.0%	19.6%	19.1%	18.8%	18.4%
Hispanic	8.2%	8.3%	8.5%	8.8%	9.3%	9.8%	10.3%
Other	3.6%	3.7%	3.8%	3.9%	4.1%	4.1%	4.2%
White	55.6%	54.6%	53.7%	53.8%	54.0%	53.7%	53.4%
Missing	10.1%	10.6%	10.9%	10.7%	10.2%	10.3%	10.5%
Language, %							
English	95.3%	95.3%	95.4%	95.5%	95.3%	94.9%	94.5%
Spanish	2.8%	2.9%	2.8%	2.8%	3.0%	3.2%	3.5%
Other	1.9%	1.8%	1.9%	1.8%	1.8%	1.9%	2.0%
Tribe Member, %							
No	98.0%	98.0%	98.0%	97.9%	97.9%	97.9%	98.0%
Yes	2.0%	2.0%	2.0%	2.1%	2.1%	2.1%	2.0%

Notes: Non-constant demographic variables are counted from first observed month in the year. For members who change eligibility categories within the year, we assign them to the category with the most observed months that year.

Table 4.2. Characteristics of Medicaid and Commercially Insured Adults - WHIO Data, 2017–2023

	2017		2018		2019		2020		2021		2022		2023	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Medicaid														
N=unique subjects	495,267	100.0%	482,404	100.0%	474,142	100.0%	497,008	100.0%	564,128	100.0%	627,105	100.0%	685,685	100.0%
Average # months enrolled in Medicaid	8.97		9.04		9.15		9.94		10.87		11.02		10.21	
Sex														
Female	297,499	60.1%	289,647	60.0%	284,135	59.9%	294,297	59.2%	329,873	58.5%	363,124	57.9%	394,115	57.5%
Male	197,760	39.9%	192,747	40.0%	189,997	40.1%	202,704	40.8%	234,245	41.5%	263,964	42.1%	291,559	42.5%
Unknown	a	0.0%	10	0.0%	a	0.0%	a	0.0%	a	0.0%	a	0.0%	a	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Age Group														
21–25	94,925	19.2%	89,889	18.6%	86,135	18.2%	88,042	17.7%	102,118	18.1%	118,066	18.8%	129,394	18.9%
26–34	171,191	34.6%	167,114	34.6%	164,095	34.6%	171,338	34.5%	193,121	34.2%	208,587	33.3%	221,315	32.3%
35–44	122,426	24.7%	122,006	25.3%	123,435	26.0%	134,502	27.1%	155,547	27.6%	173,674	27.7%	190,401	27.8%
45–54	87,279	17.6%	82,572	17.1%	79,354	16.7%	82,982	16.7%	93,248	16.5%	102,566	16.4%	112,077	16.3%
55–64	57,506	11.6%	57,243	11.9%	56,977	12.0%	60,094	12.1%	67,817	12.0%	76,648	12.2%	85,914	12.5%
Rural/Urban County of Residence														
Rural	125,564	25.4%	121,070	25.1%	118,378	25.0%	123,414	24.8%	139,664	24.8%	155,384	24.8%	169,761	24.8%
Urban	368,749	74.5%	360,465	74.7%	355,007	74.9%	372,691	75.0%	423,318	75.0%	470,313	75.0%	514,216	75.0%
Unknown	954	0.2%	869	0.2%	757	0.2%	903	0.2%	1,146	0.2%	1,408	0.2%	1,708	0.2%
Commercial Insurance														
N=unique subjects	834,045	100.0%	966,697	100.0%	969,967	100.0%	925,117	100.0%	922,940	100.0%	933,264	100.0%	913,468	100.0%
Average # months enrolled in Commercial	10.48		10.49		10.51		10.65		10.53		10.52		10.52	
Sex														
Female	423,185	50.7%	493,853	51.1%	497,277	51.3%	473,567	51.2%	471,461	51.1%	475,854	51.0%	465,429	51.0%
Male	410,819	49.3%	472,799	48.9%	472,634	48.7%	451,491	48.8%	451,390	48.9%	457,256	49.0%	447,818	49.0%
Unknown	41	0.0%	45	0.0%	55	0.0%	58	0.0%	87	0.0%	153	0.0%	221	0.0%
Missing	0	0.0%	0	0.0%	a	0.0%	a	0.0%	a	0.0%	a	0.0%	0	0.0%
Age Group														
21–25	106,360	12.8%	119,752	12.4%	119,528	12.3%	114,279	12.4%	114,786	12.4%	115,427	12.4%	113,600	12.4%
26–34	182,732	21.9%	210,448	21.8%	213,435	22.0%	202,055	21.8%	201,187	21.8%	201,085	21.5%	195,850	21.4%
35–44	184,597	22.1%	214,578	22.2%	218,800	22.6%	212,951	23.0%	214,652	23.3%	216,814	23.2%	214,407	23.5%
45–54	203,638	24.4%	228,554	23.6%	223,415	23.0%	211,037	22.8%	207,637	22.5%	207,014	22.2%	202,332	22.1%
55–64	219,924	26.4%	264,981	27.4%	267,285	27.6%	253,864	27.4%	252,280	27.3%	260,615	27.9%	253,844	27.8%
Rural/Urban County of Residence														
Rural	237,970	28.5%	274,605	28.4%	268,519	27.7%	251,776	27.2%	253,488	27.5%	255,281	27.4%	246,691	27.0%
Urban	566,120	67.9%	659,511	68.2%	669,959	69.1%	643,967	69.6%	640,516	69.4%	649,045	69.5%	638,898	69.9%
Unknown	29,955	3.6%	32,581	3.4%	31,489	3.2%	29,374	3.2%	28,936	3.1%	28,938	3.1%	27,879	3.1%
Enrolled sequentially in Medicaid and Commercial	28,531	2.1%	30,625	2.1%	30,365	2.1%	25,501	1.8%	25,493	1.7%	27,475	1.8%	32,850	2.1%

Note: Analyses of Wisconsin Health Information Organization (WHIO) data. The study population shown includes individuals with full-benefit insurance including prescription medication coverage. [a]Suppressed due to small cell size.

Question 4.1: Does the SUD demonstration waiver increase the supply of SUD providers for Medicaid enrollees?

Hypothesis 4.1a: The SUD demonstration waiver will increase the supply of SUD providers that accept and/or treat Medicaid enrollees.

We estimated the effect of the SUD demonstration waiver on the supply of residential treatment facilities that accepted Medicaid members using a difference-in-differences (DiD) design and the N-SSATS and N-SUMHSS datasets. As discussed in the methodology section, these results should not be interpreted causally because of incompatibility in the data source before and after 2021. The SAMHSA replaced the original survey (N-SSATS) with a new survey (N-SUMHSS) in 2021. We report results of this pre-specified analysis but do not draw causal conclusions from it.

Table 4.3 provides a descriptive analysis of facility- and state-level characteristics in Wisconsin relative to the comparison states. The composition of payer sources for facilities in Wisconsin and the comparison states differed during the baseline period, 2017–2019, with relatively fewer Wisconsin facilities accepting Medicaid, other public insurance, or charity care as payment sources than facilities in comparison states. For example, during the baseline period, 32.2% of SUD residential treatment facilities in Wisconsin reported that they accepted Medicaid payment for at least one type of service while 52.1% of facilities in comparison states accepted Medicaid. These differences in payer source between groups were significant at the 1% level. Facilities that provide residential SUD treatment may also provide other SUD treatment services. If those services are covered by a state's Medicaid plan, a residential treatment facility would report that they accept Medicaid as a source of payment, even in the absence of a residential treatment benefit. On average, the state-level policy and demographic characteristics of Wisconsin differed significantly from the comparison states on all measured variables at the 1% level.

Figure 4.2 shows the trend in the percentage of SUD residential treatment facilities that accepted Medicaid in Wisconsin and in the comparison states from 2017–2022. During the study's pre-period, 2017–2019, 30–35% of SUD residential treatment facilities in Wisconsin reported accepting Medicaid as a payer. Medicaid acceptance rose to almost 83% of facilities in 2021 dipping down to 78% in 2022. The percentage of facilities that accepted Medicaid in the comparison states increased from approximately 49% to 55% over the study period.

Regression results are presented in **Table 4.4**. For all models, the post period is 2021–2022. Model I is unadjusted. Model II includes facility characteristics, and Model III additionally includes state-level characteristics. In Panel A, all models exclude 2020 from the pre-period (2017–2019). Results are sensitive to model specification. In the unadjusted model, there was a 45.9 percentage point relative increase in acceptance of Medicaid among Wisconsin residential treatment facilities compared to facilities in the comparison states over the study period. In the fully adjusted model, it was a 31.1 percentage point relative increase. For completeness, we show the same set of models in Panel B that include the pandemic period (i.e., 2020).

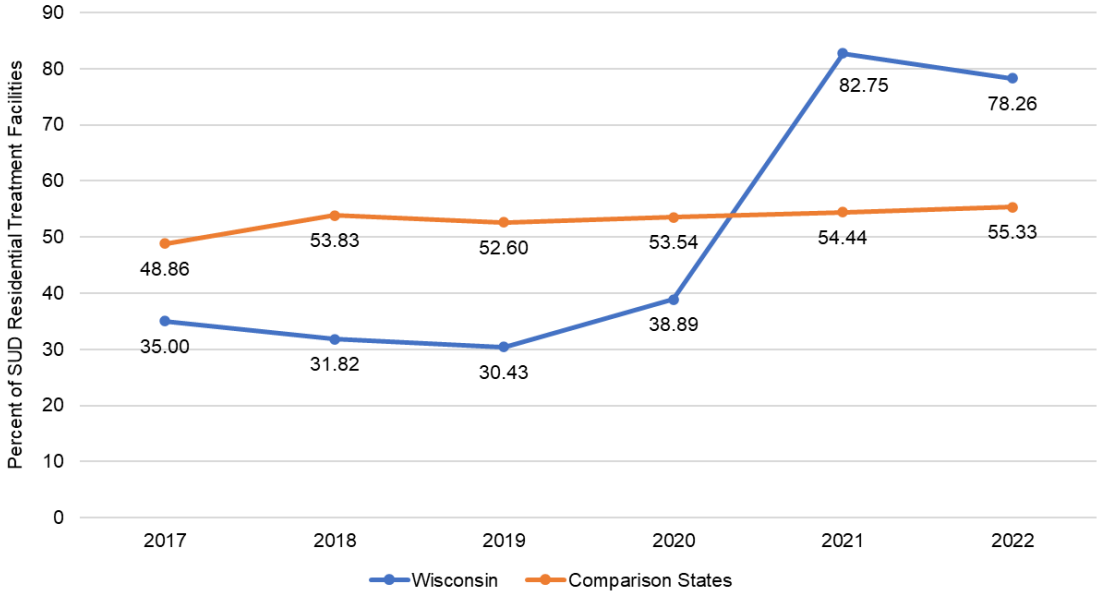
To assess a potential change in the supply of providers more broadly—including individuals, clinics, and hospitals—we compared the number of providers who newly delivered SUD services to any individual in the Medicaid cohort after implementation of the waiver relative to the prior period, to the change in the number of providers who newly delivered services for diabetes to the same population over the same period.

Table 4.3. Comparison of SUD Residential Treatment Facility- and State-Level Characteristics between Wisconsin and Comparison States, 2017–2019

	(I) Wisconsin (%)	(II) Comparison States (%)	*p* value
Observations (facility-years)	**N=91**	**N=2,363**	
Panel A Outcomes			
Sources of payment accepted			
Medicaid	32.2	52.1	<0.001
Private Insurance	73.6	69.8	0.441
Other Public Insurance	24.2	35.1	0.020
Self Payment	92.2	89.7	0.386
Charity care	41.8	73.4	<0.001
Operate an OTP program	0.0	4.8	<0.001
Ownership status			
For-profit	20.9	24.5	0.404
Non-profit/government owned	79.1	75.5	0.404
Medication for opioid use disorder provided onsite	33.0	45.2	0.018
Panel B State Characteristics			
Policy			
ACA Medicaid Expansion	0.0	42.6	<0.001
Presence of prescription drug monitoring program	100.0	95.0	<0.001
Demographics			
Age (mean)	39.4	38.9	<0.001
Male	50.1	48.8	<0.001
Race/Ethnicity			
White	87.7	74.6	<0.001
Black	6.3	16.0	<0.001
Other	5.9	9.4	<0.001
Hispanic	6.5	20.4	<0.001
Foreign Born	5.2	17.7	<0.001
Veteran	6.7	5.8	<0.001
Education			
Less than high school	10.7	12.4	<0.001
High school education	25.8	22.8	<0.001
Some college but no degree	13.9	13.7	0.002
College/university degree	31.8	32.4	<0.001

Notes: Author's calculations based on the N-SSATS (Panel A), KFF Medicaid Waiver Tracker, PDMP (Panel B-State Policy), and IPUMS CPS (Panel B-Demographics). The values shown in columns I and II reflect the average across the years, 2017–2019. We tested the equivalence of the pre-period values in Wisconsin relative to the comparison states, AL, AZ, AR, FL, GA, HI, IA, MS, MO, NV, NY, ND, SC, SD, TX, and WY.

Figure 4.2. Percentage of SUD Residential Treatment Facilities that Accept Medicaid as a Payer, 2017–2022



Notes: Authors' calculations using the N-SSATS (2017–2020) and the N-SUMHSS (2021–2022). Unit of analysis is the facility-year. The comparison states include the 16 states that did not have a Medicaid residential treatment benefit as of the end of 2022 and contributed data to the TEDS-A. AL, AZ, AR, FL, GA, HI, IA, MS, MO, NV, NY, ND, SC, SD, TX, and WY.

Table 4.4. DiD Results: Comparing the Change in Medicaid Acceptance Among Facilities in Wisconsin after Implementation of the Residential Treatment Benefit to Facilities in Comparison States

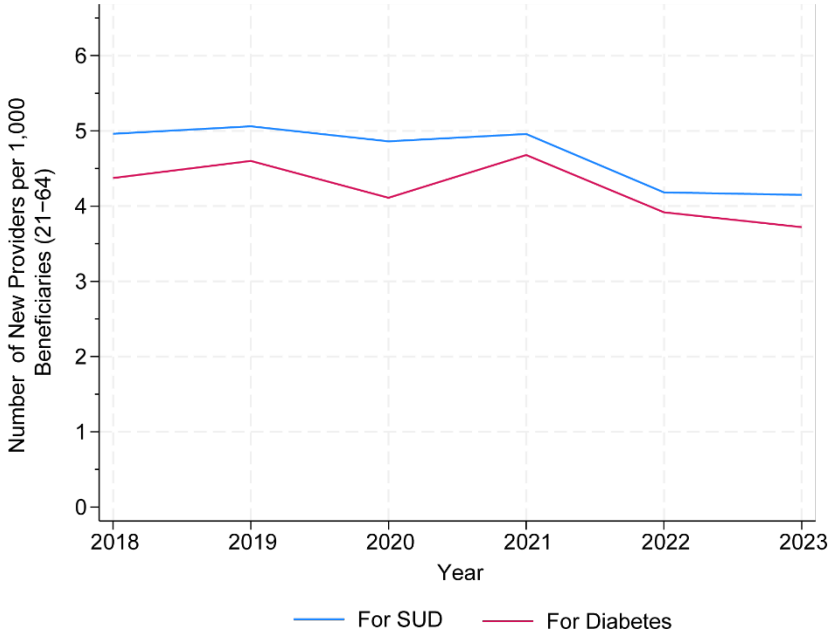
	Model I	Model II	Model III
Panel A Models Exclude 2020			
Percentage point difference in Medicaid acceptance	45.90	44.84	31.10
Standard error	2.21	2.60	4.02
p value	<0.001	<0.001	<0.001
Facility characteristics		Y	Y
State characteristics			Y
N facilities	3,862	3,860	3,860
Panel B Models Include 2020			
Percentage point difference in Medicaid acceptance	44.30	42.24	35.56
Standard error	1.95	2.32	3.31
p value	<0.001	<0.001	<0.001
Facility characteristics		Y	Y
State characteristics			Y
N facilities	4,759	4,757	4,757

Notes: The unit of analysis is a facility-year. Models are estimated with ordinary least squares. Standard errors are clustered at the state. Facility characteristics included facility ownership status (for-profit / non-profit or government owned). State characteristics included (age, race, ethnicity, foreign-born, veteran status, education), and policy variables (i.e., the presence of an ACA Medicaid expansion and the presence of a prescription drug monitoring program).

Figure 4.3 shows the trend in the number of providers per 1,000 members in the Medicaid cohort that newly delivered a SUD- or diabetes-related service by year, from 2018–2023. The trends deviated from one another in 2019.

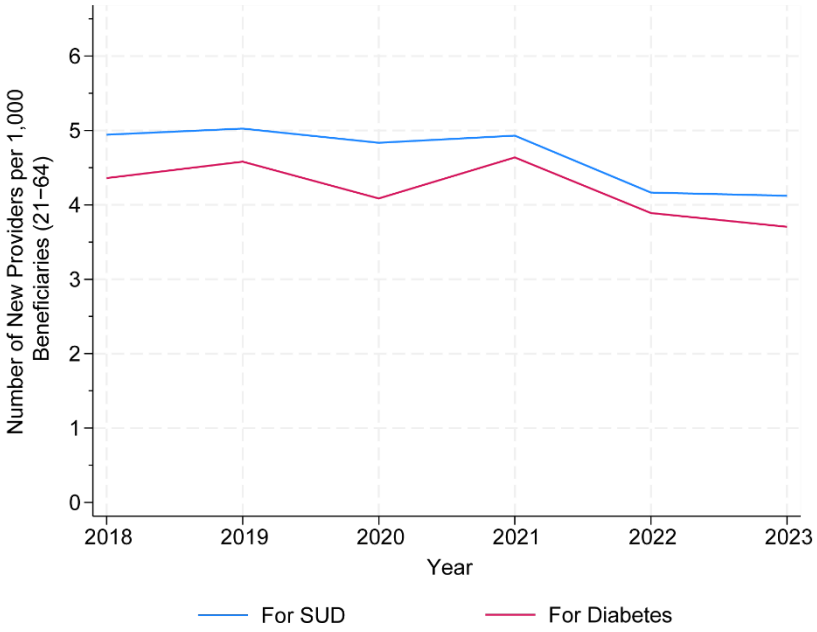
Figures 4.4 and 4.5 show the trends for established and new Medicaid providers respectively. Together these figures illustrate that the established providers were the primary source of newly delivered SUD and diabetes-related services.

Figure 4.3. Total Number of Medicaid Providers Newly Delivering SUD- or Diabetes-Related Service, 2018–2023



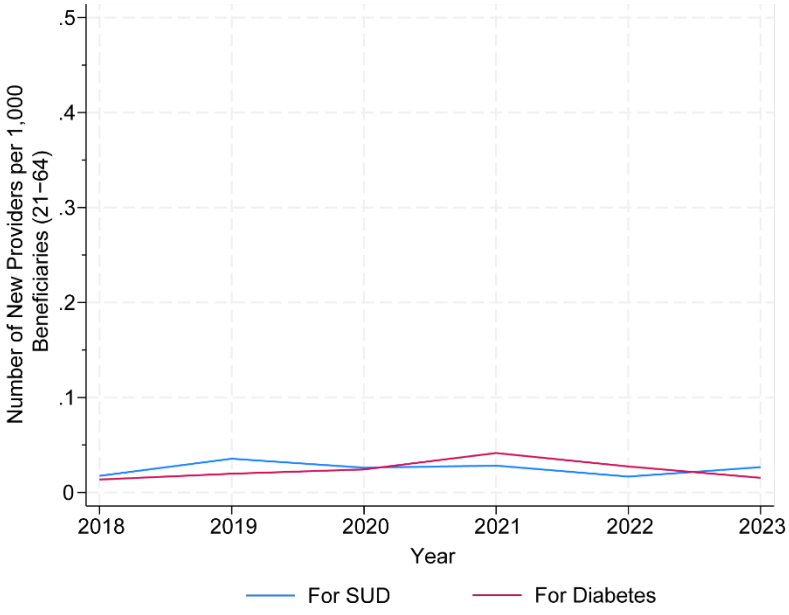
Notes: Authors' calculations using WI Medicaid enrollment and claims data. The total number of Medicaid providers newly delivering SUD- or diabetes-related service includes both established and new providers.

Figure 4.4. Number of Established Medicaid Providers Newly Delivering SUD- or Diabetes-Related Service, 2018–2023



Notes: Authors' calculations using WI Medicaid enrollment and claims data. Established providers are those with claims in the prior year for conditions other than the condition of interest.

Figure 4.5. Number of New Medicaid Providers Delivering SUD- or Diabetes-Related Service, 2018–2023



Notes: Authors' calculations using WI Medicaid enrollment and claims data. New Medicaid providers are those with zero claims in the prior year.

After implementation of the SUD demonstration waiver (2021–2023), the number of providers per 1,000 members newly delivering SUD services declined by an average of -0.58 per 1,000 members per year (95% CI: -0.71, -0.45) (**Table 4.5**). This change amounts to a 12% relative decrease from the average annual rate of 5.01 per 1,000 members during the pre-period (2018–2019). Over the same time frame, the number of providers per 1,000 members newly delivering diabetes services declined by an average of -0.38 per 1,000 members per year (95% CI: -0.53, -0.23), an 8.5% relative decrease from a baseline annual rate of 4.49 per 1,000 members during the pre-period.

After implementation of the SUD demonstration waiver, the rate of providers newly delivering SUD services declined by -0.20 providers per 1,000 members per year relative to providers newly delivering diabetes services (95% CI: -0.41, 0.01, p=0.06). This difference of was not statistically significantly different from zero at the 5% level.

Overall, the residential SUD treatment facility-level analysis is suggestive that more residential treatment facilities accepted Medicaid following introduction of the benefit. The broader provider-level analysis does not suggest increased relative availability of providers of SUD-related services compared to providers of diabetes-related services.

Table 4.5. DiD Results: Comparison of Change in SUD Provider Supply to Change in Diabetes Provider Supply After Implementation of SUD Residential Treatment Benefit

	Average Annual Rate		Average Difference (95% CI)	DiD Estimate (95% CI)	
	Pre Period (2018–2019)	Post Period (2021–2023)	Post - Pre	Unadjusted	Adjusted
Number of providers per 1,000 members per year newly delivering SUD services	5.01	4.43	-0.58	-0.20	-0.20
(Confidence Intervals)			(-0.71, -0.45)	(-0.43, 0.03)	(-0.41, 0.01)
(*p* values)				*p* = 0.09	*p* = 0.06
Number of providers per 1,000 per members per year newly delivering diabetes service	4.49	4.11	-0.38		
(Confidence Intervals)			(-0.53, -0.23)		

Notes: Authors' calculations using Wisconsin Medicaid enrollment and claims data. Providers newly delivering services (SUD or Diabetes) in the year include new providers, those with zero claims in the prior year and established providers, those with claims in the prior year for conditions other than the condition of interest. Adjusted regression models included the proportion of CLA members among the Medicaid cohort in the year.

Question 4.2. Does the SUD demonstration waiver increase access to, and use of, newly covered SUD services for Medicaid enrollees?

Hypothesis 4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time.

In this descriptive analysis, we compared awareness of the new residential treatment benefit among respondents before and after implementation of the benefit using the 2020 and 2024 Medicaid Beneficiary Surveys. The benefit awareness question is posed only to individuals with self-reported problematic substance use (henceforth "SUD" sample).

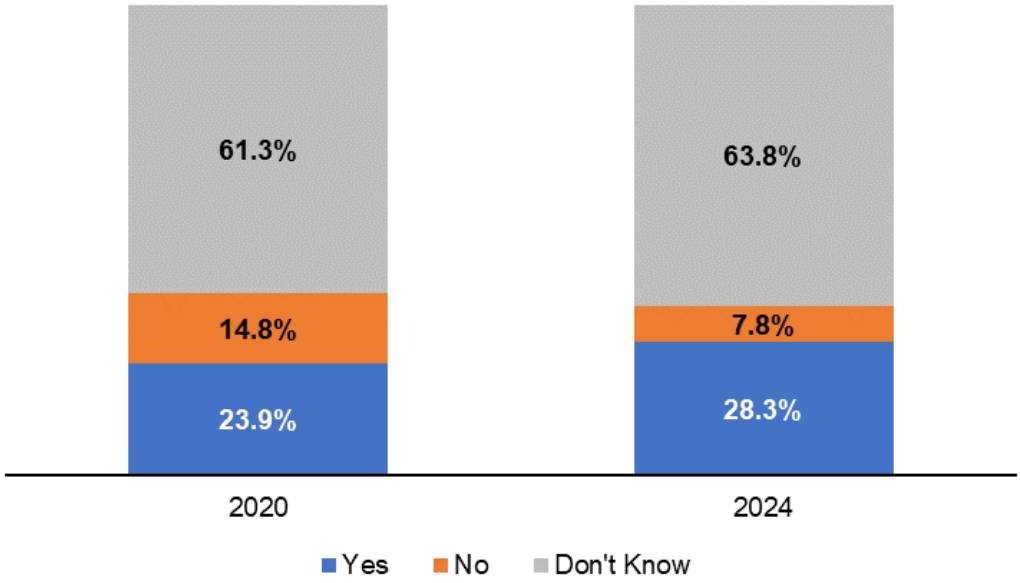
Table 4.6 provides a comparison of the characteristics of the SUD samples from the 2020 and 2024 surveys. Gender, income, and ethnicity distributions within the samples were similar across survey years. In 2024, the age distribution shifted upward relative to 2020. The racial distribution of respondents differed between the survey years, primarily concentrated in the "other" category which increased from 9.9% in 2020 to 17.7% in 2024.

Table 4.6. Characteristics of Medicaid Beneficiary Respondents: SUD Sample, 2020 and 2024

Survey Year	2020 N=529 %	2024 N=307 %	*p* value
Gender			
Male	58.4%	58.2%	0.986
Female	39.7%	40.1%	
Other	1.9%	1.8%	
Age			
18–29	29.2%	16.1%	0.001
30–39	25.9%	29.5%	
40–49	15.3%	26.3%	
50–59	19.9%	17.3%	
60–64	8.5%	10.1%	
Age 65 or older	1.2%	0.6%	
Ethnicity-Hispanic			
Yes	12.2%	11.5%	0.877
No	87.8%	88.5%	
Race			
White	62.4%	59.4%	0.031
Black	19.6%	14.7%	
Asian	0.7%	2.6%	
Native American	5.4%	5.3%	
Native Hawaiian	2.0%	0.2%	
Other	9.9%	17.7%	
Income			
Less than $4,999	32.8%	34.9%	0.193
$5,000–$14,999	36.9%	28.1%	
$15,000–$29,999	21.6%	24.6%	
$30,000 or more	8.7%	12.3%	
Current Living Situation			
Alone	29.5%	24.0%	0.151
Partner or spouse	17.7%	25.3%	0.060
Parents	15.2%	13.6%	0.623
Relatives	18.9%	14.1%	0.170
Friends or roommates	12.4%	8.6%	0.142
Other situation	14.6%	14.0%	0.862
Any Children Under 19			
Yes	28.9%	23.7%	0.221
No	71.1%	76.3%	

Survey participants in the SUD sample were asked if their health insurance plan covered residential treatment for alcohol or drugs. As shown in **Figure 4.6**, in both 2020 and 2024 over 60% of participants responded "Don't Know." The percentage that responded affirmatively increased 4.4 percentage points, from 23.9% in 2020 to 28.3% in 2024 (p = 0.05).

Figure 4.6. Does Your Insurance Plan Cover Residential Treatment for Alcohol or Drugs?



Hypothesis 4.2b. The SUD demonstration waiver will increase use of SUD treatment in IMD settings.

To test the effect of the SUD demonstration waiver on the use of SUD treatment in IMD settings, we used the TEDS-A and a DiD design to compare the change in residential treatment for substance use in Wisconsin and a comparison group of states after implementation of the benefit relative to the prior period. TEDS is the only publicly available dataset that allows cross-state comparisons of the use of specialty SUD treatment. Additionally, we conducted descriptive analysis using the Medicaid cohort to summarize the trend in the number of unique members who received residential SUD treatment in Wisconsin since February 2021.

Table 4.7 presents a comparison of the outcomes and state-level characteristics for Wisconsin and the comparison group states during the pre-period of the analysis, 2017–2019. The rate of admissions to residential SUD treatment facilities in Wisconsin during the pre-period was 68.21 per 100,000 adults ages 21–64 compared to 187.87 admissions per 100,000 adults 21–64 in the comparison states. These admissions include all payer sources. In Wisconsin, 12.77 admissions to an SUD treatment facility per 100,000 adults included MOUD as part of the treatment plan. That rate was 78.86 admissions per 100,000 adults in comparison states. The baseline differences in outcomes between Wisconsin and comparison states were statistically significant at the 1% threshold.

Table 4.7. Rate of Admissions to Residential Treatment and State-Level Characteristics for Wisconsin and Comparison States, 2017–2019

	Wisconsin Pre (2017–2019)	Comparison Group Pre (2017–2019)	*p* value
Outcomes			
Rate of admissions to residential treatment per 100,000 adults ages 21–64 in the state-year	68.21	187.87	<0.001
Rate of admissions in which MOUD was part of treatment plan per 100,000 adults ages 21–64 in the state-year	12.77	78.86	0.001
State-Characteristics			
Mean age	39.4	38.8	0.003
Male, %	50.1	49.1	<0.001
Race and Ethnicity, %			
White	87.6	75.2	<0.001
Black	6.2	13.1	<0.001
Other	6.0	11.6	0.016
Hispanic	6.8	13.1	0.001
Foreign birth, %	5.4	11.2	<0.001
Veteran, %	6.6	6.6	0.894
Educational attainment, %			
Less than high school	10.7	11.7	0.115
High school education	25.6	23.5	0.121
Some college but no degree	13.8	14.5	0.275
College/university degree	32.0	31.1	0.408

Notes: Admissions to specialty SUD treatment facilities in the 19 study states were aggregated to state-year observations. The comparison states includes all states that submitted data to TEDS-A that had no IMD waiver in effects during 2017–21 including states with or without pending waiver which include AL, AZ, AR, CT, FL, GA, HI, IA, MS, MO, MT, NV, NY, ND, SC, SD, TX, WY. In 2020, ND did not submit data to TEDS.

Figures 4.7 and 4.8 illustrate the unadjusted annual trends in the outcomes. The two study groups experienced stable, parallel trends in the rate of admissions to residential treatment facilities before onset of the PHE in 2020, the pre-implementation period. The trends in admissions in which MOUD was part of the treatment plan followed different patterns during pre-implementation. These differential trends in the latter outcome reduce confidence in the validity of DiD analysis. For both outcomes, some limitations apply: first, continuous coverage was implemented in March 2020 resulting in an alteration of the size and composition of the Medicaid cohort as shown previously in **Figure 4.1**; second, COVID itself may have impacted the two groups and their outcomes differentially. For these reasons, we suggest caution in interpreting the results causally.

Figure 4.7. Rate of Admission to Residential SUD Treatment Facilities per 100,000 Non-Elderly Adults in Wisconsin and Comparison States

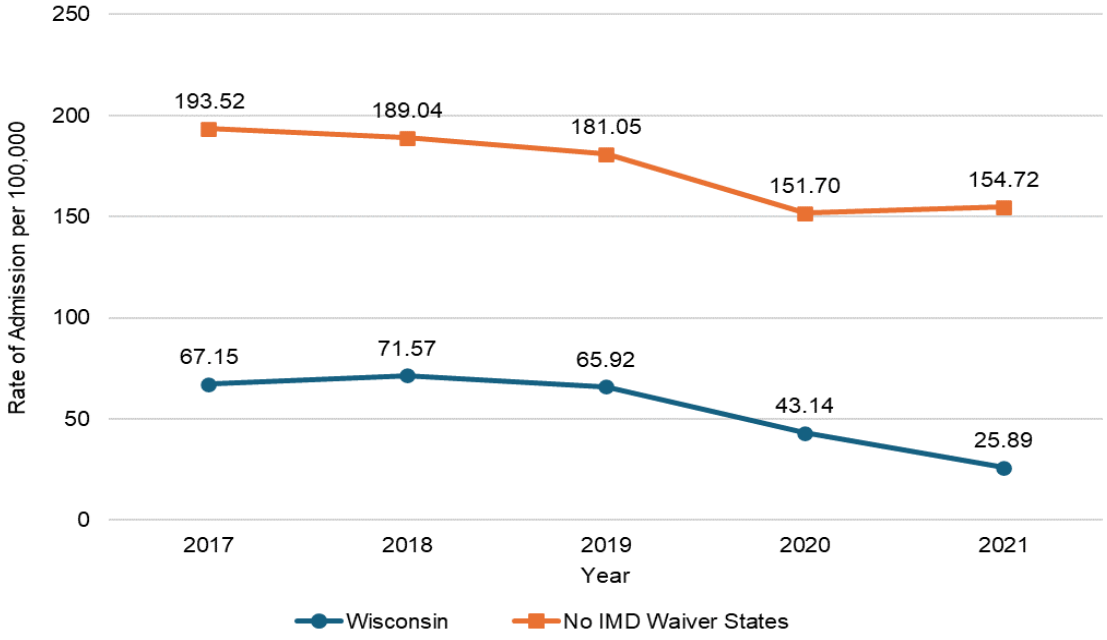
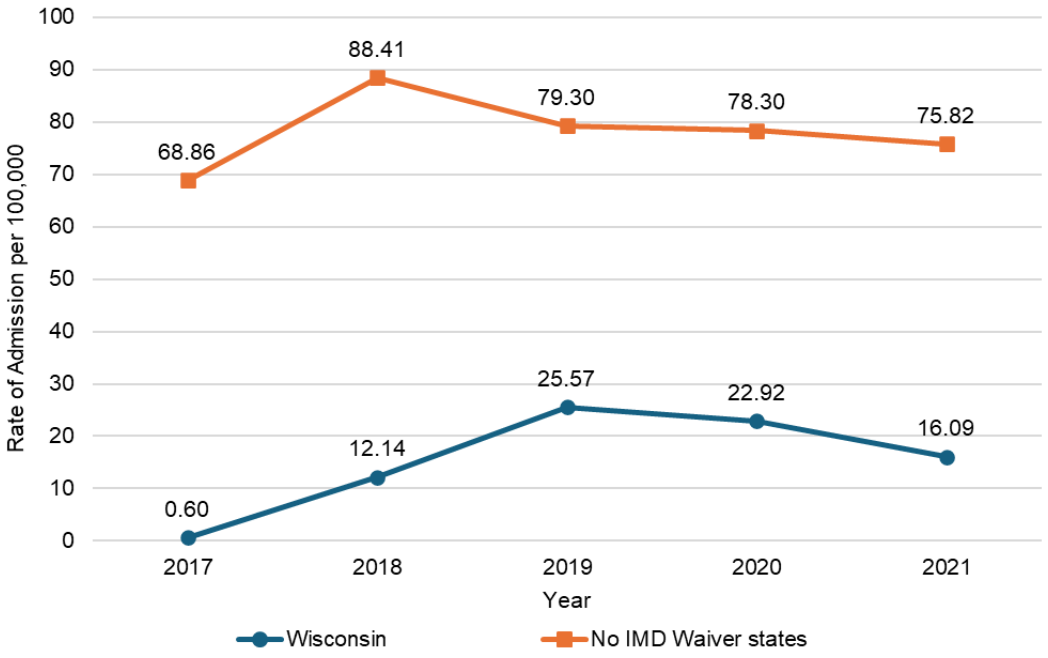


Figure 4.8. Rate of Admission to SUD Treatment Facilities in Which MOUD Was Part of the Treatment Plan per 100,000 Non-Elderly Adults in Wisconsin and Comparison States



The DiD regression results are presented in **Table 4.8**. Model I shows results from the preferred model specification which included the control variables described in **Table 4.7**, a pre-period of 2017–2019 and a post-period of 2021. The point estimate indicates an increase of 12.38 admissions to residential treatment per 100,000 adults in Wisconsin relative to the comparison states that lacked an SUD residential treatment waiver, but it is not statistically different from zero (*p* value = 0.73). The rate of admissions in which MOUD was part of the treatment plan was -25.87 per 100,000 adults in Wisconsin relative to the comparison states; it was also not statistically significantly different from zero (*p* value = 0.40). Regression results that included 2020 in the pre-period (Model II) are shown for completeness.

Table 4.8. A Comparison of the Change in the Rate of Residential SUD Treatment Admissions in Wisconsin Relative to States without an IMD Waiver, 2017–2021

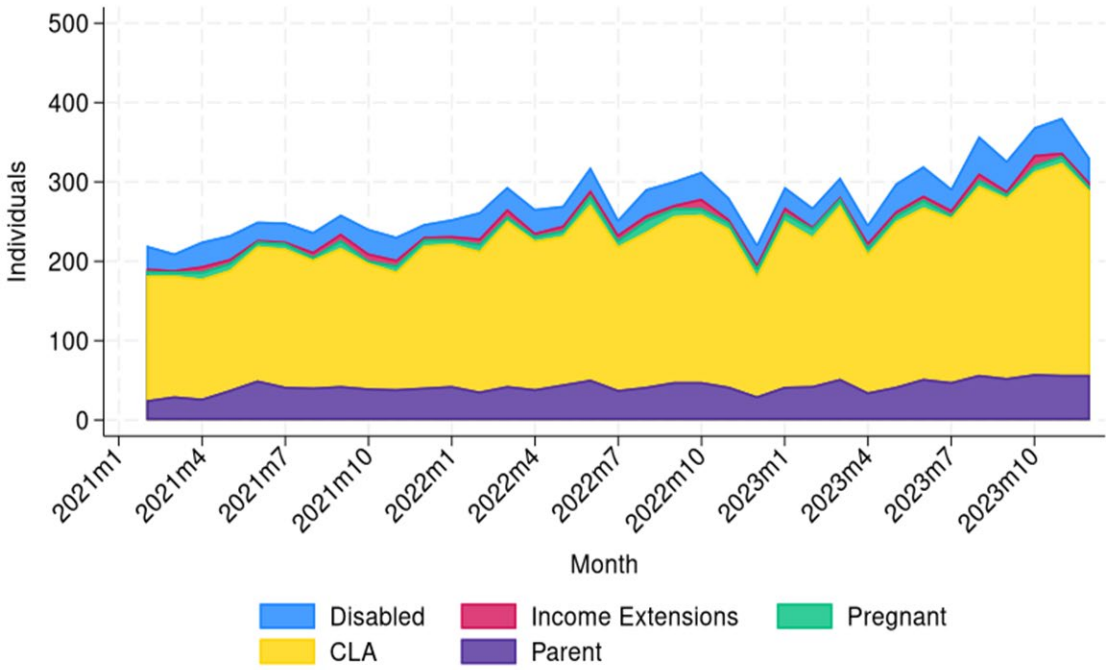
Outcome	Model I	Model II
Rate of Admissions to Residential Treatment per 100,000 Ages 21–64	12.38	-10.07
Standard error	35.81	35.42
p value	0.73	0.78
Rate of Admissions in Which MOUD Was Part of Treatment Plan per 100,000 Ages 21–64	-25.87	-25.17
Standard error	30.27	24.85
p value	0.40	0.32
N States	19	19
Control Variables	Y	Y
CY 2020 Removed (i.e., pandemic period)	Y	

Note: The unit of analysis is a state-year. DiD models are estimated with ordinary least squares with standard errors clustered at state-level. Control variables include state-year variables shown in Table 4.7. The post-period is 2021 in all models. The treatment group is Wisconsin. The comparison group includes all states that submitted data to TEDS-A that had no IMD waiver in effects during 2017–21, AL, AZ, AR, CT, FL, GA, HI, IA, MS, MO, MT, NV, NY, ND, SC, SD, TX, WY. In 2020, ND did not submit data to TEDS.

Figure 4.9 provides a within-state summary of growth in residential SUD treatment from 2021–2023 among the Medicaid cohort. The number of unique members who received treatment grew abruptly from zero in January 2021 to 235 individuals in February 2021. In the last month of the waiver, December 2023, a total of 348 unique members received residential SUD treatment. Throughout the waiver period, CLA members were the predominant recipients of residential SUD treatment.

Overall, claims for the residential SUD treatment benefit among Wisconsin Medicaid members increased after the introduction of the new benefit (**Figure 4.9**). This increase may reflect a net increase in the use of residential SUD treatment among Medicaid members or a change in payer source for Medicaid members' residential SUD treatment use (e.g., from self-pay, CCS, charity care, etc.). The imprecise null finding from the comparison of residential SUD treatment use in Wisconsin to states without an SUD IMD Medicaid waiver (**Table 4.8**) does not provide sufficient information to distinguish between these two possibilities.

Figure 4.9. Number of Medicaid Members Who Received Residential SUD Treatment by Eligibility Group, 2021–2023



Hypothesis 4.2c. The SUD demonstration waiver will increase initiation and engagement in SUD treatment.

Using a DiD approach and the state's voluntary multi-payer claims database (WHIO), we compared the likelihood of initiation and of engagement in SUD treatment after the benefit's implementation relative to the prior period among Medicaid members and commercially insured adults in the state. The population for this analysis is summarized in **Table 4.2**.

Initiation and engagement were assessed among index episodes with an SUD diagnosis. Index episodes are described in **Table 4.9** for the Medicaid and commercially insured adult populations from the WHIO. In both Medicaid and commercially insured populations, the minority of index episodes occurred among women, and among adults aged 49 and older. Treatment initiation among Medicaid members ranged from 17.9% to 22% during the study period; for engagement the range was 5.4% to 8.3%. In the commercially insured population, treatment initiation ranged from a low of 21.1% to a high of 29%; for engagement the range was 10% to 13.4%.

Table 4.9. Description of Index Episodes With an SUD Diagnosis for Medicaid and Commercially-Insured Members, 2017–2023

	2017	2018	2019	2020	2021	2022	2023
WHIO- Medicaid Members							
Number of index episodes, N	7,338	8,339	8,046	7,705	9,097	9,175	9,039
Female	43.3%	43.1%	41.6%	41.8%	39.4%	38.7%	39.4%
21–34	42.2%	41.9%	41.6%	42.2%	41.9%	39.5%	37.8%
35–49	35.6%	36.6%	36.4%	37.4%	38.0%	39.6%	40.8%
>49	22.2%	21.4%	22.0%	20.4%	20.1%	20.9%	21.4%
OUD at Index Episode	24.2%	22.5%	17.2%	16.6%	14.4%	14.5%	12.3%
Treatment initiation w/in 14 days of index	20.7%	21.2%	22.0%	21.9%	19.9%	17.9%	19.3%
Engagement w/in 30 days of initiation	6.4%	7.4%	8.3%	6.8%	6.0%	5.4%	6.5%
WHIO- Commercially Insured							
Number of index episodes, N	1,140	1,498	2,321	2,062	2,275	2,234	2,009
Female	36.3%	34.2%	34.4%	31.8%	33.5%	32.6%	33.2%
21–34	41.7%	44.3%	41.6%	38.4%	38.8%	36.8%	37.1%
35–49	29.5%	29.6%	32.1%	34.8%	33.7%	35.3%	34.5%
>49	28.9%	26.1%	26.2%	26.8%	27.5%	27.9%	28.4%
OUD at Index Episode	12.3%	11.7%	9.3%	7.4%	7.8%	6.2%	5.4%
Treatment initiation w/in 14 days of index	22.8%	21.1%	27.4%	29.0%	26.9%	25.4%	25.7%
Engagement w/in 30 days of initiation	11.4%	10.0%	13.6%	13.4%	12.5%	10.6%	12.1%

Annual trends in initiation and engagement are presented in **Figures 4.10** and **4.11**, respectively. Differential trends in the pre-implementation period, 2017–2019, among commercial enrollees compared to Medicaid members for each outcome reduces confidence in the validity of DiD analysis. Some additional limitations apply to these analyses: first, continuous coverage was implemented in March 2020 resulting in an alteration of the size and composition of the Medicaid cohort as shown previously in **Figure 4.1**; second, COVID itself may have impacted the two groups and their outcomes differentially. We report the results as pre-specified but suggest caution in interpreting them causally.

Figure 4.10. Treatment Initiation for OUD Within 14 Days of Index Episode by Year and Insurance Group

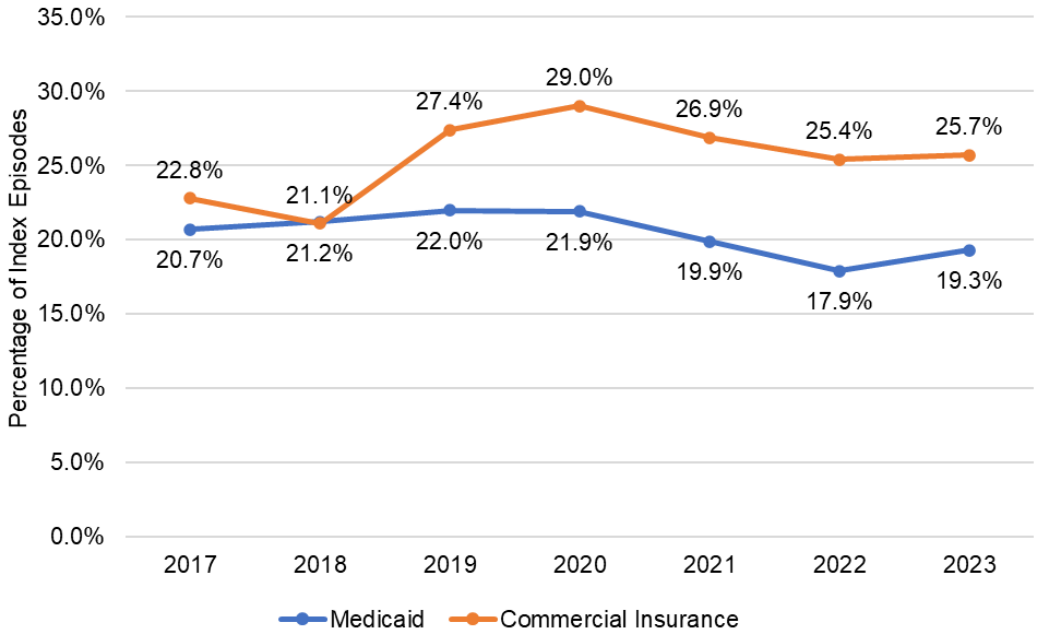


Figure 4.11. Treatment Engagement for OUD Within 30 Days of Treatment Initiation by Year and Insurance Group

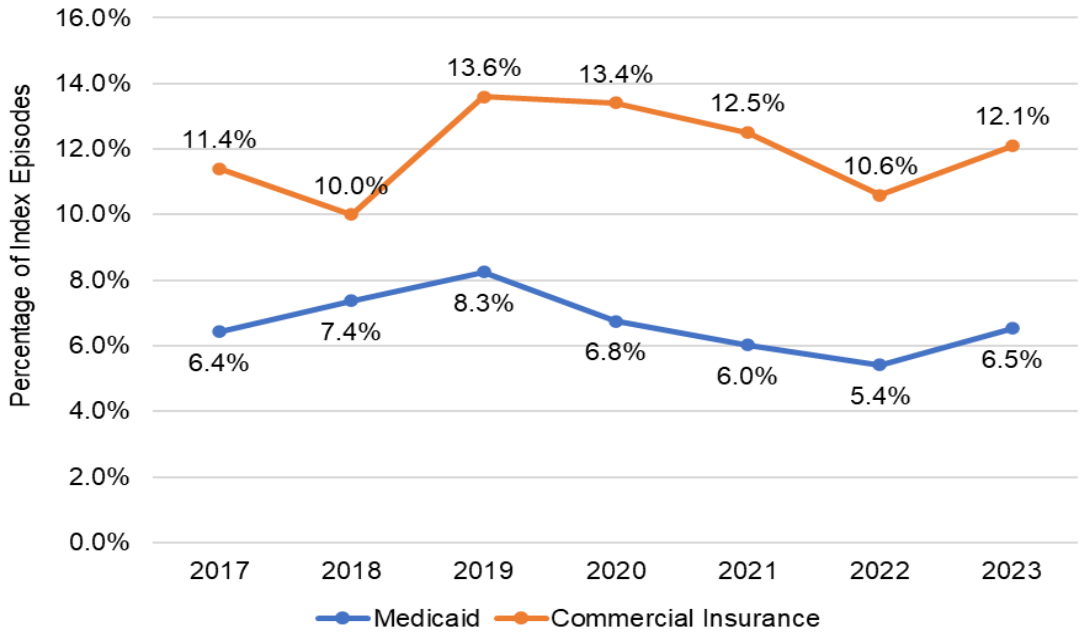


Table 4.10 presents the DiD regression results. Panel A includes treatment initiation results. Results of Model I, in which the pandemic period is excluded from the pre-period, show no evidence of a statistically meaningful change relative to the commercially insured population. Model coefficients are expressed as percentage point differences to facilitate interpretation (i.e., 100 x the regression coefficient), and standard errors have been similarly scaled. There was a 1.1 percentage point decrease in treatment engagement after implementation of the benefit among Medicaid members compared to commercially insured adults. This result was statistically significant at a threshold of 5%. Model II results include the pandemic period within the pre-period and are shown for completeness.

Table 4.10. DiD Results: Difference in the Probability of Initiation and Engagement Among Medicaid Members Compared to Commercially Insured Beneficiaries After Implementation of the SUD Benefit

	Model I	Model II
Panel A Treatment Initiation		
Percentage Point Difference in Treatment Initiation	-4.09	-3.02
Standard error	0.79	0.75
p value	<0.001	<0.001
Controls, age & sex	Y	Y
Exclude pandemic period	Y	
N (index episodes)	72,208	80,751
Panel B Treatment Engagement		
Percentage Point Difference in Treatment Engagement	-1.10	-0.62
Standard error	0.51	0.49
p value	0.032	0.202
Controls, age & sex	Y	Y
Exclude pandemic period	Y	
N (index episodes)	72,208	80,751

Notes: Author's analysis of WHIO data using an ordinary least squares estimator. The pre-period is January 2017–December 2019. The post-period is February 2021–Dec 2023. The unit of analysis is the index episode; *p* value for the test of equivalence between the parameter estimate and zero. Models include calendar month fixed effects.

Overall, awareness of SUD services did increase following implementation. While within-state descriptive analyses demonstrate growth in the number of Medicaid members who received SUD residential treatment, there was not strong evidence of increased overall SUD treatment admissions compared to states without a Medicaid residential SUD treatment benefit. Similarly, there was no evidence of a relative increase in treatment admissions with MOUD as part of the treatment plan relative to the comparison states. There was no evidence of a differential change in the initiation of treatment for SUD for Medicaid members compared to commercially insured beneficiaries while treatment engagement declined.

Question 4.3. Does the SUD demonstration waiver change Medicaid enrollees' use of existing covered SUD services?

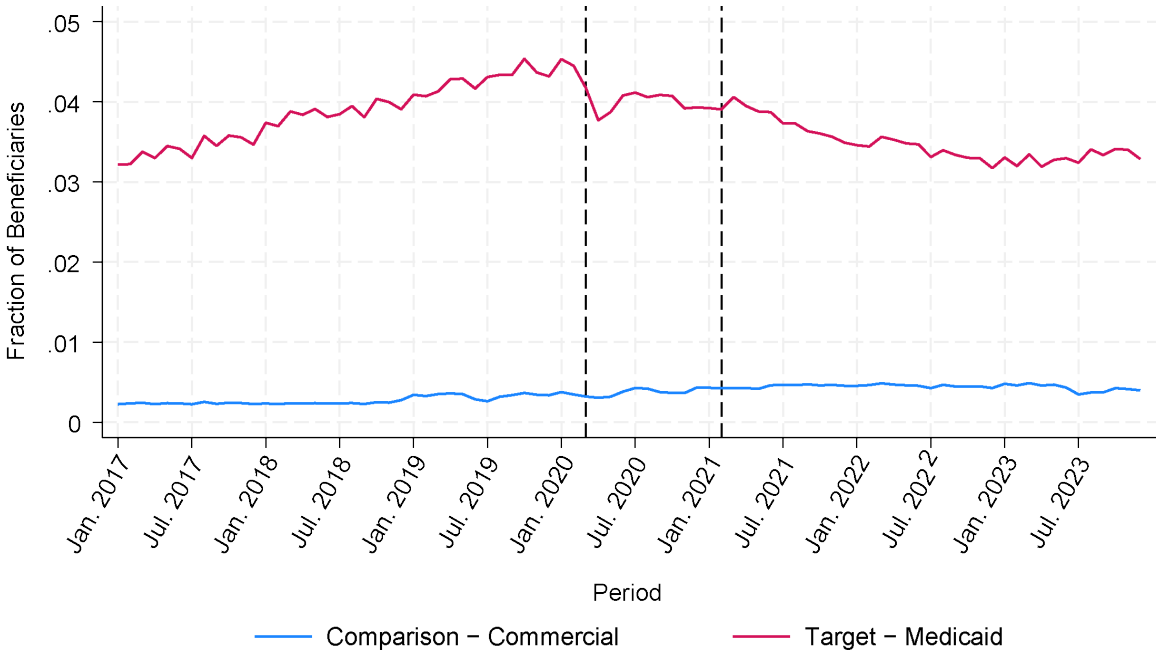
Using a DiD approach and the state's voluntary multi-payer claims database (WHIO), we compared the use of existing covered SUD services after the benefit's implementation relative to the prior period among Medicaid members and commercially insured adults in the state. The population for this analysis is summarized in **Table 4.2**. In descriptive analyses, we compared self-reported treatment for substance use among the SUD sample from the 2020 and 2024 Medicaid Beneficiary Surveys (**Table 4.6**).

Hypothesis 4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services and pharmacotherapy treatment provided outside IMD settings.

Figures 4.12–4.15 illustrate the monthly trends in SUD-related outpatient visits. For each outcome, the fraction of Medicaid and commercial insured adults with any visit in the month is shown as well as the average number of visits in the month. The denominator is the number of adults enrolled in that month within the cohort. **Figure 4.15** plots the monthly trend in the fraction of adults with an OUD diagnosis in the year that received a medication to treat OUD.

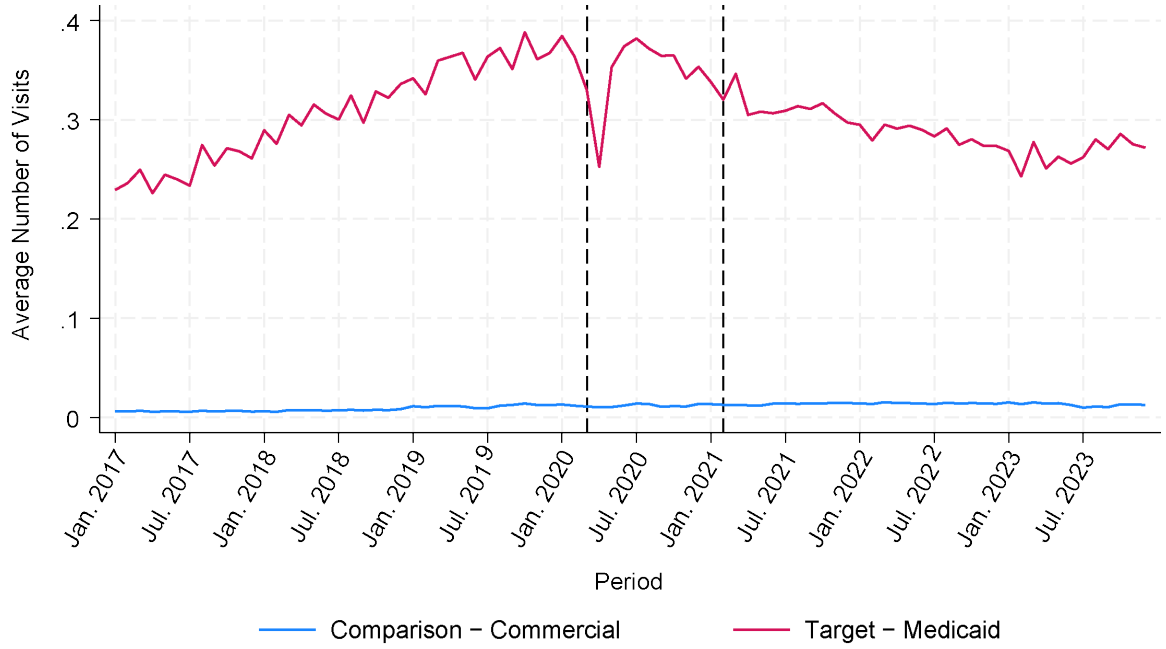
The outpatient visit outcome trends are similar across all outcomes. Specifically, within the Medicaid cohort, the outcome trend is rising until the onset of the PHE at which point it begins a decline that continues through the middle of 2023. Among commercially insured adults, the outcome trend is relatively flat through the entire observation period.

Figure 4.12. Fraction With Any SUD-Related Outpatient Visit in the Month



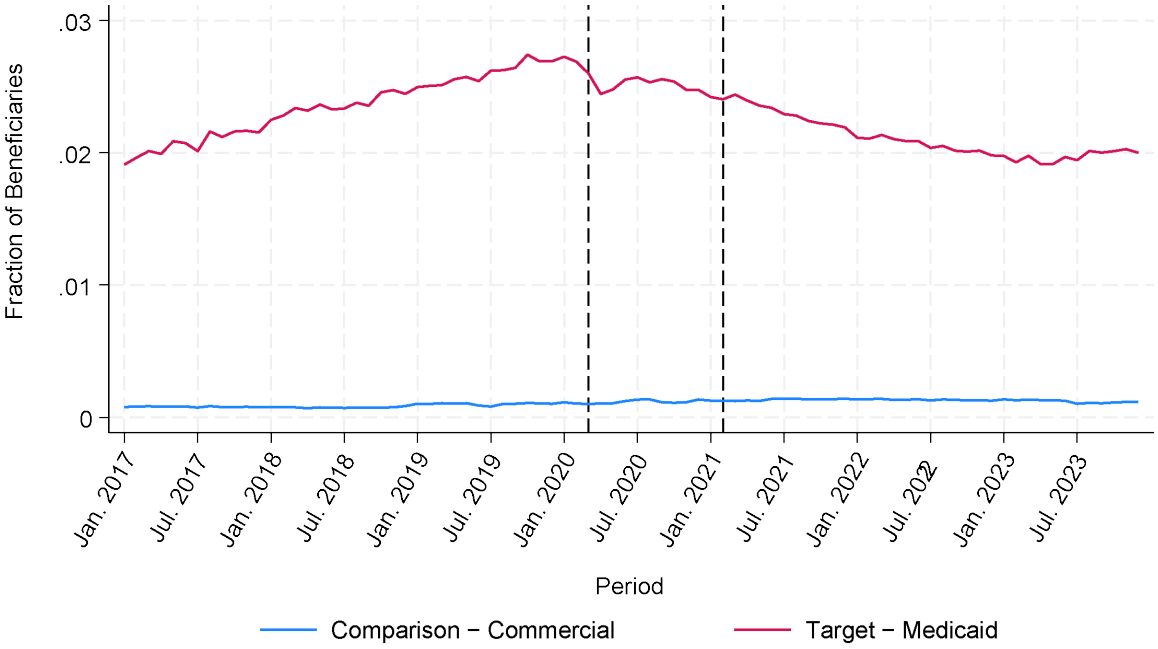
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.13. Average Number of SUD-Related Outpatient Visits per Month



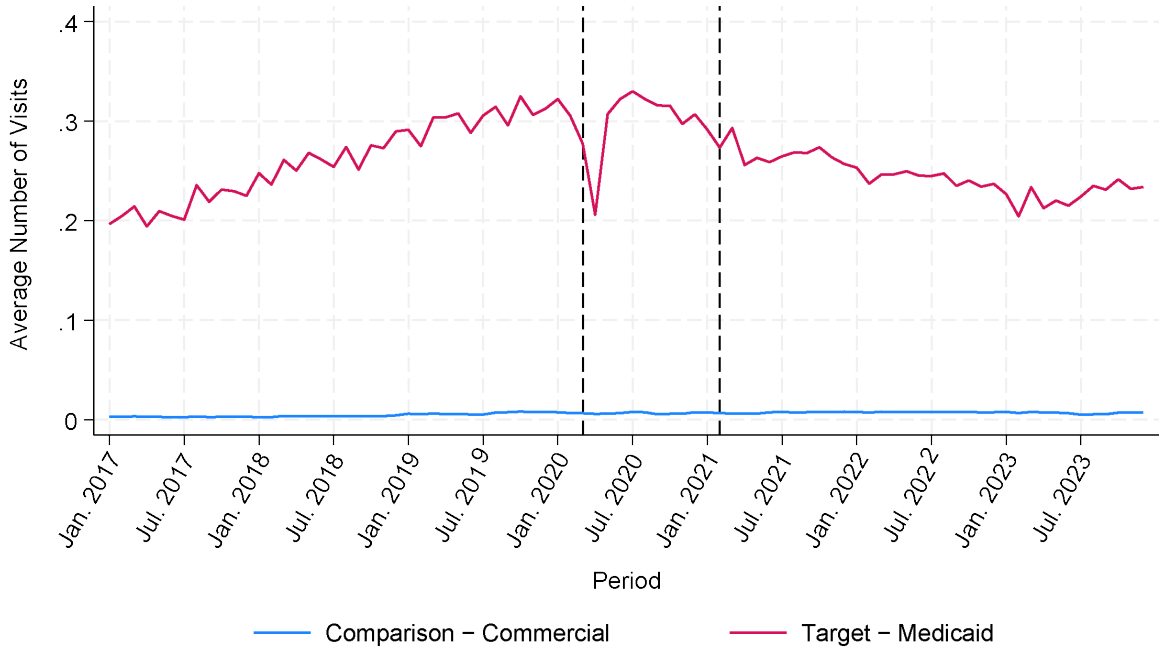
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.14. Fraction With Any OUD-Related Outpatient Visit in the Month



Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

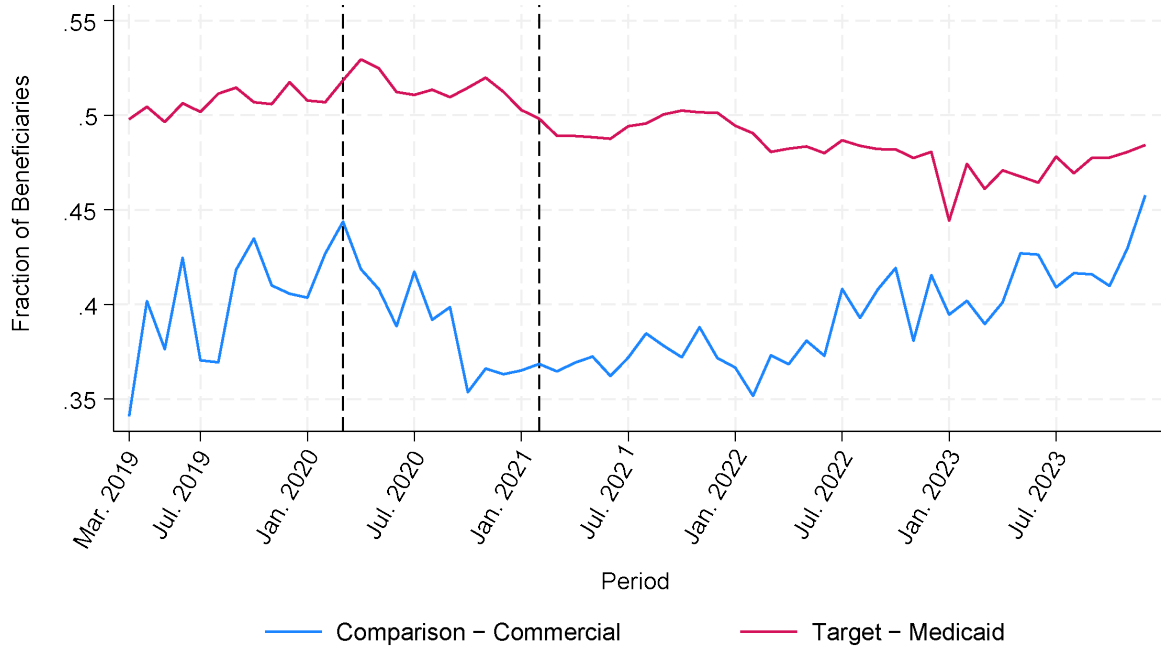
Figure 4.15. Average Number of OUD-Related Outpatient Visits in the Month



Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

The trend in receipt of any OUD medication among members with an OUD diagnosis (**Figure 4.16**) is rising slightly for the Medicaid population before the onset of the PHE and declining through the introduction of the SUD residential treatment benefit until early 2023. Within the commercial beneficiary population, the pre-PHE trend is also rising but more steeply and with greater volatility.

Figure 4.16. Fraction With Any OUD Medication in the Month Among Members With An OUD Diagnosis



Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

The differential trends in the pre-implementation period among commercial enrollees compared to Medicaid members for each of these outcomes reduces confidence in the validity of DiD analysis. Additional limitations apply to these analyses: first, continuous coverage was implemented in March 2020 resulting in an alteration of the size and composition of the Medicaid cohort as shown previously in **Figure 4.1**; second, COVID itself may have impacted the two groups and their outcomes differentially. For these reasons, we suggest caution in interpreting the results causally.

The results of the DiD analysis presented in **Tables 4.11–4.15** compare non-elderly adult Medicaid members to non-elderly adult commercial enrollees before and after the implementation of the SUD residential treatment benefit. Model I excludes the pandemic period, and Model II includes it. Both models include calendar month fixed effects and control for age and sex. For binary outcomes, model coefficients are expressed as percentage point differences to facilitate interpretation (i.e., 100 x the regression coefficient), and standard errors have been similarly scaled. The results of the regression analyses indicate a decline in the likelihood of any SUD- or OUD-related outpatient visit, the average number of those visits, and no statistically meaningful change in the likelihood of any OUD medication in the month among Medicaid members compared to commercial enrollees following the implementation of the residential treatment benefit.

We examined the robustness of the DiD results using alternative specifications including a fixed, continuously enrolled panel of both Medicaid and commercial enrollees, and beginning the pre-period at different times. None of these alternative analyses made a qualitative or major quantitative difference in the results, and for brevity we do not include them in this report.

Table 4.11. DiD Results: Comparing the Change in the Likelihood of Any Outpatient SUD Visit in the Month Between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Percentage point difference in any outpatient SUD visit	-0.65	-0.57
Standard error	0.21	0.11
p value	0.002	<0.001
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.12. DiD Results: Comparing the Change in the Average Number of Outpatient SUD Visits in the Month Between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Difference in average number of SUD outpatient visits	-0.072	-0.086
Standard error	0.025	0.014
p value	0.004	<0.001
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.13. DiD Results: Comparing the Change in the Likelihood of Any Outpatient OUD Visit in the Month Between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Percentage point difference in any OUD outpatient visit	-0.35	-0.42
Standard error	0.13	0.07
p value	0.012	<0.001
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.14. DiD Results: Comparing the Average Number of Outpatient OUD Visits in the Month Between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Difference in average number of OUD outpatient visits	-0.053	-0.076
Standard error	0.020	0.012
p value	0.011	<0.001
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

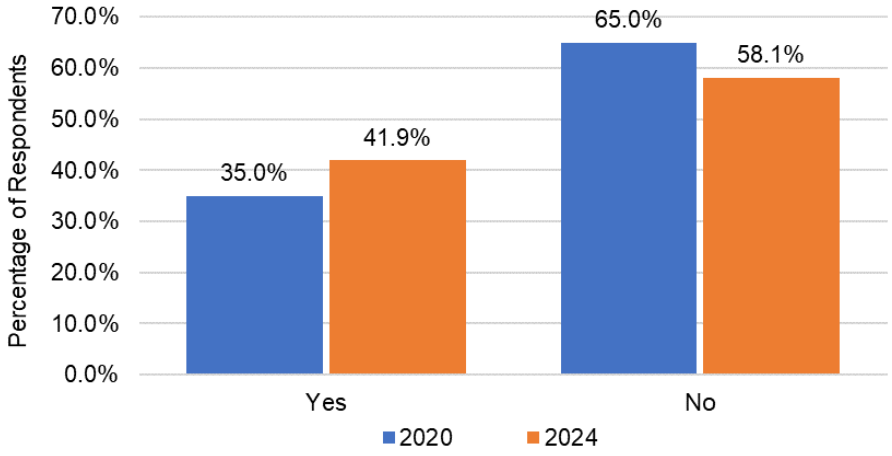
Table 4.15. DiD Results: Comparing the Change in the Likelihood of Any OUD Medication in the Month Between Medicaid and Commercially Insured Adults with An OUD diagnosis, 2019–2023

	Model I	Model II
Percentage point difference in any OUD medication	-0.81	-2.13
Standard error	1.06	0.85
p value	0.444	0.014
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	94	116

In **Figures 4.17–4.18**, we show the percentage of Medicaid Beneficiary Survey respondents that reported interest in obtaining SUD treatment, and among them, the percentage who received it. In 2020 and 2024, 35% and 42% of respondents, respectively, reported that they wanted or needed treatment or counseling for alcohol or drug use ($p = 0.13$). Among those who expressed interest in treatment, 74% received treatment or counseling in both survey years.

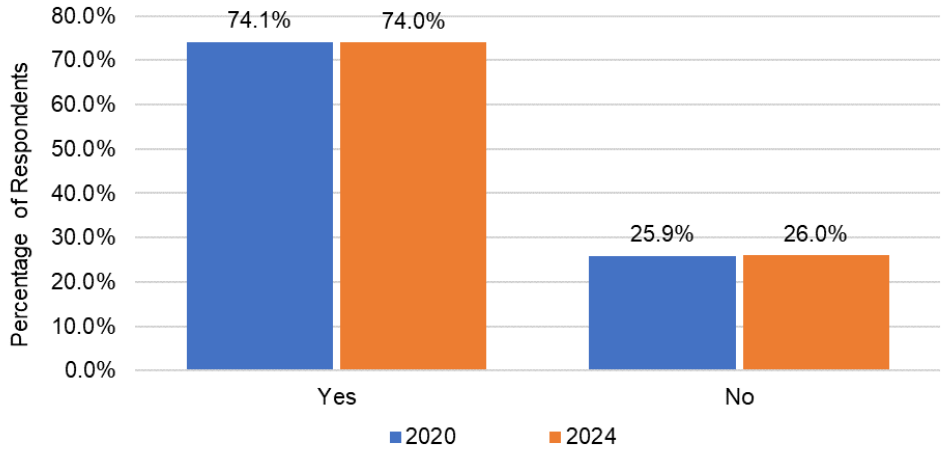
Overall, there was no evidence that SUD outpatient services or use of pharmacotherapy for OUD increased following the implementation of the benefit. There was suggestive evidence of an increase in the percentage of members who reported interest in treatment from 2020 to 2024, and among those with such interest, receipt of treatment was relatively high.

Figure 4.17. Needed or Wanted Treatment or Counseling for Alcohol or Drug Use in the Past 12 Months



Notes: Sample includes Medicaid member respondents who reported problematic substance use in the past 12 months.

Figure 4.18. Received Treatment or Counseling for Alcohol or Drug Use in the Past 12 Months



Notes: Sample includes Medicaid members who reported that they needed or wanted treatment or counseling in the past 12 months.

Hypothesis 4.3b. The SUD demonstration waiver will reduce use of hospital-based SUD services, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

The expected reduction in use of hospital-based SUD services was conditional on an increased supply of SUD providers or use of new and existing services. There was no causal evidence of an increase in supply (H4.1) or increased use of SUD services (H4.2b, H4.2c, H4.3a). Analyses for this hypothesis were completed as pre-specified but without expectation of a reduction in hospital-based SUD services attributable to the SUD waiver provision.

To examine the change in use of hospital-based SUD services after implementation of the residential SUD treatment benefit among Medicaid members relative to commercially insured, we implemented DiD analyses using the WHIO data. We also conducted descriptive analyses to examine change over time in self-reported hospital-based care use among Medicaid Beneficiary Survey respondents.

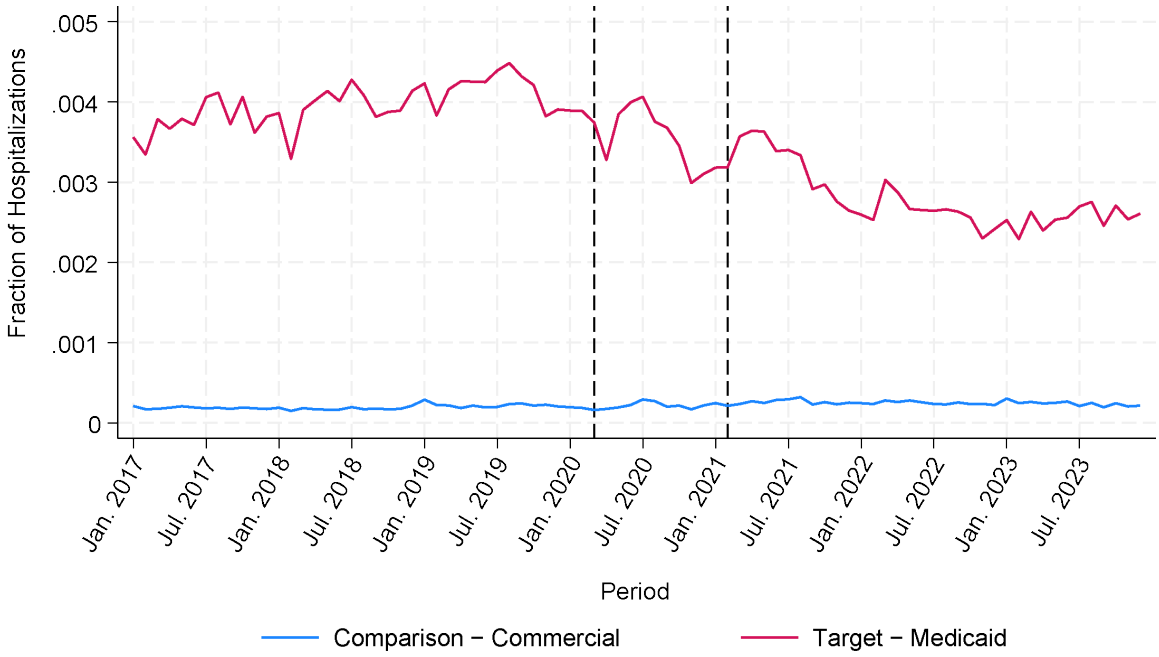
Figures 4.19–4.27 illustrate the monthly trends in hospitalizations and emergency department (ED) visits with any SUD diagnosis and with an OUD diagnosis more specifically. For each outcome, the fraction of Medicaid and commercially insured adults with a hospitalization or ED visit in the month is shown as well as the average number of visits in the month. The denominator is the number of adults enrolled in that month within the cohort. **Figure 4.23** presents the fraction of SUD-hospitalizations in the month that are followed by a readmission within 30-days.

Inpatient admissions for any SUD were infrequent events. The fraction of Medicaid members with an SUD-related hospitalization in the month ranged from approximately 0.002 to 0.004; the fraction of commercially insured with an SUD-related hospitalization in the month was less than 0.001 (**Figure 4.19**). In both populations, the fraction of adults with an OUD-related hospitalization within the month was less than 0.0015. (**Figure 4.21**). The pattern of monthly outcome trends during the pre-period differed between Medicaid members and commercially insured beneficiaries. For Medicaid members, SUD-related hospitalization outcomes initially

trended upward with a decline beginning in mid-2019. OUD-related hospitalizations trended downward throughout the pre-period. These trends were flat for the commercial population. Hospital readmissions within 30-days of an SUD-related hospitalization were stable at approximately 15% for Medicaid members during the pre-implementation period and highly variable for the commercial population.

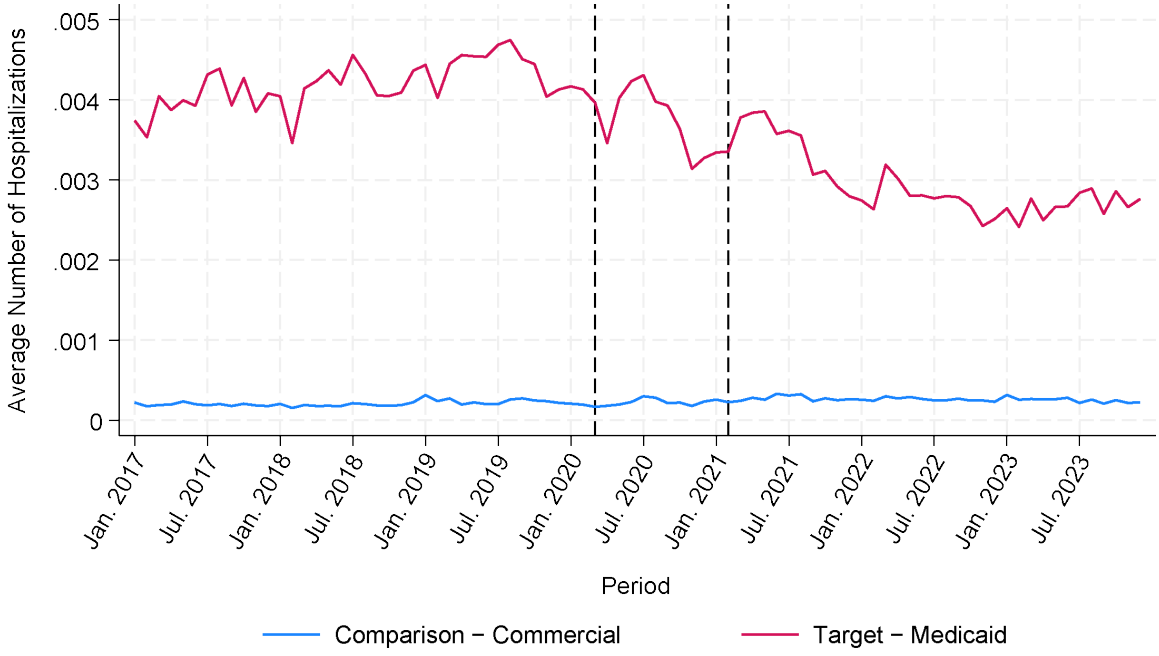
Overall, the differential trends in inpatient outcomes during the pre-implementation period among commercial enrollees compared to Medicaid members reduces confidence in the validity of DiD analysis. Additional limitations apply to these analyses: first, continuous coverage was implemented in March 2020 resulting in an alteration of the size and composition of the Medicaid cohort as shown previously in **Figure 4.1**; second, COVID itself may have impacted the two groups and their outcomes differentially. For these reasons, we suggest caution in interpreting the results causally.

Figure 4.19. Fraction of Cohort with Any SUD-Related Hospitalization in the Month



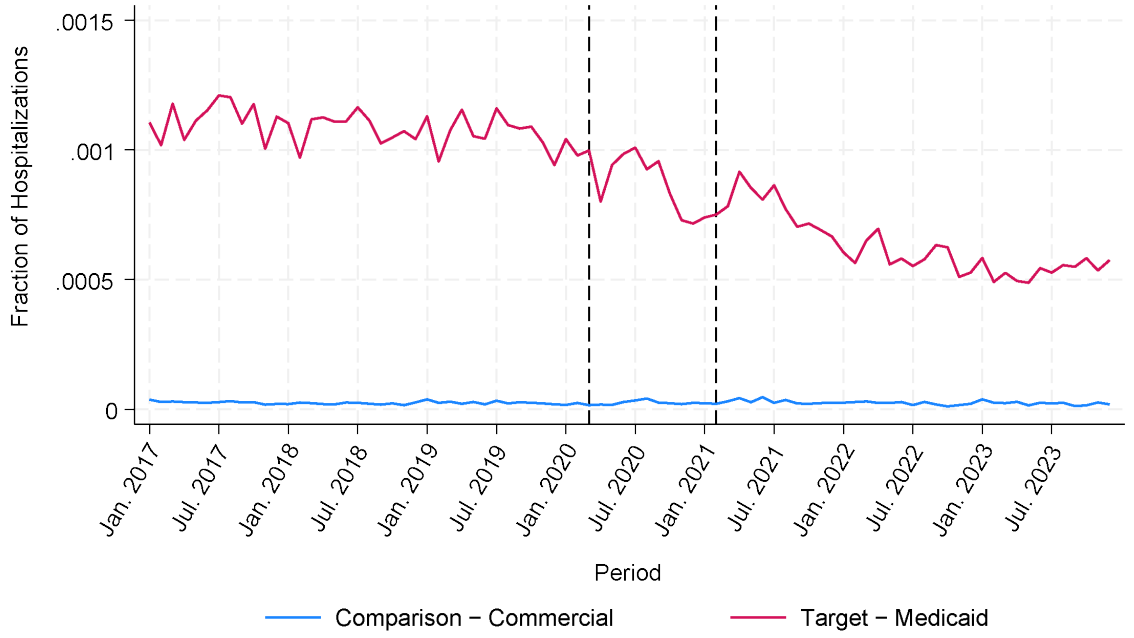
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.20. Average Number of SUD-Related Hospitalizations in the Month



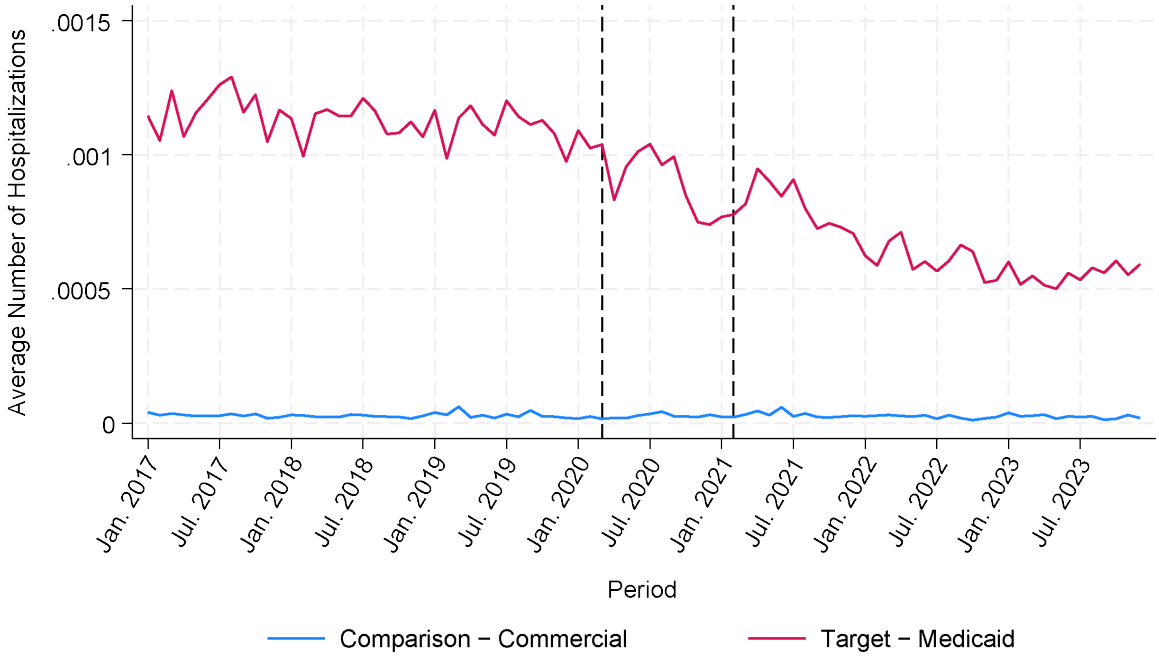
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.21. Fraction of Cohort with Any OUD-Related Hospitalization in the Month



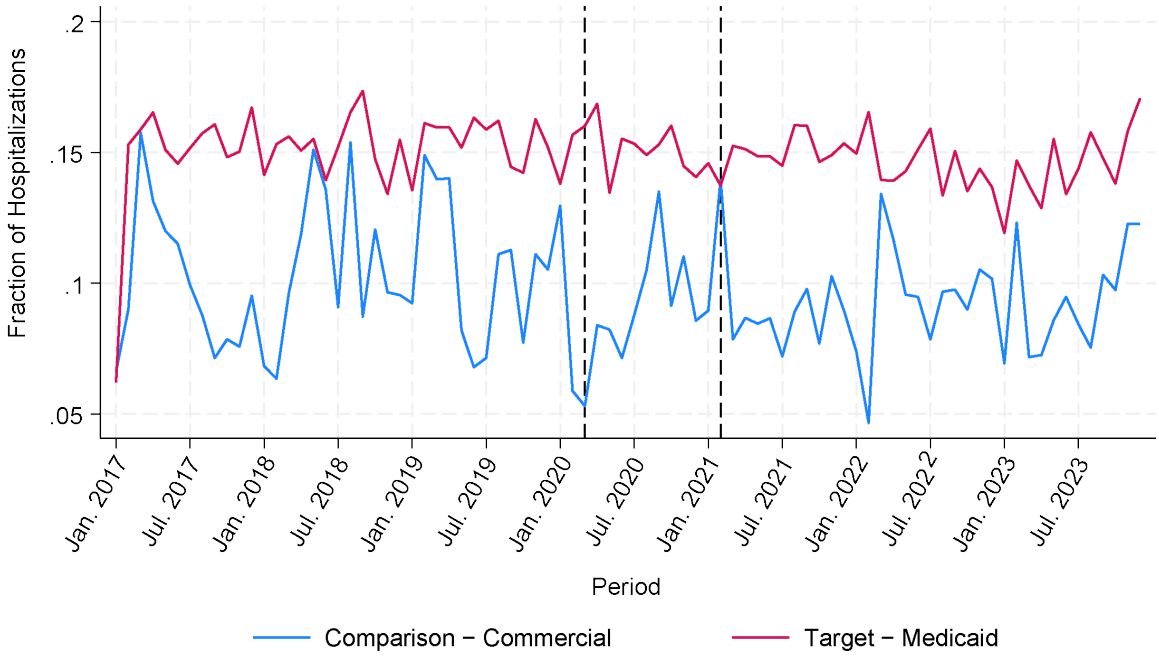
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.22. Average Number of OUD-Related Hospitalizations in the Month



Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.23. Fraction of SUD Hospitalizations with a Readmission within 30-Days



Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Results of the DiD analysis presented in **Tables 4.16–4.21** compare non-elderly adult Medicaid members to non-elderly adult commercial enrollees before and after the implementation of the SUD residential treatment benefit. Model I excludes the pandemic period, and Model II includes it. For binary outcomes, regression results are presented as percentage point differences to facilitate interpretation (i.e., 100 x the regression coefficient), and standard errors have been similarly scaled. There was a -0.02 percentage point relative decrease in the percentage of Medicaid members with an SUD hospitalization in the month for the full cohort (p = 0.419) (**Table 4.16**). As shown in **Table 4.18**, the percentage of Medicaid members with an OUD-related hospitalization in the month increased by 0.006 percentage points relative to the commercially insured (p = 0.23). The fraction of SUD-related hospitalizations followed by a readmission within 30-days was 0.49 percentage points higher after implementation for Medicaid members compared to commercially insured adults (p = 0.524) These results were not statistically different from zero. (**Table 4.20**).

Table 4.16. DiD Results: Comparing the Change in the Likelihood of Any Inpatient SUD Admission in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Percentage point difference in any SUD hospitalization	-0.02	-0.03
Standard error	0.02	0.01
p value	0.419	0.032
Calendar month fixed effects	Y	Y
Controls included	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.17. DiD Results: Comparing the Change in the Average Number of Inpatient SUD Admissions in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Difference in average number of SUD hospitalizations	-0.0002	-0.0003
Standard error	0.0002	0.0001
p value	0.49	0.037
Calendar month fixed effects	Y	Y
Controls included	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.18. DiD Results: Comparing the Change in the Likelihood of Any Inpatient OUD Admission in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Percentage point difference in any OUD hospitalization	0.006	-0.0001
Standard error	0.005	0.003
p value	0.230	0.970
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.19. DiD Results: Comparing the Change in the Average Number of OUD Admissions in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Difference in average number of OUD hospitalizations	0.00008	0.00001
Standard error	0.00005	0.00003
p value	0.127	0.719
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.20. DiD Results: Comparing the Change in the Likelihood of a Hospital Readmission within 30-Days After An SUD Hospitalization between Medicaid And Commercially Insured Adults, 2017–2023

	Model I	Model II
Percentage point difference in any readmission in 30 days	0.49	0.14
Standard error	0.76	0.70
p value	0.524	0.842
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

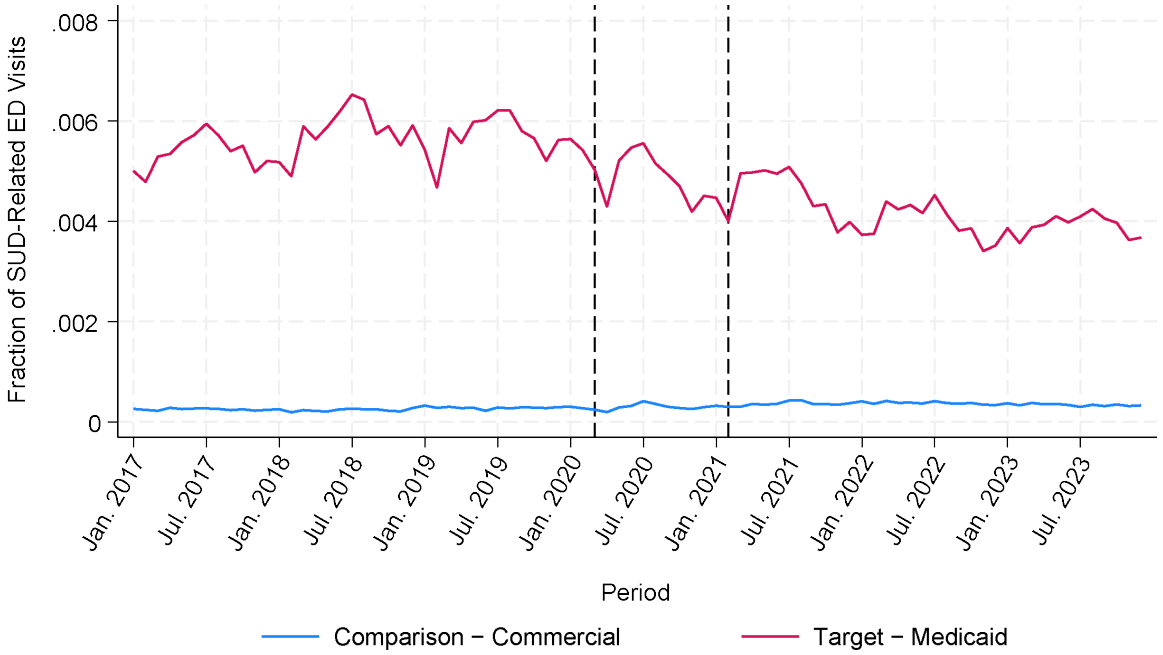
Table 4.21. DiD Results: Comparing the Change in the Average Number of Hospital Readmissions Within 30-Days After an SUD Hospitalization between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Difference in average number of readmissions in 30 days	0.006	0.002
Standard error	0.009	0.008
p value	0.499	0.850
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Monthly trends for SUD- and OUD-related emergency department visits are presented in **Figures 4.24–4.27**. During the pre-period, 2017–2019, the fraction of adults with an SUD-related ED visit in the month was relatively stable within the range of 0.005 to 0.006 for the Medicaid population and less than 0.001 for the commercially insured. These levels declined during the pandemic period and remained lower than the pre-period. The fraction of Medicaid members with an OUD-related ED visit in the month declined from just below 0.001 to approximately 0.0004 over the study period. The trend was flat for the commercially insured throughout the study period.

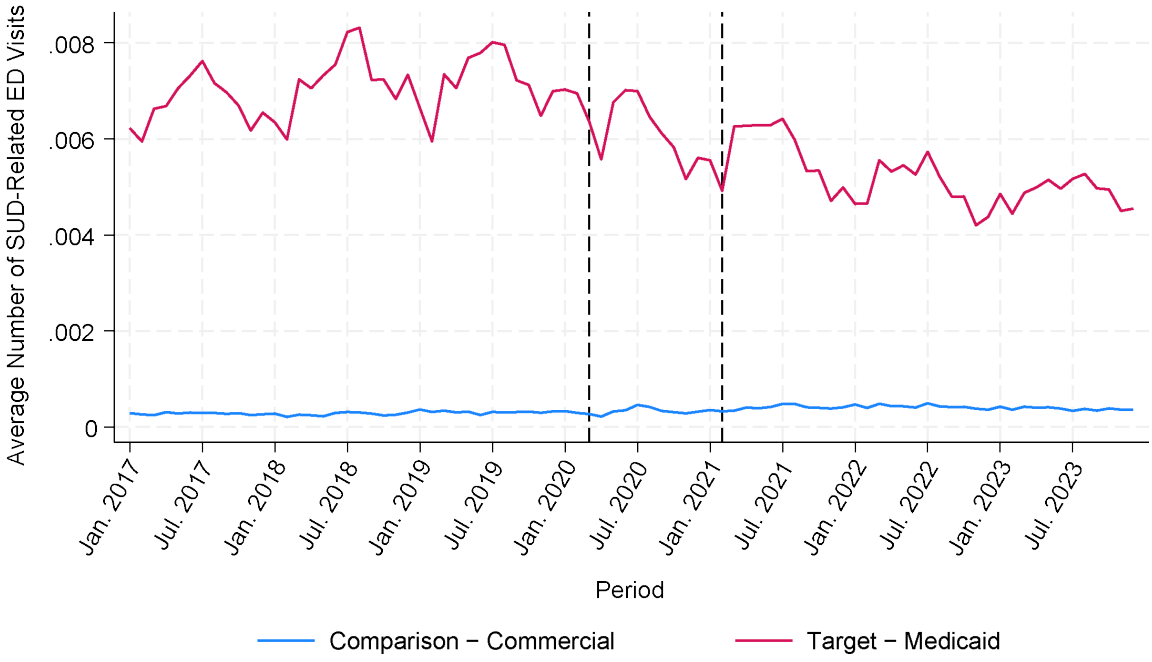
Parallel trends seem to be evident in the pre-implementation period for the two groups for the "any SUD" outcomes. That is not the case for the OUD-related outcomes where the pre-implementation outcome trend among Medicaid members alone is declining (**Figures 4.26–4.27**). Differential pre-implementation trends in this latter outcome reduce confidence in the validity of the DiD design. Additional limitations apply to these analyses: first, continuous coverage was implemented in March 2020 resulting in an alteration of the size and composition of the Medicaid cohort as shown previously in **Figure 4.1**; second, COVID itself may have impacted the two groups and their outcomes differentially. For these reasons, we suggest caution in interpreting the results causally.

Figure 4.24. Fraction of Cohort With an SUD-Related ED Visit in the Month



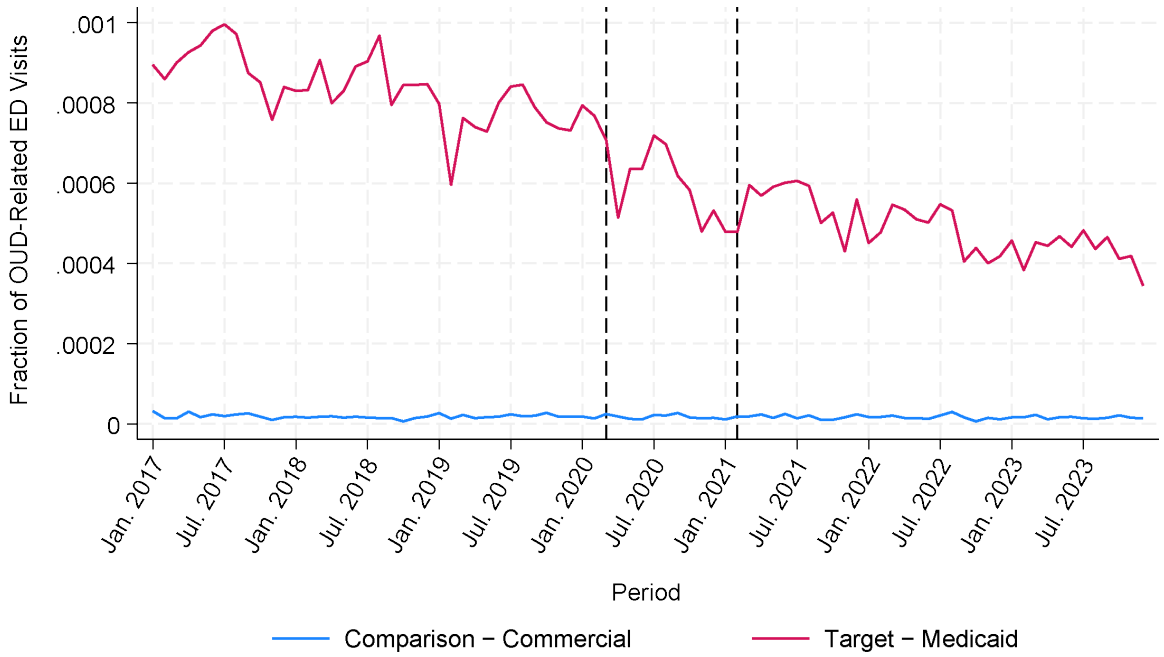
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.25. Average Number of SUD-Related ED Visits in the Month



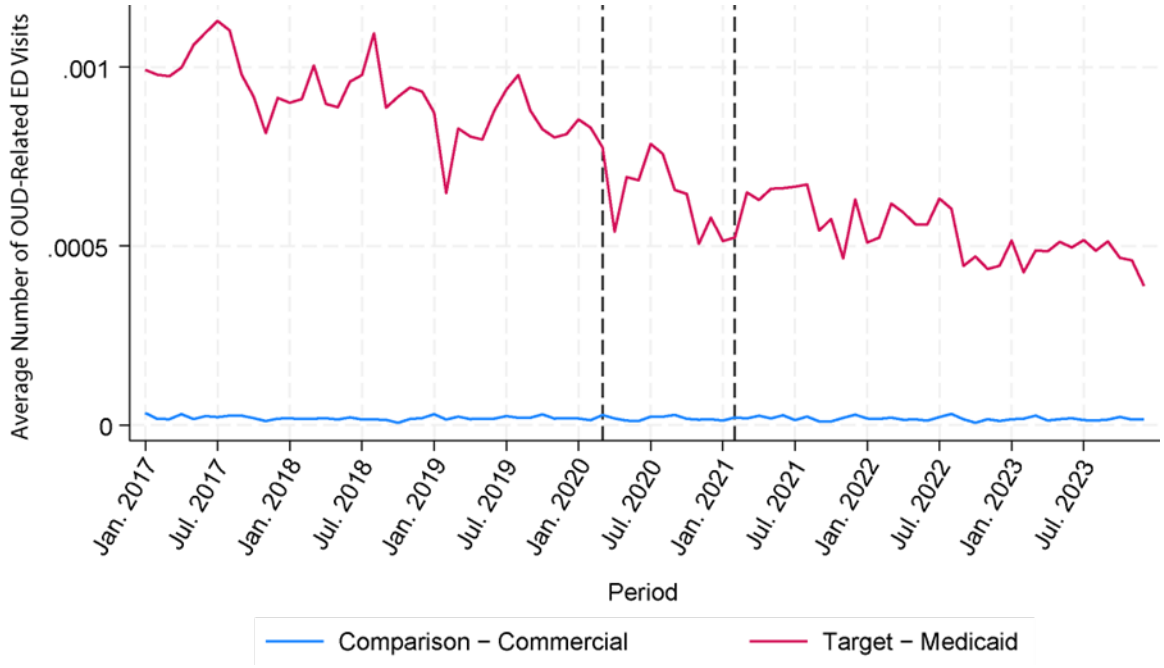
Note: Vertical lines indicate the onset of the PHE in March 2020 and the start date of the SUD provision February 2021.

Figure 4.26. Fraction of Cohort With an OUD-Related ED Visit in the Month



Note: Vertical lines indicate the onset of the PHE in March 2020 and the start date of the SUD provision February 2021.

Figure 4.27. Average Number of OUD-Related ED Visits in the Month



Note: Vertical lines indicate the onset of the PHE in March 2020 and the start date of the SUD provision February 2021.

Compared to commercially insured adults, Medicaid members experienced a 0.06 percentage point relative decline in the likelihood of an SUD-related ED visit (*p* value = 0.064), and a relative reduction in the average number of SUD-related ED visits of -0.0007 (*p* value = 0.078). There was no evidence of a difference in the likelihood of an OUD-related ED visit or the average number of these visits in the month among Medicaid members relative to commercially insured Adults within the full cohort (**Tables 4.22–4.25**). We examined the robustness of the DiD results using alternative specifications including a fixed, continuously enrolled panel of both Medicaid and commercial adults, and beginning the pre-period at different times. None of these alternative analyses made a qualitative or major quantitative difference in the results, and for brevity we do not include them in this report.

Table 4.22. DiD Results: Comparing the Change in the Likelihood of Any ED SUD Visit in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Percentage point difference in any ED SUD visit	-0.06	-0.01
Standard error	0.03	0.02
p value	0.064	0.373
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.23. DiD Results: Comparing the Change in the Average Number of ED SUD Visits in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Difference in average number of ED visits for SUD	-0.0007	-0.0002
Standard error	0.0004	0.0002
p value	0.078	0.427
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.24. DiD Results: Comparing the Change in the Likelihood of Any ED OUD Visit in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Percentage point difference in any ED visit for OUD	-0.002	0.07
Standard error	0.004	0.003
p value	0.728	0.004
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

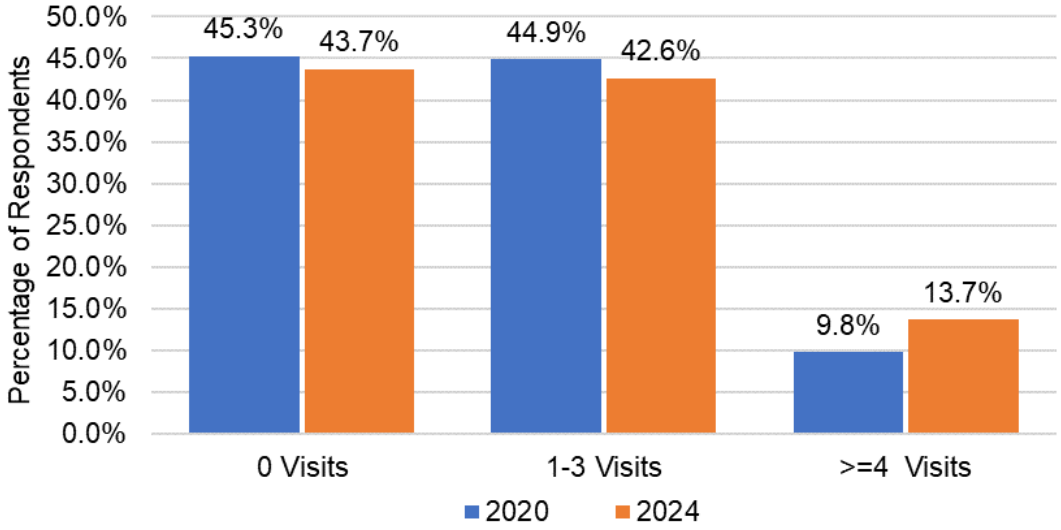
Table 4.25. DiD Results: Comparing the Change in the Average Number of ED OUD Visits in the Month between Medicaid and Commercially Insured Adults, 2017–2023

	Model I	Model II
Difference in average number of ED visits for OUD	-0.000006	0.0001
Standard error	0.00005	0.00003
p value	0.91	0.001
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

In descriptive analyses of the Medicaid Beneficiary Survey respondents who reported problematic substance use (**Figures 4.28–4.29**), there was no evidence of a change in the frequency of ED visits or having had an overnight hospital stay in the last 12 months in 2024 relative to 2020. In 2020, 45.3%, 44.9% and 9.8% reported 0, 1–3 or >=4 ED visits in the last 12 months respectively compared to 43.7%, 42.6%, and 13.7% for the same outcomes in 2024 (p = 0.410). In 2020, 24.8% of respondents reported an overnight stay in the hospital, excluding labor and delivery compared to 22.7% in 2024 (p = 0.599).

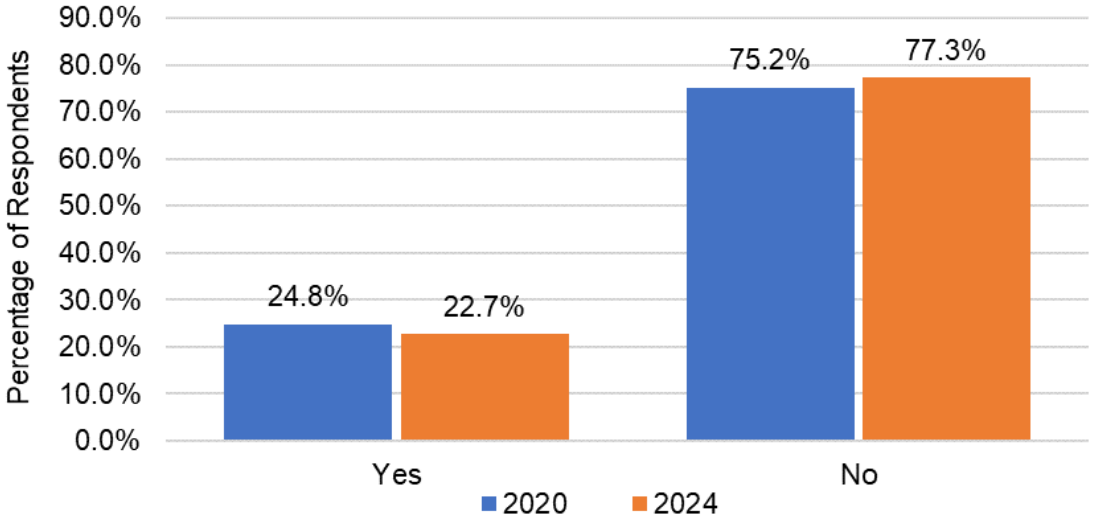
Overall, there was no strong evidence of a differential reduction in SUD-related hospital-based care after implementation of the benefit among Medicaid members relative to commercially insured adults from the claims-based analyses or as reported by Medicaid members in the beneficiary survey.

Figure 4.28. Number of ED Visits Within the Last 12 Months



Note: Sample includes Medicaid member respondents who reported problematic substance use in the past 12 months.

Figure 4.29. Any Overnight Stay in a Hospital in the Last 12 Months, Excluding Labor and Delivery



Note: Sample includes Medicaid member respondents who reported problematic substance use in the past 12 months.

Hypothesis 4.3c. The SUD demonstration waiver will increase access to health care for co-morbid physical and mental health conditions among enrollees with a SUD, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

The expected increase in health care use for comorbidities among members with SUD was conditional on an increased supply of SUD providers or use of new and existing services. There was no causal evidence of an increase in supply (H4.1) or increased use of SUD services (H4.2b, H4.2c, H4.3a). Analyses for this hypothesis were completed as pre-specified but without expectation of an increase in health care for co-morbid conditions attributable to the SUD waiver provision.

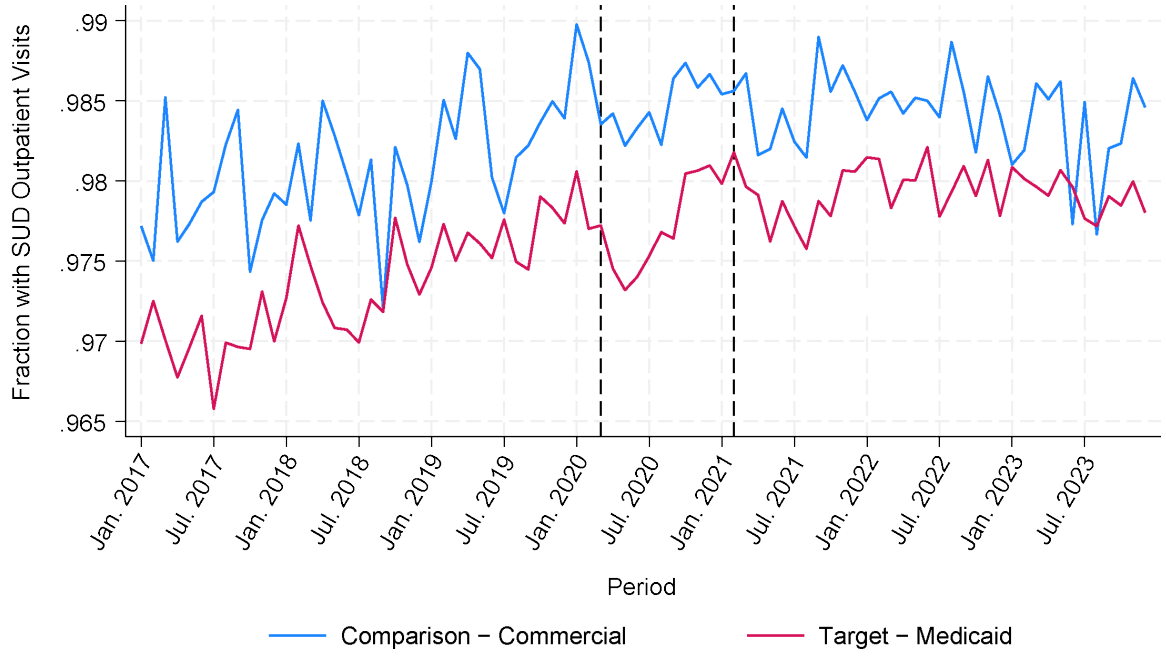
We estimated a DiD analysis using the WHIO data to compare the change in use of health care for co-morbid conditions among Medicaid and commercially insured adults after implementation of the residential treatment benefit. This DiD analysis is limited to a subset of WHIO cohort, those individuals who had a claim from any service category with an SUD diagnosis in the year. Additionally, we implemented a descriptive analysis of Medicaid Beneficiary Survey respondents' access to health care and self-reported health.

Figures 4.30–4.33 present the monthly trends for the percentage of the population with any outpatient visit, the average number of outpatient visits, any non-SUD related outpatient visit and the average number of non-SUD related outpatient visits. For both Medicaid and commercially insured populations with an SUD diagnosis, outpatient visits were common; in any given month during the study period, more than 96% of the population had a visit. The average number of any type of outpatient visit per month ranged from 4 to 10 per month (**Figure 4.30–4.31**). Daily visits to receive administered medications for opioid use disorder contribute to this relatively high average. The likelihood and average number of non-SUD related outpatient visits was substantially lower (**Figures 4.32–4.33**). Between 30%–40% of the cohort had a non-SUD

outpatient visit in any given month, and the average number of non-SUD visits was generally less than one/month in both insurance groups.

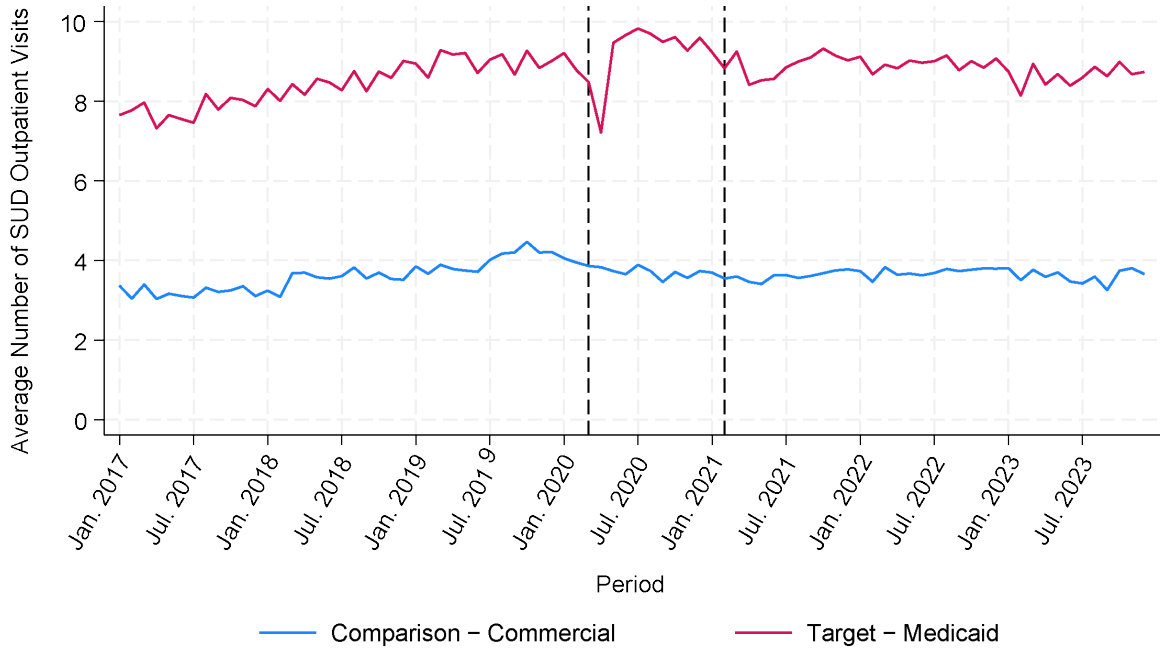
Parallel trends are present in the pre-implementation period for the two groups for each of the outpatient outcomes except for the average number of non-SUD visits in the month where trends diverge before the PHE (**Figure 4.33**). Differential pre-implementation trends in this latter outcome reduce confidence in the validity of the DiD design. Additional limitations apply to these analyses: first, continuous coverage was implemented in March 2020 resulting in an alteration of the size and composition of the Medicaid cohort as shown previously in **Figure 4.1**; second, COVID itself may have impacted the two groups and their outcomes differentially. For these reasons, we suggest caution in interpreting the results causally.

Figure 4.30. Fraction of the Cohort With an SUD Diagnosis With Any Outpatient Visit in the Month



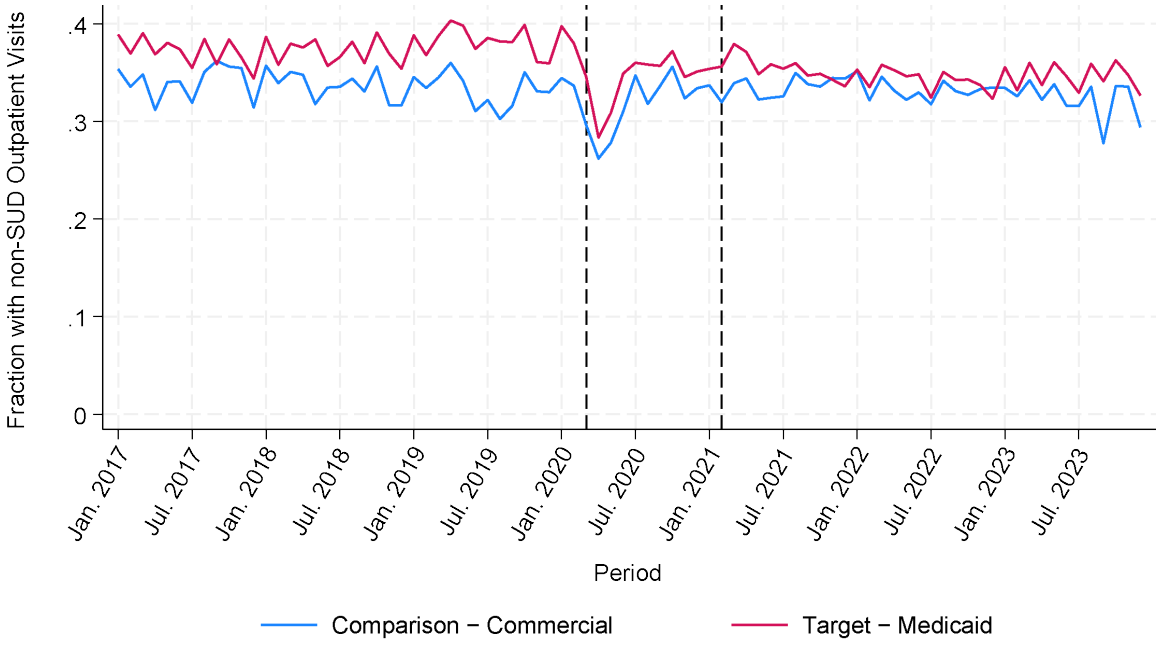
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.31. Average Number of Outpatient Visits in the Month Among Adults With an SUD-Diagnosis



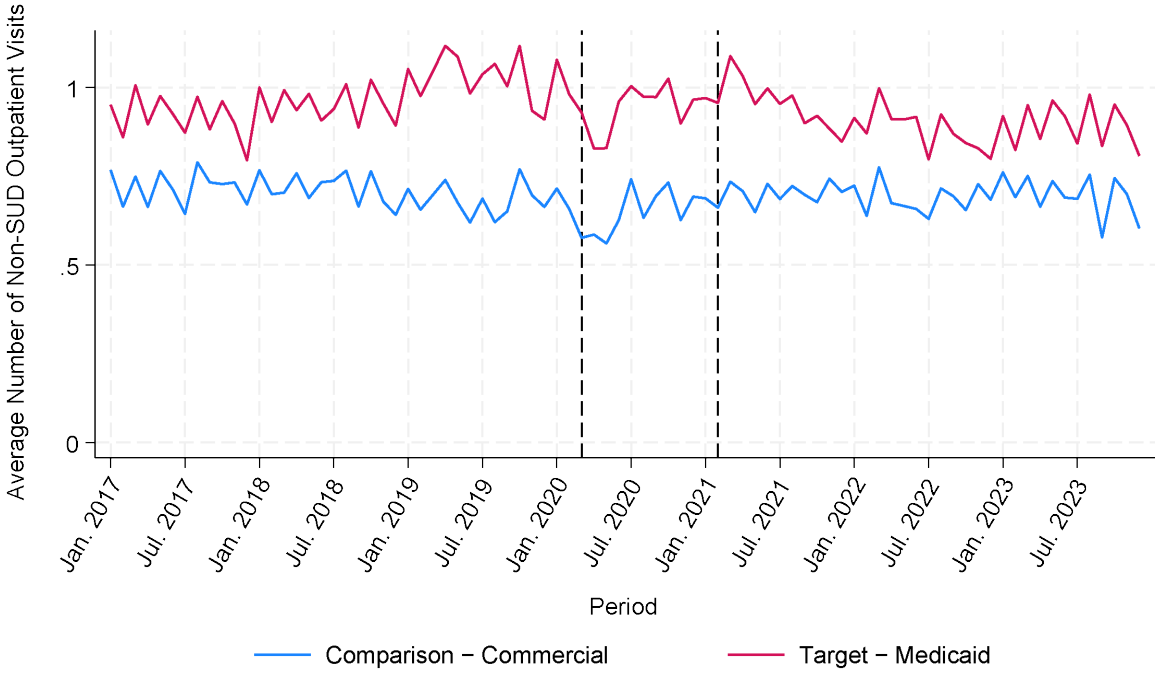
Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.32. Fraction of the Cohort With an SUD Diagnosis With a Non-SUD Related Outpatient Visit in the Month



Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

Figure 4.33. Average Number of Non-SUD Related Outpatient Visits in the Month Among Adults With an SUD Diagnosis



Note: Vertical lines indicate the onset of the PHE, March 2020 and the start date of the SUD provision February 2021.

The DiD results are shown in **Tables 4.26–4.29**. Model I excludes the pandemic period, and Model II includes it. Both models include calendar month fixed effects and control for age and sex. Model coefficients for binary outcomes are expressed as percentage point differences to facilitate interpretation (i.e., 100 x the regression coefficient), and standard errors have been similarly scaled. There was no differential change in the likelihood or frequency of an outpatient visit in the month after implementation of the residential treatment benefit between Medicaid and commercially insured adults with an SUD diagnosis (**Tables 4.26–4.27**). There was a 3.77 percentage point decline in the likelihood of any non-SUD related visit in the month for Medicaid members relative to the commercially insured population that was statistically significant at the 5% threshold (**Table 4.28**). The average number of non-SUD related outpatient visits per month also declined within the Medicaid population by 0.078 visits compared to the commercially insured but was not statistically meaningful (p = 0.22) (**Table 4.29**).

We examined the robustness of the DiD results using alternative specifications including a fixed, continuously enrolled panel of both Medicaid and commercial enrollees, and beginning the pre-period at different times. None of these alternative analyses made a qualitative or major quantitative difference in the results, and for brevity we do not include them in this report.

Table 4.26. DiD Results: Comparing the Change in Likelihood of Any Outpatient Visit in the Month Between Medicaid and Commercially Insured Adults With an SUD, 2017–2023

	Model I	Model II
Percentage point difference in any outpatient visit	-0.34	0.02
Standard error	0.35	0.19
p value	0.334	0.932
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.27. DiD Results: Comparing the Change in the Average Number of Outpatient Visits in the Month Between Medicaid and Commercially Insured Adults With an SUD, 2017–2023

	Model I	Model II
Difference in average outpatient visits	0.220	-0.640
Standard error	0.230	0.170
p value	0.345	<0.001
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.28. DiD Results: Comparing the Change in Likelihood of Any Non-SUD Outpatient Visit in the Month Between Medicaid and Commercially Insured Adults With an SUD, 2017–2023

	Model I	Model II
Percentage point difference in non-SUD outpatient visit	-3.77	-1.50
Standard error	1.63	1.18
p value	0.023	0.208
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Table 4.29. DiD Results: Comparing the Change in the Average Number of Non-SUD Outpatient Visits in the Month Between Medicaid and Commercially Insured Adults With an SUD, 2017–2023

	Model I	Model II
Difference in average non-SUD outpatient visits	-0.078	-0.103
Standard error	0.063	0.038
p value	0.220	0.008
Calendar month fixed effects	Y	Y
Controls	Y	Y
Pandemic period removed	Y	
N observations	146	168

Results from the Medicaid Beneficiary Survey are presented in **Table 4.30**. The percentage of all survey respondents that reported drinking or using drugs more than they had meant to in the last 12 months was 14.9 and 14.5 in 2020 and 2024 respectively ($p = 0.87$). In 2020, 18.5% reported that they had felt that they wanted or needed to cut down on drinking or drug use in the last 12 months compared to 17.2% in 2024 ($p = 0.65$).

In 2020, 88.4% of respondents reported having a usual source of care compared to 84.9% in 2024 ($p = 0.244$). The percentage of members that reported receiving all the care that they needed in the past 12 months was 84.7% in 2020 and 77.1% in 2024 ($p = 0.056$). Among persons who reported a time in the last 12 months that they needed prescription medications, 89.3% and 74.6% in 2020 and 2024 respectively, reported getting all that was needed ($p < 0.001$). The distribution of doctor visit frequency in the past 12 months from 2020 to 2024 did not change significantly.

Self-reported physical and mental health status was reported in five descending categories from Excellent to Poor. Within each outcome, the distribution of responses was similar across years. 51.1% and 59.1% reported good, very good or excellent physical health in 2020 and 2024 respectively ($p = 0.345$), and 40.1% and 39.0% reported good, very good, or excellent mental health in 2020 and 2024 respectively ($p = 0.985$). There was an increase from 52.7% to 61.9% of members that reported that a physical, mental, or emotional condition limited their ability to work at a job ($p = 0.04$). There was no difference across the survey years in the self-reported symptoms of depression.

Overall, there was no evidence of an increase in the use of health care for co-morbid physical or mental health conditions among members with an SUD.

Table 4.30. Substance Use, Health Care Access, and Self-Reported Health Status Among Medicaid Beneficiary Survey Respondents, 2020 and 2024

	2020 N=2401 %	2024 N=1558 %	*p* value
Panel A: All Respondents			
Substance use history			
In the last 12 months did you ever drink or use drugs more than you meant to?			
Yes	14.9%	14.5%	0.872
No	84.7%	85.0%	
Missing	0.4%	0.5%	
In the last 12 months, have you felt you wanted or needed to cut down on your drinking or drug use?			
Yes	18.5%	17.2%	0.648
No	79.7%	80.8%	
Missing	1.8%	2.1%	
Panel B: Answered "Yes" to Either Question in Panel A			
Health care access and use			
Have a usual place for care			
Yes	88.4%	84.9%	0.244
No	11.6%	15.1%	
Got all care need in last 12 months			
Yes	84.7%	77.1%	0.056
No	11.5%	19.2%	
I did not need any health care	3.8%	3.7%	
Was there a time in the last 12 months when you needed prescription medication?			
Yes	90.9%	86.1%	0.084
No	9.1%	13.9%	
In the last 12 months, did you get all the prescription medications you needed?			
Yes	89.3%	74.6%	<0.001
No	10.7%	18.1%	
Did not need prescription medication in last 12 months	0.0%	7.3%	
Number of in-person doctor visits in last 12 months			
0 times	11.5%	15.1%	0.215
1 to 3 times	47.1%	37.9%	
4 to 8 times	24.0%	27.0%	
9 or more times	17.4%	20.0%	
Health Status and Chronic Conditions			
Self-rated physical health			
Excellent	4.1%	5.3%	0.345
Very good	15.6%	21.6%	
Good	31.3%	32.3%	
Fair	35.4%	30.5%	
Poor	13.5%	10.4%	

	2020 N=2401 %	2024 N=1558 %	*p* value
Self-rated mental health			
Excellent	4.0%	4.3%	0.985
Very good	13.1%	11.4%	
Good	23.0%	23.2%	
Fair	35.6%	35.7%	
Poor	24.3%	25.3%	
Does a physical, mental, or emotional condition now limit your ability to work at a job?			
Yes	52.7%	61.9%	0.041
No	47.3%	38.1%	
Over the past two weeks, how often have you been bothered by having little interest or pleasure in doing things?			
Not at all	19.5%	16.2%	0.500
A few times	32.4%	38.9%	
More than half the days	18.4%	17.9%	
Nearly every day	29.7%	27.0%	
Over the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?			
Not at all	19.3%	17.6%	0.849
A few times	36.6%	38.1%	
More than half the days	19.7%	22.1%	
Nearly every day	24.4%	22.2%	

Hypothesis 4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

Table **4.31** describes the volume and characteristics of MOUD index episodes among adult Medicaid members and commercially insured adults from 2017-2023. Continuity of MOUD for at least 90 days was observed for 64% of Medicaid members' MOUD episodes during the baseline year (2019) and 67% of commercially insured beneficiaries' MOUD episodes. The analogous results for 180-days of continuous MOUD treatment were 42% for Medicaid members and 34% for commercially insured beneficiaries.

Figures **4.34** and **4.35** illustrate the annual trends in each of the MOUD continuity measures. For both measures, the Medicaid and commercial trends deviate from one another during the years before implementation of the new benefit. Differential pre-implementation trends reduce confidence in the validity of the DiD design. Additional limitations apply to these analyses: first, continuous coverage was implemented in March 2020 resulting in an alteration of the size and composition of the Medicaid cohort as shown previously in **Figure 4.1**; second, COVID itself may have impacted the two groups and their outcomes differentially. For these reasons, we suggest caution in interpreting the results causally.

DiD results are shown in **Table 4.32.** Model coefficients are expressed as percentage point differences to facilitate interpretation (i.e., 100 x the regression coefficient), and standard errors have been similarly scaled. In adjusted models that exclude the pandemic period, there was no meaningful change in the likelihood of MOUD continuity of >=90 days for adult Medicaid members relative to commercially insured adults. The likelihood of MOUD continuity of >=180 days decreased by 6.4 percentage points ($p < 0.001$) among Medicaid members compared to commercially insured adults. This relative decline was driven by an increase in 180-day MOUD continuity among commercially insured adults over this time rather than an absolute decrease within the Medicaid population as shown in **Table 4.31** and **Figure 4.35**.

Table 4.31. Frequency and Characteristics of MOUD Episodes 2019–2023 Among Adult Medicaid Members and Commercially-Insured Beneficiaries

	2019		2020		2021		2022		2023	
	Commercial	Medicaid	Commercial	Medicaid	Commercial	Medicaid	Commercial	Medicaid	Commercial	Medicaid
Number of MOUD Episodes										
Total Episodes	937	10,120	1,180	11,051	1,424	12,667	1,542	12,873	1,488	12,975
Age Group										
21–34	39%	43%	36%	40%	35%	37%	31%	32%	28%	29%
35–49	40%	40%	43%	42%	44%	45%	46%	49%	48%	51%
>49	17%	12%	16%	12%	17%	13%	19%	14%	20%	15%
Sex										
Male	66%	46%	67%	47%	68%	48%	69%	49%	67%	48%
Percent of MOUD Episodes										
With >= 90-Day Continuity (among those with >=90 days enrollment)	67%	64%	63%	54%	65%	63%	66%	65%	68%	65%
With >= 180-Day Continuity (among those with >=180 days enrollment)	34%	42%	41%	35%	41%	44%	43%	44%	40%	41%

Notes: Authors' analysis of WHIO data. MOUD episodes are defined as the member's first MOUD prescription medication claim or medication administration code during the calendar year with any diagnosis of OUD within six months before or after the MOUD claim. The year 2019 excludes data from January and February due to anomalies in the underlying dataset.

Figure 4.34. Annual Trends in Percentage of MOUD Episodes with >= 90-Day Continuity

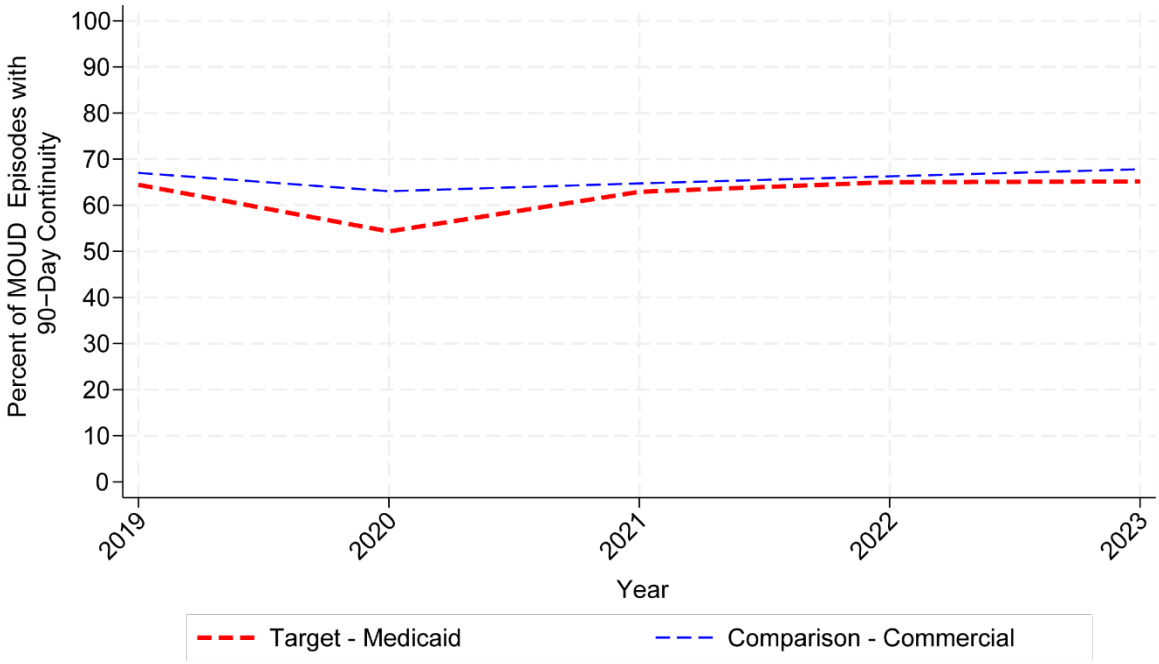


Figure 4.35. Annual Trends in Percentage of MOUD Episodes with >= 180-Day Continuity

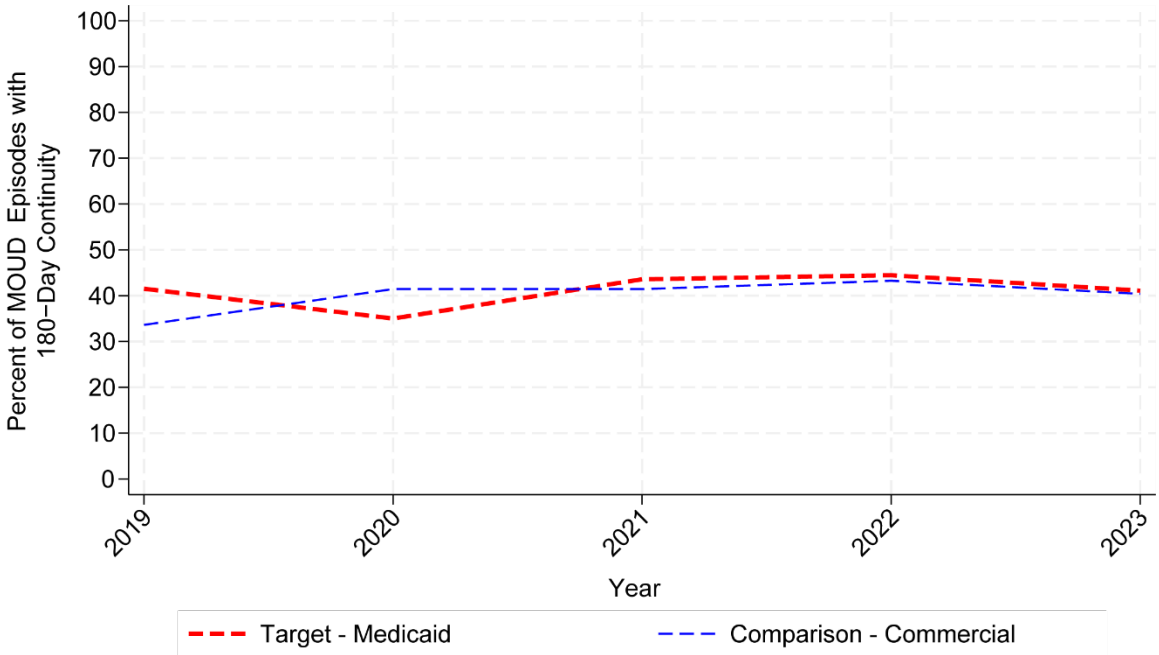


Figure notes, 4.34-4.35. Authors' analysis of WHIO data. MOUD episodes are defined as the member's first MOUD prescription medication claim or medication administration code during the calendar year with any diagnosis of OUD within six months before or after the MOUD claim. The year 2019 excludes data from January and February due to anomalies in the underlying dataset.

Table 4.32. Change in Probability of 90- and 180-Day MOUD Continuity among Medicaid Members Relative to Commercially Insured Comparison Population

	90-Day Continuity		180-Day Continuity	
Percentage Point Difference	3.70	0.61	1.16	-6.64
Standard Error	1.34	1.80	1.36	1.86
p-value	0.006	0.735	0.395	<0.001
Calendar month fixed effects	Y	Y	Y	Y
Controls	Y	Y	Y	Y
Pandemic period removed		Y		Y
Number of episodes	**66,257**	**54,026**	**66,257**	**54,026**

Notes: Author's analysis of WHIO data using an ordinary least squares estimator. The unit of analysis is the MOUD episode. P-value for the test of equivalence between the parameter estimate and zero.

Overall, the results for Hypothesis 4.3a-d suggest a relative reduction in some types of outpatient care use and no meaningful change in hospital-based services for Medicaid members compared to commercial insurance enrollees rather than a reduction in acute services and an increase or steady rate of utilization for outpatient care. However, these results should be interpreted with caution due to the limitations; additionally, given the lack of a relative change in providers for SUD evident in H4.1, and lack of evidence of increased use of services in H4.2 and H4.3a, we would not expect reductions in hospital-based care or increases in outpatient services as measured in H4.3b-d. Survey results suggested no change in utilization compared to baseline among members with reported problematic substance use in the last 12 months.

Question 4.4, Does the SUD demonstration waiver reduce the rate of drug overdose deaths among Medicaid enrollees including opioid-related deaths?

Hypothesis 4.4a. The SUD demonstration waiver will reduce the rate of drug overdose deaths among Medicaid beneficiaries, including opioid-related overdose deaths, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

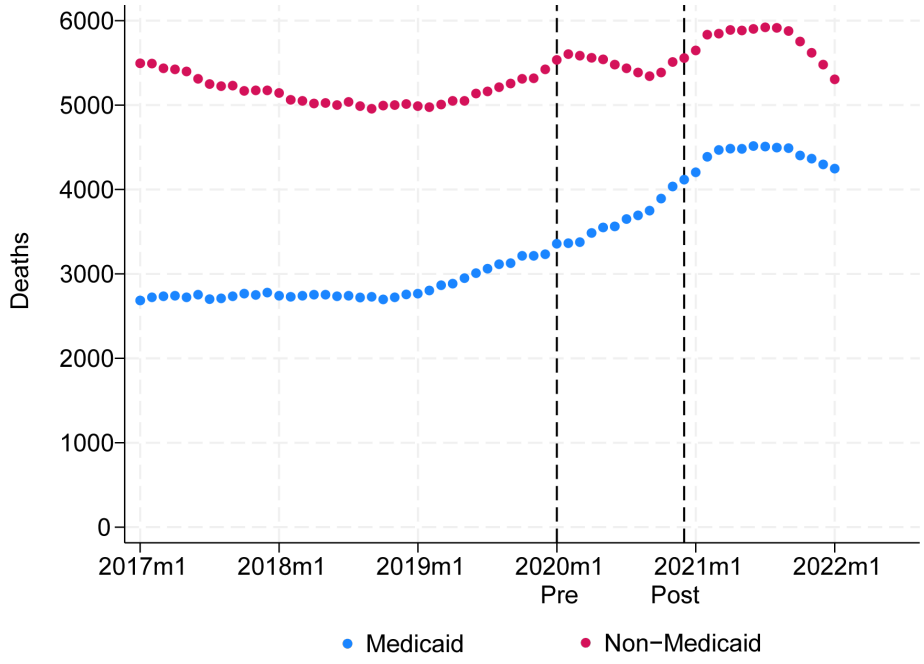
The expected reduction in the rate of drug overdose deaths among Medicaid members was conditional on an increased supply of SUD providers or use of new and existing services. There was no causal evidence of an increase in supply (H4.1) or increased use of SUD services (H4.2b, H4.2c, H4.3a). Analyses for this hypothesis were completed, but without expectation of a reduction in drug overdose deaths attributable to the residential SUD treatment benefit.

Using Wisconsin vital statistics linked to Medicaid data, we use a DiD analysis to compare the rate of drug overdose deaths and deaths for all-causes among Medicaid members to non-Medicaid members before and after implementation of the SUD demonstration waiver.

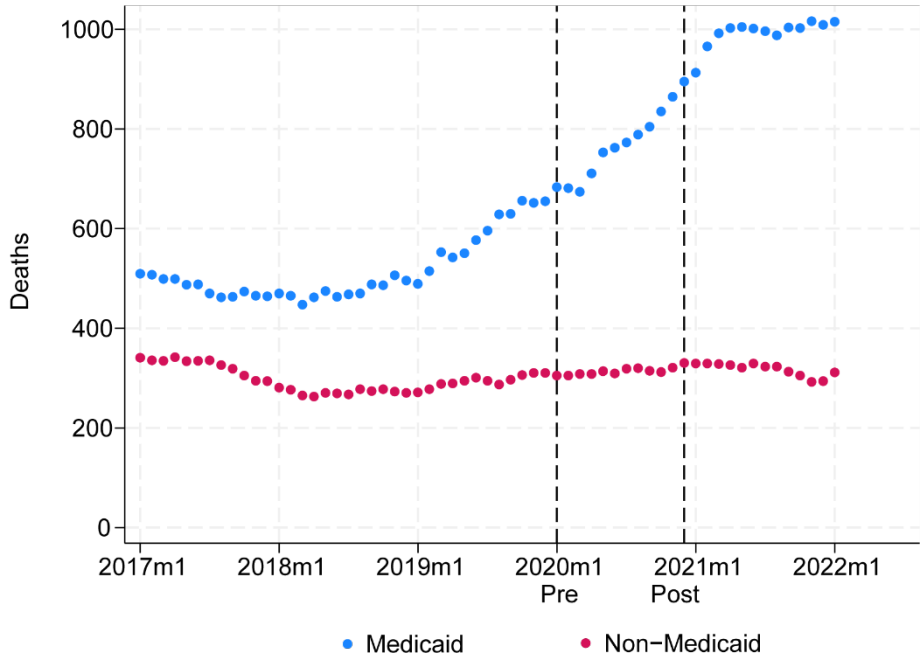
Figures 4.36a-c present the raw number of deaths within 12 months for each month and group, Medicaid and non-Medicaid adults. Dashed vertical lines mark the start and end of 2020 which is defined as the pandemic period for purposes of this analysis. The total number of deaths within 12 months is relatively greater for the non-Medicaid population throughout the study period which is expected because of its larger size compared to the Medicaid population. The number of deaths within 12 months from an overdose (**Figure 4.36b**) is higher in each month for the Medicaid population compared to the non-Medicaid population as are the number of opioid-related overdose deaths (**Figure 4.36c**).

Figure 4.36. Number of Deaths Within 12-Months By Month and Insurance Group

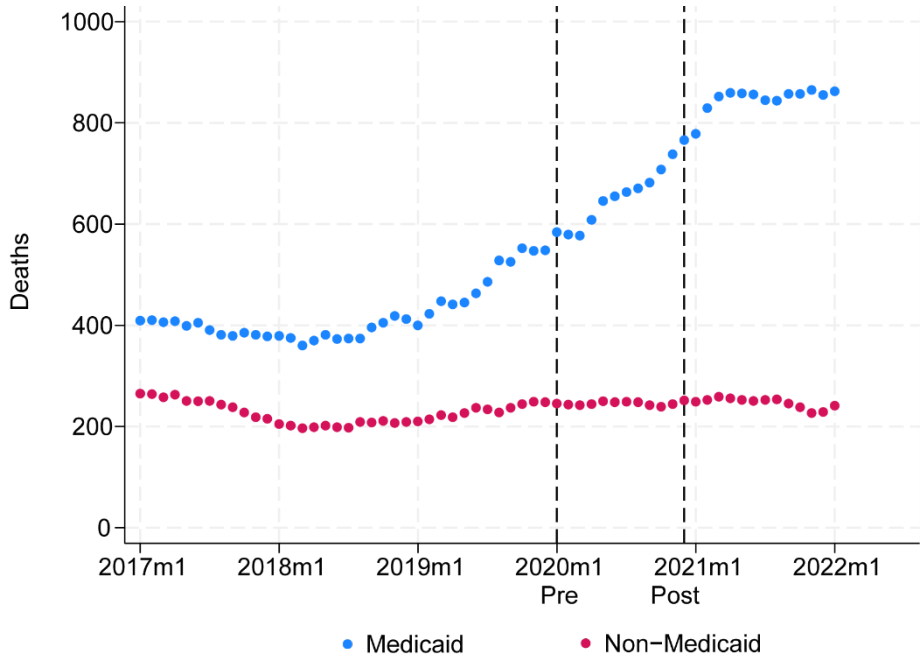
A. All Deaths Ages 20–60



B. OD Deaths Ages 20−64



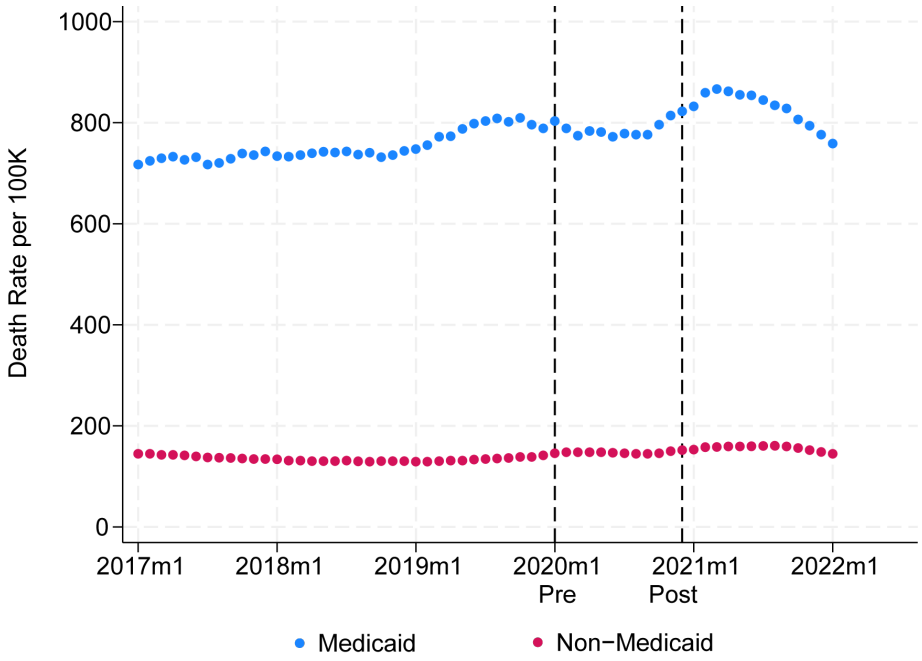
C. Opioid Deaths Ages 20−64



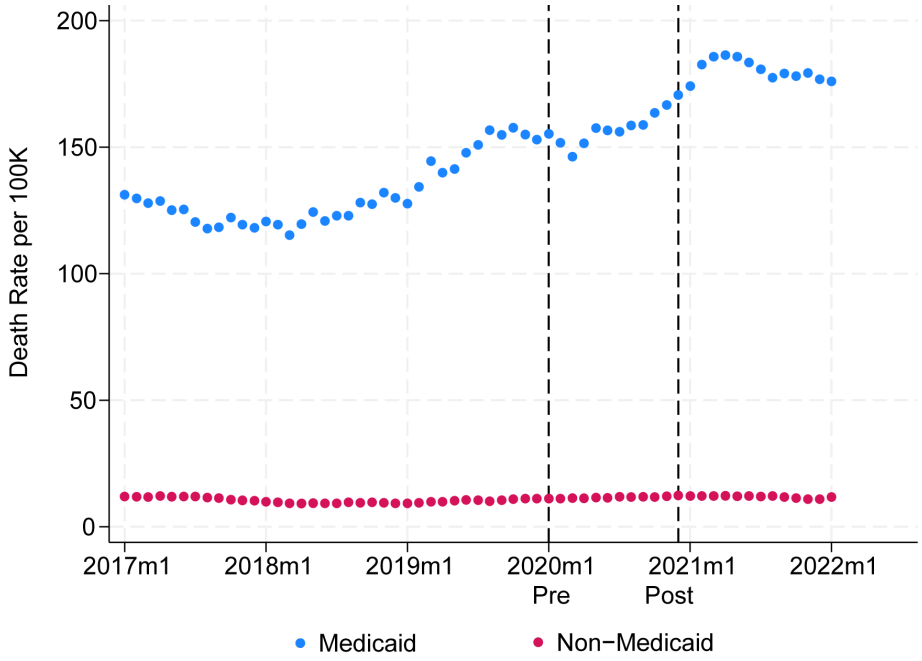
The age-adjusted death rates are shown in **Figures 4.37a-c**. Among Medicaid members from the start to the end of the study period, the age adjusted death rate rose from 717 to 759 deaths per 100,000; the overdose death rate rose from 131 to 176 deaths per 100,000; and the opioid overdose death rate rose from 103 to 149 deaths per 100,000. Among non-Medicaid members from the start to the end of the study period, the age adjusted death rate rose from 182 to 189 deaths per 100,000; the overdose death rate remained stable at around 11.8 deaths per 100,000; and the opioid overdose death rate remained stable at 9 deaths per 100,000.

Figure 4.37. Adjusted Rate of Death Within 12-Months per 100,000 Adults, by Month and Insurance Group

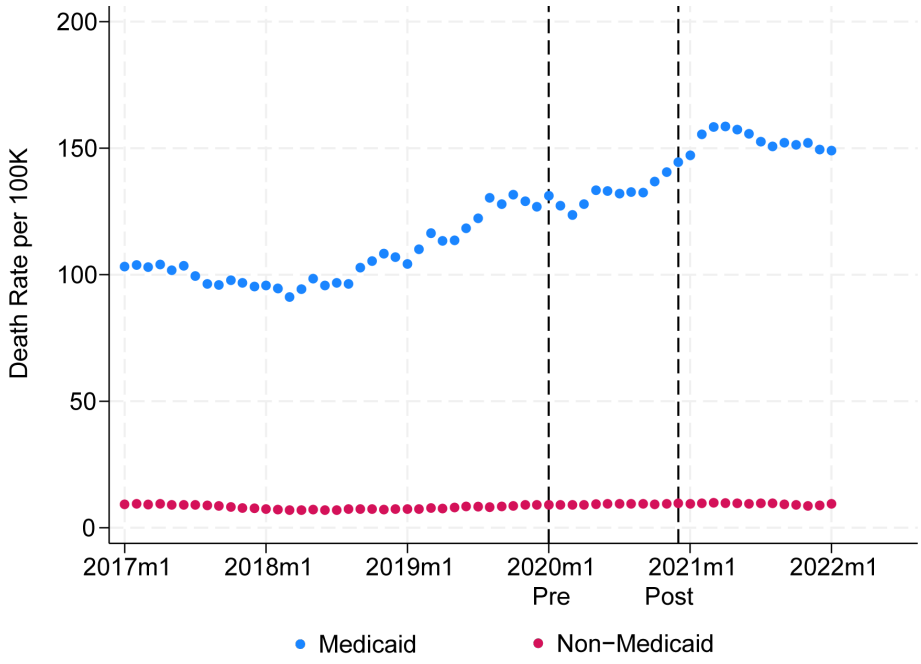
A. All Death Rate Ages 20−64, Age Adjusted



B. OD Death Rate Ages 20−64, Age Adjusted

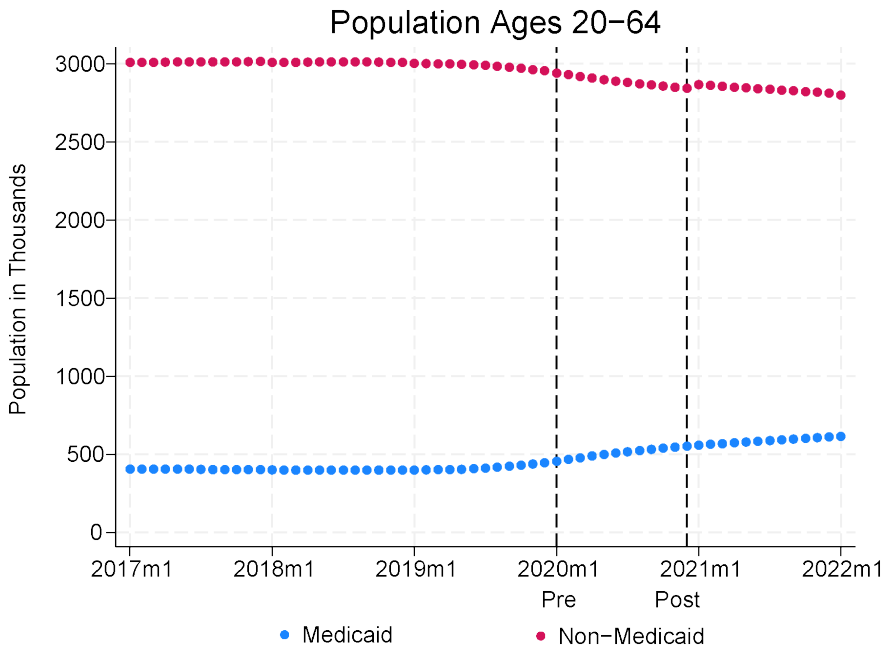


C. Opioid Death Rate Ages 20−64, Age Adjusted



The differential trends in age-adjusted death rates in the pre-implementation period among Medicaid and non-Medicaid groups reduces confidence in the validity of DiD analysis. Additional limitations apply to this analysis: first, the size and composition of the Medicaid and non-Medicaid enrolled populations changed following the onset of the PHE and maintenance of eligibility policy as illustrated in **Figure 4.38** and **Figure 4.1**; and second, COVID may have differentially affected mortality risk across the two populations. We report the results as pre-specified but suggest caution in interpreting them causally.

Figure 4.38. Population Size by Month and Insurance Group



Results from the DiD analyses, shown in **Table 4.33**, compared the change in age-adjusted death rates. Model I excludes the pandemic period, defined as calendar year 2020 in this analysis, while Model II includes it. The Medicaid group exhibited 56.0 more deaths from any cause per 100,000 individuals relative to the non-Medicaid group (95% CI: 35.66, 76.40) after implementation of the residential treatment benefit. This finding was driven by opioid overdoses. Relative to the non-Medicaid group, the Medicaid group exhibited 47.6 (95% CI: 39.83, 55.33) and 45.29 (95% CI: 38.30, 52.38) more overdose and opioid overdose deaths, respectively, per 100,000 individuals, after implementation of the residential treatment benefit.

Overall, there was no evidence of a relative reduction in death rates among Medicaid members from all causes or from overdoses following implementation of the SUD demonstration waiver.

Table 4.33. DiD Results: Comparing The Change In Age Adjusted Death Rates per 100,000 Wisconsin Adults, Enrolled and Not Enrolled In Medicaid, 2017–2022

	Model I Coefficient; (Confidence Interval)	Model II Coefficient; (Confidence Interval)
All-Cause Death		
Post Period	22.39***	12.32
	(7.95, 36.83)	(-2.54, 27.17)
Medicaid	616.60***	585.26***
	(606.11, 627.09)	(571.47, 599.04)
Post*Medicaid	56.03***	2.97
	(35.66, 76.40)	(-18.04, 23.98)
Overdose Death		
Post Period	1.63	0.84
	(-3.86, 7.13)	(-3.80, 5.48]
Medicaid	121.02***	102.69***
	(117.03, 125.01)	(98.39, 107.00)
Post*Medicaid	47.58***	10.65***
	(39.83, 55.33)	(4.09, 17.21)
Opioid Overdose Death		
Post Period	1.55	0.48
	(-3.41, 6.51)	(-3.85, 4.81)
Medicaid	98.38***	81.29***
	(94.77, 101.98)	(77.27, 85.31)
Post*Medicaid	45.29***	9.81***
	(38.30, 52.28)	(3.68, 15.94)
Calendar Month Fixed effects	Y	
Group-period time trends		Y
Pandemic period (2020) removed	Y	
N (months)	98	122

Notes: The unit of analysis is the insurance group-month. Model compares the change in annual age-adjusted death rates before and after implementation of the SUD waiver. The post period includes 2021–2022. For Model I the pre-period includes 2017–2019; For Model II, the pre-period includes 2017–2020.

Question 4.5. What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?

To examine the patterns and trends in Medicaid costs associated with the SUD demonstration waiver, we conducted descriptive analysis of total average real annual expenditures per member and a break down by service category and SUD-related expenditures within each category. Total expenditures include all services paid including those services not captured by the five named categories (e.g., lab, x-ray, medical device, etc.); as such it may exceed the sum of those categories.

As shown in **Table 4.34**, the average total annual expenditures per member was $8,737 in 2017 and increased to a high of $9,686.82 in 2020 before falling to $8733.28 by 2023. The average total SUD-related expenditures followed the same pattern with 2017 and 2023 values of approximately $800 per member per year. Among the service categories, prescription medications accounted for the largest share of expenditures in each year increasing from 26% of expenditures ($2,239.09 / $8,737.68) to almost 44% of expenditures ($3,836.14 / $8,733.28) in 2023. Outpatient visits accounted for the next largest share of expenditures per member. The steadily increasing trend in average prescription medication expenditures per member from 2017–2023 contrasts with the trend observed for each other category.

Table 4.34. Average Real Annual Expenditures per Member in the Medicaid Study Cohort, 2017–2023

	2017	2018	2019	2020	2021	2022	2023
	$	$	$	$	$	$	$
	SE	SE	SE	SE	SE	SE	SE
Total Expenditures	$8,737.68	$9,295.86	$9,560.34	$9,686.82	$9,688.48	$9,163.93	$8,733.28
	40.82	50.54	47.77	49.46	44.25	53.65	39.76
Total SUD-Related Expenditures	$801.57	$940.88	$1,008.93	$975.94	$951.50	$869.04	$802.63
	9.18	9.94	9.66	8.08	7.96	7.17	6.88
Prescription medications	$2,239.09	$2,494.95	$2,823.80	$3,294.92	$3,441.09	$3,707.14	$3,836.14
	19.59	22.79	26.34	31.36	28.11	26.77	26.63
SUD-Related Prescription Medications	$113.06	$123.89	$150.76	$172.78	$161.29	$157.61	$156.85
	5.87	3.85	4.51	3.08	1.93	1.68	1.63
Outpatient Visits	$1,908.46	$2,039.66	$2,092.92	$1,951.60	$1,965.70	$1,790.20	$1,643.58
	9.23	10.25	9.62	10.91	8.07	8.20	6.80
SUD-Related Outpatient Visits	$295.86	$389.15	$422.19	$383.04	$362.76	$339.38	$301.66
	3.10	4.11	4.29	3.83	3.12	3.13	2.73
Emergency Department Visits	$463.86	$459.93	$460.17	$436.83	$453.52	$454.62	$422.02
	3.95	4.39	3.57	4.23	3.30	3.69	3.32
SUD-Related Emergency Department Visits	$52.33	$57.21	$55.42	$56.75	$57.49	$56.51	$54.08
	1.04	1.20	1.37	1.06	1.08	1.00	1.45
Hospitalizations	$1,885.57	$1,929.17	$1,909.52	$1,823.19	$1,783.58	$1,511.48	$1,344.42
	23.10	42.27	20.01	21.29	17.75	16.12	12.72
SUD-Related Hospitalizations	$474.86	$498.21	$538.64	$519.76	$492.33	$430.53	$392.46
	8.65	7.72	8.88	9.30	7.35	7.66	5.87
SUD-Residential Treatment Benefit					$28.15	$32.30	$35.13
					0.78	0.87	0.82

Notes: Study cohort includes members ages 21–64 with at least one month of eligibility in the study years in the following categories: childless adult, parent and caretaker, pregnant, income extension, disabled. SE refers to standard error. All dollars are inflated to $2023.

Conclusions

The logic of this evaluation was to determine whether the residential SUD treatment provision led to improved access to SUD services, and if so, to examine the causal effects of the SUD waiver provision on downstream outcomes and overdose deaths. The driver diagram for this provision as shown in the Methodology Section identifies these access-related outcomes as "secondary drivers" while downstream outcomes are identified as "primary drivers."

The access-related outcomes included SUD provider availability (H4.1) member awareness of the residential SUD treatment benefit (H4.2a), use of residential SUD treatment (H4.2b), and use of outpatient and pharmacotherapeutic SUD services (H4.2c, H4.3a). We did not find evidence of an increase in SUD provider availability—defined as the number of providers newly delivering SUD service—after the implementation of the SUD demonstration waiver relative to the comparison group (i.e., providers newly delivering diabetes care). However, the pre-implementation outcome trends for the two groups indicate that the diabetes providers may not be a good comparison group and suggest caution in interpreting the results of these models as causal effects of the new benefit.

Awareness of the new residential SUD treatment benefit increased among member survey respondents with problematic substance use from 23.9% in 2020 to 28.3% in 2024. In both years, more than 60% of respondents reported that they did not know if their insurance plan covered residential SUD. Together, these results mean that a large majority of potentially affected members are unaware of the residential SUD treatment benefit though there is evidence of improvement over time.

As presented in the Interim Report based on Wisconsin Medicaid data only, and now extended to include all waiver years in this report, the number of members who received residential SUD treatment abruptly increased beginning in February 2021, the first month of implementation and continued to grow until late 2023. This finding was expected because residential SUD treatment for adult Wisconsin Medicaid members was not covered and thus not observable in Medicaid data until February 2021.

Using cross-state analyses of admissions from all payers, we sought to determine if this observed increase in the Wisconsin Medicaid data reflected an actual change in the volume of residential SUD treatment admissions among Medicaid members or a change from a non-Medicaid payer source to Medicaid as payer. To do so, we compared these admission rates in Wisconsin to admission rates in the 18 states that lacked a Medicaid SUD residential treatment waiver during the study period. Although the point estimate was positive, suggesting a relative increase in Wisconsin, the difference was not statistically meaningful.

This finding would then support a conclusion that the SUD waiver had no net effect on admission rates to SUD treatment facilities in Wisconsin for Medicaid members. However, such a conclusion relies on the assumption that there were no differential changes between Wisconsin and the comparison states from the pre-period (2017–2019) to the post-period (2021) in factors causally related to SUD residential treatment use. The onset of the COVID-19 pandemic in 2020 and its continuation through 2021, the single year of the analytic post-period, challenges the plausibility of this assumption. This limitation points toward caution in interpreting these results as the causal impact of the SUD waiver provision on SUD residential treatment use among Medicaid members.

The final set of access-related outcomes included outpatient SUD services, evaluated using models that compared non-elderly adult Medicaid members to non-elderly adult commercially insured beneficiaries. We observed small relative decreases in the probability and average number of SUD visits, and a decline in treatment engagement, among Medicaid members relative to commercial beneficiaries after implementation of the waiver. This finding would suggest that the newly available services reduced outpatient, non-acute SUD care for which there is no strong theoretical explanation. Instead, we point to the dissimilar pre-implementation outcome trends across the two groups in SUD-related outpatient visits and the initiation and engagement outcomes which reduces confidence in the validity of DiD analysis.

Overall, and subject to the limitations noted above, we did not find evidence that the SUD waiver provision increased access to SUD treatment services, the mechanism by which it was hypothesized to impact downstream outcomes and overdose deaths. Absent that evidence, the evaluation design specified that analyses examining the association between the SUD waiver and downstream outcomes should not be considered causal. Conclusions related to these outcomes, hospital-based SUD services (H4.3b), use of health care for co-morbid conditions among members with SUD (H4.3c), adherence to SUD pharmacotherapy (H4.3d), and drug overdose deaths (H4.4) are presented with this caveat in mind.

Implementation of the SUD waiver was not associated with any meaningful differential change in the likelihood or frequency of an SUD emergency department visit or inpatient admission among Medicaid and commercially insured adults within the full cohort. Among the subset of cohort members with an SUD, there was a relative decrease in non-SUD related outpatient visits after implementation of the SUD waiver compared to commercially insured adults but no differential change in outpatient visits overall. This means that the composition of outpatient visits for Medicaid members with a SUD changed over time with a shift away from visits for physical and mental health comorbidities toward SUD visits.

All-cause mortality rates, and overdose-specific mortality, increased for Medicaid members relative to the comparison population over the study period. The 12-month drug overdose mortality rate for non-elderly adult Medicaid members increased by approximately 48 per 100,000 members, after implementation of the SUD waiver compared to non-elderly adults who were not Medicaid members. We caution against interpreting these results as the causal impacts of the waiver because of the dissimilar pre-implementation trends in age-adjusted death rates between the groups, the simultaneity of the COVID-19 pandemic, and changes in the size and composition of the groups beginning with onset of the PHE.

Policy Implications

Our overall assessment is that the residential SUD treatment benefit, as implemented in the context of the COVID-19 pandemic, was not associated with meaningful changes in Medicaid members' SUD-related health care use or overdose mortality risk. Drawing implications for current state and federal Medicaid policy, from the results of the SUD waiver evaluation, is difficult because of the challenges described above, including the concurrent COVID-19 pandemic. We do not have confidence in the internal validity for causal inference or generalizability of the empirical findings.

While 37 states[34] now provide Medicaid coverage for residential SUD treatment, there is limited evidence of the causal impacts of this coverage due to a combination of data limitations, benefit implementation processes, and confounding events. However, recent research largely overcame these challenges and found that a new Medicaid residential SUD treatment benefit increased Medicaid members' use of residential SUD treatment by 25% during its first year.[35] By exploiting a staggered roll-out of a residential SUD treatment benefit across California counties, and using data that included admissions from all payers, this study was able to identify an increase in net Medicaid member residential admissions as distinct from an increase in Medicaid-paid admissions. This finding supports states' ongoing coverage for SUD residential treatment as a means of expanding access to that treatment.

In this evaluation, only about 25% of Medicaid members with recent, problematic substance use were aware of the residential treatment benefit. This figure signals an outreach opportunity and a challenge. In all states, the subset of adult Medicaid members that are potential candidates for residential SUD treatment, considering the joint prevalence of severe addiction and interest in recovery, is small relative to the overall adult Medicaid population. As states consider their member outreach and education activities, targeted messaging to individuals whose health care history suggests persistent or severe addiction could be considered to improve access to treatment.

Lessons Learned and Recommendations

The lessons and recommendations we derive from this evaluation concern areas of active discussion and experimentation across states with IMD demonstrations.

Restrictions on the use of federal Medicaid funds for room and board costs presents a challenge to states implementing IMD demonstrations, whether those demonstrations focus on SUDs or non-addiction related mental illness. States have responded with a variety of strategies to shield members from this component of the cost of treatment. The State of Wisconsin, for example, used a portion of the National Prescription Opiate Litigation settlement funds to support these costs for members with OUD through a grant-making process to counties and tribal nations that contract with residential SUD treatment programs. Future initiatives might provide states with guidance or example approaches for addressing this non-covered portion of residential treatment which may otherwise impede member use. Accompanying evaluation of the relative administrative burden and the identification of implementation best practices for alternative approaches to funding room and board costs could also be considered.

The requirement that residential SUD treatment providers make medication for opioid use disorder (MOUD) available to patients with OUD is a strength of this waiver. A large body of evidence demonstrates the effectiveness of MOUD to reduce the risk of overdose and to

[34]Section 1115 Benefit Changes. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table4 Accessed 3/14/25

[35]Bass B, Urada D, Khurana D, Boustead A, Joshi V. (2023). The Effect of the Drug Medical Organized Delivery System 1115 Demonstration Waiver on Substance Use Disorder Treatment Access: Evidence from California. Drug and Alcohol Dependence. 246(109847).

increase the likelihood of recovery.[36,37,38] In Wisconsin, as in other states that provide an SUD residential treatment benefit, treatment programs may offer this treatment onsite or facilitate access to it offsite. Pilot studies to compare the relative effectiveness of these approaches to residential treatment for individuals with OUD on their post-discharge outcomes could be considered to inform the current and future demonstration designs.

In any given state and year, the supply of residential SUD treatment programs may be insufficient to meet the demand for such treatment. Waitlists for residential addiction treatment are well-documented, and the geographic distribution of programs within states is uneven.[39,40] Future demonstrations may benefit from a systematic, and ideally live, inventory of beds available for Medicaid members to facilitate optimal use of the resources available. Developing measures of distance to the closest bed available could also be considered to further understand if additional supports (e.g., transportation) may be needed to facilitate member access.

[36]Burns, Tang, Kim, Allen, Cunningham, Gordon et al. Duration of Medication Treatment for Opioid-Use Disorder and Risk of Overdose among Medicaid Enrollees in Eleven States. *Addiction*. 2022;117(12):3079-3088.

[37]Volkow, C. (2017). The role of science in addressing the opioid crisis. *New England Journal of Medicine*, 377(4):391-394

[38]Giacomuzzi, Erta, Kemmler, Riemer, Vigl. (2005). Sublingual buprenorphine and methadone maintenance treatment: A three-year follow up of quality of life assessment. *Scientific World Journal*, 5:452-468.

[39]King CA, Beetham T, Smith N, Englander H, Button D, Brown PCM, et al. (2024). Adolescent Residential Addiction Treatment in the U.S.: Uneven Access, Waitlists, and High Costs. *Health Affairs*. Vol 43 No. 1

[40]Beetham T, Saloner B, Gaye M, Wakeman SE, Frank RG, Barnett ML. (2021). Admission Practices and Cost of Care for Opioid Use Disorder at Residential Addiction Treatment Programs in the US. *Health Affairs*, Vol 40, No 2.

ATTACHMENT 1: 2019–2023 EVALUATION DESIGN REPORT

Wisconsin's Medicaid & BadgerCare Plus Health Coverage
CMS § 1115 Waiver Provisions for 2019-2023

Evaluation Design Report

Revised Version 3
Based on CMS Review and Comments

Submitted to the
Wisconsin Department of Health Services

September 15, 2021

Institute for Research on Poverty
UNIVERSITY OF WISCONSIN–MADISON

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The preparation of this design report benefited from regular consultation with staff of the Wisconsin Department of Health Services

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ABBREVIATIONS & GLOSSARY OF TERMS

ACS	American Community Survey
BRFSS	Behavioral Risk Factor Surveillance Survey
CARES	Wisconsin Medicaid's Eligibility and Enrollment System
CE	Community Engagement: Requirements for Medicaid program beneficiaries to participate in employment, training, education, or other qualifying activities
CLA	Childless Adults: Adults without dependent children who are eligible for Wisconsin's BadgerCare program
CMS	U.S. Centers for Medicare and Medicaid Services
DHS	Wisconsin Department of Health Services
DiD	Difference-in-Differences method
DOL	U.S. Department of Labor
FPL	Federal Poverty Level
FSET	Food Share Employment and Training program: Required activities for non-excluded able-bodied adults who receive nutrition support benefits.
HIPAA	Health Insurance Portability and Accountability Act: Federal law governing privacy of patient and consumer health information
IRP	University of Wisconsin-Madison Institute for Research on Poverty: independent evaluators for Wisconsin's Medicaid waiver
ITS	Interrupted Time Series method
RD	Regression Discontinuity method
SAHIE	Small Area Health Insurance Estimates
SID	State Inpatient Databases
SNAP	Supplemental Nutrition Assistance Program, called "FoodShare" in Wisconsin
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TEDS-A	Treatment Episode Data Set – Admissions
UI	Unemployment Insurance
WHIO	Wisconsin Health Information Organization: Wisconsin's private sector, voluntary all-payer claims database

WAIVER PROVISION IMPLEMENTATION DATES: REFERENCE KEY

The Wisconsin Department of Health Services (DHS) has been adjusting the dates for implementation of the various waiver provisions, with some initial programmatic delays, the onset of the COVID-19 public health emergency in March 2020, and finally the withdrawal of CMS approval for the community engagement requirements in April 2021. (See, for reference, Attachment A: Waiver approval letter, waiver provisions.) Specific evaluation elements have undergone adjustments as changes occur to the implementation of the waiver provisions. (Table 1)

The Evaluation Design Report submitted in December 2019 did not reference specific dates but, rather, tied various evaluation elements to implementation milestones. In 2020, several evaluation documents were submitted to DHS and CMS that describe changes to the evaluation plan under changing circumstances. Finally, in 2021, the Evaluation Design Report was revised to reflect the new set of approved waiver provisions. The changes are reviewed in Attachment B: CMS Comments and UW/DHS Responses.

Table 1. Waiver Provisions' Implementation Status as of January 2021

Waiver Provision	Time Frame/Status
Community Engagement	Suspended during PHE
Launch member communications	Initiated in November 2019, through February 2020, then suspended
Employability assessment and plan (App/ACCESS)	Suspended, then approval was withdrawn for the CE requirements provision by CMS on April 6, 2021
Activity reporting portal (App/ACCESS) soft-launch	
Member notices begin	
Member reporting of CE begins CLAs	
E&T program in place for CLAs	
48-month clock begins CLAs	
HRA/HNA	Suspended during PHE
HRA (Treatment Needs Questionnaire) and HNA questions added to the application process	HNA and Treatment Needs Questionnaire added to enrollment process in February 2020, and suspended in mid-March 2020, upon declaration of PHE. Data had been collected for that brief time frame.
Premiums	Suspended during PHE
Member communication begins	Initiated in November 2019, through February 2020, then suspended
First premiums charged/premium payment begins	Suspended
ED Co-Payment	Delayed, then Commenced July 1, 2020
Member notices begin	Implementation delayed, with member notices delivered in May-June 2020
First co-payments charged	July 1, 2020
SUD Program	Start February 1, 2021
Residential treatment benefit begins	Implementation delayed, with implementation launched February 2021
Coverage of current SUD services within IMD settings	

I. EXECUTIVE SUMMARY

The University of Wisconsin-Madison Institute for Research on Poverty is conducting an evaluation of the Wisconsin BadgerCare Reform Demonstration Project, as proposed by the Wisconsin Department of Health Services (DHS) and approved by the federal Centers for Medicare and Medicaid Services (CMS). The evaluation uses quasi-experimental study designs to assess how the provisions of Wisconsin's Medicaid § 1115 Waiver Demonstration, for the period CY2019-CY2023, affect two Medicaid populations: (1) childless adults (CLAs) with an effective income at or below 100% of the federal poverty level (FPL), and (2) all Medicaid beneficiaries eligible for an expanded coverage of treatment services for substance use disorders (SUD).

The evaluation addresses the waiver demonstration provisions defined by DHS and approved by CMS for a five-year demonstration period, ending December 31, 2023. (Attachment A. Approved Waiver) Hypotheses and associated research questions focus on the following provisions and programmatic changes:

- Extension of a full Medicaid benefit for adults without dependent children ("childless adults") with incomes up to and including 100% FPL.
- Premiums for childless adults with incomes greater than 50% up to and including 100% FPL as a condition of enrollment.
- A period of non-eligibility for up to six months for childless adults who do not pay the required premium, with on-ramps to reactivate coverage during the non-eligibility period.
- An $8 co-payment for non-emergency use of the emergency department.
- Required completion of a health risk assessment as a condition of eligibility for childless adults.
- Opportunity for reduced premiums for childless adults based on the health risks and healthy behaviors reported on health risk and needs assessments.
- Expanded coverage for substance use disorders including a residential treatment benefit and coverage for existing services when they are provided in an institution of mental disease (IMD) specifically including medically supervised withdrawal management, inpatient services, and medication-assisted treatment (MAT).

The evaluation requires administrative data from the Wisconsin DHS pertaining to application and enrollment, claims and encounters, health risk and needs assessments, premium payments, and vital statistics (for example, death records). The evaluation team also uses several other sources of administrative data, including Wisconsin's all-payer claims database and unemployment insurance data, along with state and national population survey data. Three separate beneficiary surveys, occurring in CY2020, CY2022, and CY2024, will provide an important source of primary data for evaluation of multiple hypotheses and research questions.

The COVID-19 public health emergency led the state to suspend implementation of several waiver provisions. In adhering to provisions of the federal Families First Coronavirus Response Act, the state

Medicaid agency has generally not conducted eligibility redeterminations or disenrollments since March 28, 2020. The pandemic-related and other changes to the waiver implementation include the following:

- Suspended the emergency department co-payment, and then initiated it on July 1, 2020.
- During the entire period of the federally-designated public health emergency (PHE):
    - Suspended premium co-payments, including those for childless adults with incomes between 51-100% FPL.
    - Suspended community-engagement/work requirements reporting and start-up.
    - Suspended requirement for completion of the Health Risk Assessment and Treatment Needs Question, which had been implemented for the month of March 2020.
- Delayed initiation of the SUD waiver provision, as the state addressed various policy and programmatic details. The SUD residential treatment benefit was implemented on February 1, 2021.

This evaluation design report, originally submitted in 2019, has been updated to reflect those changes along with responses to CMS comments received throughout CY2020. (See Attachment B: CMS Comments and UW/DHS Responses.) The report describes how the evaluation plan has been adjusted to account for the change in the waiver's implementation, and for the unusual pandemic circumstances as they might affect Medicaid enrollment, health care use, and other data trends.

In April 2021, CMS withdrew approval for the community engagement requirement provision of the waiver. The evaluation design report has been updated to reflect this provision's withdrawal. Although it was never implemented, because members received some communications about this requirement prior to its suspension at the beginning of the COVID-19 pandemic, we have retained some references to this former provision where appropriate.

This multi-disciplinary evaluation team, with collaborating scholars from several universities, has conducted Medicaid section 1115 waiver evaluations for over a decade, and has published a wide range of Medicaid-related research and evaluation studies. The investigators bring expertise and skills with the full range of health services and econometric methods needed to assure a rigorous independent evaluation. The Wisconsin Medicaid agency lays out ambitious goals with this demonstration waiver, and the evaluation will contribute important findings for state and federal Medicaid policy.

WAIVER PROVISIONS AND HYPOTHESES

Provision 1: Medicaid benefits to non-elderly childless adults (CLAs) up to 100% FPL.

- H1.1. Expansion of benefits to non-elderly childless adults will reduce the state's uninsured rate.
- H1.2. Expansion of benefits to CLAs will lead to their increased access to medical care.
- H1.3. Expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals.
- H1.4. Additional requirements of the current demonstration may increase administrative costs.

Provision 2: Health Assessment linked to eligibility and premiums

- H2.1. Beneficiaries for whom the health assessment has eligibility and premium consequences will reduce risky behaviors and engage in healthier behaviors.
- H2.2. The health assessment will increase the number of beneficiaries receiving treatment for substance-use disorders
- H2.3. The requirement to answer the health assessment as a condition of eligibility will discourage some potential beneficiaries from enrolling in Medicaid.

Provision 3: Premiums for childless adult beneficiaries ages 19-64 with income 50% through 100% FPL; $8 co-payment for non-emergent use of the emergency department for childless adults

- H3.1. Beneficiaries who are required to make premium payments will gain familiarity with a common feature of commercial health insurance.
- H3.2. The imposition of premium requirements for childless adults will reduce enrollment in Medicaid.
- H3.3. The imposition of premium requirements for childless adults will increase enrollment in commercial insurance following exits from Medicaid.
- H3.4. The imposition of premium requirements for childless adults will lead to pent-up demand for medical care among beneficiaries disenrolled due to failure to pay premiums.
- H3.5. The imposition of a co-payment for non-emergent use of the emergency department will lead to more appropriate uses of medical care among childless adults enrolled in Medicaid.
- H3.6. Hospitals vary in how they implement the required co-payment for non-emergency use of the ED.

Provision 4: Substance Use Disorder (SUD) Demonstration Waiver: Expansion of coverage of substance abuse disorder treatment services*

- Q4.1. Does the waiver increase the supply of SUD providers for Medicaid enrollees?
- Q4.2. Does the waiver increase access to, and use of, newly covered SUD services for Medicaid enrollees?
- Q4.3. Does the waiver change Medicaid enrollees' use of existing covered SUD services?
- Q4.4. Does the waiver reduce the rate of drug overdose deaths among Medicaid enrollees including opioid-related deaths?
- Q4.5. What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?

* Consistent with the CMS guidance for evaluation of SUD waivers, the evaluation for the SUD portion is organized around evaluation questions, with specific hypotheses following each question (as shown in Section IIIE)

II. DEMONSTRATION WAIVER AND EVALUATION BACKGROUND

The University of Wisconsin-Madison Institute for Research on Poverty (IRP) is conducting an evaluation of the Wisconsin BadgerCare Reform Demonstration Project, as proposed by the Wisconsin Department of Health Services (DHS) and approved by the federal Centers for Medicare and Medicaid Services (CMS). BadgerCare is Wisconsin's combined Medicaid and Children's Health Insurance Program (CHIP) for low-income families and for adults without dependent children.

IIA. Waiver Overview and Target Populations

The 2018 Wisconsin waiver primarily concerns adults without dependent children, referred to as childless adults (CLAs), and also includes a substance use disorder (SUD) provision that applies to the entire Medicaid population. CMS approved the waiver provisions on October 31, 2018, with an approval period through December 31, 2023. The various provisions take effect gradually throughout the calendar years 2019-2021.[1]

Childless Adults Waiver Provisions

The BadgerCare Reform demonstration waiver authorizes Wisconsin to provide a full Medicaid benefit package to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including 100% FPL. This coverage began under a prior waiver, initiated in April 2014, and the current demonstration approval continues coverage for this population for five years.

The 2018 waiver also includes several other important features, also subject to evaluation. Childless adults with incomes greater than 50% and up to and including 100% FPL are required to pay a premium as a condition of eligibility. They are subject to termination and a period of non-eligibility for up to six months if they do not pay the required premium by the end of their certification period, with on-ramps to reactivate coverage during the non-eligibility period. The waiver introduces an $8 co-payment for non-emergent use of the emergency department for childless adults. It requires completion of a health risk assessment as a condition of eligibility for childless adults and offers opportunities for reduced premiums based on the health risks and healthy behaviors reported on health risk and needs assessments.

The original waiver allowed Wisconsin to require these childless adult beneficiaries, ages 19 through 49, with certain exceptions, to participate in, document, and report 80 hours per month of community engagement activities. Qualifying activities included employment, self-employment, in-kind work, job training, or community service. The community engagement incentive was not to apply to beneficiaries ages 50 and older. Medicaid beneficiaries subject to the community engagement requirement, but who have not met the community engagement requirements for 48 aggregate months (without qualifying for an exemption), would have been disenrolled from Medicaid at the end of their certification period and

[1] For additional detail regarding the 2018 WI Medicaid waiver and the Special Terms and Conditions, see Wisconsin Department of Health Services. Section 11115 BadgerCare Reform Demonstration Waiver. Available at https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm

unable to re-enroll as a childless adult for six months. However, if that individual reapplied for Medicaid during that six-month period of non-eligibility and is found eligible under another Medicaid eligibility group, the individual would be enrolled into Medicaid. Early information about this provision was communicated to members, but the requirement was suspended and later approval for the provision was withdrawn by CMS, so it has never been in effect.

SUD Waiver Provision

This demonstration waiver also includes a substance use disorder (SUD) program available to all Wisconsin Medicaid beneficiaries. The SUD program expands coverage for substance use disorder treatment in facilities that qualify as institutions for mental diseases (IMDs) for all Medicaid enrollees. The provision authorizes a new residential treatment benefit and coverage for existing services when provided in an institution of mental disease (IMD) specifically including medically supervised withdrawal management, inpatient services, and medication-assisted treatment (MAT). The purpose of the program is to ensure that a broad continuum of care is available to Wisconsin Medicaid beneficiaries with a substance use disorder, helping improve the quality, care, and health outcomes for those Medicaid beneficiaries. The State of Wisconsin identifies this waiver provision as part of a comprehensive statewide strategy to combat substance use disorders and drug overdose.

COVID-Related Changes to Waiver Implementation

The federal Families First Coronavirus Response Act, in providing increased Medicaid funding for states during the federally declared public health emergency (PHE), includes a continuous coverage provision that prohibits Medicaid agencies from terminating coverage for most enrollees during the PHE. Wisconsin has been adhering to this provision and, as of March 2020, has not terminated Medicaid coverage during the PHE unless an enrollee requests termination, moves out of state, or dies. As well, states may not impose conditions of eligibility more restrictive than those in place as of January 1, 2020.

This policy placed in suspension many of the existing waiver's provisions. As well, Medicaid beneficiaries would normally be required to complete annual eligibility renewals, report changes in income and other circumstances, and otherwise respond to requests for information when the Medicaid agency identifies a potential need to verify income. The state will prepare re-activate this process in CY2021, at the end of the federally-declared public health emergency. But, since March 2020, virtually no Medicaid disenrollments have occurred.

In summary, the following changes occurred to the implementation of the waiver's provisions:

- Suspended the emergency department co-payment, and then initiating it on July 1, 2020.
- During the entire period of the federally-designated PHE:
    - Suspended premium co-payments, including those for childless adults with incomes between 51-100% FPL.
    - Suspended community-engagement/work requirements reporting and start-up.
    - Suspended requirement for completion of the Health Risk Assessment and Treatment Needs Question, which had been implemented for the month of March 2020.

- Delayed initiation of the SUD waiver provision, as the state addressed various policy and programmatic details. The SUD residential treatment benefit was implemented in February 2021.
- CMS withdrawal of permission for the community engagement requirements in April 2021

The evaluation team has adjusted its data collection and analysis plan in response to the changes in waiver implementation and approval. Memos submitted by the evaluation team review these changes. (Attachment B: CMS Comments and UW/DHS Responses) These changes are incorporated into this updated Design Report.

IIB. Evaluation Team Background and Qualifications

Our team has conducted and published studies on a broad range of Medicaid-related evaluation and research topics, addressing coverage and care utilization, labor market impacts, crowd-out of private insurance, premiums, restrictive non-enrollment periods, health needs assessments, application and enrollment systems, and churning.[2] Sponsors of this team's work include the state and federal governments, foundations, and private sector concerns. We have conducted the CMS-required evaluations of Wisconsin's BadgerCare demonstration § 1115 waivers that were approved in 2008, 2012, and 2014, of Wisconsin's SeniorCare prescription drug program, and of the Medicaid medical homes for high risk pregnant women.

The multi-disciplinary team of faculty and staff researchers is based at the University of Wisconsin-Madison, in the Institute for Research on Poverty, with the following collaborating faculty investigators: Dr. Marguerite Burns, a health services researcher in the UW School of Medicine and Public Health; Dr. Laura Dague, an economist at Texas A&M University's Bush School of Government & Public Service; Dr. Thomas DeLeire, an economist at the Georgetown University McCourt School of Public Policy; Dr. Brendan Saloner, a health services researcher at Johns Hopkins University Bloomberg School of Public Health; Dr. Justin Sydnor, an economist at the UW School of Business; and Dr. Alyssa Tilhou, a physician and health services researcher at Boston University in the Department of Family Medicine.

IIC. Evaluation Design Approach and Methods

The evaluation of the demonstration waiver will involve a variety of analytic approaches. We describe below the three approaches that cut across most components of the evaluation design. Further detail regarding the application of these methods to specific evaluation questions is included in the Section III of this evaluation design report, in addition to methods that are unique to a given question or hypothesis.

Section III, below, also details the planned changes to the evaluation plan that account for the pandemic circumstances and the state's delay in implementing various waiver provisions. In general, we will treat 2020 carefully in any analytical models that rely on across-time comparisons, including allowing for flexibility in modeling time and excluding 2020 from the models. Where relevant, we will be using 2019

[2] Information about the team's work is available here: https://www.irp.wisc.edu/health-policy/

rather than 2020 as baseline for analyses of the pre-period and for secondary data. Any comparisons over time will account for differences in the pool of beneficiaries enrolled in 2020 and later.

We also consider how the beneficiary pool and outcomes in 2021 and later will be affected by the pandemic. Instead of previously planned use of ITS models, we place greater emphasis on DiD, regression discontinuity (RD), and other models that use a simultaneous comparison group, because they are better able to control for pandemic impacts. The evaluation will use time period indicators in regression models that control for pandemic months or estimate treatment effects for periods before, during, and after the public health emergency period. Planned analyses include robustness checks. We will also, as appropriate, consider sensitivity analyses that keep the analytic sample constant in order to isolate the demonstration impact from changing characteristics of Medicaid beneficiaries.

Difference-in-Differences (DiD) Method

The objective in evaluating a treatment's effect on an outcome is to find the difference between the improvement (or degradation) in an outcome in the presence of the treatment to the change in an outcome that would have occurred in the absence of the treatment. In the group of individuals who receive the treatment, this counterfactual change—the amount that an outcome would have improved absent the treatment—is not observed. Therefore, this counterfactual change must be estimated somehow.

A popular method applied to estimate this change is the difference-in-differences (DiD) approach. In this approach, two populations of subjects, treatment and control, are observed at two points in time: at baseline, before the intervention is applied, and at follow-up, after the intervention is applied to the treatment population. The outcome is measured in each population at each time. The average effect of the treatment is estimated by subtracting the change in outcomes in the control group from the change in outcomes in the treatment group. The control group thus provides the counterfactual for the trend that would have occurred in the treatment group in the absence of the intervention.

DiD can be implemented either by literally taking averages and subtracting, as described above, or via regression modeling. The advantages of using a regression framework is that a researcher can incorporate more than one time period before and after intervention into the empirical analysis and can adjust for potential confounders arising from differences in demographic and baseline health characteristics and time trends. For continuous outcomes, a linear regression model takes the form:

$$(1) \qquad Outcome_{it} = \alpha + \beta T_i + \delta post_t + \lambda T_i \times post_t + \gamma X_{it} + \varepsilon_{it}$$

where $Outcome_{it}$ is the outcome measure of interest for subject *i* at time *t*; T_i takes the value of 1 if subject *i* is in the treatment group, and 0 otherwise; and post_t equals 1 if time *t* is after the treatment/intervention was applied, and equals 0 otherwise. The interaction term, $T_i \times \text{post}_t$, equals 1 for members in the treatment group after the treatment has been applied. X_{it} represents a set of control variables for subject *i* at time *t*, such as demographic and health characteristics. These

characteristics are either measured in the baseline period or considered not to be directly influenced by the treatment. The average effect of the treatment/intervention is measured by the estimate of the coefficient λ. Where feasible and appropriate, the set of control variables may include county by year fixed effects to address the potential for time-varying geographic differences to help isolate the demonstration impact.

One can readily generalize this regression framework to deal with non-continuous outcome variables such as discrete outcomes, proportions, or percentages. A major advantage of using this DiD regression approach is that it can yield an estimate unbiased by time-invariant differences between treatment and comparison group individuals when covariates are included to control for initial heterogeneity of treatment and comparison groups. We will also include specifications that allow for heterogeneity in the effect by year (defining *post* as indicator variables for year) to observe the impact of the demonstration in years during and right after the COVID-19 pandemic and in later years when the pandemic has further subsided, where appropriate.

It will not generally be possible to create control groups that perfectly match the treatment groups on all observable correlates related to the various outcomes of interest. Consequently, the distribution of the characteristics of subjects will, to some extent, differ between treatment and control groups. To create unbiased estimates of intervention effects in the presence of such heterogeneity and to improve the precision of our estimates, we will implement matching methods such as propensity score matching and the more general approach of "cell matching."

In cell matching, sample members in treatment and comparison groups are allocated to cells based on values of their covariates which have been determined to be potential factors influencing outcomes (e.g., age, gender, region, race, health status, etc.). Cells, then, comprise persons with similar values of combination of covariates. Given this homogeneity within cells, treatment effects can essentially be estimated by cell using the simple variant of DiD methods described above, and an average treatment effects for a population can be estimated by weighting cell estimates by the proportions of the population deemed to occupy each cell.

Regression Discontinuity (RD)

Regression Discontinuity (RD) is generally regarded as a strong program evaluation design.[3,4] The RD takes the following form:

$$(1) \qquad Y_i = \alpha + \theta(X_i - x_0) + \tau W_i + \gamma(X_i - x_0)W_i + \epsilon_i,$$

[3] Lee, David S., and Thomas Lemieux.2010. Regression Discontinuity Designs in Economics. *Journal of Economic Literature* 48, No. 2 (2010): 281-355.

[4] Abadie, Alberto, and Matias D. Cattaneo. 2018. Econometric Methods for Program Evaluation." *Annual Review of Economics* 10: 465-503.

Implemented via local linear regression with triangular kernel weights, where all observations outside the bandwidth h (more than h away from x_0) are discarded. Here, Y_i is the outcome under consideration, X_i is the running variable that determines whether the individual is subject to the treatment (e.g., age of the member), x_0 is the cutoff level of *X*, , W_i is an indicator for whether or not the individual was subject to the treatment (e.g., subject to premiums) and equals zero if not and 1 if so, and ϵ_i is a random error term. The treatment effect of interest is τ. The coefficients θ and γ allow the slope of the regression to differ on either side of the cutoff x_0. The design also allows us to control for potentially confounding covariates.

Interrupted Time Series (ITS) Estimation

We had planned to assess outcome changes before and after implementation of the demonstration waiver within the enrollee population using an Interrupted Time Series (ITS) model, an approach that is commonly relied upon to ascertain outcomes when an intervention or policy is implemented for an entire population at the same time. In an ITS model, a researcher can segment outcome data into pre- and post-waiver components in a linear regression specification and quantify the differences between the two segments by testing the change in levels (absolute change in outcome) and slopes (rate of change in outcome) before and after program enrollment. This specification can also adjust for autocorrelation properties of error terms in empirical specification of the sort illustrated below:

$$(2) \qquad \text{Outcome}_{it} = \alpha + \delta \text{post}_t + \gamma X_{it} + \varepsilon_{it}$$

In this framework, the effect of the change in treatment is estimated by the regression estimator of δ. The framework can allow differences in the trend in outcomes trend between pre- and post-treatment periods by interacting post_t with the time trend variable(s) in X_{it}. Additionally, treatment effects may be permitted to differ among individuals by interacting post_t with other elements of X_{it}.

The pandemic-related disruptions, however, hinder the use of data from CY2020 (and perhaps 2021), in an ITS model. We have generally abandoned previously planned use of ITS models, placing greater emphasis on DiD, regression discontinuity (RD), and other models that use a comparison group because they are better able to control for pandemic impacts.

IID. Data Sources

The evaluation of the demonstration waiver will rely on multiple data sources, including state and national administrative data, population survey data, and a beneficiary survey. These data elements are described below. The specific sources that will be used to evaluate each provision, and the outcomes derived from each source, are noted in the relevant sections of this evaluation design report.

1. All Payer Claims Database, WHIO.[5] The Wisconsin Health Information Organization, known as WHIO, is private-sector-operated, voluntary, multi-payer claims database. WHIO includes Medicaid along with commercial insurance covering most of Wisconsin's population. It is missing

[5] Wisconsin Health Information Organization. Datamart Guide Version 2.1. 2014. Optum, Inc: Waltham, MA.

Medicare fee-for-service, self-funded employers whose third-party administrators do not submit claims, and individuals insured by national or border state companies (examples include HealthPartners, Aetna, and Cigna). The WHIO data have both a claims file and a member enrollment file, which permits us to track unique individuals' enrollment in health insurance regardless of whether members actually incur claims. WHIO does not release identifiable data, so it is not possible to link these data directly to Medicaid administrative data in order to identify the Medicaid sample. Rather, we will use the member file to identify both the Medicaid and privately insured samples.

Note: In 2019, the WHIO hired a new contractor to collect and construct the all-payer-claims database. We do not expect that the change in contractor will impede the use of these data longitudinally; however, we will confirm that there have been no changes in the methodology for data construction that would introduce bias into the study designs when technical information is available from the new contractor. In the evaluation, the WHIO provides a source for a within state comparison group of commercially insured individuals to complement the primary designs. Thus, in the unlikely event that the new WHIO data are not usable, our capacity to answer the research question will not be affected.

2. American Community Survey. The American Community Survey (ACS), a nationally representative survey conducted by the U.S. Census Bureau, contains state-level geographic identifiers. The survey asks about sources of health insurance coverage in the previous year, including Medicaid coverage, private group and non-group insurance, Medicare, and military coverage. The survey is administered annually and is publicly available with only a short lag.

3. Behavioral Risk Factor Surveillance System (BRFSS)**.** Run by the Centers for Disease Control and Prevention, the BRFSS is a set of state-level surveys that collect data from all 50 states and the District of Columbia on the health and health behaviors of U.S. residents. The survey also collects information on health insurance coverage, though not the source of that coverage, and on employment. The data are available at the state level and with roughly a two-year lag.

4. CARES*.* Wisconsin CARES is the state's online eligibility and enrollment portal for public benefits, including Medicaid, TANF, and FoodShare (SNAP). We use data from CARES to attain longitudinal administrative data pertaining to enrollment. Demographic information includes age, sex, educational attainment, county of residence, income, and income sources. CARES data also include reason codes associated with disenrollment, and "premium payment files" that contain monthly information on the dollar amount of premium owed, whether it was paid, and the date of payment.

5. Hospital Cost Reports. These reports are submitted annually to CMS by all acute-care and critical access hospitals. Data on uncompensated care (UCC) are reported in Worksheet S-10 of Form CMS-2552-10, which was first used beginning in May 2010. UCC is the sum of two reported items: the cost of charity care provided to uninsured patients (line 23 column 1) and the cost of

non-Medicare bad-debt expense (line 29). As needed, we will supplement Hospital Cost Report data with Wisconsin data on hospital uncompensated care available from the Wisconsin Hospital Association.[6]

6. Marketplace Enrollment. CMS public use files provide data on enrollment at the zip code and county level, by FPL, in ACA Marketplace plans for each annual open enrollment period. These data do not allow matching on the individual level, but may be used to demonstrate trends in enrollment at various income levels over time.

7. Medicaid Beneficiary Survey. Described in detail in Section IIE. Primary Data Collection, below.

8. National Survey of Substance Abuse Treatment Services (N-SSATS).[7] The Substance Abuse and Mental Health Services Administration (SAMHSA) conducts this annual survey to provide a census of facilities nationwide that provide substance abuse treatment and collect data on their location in each state and characteristics including populations served, available services, and whether the facility accepts Medicaid as a payer.

9. Other Wisconsin Medicaid Administrative Data. The Wisconsin Medicaid agency will provide the data from the health risk and health needs assessments, including completion rates and substantive response information.

10. Small Area Health Insurance Estimates (SAHIE). The SAHIE program was created to develop model-based estimates of health insurance coverage for counties and states. SAHIE data can be used to analyze geographic variation in health insurance coverage, as well as disparities in coverage by race/ethnicity, sex, age and income levels that reflect thresholds for state and federal assistance programs.

11. Wisconsin Mental Health and Substance Use Needs Assessment.[8] The Wisconsin Division of Care and Treatment Services publishes this report biannually. It provides county-specific indicators of SUD treatment needs and available resources.

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[6] Uncompensated care for Wisconsin hospitals is reported by the Wisconsin Hospital Association annually, available here: https://www.whainfocenter.com/uploads/PDFs/Publications/Uncompensated/Uncompensated_2017.pdf ; Other financials for WI hospitals available here: https://www.whainfocenter.com/services/publications/?ID=49

[7] Substance Abuse and Mental Health Services Administration. National Survey of Substance Abuse Treatment Services. Information available at: https://www.samhsa.gov/data/data-we-collect/nssats-national-survey-substance-abuse-treatment-services

[8] Wisconsin Department of Health Services, Division of Care and Treatment Services. 2017 Wisconsin Mental Health and Substance Use Needs Assessment. July 2018. P-00613. Accessed 6/27/19 at https://www.dhs.wisconsin.gov/publications/p00613-17.pdf

12. Wisconsin Family Health Survey. The Wisconsin Family Health Survey is an annual statewide random-sample telephone survey of all household residents. This survey includes topics such as health insurance coverage, health status, health problems, and use of health care services. It is currently available from 2008 through 2017 (and we will add additional years as they become available).

13. Wisconsin Medicaid claims and encounter data. We will obtain claims and encounter data from the State's MMIS claims database. These data files include detailed ICD-10 diagnostic codes. The claims and encounter data contain detailed information on diagnoses, procedure, and billing codes from which we will construct outcomes measures of health care use.

14. State Inpatient Databases (SID). The SIDs are part of the Healthcare Cost and Utilization Project (HCUP). The SID includes inpatient and emergency department discharge records from community hospitals in participating states. SID files encompass all patients, regardless of payer. The SID contain a core set of clinical and nonclinical information on all patients, including individuals covered by Medicare, Medicaid, or private insurance, as well as those who are uninsured. We will use Wisconsin data from 2012 through 2017, the last year of data currently available (and will add additional years of data as they become available). We will also obtain data from the same years for two Midwestern states that expanded Medicaid (Michigan and Minnesota) and three states that did not expand Medicaid (Florida, North Carolina, and Kansas).

15. Treatment Episode Data Set – Admissions (TEDS-A).[9] The TEDS-A is a national dataset that includes substance abuse treatment admission-level data for facilities that receive state funds or federal block grant funds to provide alcohol and/or drug treatment services. The dataset is structured at the admission-level and includes many characteristics of each admission including patient demographics, dates of admission, payer, services received, and the state in which facility is located. This dataset is published approximately two-years after the close of the calendar year (e.g., May 2019 for the 2017 dataset).

16. Unemployment Insurance Wage and Benefits Records (UI). UI wage and benefits records are longitudinal administrative data from the UI earnings reporting system, with individual-level measures of reported quarterly employment, wages, and firm industry code. These data may be matched to Medicaid administrative enrollment data from CARES, to identify an individual's employment status regardless of whether they are currently enrolled in Medicaid.

17. Wisconsin Death Records. The State Registrar in the WIDHS collects vital statistics death data. The source of these data are death certificates filed with the WIDHS. Cause of death is coded according to ICD-10. We will examine resident deaths, specifically all deaths that occurred in Wisconsin within the Wisconsin resident population. Conditional on approval by the WI DHS, we

[9] Substance Abuse and Mental Health Services Administration. Treatment Episode Data Set. Accessed 6/27/19 at https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set.

will link death records to Medicaid enrollment date to identify deaths among Medicaid enrollees.

18. Wisconsin Third Party Liability (TPL) Database. TPL is an individual-level database that contains all enrollees in state health insurance programs who are covered by a private health insurance plan. We can match individuals in TPL using social security numbers. This database may not contain information on whether individuals were covered by health insurance provided by a self-funded employer (whose policies are not subject to state regulation).

19. U.S. Department of Labor (DOL) Self-Insured Firms list: To assess whether enrollees may have access to health insurance coverage through a self-funded employer, we can connect CARES cases to their employers by linking CARES through SSNs to a database of quarterly earnings records from Wisconsin's UI system. Next, we can use FEINs (obtained from UI) to link to data from the DOL that comes from the required reporting of self-insured firms to the Internal Revenue Service. The DOL data cover the universe of self-insured employers within the United States. We have previously obtained these data through a Freedom of Information Act request, and we will use the process again for this project. From these data, we can infer coverage from a self-insured firm.

IIE. Primary Data Collection: Medicaid Beneficiary Survey

A survey of current and former Medicaid beneficiaries provides the opportunity to examine the respondents' experiences specifically in relation to the waiver provisions, including several domains not well-suited to measurement with administrative data or other state and national data. These domains include perceptions and understanding of various waiver provisions, reported reasons for changes in enrollment status or health care use, reported health status over different enrollment entry and exit spells, and knowledge of and interest in various services (such as SUD treatment).

The evaluation design includes use of a survey at three separate points in the five-year evaluation period, in CY2020, 2022, and 2023-24 (Table 6). This design report provides detail about the first survey, including sample construction, data collection, and next steps. The evaluation plan, under the highly fluid policy environment, relies on an agile project management approach for design of the subsequent two beneficiary surveys. We expect to re-define the more specific parameters of the survey cohorts, instrument domains, and data collection as the dates for those next surveys draw near.

i. Survey Domains

The evaluation design includes plans to field cross-sectional surveys of beneficiaries at three separate points in the five-year evaluation period. Overall plans are as follows:

- Mixed mode (self-administered questionnaire (SAQ), web, and telephone)
- Surveys in the first and final round are sent to 15,000 people; Offered in Spanish and English
- Sample groups include childless adults and parents/caretakers, people with a history of SUD treatment, and previous Medicaid members who have left the program

- The second round of data collection will target a smaller group of individuals for open-ended qualitative interviews

The domains within the 2020/2021 survey instrument included the following:

- Health insurance coverage status – past year and current
- Medicaid eligibility and enrollment changes
- Health care needs, access and use
- Health status and health behaviors
- Access to care and use of services related to COVID-19
- Employment and workforce activities
- Awareness of waiver provisions
- Demographics

Questions were developed using items from previous surveys of Wisconsin Medicaid beneficiaries, from national surveys and from other state surveys of Medicaid beneficiaries. These include: the Behavioral Risk Factor and Surveillance System, the Urban Institute Health Reforming Monitoring Survey, Kaiser Family Foundation Health Tracking Polls, the National Health Interview Survey, the Michigan waiver's survey of Medicaid beneficiaries[10] and the Oregon Health Insurance Experiment[11].

Table 4 displays how the waiver provision and hypotheses relate to each of the survey domains.

We may adjust future survey questions and planned analyses depending on the outcomes of the 2020/2021 wave, and also to account for changes in the waiver implementation and in the Medicaid context and policy environment over the demonstration time period.

ii. Sample Construction and Data Collection

The original planned field date for the baseline survey was May 2020, but was delayed due to the postponement of waiver provisions and logistical challenges arising at the start of the COVID-19 pandemic. It was re-scheduled to begin in the first week of October 2020 and concluded in February 2021.

Beginning with the onset of the federal public health emergency in March 2020, we worked with our survey partner, NORC at the University of Chicago, to carefully reconsider the timing and schedule for fielding the survey. We explored different strategies for contacting and offering incentives to beneficiaries to participate in the survey, because the pandemic made data collection more challenging.

The revised timing of the 2020/2021 survey was designed to provide a baseline for the evolving timeline of state waiver provisions. While some of the waiver provisions remain suspended under the public health emergency, the state Medicaid agency has begun to implement some waiver provisions and has

[10] Healthy Michigan Voices Survey. https://ihpi.umich.edu/featured-work/healthy-michigan-plan-evaluation/healthy-michigan-voices-survey

[11] Oregon Health Insurance Experiment – Documents. https://www.nber.org/programs-projects/projects-and-centers/oregon-health-insurance-experiment/oregon-health-insurance-experiment-documents

been preparing for others. The emergency department co-payment took effect in July 2020. When other provisions would be activated has remained unclear. The ability to collect useful baseline data would be eroding as Medicaid members became exposed to any waiver provisions over time, motivating our decision to field the survey in early fall 2020.

The evaluation will include three rounds of data collection, but the timeline for this data collection has been revised. We concluded that it would not be feasible to postpone the first survey until late 2021, for a potential post-pandemic time frame. The original evaluation plan had specified two data collection rounds, one at the demonstration period start, in waiver year 01, and the other at the late stage in waiver year 04-05. CMS, in its response, requested that the evaluation plan add a third beneficiary survey or interview protocol, to occur at a mid-point, around year 02 of the waiver. The evaluation team then met this request, submitting a plan to field the added survey in 2022.

With the evaluation plan now entailing three surveys in a five-year period, the workplan schedule requires a continuous cycle of 1) survey planning and preparation, 2) data collection, and 3) data analysis and reporting. The evaluation has proceeded with baseline data collection in fall 2020, with plans for a second data collection effort scheduled for CY22.The fielding of the survey in fall 2020 included the addition of some items specific to the COVID-19 pandemic and the experience of Medicaid members under the pandemic circumstances, which will support the analysis of the administrative data.

The first survey data collection included the following contacts:

- Contact 1: A mailing was sent to 15,000 current and former Badger Care recipients following the sampling plan developed by UW. This mailing included a “push to web,” with a URL allowing individuals to complete the survey by the web.
- Contacts 2 and 3: NORC sends a self-administered questionnaire (SAQ) mailing to those respondents who have not yet completed the web survey (1 page cover letter, first class postage-paid return envelope, 16-page survey); then a follow-up second mailing of the SAQ to those respondents who have not yet completed the survey.
- Contact 4: NORC team of interviewers contact potential respondents who have not responded to the web survey invitation or the SAQ. NORC will place up to six calls to each sampled beneficiary in order to maximize response. When NORC encounters disconnected or invalid lines, it uses a proprietary database to search for other contact information (e.g., using contact information that is harvested by credit reporting agencies).

Table 2 shows the CY20 data collection timeline.

Table 2. Survey Data Collection Timeline

Milestone	Start	End	Weeks
Modified Contract start date	8/24/20		
Multi-mode Survey Data Collection			
Develop survey instrument	N/A	8/10/20	
Recruit and hire interviewers	8/10/20	9/21/20	6
Program, test, and deploy survey instrument and case management system	8/10/20	10/2/20	8
IRB submission and approval	8/24/20	9/21/20	4
Train interviewers	9/21/20	9/28/20	1
Survey Data Collection	10/5/20	1/25/21	16
Contact 1: Mail invitation to web survey	10/5/20	N/A	
Contact 2: Mail SAQ	10/19/20		
Contact 3: second mailing of SAQ	10/26/20		
Contact 4: Initiate telephone follow-up calling	12/1/20	1/25/21	8
Survey data delivery	1/26/21	3/22/21	8

Table 3 displays the sample groups included in the CY2020 survey. The main sample groups are based on eligibility and enrollment status.

The baseline survey, which sampled 15,750 people to be interviewed, includes a subgroup of individuals who had been enrolled as childless adults during the time frame from August 2019 through March 2020 but disenrolled from that coverage prior to April 2020. These individuals would otherwise have been subject to the waiver provisions had they remained enrolled. The inclusion of this cohort is intended to provide information about 1) the target population's understanding of the pending waiver provisions and 2) the degree to which the state notifications about upcoming implementation of the waiver (which occurred in the months prior to April 2020) may have affected these former members' continuing enrollment in Medicaid.

We ask both current and former beneficiaries the same set of questions so that we are able to measure different response outcomes; survey items such as questions 2 and 4 help us to assess current enrollment and reasons for leaving BadgerCare.

We also designed for inclusion of Spanish-language speakers, given the unique challenges – in health insurance and in employment -- that face this population. The survey recruited an oversample of Medicaid/BadgerCare members, adding 750 people to the survey sample who were identified (in the administrative data) as having Spanish as their primary language.

Table 3. Survey Sample Groups

Group	Composition	Sample	Spanish Language Over-Sample	Total Sample
A	Childless adults randomly sampled from the list of current enrollees at the time of the sample construction with incomes 0–49 FPL	2,135	107	2,242
B	Childless adults randomly sampled from the list of current enrollees at the time of the sample construction with incomes 50–100% FPL	2,300	115	2,415
C	(A subset of the other sample groups) All adults who have a diagnosis of a substance use disorder or a hospital/ED visit related to a substance use disorder in the prior 12 months based on recent claims	2,994	150	3,144
D	Childless adults who have been long-term enrolled (>24 months) in the program without a history of employment	2,203	110	2,313
E	Individuals who disenrolled from CLA and were likely to have been subject to the waiver provisions	2,375	119	2,494
F	Parents and caregivers who are not subject to the premium requirement, and will serve as a contemporaneous comparison group	2,993	149	3,142
Total Sample		**15,000**	**750**	**15,750**

The interim evaluation reports will detail the survey response rates across subpopulations, describe how the pandemic may have affected beneficiary responses, and outline efforts to improve data collection in the next survey waves. We will also continuously assess how any pandemic-related complications may affect the interpretation of survey results and other data analyses.

As noted, and particularly relevant to group E, the state suspended Medicaid disenrollment during the public health emergency. Medicaid disenrollments will resume once the PHE expires. The next round of data collection in CY22 will include a cohort of members who had previously been enrolled in Medicaid/BadgerCare at the start of the waiver, but were no longer enrolled at the point of the survey data collection.

The CY22 data collection plan includes a close-ended survey cohort of 1,500 randomly selected current and former Medicaid members:

- Formerly enrolled adults, who had been enrolled between October 1, 2019 and December 31, 2021.

- Medicaid members who enrolled in April-May 2020, during the COVID-19 pandemic (regardless of their CY22 enrollment status).
- Childless Adults and Parents/Caretaker Adults currently enrolled (at the time of the survey frame sample drawing), who had enrolled prior to policy implementation
- Childless Adults and Parents/Caretaker Adults currently enrolled (at the time of the survey frame sample drawing), who had enrolled after policy implementation

We will carefully assess the quality and representativeness of the data collected from the 2020 survey, and may adjust the sample frame and cohorts for the 2022 and 2024 surveys to assure that they match the goals at the time. Our plan for the second survey, in 2022, focuses on current and former member experience with the waiver implementation process and requirements, and will involve a set of semi-structured interviews to complement the survey protocol. The waiver implementation has, to date, been highly fluid, with several of the provisions remaining subject to change going forward. For this reason, and as noted above, we use an agile project management approach to planning for each of the three beneficiary surveys, and expect to re-define the more specific parameters of the survey cohorts, instrument domains, and data collection as the dates for those next surveys draw near.

iii. Weighting, Coding, and Analysis

After the baseline data are collected, we will construct survey weights. Following best practices in statistical survey, we will likely use "raking weights" (i.e., iterative proportional fitting)[12], as we did in our prior survey analysis. This method will allow us to adjust for non-response to the survey by adjusting on observed factors from the sample to make it match the sampling frame (e.g., in terms of age, sex, race/ethnicity, and rurality).

Survey weights will be designed to address two issues: purposeful over-sampling of subgroups and differential non-response (i.e., differences in the likelihood of different contacted individuals completing the survey). Survey weighting will take place in two steps. First, we will derive weights within each sampling group to upweight or downweight respondents to more closely resemble the known demographic characteristics of the population from which they were sampled. Raking weights work by first adjusting to make the sample weights adjust to the sampling frame on each factor (e.g., age), and then iteratively readjusting the weights to ensure strong match on additional factors (e.g., sex, race/ethnicity). This evaluation team used raking weights in prior beneficiary surveys fielded by this team in 2016 and 2018.

Second, we will create weights that will allow us to derive estimates of the prevalence of different indicators among all childless adults by upweighting or downweighting the survey groups (i.e., the survey strata) to their proportions in the childless adult population. Strata weights will not be required for parents and caregivers since we are pulling a simple random sample from this group.

[12] Battaglia, M. P., Izrael, D., Hoaglin, D. C., & Frankel, M. R. (2009). Practical considerations in raking survey data. *Survey Practice*, *2*(5), 1-10.

As with prior surveys, we will recode variables from their "raw" response categories to grouping that enhance their interpretability. We will also examine outlier values and ensure logical consistency, making data cleaning decisions that we will document for consumers of the survey.

Planned analytic tasks include the following:

- Conduct descriptive analysis with weighted and unweighted samples.
- Examine means and frequencies for all key study variables and compare differences across different study populations of interest (e.g., between childless adults and parents/caretakers).
- Focus some analyses on specific groups (e.g., use of substance use treatment among people with recent experiences of treatment).
- Run regression models to predict the likelihood of key study outcomes. For example, since age and sex may independently influence health care demand, we will include the variables in regression models examining group-level differences in health care use.
- Leverage data from historical surveys (e.g., 2018 waiver evaluation) to compare trends in outcomes that may be influenced by changes in program design over time.

After the survey is implemented, our design will allow us to link survey responses back to administrative data.

iv. Relationship of the Survey to Econometric Study Designs

The survey is designed to test for differences-in-differences (DiD) comparing different segments of the CLA population and to support descriptive analyses. Based on the survey sample groups A-F shown in **Table 3**. **Table 5** identifies how each of these study design group will be used for comparisons.

Notably, Provision 4 relates to a program change that is implemented statewide. Accordingly, we have no true comparison group within the state for the survey. For this hypothesis, we will not be able to implement a quasi-experimental comparison with study data and will therefore only implement descriptive analyses to identify rates of service use without attempting to draw causal inferences.

v. Power Calculations

Our difference-in-difference analysis will be conducted using a regression-based approach where random effect regression model is fit to estimate (for linear models) or (for dichotomous outcomes) $\Lambda(\Pr(y_{it}=1)) = \zeta + \phi Treat_i + \gamma t + \lambda Treat_i \times t + u_i$ where Λ is the logistic function that links the predicted probability into an expression of log-odds. The power analyses presented here evaluate the chance of a significant result on parameter λ.

Linear Models

For linear models, the effect size of standardized mean differences is defined as $\delta = \frac{\lambda}{\sigma_T}$, where σ_T is the residual variance defined as $\sigma_T = \sqrt{\sigma_u^2 + \sigma_e^2}$. The Intraclass correlation is defined as $ICC = \frac{\sigma_u^2}{\sigma_T^2}$, and the within-group standard deviation used in the random intercept model is (1-ICC; details in working paper). Based on work conducted by Hedberg (2020 working paper), the linear model minimum detectable effect size can be approximated by the following formula:

$$\delta = g(\alpha, \beta)\sqrt{\frac{\text{Deff}}{nT(P^2 - P)(Q^2 - Q)}(1 - ICC)}$$

Where g is a factor based on the desired level of significance (α) and power ($1 - \beta$). For .8 power and $\alpha = .05$, this factor is approximately 2.8. The other parameters include the ICC, a design effect due to weighting, the total number of respondents followed (n), the total number of time points ($T = 2$), the proportion of time points exposed to the program ($P = .5$) and the proportion of units exposed the program (Q).

Logistic Models

For logistic models fitting the probability of a positive response to a dichotomous outcome, the effect size is the estimated difference in the log-odds (λ), and its exponent expresses the odds-ratio as the effect size. Since the effect size is based only on the model coefficient, the difference in the log-odds (λ), the formulas for the minimum detectable effect size is adjusted by the square root of the inverse variance of the logistic (log-odds) distribution, which is $\frac{1}{\sqrt{\frac{\pi^2}{3}}} = \frac{\sqrt{3}}{\pi}$.

The minimum odds ratio formula contains additional elements, namely the square root of the variance of the logistic distribution, adding $\left(\frac{\pi}{\sqrt{3}}\right)$ s the within cluster variance.

$$\ln(OR) = \delta\sqrt{\frac{\pi^2}{3}} = g(\alpha, \beta)\sqrt{\frac{\left(\frac{\pi}{\sqrt{3}}\right)\text{Deff}}{nT(P^2 - P)(Q^2 - Q)}}$$

In addition, the design effect due to clustering is different. Since the ICC is employs the well-known variance of the logistic model ($\frac{\pi^2}{3}$) as the level 1 variance component, it is defined as $ICC = \frac{\sigma_u^2}{\sigma_u^2 + \frac{\pi^2}{3}}$, with the identity that $\sigma_u^2 = \left(\frac{\pi^2}{3}\right)\frac{ICC}{1-ICC}$, this will lead to another factor that must be applied to the linear minimum effect size to estimate the minimum difference in log odds.

$$\frac{V_{cluster}}{V_{srs}} = \frac{\sigma_u^2 + \frac{\pi^2}{3}}{\frac{\pi^2}{3}} = \frac{\left(\frac{\pi^2}{3}\right)\frac{ICC}{1-ICC} + \frac{\pi^2}{3}}{\frac{\pi^2}{3}} = 1 + \frac{ICC}{1-ICC}$$

The natural log of this minimum odds ratio is

$$\ln(OR) = g(\alpha,\beta)\sqrt{\frac{\left(\frac{\pi}{\sqrt{3}}\right)\text{Deff}}{nT(P^2-P)(Q^2-Q)}\left(1+\frac{ICC}{1-ICC}\right)}$$

For our hypothesis-testing difference-in-differences analyses, and as elaborated above, we expect to achieve an average response rate of 40%. That means that we would expect to have sample sizes of 840 for each of the groups A-E and 1800 in group F in each survey round.

Using a power calculation tool developed by a statistician at NORC.[13] we have conducted a power calculation to illustrate the minimum effect sizes (for linear and logit models) we would be powered to detect with these sample sizes. Specifically, we assume that we are testing two-sided hypotheses at an alpha level of .05 and are adopting a power level of 80%. We assume that each sample is drawn independently and there is no correlation among survey respondents across years. We also assume a weighting design effect of 1.25, which is similar to what is seen in other analyses of this type. Under these circumstances, we assume that we would obtain a minimum detectable effect of 0.11 standard deviations for linear models, and an odds ratio of 1.52. These calculations are for unconditional models without covariates. If the correlation between the covariates and the treatment indicator are small, power will improve. However, if the correlations are large, the benefit of covariates may be outweighed by the induced multicollinearity.

vi. Beneficiary Interviews

In addition to the surveys, the evaluation team plans to conduct a series of individual interviews with beneficiaries, in CY 2022, using a protocol designed and implemented by NORC at the University of Chicago for use in the evaluation of the Kentucky Medicaid 1115 waiver. The Kentucky waiver protocol had included surveys with 125 Medicaid beneficiaries. For Wisconsin's project, we have planned to conduct interviews with 25 beneficiaries. This number of interviews will yield sufficient information to inform the process and quality improvement aims attached to this component of the evaluation.

Respondents who complete and return the CY22 mail survey will be considered eligible for an in-person interview if they indicate willingness to be contacted for a follow-up interview. We will select potential interview sample members from two to three targeted geographic areas within the state of Wisconsin, from both urban and rural regions with an aim toward including diverse perspectives. The interview participants will receive a $50 participation incentive, designed to attract interest in participation. The

[13]Hedberg E. Optimal Time-points for Difference in Difference Models with Multiple Indicators and (Possibly) Repeated Cross Sections. NORC, Chicago. Unpublished Working Paper.

selection of participants will be finalized once the full universe of interested potential participants is identified.

We consider it important to seek diverse perspectives in the interview pool, along characteristics such as urban/rural residents, sex or gender identity, age, race, ethnicity, health status. But, for the intended purposes of the qualitative methods, we are not particularly concerned about statistical representation across each specific geographic area of the state.

The collection of interview data, using qualitative methods, is not expected to provide a fully representative sample of the state population. Rather, this approach to data collection is designed to answer questions about lived experiences, gathering narrative (rather than numeric) data, and analyzing these data thematically (rather than mathematically). These qualitative methods help to understand how people experience events, programs, policies and services, and how and why they may respond in various ways.

Such qualitative methods help evaluators to better understand the role of factors that are difficult to fully quantify or isolate, such as feelings, attitudes, social environments, relationships, and how these factors might affect individuals differently. Qualitative methods can be especially useful for constructing theories or generating hypotheses in areas in which causal pathways are unclear. In this way, our planned qualitative methods can help support or alter hypotheses and suggest underlying mechanisms to explain observed trends and otherwise measured outcomes.

Table 4. Survey Domains Relevant to Study Hypotheses

Hypothesis	Target population	Survey domain(s)	Survey question(s)
Provision 1: Provide state plan benefits, other than family planning and tuberculosis-related services, to non-elderly childless adults with family income of up to 100% FPL			
Hypothesis 1.2. The expansion of benefits to non-elderly childless adults (CLAs) will lead to increased access to medical care among poor CLAs.	CLA	• Health insurance status and recent history of uninsurance • Access and use of general medical care • Demographics and socioeconomic status	Self-reported access/barriers to care, utilization of care, self-reported quality of care, annual household income, recently uninsured status
Hypothesis 1.3. The expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals.		• Health insurance status and recent history of uninsurance • Access and use of general medical care	Self-reported use of uncompensated care, recently uninsured status
Provision 2: Health Assessment Linked to Eligibility and Premiums			
Hypothesis 2.1 Beneficiaries for whom the health assessment has eligibility and premium consequences will reduce risky behaviors and engage in more healthy behaviors.	CLA	• Exercise, smoking, diet and other preventive health behaviors • Health status and chronic conditions • Access and utilization of general medical care • Knowledge and perceptions of current provisions of the waiver • Attitudes about consumerism and personal responsibility • Demographics and socioeconomic status	Self-reported eligibility for the premiums, knowledge and completion of HA, risk behaviors (e.g., tobacco use), healthy behaviors (e.g., exercise and seatbelt use), motivation and attempts to change behaviors

Hypothesis	Target population	Survey domain(s)	Survey question(s)
Hypothesis 2.2 The health assessment will increase the number of beneficiaries receiving treatment for substance-use disorders.		• Substance use and use disorders • Access and utilization of drug treatment • Exercise, smoking, diet and other preventive health behaviors • Health status and chronic conditions • Access and utilization of general medical care • Demographics and socioeconomic status	Substance use/use disorders, access and utilization of SUD treatment, interest and motivation to receive SUD treatment; self-reported eligibility for the premiums, ability to pay premiums
Provision 3: Implement premiums for childless adult beneficiaries ages 19-64 with income between 50% and 100% FPL; Allow termination and a period of non-eligibility for up to six months for childless adults who do not pay the required premium; Implement an $8 copayment for non-emergent use of the emergency department for childless adults			
Hypothesis 3.1. Beneficiaries who are required to make premium payments will gain familiarity with a common feature of commercial health insurance.	CLA	• Knowledge and perceptions of current provisions of the waiver • Attitudes about consumerism and personal responsibility • Demographics and socioeconomic status	Health insurance literacy; self-reported eligibility for the premiums, ability to pay premiums
Hypothesis 3.5. The imposition of a copayment for non-emergent use of the emergency department (ED) will lead to more appropriate uses of medical care among CLAs enrolled in Medicaid.		• Knowledge and perceptions of current provisions of the waiver • Attitudes about consumerism and personal responsibility • Demographics and socioeconomic status	Health insurance literacy; self-reported eligibility for the copayments, ability to pay copayments

Hypothesis	Target population	Survey domain(s)	Survey question(s)
Provision 4: Provide residential benefit for SUD treatment and coverage for existing SUD services when they are provided in an institution of mental disease (IMD).			
Hypothesis 4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time	All Medicaid-Enrolled Adults	• Substance use and use disorders • Access and utilization of drug treatment • Knowledge and perceptions of current provisions of the waiver	Substance use/use disorders, access and utilization of SUD treatment, interest and motivation to receive SUD treatment
Hypothesis 4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services and pharmacotherapy treatment provided outside of IMD settings.		• Substance use and use disorders • Access and utilization of drug treatment • Knowledge and perceptions of current provisions of the waiver	Substance use/use disorders, access and utilization of SUD treatment, interest and motivation to receive SUD treatment
Hypothesis 4.3b. The SUD demonstration waiver will reduce use of hospital-based services, conditional on increased supply of SUD providers or increased use of new and existing covered SUD services.	All Medicaid-Enrolled Adults	• Access and utilization of general medical care • Substance use and use disorders • Access and utilization of drug treatment • Knowledge and perceptions of current provisions of the waiver	Self-reported access/barriers to care, utilization of care; substance use/use disorders, access and utilization of SUD treatment, interest and motivation to receive SUD treatment
Hypothesis 4.3c. The SUD demonstration waiver will increase use of health care for co-morbid physical and mental health conditions among enrollees with an SUD, conditional on increased supply of SUD providers or increased use of new and existing covered SUD services.		• Health status and chronic conditions • Access and utilization of general medical care • Substance use and use disorders • Access and utilization of drug treatment • Knowledge and perceptions of current provisions of the waiver	Self-reported access/barriers to care, utilization of care, quality of care; substance use/use disorders, access and utilization of SUD treatment, interest and motivation to receive SUD treatment

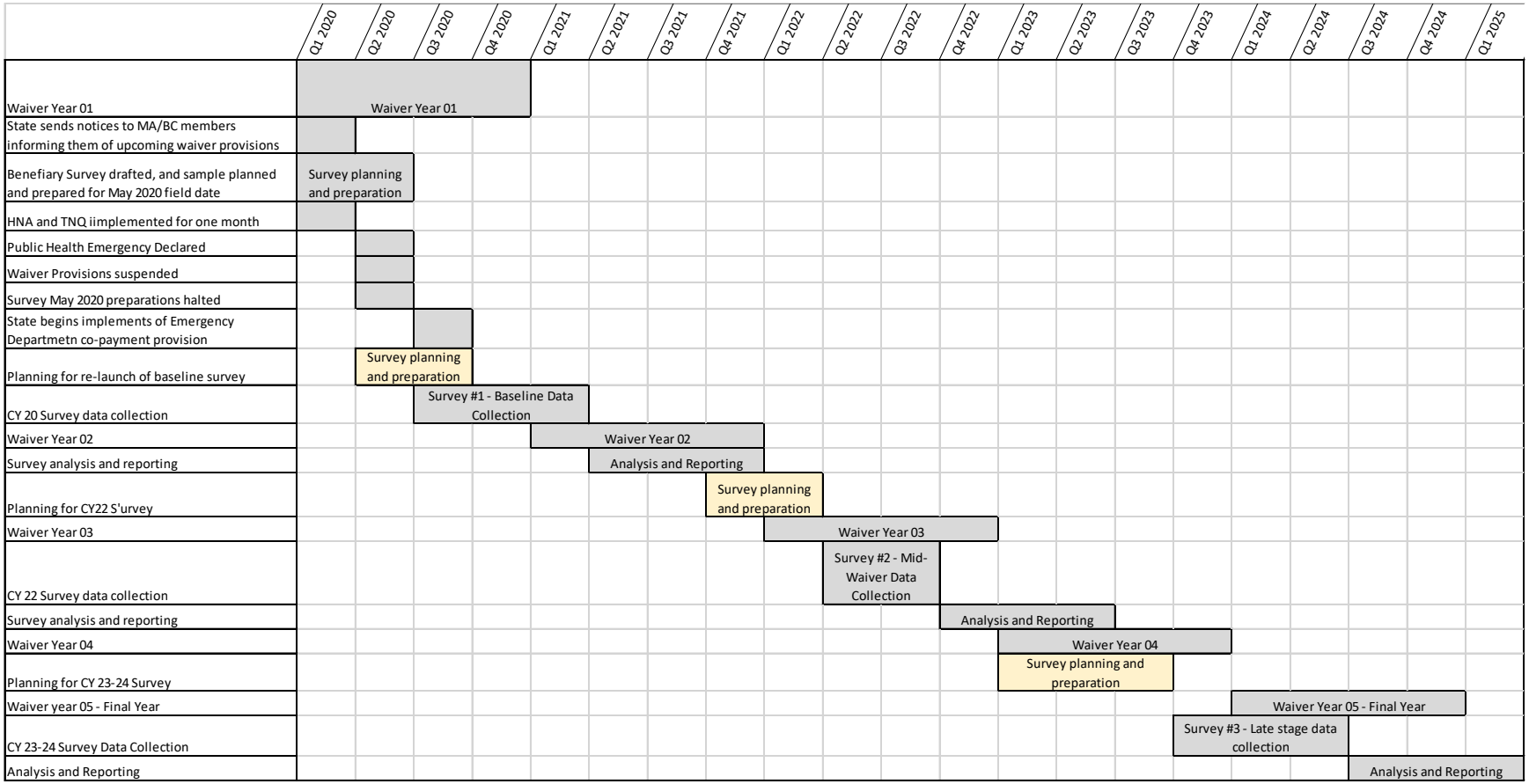
Hypothesis	Target population	Survey domain(s)	Survey question(s)
Hypothesis 4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers or increased use of new and existing covered SUD services.		• Substance use and use disorders • Access and utilization of drug treatment • Knowledge and perceptions of current provisions of the waiver	Self-reported access/barriers to care, utilization of care; substance use/use disorders, access and utilization of SUD treatment, interest and motivation to receive SUD treatment

Table 5. Survey Study Design Comparisons

Provision	Primary treated group(s)	Primary comparison group(s)
Provision 1: Provide state plan benefits, other than family planning and tuberculosis-related services, to non-elderly childless adults with family income of up to 100% FPL		
Hypothesis 1.2. The expansion of benefits to non-elderly childless adults (CLAs) will lead to increased access to medical care among poor CLAs.	Groups A+B	Group E
Hypothesis 1.3. By expanding the safety net, the expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals.	Groups A+B	Group E
Provision 2: Health Assessment Linked to Eligibility and Premiums		
Hypothesis 2.1 Beneficiaries for whom the health assessment has eligibility and premium consequences will reduce risky behaviors and engage in more healthy behaviors.	Groups A+B	Group E
Hypothesis 2.2 The health assessment will increase the number of beneficiaries receiving treatment for substance-use disorders.	Groups A+B	Group E
Provision 3: Implement premiums for childless adult beneficiaries ages 19-64 with income between 50% and 100% FPL; Allow termination and a period of non-eligibility for up to six months for childless adults who do not pay the required premium; Implement an $8 copayment for non-emergent use of the emergency department for childless adults		
Hypothesis 3.1. Beneficiaries who are required to make premium payments will gain familiarity with a common feature of commercial health insurance.	Groups B, D	Group A
Hypothesis 3.54. The imposition of a copayment for non-emergent use of the emergency department (ED) will lead to more appropriate uses of medical care among CLAs enrolled in Medicaid.	Groups B, D	Group A

Provision	Primary treated group(s)	Primary comparison group(s)
Provision 4: Provide residential treatment benefit for SUD and coverage for existing SUD services when they are provided in an institution of mental disease (IMD).		
Hypothesis 4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time	Group A, B, C, F	None
Hypothesis 4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services and pharmacotherapy treatment provided outside of IMD settings.	Group A, B, C, F	None
Hypothesis 4.3b. The SUD demonstration waiver will reduce use of hospital-based services, conditional on increased supply of SUD providers or increased use of new and existing covered SUD services.	Group A, B, C, F	None
Hypothesis 4.3c. The SUD demonstration waiver will increase use of health care for co-morbid physical and mental health conditions among enrollees with an SUD, conditional on increased supply of SUD providers or increased use of new and existing covered SUD services.	Group A, B, C, F	None
Hypothesis 4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers or increased use of new and existing covered SUD services.	Group A, B, C, F	None

Table 6. Beneficiary Surveys: Timeframe across the Waiver Demonstration Period



III. EVALUATION PROVISIONS, HYPOTHESES, AND QUESTIONS

Note regarding the COVID-19 pandemic's effect on the waiver evaluation:

Since the COVID-19 public health emergency declared on March 18, 2020, the Wisconsin Medicaid program has suspended the several of its waiver provisions, including premiums and the health needs assessment. We expect that these provisions will remain in suspension during the entire period of the federally-designated public health emergency. The state has implemented, as of July 2020, the provision requiring a copayment for emergency department services when identified as a non-emergency. The SUD residential treatment benefit was implemented in on February 1, 2021.

The evaluation team adjusted its data collection and analysis plan, previously detailed in the December 2019 version of the Design Report, in response to the change in waiver implementation. Generally, these revisions include greater flexibility in modeling time, the exclusion of 2020 from the baseline or pre-period, and dropping interrupted time series analyses as the assumption of a stable pre-trend is no longer tenable. The following sections outline in detail these changes to the evaluation plan including the effects of potential changes in the beneficiary pool. The team continues to monitor COVID-19 related secular and programmatic changes that may influence evaluation outcomes (e.g., expanded coverage for telehealth services, maintenance of eligibility, expanded access to subsidized Marketplace coverage, etc.). We will continue to analyze changes in enrollment and health care use patterns among the waiver populations that are associated with these programmatic and secular changes to inform if or how we need to account for such changes in the evaluation of the waiver provisions.

IIIA. Provision I: Coverage up to 100% FPL for Childless Adults

A1. General Background Information

Provision: Provide state plan benefits, other than family planning and tuberculosis-related services, to non-elderly childless adults with family income of up to 100% FPL.

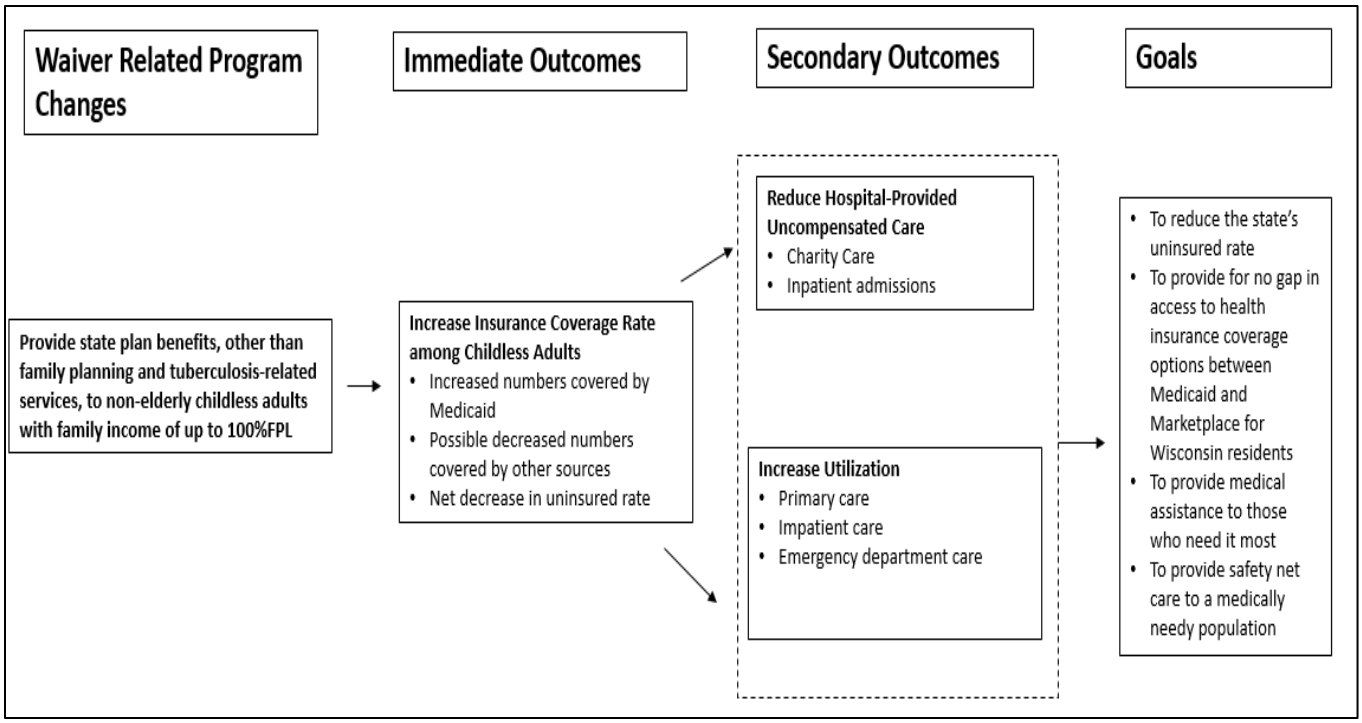
In April 2014, Wisconsin initiated a CMS-approved 1115 Demonstration Waiver that allowed federal Medicaid matching funds for providing health care coverage for childless adults between the ages of 19 and 64 years old who have income at or below 100% FPL. The childless adult population receives the standard benefit plan, which is the same benefit plan that covers parents, caregivers, and children. That waiver expired on December 31, 2018, and the new CMS waiver approved through 2023 extends this existing coverage for childless adults.

Medicaid program goal: To improve health outcomes and reduce unnecessary services. As well, by establishing an eligibility income limit at 100% FPL, rather than implementing a full ACA-authorized Medicaid expansion, the State of Wisconsin focused on "creating a program that is sustainable" and "available to those who need it most."

A2. Evaluation Questions and Hypotheses

A2.1. Driver Diagram

Figure 1. Driver Diagram for Childless Adults Coverage Expansion



A2.2. Hypotheses & Research Questions

Hypothesis 1.1. The expansion of benefits to non-elderly childless adults (CLAs) will reduce the state's uninsured rate.

Primary Research Question 1.1: Did the expansion of benefits to CLAs reduce the state's uninsured rate?

Q 1.1a. What are the trends in Wisconsin's adult uninsured rate and uninsured rate among CLAs?

Q 1.1b. How much did the change in the number of CLAs due to the Medicaid expansion contribute to the overall change in the adult uninsured rate in Wisconsin?

Hypothesis 1.2. The expansion of benefits to CLAs will lead to increased access to medical care among poor CLAs.

Primary Research Question 1.2: How did the CLA expansion affect the use of health care services?

Q 1.2a. Did the expansion of benefits to CLAs increase the use of primary care among poor CLAs in Wisconsin?

Q 1.2b. What are the short- and long-term effects of eligibility and coverage policies, including maintenance of eligibility, on Medicaid health service expenditures?

Hypothesis 1.3. By expanding the safety net, the expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals.

Primary Research Question 1.3. Did the expansion of benefits to CLAs reduce the provision of uncompensated care (charity care plus bad debt) among Wisconsin acute care hospitals?

Q 1.3a. What are the trends in the provision of uncompensated care among Wisconsin hospitals and did it change along with the expansion of benefits to CLAs?

Q 1.3b. Did hospitals in areas with greater reductions in the number of uninsured CLAs experience differential changes in uncompensated care?

Hypothesis 1.4. Additional requirements of the current demonstration may increase administrative costs.

Primary Research Question 1. 4. What are the administrative costs incurred by the state and counties to implement and operate the demonstration?

Q1.4a What are the administrative costs incurred by the state to implement and operate the demonstration?

Q1.4b How did county income maintenance staff workloads change around implementation of the current demonstration?

A3. Methodology

A3.1. Evaluation design summary

We will use three analytic approaches to address the primary research question for evaluation of waiver provision 1, the expansion of Medicaid coverage to childless adults up to 100% FPL. These are ITS, DiD, and panel data models based on geographically contiguous and matched counties.

COVID-related note: Waiver provision 1 has been underway since 2014. Its evaluation does not rely on post 2020 data for causal inference and can include the pandemic and post-pandemic periods in a descriptive form. The evaluation of this provision can readily exclude the 2020 period and retain the use of ITS methods. However, because trends in the waiver population during the pandemic period and beyond are of interest to understand the remaining waiver provisions, we will also include a description of them, allowing for heterogeneity over time, when feasible.

The Design Table (**Table 7**) summarizes the key features of the evaluation design.

Table 7. Provision 1: Summary of Hypotheses, Questions, Data Sources, and Analytic Approaches for Evaluation of the Expansion of Medicaid Benefits to Childless Adults (CLAs)

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	**Revised**
Hypothesis 1.1: *The expansion of benefits to CLAs will reduce the state's uninsured rate.*				
Primary research question 1.1: Did the expansion of benefits to CLAs reduce the state's uninsured rate?				
Question 1.1a: What are the trends in Wisconsin's adult uninsured rate and uninsured rate among CLAs?				
CLAs prior to expansion	No source of insurance coverage	American Community Survey	ITS	This analysis will only rely on data prior to 2020.
	Covered by Medicaid/BadgerCare			
	Covered by private insurance	Family Health Survey		
	Other public coverage			
Question 1.1b: How much did the change in the number of CLAs due to the Medicaid expansion contribute to the overall change in the adult uninsured rate in Wisconsin?				
CLAs in other states	No source of insurance coverage	American Community Survey	DiD	Causal analysis will only rely on data prior to 2020; descriptive analysis of 2020 forward will be included.
	Covered by Medicaid/BadgerCare			
	Covered by private insurance	Behavioral Risk Factor Surveillance System		
	Other public coverage			
Adults in counties that neighbor Wisconsin	No source of insurance coverage	Small Area Health Insurance Estimates	Panel data models based on geographically contiguous and matched border counties	

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 1.2: *The expansion of benefits to CLAs will lead to increased access to medical care among poor CLAs.*				
Primary research question 1.2: How did the CLA expansion affect the use of health care services?				
Question 1.2a: Did the CLA expansion increase the use of medical care among low-income CLAs in Wisconsin?				
CLAs in other states	Doctor Visits	Behavioral Risk Factor Surveillance System	DiD	Causal analysis will only rely on data prior to 2020; descriptive analysis of 2020 forward will be included.
	Dentist Visits			
	Health care access	Family Health Survey		
Adults in other states	Hospital stays	State Inpatient Databases	DiD	Causal analysis will only rely on data prior to 2020; descriptive analysis of 2020 forward will be included.
	Emergency department visits			
Parents and caregivers in Wisconsin	Self-reported utilization and access to care	Survey of beneficiaries	DiD	
Question 1.2b: What are the short- and long-term effects of eligibility and coverage policies, including maintenance of eligibility, on Medicaid health service expenditures?				
CLAs in other states	Total Medicaid-paid inpatient expenditures	State Inpatient Databases	DiD	This analysis will only rely on data prior to 2020.
	Per-person Medicaid-paid inpatient expenditures			
Parents and caregivers in Wisconsin	Total Medicaid-paid health care expenditures	State Medicaid Claims	DiD	Causal analysis will only rely on data prior to 2020; descriptive analysis of 2020 forward will be included.
	Per-person Medicaid-paid health care expenditures			

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 1.3: *By expanding the safety net, the expansion of benefits to CLAs will lead to lower provision of uncompensated care by hospitals.*				
Primary research question 1.3: Did the CLA expansion reduce the provision of uncompensated care among Wisconsin acute care hospitals?				
Question 1.3a: What are the trends in the provision of uncompensated care among Wisconsin hospitals and did it change along with the expansion of benefits to CLAs?				
Hospitals prior to CLA expansion	Dollar amount of charity care provision Dollar amount of bad debt	CMS Hospital Cost Reports	ITS	This analysis will only rely on data prior to 2020.
Question 1.3b: Did hospitals in areas with greater reductions in the number of uninsured CLAs experience differential changes in uncompensated care?				
Hospitals in other states	Dollar amount of charity care provision Dollar amount of bad debt	CMS Hospital Cost Reports	DiD	Causal analysis will only rely on data prior to 2020; descriptive analysis of 2020 forward will be included.
Hospitals in neighboring geographic areas	Dollar amount of charity care provision Dollar amount of bad debt	CMS Hospital Cost Reports	Panel data models based on geographically contiguous and matched border areas	Causal analysis will only rely on data prior to 2020; descriptive analysis of 2020 forward will be included.
Hypothesis 1.4: *Additional requirements of the demonstration may increase administrative costs.*				
Primary research question 1.4: What are the administrative costs incurred by the state and counties to implement and operate the demonstration?				
Question 1.4a: What are the administrative costs incurred by the state to implement and operate the demonstration?				
N/A	Administrative costs associated with demonstration startup Ongoing administrative costs of demonstration operations	DHS-provided estimates of contract costs, staff-time equivalents, and other costs	Descriptive analysis of administrative costs over time	Unchanged
Question 1.4b: How did county income maintenance staff workloads change around implementation of the current demonstration?				
N/A	County administrative costs	County workload reporting data	Descriptive analysis of administrative costs over time	Unchanged

A3.2. Target and Comparison Populations

The target populations for the evaluation of waiver provision 1 include (i) CLAs in Wisconsin; (ii) adults in Wisconsin; and (iii) acute-care hospitals in Wisconsin.

We will address each of the primary research questions as follows:

Q 1.1. "Did the CLA expansion reduce the state's uninsured rate?": Construct three comparison groups for CLAs subject to the CLA expansion. The first is CLAs in years prior to the CLA expansion (years prior to 2014). The second comparison group is CLAs from other states (both states that fully expanded Medicaid to 138% FPL and states that did not expand at all). The third comparison group is adults in counties that border Wisconsin.

Q 1.2. "How did the CLA expansion affect the use of health care services?": Construct three comparison groups: CLAs in other states, adults in other states, and parents and caregivers in Wisconsin BadgerCare who were consistently able to access comprehensive benefits.

Q 1.3. "Did the CLA expansion reduce the provision of uncompensated care among Wisconsin acute care hospitals?": Compare acute care hospitals in Wisconsin to three comparison groups of hospitals: hospitals in Wisconsin prior to the CLA expansion, hospitals in other states, and hospitals in geographic areas in other states that border Wisconsin.

Q 1.4. "What are the administrative costs incurred by the state and counties to implement and operate the demonstration?" No comparison group; descriptive analysis of administrative costs over time as reported by state records and through interviews.

Table 8. Provision 1 Data Sources

	Hypotheses
The American Community Survey (ACS). To estimate sources of health insurance coverage in the previous year among CLAs in Wisconsin and in comparison states.	H1.1
Behavioral Risk Factor Surveillance System (BRFSS). To estimate both health insurance coverage and measures of access to health care.	H1.1 H1.2
Small Area Health Insurance Estimates (SAHIE). To estimate health insurance coverage rates at the county level.	H1.1
Wisconsin Family Health Survey (FHS). To estimate Wisconsin rates of health insurance coverage, measures of health status, health problems, and use of health care services.	H1.1 H1.2
State Inpatient Databases (SID). Data on six states from the SID to measure inpatient stays and emergency department visits.	H1.2
Medicaid beneficiary survey. To assess CHA enrollees' experiences with barriers related to cost, availability, and benefit design.	H1.2
Hospital Cost Reports. To measure hospitals' provision of uncompensated care.	H1.3
State and Managed Care Administrative Records. To estimate the staff and other inputs for implementing and operating the demonstration.	H1.4
Interviews with state agency staff and partner organizations. To identify staff effort and administrative costs associated with implementing and operating the demonstration.	H1.4

A3.3. Evaluation Period

The evaluation period will include the years 2012 (prior to initial CLA coverage expansion), through 2023, including both a period prior to and a period following the launch of the new waiver in 2020. The Provision 1 analyses will apply to the current demonstration period while including the timeline of the 2014 initial expansion to the CLA population as relevant contextual background. Effects may differ across these time periods, which we will allow for in the analyses.

A3.4. Data Sources & Outcome Measures

The outcome measures for this evaluation are defined in **Table 7**. This evaluation will involve multiple data sources. They are noted in **Table 8**, along with the hypotheses for which these data will be used. Section IID, above, provides a full description of these data sources.

A3.5. Analytic Methods

We will address each of the primary research questions as follows:

Q1.1. "Did the CLA expansion reduce the state's uninsured rate?": Compare CLAs in Wisconsin both pre- and post-expansion. We will conduct interrupted time-series analyses (described below and in Section IIB) to determine whether the CLA expansion reduced the fraction of CLAs in the state who did not have any source of health insurance. Additional outcomes we will examine include sources of insurance coverage, including Medicaid/BadgerCare, private insurance, and other sources of public coverage (such as Medicare). We can construct these groups using data from the American Community Survey (ACS) and from Wisconsin's Family Health Survey.

We will also compare CLAs in Wisconsin with CLAs in other states using DiD (described below and in Section IIB). In particular, we will use the ACS to compare the change in the fraction of CLAs in Wisconsin without health insurance with the change in the fraction of CLAs in states that did not expand Medicaid and, similarly, with the change in states that fully expanded Medicaid. This analysis will also examine changes in sources of coverage (Medicaid/BadgerCare, private, other public).

We will compare adults in counties that border Wisconsin with adults in Wisconsin by geographically matching border counties in Wisconsin to their contiguous border counties in neighboring states and by estimating panel data models (described below) and using data from the Census Small Area Health Insurance Estimates program. These models will enable us to determine the effect of the CLA expansion on the fraction of adults without health insurance. Since all of Wisconsin's neighboring states implemented a full ACA Medicaid expansion (with the exception of Iowa), we will be comparing the CLA expansion to a full Medicaid expansion.

Q1.2. "Did the CLA expansion increase the use of medical care among poor CLAs in Wisconsin?" We will compare CLAs in Wisconsin with CLAs in other states using DiD and data from the BRFSS. Comparing adults in Wisconsin and in other states and using data from the SID, we will estimate DiD models on the number of hospital stays, and emergency department visits. We will undertake a similar comparison between parents and caregivers enrolled in Medicaid and CLAs enrolled in

Medicaid taking advantage of the historical data available in the Wisconsin Medicaid beneficiary survey (i.e., data that our team collected in 2014, 2016, and 2018).

Q1.3. "Did the CLA expansion reduce the provision of uncompensated care among Wisconsin acute care hospitals?": We will employ ITS, DiD, and panel data models on hospitals in geographically matched areas to determine the impact of the CLA expansion on the provision of charity care and on bad debt by hospitals.

Q1.4. "What are the administrative costs incurred by the state to implement and operate the demonstration?": We will perform a descriptive analysis of DHS-provided reports of contract costs, staff-time equivalents, and other administrative costs 1) to establish demonstration policies, typically incurred in the years prior to and including the initial year of the demonstration, 2) operate the ongoing demonstration, and 3) for state agencies partnering with Medicaid to implement and operate the demonstration.

Difference-in-Differences Method

When using data sources that span multiple states, and when we are able to construct comparison group of CLAs in other states, we will use DiD to compare changes in outcomes among CLAs in Wisconsin to that change among CLAs in other states. This method is described in Section IIC.[14] We will allow effects to differ over time.

ITS Estimation

It may not be possible to construct valid control groups to estimate each treatment effect, because the Medicaid program will implement select waiver provisions for all eligible beneficiaries at the same time, and may change implementation practices in light of information learned in the process of monitoring, rapid-cycle evaluation, shared learning, and quality/process improvement. These changes in implementation are intended to improve population outcomes, and evaluating these changes is an important component of the analysis. Consequently, to the extent that these changes affect an entire state's enrolled population, there will be no control group against which to compare. To account for this, we will also assess changes in outcomes for Wisconsin CLAs using time series models such as the ITS (ITS) model, which is described in Section IIC.[15] The pandemic-related disruptions in data do not affect the use of ITS for this provision, as we are able to use data entirely prior to that year to observe the effects of the policy change, which occurred in 2014.

[14]See Wing, C., Simon, K., & Bello-Gomez, R. A. (2018) Designing Difference in Difference Studies: Best Practices for Public Health Policy Research. Annual Review of Public Health 39(1):453-469; Dague L, Lahey JN. Causal Inference Methods: Lessons from Applied Microeconomics. 2019. Journal of Public Administration Research and Theory. 29(3): 511–529.

[15] See Kontopantelis E, Doran T, Springate DA, Buchan I, Reeves D. 2015. Regression-Based Quasi-Experimental Approach When Randomisation Is Not an Option: Interrupted Time Series Analysis BMJ. 350:h2750.

Panel Data Methods with Geographically Matched Border Counties

We will implement our panel data models on a geographically matched sample, following the local identification methodology of Dube, Lester, and Reich (2010)[16], and compare outcomes in adjacent counties that straddle a state border with Wisconsin. This local identification strategy relies on contiguous counties being similar in terms of population and market characteristics. We will use the U.S. Census County Adjacency File to identify all counties in states that are adjacent to one or more counties in Wisconsin. To estimate the effect of the CLA expansion on outcomes, we estimate the following fixed-effects regression on a sample of matched counties:

$$(1) \qquad y_{c,m,t} = \alpha + \gamma expansion_{c,m,t} + \varphi_m + \phi_c + \tau_t + e_{c,m,t}.$$

where $y_{c,m,t}$ is the outcome in county *c* in the matched-county pair *m* in year *t*, $expansion_{c,m,t}$ is a dummy variable indicating that county *c* in group *m* is in a Wisconsin following the CLA expansion, τ_t is a year fixed effect, φ_m is a matched-county pair fixed effect, and ϕ_c is a county fixed effect. We will allow effects to differ over time.

A4. Methodological Limitations

Because the CLA expansion was implemented at a single time statewide and without randomized controls, the evaluation relies on quasi-experimental methods.

IIIB. Provision 2: Health Assessment Linked to Eligibility and Premiums

B1. General Background Information

Provision: For childless adults, 1) require completion of a health risk assessment as a condition of eligibility and linked to potential reduction in premiums for those subject to premiums, and 2) provide a voluntary health needs assessment linked to potential reduction in premiums for those subject to premiums.

The Wisconsin Medicaid program had planned and did initiate this provision in February 2020. However, it was in effect only until March 18, 2020, the date of enactment of the federally public health emergency, at which point this provision were suspended.

Once re-activated, the target population for this provision includes childless adult applicants and beneficiaries. The two parts include 1) a single question, presented during the application process, which requires a response from any childless adult applicant as a condition of eligibility and is linked to premium reductions for childless adults who are subject to premiums, and 2) voluntary questions, linked

[16] Dube A, Lester TW, Reich M. 2010. Minimum Wage Effects Across State Borders: Estimates Using Contiguous Counties. The Review of Economics and Statistics. Vol. 92(4):945-964.

to premium reductions for childless adults who are subject to premiums (the childless adult population with incomes 50% through 100% FPL).

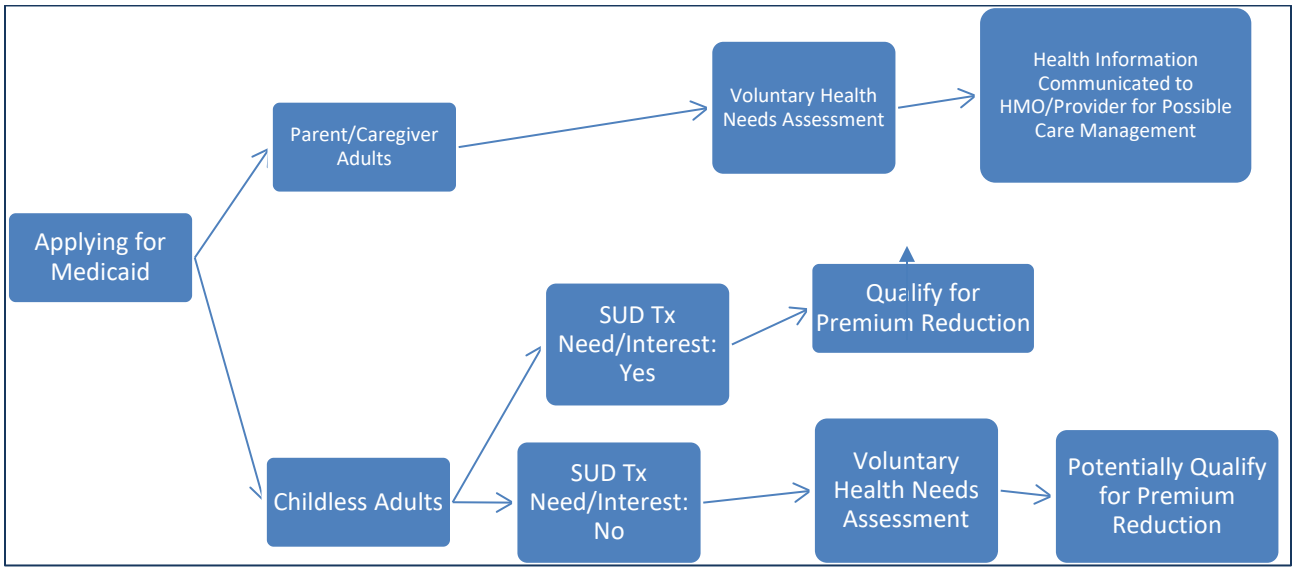
All childless adults applying for Medicaid will be asked, as part of the application process, a single question to assess the applicant's (or renewing beneficiary's) interest in receiving treatment for a substance use disorder. The state refers to this as the Treatment Needs Questionnaire (TNQ). Any response to the question satisfies the condition of eligibility. The Medicaid program will inform the beneficiary's HMO if s/he is interested in receiving treatment for a SUD. An affirmative response will also reduce the premium for CLAs that are subject to premiums. It is important to note that CLA applicants/beneficiaries will not be aware of any potential premium implications related to their response on their interest in receiving treatment for a substance use disorder. Notification of premium reductions will occur only after completion of the entire enrollment process. For this reason, any impact of the health assessment on treatment for SUDs will likely result from identification of the SUD and subsequent communication to the HMO for treatment follow up. The premium differentials are not a likely mechanism through which the health assessment could affect SUD treatment.

After the application, all CLAs will be invited to complete further questions within the voluntary component of the health assessment. The introductory text will inform the individual that completion of this portion of the assessment provides an opportunity to reduce the monthly premium for those income-eligible for premiums. The introductory text will also suggest that the question will be used to communicate care needs to the members' HMOs. The assessment will include questions about health-promoting behaviors (such as daily exercise), health risks (such as smoking), and about intention to reduce those risks through health care-seeking and/or behavior change. The substantive responses to these questions determine whether a premium-eligible CLA qualifies for a premium reduction.

The Medicaid program will also make this voluntary component of the health assessment available for any parent/caregiver applicant or adult BadgerCare Plus beneficiary who wishes to complete it. This beneficiary population is not subject to premiums. This group will see the same introductory language pertaining to the use of the health assessment for communicating with the HMOs and better managing their care plans.

Medicaid program goals: To improve beneficiaries' engagement in their health care choices by increasing their awareness of behaviors that might be detrimental to their health, while also encouraging them to make healthier choices.

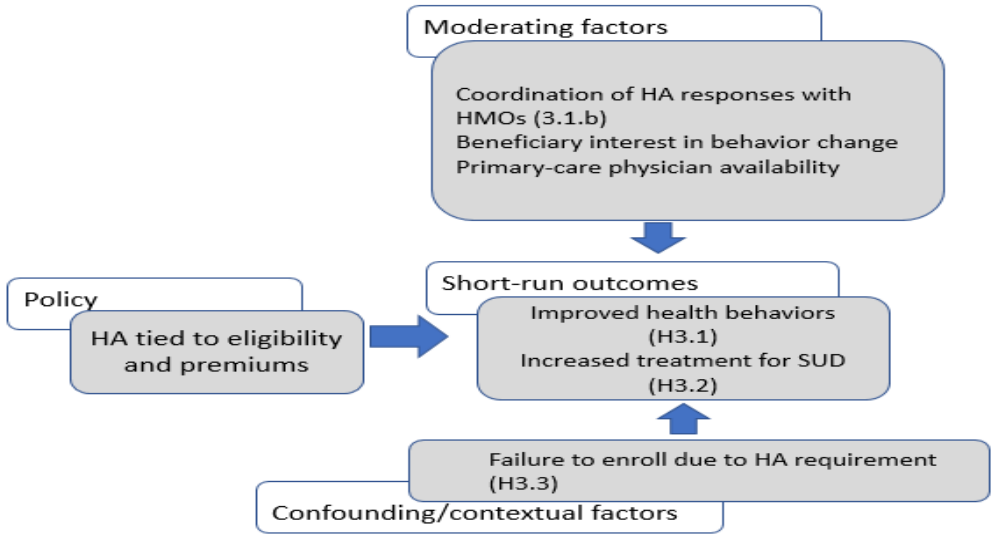
Figure 2. Health Assessment Pathways: Eligibility, Health Assessment, and Premium Reduction



B2. Evaluation Questions and Hypotheses

B2.1. Driver Diagram

Figure 3. Driver Diagram: Health Risk and Needs Assessment



B2.2. Hypotheses & Research Questions

This provision of the demonstration waiver will implement an assessment of health risks and needs that is linked to eligibility and premium reductions for childless adult beneficiaries. Childless adults (CLAs) are required to answer a question on their interest in treatment for substance-use disorders as a requirement of eligibility (the treatment needs questionnaire), and an affirmative response will reduce the premium for CLAs who are subject to the premium requirement. The voluntary health needs assessment includes additional questions assessing healthy behaviors (e.g., alcohol consumption, smoking, exercise). Answering the additional questions on healthy behaviors is not a requirement of eligibility, but CLAs with incomes greater than 50% and up to and including 100% will receive a premium reduction if their responses reveal that they engage in at least one risk-mitigating or healthy behavior.

Hypothesis 2.1. Beneficiaries for whom the health assessment has eligibility and premium consequences will reduce risky behaviors and engage in healthier behaviors.

Primary Research Question 2.1: Did CLA beneficiaries reduce risky health behaviors and increase healthy behaviors after the introduction of the health assessment?

Q 2.1.a. What fraction of CLA enrollees completed the second part of the health assessment? How does this compare to the fraction of non-CLA adult enrollees completing it?

Q 2.1.b. What is the distribution of healthy behaviors reported by CLAs completing the health assessment? What fraction of CLAs achieved a premium reduction based on their answers to the health assessment? How did these two patterns trend over time?

Q 2.1.c. How did the number of health behaviors reported by CLAs in the health assessment change from initial enrollment to reenrollment?

Q 2.1.d. Did the fraction of CLAs self-reporting higher alcohol consumption and low physical activity fall after the introduction of the health assessment?

Q 2.1.e. Did the fraction of CLAs receiving prescriptions for nicotine cessation medications (e.g., nicotine replacement therapies, bupropion, and varenicline) increase after the introduction of the health assessment?

Hypothesis 2.2. The health assessment will increase the number of beneficiaries receiving treatment for substance-use disorders.

Primary Research Question 2.2: Did implementation of the health assessment increase use of non-emergency, outpatient treatment for SUDs, and medication-assisted treatment for opioid use disorder in particular?

Hypothesis 2.3. The requirement to answer the health assessment as a condition of eligibility will discourage some potential beneficiaries from enrolling in Medicaid.

Primary Research Question 3.3: Did monthly new enrollments by CLAs in Medicaid fall after the introduction of the health assessment requirement?

Q 2.3a. Did the monthly fraction of incomplete applications increase among childless adult applicants and renewing beneficiaries after introduction of the health assessment as a condition of eligibility?

B2. Methodology

B2.1. Evaluation Design Summary

We will address the evaluation questions of this waiver provision, the implementation of a health assessment linked to eligibility and premium reductions for CLAs, using DiD, and simple pre-post regression comparisons.

COVID-related note: the Health Needs Assessment and Treatment Needs Question has been suspended during the federally-declared public health emergency. The evaluation of this provision will no longer involve an ITS. We will include analyses that exclude the pandemic period from the baseline period because of the potential for COVID-related disruptions and/or allow for heterogeneity in the treatment effect over time as appropriate. We believe that, due to the pandemic, it may be difficult to assess one of the research questions: Did monthly new enrollments by CLAs in Medicaid fall after the introduction of the health assessment requirement? The parallel trends assumption for enrollment between CLAs and Parents/Caregivers in a DiD analysis is more questionable in the current environment. We will analyze enrollment trends for these two groups during 2020 (when the provision was delayed but COVID disruptions were present) to help gauge whether parallel trends may be a reasonable assumption. Based on that analysis we will determine whether to include analysis of this question in our evaluation. Even if the analysis for the primary research question 3.3 cannot be completed, we will be able to investigate Q 3.3a that explores whether the fraction of incomplete applications changed for childless adults.

The Design Table (**Table 9**) summarizes the key features of the evaluation design.

Table 9. Provision 2: Summary of Hypotheses, Questions, Data Sources, and Analytic Approaches for Evaluation of HRA/HNA

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 2.1: *Beneficiaries for whom the health assessment has eligibility and premium consequences will reduce risky behaviors and engage in more healthy behaviors.*				
Primary research question 2.1: Did CLA beneficiaries reduce risky health behaviors and increase healthy behaviors after the introduction of the health assessment?				
Question 2.1a: What fraction of CLA enrollees completed the second part of the health assessment? How does this compare to the fraction of non-CLA adult enrollees completing it?				
n.a. (descriptive)	Completion of health assessment	Wisconsin Medicaid Administrative Data	Descriptive analysis of completion rates	Unchanged
Question 2.1.b: What is the distribution of healthy behaviors reported by CLAs completing the health assessment? What fraction of CLAs achieved a premium reduction based on their answers to the health assessment? How did these two patterns trend over time?				
n.a. (descriptive)	Number of healthy behaviors reported in the health assessment	Wisconsin Medicaid Administrative Data	Descriptive analysis of numbers of healthy behaviors reported in health assessment	Unchanged
Question 2.1.c: How did the number of health behaviors reported by CLAs in the health assessment change from initial enrollment to reenrollment?				
CLAs in Wisconsin subject to the waiver at initial enrollment are comparison for same enrollee at reenrollment.	Number of healthy behaviors reported in the health assessment	Wisconsin Medicaid Administrative Data	Regression analysis of the change in number of healthy behaviors for re-enrollees relative to initial enrollment.	Unchanged, but the caveats on interpreting these patterns will be even stronger during the COVID-19 pandemic and recession.

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Question 2.1.d: Did the fraction of CLAs self-reporting problems with alcohol consumption and low physical activity fall after the introduction of the health assessment?				
CLAs in Wisconsin prior to waiver.	Fraction of CLAs with a claim diagnosis code related to alcohol consumption	Wisconsin Medicaid Enrollment, Claims and Encounter Data	ITS	We no longer plan to do the ITS analysis due to 2020 COVID disruptions. We will instead focus our attention on the DiD analysis listed just below.
Parents/Caregivers and CLAs in Wisconsin not subject to premiums under the waiver (i.e., income < 50% FPL).	Fraction of CLAs with a claim diagnosis code related to alcohol consumption	Wisconsin Medicaid Enrollment, Claims and Encounter Data	DiD	Include models that exclude pandemic period from baseline.
Question 2.1.e: Did the fraction of CLAs receiving prescriptions for nicotine cessation medications (e.g., nicotine replacement therapies, bupropion, and varenicline) increase after the introduction of the health assessment?				
CLAs in Wisconsin prior to waiver.	Fraction of CLAs receiving prescription for nicotine replacement therapies	Wisconsin Medicaid Enrollment, Claims and Encounter Data	ITS	We no longer plan to do the ITS analysis due to 2020 COVID disruptions. We will instead focus our attention on the DiD analysis listed just below.
Parents/Caregivers and CLAs in Wisconsin not subject to premiums under the waiver (i.e., income < 50% FPL).	Fraction of CLAs receiving prescription for nicotine replacement therapies	Wisconsin Medicaid Enrollment, Claims and Encounter Data	DiD	Include models that exclude pandemic period from baseline.

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 2.2: *The health assessment will increase the number of beneficiaries receiving treatment for substance-use disorders.*				
Primary research question 2.2: Did implementation of the health assessment increase use of non-emergency, outpatient treatment for SUDs, and medication-assisted treatment for opioid use disorder in particular?				
CLAs in Wisconsin prior to waiver.	Claims for outpatient substance-use services and prescription medications for substance use disorders (any claim for buprenorphine, naltrexone (oral), injectable naltrexone, buprenorphine/Naloxone or a HCPCs code for buprenorphine or buprenorphine/naloxone, methadone administration, or naltrexone).	Wisconsin Medicaid Enrollment, Claims and Encounter Data	ITS	No longer plan to do the ITS analysis due to 2020 COVID disruptions. We will instead focus our attention on the DiD analysis listed just below.
Parents/ Caregivers.	Claims for outpatient substance-use services and prescription medications for substance use disorders (any claim for buprenorphine, naltrexone (oral), injectable naltrexone, buprenorphine/Naloxone or a HCPCs code for buprenorphine or buprenorphine/naloxone, methadone administration, or naltrexone).	Wisconsin Medicaid Enrollment, Claims and Encounter Data	DiD	Include models that exclude pandemic period from baseline.
Hypothesis 2.3: *The requirement to answer the health assessment will discourage some potential beneficiaries from enrolling in Medicaid.*				
Primary research question 2.3: Did monthly new enrollments by CLAs in Medicaid fall after the introduction of the health assessment requirement?				
CLAs in Wisconsin prior to waiver.	Number of new Medicaid enrollments at the monthly level	CARES	ITS	We will no longer use ITS in this hypothesis, and will monitor the enrollment trends through early 2020 to determine whether parallel trends assumption may be reasonable for DiD analysis.
Parents/ Caregivers.	Number of new Medicaid Enrollments at the monthly level	CARES	DiD	
Question 2.3.a Did the fraction of incomplete applications increase among childless adult applicants and renewing beneficiaries after introduction of the health assessment as a condition of eligibility?				
Wisconsin CLAs prior to waiver.	Ratio of incomplete to total initiated applications at the monthly level	CARES	ITS	Transition this approach to a DiD with Parents/ Caregivers, include models in which the baseline does not include the pandemic period.

B2.2. Target and comparison populations

We will use the following approaches to answer each primary research question:

Q2.1. "Did CLA beneficiaries reduce risky health behaviors and increase healthy behaviors after the introduction of the health assessment?": We will use two primary analytic approaches: simple pre-post regression comparisons and DiD. The target population for this part of the demonstration waiver is CLAs. All CLAs are required to complete the first part of the health assessment to gain Medicaid eligibility, and for CLAs with income between 50% and 100% FPL both parts of the health assessment can result in premium reductions. For the simple pre-post regression, we will compare the group of CLAs subject to this waiver requirement after the waiver is implemented to the same group of CLAs prior to the implementation of the waiver. The analysis in 2.1.c looks simply at the change in reported number of healthy behaviors for a given CLA subject to the waiver provision between initial enrollment and reenrollment and can only be analyzed for those who reenroll. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

For the DiD comparisons, we will compare the change in outcomes for CLAs with income between 50-100% FPL pre and post waiver to the changes in those same outcomes for two groups of Medicaid beneficiaries: (a) individuals who are not subject to the health assessment waiver requirements, parents and caregivers; and b) CLAs with incomes less than 50% of FPL, who are required to complete part 1 of the health assessment as a condition of eligibility but are not subject to the waiver's premium requirements and hence do not have a premium differential tied to their health assessment answers.

Primary research question 2.1 will also involve several supplementary descriptive analyses for which there are no comparison populations available (2.1.a – 2.1.b). These analyses will help to illuminate the extent to which each group considered above -- CLAs below 50% FPL, CLAs between 50%-100% FPL, and parents and caregivers -- are engaging with the health assessment.

Q2.2. "Did implementation of the health assessment increase use of non-emergency, outpatient treatment for SUDs, and medication-assisted treatment for opioid use disorder in particular"?: We will use DiD. The target population for this question is the full set of CLAs, including those with incomes below 50% of the FPL. These lower income CLAs, while not subject to the premium provisions of the waiver, are required to answer the first part of the health assessment on interest in treatment for substance-use disorders as a requirement for eligibility. For the DiD the comparison sample for this analysis is only the parents and caregivers population. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

Q2.3. "Did new enrollments by CLAs in Medicaid fall after the introduction of the health assessment requirements?": We will use DiD, with the target population as the full set of CLAs, including those with incomes below 50% of the FPL. These lower income CLAs, while not subject to the premium provisions of the waiver, are required to answer the first part of the health assessment

on interest in treatment for substance-use disorders as a requirement for eligibility. As such, they are exposed to the health assessment and any deterrent effect of answering these questions could be expected for this population as well. For the DiD the comparison sample for this analysis is only the parent and caregiver population. In both cases we will use enrollment data at the monthly level and examine whether there are reductions in completed application rates in the months immediately following the launch of the health assessment. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

B2.3. Evaluation Period

The evaluation period will include the years 2016 through 2023, which includes a pre-period before the demonstration waiver begins and continues through the waiver demonstration period. We will include models that exclude the pandemic period from the DiD analysis, to avoid COVID-related disruptions in the baseline, and the implementation period will commence once the provision is re-activated.

B2.4. Data Sources & Outcome Measures

The outcome measures for this evaluation are defined in **Table 9**. This evaluation will involve multiple data sources. They are noted in **Table 10**, below, along with the hypotheses for which these data will be used. Section IID, above, provides a full description of these data sources.

Table 90. Provision 2 Data Sources

	Hypotheses
Wisconsin Medicaid Administrative Data. Administrative data on health assessment completion and reporting will address Questions 2.1.a-2.1.c. These data will allow us to analyze both the patterns of enrollees engaging with the health assessment and the distributions of healthy behaviors reported. For Question 2.1.b. we will also see administrative data on the completion of health assessments administered by participating HMOs in years prior to this waiver provision.	H2.1
Wisconsin Beneficiary Survey. The survey will include questions designed to assess substance use and use disorder treatment, engaging in other risky behaviors (e.g., tobacco use), and physical activity. The responses to these questions will be used to answer Question 2.1.d.	H2.1
Medicaid claims, and encounter data. These data will track the use of nicotine replacement therapies as one of the key markers of treatment for risky behaviors that might be affected by the health assessment in Question 2.1.e. We will also use these data to investigate where the health assessment is associated with increased use of outpatient services for substance use disorders in Question 2.2.	H2.1 H2.2
CARES enrollment data. These data will track application and enrollment trends, and whether applicants abandon applications at any point during the application process when reaching specific questions pertaining to substance abuse or other health behaviors.	H2.3

B3.5. Analytic Methods

Q2.1. "Did CLA beneficiaries reduce risky health behaviors and increase healthy behaviors after the introduction of the health assessment?" We begin with a descriptive analysis of the patterns of responses to the health assessment itself. These analyses, described in Q2.1.a – 2.2.c, do not have a causal interpretation with a comparison group. For question 2.1.d we will use multiple approaches. First, we will use Medicaid Claims files to analyze the fraction of beneficiaries with at least one claim tied to a diagnosis code related to alcohol consumption. For this analysis we will use a DiD strategy (described in section IIB), comparing the change in this fraction with at least one alcohol-related diagnosis between the CLAs subject to the premium provision to the combined group of Parents/Caregivers and the CLAs between 0 and 50% of FPL. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

We will also use a simple regression approach to compare whether self-reports of healthy behaviors from the Medicaid Beneficiary Survey differ between early waves of the survey, around the time of the launch of the waiver provision, and later waves of the survey after the implementation of the health assessment. We will also do this pre-post comparison using a DiD strategy (described in section IIB) using the parents and caregivers as well as CLAs with incomes below 50% of the FPL as comparison groups. For these analyses we will use the full random samples of these groups from the Medicaid Beneficiary Survey.

Finally, for Question 2.1.e we will use claims data to estimate how the introduction of the health assessment affected use of nicotine replacement therapies, using DiD design (described in section IIB, above), again using the parents and caregivers as well as the CLAs with incomes below 50% FPL as comparison groups for the DiD. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

Q2.2. "Did implementation of the health assessment increase use of non-emergency, outpatient treatment for SUDs, and medication-assisted treatment for opioid use disorder in particular?" For this question we will analyze patterns of claims for outpatient substance-use services and medications for substance use disorders. Similar to Question 2.1. above, we will use DiD design. In this case, the DiD will use only the parents and caregivers (and not the CLAs with incomes below 50% FPL) because the requirement for answering the first part of the health assessment on substance use disorders is the same for all CLAs. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

Q2.3. "Did new enrollments by CLAs in Medicaid fall after introduction of the health assessment requirement?" To answer this question we will analyze patterns of Medicaid enrollments at the monthly level using a DiD design. The comparison group – parents and caregiver adults -- is the same as 2.2 above. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

B3. Methodological Limitations

Because the waiver provision will be implemented at a single time statewide and without randomized controls, the evaluation relies on quasi-experimental methods. There are two important limitations specific to the evaluation of the health assessment requirement. First, the health assessment will be available voluntarily to parents and caregiver populations. While there is no requirement that they engage with the health assessment, some may do so. This weakens our ability to use the parents and caregivers as a comparison sample for the difference-in-difference analysis described above for primary research questions 2.1-2.3. The descriptive analysis in questions 2.1.a-2.1.b will help illuminate the extent to which voluntary completion of the health assessment by parents and caregivers is a significant challenge for the evaluation strategy. A key requirement will be that the engagement with the health assessment is significantly higher for the CLAs subject to the waiver provision.

The second limitation is that Wisconsin's Medicaid-participating HMOs have been conducting their own health assessments with members prior to the implementation of this new waiver. This waiver provision replaces HMO-specific assessments with a newly designed Medicaid-level health assessment. The specific HMO-specific pre-waiver experience will vary across HMOs, which will require some of the analysis specified above to be conducted separately for different HMOs. Doing those splits will reduce the precision of estimates. The necessity of analyzing results separately by HMO will be clarified by the analysis in Questions 2.1.b.

IIIC. Provision 3: Premiums, Lock-out Periods, and ED Co-Payments

C1. General Background Information

Provision 3: Implement two cost-sharing components:

> 1) Premiums for CLA beneficiaries ages 19-64 with income between 50% and 100%FPL; and 2) For CLAs, require an $8 co-payment for non-emergent use of the hospital emergency department.

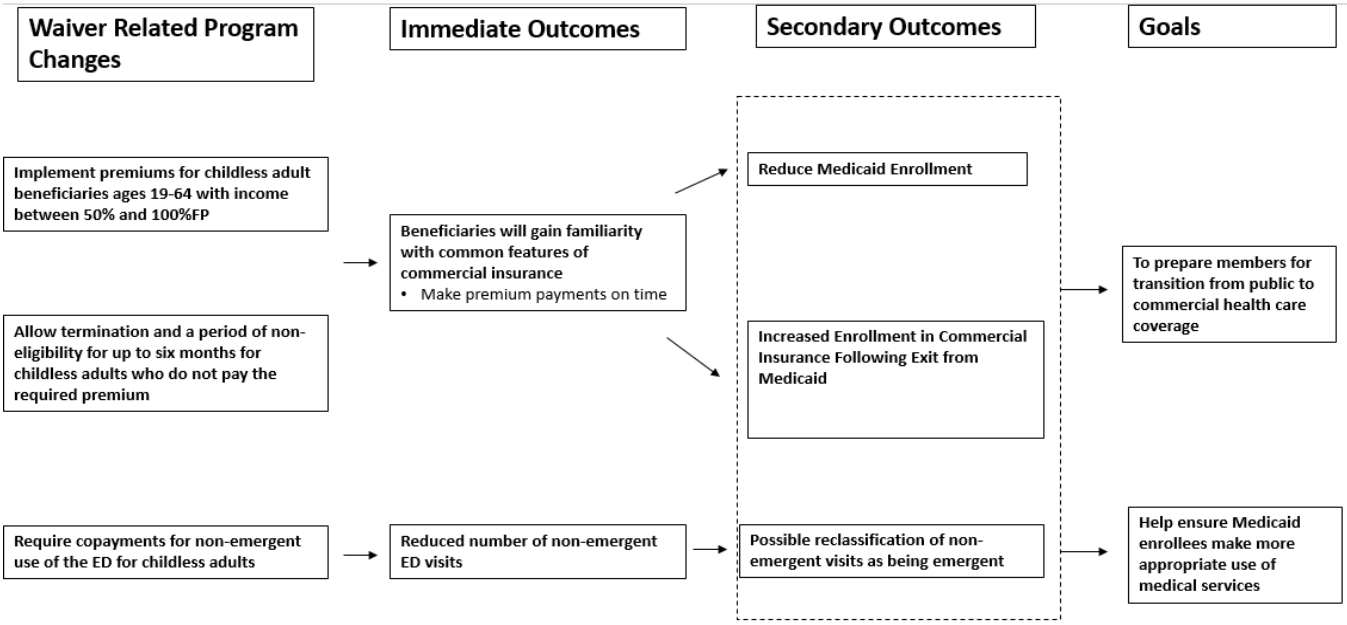
Those CLAs who are subject to the premium requirement but do not make such payments will, at the time of annual renewal, be terminated from Medicaid enrollment and placed in a period of non-eligibility for up to six months. However, the beneficiary may reenroll at any time prior to the end of the six-month period if he or she pays all owed premiums, or if his or her situation changes such that he or she would no longer be subject to a premium requirement. After the six-month period, the beneficiary may be re-enrolled in BadgerCare upon request, if he or she meets all program rules, even if he or she continues to have unpaid premiums from the prior period of enrollment.

Medicaid program goal: To provide beneficiaries with coverage that more closely aligns with commercial coverage, promote participant engagement and readiness to transition to commercial coverage.

C2. Evaluation Questions and Hypotheses

C2.1. Driver Diagram

Figure 4. Driver Diagram: Premium and Emergency Department Co-Payment Requirements



C2.2. Hypotheses & Research Questions

Hypothesis 3.1. Beneficiaries who are required to make premium payments will gain familiarity with a common feature of commercial health insurance.

Primary Research Question 3.1: Did beneficiaries required to make premium payments understand their requirements and make premium payments?

Q 3.1a. How many beneficiaries are required to make premium payments? How does this number change over time?

Q 3.1b. How many beneficiaries make premium payments? On what timeline do beneficiaries typically make payments (monthly, quarterly, annually, or other? How do these numbers change over time?

Q 3.1c. How do the characteristics of those who make their required premium payments differ from those of beneficiaries who fail to make these payments? How do these characteristics change over time?

Q 3.1d. How many beneficiaries have premium payments made on their behalf by third-party entities? How do these numbers change over time?

Q 3.1e. How many beneficiaries are terminated for non-payment and being locked out? Of those terminated, how many re-enroll at the end of their period of non-eligibility? How do these numbers change over time?

Q 3.1f. Do beneficiaries with premium requirements understand their payment obligations and the consequences of non-payment?

Hypothesis 3.2. The imposition of premium requirements for CLAs will reduce enrollment in Medicaid.

Primary Research Question 3.2. Did the imposition of premium requirements reduce enrollment in Medicaid?

Q 3.2a. What effects does the premium requirement have on total and new enrollment in Medicaid?

Q 3.2b. Do beneficiaries with premium obligations who initiate payments continue to make regular payments throughout their 12-month enrollment periods?

Q 3.2c. What effects do premiums have on continuity of coverage, as reflected by mid-year disenrollments and renewal decisions?

Hypothesis 3.3. The imposition of premium requirements for CLAs will increase enrollment in commercial insurance following exits from Medicaid.

Primary Research Question 3.3: Did the imposition of premium requirements increase enrollment in commercial insurance following exits from Medicaid?

Q 3.3a. Did the imposition of premium requirements increase enrollment in employer-sponsored / large group insurance following exits from Medicaid?

Q 3.3b. Did the imposition of premium requirements increase enrollment in individual market / ACA Marketplace insurance following exits from Medicaid?

Q3.3c. To what extent do disenrolled beneficiaries re-enroll in Medicaid following their period of non-eligibility?

Hypothesis 3.4. The imposition of premium requirements for CLAs will lead to pent-up demand for medical care among beneficiaries disenrolled due to failure to pay premiums.

Primary Research Question 3.4. Did the imposition of premium requirements lead to pent-up demand for medical care among beneficiaries disenrolled due to failure to pay premiums?

Hypothesis 3.5. The imposition of a co-payment for non-emergent use of the emergency department will lead to more appropriate uses of medical care among CLAs enrolled in Medicaid.

Primary Research Question 3.5: Did the imposition of a co-payment for non-emergent use of the emergency department reduce the number of non-emergency visits to the emergency department among CLAs enrolled in Medicaid?

Q 3.5a. What was the number of non-emergent visits to the emergency department among CLAs prior to the imposition of copayments?

Q 3.5b. What was the total number of emergency department visits among CLAs prior to the imposition of copayments?

Q 3.5c. How did the numbers of emergency department visits and non-emergent visits change among CLAs after the imposition of copayments?

Q 3.5d. How did the use of primary care change among CLAs after the imposition of copayments for non-emergent visits to the emergency department?

Q 3.5e. Do beneficiaries with co-payment requirements understand their payment obligations?

Hypothesis 3.6. Hospitals vary in how they implement the required co-payment for non-emergency use of the ED.

Primary Research Question 3.6: Are hospitals consistent in how they define non-emergent use of the emergency department, as necessary to apply the associated Medicaid co-payment policy?

Q 3.6a. Do hospitals understand the policy requiring a co-payment for non-emergent use of the emergency department?

Hypothesis 3.7. Hospitals are implementing the policy requiring a co-payment for non-emergent use of the emergency department in a consistent manner.

Primary Research Question 3.7: Are hospitals consistent in how they are implementing the policy requiring a co-payment for non-emergent use of the emergency department?

Q 3.7a. Is the definition of non-emergent ED visits consistently applied across hospitals?

C3. Methodology

C3.1. Evaluation Design Summary

We will use three analytic approaches to address the primary research questions for evaluation of waiver Provision 3, the premium and co-payment requirement for CLAs: ITS, DiD, and RD.

COVID-related note: Provision 3, pertaining to premiums and copayments, is the provision most affected by the change in implementation schedule and by the pandemic circumstances. The implementation of premiums was halted and will not commence until the end of the federally-declared public health emergency. The co-payments for emergency department visits took effect on July 1, 2020, after an initial delay, but this provision is underway during the pandemic and a time of substantial distortions in health care use patterns.

We will no longer use ITS or individual-level fixed effects models to address the research questions under this provision but will instead rely on DiD and RD designs. We will include models that exclude the pandemic period for DiD analyses, to avoid COVID-related disruptions in the baseline. The approach to answer several research questions involved a descriptive analysis of trends and, in these cases, we do not have alternatives available and must carefully interpret results as they are likely affected by the pandemic.

The Design Table (**Table 11**) summarizes the key features of the evaluation design.

Table 101. Provision 3: Summary of Hypotheses, Questions, Data Sources, and Analytic Approaches for Evaluation of Premiums for CLAs

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 3.1: *Beneficiaries who are required to make premium payments will gain familiarity with a common feature of commercial health insurance.*				
Primary research question 3.1: Did beneficiaries required to make premium payments understand their requirements and make premium payments?				
Question 3.1a: How many beneficiaries are required to make premium payments? How does this number change over time?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Counts of CLAs required to make premium payments	CARES	Descriptive	Unchanged
Question 3.1b: How many beneficiaries make premium payments? On what timeline do beneficiaries typically make payments (monthly, quarterly, annually, or other? How do these numbers change over time?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Counts of CLAs who make premium payments	CARES	Descriptive	Unchanged
Question 3.1c: How do the characteristics of those who make their required premium payments differ from those of beneficiaries who fail to make these payments? How do these characteristics change over time?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Demographic and health-related characteristics and of CLAs required to make premium payments	CARES and WI Medicaid Claims and Encounter Data	Descriptive	Unchanged

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Question 3.1d: How many beneficiaries have premium payments made on their behalf by third-party entities? How do these numbers change over time?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Counts of CLAs whose premium payments were made by third parties.	CARES	Descriptive	Unchanged
Question 3.1e: How many beneficiaries are terminated and locked out for non-payment? Of those terminated, how many re-enroll at the end of their period of non-eligibility? How do these numbers change over time?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Counts of CLAs terminated for failure to make premium payments	CARES	Descriptive	Unchanged
	Counts of previously locked-out CLAs who re-enroll following the lock-out period.			
Question 3.1f: Do beneficiaries with premium requirements understand their payment obligations and the consequences of non-payment?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Understanding of premium requirements	CLA Survey	Descriptive	Unchanged

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 3.2: *The imposition of premium requirements for childless adults will reduce enrollment in Medicaid.*				
Primary research question 3.2: Did the imposition of premium requirements reduce enrollment in Medicaid?				
Question 3.2a: What effects does the premium requirement have on total and new enrollment in Medicaid?				
CLAs in other states	Medicaid enrollment	American Community Survey	DiD	Include models that exclude pandemic period from baseline; Comparator states will be selected so as to be similar as possible in both COVID-19 outcomes as well baseline characteristics.
Parents and CLAs in Wisconsin not subject to premiums	Medicaid reenrollment and disenrollment	CARES	DiD	
CLAs in Wisconsin not subject to premiums	Medicaid reenrollment and disenrollment	CARES	RD	Unchanged
CLAs in Wisconsin prior to waiver	Medicaid reenrollment and disenrollment	CARES	ITS	Because of the disruption in 2020 and the change in disenrollment rules, we no longer consider ITS a valid evaluation strategy and we will rely on DiD and RD approaches to answer this question.

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Q 3.2b: Do beneficiaries with premium obligations who initiate payments continue to make regular payments throughout their 12-month enrollment periods?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Counts of CLAs who continuously make premium payments throughout their 12-month enrollment period	CARES	Descriptive	Unchanged
Q 3.2c: What effects do premiums have on continuity of coverage, as reflected by mid-year disenrollments and renewal decisions?				
CLAs in other states	Mid-year disenrollment and renewals	American Community Survey	DiD	Include models that exclude pandemic period from baseline; Comparator states will be selected so as to be similar as possible in both COVID-19 outcomes as well baseline characteristics.
Parents and CLAs in Wisconsin not subject to premiums	Mid-year disenrollment and renewals	CARES	DiD	
CLAs in Wisconsin not subject to premiums	Mid-year disenrollment and renewals	CARES	RD	Unchanged
CLAs in Wisconsin prior to waiver	Mid-year disenrollment and renewals	CARES	ITS	Because of the disruption in 2020 and the change in disenrollment rules, we no longer consider ITS a valid evaluation strategy and we will rely on DiD and RD approaches to answer this question.

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 3.3: *The imposition of premium requirements for childless adults will increase enrollment in commercial insurance following exits from Medicaid.*				
Primary research question 3.3: Did the imposition of premium requirements increase enrollment in commercial insurance following exits from Medicaid?				
Question 3.3a: Did the imposition of premium requirements increase enrollment in employer-sponsored / large group insurance following exits from Medicaid?				
CLAs leavers prior to waiver	Enrollment in commercial insurance	WI TPL data UI Data linked to DOL self-insured data WHIO	ITS	Because of the disruption in 2020 and the change in disenrollment rules, we no longer consider ITS a valid evaluation strategy and we will rely on an RD approach to answer this research question.
CLAs leavers not subject to premiums prior to waiver	Enrollment in commercial insurance	WI TPL data UI Data linked to DOL self-insured data WHIO	RD	Unchanged
Question 3.3b: Did the imposition of premium requirements increase enrollment in individual market / ACA Marketplace insurance following exits from Medicaid?				
CLAs leavers prior to waiver	Enrollment in commercial insurance	WI TPL data UI Data linked to DOL self-insured data WHIO	ITS	Because of the disruption in 2020 and the change in disenrollment rules, we no longer consider ITS a valid evaluation strategy and we will rely on an RD approach to answer this research question.
CLAs leavers not subject to premiums prior to waiver	Enrollment in commercial insurance	WI TPL data UI Data linked to DOL self-insured data WHIO	RD	Unchanged

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Question 3.3c: To what extent do disenrolled beneficiaries re-enroll in Medicaid following their period of non-eligibility?				
Answering this research questions requires only data on CLAs in Wisconsin who are subject to premiums; no comparison strategy is required	Counts of CLAs disenrolled from Medicaid due to lack of premium payment who subsequently re-enroll in Medicaid following their period of non-eligibility	CARES	Descriptive	Unchanged
Hypothesis 3.4: *The imposition of premium requirements for CLAs will lead to pent-up demand for medical care among beneficiaries disenrolled due to failure to pay premiums.*				
Primary research question 3.4: Did the imposition of premium requirements lead to pent-up demand for medical care among beneficiaries disenrolled due to failure to pay premiums?				
CLAs prior to disenrollment	Use of medical care	CARES and WI Medicaid Claims and Encounter Data	Individual-level fixed effects analysis	Because of the disruption in 2020 and the change in disenrollment rules, we no longer consider individual fixed effects a valid evaluation strategy and we will rely on a DiD approach to answer this question.
Continuously enrolled CLAs	Use of medical care	CARES and WI Medicaid Claims and Encounter Data	DiD	Include models that exclude pandemic period from baseline.

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 3.5: *The imposition of a co-payment for non-emergent use of the emergency department will lead to more appropriate uses of medical care among CLAs enrolled in Medicaid.*				
Primary research question 3.5: Did the imposition of a co-payment for non-emergent use of the emergency department reduce the number of non-emergency visits to the emergency department among CLAs enrolled in Medicaid?				
Question 3.5a: What was the number of non-emergent visits to the emergency department among CLAs prior to the imposition of copayments?				
Answering this research questions requires only data on CLAs who are subject to premiums; no comparison strategy is required	Number of non-emergent ED visits	CARES and WI Medicaid Claims and Encounter Data	Descriptive	Unchanged
Question 3.5b: What was the total number of emergency department visits among CLAs prior to the imposition of copayments?				
Answering this research questions requires only data on CLAs who are subject to premiums; no comparison strategy is required	Total number of ED visits	CARES and WI Medicaid Claims and Encounter Data	Descriptive	Unchanged
Question 3.5c: How did the numbers of emergency department visits and non-emergent visits change among CLAs after the imposition of copayments?				
CLAs enrolled prior to introduction of ED copayments	Total number and number of non-emergent ED visits	CARES and WI Medicaid Claims and Encounter Data	ITS	Because of the disruption in 2020 and the change in disenrollment rules, we no longer consider ITS a valid evaluation strategy and we will rely on a DiD approach to answer this question.
Parents and caregiver adults	Total number and number of non-emergent ED visits	CARES and WI Medicaid Claims and Encounter Data	DiD	Include models that exclude pandemic period from baseline
Commercially insured adults	Total number and number of non-emergent ED visits	WHIO	DiD	Include models that exclude pandemic period from baseline

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Question 3.5d: How did the use of primary care change among CLAs after the imposition of copayments for non-emergent visits to the emergency department?				
Parents and caregiver adults	Total number and number of primary care visits	CARES and WI Medicaid Claims and Encounter Data	DiD	Include models that exclude pandemic period from baseline
Commercially insured adults	Total number and number of primary care visits	WHIO	DiD	Include models that exclude pandemic period from baseline
Question 3.5e: Do beneficiaries with co-payment requirements understand their payment obligations?				
Answering this research questions requires only data on CLAs who are subject to premiums; no comparison strategy is required	Knowledge and understanding of payment obligations	Beneficiary survey	Descriptive	Unchanged
Hypothesis 3.6: *Hospitals vary in how they implement the required co-payment for non-emergency use of the ED.*				
Primary research question 3.6: Are hospitals consistent in how they are defining non-emergent use of the emergency department, as necessary to apply the associated Medicaid co-payment policy?				
Q 3.6a. Do hospitals understand the policy requiring a co-payment for non-emergent use of the emergency department?				
Answering this research questions requires only data on Wisconsin hospitals; no comparison strategy is required	Understanding of co-payment requirements	Hospital focus groups	Descriptive	Unchanged

Comparison strategy	Outcome measures	Data sources	Analytic approach	
			Original	Revised
Hypothesis 3.7. *Hospitals implement the policy requiring a co-payment for non-emergent use of the emergency department in a consistent manner.*				
Primary research question 3.7: Are hospitals consistent in how they are implementing the policy requiring a co-payment for non-emergent use of the emergency department?				
Question 3.7a: Is the definition of non-emergent ED visits consistently applied across hospitals?				
CLAs subject to co-payments	Hospital-level measure of the ratio of visits for which co-payments assessed, relative to the number of non-emergent visits measured using the Billings (2000) probabilistic method	CARES and WI Medicaid Claims and Encounter Data	Descriptive	Unchanged
Parents and caregiver adults	Hospital-level measure of the ratio of non-emergent to total ED visits	CARES and WI Medicaid Claims and Encounter Data	DiD	Include models that exclude pandemic period from baseline

C3.2. Target and Comparison Populations.

The target populations for the evaluation of waiver provision 3 -- premium requirement for CLAs and co-payments for non-emergent use of the emergency department -- include CLAs in the Wisconsin Medicaid program and CLAs who exit Medicaid in Wisconsin. We will address the primary research questions as follows:

Q3.1. "Did beneficiaries required to make premium payments understand their requirements and make premium payments?": Conduct a descriptive analysis using data from Wisconsin administrative enrollment systems, which does not require the use of a comparison group.

Q3.2. "Did the imposition of premium requirements reduce enrollment in Medicaid?": Use three different comparison groups. We will first use a comparison group of lower-income CLAs in Wisconsin enrolled in Medicaid that are not subject to premiums. The second comparison group is parents/caregivers in Wisconsin enrolled in Medicaid that also are not subject to premiums. Finally, we will use CLAs enrolled in Medicaid prior to the waiver implementation (and who look like they would have been subject to premiums).

Q3.3. "Did the imposition of premium requirements increase enrollment in commercial insurance among CLAs who exit Medicaid?": Use two comparison groups. First, CLAs who exited Medicaid prior to the imposition of the premium requirement and, second, lower income CLAs who are not subject to premiums and who exit Medicaid.

Q3.4. "Did the imposition of premium requirements lead to pent-up demand for medical care among beneficiaries disenrolled due to failure to pay premiums?": Use two different comparison groups. We will first use a comparison group of CLAs enrolled in Medicaid prior to the waiver implementation (and who look like they would have been subject to premiums). Second, we will use a comparison group of continuously enrolled CLAs (who were also subject to premiums).

Q3.5. "Did the imposition of a copayment for non-emergent use of the emergency department reduce the number of these visits among CLAs enrolled in Medicaid?": Use three comparison groups. First, CLAs enrolled in Medicaid prior to the imposition of co-payments for non-emergent use of the emergency department. Second, parents and caregivers in Wisconsin who were enrolled in Medicaid. Third, adults enrolled in commercial insurance in Wisconsin.

Q3.6. "Are hospitals consistent in how they are defining non-emergent use of the emergency department, as necessary to apply the associated Medicaid co-payment policy?": Conduct interviews with hospitals, which does not require the use of a comparison group.

Q3.7. "Are hospitals consistent in how they are implementing the policy requiring a co-payment for non-emergent use of the emergency department?": Use two comparison groups. First, CLAs enrolled in Medicaid prior to the imposition of co-payments for non-emergent use of the emergency department. Second, parents and caregivers in Wisconsin who were enrolled in Medicaid.

C3.3. Evaluation Period

The evaluation period will include the years 2016 through 2023, which includes a pre-period before premiums and copayments begin, through the end of the evaluation period.

C3.4. Data Sources and Outcome Measures

The outcome measures for this evaluation are defined in **Table 11**, above. This evaluation will involve multiple data sources. They are noted in **Table 12**, along with the hypotheses for which these data will be used. Section IID, above, provides a full description of these data sources.

Table 112. Provision 3 Data Sources

	Hypotheses
Medicaid enrollment (CARES), claims, and encounter data. To estimate the number of CLAs that are required to make premium payment and do make premium payments. We also will use any available data on whether a third-party makes premium payments on behalf of a beneficiary. Finally, we will use these data to calculate Medicaid enrollment rates for the target and comparison groups noted in Table 11.	H1 H2 H4 H5 H7
Medicaid Beneficiary Survey. Data from the questions intended to elicit understanding of premiums, knowledge of program requirements related to premiums, and self-reported reasons why individuals may experience difficulty paying required premiums.	H1
Wisconsin's All-Payer Claims Database (known as WHIO). To measure Medicaid enrollment and transitions to commercial insurance.	H2 H3 H5
Wisconsin Third Party Liability Database (TPL). To identify individuals enrolled in Medicaid who are covered by a private health insurance plan.	H3
Unemployment Insurance data (UI) and Department of Labor data (DOL). To match individuals enrolled in Medicaid to their current and future employers, which when linked to DOL data, can be used to identify individuals transitioning into employment at self-insured firms.	H3

C3.5. Analytic Methods

We will address the primary research questions as follows:

Q3.1. "Did beneficiaries required to make premium payments understand their requirements and make payments on time?" We will conduct a descriptive analysis using data from Wisconsin administrative enrollment systems.

Q3.2. "**Did the imposition of premium requirements reduce enrollment in Medicaid?"** We will employ DiD and RD (each described in Section IIB, above). Using the comparison group of adults in Wisconsin enrolled in Medicaid that are not subject to premiums, we will estimate DiD models on Medicaid enrollment and disenrollment. In addition, using the comparison group of lower-income CLAs in Wisconsin enrolled in Medicaid who are not subject to premiums, we will employ RD models on Medicaid enrollment and disenrollment.

Q3.3. "Did the imposition of premium requirements increase enrollment in commercial insurance among CLAs who exit Medicaid?" We will employ an RD design (described in Section IIB, above. Using the comparison group of low-income adults exiting Medicaid who were not subject to premiums, we will employ RD models on enrollment in commercial insurance. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

Q3.4. "Did the imposition of premium requirements lead to pent-up demand for medical care among beneficiaries disenrolled due to failure to pay premiums?" We will employ two different analytic approaches, individual-level fixed effects and DiD. Use of medical case will be measured by total number of visits, number of inpatient hospital stays, and number of visits to the ED.

Q3.5. "Did the imposition of a co-payment for non-emergent visits to the emergency department reduce the number these visits among CLAs enrolled in Medicaid?" We will employ a DiD design (described in Section IIB, above). Non-emergent visits will be measured using a using a probabilistic method developed for claims data.[17] By using this method, we will ensure that we will identify non-emergent visits before and after implementation in a consistent manner. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

To conduct the analysis, we will first conduct interrupted time-series analyses to determine whether the CLAs enrolled in Medicaid reduced their non-emergent use of the emergency department following the imposition of co-payments. We also will examine the total number of ED visits to help determine whether any observed reduction in non-emergent visits was the result of reclassification. Second, using the comparison group of parents and caregivers enrolled in Wisconsin Medicaid, we will estimate DiD models on non-emergent and total ED visits. We also will estimate DiD models on non-emergent and total emergency department visits using the comparison group of commercially insured adults in Wisconsin.

Q3.6. "Are hospitals consistent in how they are defining non-emergent use of the emergency department, as necessary to apply the associated Medicaid co-payment policy?":

We will perform a thematic analysis of focus group results.

[17] Codes available here: https://wagner.nyu.edu/faculty/billings/acs-algorithm
See, for reference: Billings J, Parikh N, Mijanovich T. Emergency Department Use: The New York Story. New York (NY): Commonwealth Fund; 2000 Nov. (Issue Brief). Available at: https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2000_nov_emergency_room_use__the_new_york_story_billings_nystory_pdf.pdf

Q3.7. "Are hospitals consistent in how they are implementing the policy requiring a co-payment for non-emergent use of the emergency department?": We will employ DiD method (described in Section IIB, above). Collections of co-payments will be determined from administrative data. Non-emergent visits will be measured using a using the probabilistic method developed for claims data described above. Due to pandemic-related disruptions in waiver implementation and data trends, we have abandoned plans also to use an ITS method.

To conduct the analysis, we will first conduct a descriptive analysis of the extent of variation across hospitals in whether they collect co-payments, relative to a consistent measure of non-emergent visits. Second, using the comparison group of parents and caregivers enrolled in Wisconsin Medicaid, we determine whether hospitals changed their coding of ED visits following the imposition of the co-payment requirement.

C4. Methodological Limitations

Because the CLA coverage expansion was implemented at a single time statewide and without randomized controls, the methods we propose are all quasi-experimental. It is possible that there are other factors that are not fully accounted for in the design that may have a more direct effect on outcomes, particularly enrollment in commercial insurance, such as the availability of commercial coverage options, co-insurance costs, and income levels. The original design had assumed that co-payments for non-emergent use of the emergency department were to be implemented, as planned, concurrent with the premium. However, this limitation may be partially mitigated because the implementation sequence has changed under the pandemic public health emergency. While the premiums remain suspended, the ED co-payment took effect on July 1, 2020. The main remaining limitation is the occurrence of the implementation during the pandemic.

IIID. Provision 4: Substance Use Disorder – Expansion of Covered Services

D1. General Background Information

Provision: Modify the benefit package for substance use disorder (SUD) treatment for all Medicaid enrollees. Specifically, the demonstration waiver authorizes federal funding for treatment provided to all WI Medicaid enrollees in Institutions for Mental Disease (IMD) allowing WI Medicaid to make two significant programmatic changes: 1) to establish a residential treatment benefit for SUD; and 2) to cover existing services when they are provided in an IMD specifically including medically supervised withdrawal management, inpatient services, and medication-assisted treatment (MAT). Wisconsin Medicaid delayed implementation of both programmatic changes due to various challenges in CY2020, but the provisions took effect on February 1, 2021.

Additionally, the demonstration waiver includes several new or revised policies to support the implementation and quality of these newly covered services. These policies, took effect on February 1, 2021, are as follows: updated licensure/certification requirements for providers (ongoing); ensuring

ASAM-consistent placement criteria (ongoing); utilization management for the residential treatment benefit; residential treatment provider qualifications that align with national standards (ongoing); requirement that residential treatment facilities offer MAT.
The new residential treatment benefit builds on the existing robust set of services currently covered by the Wisconsin Medicaid program to treat substance use disorders (SUDs) for all enrollees, including outpatient counseling, day treatment, psychosocial rehabilitation, MAT, telehealth services (expanded with the onset of the COVID-19 PHE) and inpatient treatment.

The period of evaluation for the SUD demonstration waiver encompasses a six-year period, February 2017 – January 2023, allowing up to 3 years of observation before (2017-2019) and after (2021-2023) implementation of the first provision of the demonstration waiver, coverage for residential treatment services.

Medicaid program goal: To reduce the incidence of drug overdose deaths, including opioid-related deaths, by improving access to the full continuum of treatment.

D2. Evaluation Questions and Hypotheses

The following section of the evaluation design report follows the format and guidance that CMS issued specifically for evaluation of SUD demonstration waivers.[18] For this reason, the format of this section of the design report and its related tables/figures differs in some respects from the sections of the evaluation design that are focused on other provisions in the demonstration waiver (e.g., premium reductions).

D2.1. Driver Diagram

Figure 5 displays the driver diagram. In the logic of a driver diagram, secondary drivers are mechanisms or conditions that are necessary to achieve the primary drivers which in turn contribute directly to realizing the overall purpose of the demonstration waiver. **Figure** 5 also includes the specific programmatic changes that the Wisconsin Medicaid program will implement under the SUD demonstration waiver. We do so to show how these changes hypothetically relate to the demonstration waiver's overall goal of reducing drug overdose deaths in the Medicaid population.

The programmatic changes fall within three functional categories: supply of Medicaid SUD providers at all levels of care; coverage for SUD services; and quality of SUD services. These changes have the potential to impact the rate of drug overdose deaths through a sequence of mechanisms. Most directly, the programmatic changes have the potential to increase the supply of SUD providers that accept and treat Medicaid enrollees, and to increase Medicaid enrollees' use of SUD services. These mechanisms are represented in **Figure** 5 as secondary drivers.

[18] Centers for Medicare and Medicaid Services. Substance Use Disorder Section 1115 Demonstration Evaluation Design- Technical Assistance. March 6, 2019. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html

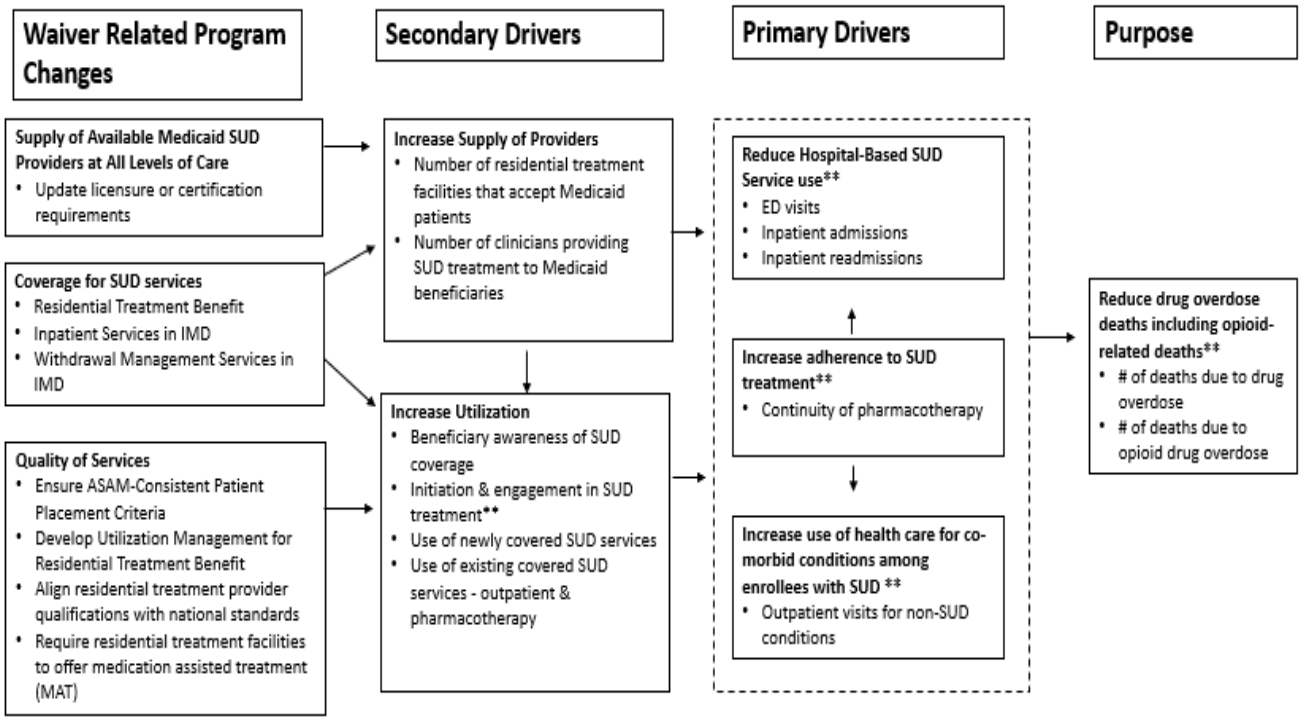
These secondary drivers may, in turn, influence the primary drivers: 1) enrollees' health care needs and preferences, and 2) their capacity to seek care that is suited to their needs. For example, increased access to SUD providers and increased use of SUD services may reduce symptoms of SUD, increase the likelihood of recovery, increase engagement in health care, and foster knowledge and awareness of treatment needs. These changes may thus enable enrollees to remain in SUD treatment, reduce hospital-based SUD service use, and/or address previously ignored physical and mental health co-morbidities. Improvements in outcomes considered primary drivers then have the potential to influence the waiver's overall goal of reducing drug overdose deaths among Medicaid enrollees.

We derive the evaluation design for the SUD demonstration waiver from the logic of the driver diagram and will proceed in stages. In the first stage of the evaluation, we will assess the causal effects of the demonstration waiver on the outcomes listed as secondary drivers because the planned programmatic changes are most directly related to these outcomes. We anticipate that the programmatic changes will increase the supply of providers, particularly residential treatment providers, and enrollees' use of newly covered SUD services.

In the second stage of the evaluation, we will evaluate the causal effects of the SUD demonstration waiver on the outcomes noted as primary drivers in **Figure** 5 -- conditional on finding that the waiver influences the supply of SUD providers and/or use of SUD services. If the SUD demonstration waiver has no significant impact on the secondary drivers, we will not attempt to estimate the causal effects of the SUD demonstration waiver on primary drivers, because there would be no empirical basis on which to expect an effect. Rather, we will conduct descriptive analyses to quantify the association between the primary drivers and factors that may provide insight to the Wisconsin Medicaid program regarding potential change over time in these outcomes. These factors include beneficiary characteristics, county-level SUD prevention and treatment resources, and significant state or federal policies related to SUD prevention and treatment implemented during the observation period.

If we find that the SUD demonstration waiver significantly impacts the primary drivers as hypothesized in **Figure** 5, we will assess the demonstration waiver's causal impact on the rate of drug overdose deaths among Medicaid beneficiaries. If the SUD waiver has no effect on the primary drivers, or if we do not conduct that causal analysis because of null effects in the first stage of the evaluation, we will conduct descriptive analyses to quantify the association between the rate of deaths due to drug overdose and factors that may provide insight to the Wisconsin Medicaid program regarding potential change over time in this outcome. These factors include beneficiary or population characteristics, county-level SUD prevention and treatment resources, and significant state or federal policies related to SUD prevention and treatment implemented during the observation period.

Figure 5. Driver Diagram: Substance use Disorder Waiver Provision



**Goal for SUD treatment reform per Wisconsin Medicaid's SUD Implementation Protocol, June 2019

D2.2. Hypotheses and Research Questions

SUD Demonstration Waiver: Expands coverage for SUD treatment in IMD settings including a new residential treatment benefit and coverage for inpatient and medically supervised withdrawal management services, and adopts new or revised policies to support implementation of this coverage expansion.

Question 4.1. Does the SUD demonstration waiver increase the supply of SUD providers for Medicaid enrollees?

H4.1a. The SUD demonstration waiver will increase the supply of SUD providers that accept and/or treat Medicaid enrollees.

Question 4.2. Does the SUD demonstration waiver increase access to, and use of, newly covered SUD services for Medicaid enrollees?

H4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time.

H4.2b. The SUD demonstration waiver will increase use of SUD treatment in IMD settings including residential treatment, impatient treatment, medically supervised withdrawal services and MAT for opioid use disorder.

H4.2c. The SUD demonstration waiver will increase initiation and engagement in SUD treatment.

Question 4.3. Does the SUD demonstration waiver change Medicaid enrollees' use of existing covered SUD services?

H4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services, including in-person and telehealth, and pharmacotherapy treatment provided outside IMD settings.

H4.3b. The SUD demonstration waiver will reduce use of hospital-based SUD services, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H4.3c. The SUD demonstration waiver will increase access to health care for co-morbid physical and mental health conditions among enrollees with a SUD, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

H4.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

Question 4.4. Does the SUD demonstration waiver reduce the rate of drug overdose deaths among Medicaid enrollees including opioid-related deaths?

H4.4a. The SUD demonstration waiver will reduce the rate of drug overdose deaths among Medicaid beneficiaries, including opioid-related overdose deaths, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.

The final research question, Q4.5, follows from the recommendations in the CMS technical assistance guidance on SUD demonstration waiver evaluations. Consistent with this guidance, there are no accompanying hypotheses.

Question 4.5. What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?

D3. Methodology

D3.1. Evaluation Design Summary

We will use descriptive analyses to characterize changes over time in evaluation outcomes and to identify key correlates associated with the outcomes including beneficiary characteristics, county-level SUD prevention and treatment resources, and potential changes in state and federal policy or events within and beyond the Medicaid program that are related to SUD prevention and treatment. (e.g., expanded coverage of telehealth services for SUD treatment.) For causal analysis, we will use DiD. Section IIC, above, provides an overview of this analytic approach, and a discussion of its application to this component of the evaluation follows in section E3.5.

COVID-related note: Provision 4, the SUD residential treatment benefit, was substantially delayed, with implementation taking effect on February 1, 2021; The evaluation plan is affected by this change in schedule and by the pandemic circumstances. The original plan called for a combination of ITS and DiD approaches. We will no longer implement the ITS analysis, as it will be strongly confounded by COVID disruptions. We are still able to address all of the research questions. We will implement the DiD models excluding 2020 from the baseline period to avoid COVID19 related effects on outcomes during the baseline. The comparison populations and data sources for the DiD models are largely unchanged from the original analysis plan. Interpretation of DiD findings will include discussion of the potential residual confounding effects of the pandemic.

The Design Table (**Table 13**) summarizes the key features of the evaluation design, including evaluation questions, hypotheses, data sources and analytic approaches. As noted above, the format of this table conforms to CMS guidance for evaluation of the SUD provision and differs somewhat from the form of the table presented in prior sections.

Table 123. Provision 4: Summary of Questions, Hypotheses, Data Sources, and Analytic Approaches for Evaluation of the SUD Demonstration Waiver

NOTE: Implementation of this provision was delayed, with the new implementation set to February 1, 2021.							
DRIVER	**MEASURE DESCRIPTION [steward]**	**NUMERATOR**	**DENOMINATOR**	**DATA SOURCE**	**COMPARISON GROUP(S)**	**ANALYTICAL APPROACH**	
						Original	**Revised**
Q4.1 Does the SUD demonstration waiver increase the supply of SUD providers for Medicaid enrollees?							
H4.1a. The SUD demonstration waiver will increase the supply of SUD providers that accept and/or treat Medicaid enrollees.							
Secondary Driver (Increase Supply of Providers)	Number of residential treatment facilities that accept Medicaid patients [n/a]	Facility reports willingness to accept Medicaid patients	Federal, state, and local government and private residential treatment facilities that provide substance abuse treatment services	National Survey of Substance Abuse Treatment Facilities	All treatment facilities in Wisconsin and in selected comparison states for the measurement period	DiD	Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Modify selection criteria of comparison states to include state-level COVID-19 outcomes. Interpretation of DiD findings will include discussion of the potential residual confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
Secondary Driver (Increase Supply of Providers)	Proportion of Medicaid clinicians that provide treatment for SUD [n/a]	Number of clinicians that provide one or more services with an SUD diagnosis in any category of service (i.e., outpatient, inpatient, emergency department) in the measurement period	Number of active clinicians that provide any outpatient, inpatient, IMD, or emergency department service to one or more adult Medicaid enrollees in the measurement period.	WI Medicaid claims and encounter	Clinicians who provided any service to one or more adult Medicaid enrollee during the three years before SUD waiver implementation, and clinicians who provided any service to one or more adult Medicaid enrollee during the three years after SUD waiver implementation.	ITS	No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Implement a DiD in which we compare the change in # of clinicians that provide one or more services with an SUD diagnosis, to the change in # of clinicians who provide one or more services with a diabetes diagnosis. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
Q4.2 Does the SUD demonstration waiver increase access to, and use of, newly covered SUD services for Medicaid enrollees?							
H4.2a. After implementation of the SUD demonstration waiver, enrollees' awareness of available SUD treatment services will increase over time							
Secondary Driver (Increase Utilization)	Awareness of Medicaid coverage for SUD services [n/a]	Beneficiary Survey	Beneficiary Survey	Beneficiary Survey	Cross-sectional sample of enrollees at two post-implementation time points	Descriptive Analysis	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analysis will compare pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.
H4.2b. The SUD demonstration waiver will increase use of SUD treatment in IMD settings including residential treatment, inpatient treatment, medically supervised withdrawal services and MAT for opioid use disorder.							
Secondary Driver (Increase Utilization)	Any use of SUD treatment in IMD setting and volume of use, overall and by service type [n/a]	Any SUD treatment use overall and by service type; Quantity of SUD treatment services received by service type.	All admissions during the measurement period from treatment facilities that receive state funds or federal block grant funds to provide alcohol and/or drug treatment services	Treatment Episode Dataset - Admissions	Admissions to drug treatment facilities in WI and a set of comparison states for three years before and two years after implementation of the SUD demonstration waiver in WI.	DID	Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Modify selection criteria of comparison states to include state-level COVID-19 outcomes. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
H4.2c. The SUD demonstration waiver will increase initiation and engagement in SUD treatment.							
Secondary Driver (Increase Utilization)	Initiation and engagement of alcohol and other drug dependence treatment [NCQA-IET]	Initiation- # of enrollees who initiated treatment w/in 14 days of the index episode. Engagement- # of enrollees who initiated treatment & had >=2 additional services with a diagnosis of AOD w/in 30 days of initiation visit	Enrollees with a new diagnosis of AOD received between 1/1-11/15 of the measurement year, and continuous enrollment 60 days before new diagnosis and 44 days post.	WI all payer claims database (DD analysis); Medicaid claims and encounter (validation analysis)	For DD: Non-elderly adults enrolled in Medicaid and non-elderly adults enrolled in private insurance during the three years before and/or after implementation of the waiver.	ITS and DiD	No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Implement descriptive trend analysis with Medicaid data to validate all-payer data. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
Q4.3 Does the SUD demonstration waiver change Medicaid enrollees' use of existing covered SUD services?							
H4.3a. The SUD demonstration waiver will increase or have no effect on SUD outpatient services, including in-person and telehealth, and pharmacotherapy treatment provided outside of IMD settings.							
Secondary Driver (Increase Utilization)	Any outpatient visit for SUD treatment, and volume of outpatient visits for SUD treatment. [MODRN]	any, and # of non-emergency department, outpatient claims with a SUD diagnosis and of an OUD diagnosis. Outpatient visits include in-person and telehealth visits.	all member-months observed for target population and comparison group during the measurement period	same as H4.2c	same as H4.2c	same as H4.2c	No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.
Secondary Driver (Increase Utilization)	Any medication assisted treatment for opioid use disorder [MODRN]	any claim for buprenorphine, naltrexone (oral), injectable naltrexone, buprenorphine/Naloxone or a HCPCs code for buprenorphine or buprenorphine/ naloxone, methadone administration, or naltrexone	all member-months observed for enrollees with at least one encounter with a diagnosis of OUD in inpatient, outpatient and professional claims during the measurement period	same as H4.2c	same as H4.2c	same as H4.2c	No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
Secondary Driver (Increase Utilization)	Any outpatient visit for SUD treatment; any prescription medication treatment for SUD [n/a]	Beneficiary Survey	Beneficiary Survey	Beneficiary Survey	Cross-sectional sample of enrollees at two post-implementation time points	Descriptive Analysis	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analysis will compare pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
H4.3b. The SUD demonstration waiver will reduce use of hospital-based services, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.							
Primary Driver (Reduce Hospital-Based SUD Service Use)	Any emergency department visit with a SUD-diagnosis, and volume of emergency department visits with an SUD diagnosis [MODRN]	any, and # of ED visits with a SUD diagnosis of any kind; any and # of ED visits with an OUD diagnosis	all member-months observed for target population and comparison group during the measurement period	same as H4.2c	same as H4.2c	Descriptive Analysis, and same as H4.2c	Descriptive analyses are unchanged. No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.
	Any hospitalization with a SUD diagnosis, and number of hospitalizations with a SUD diagnosis [MODRN]	any, and # of hospitalizations with a SUD diagnosis of any kind; any, and # of hospitalizations with an OUD diagnosis	all member-months observed for target population and comparison group during the measurement period	same as H4.2c	same as H4.2c	Descriptive Analysis, and same as H4.2c	Descriptive analyses are unchanged. No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
Primary Driver (Reduce Hospital-Based SUD Service Use)	Any, and volume of readmissions within 30-days following hospitalization for a SUD diagnosis [n/a]	any, and # of readmissions to the hospital within 30-days for an SUD diagnosis of any kind; any and # of readmissions to the hospital within 30-days for an OUD diagnosis	Hospital discharges with a diagnosis of SUD in the measurement period among enrollees with continuous enrollment for a least 31 days post-hospitalization.	same as H4.2c	same as H4.2c	Descriptive Analysis, and same as H4.2c	Descriptive analyses are unchanged. No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.
	Any emergency department visit for a SUD; any hospitalization for a SUD [n/a]	Beneficiary Survey	Beneficiary Survey	Beneficiary Survey	Cross-sectional sample of enrollees at two post-implementation time points	Descriptive Analysis	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analysis will compare pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
H4.3c The SUD demonstration waiver will increase use of health care for co-morbid physical and mental health conditions among enrollees with a SUD, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.							
Primary Driver (Increase Use of Health Care for Co-Morbid Conditions)	Any outpatient visit for a non-SUD diagnosis; Quantity of outpatient visits for a non-SUD diagnosis [n/a]. Outpatient visit includes in-person and telehealth visits.	any, and # of non-emergency department, outpatient claim with a non-SUD diagnosis; any, and # of non-emergency department outpatient claims with a non-SUD diagnosis	all member-months observed for target population and comparison group members with at least one inpatient, outpatient, emergency department or IMD claim with an SUD diagnosis	same as H4.2c	same as H4.2c	Descriptive Analysis, and same as H4.2c	Descriptive analyses are unchanged. No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.
Primary Driver (Increase Use of Health Care for Co-Morbid Conditions)	Health status and chronic conditions; Access and use of general medical care; Substance use and SUD; Access and use of drug tx; knowledge/ understanding of waiver provisions	Beneficiary Survey	Beneficiary Survey	Survey	Cross-sectional sample of enrollees at two post-implementation time points	Descriptive Analysis	The delayed implementation of the SUD waiver results in one survey assessment pre-implementation (Fall 2020). Descriptive analysis will compare pre- and post-implementation outcomes recognizing the potential confounding effect of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
H5.3d. The SUD demonstration waiver will increase adherence to SUD treatment, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.							
Primary Driver (Increase adherence to SUD treatment)	Continuity of pharmacotherapy for OUD [NQF 3175, MODRN]	Enrollees who have at least a) 90 days, and b) 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than 7 days.	Enrollees that meet Inclusion criteria: individuals with a diagnosis of OUD in inpatient, outpatient or professional claims at any time during the measurement period; and at least one claim for an oral OUD medication during the measurement period received with at least 180 days before the end of the final calendar year of the measurement period; and continuously enrolled for at least 6 months after the month with the first OUD medication claim in the measurement period with no gap in that enrollment.	same as H4.2c	same as H4.2c	Descriptive Analysis, and same as H4.2c	Descriptive analyses are unchanged. No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential residual confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
Q4.4 Does the SUD demonstration waiver reduce the rate of drug overdose deaths among Medicaid enrollees including opioid-related deaths?							
H4.4a. The SUD demonstration waiver will reduce the rate of drug overdose deaths among Medicaid beneficiaries, conditional on increased supply of SUD providers, and/or increased use of new and existing covered SUD services.							
Purpose (Reduce drug overdose deaths including opioid-related deaths)	Rate of drug overdose death, and opioid-related drug overdose death [WIDHS - Technical Notes Annual Death Report, 2017, P-01170-19]	# of deaths due to any type of drug overdose; # of deaths due to opioid drug overdose	Medicaid non-elderly adult population for the measurement period; Estimated Wisconsin non-elderly adult population not enrolled in Medicaid for the measurement period; Estimated Wisconsin non-elderly population in the measurement period.	WI Death Records; Census Estimates; Medicaid Enrollment	For DD: Wisconsin non-elderly adult population not enrolled in Medicaid during the measurement period	Descriptive Analysis, ITS, DiD	Descriptive analyses are unchanged. No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions. Exclude 2020 from the baseline period for DiD models to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential confounding effects of the pandemic.

DRIVER	MEASURE DESCRIPTION [steward]	NUMERATOR	DENOMINATOR	DATA SOURCE	COMPARISON GROUP(S)	ANALYTICAL APPROACH	
						Original	Revised
Q4.5 What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?							
	Total health care costs; SUD and Non-SUD costs; Category-specific costs (e.g., Inpatient, Pharmacy, Outpatient non-ED, outpatient ED, long-term care). [CMS SUD Evaluation Design TA Attachment A]	Medicaid amount paid for each outcome noted.	All member-months observed during the measurement period for the target population.	Medicaid claims and encounter data.	Non-elderly adult Medicaid beneficiaries enrolled during the 3 years before and/or after waiver implementation.	Descriptive analysis and ITS	Descriptive analyses are unchanged. No longer do the ITS analysis, as it will be strongly confounded by COVID disruptions.
TABLE NOTES							
MODRN refers to the Medicaid Outcomes Distributed Research Network's Opioid Use Disorder workgroup. https://www.academyhealth.org/MODRN							

D3.2. Target and Comparison Populations

The provisions in the SUD demonstration waiver affect the full Wisconsin Medicaid population. The evaluation focuses specifically on non-elderly adult Medicaid beneficiaries, ages 21-64, the Medicaid population in Wisconsin with the highest rates of SUD. We exclude adults who are dually enrolled in Medicaid and Medicare because we cannot observe all of their health care use in Medicaid claims and encounters. We will employ several comparison groups; these vary according to the research question as described below.

To address question 4.1, "*Does the SUD demonstration waiver increase the supply of SUD providers for Medicaid enrollees*?" we will construct two comparison groups. First, to estimate the causal effect of the demonstration waiver on the supply of clinicians who provide SUD services to enrollees, we will use Wisconsin Medicaid claims and encounter data to identify the clinicians who provided any service to an adult Medicaid beneficiary during the three years before implementation of the residential treatment benefit, and similarly, the clinicians who provided any service to an adult Medicaid beneficiary during the three years after its implementation. Using these two groups, and an ITS analyses, we will determine if the demonstration waiver increased the fraction of Medicaid providers that delivered at least one SUD service to an adult Medicaid beneficiary. As a placebo test, we will replicate this analysis for an outcome that we would not expect to change as a consequence of the SUD demonstration waiver (e.g., the fraction of Medicaid providers that delivered at least one diabetes-related service to an adult beneficiary.)

Second, to estimate the causal effect of the demonstration waiver on the supply of residential treatment facilities that accept Medicaid beneficiaries, we will use the National Survey of Substance Abuse Treatment Facilities to identify the facilities that provided residential treatment for adults during the three years before and after implementation of the residential treatment facility. We will construct this sample of facilities in Wisconsin, and a sample of facilities from a set of comparison states that did not implement a SUD waiver during the study period. We will use a DiD design to determine if any potential change in the likelihood that a residential treatment facility accepts Medicaid patients after implementation of the wavier relative to the pre-period was greater than the any potential change experienced in the comparison states. We will select the comparison states based on their similarity to Wisconsin in demographics, Medicaid program characteristics, and federal resources available for SUD prevention and treatment (e.g., Substance Abuse and Mental Health Services Administration funding).

To address question 4.2, "*Does the SUD demonstration waiver increase access to, and use of, newly covered SUD services for Medicaid enrollees?"* we will construct several comparison groups. First, to determine the magnitude of increase in beneficiary awareness of SUD treatment services in the years following its implementation (H5.2a), we will compare respondents to the second survey of Medicaid beneficiaries that the team will field in CY2023 relative to respondents of the first survey of Medicaid beneficiaries that we will field in CY2020. Second, to test the effect of the demonstration waiver on the use of IMD-based SUD services (H4.2b), we will use the Treatment Episode Dataset (TEDS) to construct a sample of admissions to drug treatment facilities in Wisconsin and in a set of comparison

states for three years before and two years after implementation of the residential treatment benefit in Wisconsin. We will use a DiD design to determine if the change in use of IMD-based services after implementation of the wavier relative to the pre-period was greater than the any potential change experienced in the comparison states. We will select the comparison states for this analysis using the same criteria noted above in addition to consideration of the comparability of data submitted by each state to the TEDS.

To address the last hypothesis within question 4.2 pertaining to an expected increase in initiation and engagement in SUD treatment (H4.2c), we will use the state's all payer claims database to construct a comparison group of privately insured adults, and to construct a cohort of all non-elderly adult Medicaid beneficiaries enrolled at any point between February 2017 and January 2023. We will use a DiD design to compare the change in the likelihood of initiation and engagement in SUD treatment among Medicaid enrollees relative to privately insured adults in the three years after implementation of the residential treatment benefit relative to the pre-period, 2017-2019.

We will use the comparison strategies identified above for H4.2c to answer question 4.3, "*Does the SUD demonstration waiver change Medicaid enrollees' use of existing covered SUD services*?" To address question 4.4, "*Does the SUD demonstration waiver reduce the rate of drug overdose deaths among Medicaid enrollees including opioid-related deaths?*" we will use two comparison groups in addition to a statewide, population-level analysis. The first includes adult Medicaid enrollees in the three years before implementation of the residential treatment benefit which we will identify from Medicaid enrollment data.

We will implement a DiD design to compare the change in the drug overdose death rate three years after implementation of the waiver relative to the pre-period (2017-2019) for adult Medicaid enrollees relative to adult non-Medicaid enrollees in Wisconsin. We will estimate the size of the non-Medicaid group from census data and the Medicaid population from Medicaid enrollment data. Finally, to address question 4.5, "What are the patterns and trends in Medicaid costs associated with the SUD demonstration waiver?" We use the Medicaid enrollment data to construct a sample that includes all non-elderly adult Medicaid beneficiaries enrolled at any point between February 2017 and January 2023. We will use descriptive analysis to summarize and plot the trend in health care costs during the evaluation period beginning in 2017 through 2023. Originally planned as an ITS analysis, it is no longer viable given the pandemic-induced disruptions in health care use during the pre-waiver implementation period.

D3.3. Evaluation Period

The implementation of the residential treatment benefit and the implementation date for coverage of existing services within an IMD setting (i.e., inpatient services and medically supervised withdrawal services) took effect on February 1, 2021. The evaluation period for the SUD waiver is February 1, 2017 – January 31, 2023. This delay in implementation slightly alters the post-implementation time frame for observation, in that the waiver's planned time frame had allowed for up to 36 months of observation before and after implementation of specific SUD demonstration waiver provisions while

allowing for adequate time to complete the analyses and interpretation of analyses in the fourth and final year of the evaluation waiver. The specific duration of the evaluation period may vary according to the question and hypothesis.

D3.4. Data Sources

The outcome measures for this evaluation are defined in **Table 1**3. This evaluation will involve multiple data sources. They are noted in **Table 1**4, along with the hypotheses for which these data will be used. Section IID, above, provides a full description of these data sources.

Table 134. Provision 4 Data Sources

	Hypotheses
All Payer Claims Database, WHIO. Use the member file to identify both the Medicaid and privately insured samples to implement difference-in-difference analyses, and the claims files as the source of health care-use related outcomes. We will purchase the data for the evaluation years from the WHIO. We note that in 2019, the WHIO hired a new contractor to collect and construct the all-payer-claims database. We do not expect that the change in contractor will impede the use of these data longitudinally; however, we will confirm that there have been no changes in the methodology for data construction that would introduce bias into the study designs when technical information is available from the new contractor. In the evaluation of the SUD provision of the waiver, the WHIO provides a source for a within state comparison group of commercially insured individuals to complement the primary designs that estimate the effect of the SUD provision for the affected populations using ITS which does not rely upon a within-state comparator. Thus, in the unlikely event that the new WHIO data are not usable, our capacity to answer the research question will not be affected.	H4.2c H4.3a-d
American Community Survey. To estimate the annual size of the adult population in Wisconsin by age, an input into calculating age-adjusted rate of death due to drug overdose overall and opioid-related specifically. The ACS is a publicly available survey. As we have done for previous studies, we will obtain these data from IPUMS, https://usa.ipums.org/usa/.	H4.4a
Medicaid beneficiary survey. To assess enrollees' awareness of coverage for SUD treatment services under Medicaid, use of those services and self-reported treatment outcomes particularly among individuals who self-report harmful substance use. The Medicaid Beneficiary Survey will be designed and implemented by this evaluation team. We will obtain the data from within the project.	H4.2a H4.3a H4.3b

Data Sources	Hypotheses
Medicaid enrollment, claims, and encounter data. Construct all of the health-care-use-related outcome measures and cost outcomes shown in Table 13 for the target population. We obtain enrollment, claims and encounter data through regular extracts from the Department of Health Services. We use the fee-for-service allowable charges schedule to impute costs for encounter data. HMOs have a strong incentive to accurately and completely report encounter data to the WI DHS because these data are considered within the rate-setting process. The WI DHS contractually requires HMOs to provide at least 90% of adjudicated claims as encounters within 90 days and 99% within 150 days. Internal analyses conducted by the WI DHS from 2016-2018 show that missing data across HMOS is consistently modest ranging from 1.4% to 5.3%.	H4.1a H4.2c H4.3 H4.4a Q4.5
National Survey of Substance Abuse Treatment Services (N-SSATS). This N-SSATS is the key source of treatment facilities and facility characteristics in each state for our analysis of facility acceptance of Medicaid patients. We will compare the facilities identified in the N-SSATS for Wisconsin to the Wisconsin Division of Quality Assurance list to ensure that we have the most relevant sample in Wisconsin. The N-SSATS is a publicly available dataset. We will download these data from the following site, https://www.datafiles.samhsa.gov/study-series/national-survey-substance-abuse-treatment-services-n-ssats-nid13519	H4.1a
Treatment Episode Data Set – Admissions (TEDS-A). The TEDS-A is the source of outcome data to assess Medicaid enrollee use of SUD services within an IMD setting. This dataset is published approximately two-years after the close of the calendar year (e.g., May 2019 for the 2017 dataset), so we expect to use five datasets covering the years 2017 – 2021. The TEDS-A is a publicly available dataset. We will download these data from the following site, https://www.datafiles.samhsa.gov/study-series/treatment-episode-data-set-admissions-teds-nid13518	H4.2b
Wisconsin Death Records. To obtain deaths due to drug overdose overall and opioid-related specifically. We will obtain these data from the Wisconsin Department of Health Services Vital Records Services under the terms of the data use agreement for this evaluation.	H4.4a
Wisconsin Mental Health and Substance Use Needs Assessment. To use as a source of control variables. We will obtain this publicly available report from the Wisconsin Division of Care and Treatment Services. It is published biannually and provides county-specific indicators of SUD treatment needs and available resources.	H4.1a, H4.2c H4.3a-d

D3.5. Analytic Methods

In this section we describe the analytic methods we will implement to complete our descriptive and causal analyses. The hypotheses for which each method will be used are noted in brackets following a description of the approach.

Descriptive Analyses

We will implement descriptive analyses to achieve the following objectives: a) to characterize and compare the equivalence of characteristics and baseline outcomes across study groups; b) to describe, and test for change over time in study outcomes; and c) to quantify the association between study outcomes and factors that may influence those outcomes including beneficiary characteristics, the implementation of the SUD demonstration waiver, and county-level SUD prevention and treatment resources. We will use bivariate statistical tests (e.g., t-test, chi-square test) to determine the equivalence of unadjusted characteristics or outcomes across groups and over time, and regression methods to quantify the association between specific covariates and study outcomes while adjusting for other relevant covariates. The general forms of the regression models that we will use to execute our descriptive analyses are described below.

$$(1) \qquad Y_{it} = \beta_1 svy2_t + \varphi X_i + \varepsilon_{it}$$

Equation (1) describes the regression model that we will implement to test for an increase in beneficiary awareness and self-reported use of SUD services from the first to the second survey in the post-waiver implementation period. Specifically, Y is an outcome of interest for person *i* at time *t*, svy2 is an indicator that takes on a value of 1 for responses from the second beneficiary survey. We allow X to stand for control variables and ε represent a random error term. The coefficient of interest β_1, represents the difference in the outcome in the second beneficiary relative to the first survey. We will use ordinary least squares or logistic regression analysis as appropriate to the outcome. [H4.2a, H4.3a, H4.3b]

$$(2) \qquad Y_{it} = \varphi X_i + \gamma M_t + \tau P_t + \pi_t + \varepsilon_{it}$$

Equation (2) illustrates the general model we will implement to quantify the association between a given outcome, *Y* for unit *i* at time *t*, and select covariates: a vector, *X,* of beneficiary characteristics; a vector, *M,* of county-level SUD prevention and treatment resources; *P,* a vector of state or federal policies related to SUD prevention and treatment; and a time fixed effect, π_t. Observations are at the unit-time period that is appropriate to the outcome, and ε represent a random error term. We will select the specific type of regression analysis for each model according to the functional form relationship between the parameter of interest (e.g., conditional mean) and the key independent variable(s). We will adjust standard errors for multiple observations within person over time as appropriate to the outcome.

To describe potential differences in health care costs after implementation of the waiver relative to the prior period, we will implement a modified version of Equation (2) that includes an indicator variable for the post-waiver period (i.e., on or after Timeframe B). We will use two-part generalized linear models selecting the appropriate link and variance functions using a modified version of the Hosmer-Lemeshow test and the Park test respectively.[19,20] [H4.3a-H4.3d, H4.4a, Q4.5]

Causal Analyses

As noted above, the original evaluation plan included a combination of ITS and DiD approaches. We will no longer implement the ITS analysis, as it will be strongly confounded by COVID disruptions. We are still able to address all of the research questions. We will implement the DiD models excluding 2020 from the baseline period to avoid COVID19 related effects on outcomes during the baseline. Interpretation of DiD findings will include discussion of the potential residual confounding effects of the pandemic.

We will implement a DiD design[21] to test the equivalence of a change in an outcome after implementation of the SUD demonstration waiver relative to the pre-waiver period for the target group relative to a change in the outcome for a concurrent comparison group. A general description of this approach is provided in Section IIB.

The DiD design allows us to identify the causal effect of the SUD demonstration waiver by assuming that the outcomes for the target group would have evolved similarly over time as that of the comparison group(s) in the absence of the implementation of the waiver. While this assumption is not directly testable, we will assess its plausibility by comparing the pre-intervention outcome trends for the target and comparison groups. Our particular application of DiD regression analyses to the evaluation of the SUD demonstration waiver is described immediately below beginning with the general form of the model. [Q4.1a, Q4.2b, Q4.2c, Q4.3a-Q4.3d, Q4.4a]

$$(4) \qquad Y_{it} = \beta_1 TG_i + \beta_2 post_t + \beta_3 (TG_i * post_t) + \varphi X_i \ + \ \gamma M_t \ + \varepsilon_{it}$$

Y is an outcome of interest for unit *i* at time *t*, TG is an indicator for membership in the target group, and $post$ is an indicator for the post-waiver period, the period on or after the first implementation date for the SUD demonstration waiver. Observations are at the unit and time period (e.g., person-month, facility-year, etc.,) that is appropriate to the outcome. We allow X to stand for control variables. For models in which both the target and comparison groups are drawn from the State of Wisconsin, we will include a vector M that includes county-level control variables related to SUD treatment prevention and resources access from the Wisconsin Mental Health and Substance Use

[19] Manning WG, Basu A, Mullahy J. Generalized modeling approaches to risk adjustment of skewed outcomes data. Journal of Health Economics. 2005;24:465-488.

[20] Manning WG, Mullahy J. Estimating log models: to transform or not to transform? Journal of Health Economics. 2001;20:461-494.

[21] Wing C, Simon K, Bello-Gomez RA. 2018. Designing Difference-in-difference Studies: Best Practices for Public Health Policy Research. Annual Review of Public Health. 39:453-69.l

Needs Assessment data. Where feasible and appropriate, the set of control variables may include county by year fixed effects to address the potential for time-varying geographic differences to help isolate the demonstration impact. We will also include specifications that allow for heterogeneity in the effect by year (defining *post* as indicator variables for year) to observe the impact of the demonstration in years during and right after the COVID-19 pandemic and in later years when the pandemic has further subsided, where appropriate. The random error term is represented by ε. The coefficient of interest is the coefficient on the interaction term, β_3. Standard errors will be adjusted for multiple observations within person over time as needed.

We will select the specific type of regression analysis for each DiD model according to the functional form relationship between the parameter of interest (e.g., conditional mean) and the key independent variable(s). In cases where we implement non-linear regression analyses, we will report post-estimation average marginal effects to facilitate interpretation of the DiD results.[22]

D4. Methodological Limitations

Comparison strategies. Implementation of the SUD provision for all adult Medicaid beneficiaries at the same points in time precludes the inclusion of a concurrent, within-state Medicaid comparison group that is exposed to all other potential changes in Medicaid policies during the observation period except the SUD demonstration waiver provisions. However, we will assess the potential confounding influence of other demonstration waiver provisions that are implemented coincident with the SUD provisions (e.g., HRA/HNAs, premiums, etc.,) on the outcomes described in Table 13 by estimating separate models for adults with and without dependent children when feasible. Adults without dependent children are subject to all provisions in the demonstration waiver. By contrast, parents and caregivers are only subject to the SUD demonstration waiver provisions.

For outcomes that require health care claims for their construction, the proposed evaluation design for the SUD demonstration waiver lacks an out-of-state comparison group; thus, we cannot rule out the possibility that national secular events or trends may confound the relationship between implementation of the SUD provision and the study outcomes. As a member of the OUD workgroup in the multi-state Medicaid Outcomes Distributed Research Network (MODRN),[23] we considered the possibility of engaging another MODRN state(s) as a comparison state. However, after consultation with MODRN leadership, we concluded that it was not feasible due to resource constraints. Specifically, each state-university partnership within the MODRN employs a common data model, common measurement periods, common definitions of eligibility groups, and common measures to assess OUD prevalence, treatment and outcomes for purposes of the MODRN's research and learning objectives.

[22] Karaca-Mandic P, Norton EC, Dowd B. 2012. Interaction Terms in Nonlinear Models. Health Services Research.47(1, Part 1):255-274.

[23] A description of the Medicaid Outcomes Distributed Research Network is available at: https://www.academyhealth.org/MODRN

To participate as a comparator state for an 1115 waiver evaluation would require significant adaptation of this work including modification of the measurement periods to construct the measures and define the study population, potential revision to the definition of the eligibility groups, and a willingness to share aggregate data (at a minimum) with another state for a non-MODRN purpose. These revisions and activities would demand significant staff and investigator time from each potential comparison state that goes well beyond what is supported through the MODRN. At present, we are not aware of any CMS resources available to facilitate or incentivize states' participation as comparison states for 1115 waiver evaluations. If such resources are available, we would be happy to pursue further discussions with our MODRN colleagues about the possibility of serving in that role.

Compositional changes in population. Implementation of the SUD demonstration waiver may alter the composition of the adult beneficiary population in ways that are relevant to our outcomes to the extent that individuals newly enroll in Medicaid because of the availability of expanded SUD services. Such individuals, for example, may be more likely to have an SUD and a desire for treatment. It is important to distinguish the potential effects of the demonstration waiver on study outcomes, from changes in study outcomes that are attributable to compositional changes in the beneficiary population.

We will take two steps to assess and mitigate this possibility. First, in our evaluation of the change over time in drug overdose deaths, we include a population-level analysis that does not distinguish between Medicaid and non-Medicaid enrollees in the event that the risk-profile of these two groups changes over time. Second, as our data permit, we will execute sensitivity analyses that hold the analytic sample constant before and after implementation of the waiver as our data allow to rule out the potential confounding effects of changes in the characteristics of the beneficiary population.

IV. ATTACHMENTS

Attachment A: Waiver approval letter, waiver provisions, and Special Terms and Conditions (STCs)

Attachment B: CMS Comments and UW/DHS Responses

Attachment C: Independent Evaluator Assurance of No Conflict

Attachment D: Timelines of Major Evaluation Milestones

Attachment A: Waiver approval letter, waiver provisions, and STCs

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

OCT 3 1 2018

Casey Himebauch
Deputy Medicaid Director
Administrator, Division of Medicaid Services
Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53703

Dear Mr. Himebauch:

Under Section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115 of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115 of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Wisconsin's request for extension and amendment of its Medicaid demonstration project entitled, "BadgerCare Reform" (Project No. 11-W-00293/5), in accordance with section 1115(a) of the Act.

This amendment and extension approval (the "approval"), among other things, extends the operation of Wisconsin's Medicaid demonstration past its current expiration of December 31, 2018. The approval is effective October 31, 2018 through December 31, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. After December 31, 2018, the state will no longer have the authority to charge premiums to the Transitional Medical Assistance adults through the demonstration. CMS's approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STC). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 if, in his judgment, the project is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include the appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This appropriations provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries and that it is appropriate for the state to structure its demonstration program in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care, and focus on evidence-based interventions that drive better health outcomes and quality of life improvements, and may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But in the long term they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage may decrease the number of individuals who need financial assistance from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[1] By

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom

the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Background on Medicaid Coverage in Wisconsin

Wisconsin has not adopted the Affordable Care Act (ACA) adult expansion population, but it implemented its BadgerCare Reform section 1115 demonstration on January 1, 2014, to expand coverage to a childless adult demonstration-only population using expenditure authority under section 1115(a)(2) of the Act. BadgerCare Reform primarily provides authority for the state to provide a robust benefit package which includes most state plan benefits to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including 100 percent of the federal poverty level (FPL). As of June 30, 2018, more than 178,000 individuals receive coverage under this demonstration authority.

In addition to providing this coverage for the BadgerCare Reform population, Wisconsin's state plan provides coverage for other optional populations such as parents and caretaker relatives with income up to 100 percent of the FPL and pregnant women above 138 percent of the FPL. In addition, the Wisconsin state plan currently covers an array of optional services including prescription drugs, dental services, and occupational therapy.

Extent and Scope of Demonstration

The BadgerCare Reform demonstration primarily provides authority for the state to provide a robust benefit package to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including 100 percent of the FPL. This demonstration approval continues coverage for this population for five years. It also allows Wisconsin to require these childless adult beneficiaries, ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities. Qualifying activities include employment, job training, community service, or enrollment in an allowable work

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their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to offer Medicaid coverage to populations not specifically included in the statute by using expenditure authority under section 1115(a)(2) of the Act. This authority has been used to allow a number of states, including Wisconsin, to expand Medicaid eligibility beyond the allowable statutory categories. The same authority at section 1115(a)(2) of the Act can be used for states to cover benefits beyond what is authorized by statute as well. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

program. The community engagement incentive will not apply to beneficiaries ages 50 and older so as to ensure alignment and consistency with the state's Supplemental Nutrition Assistance Program (SNAP) requirements, which is intended to minimize confusion for beneficiaries who may receive both SNAP and Medicaid. To help ensure the success of these beneficiaries, CMS is allowing states to align the community engagement requirements in Medicaid with the work requirements in other federal programs.

Beneficiaries subject to the community engagement requirement who have been enrolled in the demonstration, but who have not met the community engagement requirements for 48 aggregate months (without qualifying for an exemption) will be disenrolled from the demonstration and unable to re-enroll as a childless adult for six months. However, if that individual reapplies for Medicaid during that six-month period of non-eligibility and is found eligible under another Medicaid eligibility group (MEG), the individual will be enrolled into Medicaid.

CMS also is providing authority to allow the state to implement additional features, including:

- Implementing premiums on childless adults with incomes from 50 percent up to and including 100 percent of the FPL as a condition of eligibility;
- Allowing termination and a period of non-eligibility as a childless adult for up to six months for childless adults who do not pay the required premium, with on-ramps to reactivate coverage during the non-eligibility period;
- Allowing the state to vary premiums for childless adults based on the responses on a health risk assessment (HRA) and avoiding health risk behaviors;
- Charging childless adults an $8 co-payment for non-emergency use of the emergency department (ED), consistent with 42 CFR § 447.54(b); and
- Requiring full completion of an HRA as a condition of eligibility, as a part of the application for childless adults, in order to identify healthy behaviors.

The eligibility conditions discussed above will apply only to the non-mandatory population receiving coverage through BadgerCare Reform. In addition, this demonstration will also include a substance use disorder (SUD) program (described in STCs 26–32) available to all Wisconsin Medicaid beneficiaries. The purpose of the program is to ensure that a broad continuum of care is available to Wisconsin Medicaid beneficiaries with a substance use disorder, which will help improve the quality, care, and health outcomes for those Medicaid beneficiaries. The SUD program contributes to a comprehensive statewide strategy to combat prescription drug abuse and opioid use disorders and expands the SUD benefits package to cover short-term residential services in facilities that qualify as institutions for mental diseases (IMDs) for all Medicaid enrollees.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

For reasons discussed below, the Secretary has determined that BadgerCare Reform is likely to assist in promoting the objectives of the Medicaid program.

The demonstration provides coverage beyond what the state plan provides.

CMS has determined that BadgerCare Reform is likely to promote the objective of furnishing medical assistance because it gives the state the expenditure authority to continue, past the demonstration's expiration date at the end of 2018, to offer Medicaid coverage under section 1115(a)(2) of the Act to the population of non-pregnant, non-disabled, childless adults with incomes up to and including 100 percent of the FPL. While new features to the demonstration, like the addition of community engagement, requirement to complete the HRA, and premium requirements may impact overall coverage levels if the individuals subject to these demonstration provisions choose not to comply with them, the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. Should this demonstration not be approved, the amended BadgerCare demonstration would not continue past its current expiration of December 31, 2018, and the individuals currently covered by that demonstration would likely lack access to any source of affordable health coverage. In addition, Wisconsin expects that the demonstration will result in healthier, more financially independent beneficiaries and as a result, the demonstration will "improve health outcomes, reduce unnecessary services, and improve the cost-effectiveness of Medicaid services." Such goals are in furtherance of Wisconsin's broader stated objective of creating a program that is "sustainable" so Wisconsin's health care safety net is available to those who need it most. Implementing the new features discussed further below facilitate Wisconsin's ability to extend coverage to the demonstration population under BadgerCare from 2019 through 2023, thereby furthering Medicaid's purpose of enabling states to furnish medical assistance.

This approval will also allow the state to offer the SUD program. The SUD program will improve access to high-quality addiction services and is critical to addressing Wisconsin's substance use epidemic. Under this initiative, all Medicaid beneficiaries will continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries ages 21 through 64 will have access to additional covered services, authorized under section 1115(a)(2) of the Act, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an Institution for Mental Diseases (IMD). These services would otherwise be excluded from federal reimbursement.

The demonstration promotes the objectives of helping beneficiaries attain or retain independence.

BadgerCare Reform, as amended, is likely to promote the objective of helping beneficiaries attain or retain independence, which would lead to higher quality care at a sustainable cost. For example, the community engagement provisions generally require adults in this demonstration-

only population to work, look for work, or engage in activities that enhance their employability such as job training, or community service. The demonstration will thus help the state and CMS evaluate whether the community engagement requirement helps adults in this population transition from Medicaid to financial independence and commercial insurance, including the federally subsidized coverage that is available through the Exchanges. To help prepare individuals in this group for the commercial insurance market, other provisions of BadgerCare Reform give them experience with premiums, including the opportunity to pay a reduced premium for not engaging in certain behaviors that increase health risks.

To the extent that the community engagement requirements help individuals achieve financial independence and transition into commercial coverage, the demonstration may reduce dependency on public assistance while still promoting Medicaid's purpose of helping enable states to furnish medical assistance. By helping people to transition to commercial coverage, community engagement will help Wisconsin stretch its limited Medicaid resources and will thus promote Medicaid's purpose of helping enable states to furnish medical assistance. As Wisconsin noted in its amendment application and as explained further below, such increases in beneficiary independence also help to ensure that Wisconsin's Medicaid program is sustainable so its health care safety net is available for those Wisconsin residents who need it most. The state of Wisconsin currently finances almost 60 percent of the cost of care for this demonstration group.

BadgerCare Reform, as amended, contains provisions that could result in some beneficiaries losing coverage, including having their eligibility terminated with a non-eligibility period for up to six months for failure to comply with the community engagement or premium requirements, or being denied coverage for failure to complete a HRA. While CMS and the state are testing the effectiveness of an incentive structure that attaches penalties to failure to take certain measures, the program is designed to make compliance with requirements achievable. As an initial matter, the community engagement requirement does not result in a loss of eligibility until a person has failed to comply for 48 months, and individuals who are determined to be unfit for employment (which can include mentally or physically unfit), experiencing chronic homelessness, or participating in SUD treatment, do not accrue months of noncompliance. Moreover, Wisconsin has taken steps to include adequate beneficiary protections to ensure that the demonstration program requirements apply only to those beneficiaries who can reasonably be expected to meet them and to notify beneficiaries of their responsibilities under the demonstration. Any individual whose coverage is terminated for failure to meet the requirements, or who experiences any other adverse action, will have the right to appeal the state's decision as with other types of coverage terminations, consistent with all existing appeal and fair hearing protections. Furthermore, the incentives to meet the requirements, if effective, may result in individuals becoming ineligible because they have attained financial independence – a positive result for the individual.

The demonstration tests reforms designed to strengthen beneficiary engagement, incentivize responsible decision-making, and promote better health outcomes.

The demonstration will evaluate the effectiveness of policies that are designed to improve the health of Medicaid beneficiaries and encourage them to make responsible decisions about their health and accessing health care. BadgerCare Reform's community engagement requirement is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness, which ultimately helps to keep health care costs at sustainable levels.

Additionally, the demonstration is designed to improve health by increasing beneficiary awareness about healthy behaviors and encouraging demonstration participants to engage in such behaviors by: (1) requiring completion of an HRA; and (2) rewarding those who avoid or manage certain health risk behaviors with lower premiums. More specifically, BadgerCare Reform requires that beneficiaries complete an HRA as a condition of eligibility. As discussed below, this policy is expected to improve beneficiaries' engagement in their health care choices by increasing their awareness of behaviors that might be detrimental to their health, while also encouraging them to make healthier choices. The completion of the assessment will also help the beneficiary's managed care plan identify health risks and improve the plan's ability to provide effective care management and address beneficiary health care needs. The state will reduce premiums for individuals who do not engage in certain behaviors that increase health risks or attest to actively managing certain unhealthy behaviors. Premium reductions will be based on beneficiary behaviors, not on a beneficiary's health status or pre-existing condition. Furthermore, beneficiaries who engage in behaviors that increase certain health risks but do so as a result of a health condition will also still be eligible for reduced premiums. Consistent with privacy laws, the state will share this information with beneficiaries' managed care plans which may offer additional supports.

Wisconsin will also evaluate whether the use of the HRA and the opportunity for beneficiaries who avoid or manage certain health risk behaviors to pay a reduced premium will strengthen beneficiary engagement in their personal health care plan and provide an incentive structure to support responsible consumer decision-making about accessing care and services. A prior evaluation of one demonstration project with beneficiary engagement components has shown some promise that these strategies can have a positive impact on beneficiary behavior.[2] Overall the research findings on the effects of healthy behavior incentives in Medicaid have shown some promising results but require further study. Wisconsin will include evaluation of the outcomes associated with these requirements in its evaluation design to further enrich the evidence regarding beneficiary engagement strategies.

Taken together, the evidence tying certain beneficiary behaviors to improved health outcomes supports a determination that all of the above-mentioned features of the demonstration promote the objectives of the Medicaid program. Promoting beneficiary health and independence advances the objectives of the Medicaid program; indeed, in 2012, HHS specifically encouraged

[2] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes."[3] And to the extent that greater beneficiary health and independence make these individuals less costly for Wisconsin to care for, this outcome further advances the objectives of the Medicaid program by helping Wisconsin stretch its limited Medicaid resources and ensure the long-term fiscal sustainability of the program.

The demonstration also promotes responsible decision making and improved health by encouraging appropriate use of health care services and behavior that is mindful of health care value. This demonstration will allow the state, consistent with 42 CFR § 447.54(b), to charge beneficiaries an $8 copayment for utilization of the ED for non-emergency services. Wisconsin believes this will help beneficiaries learn about the importance of choosing appropriate care in the appropriate setting—which is generally not the ED—by educating beneficiaries about the direct cost of health care services and the importance of seeking preventive services and similar care in the most appropriate setting. Receiving preventive and similar care in non-emergency settings can improve the health of beneficiaries, because they can build and maintain relationships with their regular treating providers. Over time, this may lead to the prevention of chronic disease, as prevention and health promotion are difficult to achieve and sustain through episodic ED visits. Additionally, this policy will improve the ability of beneficiaries who truly need emergency care to access it, by preserving ED resources for those who are truly in need of timely emergency care. Moreover, we expect that this copayment policy will decrease the use of inefficient and costly care in less appropriate settings, thereby making beneficiaries less costly to care for and Wisconsin's Medicaid program more sustainable—both in furtherance of the Medicaid program's objectives.

The demonstration will provide beneficiaries with coverage that more closely aligns with commercial coverage and promotes independence.

Coverage for the adult demonstration-only group under BadgerCare Reform is designed to work more like insurance products sold on the commercial market. Many individuals in this group are estimated to move between Medicaid eligibility and Marketplace coverage. This approval seeks to provide beneficiaries with the tools to successfully utilize commercial market health insurance, thereby removing potential obstacles to a successful transition from Medicaid to commercial coverage, removing incentives for remaining on Medicaid, and enhancing the sustainability of Wisconsin's medical assistance program.

For instance, BadgerCare Reform, as amended, includes premium payment requirements (with a non-eligibility period for certain beneficiaries for non-payment, similar to provisions CMS has approved in other states[4]) and varies premium amounts based on beneficiary health behaviors, all of which beneficiaries are likely to encounter should they transition off of Medicaid and into commercial coverage.

[3] CMS, Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid at 15 (Dec. 10, 2012).
[4] Section 1115 demonstration, Healthy Indiana Plan, available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=25478

As described in the STCs, if monitoring or evaluation data indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

Consideration of public comments

To increase the transparency of demonstration projects, the ACA directed the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 project that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. Act § 1115(d)(1), (2). The first comment period occurs at the state level before submission of the section 1115 application, *id.* §1115(d)(2)(A), and the second occurs at the federal level after the application is received by the Secretary, *id*. §1115(d)(2)(C).

The ACA specified that comment periods should be "sufficient to ensure a meaningful level of public input," id. § 1115(d)(2)(A) & (C), but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments. 42 C.F.R. § 431.416(d)(2); *see also* Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 75 Fed. Reg. 56947, 56953 (Sept. 17, 2010) (proposed rule).

CMS received 652 comments during the federal comment periods on the amendment and extension requests to BadgerCare Reform. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS' analysis of those issues for the benefit of stakeholders.

General comments

The vast majority of the comments CMS received were from self-identified Wisconsin citizens who opposed either the demonstration as a whole or certain features of it. Many of those comments expressed general concerns that the demonstration will result in many poor citizens losing Medicaid. CMS shares the commenters' concern that everyone who needs Medicaid and meets programmatic eligibility criteria has access to it. As previously stated, however, CMS believes the features of this demonstration are worth testing to determine whether there is a more effective way to furnish medical assistance to the extent practicable under the conditions in Wisconsin. That is why CMS has carefully reviewed the demonstration as a whole to ensure it is likely to further Medicaid's objectives.

Specifically, this demonstration does not simply cut off benefits for any beneficiaries. Instead, it is designed to extend coverage. Were CMS to decline to approve this application, the current demonstration would automatically terminate on December 31, 2018, leaving able-bodied applicants who meet the criteria without coverage. This extension permits the state to continue

to provide coverage to this broader group. Also, the demonstration is designed to improve health outcomes and reduce dependency on public assistance by incentivizing healthy behaviors and giving beneficiaries the choice to either engage in those behaviors or to no longer participate in Medicaid. CMS has worked together with Wisconsin to include guardrails that will protect beneficiaries. These guardrails, which are contained in a series of assurances in the STCs, include requirements that the state: screen beneficiaries and determine eligibility for other bases of Medicaid eligibility and review for eligibility for insurance affordability programs prior to suspension; provide full appeal rights prior to disenrollment; develop and implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements; provide beneficiaries with periodic updates on how many months have counted towards the 48 months of noncompliance necessary to lose eligibility; and maintain a system that provides reasonable modifications related to meeting the community engagement requirements to beneficiaries with disabilities, among other assurances. The STCs include a provision granting CMS the authority to discontinue the demonstration if the agency determines that it is not furthering Medicaid's objectives. Moreover, CMS will regularly monitor BadgerCare Reform and will work with the state to resolve any issues that arise as Wisconsin works to implement the demonstration.

Some comments argued that a demonstration cannot advance the Medicaid program's objectives if the project is expected to reduce Medicaid enrollment or Medicaid spending. We recognize that some individuals may choose not to comply with the conditions of eligibility imposed by the demonstration, and therefore may lose coverage, as may occur when individuals fail to comply with other requirements like participating in the redetermination process. But the goal of the demonstration is to incentivize compliance, not reduce coverage. Indeed, CMS has incorporated safeguards into the STCs intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with Wisconsin to ensure that the demonstration advances the objectives of Medicaid. Furthermore, we anticipate that beneficiaries will be connected with employment, and may disenroll from Medicaid if they obtain employer-sponsored or other commercial coverage and no longer qualify for the program. Finally, we note that in some cases, reductions in Medicaid costs can further the Medicaid program's objectives, such as when the reductions stem from reduced need for the safety net or reduced costs associated with healthier, more independent beneficiaries. These outcomes promote the best interests of the beneficiaries whose health and independence are improved, while also helping to support the long-term fiscal sustainability of Medicaid programs.

In a similar vein, some comments suggested that it is impermissible for a demonstration to rely on disenrollment and a non-eligibility period as incentives for compliance with the project's requirements. As noted above, section 1115 explicitly contemplates that demonstrations may "result in an impact on eligibility" and the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. Other comments predicted that BadgerCare Reform or its component parts will fail to achieve their objectives. For instance, some comments argued that beneficiaries subject to the community engagement requirement will be unable to comply. To some extent, these comments reflect a misunderstanding of the nature of the community engagement requirement, which the comments described as a work requirement. In fact, the community engagement requirement is designed to help beneficiaries achieve success, and CMS and the state have made

every effort to devise a requirement that beneficiaries should be able to meet. For example, the community engagement requirement may be satisfied through an array of activities including education, job training, job search activities, and community service.

More generally, these comments reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making. As HHS previously explained, demonstrations can "influence policy making at the State and Federal level, by introducing new approaches that can be a model for other States and lead to programmatic changes nationwide." 75 Fed. Reg. at 56947. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See*, *e.g.*, *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which Wisconsin's demonstration project succeeds in achieving the desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. That in itself promotes the objectives of the Medicaid statute.

Comments addressing coverage losses

Some comments argued that the demonstration will cause individuals to lose Medicaid coverage and, for that reason, the project cannot be consistent with the objectives of the Medicaid program. First, it is important to acknowledge that otherwise potentially eligible Medicaid beneficiaries lose coverage today for many reasons where they have failed to comply with program requirements, like completing their annual redetermination. Second, we note that the demonstration provides coverage to individuals that are not eligible under the state plan. Any potential loss of coverage that may result from a demonstration must be considered in the context of a state's substantial discretion to eliminate optional benefits, cease demonstration projects, or otherwise eliminate coverage for existing (but optional or demonstration) populations. Experiments designed to help able-bodied adults transition out of Medicaid are particularly appropriate in light of the fact that beneficiaries who receive coverage under an expansion under section 1115(a)(2) of the Act that is less generous than state plan coverage for categorically eligible beneficiaries are still better off than receiving no coverage at all. Finally, conditioning eligibility for Medicaid coverage on compliance with certain measures is an important element of the state's efforts, through experimentation, to improve beneficiaries' health and independence and enhance programmatic sustainability. To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence. This may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the demonstration is not designed to encourage this result; rather, the demonstration is intended to incorporate achievable conditions of continued coverage. And any loss of coverage as the result of noncompliance must be weighed against the benefits Wisconsin hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.

Commenters expressed concern over the state disenrolling individuals from the demonstration who are non-compliant for 48 months of enrollment as a childless adult and then subjecting those individuals to a six month period of non-eligibility before they are able to enroll as a childless adult again. The state addressed these concerns by pointing out that for every month that a beneficiary engages in a qualifying community engagement activity or meets an exemption, beneficiaries are able to remain in the demonstration. Coverage loss would occur only if the individual chooses not to comply with the program's requirements for an aggregate period of 48 months; therefore, we anticipate that very few beneficiaries will be subject to the period of non-eligibility. In those cases, we note that individuals always are able to re-apply for Medicaid and have eligibility determined for other Medicaid groups for which they can be immediately enrolled. Additionally, we believe this feature of the demonstration provides an important incentive to ensure that beneficiaries are engaged with their communities.

It would be counterproductive to deny states the flexibility they need to implement demonstration projects designed to examine innovative ways to incentivize beneficiaries to engage in desired behaviors that improve outcomes and lower healthcare costs, given that states have the prerogative to terminate coverage for non-mandatory services and populations. Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment. That is one of the metrics to be measured. But even assuming that BadgerCare Reform would result in the loss of coverage for some individuals as commenters suggested, and even assuming that most of these individuals would not transition to commercial coverage, such losses are likely dwarfed by the 166,000 childless adults who would not otherwise have coverage if Wisconsin elects not to extend the demonstration.

Furthermore, the Wisconsin state plan covers other optional populations such as parents/caretakers with incomes up to 100 percent of the FPL as well as optional services such as prescription drug, dental, and occupational therapy benefits. As a matter of federal law, it is a state's prerogative to reduce or eliminate non-mandatory coverage. Such judgments are left to the policy preferences of the state government and its electorate, and states are to be given great latitude in making tradeoffs in how the state furnishes medical assistance "as far as practicable under the conditions" in the state. Act § 1901. In evaluating Wisconsin's demonstration project, it is appropriate to consider the possibility of coverage loss among the demonstration population against the benefits that may accrue to members of the childless adult demonstration-only population who comply with the conditions of eligibility and receive coverage they may not otherwise have received, as well as benefits that may accrue to the traditional Medicaid population as a result of the demonstration population growing more independent, healthier, and less expensive to cover. Wisconsin will measure actual effects on enrollment as part of the demonstration, and that information should be useful in informing future Medicaid policy.

Comments addressing the community engagement requirements

Many commenters also expressed concerns regarding the demonstration's community engagement requirements, including: (1) that the reporting requirement will cause beneficiaries to lose Medicaid coverage because of failure to report their hours, changes in circumstances, or

because of clerical errors by Wisconsin's Medicaid agency; (2) that the community engagement program will be an additional burden on beneficiaries, particularly those who have chronic illnesses, are homeless, or are domestic violence victims; (3) that many beneficiaries are already working, going to school, or engaging in some other employment and training activity; and (4) that allowing individuals to maintain health coverage better enables individuals to obtain and maintain employment. Some commenters suggested reducing the 80-hour per month requirement.

CMS has worked closely with Wisconsin to ensure there are substantial beneficiary protections in place. Beneficiaries already have a responsibility to report changes in income or circumstances to the state, and the state must maintain and process that information. The state also included exemptions for individuals who have been determined unfit for employment (which can include mentally or physically unfit), experiencing chronic homelessness, or participating in SUD treatment, so individuals that have additional burdens are not required to complete the requirements. Both CMS and the state acknowledge what commenters noted—many beneficiaries are already working or attending school; therefore, those activities are included as meeting the community engagement component and these beneficiaries' access to coverage should not be impacted.

The STCs provide for Wisconsin to educate and reach out to beneficiaries and contain assurances that Wisconsin will seek data from other sources, including SNAP, TANF, and other existing systems. This is expected to reduce the burden on beneficiaries and allow the state to efficiently verify community engagement hours and process beneficiary redeterminations. The STCs require the state to provide CMS with a community engagement implementation plan and assurances regarding timely and adequate notices to beneficiaries.

Other comments suggest that a community engagement requirement which many people will fulfill by working one or multiple part-time, minimum-wage jobs or through unpaid means (volunteering), will not directly lead to financial independence. CMS disagrees with that conclusion. While some of the activities that meet the community engagement requirement may not immediately cause all beneficiaries to be financially independent, those activities are nonetheless positive steps for beneficiaries to take on their path to financial independence. In addition, participation in these activities may reduce social isolation, which multiple studies have linked to higher rates of mortality.[5] At the very least, whether BadgerCare Reform's community-engagement requirement will lead to beneficiaries' financial independence is an open question, which is why this demonstration project is necessary to test whether the incentive structure will have the desired effect. That is also why CMS will regularly evaluate the effects of BadgerCare Reform on affected beneficiaries and reserves the right to discontinue specific waiver and expenditure authorities if CMS determines that it would no longer be in the beneficiaries' interest or promote Medicaid's objectives. Moreover, even if those activities do not cause beneficiaries to become financially independent, they are nevertheless linked to improved health outcomes, which itself furthers Medicaid's objectives.

[5] Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspect Psychol Sci 2015;10:227–37. [PubMed]

Some commenters also suggest that suspending eligibility for beneficiaries that fail to comply with the community engagement requirement will make it harder for beneficiaries to find employment, and some cited research that shows that individuals' access to health coverage improves their ability to find employment. CMS has reviewed and considered the research cited by commenters and notes that other research shows a positive link between community engagement and improved health outcomes.[6,7,8,9,10,11] None of the existing research, however, definitively shows whether a community engagement requirement as a condition for continued Medicaid coverage will help beneficiaries attain financial independence and improve health outcomes. Thus, CMS has determined that it is appropriate to permit states to use section 1115 demonstration projects to determine whether they can achieve such an outcome using community-engagement requirements.

Comments addressing community engagement for American Indian/Alaska Native beneficiaries

During tribal consultation, the tribes informed the state that they were concerned that American Indian/Alaska Native beneficiaries are required to participate in the community engagement program or that cultural work programs are not included as qualifying activities. CMS understands the tribes' concerns and the state has committed to working with the tribes after approval on how to make community engagement a program in which American Indian/Alaska Native beneficiaries can succeed. The STCs require the state to submit a plan to CMS with a timeline for addressing any tribal concerns related to the impact of the community engagement requirements. The STCs also include, as an activity that counts toward meeting the community engagement requirement, participation in an allowable work, job training, or job search program, such as a tribal work program. The state also exempts from the community engagement requirement persons who are regularly participating in an alcohol or other drug abuse (AODA) treatment or rehabilitation program, including verified participation in cultural interventions specific to the Native American community, as well as other analogous programs.

Comments related to premiums

Many commenters agreed with Wisconsin's goal of encouraging beneficiaries to engage in their own health care; some acknowledge that requiring beneficiaries to pay a premium is a successful way to encourage such engagement. However, there were many concerns about whether beneficiaries living at poverty would be able to afford the premium and still pay for other basics,

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[6] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK.
[7] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).
[8] Crabtree, S. In U.S., Depression Rates Higher for Long-Term Unemployed. (2014). Gallup. http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx.
[9] United Health Group. Doing good is good for you. 2013 Health and Volunteering Study.
[10] Jenkins, C. Dickens, A. Jones, K. Thompson-Coon, J. Taylor, R. and Rogers, M.Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteersBMC Public Health 2013. 13 (773).
[11] Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA. 2016; 315(16):1750-1766.

such as food or housing, and whether or not beneficiaries will have a bank account or credit card to pay the premium. In addition, commenters were concerned about the administrative complexity of the premium structure and whether the state would spend more money trying to enforce the premium requirements. Wisconsin considered the state level comments and in response, restructured the multiple tiers in the draft proposal into two tiers so beneficiaries with incomes above 50 percent of the FPL up to and including 100 percent of the FPL will pay one flat rate premium, and those individuals with income at or below 50 percent of the FPL will not pay a premium. In addition, beneficiaries will receive benefits upon enrollment, regardless of when the first payment is made, and beneficiaries will only be disenrolled for failure to pay premiums if the individual has unpaid premiums at the annual redetermination. In addition to the potential benefits to beneficiaries of aligning with the commercial health insurance approach, establishing premiums may encourage members to place increased value on their health care and utilize it more effectively. Interim evaluation findings regarding premiums in one state found that beneficiaries who paid premiums are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not.[12] Therefore, preventive care service utilization is expected to increase as members seek to utilize appropriate health care services. As a result, high costs related to emergency department usage may decline since health care needs will be met before conditions reach the level that require an emergency department visit. These trends would enhance program sustainability. As part of its demonstration, Wisconsin will test these hypotheses.

Comments related to the Health Risk Assessment (HRA)

Commenters were supportive of the use of an HRA to help beneficiaries understand their health care needs and to encourage avoidance of health risk behaviors, but some expressed concern about beneficiaries having to pay a higher premium for not "managing" risky behavior. The state acknowledged these responses and revised its proposal so that individuals with income at or below 50 percent of the FPL will not pay a premium.

All beneficiaries, however, will be required, as a condition of eligibility, to complete the HRA. This reflects the state's interest, not only in helping individuals identify their own health risks, but also to help managed care plans address health care needs, identify appropriate treatment plans, ensure provision of care management, and give individuals the opportunity to facilitate their access to treatment. As part of the state's initiative to tackle SUD, the state initially requested authority to require applicants and beneficiaries to complete a drug screening assessment, and if indicated from the assessment, a drug test. In response to concerns identified by CMS and commenters, Wisconsin revised its approach to include completion of the HRA as a condition of eligibility. Responses to questions on the HRA will result in a referral for treatment, as applicable, but not impact an applicant's Medicaid eligibility.

Comments related to non-emergency use of the emergency department

Commenters at the state level expressed concern with a high copayment amount for beneficiaries who visit the ED, because some beneficiaries might have no other avenue to seek acute care,

[12] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

particularly those beneficiaries who suffer from chronic conditions. In response, the state lowered the copayment for non-emergency use of the ED to $8, which is the amount currently permitted in Medicaid regulations and has been imposed by other states. We do not believe this amount will be prohibitive, and we expect that this policy will result in improved health outcomes for both the beneficiaries who no longer visit the ED for non-emergency services and those who need emergency services and will now have greater access to the ED. Furthermore, as inefficient and costly care in less appropriate settings decreases, we expect that beneficiaries will become less costly to care for, thereby improving the sustainability of Wisconsin's Medicaid program and making available more program resources for those who need them most. Finally, we remind commenters that this copayment will not be imposed on beneficiaries who visit the emergency department because they are experiencing an emergency and need emergency department care. The copayment will only apply to beneficiaries who choose not to seek non-emergency care through a more appropriate avenue.

Other Information

CMS's approval is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Shanna Janu. She is available to answer any questions concerning your section 1115 demonstration. Ms. Janu's contact information is as follows:

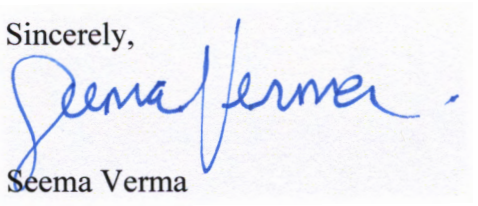
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Shanna.Janu@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to your project officer and Ms. Ruth Hughes, Associate Regional Administrator in our Chicago Regional Office. Ms. Hughes's contact information is as follows:

Ms. Ruth Hughes
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children Health Operations
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519
Email: Ruth.Hughes@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.
Thank you for all your work with us, as well as stakeholders in Wisconsin, over the past months to reach approval.

Sincerely,



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Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform**

AWARDEE: **Wisconsin Department of Health Services**

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the affected populations, as described for the demonstration project from October 31, 2018 through December 31, 2018, as these two waivers will sunset on December 31, 2018.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the state plan requirements contained in section 1902 of the Act are granted in order to enable Wisconsin to implement the Wisconsin BadgerCare Reform Medicaid section 1115 demonstration.

1. Provision of Medical Assistance Eligibility — **Section 1902 (a)(8)** **Section 1902(a)(10)**

To the extent needed to enable the state to enforce premium payment requirements under the demonstration by not providing medical assistance for a period of three months for adults that qualify for Medicaid only under section 1925, or sections 1902(e)(1) and 1931(c)(1), of the Act whose eligibility has been terminated as a result of not paying the required monthly premium.

2. Premiums — **Section 1902(a)(14) insofar as it incorporates section 1916** **Section 1902(a)(52)**

To the extent needed to permit the state to impose monthly premiums based on household income on individuals that qualify for Medicaid only under Transitional Medical Assistance (TMA). This waiver allows the state to apply premiums to TMA Adults with income above 133 percent of the federal poverty level (FPL) starting from the date of enrollment, and to TMA Adults with income from 100-133 percent of the FPL starting after the first six calendar months of TMA coverage.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform Section 1115 Demonstration**

AWARDEE: **Wisconsin Department of Health Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this demonstration, shall be regarded as expenditures under the state's title XIX plan.

The following expenditure authority shall enable the state to operate its BadgerCare Reform section 1115 Medicaid demonstration beginning October 31, 2018 through December 31, 2023.

1. **Childless Adults Demonstration Population.** Expenditures for health care-related costs for eligible non-pregnant, uninsured adults ages 19 through 64 years who have family incomes up to 95 percent of the federal poverty level (FPL) (effectively 100 percent of the FPL including the five percent disregard), who are not otherwise eligible under the Medicaid State plan, other than for family planning services or for the treatment of Tuberculosis, and who are not otherwise eligible for Medicare, Medical Assistance, or the State Children's Health Insurance Program (CHIP).

2. **Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Wisconsin or tribe in such other state on the date of attaining 18 years of age (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid on that date, and are now applying for Medicaid in Wisconsin.

3. **Residential and Inpatient Treatment Services for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Childless Adults Demonstration Population beginning October 31, 2018, through December 31, 2023.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to require enrollment of eligible individuals in managed care organizations.

2. Premiums **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**

To the extent necessary to the state to charge an $8 monthly premium to the childless adult population with household incomes over 50 percent of the FPL, up to and including 100 percent of the FPL.

3. Comparability **Section 1902(a)(17)/Section 1902(a)(10)(B)**

To the extent necessary to enable the state to vary monthly premiums for the childless adult population based on health behaviors and health risk assessment completion.

To the extent necessary to enable the state to establish a non-emergency use of the emergency department copayment of $8 for the childless adult population.

4. Eligibility **Section 1902(a)(10) and 1902(a)(52)**

To the extent necessary to enable the state to deny eligibility and prohibit reenrollment for up to six months for beneficiaries, between the ages of 19 and 49 years old, who have been enrolled in Medicaid as childless adults for 48 months and who have not otherwise met the employment and training incentive or an exemption, as described in these special terms and conditions (STC).

To the extent necessary to enable the state to deny eligibility and prohibit reenrollment for up to six months for the childless adults population who are disenrolled for failure to pay premiums.

To the extent necessary to enable the state to deny eligibility for the childless adults population who does not complete a health risk assessment.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00293/5

TITLE: Wisconsin BadgerCare Reform

AWARDEE: Wisconsin Department of Health Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) to enable Wisconsin (state) to operate the Badger Care Reform section 1115(a) BadgerCare demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and amendments and the state's obligations to CMS related to this demonstration and amendments. The STCs are effective October 31, 2018 and the BadgerCare Reform demonstration is approved through December 31, 2023.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Community Engagement Program
VI. Benefits
VII. Cost Sharing (Premiums, Copays, and Healthy Behavior Incentive)
VIII. Delivery System
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. Evaluation of the Demonstration
XIII. Schedule of State Deliverables during the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A. Summary of Cost-sharing for TMA Adults Only
Attachment B. Substance Use Disorder Implementation Plan Protocol
Attachment C. Substance Use Disorder Monitoring Protocol
Attachment D. Developing the Evaluation Design
Attachment E Preparing the Evaluation Report
Attachment F. Evaluation Design
Attachment G. Community Engagement Implementation Plan
Attachment H. Monitoring Protocol

Attachment I. Tribal Consultation Plan

II. PROGRAM DESCRIPTION AND OBJECTIVES

With the implementation of the Affordable Care Act provisions, that will provide federally-funded subsidies to help individuals and families purchase private health insurance, Wisconsin saw the BadgerCare Reform amendment as an opportunity to reduce the uninsured rate and encourage beneficiaries to access coverage in the private market.
The Wisconsin BadgerCare Reform amendment provided state plan benefits, other than family planning services and tuberculosis-related services, to childless adults who had effective family incomes up to 100 percent of the Federal Poverty Level (FPL) (effective income is defined to include the five (5) percent disregard), and permitted the state to charge premiums to adults who were only eligible for Medicaid through the Transitional Medical Assistance eligibility group (hereinafter referred to as "TMA Adults") with incomes above 133 percent of the FPL starting from the first day of enrollment and to TMA Adults from 100-133 percent of the FPL after the first six (6) calendar months of TMA coverage.

The BadgerCare Reform amendment allowed the state to provide health care coverage for the childless adult population at or below an effective income of 100 percent of the FPL with a focus on improving health outcomes, reducing unnecessary services, and improving the cost-effectiveness of Medicaid services. Additionally, the amendment enabled the state to test the impact of providing TMA to individuals who were paying a premium that aligned with the insurance affordability program in the Marketplace based upon their household income when compared to the FPL.

In accordance with CMS' November 21, 2016 CMCS Informational Bulletin (CIB), *Section 1115 Demonstration Opportunity to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the BadgerCare Reform demonstration was amended in December 2017 to add coverage of former foster care youth defined as individuals under age 26 who were in foster care in another state or tribe of such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid at that time or at some point while in such foster care, and are now applying for Medicaid in Wisconsin. With the addition of this population, Wisconsin has a new demonstration goal to increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

The 2017 amendment request was prompted by the Wisconsin 2015-2017 Biennial Budget (Act 55), which required the Wisconsin Department of Health Services (DHS) to request an amendment to the BadgerCare Reform amendment in order to apply a number of new policies to the childless adult population. Act 55 requirements included: establishing monthly premiums, establishing lower premiums for members engaged in healthy behaviors, requiring completion of a health risk assessment, limiting a member's eligibility to no more than 48 months, and requiring as a condition of eligibility that an applicant or member complete a drug screening, and if indicated, a drug test and treatment; however, a drug test as a condition of eligibility and a 48-month limit are not part of this approval. Policies not required by Act 55, but included in the amendment request in order to meet the program objectives involve charging an increased copayment for non-emergent use of the emergency department utilization for childless adults, establishing a work or community engagement option for childless adults, and providing full

coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, establishing eligibility for an exemption from community engagement requirements on the basis of disability, meeting and documenting community engagement requirements and meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as well as a modified allotment neutrality worksheet as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP, whether administrative or service-based expenditures, will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An explanation of the public process used by the state consistent with the requirements of STC 13; and,

    d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in

accordance with the timelines contained in statute. Otherwise, no later than twelve months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-oute plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and how the state incorporated the received comment into the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration

activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the demonstration authority expiration plan.

d. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

11. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

12. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.
The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

14. Federal Financial Participation (FFP). No federal matching for expenditures, both administrative and service, for this demonstration will take effect until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or

alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

16. State Plan Eligibility Groups Affected By the Demonstration. The state plan populations affected by this demonstration are outlined in Table 1, which summarizes each specific group of individuals and specifies the authority under which they are eligible for coverage and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed.

17. Demonstration Expansion Eligibility Groups. Table 1 summarizes the specific groups of individuals, and specifies the authority under which they are eligible for coverage. Table 1 also specifies the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed. Demonstration Population 2 in Table 1 is made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration. Coverage of Demonstration Population 2 is subject to Medicaid laws and regulations (including all enrollment requirements described in paragraph b. below) unless otherwise specified in the "Title XIX Requirements Not Applicable to the Demonstration Population" section of the expenditure authorities document for this demonstration.

Table 1: Eligibility Groups Affected by the Demonstration			
Medicaid State Plan Mandatory Groups	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Population 1. Parents and caretaker relatives who are non-pregnant, those who do not qualify for Medicaid on the basis of disability, and whose effective family income is above 100 percent FPL and who qualify for TMA under section 1925 of the Act	Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1925 of the Act or 1931(c)(1) of the Act.	Title XIX	TMA Adults
Demonstration Expansion Groups	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting

Population 2. Non-pregnant childless individuals Age 19 through 64 with an effective monthly income that does not exceed 100 percent FPL	• Ages 19 through 64 • Effective monthly income at or below 100 percent of the FPL • Not pregnant • Do not qualify for any other full-benefit Medicaid or CHIP eligibility group • Are not receiving Medicare • Childless adults may have children, but do not qualify as a parent or caretaker relative (e.g., either the children are not currently living with them or those children living with them are 19 years of age or older) • Fully complete a Health Risk Assessment (HRA)	Title XIX	BC Reform Adults
Population 3. Former Foster Care Youth ("FFCY") from Another State	• Individuals under age 26, who we were in foster care under the responsibility of a state other than Wisconsin or a tribe in such other state when they turned 18 or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid at that time or at some point while in such foster care, are now applying for Medicaid in Wisconsin, and are not otherwise eligible for Medicaid.	Title XIX	FFCY

V. Community Engagement Program

18. Overview. The state will implement a community engagement requirement, otherwise known as the Employment and Training Incentive, as a condition of continued eligibility for BadgerCare Reform beneficiaries, ages 19 through 49, in Demonstration Population 2, who are not otherwise exempt, as defined below. To maintain Medicaid eligibility, non-exempt beneficiaries will be required to participate in specified activities and report on those activities periodically. The activities may include employment, training, or education as specified in STC 20. Beneficiaries who do not meet the community engagement requirement for 48 consecutive or non-consecutive months will be disenrolled and lose eligibility for a period of six months and may not qualify to regain eligibility during this six month period unless they are found eligible for Medicaid under a different eligibility group.

19. Exempt Populations. Childless adults under Demonstration Population 2, ages 19 through 49, are exempt from the community engagement requirement for a given month if any of the following is true for that month:

a. The beneficiary is unable to work or participate in the workforce training activities, which includes someone who is:

    i. Receiving temporary or permanent disability benefits from the government or a private source (e.g., social security disability insurance (SSDI));

    ii. Mentally or physically unable to work, as determined by the state;

    iii. Verified as unable to work in a statement from a health care professional or a social worker; or

    iv. Experiencing chronic homelessness.

b. The beneficiary is a primary caregiver for a person who cannot care for himself or herself.

c. The beneficiary is receiving or has applied for unemployment compensation (UC) and is complying with the UC work requirements.

d. Exempt from Supplemental Nutrition Assistance Program (SNAP) work requirements.

e. The beneficiary is regularly participating in an alcohol or other drug abuse (AODA) treatment or rehabilitation program (excluding alcoholics anonymous/narcatics anonymous (AA/NA), but including verified participation in cultural interventions specific to the Native American community, as well as other analogous programs).

f. The beneficiary is enrolled in an institution of higher learning (including vocational programs or GED classes) at least half-time.

g. The beneficiary is attending high school at least half-time.

20. Qualifying Activities. Beneficiaries in Demonstration Population 2 who are not exempt may be considered active in community engagement through a variety of activities, including but not limited to:

a. Working in exchange for money;

b. Working in exchange for goods or services (“in-kind”);

c. Unpaid work (e.g., volunteer work, community service);

d. Self-employment at any wage;

e. Taking part in an allowable work, job training, or job search program, such as:

    i. FoodShare Employment and Training (FSET), including FSET WorkFare component (the state’s SNAP program);

ii. Wisconsin Works (W-2);

iii. Workforce Innovation and Opportunity Act (WIOWA) programs;

iv. Refugee Employment and Training;

v. Trial Employment Match Program (TEMP);

vi. Children First;

vii. Programs under section 236 of the Trade Act;

viii. Tribal work programs; or

ix. Other state-approved workforce programs.

21. Hour Requirements. Beneficiaries under Demonstration Population 2 must complete at least 80 hours per calendar month of one, or any combination, of the qualifying activities to meet the community engagement requirement and report these activities to the state, in a manner to be specified by the state in the community engagement implementation plan (STC 46). The months in which a beneficiary meets the community engagement requirement will not count towards the 48 month period, described in STC 22.

22. Limits on Eligibility While Not Meeting Community Engagement Requirements.

a. Overview. For the duration of this demonstration project, unless amended, beneficiaries under Demonstration Population 2, ages of 19 and 49, who are not participating in work, training, or other activities referenced in STC 20, unless they qualify for an exemption as described in STC 19, will have 48 (consecutive or non-consecutive) months of eligibility for coverage of Medicaid benefits before losing eligibility for a period of six months. The count of the 48-month period for current beneficiaries who are not participating in work, training or other activities as described in STC 20 will begin no sooner than 12 months after waiver approval, or not sooner than the first of the month when eligibility of a beneficiary is established, provided that all beneficiaries who will be subject to this requirement have been adequately notified. Once a beneficiary has been enrolled in Medicaid for a cumulative 48 months while not participating in the workforce initiative or meeting the community engagement requirement, the beneficiary will be disenrolled and become ineligible for BadgerCare under this demonstration authority for a period of six months, unless the beneficiary meets another category of Medicaid assistance. After completing the six month non-eligibility period, the beneficiary will be able to reapply and regain eligibility under Population 2 provided that all other eligibility criteria are satisfied.

b. Good Cause. Beneficiaries may request a temporary exemption from the community engagement/workforce training initiative for good cause. Circumstances that could give rise to a finding of good cause include, but are not limited to, at a minimum, the following verified circumstances:

i. The beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or an immediate family member who was living in the home with the beneficiary experiences a hospitalization or serious illness;

ii. The beneficiary experiences the birth, or death, of a family member living with the beneficiary;

iii. The beneficiary experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement; or

iv. The beneficiary has a family emergency or other life-changing event (e.g., divorce or domestic violence).

23. Reasonable modifications. Wisconsin must provide reasonable accommodations for beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act, when necessary, to enable them to have an equal opportunity to participate in and benefit from the program. The state must provide reasonable modifications for program protections and procedures, including but not limited to assistance with demonstrating eligibility for good cause exemptions; appealing disenrollment; documenting community engagement activities and other documentation requirements; understanding notices and program rules; and other types of reasonable modifications.

a. Reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state must evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

24. State Assurances. Prior to implementation of community engagement requirements as a condition of eligibility, the state shall:

a. Maintain mechanisms to stop payments to a managed care organization when a beneficiary is terminated for failure to comply with program requirements.

b. Ensure that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, and systems to permit beneficiaries to efficiently report community engagement hours or obtain an exemption, in accordance with 42 CFR 435.907(a), and 435.945, and to permit Wisconsin to monitor compliance.

c. If a beneficiary has requested a good cause, that the good cause has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.

d. Assure that termination, disenrollment, or denial of eligibility will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).

e. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:

    i. When community engagement requirements will commence for that specific beneficiary;

    ii. Whether a beneficiary is exempt, and under what conditions the exemption would end;

    iii. A list of the specific activities that may be used to satisfy the community engagement requirements and a list of the specific activities that beneficiaries can engage in, as described in STC 20;

    iv. The specific number of community engagement hours per month that a beneficiary is required to complete to meet the requirement, and when and how the beneficiary must report participation or request an exemption;

    v. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are available to assist beneficiaries in meeting the community engagement requirement;

    vi. Information about how community engagement hours will be counted and documented;

    vii. Periodic updates on how many months have counted towards the 48 months;

    viii. What gives rise to a termination of eligibility, what a termination would mean for the beneficiary, and how to avoid a termination, including how and when to apply for good cause and what kinds of circumstances might give rise to good cause;

    ix. How beneficiaries are expected to report the hours and exemptions and that this is communicated to the beneficiaries; and

    x. If a beneficiary's eligibility is terminated, how to appeal the termination.

f. Ensure application assistance is available to beneficiaries (in person and by phone).

g. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.

h. Maintain ability to report on and process applications in-person, via phone, via mail and electronically;

i. Provide full appeal rights as required under 42 CFR, Part 431, subpart E prior to termination of eligibility, and observe all requirements for due process for beneficiaries whose eligibility will be terminated for meeting 48 months of non-compliance with the community engagement requirement, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the suspension or termination, and provide additional documentation through the appeals process.

j. Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting the community engagement requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports.

k. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas that lack public transportation to determine whether there should be further exemptions from the community engagement requirement and/or additional mitigation strategies, so that the community engagement requirement will not be impossible or unreasonably burdensome for beneficiaries to meet.

l. Provide each beneficiary who has been disenrolled from BadgerCare Reform with information on how to access primary care and preventative care services at low or no cost to the individual. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. Wisconsin shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.

m. Makes the general assurance that it is in compliance with protections for beneficiaries with disabilities under ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act.

VI. BENEFITS

25. Wisconsin BadgerCare Demonstration. All enrollees in this demonstration (as described in Section IV) will receive benefits as specified in the Medicaid state plan, to the extent that such benefits apply to those individuals. Beneficiaries in Demonstration Population 2 will not receive family planning services or tuberculosis-related services. In addition, beneficiaries in the Demonstration Population 2 will not receive pregnancy related services, but instead must be administratively transferred to the pregnant women group in the state plan if they are

pregnant. Refer to the state plan for additional information on benefits. Former foster care youth from another state receive full Medicaid State Plan benefits.

26. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program. Effective upon CMS' approval of the SUD Implementation Protocol, the demonstration benefit package for all Wisconsin Medicaid recipients will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matched expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Wisconsin Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Wisconsin will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 28 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD treatment services and withdrawal management during short term residential and inpatient stays in IMDs will expand Wisconsin's current SUD benefit package available to all Wisconsin Medicaid recipients as outlined in Table 2. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as impatient facilities under section 1905(a) of the Act.

Table 2: Wisconsin OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefits	Wisconsin Medicaid Authority	Expenditure Authority
Outpatient Services	State Plan	n/a
Intensive Outpatient Services	State Plan	n/a
Medication Assisted Treatment	State Plan (Individual services covered)	Services provided to individuals in IMDs
Residential Treatment Services	State Plan (Individual services covered)	Services provided to individuals in IMDs
Inpatient Services	State Plan (Individual services covered)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State Plan	Services provided to individuals in IMDs

27. SUD Implementation Plan Protocol. The state must submit a SUD Implementation Plan Protocol within ninety (90) days after approval of the SUD program under this demonstration approval. The state may not claim FFP for services provided in IMDs until CMS has approved the SUD Implementation Plan Protocol. Once approved, the Implementation Plan Protocol will be incorporated into the STCs, as Attachment B, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Plan Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Plan Protocol or failure to obtain CMS approval will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such,

would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in funding deferral. At a minimum, the SUD Implementation Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD program in this demonstration:

a. Access to Critical Levels of Care for OUD and other SUDs: Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

b. Use of Evidence-based SUD-specific Patient Placement Criteria. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. Patient Placement. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

d. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities. Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Wisconsin administrative code. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

e. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

f. Standards of Care. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval.

g. Sufficient Provider Capacity at each Level of Care, including Medication Assisted Treatment for OUD. An assessment of the availability of providers in the key levels of

care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval.

h. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

i. SUD Health IT Plan**.** Implementation of the milestones and metrics as detailed in STC 32.

j. Improved Care Coordination and Transitions between levels of care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

28. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of the SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment C. At a minimum, the SUD Monitoring Protocol will include reporting of the average length of stay for residential treatment and reporting relevant to each of the program implementation areas listed in STC 27. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 46 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the SUD Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

29. Mid-Point Assessment. The state must conduct an independent mid-point assessment of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones

and targets not yet met and about the risk of possibly missing those milestones and performance targets. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report. For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Plan Protocol and SUD Monitoring Protocols for ameliorating these risks subject to CMS approval.

30. SUD Evaluation. The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections VIII General Reporting Requirements and XII Evaluation of the Demonstration of the STCs.

31. SUD Evaluation Design. The state must submit, for CMS review and approval, a revision to the Evaluation Design to include the SUD program, no later than one-hundred-and-eighty (180) days after the effective date of these amended STCs. Failure to submit an acceptable and timely evaluation design along with any required monitoring, expenditure, or other evaluation reporting will subject the state to a $5 million deferral. The state must use an independent evaluator to design the evaluation.

a. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

b. Evaluation Questions and Hypotheses Specific to SUD Program. The state must follow the general evaluation questions and hypotheses requirements as specified in guidance provided in Attachment D of the STCs. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this section 1115 demonstration, to include, but is not limited to: initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of

Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

32. SUD Health Information Technology (Health IT). The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be submitted as a component of the State Medicaid Health IT Plan (SMHP), and included as a section of the state's "Implementation Plan" to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them (see Attachment B).

b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[2] *Ibid*.

f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]

g. In developing the Health IT Plan, states should use the following resources.

   i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

   ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

   iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state will include in its Monitoring Protocol (see STC 28) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 46).

j. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

k. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

l. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

33. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

VII. COST SHARING (PREMIUMS, COPAYS, AND HEALTHY BEHAVIOR INCENTIVE)

34. Cost sharing. For all enrollees in this demonstration, cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies and be reflected in the state plan, except for premiums for Demonstration Population 1 (TMA Adults), and except for copayments for non-emergency use of the ED for Demonstration Population 2.

a. Premiums for Demonstration Population 1 (TMA Adults). TMA Adults with income of 133 percent of the FPL or greater are subject to monthly premiums based on the sliding scale as outlined in Attachment A from the date of enrollment. TMA Adults with effective income over 100 percent but less than 133 percent of the FPL are subject to monthly premiums based on a sliding scale starting six calendar months after the date of enrollment. There will be a 30-day grace period for non-payment of the monthly premium before being disenrolled. Eligibility and enrollment for TMA will be terminated for a maximum period of three months for demonstration participants who fail to make a required premium payment before the end of the grace period. However, a participant may re-enroll at any point during this three -month period by paying owed premiums. After the three-month period of non-eligibility, TMA Adults must be reenrolled in TMA on request, even if they have an outstanding unpaid premiums, provided their respective 12-month TMA period has not yet expired. The three-month period of non-eligibility does not toll the 12-month TMA period. If section 1925 of the Act sunsets or is otherwise inapplicable and TMA is then available only for a four month extension, Demonstration Population 1 individuals may not re-enroll in TMA. No premium may be charged during the three-month period of non-eligibility, and nonpayment of premiums that remain unpaid from a prior TMA enrollment period may not be used as a basis for terminating a beneficiary's enrollment during a subsequent period of TMA enrollment after the three-month period of non-eligibility.

i. Premiums for TMA Adults whose income changes after time of application (i.e., decreases or increases, including an increase in which the individual's income increases to 200 percent of the FPL or more), but before his/her annual redetermination, will be recalculated after the individual has reported the change. Once the state has calculated an individual's new monthly premium amount based on the sliding scale outlined in Attachment A, the state will provide the individual with at least a 10-day notice prior to effectuating the new monthly premium amount. If income increases to 133 percent FPL or more for TMA demonstration

enrollees who had income under 133 percent FPL when their TMA began, premiums will be due immediately after the 10-day notice.

ii. Consistent with 42 CFR 447.56, American Indians and Alaska Natives (AI/AN) who are eligible to receive or who have received an item or services furnished by an Indian health care provider or through referral under contract health services are exempt from the premium amounts outlined above.

iii. TMA adults may be disenrolled for failure to pay premiums after a 30-day grace period. Once they are disenrolled, they will be restricted from re-enrollment during a three month period of non-eligibility. They may enroll in Medicaid under another eligibility group if they become eligible under such other eligibility group during the three-month non-eligibility period. At any point during this three-month period, they may pay the owed premiums to re-enroll in TMA for the remainder of the 12-month TMA extension period and be re-enrolled. After the three-month period, they may re-enroll for TMA for the remainder of the 12-month TMA extension period, if requested, even if they have an outstanding unpaid premiums from the prior TMA enrollment period. In this case, nonpayment of premiums that remain unpaid from the prior TMA enrollment period may not be used as a basis for terminating the beneficiary's enrollment during the subsequent period of TMA enrollment.

STC 34(a) will sunset on December 31, 2018 and demonstration premiums will no longer be charged to the TMA adults after this date.

b. Premiums for Demonstration Population 2. For individuals in demonstration population 2, a monthly premium payment is required for those with monthly household income above 50 percent of the FPL. Monthly premium amounts are divided into the following two income tiers:

Table 3: Income Tiers for Monthly Premiums for Demonstration Population 2	
Monthly Household Income	**Monthly Premium Amount**
0 to 50 percent of the FPL	No premium
Above 50 percent of the FPL	$8 per household

i. Beneficiaries with household income up to 50 percent of the FPL are exempt from paying monthly premiums. AI/AN who are eligible to receive or who have received an item or services furnished by an Indian health care provider or through referral under contract health services are also exempt from the monthly premiums outlined above, consistent with section 1916(j) of the Act and with 42 CFR 447.56.

ii. Beneficiaries in Demonstration Population 2 may be disenrolled for failure to pay premiums only at annual redetermination. The state will notify beneficiaries who have unpaid premium amounts for the coverage year and provide a reasonable opportunity for the beneficiary to pay before disenrolling the beneficiary for the next coverage year. If a beneficiary is disenrolled at annual redetermination for

failure to pay premiums who would have continued to have a premium requirement during the next coverage year if not disenrolled, the beneficiary will be subject to a period of non-eligibility for up to six months. Such a beneficiary may reenroll at any time prior to the end of the six-month period if he or she pays all owed premiums, or if his or her situation changes such that he or she would no longer be subject to a premium requirement. After the six-month period, the beneficiary may be re-enrolled in BadgerCare upon request, if he or she meets all program rules, even if he or she continues to have unpaid premiums from the prior period of enrollment.

c. The state will monitor and include in the quarterly report information related to disenrollments from the demonstration, including due to nonpayment of premiums.

35. Healthy Behavior Incentives. Beneficiaries enrolled in Demonstration Population 2 who are subject to a premium requirement will have their household premium requirement reduced by up to 50 percent if they demonstrate that they do not engage in behaviors that increase health risks ("health risk behaviors"). For beneficiaries who do not demonstrate that they do not engage in health risk behaviors, but attest to actively managing their behavior(s) and/or that they have a health condition that causes them to engage in one or more health risk behaviors, the premium will also be reduced by up to half. For beneficiaries who do not demonstrate that they do not engage in health risk behaviors and do not attest that they are actively managing their behavior(s) and/or that they have a health condition that causes them to engage in one or more health risk behaviors, the standard premium will apply. Beneficiaries will have the opportunity to update and self-attest to any changed health risk behavior or conditions that affect health risk behaviors at a minimum on an annual basis, when eligibility is re-determined. Health risk behaviors include, but are not limited to, excessive alcohol consumption, failure to engage in dietary, exercise, and other lifestyle (or "healthy") behaviors in attempt to attain or maintain a healthy body weight, illicit drug use, failure to use a seatbelt, and tobacco use. To identify beneficiaries who are engaging in health risk behaviors, individuals will be asked to complete a Health Risk Assessment (HRA) when applying for coverage under the demonstration or, for current beneficiaries, no sooner than 12 months after waiver approval. Beneficiaries will also use the HRA to self-attest to their active management of a health risk behavior and/or to having an underlying health condition that causes them to engage in one or more health risk behaviors, if either of these is applicable.

Because health risk is assessed at an individual level, a married couple may include one beneficiary who qualifies for a premium reduction and one beneficiary who does not. If this happens, the household premium would be reduced by 25 percent. If both beneficiaries qualify for a premium reduction, the household's premium would be reduced by 50 percent.

Beneficiaries enrolled in Demonstration Population 2 must fully complete a HRA to be determined eligible for coverage at application and renewal. If an individual fails to answer all questions on the HRA, eligibility for the demonstration will be denied, but there is no period of non-eligibility and that individual can re-apply at any time.

36. Copayments for Use of the Emergency Department. Individuals in Demonstration Population 2 are required to pay a copayment for each non-emergent use of the emergency

room (ER). This copayment shall be charged consistent with 1916A(e)(1) of the Act and 42 CFR 447.54.

a. Under the provisions of section 1916A(e) of the Act, the state has the authority to impose a copayment for services received at a hospital emergency room if the services are not emergency services.

b. As provided under 42 CFR 447.54, the amount of this co-pay will be $8 for each non-emergent use of the emergency department.

c. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.

d. Providers cannot refuse treatment for nonpayment of the co-payment.

e. AI/AN who are currently receiving or who have ever received an item or services furnished by an Indian health care provider or through referral under contract health services are exempt from the copayment requirements outlined above, consistent with section 1916(j) of the Act and 42 CFR 447.56.

VIII. DELIVERY SYSTEM

37. General. Demonstration Populations 1 and 2 will be enrolled in the managed care organizations (MCO) that are currently contracted to provide health care services to the existing Medicaid and BadgerCare programs in most of the state to serve persons eligible under this demonstration. Demonstration enrollees will be required to join a MCO as a condition of eligibility, as long as there is at least one MCO available in their county of residence, and the county has been granted a rural exception under Medicaid State plan authority. The state may mandate enrollment into the single MCO in the counties that have been granted the rural exception by CMS. If the county has not been granted a rural exception, the state must offer the option of either MCO enrollment or Medicaid fee-for-service. All demonstration eligible beneficiaries must be provided a Medicaid card, regardless of MCO enrollment. MCOs may elect to provide a MCO specific card to MCO enrollees as well. The state must comply with the managed care regulations published at 42 CFR §438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of sixty (60) days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

IX. GENERAL REPORTING REQUIREMENTS

38. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by

these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

    i. CMS may decline the extension request.

    ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

    iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

39. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

40. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

41. General Financial Requirements. The state must comply with all general financial requirements under title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section X of these STCs.

42. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XI of these STCs.

43. Community Engagement Implementation Plan. The state must submit a Community Engagement Implementation Plan to CMS no later than 90 calendar days after approval of the demonstration. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment G. At a minimum, the Community Engagement Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach and implementation plan for those policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the implementation plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

44. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment H.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 46(b)), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g, operational updates as described in STC 46(a)), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

45. Tribal Consultation Plan. The state must consult with federally recognized tribal governments and with Indian health care providers, and through consultation, identify any tribal concerns. The state must deliver to CMS a plan and timeline for addressing any tribal concerns related to the impact of the community engagement requirements. The plan and timeline are due to CMS within 60 calendar days after approval of this demonstration and will be incorporated into the STCs, as Attachment I. CMS will work with the state if we determine changes are necessary to the state's submission, or if issues are identified as part of the review.

46. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The Annual Report is due no later than ninety (90 days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework. The performance metrics will reflect all components of the state's demonstration, and may include, but are not limited to, measures associated with eligibility and coverage (including community engagement). Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation

hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

47. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

48. Close-Out Report. Within 120 days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

d. The final Close-Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 38.

49. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

50. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

51. Transformed Medicaid Statistical Information Systems Requirements (T-MSIS). The state shall comply with all T-MSIS milestones and associated timelines indicated below. Failure to meet these milestones on the below timeline will result in a deferral, as described in STC 38:

a. By December 31, 2018 state will address and correct all post go-live corrective actions (except waiver population reporting).

b. By January 31, 2019, state will achieve and maintain currency in T-MSIS data reporting.

c. By June 30, 2019 state will implement corrective action for waiver reporting.

X. GENERAL FINANCIAL REQUIREMENTS. This project is approved for title XIX services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

52. Quarterly Financial Reports. The state must provide quarterly title XIX expenditure reports using Form CMS-64, to separately report total title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section XI of the STCs.

53. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit, including baseline data and member months, must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Using specific medical status codes, the state has the capacity to use its MMIS system to stratify manufacturer's rebate revenue that should be assigned to net demonstration expenditures for BC Reform Adults. The state will generate a demonstration-specific rebate report to support the methodology used to assign rebates to the demonstration. The state will report the portion of rebate revenue assigned to BC Reform Adults on the appropriate Forms CMS-64.9 WAIVER. This revenue will be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid. Budget neutrality will reflect the net cost of prescriptions.

e. Federally Qualified Health Center Settlement Expenses. Using specific medical status codes, the state will assign FQHC settlement expenses to claims covered under the demonstration for BC Reform Adults and will report these costs on the appropriate Forms CMS-64.9 WAIVER. The state will be able to generate reports using MMIS data to show the assignment of these settlement payments to demonstration expenditures.

f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. These amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

g. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration (Section XI of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:

    i. "BC Reform Adults"

    ii. "TMA Adults"

    iii. "FFCY"

iv. "SUD"

h. Demonstration Year Definition. The Demonstration Years (DYs) will be defined as follows:

January 1, 2014 through December 31, 2014	Demonstration Year 1 (DY1)
January 1, 2015 through December 31, 2015	Demonstration Year 2 (DY2)
January 1, 2016 through December 31, 2016	Demonstration Year 3 (DY3)
January 1, 2017 through December 31, 2017	Demonstration Year 4 (DY4)
January 1, 2018 through December 31, 2018	Demonstration Year 5 (DY5)
January 1, 2019 through December 31, 2019	Demonstration Year 6 (DY6)
January 1, 2020 through December 31, 2020	Demonstration Year 7 (DY7)
January 1, 2021 through December 31, 2021	Demonstration Year 8 (DY8)
January 1, 2022 through December 31, 2022	Demonstration Year 9 (DY9)
January 1, 2023 through December 31, 2022	Demonstration Year 10 (DY10)

54. Administrative Costs. The state must track administrative costs for state-approved workforce programs under Section V. Administrative costs, including state-approved workforce programs under Section V, will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs ("ADM").

55. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

56. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for BadgerCare Reform Demonstration adults and separately the actual number of eligible member months for former foster care youth (i.e. FFCY). The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member months to the total. Two individuals who are eligible for two (2) months each contribute two (2) eligible member months to the total, for a total of four (4) eligible member months.

57. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

58. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section X of these STCs:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

59. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be

addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding, including up to date responses to the CMS standard funding questions

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

60. State Certification of Funding Conditions. The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

61. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

62. Risk. The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in Section IV, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

63. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, an annual budget limit will be calculated for each DY on a total computable basis. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 64 below.

The demonstration expenditures subject to the budget neutrality limit related to Demonstration Population 2 as described in STC 17 are those reported under the following Waiver Name: BC Reform Adults. The demonstration expenditures subject to the budget neutrality limit related to Demonstration Population 3 as described in STC 17 are those reported under the following Waiver Name: FFCY. The demonstration expenditures subject to the budget neutrality limit related to SUD as those reported under the following Waiver Name: SUD.

For each DY, separate annual budget limits of demonstration service expenditures will be calculated based on projected PMPM expenditures for BC Reform Adults, Former Foster Care Youth, and SUD. The PMPM amounts for BC Reform Adults, Former Foster Care Youth, and SUD are shown on the table below.

MEG	TREND RATE	2018 DY 5 – PMPM	2019 DY 6 - PMPM	2020 DY 7 PMPM	2021 DY 8 – PMPM	2022 DY 9 – PMPM	2023 DY 10 PMPM
BC Reform Adults	4.7%	$710.95	$744.36	$779.35	$815.98	$854.33	$894.48

Former Foster Care Youth	3.7%	$2,538.20	$2,632.11	$2,729.50	$2,830.49	$2,935.22	$3,043.82
SUD	4.6%	$5,561	$5,816.81	$6,084.38	$6,364.26	$6,657.02	$6,963.24

64. Hypothetical Eligibility Group. BC Reform Adults (as related to Demonstration Population 2 defined under STC 17), SUD, and Former Foster Care Youth (Demonstration Population 3) are considered to be a hypothetical populations for budget neutrality. BC Reform Adults consist of individuals who could have been added to the Medicaid program through the state plan, but instead are covered through demonstration authority.

Former Foster Care Youth from Another State are individuals that were or would have been eligible for state plan coverage as described in the January 22, 2013 CMS notice of proposed rulemaking that permitted the option to cover formerly out-of-state former foster care youth up to age 26 pursuant to section 1902(a)(10)(A)(i)(IX) of the Act. This coverage is now only permissible under the authority of this section 1115 demonstration as outlined in the November 21, 2016 CIB on transition coverage for Former Foster Care Youth.

As part of the SUD initiative, the state may receive FFP for the continuum of services specified in Table 2 to treat OUD and other SUDs that are provided to Medicaid beneficiaries in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the services listed in Table 2 that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality "savings" from these services. Therefore, a separate expenditure cap is established for SUD services.

The budget neutrality expenditure limits for these populations reflect the expected costs for these populations and there is no requirement that the state produce savings from elsewhere in its Medicaid program to offset hypothetical population costs. States may not accrue budget neutrality "savings" from hypothetical populations.

65. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual expenditures for BC Reform Adults during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

66. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy

interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

67. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap on a PMPM basis by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition on a PMPM basis	Percentage
DY 1	Cumulative budget neutrality limit plus:	1 percent
DY 2	Cumulative budget neutrality limit plus:	0.75 percent
DY 3	Cumulative budget neutrality limit plus:	0.5 percent
DY 4	Cumulative budget neutrality limit plus:	0.25 percent
DY 5	Cumulative budget neutrality limit plus:	0 percent
DY 6	Cumulative budget neutrality limit plus:	0 percent
DY 7	Cumulative budget neutrality limit plus:	0 percent
DY 8	Cumulative budget neutrality limit plus:	0 percent
DY 9	Cumulative budget neutrality limit plus:	0 percent
DY 10	Cumulative budget neutrality limit plus:	0 percent

68. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

69. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data

and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 38.

70. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

71. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 days after approval of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable Community Engagement evaluation design guidance provided by CMS.

b. Attachment D (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD evaluation designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a draft evaluation design.

72. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

73. Evaluation Questions and Hypotheses. Consistent with Attachments D and E (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment

of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS' measure sets for eligibility and coverage (including community engagement), Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

74. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

75. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

    a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

    d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

    e. The Interim Evaluation Report must comply with Attachment E (Preparing the Evaluation Report) of these STCs.

76. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment E (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's

current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

77. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's interim evaluation report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

78. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

79. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, Approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

80. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

April 6, 2021

Jim Jones
Medicaid Director
Division of Medicaid Services, Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

Dear Mr. Jones:

On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the October 31, 2018 extension of the section 1115 demonstration project entitled "BadgerCare Reform" (Project Number 11-W-00293/5). The letter advised that CMS would commence a process of determining whether or not to withdraw the authorities previously approved in the BadgerCare Reform demonstration that permit the state to require work and other community engagement activities as a condition of continued Medicaid eligibility through the demonstration. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, Wisconsin's community engagement requirement risks significant coverage losses and harm to beneficiaries. For the reasons discussed below, CMS is now withdrawing approval of the community engagement requirement in the October 31, 2018 extension of the BadgerCare Reform demonstration, which is not currently in effect and which would have expired by its terms on December 31, 2023.

Section 1115 of the Social Security Act (the Act) provides that the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act. In so doing, the Secretary may waive Medicaid program requirements of section 1902 of the Act, and approve federal matching funds per section 1115(a)(2) for state spending on costs not otherwise matchable under section 1903 of the Act, which permits federal matching payments only for "medical assistance" and specified administrative expenses.[1] Under section 1115 authority, the Secretary can allow states to undertake projects to test changes in Medicaid eligibility, benefits, delivery systems, and other areas across their Medicaid programs that the Secretary determines are likely to promote the statutory objectives of Medicaid.

As stated in the above referenced letter sent on February 12, 2021, under section 1115 and its implementing regulations, CMS has the authority and responsibility to maintain continued oversight of demonstration projects in order to ensure that they are currently likely to assist in promoting the objectives of Medicaid. CMS may withdraw waivers or expenditure authorities if it "find[s] that [a] demonstration project is not likely to achieve the statutory purposes." 42 C.F.R. § 431.420(d); see 42 U.S.C. § 1315(d)(2)(D).

As the February 12, 2021 letter explained, the BadgerCare Reform community engagement requirement is not in effect. Although the amendment and extension was approved in October

[1] 42 U.S.C. § 1315.

2018, the state has not yet implemented the community engagement requirement. Since that time, the COVID-19 pandemic and its expected aftermath have made the BadgerCare Reform community engagement requirement infeasible. In addition, implementation of the community engagement requirement is currently prohibited by the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, Div. F, § 6008(a) and (b), 134 Stat. 208 (2020), which conditioned a state's receipt of an increase in federal Medicaid funding during the pandemic on the state's maintenance of certain existing Medicaid parameters. Wisconsin has chosen to claim the 6.2 percentage point FFCRA Federal Medical Assistance Percentage (FMAP) increase, and therefore, while it does so, must maintain the enrollment of beneficiaries who were enrolled as of, or after, March 18, 2020.

The February 12, 2021 letter noted that, although the FFCRA's bar on disenrolling such beneficiaries will expire after the COVID-19 public health emergency ends, CMS still has serious concerns about testing policies that create a risk of substantial loss of health care coverage and harm to beneficiaries even after the expiration of the bar on disenrolling beneficiaries. The COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries. Uncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities (including job skills training, work and other activities used to satisfy the community engagement requirement, i.e., work and other similar activities), and access to transportation and affordable child care, have greatly increased the risk that implementation of the community engagement requirement approved in this demonstration will result in substantial coverage loss. In addition, the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harms of coverage loss for Medicaid beneficiaries.

Accordingly, the February 12, 2021 letter indicated that, taking into account the totality of circumstances, CMS had preliminarily determined that allowing the community engagement requirement to take effect in Wisconsin would not promote the objectives of the Medicaid program. Therefore, CMS provided the state notice that we were commencing a process of determining whether to withdraw the authorities approved in the BadgerCare Reform demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility through the demonstration. See Special Terms and Conditions ¶ 11. The letter explained that if CMS ultimately determined to withdraw those authorities, it would "promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date." *Id*. The February 12, 2021 letter indicated that, if the state wished to submit to CMS any additional information that in the state's view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days. We have not received any additional information from Wisconsin in response to the February 12, 2021 letter.

In light of these concerns, for the reasons set forth below, CMS has determined that, on balance, the authorities that permit Wisconsin to require work and community engagement as a condition of eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing the community engagement authorities that were added in the Secretary's October 31, 2018 extension approval of the BadgerCare Reform demonstration.

Background of Wisconsin's Demonstration

The BadgerCare Reform demonstration was originally approved by CMS on December 30, 2013. Wisconsin has not adopted the Affordable Care Act (ACA) new adult group population (beneficiaries authorized under 1902(a)(10)(a)(i)(VIII) of the Act), but the 2014 approval of the BadgerCare Reform section 1115 demonstration expanded coverage to a childless adult population through expenditure authority under section 1115(a)(2) of the Act. The BadgerCare Reform demonstration primarily provides authority for the state to provide most Medicaid state plan benefits to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including 100 percent of the federal poverty level (FPL).

On October 31, 2018, CMS approved an amendment as part of the demonstration extension requiring most of the childless adult beneficiaries, ages 19 to 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, job skills training, or community service, as a condition of continued Medicaid eligibility. Failure to comply with the requirement for 48 cumulative months (or qualify for an exemption) would result in disenrollment from the demonstration and the individual would be locked out of re-enrollment for six months (unless eligible during the six-month period under a different Medicaid eligibility group). After completing the six-month lockout period, the individual would be eligible to reapply for coverage in the childless adult demonstration population, if otherwise still eligible.

Early Experience from the Implementation of Community Engagement Requirements through Medicaid Section 1115 Demonstrations in Other States

The community engagement requirement under the BadgerCare Reform demonstration has never been implemented due to delays initiated by the state prior to the COVID-19 pandemic,[2,3] and subsequently because of the pandemic. A Medicaid and CHIP Payment and Access Commission (MACPAC) Issue Brief from June 2020 indicated that Wisconsin had not yet specified how it would track and verify beneficiary compliance with the community engagement requirement, or exemptions from it, in any public documents,[4] and this information was not provided in the state's preliminary draft implementation plan submitted to CMS.

Although the demonstration's community engagement requirement was never implemented, data suggest that there is a relatively small minority of beneficiaries who would have been subjected to the community engagement requirement. According to research from the Kaiser Family Foundation using the Current Population Survey (CPS) data,[5] in Wisconsin, 75 percent (63

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[2] The Associated Press. (2020). Wisconsin seeks to delay Medicaid work requirement again. Retrieved from https://apnews.com/article/39766cea4e958a8845738b729a850186

[3] State of Wisconsin Joint Committee on Finance. (2019). 14-Day Passive Review Approval – DHS. Retrieved from https://docs.legis.wisconsin.gov/misc/lfb/jfc/100_section_16_505_16_515_passive_review_requests/2019_10_08_health_services_badgercare_reform_demonstration_project.pdf

[4] MACPAC Issue Brief. (2020). Medicaid Work and Community Engagement Requirements. Medicaid and CHIP Payment and Access Commission. Retrieved from https://www.macpac.gov/wp-content/uploads/2019/10/Medicaid-Work-and-Community-Engagement-Requirements.pdf

[5] Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from

percent nationally) of Medicaid beneficiaries aged 19 to 64 without Supplemental Security Income (SSI) in 2019 were working, and of those who were not working in Wisconsin, 32 percent (27 percent nationally) indicated that their reason for not working was due to illness or disability. While data for Wisconsin were too limited to be conclusive, more than half of Medicaid beneficiaries not working nationally indicated they were caretaking or attending school. Under Wisconsin's community engagement requirement, illness, disability, educational activities, and caregiving are qualifying exemptions. Accordingly, these data suggest that the vast majority of beneficiaries who could be subject to Wisconsin's community engagement requirement but were not working would have been otherwise exempt from the requirement. Thus, if implemented, there would be little margin for the program to increase work or community engagement in Wisconsin.

This is consistent with research indicating more generally that most Medicaid beneficiaries are already working or are likely to be exempt from a potential community engagement requirement.[6,7,8,9] For example, the Kaiser Family Foundation found that 81 percent of adults with Medicaid coverage live in families with a working adult, and 6 in 10 are working themselves.[10] Similarly, a study published in 2017 reported that, out of the 22 million adults covered by Medicaid nationwide (representing 58 percent of all adults on Medicaid) who could be subject to a community engagement requirement designed like that in the BadgerCare Reform demonstration, 50 percent were already working, 14 percent were looking for work, and 36 percent were neither working nor looking for work.[11] For those beneficiaries not working or looking for work, 29 percent indicated that they were caring for a family member, 17 percent were in school, and 33 percent noted that they could not work because of a disability (despite excluding from analysis those qualifying for Medicaid on the basis of disability, highlighting the difficulty with disability determination), with the remainder citing layoff, retirement, or a temporary health problem.

Thus, overall, prior to the pandemic, the available data indicated that the substantial majority of the population that would be targeted by a community engagement requirement in Wisconsin's

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https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[6] Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[7] Huberfeld, N. (2018). Can work be required in the Medicaid program? N Engl J Med;378:788-791. DOI: 10.1056/NEJMp1800549

[8] Goldman, A.L., Woolhandler, S, Himmelstein, D.U., Bor, D.H. & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. JAMA Intern Med, 178:1549-1552. DOI:10.1001/jamainternmed.2018.4194

[9] Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed

[10] Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[11] Leighton Ku, L & Brantley, E. (2017). Medicaid Work Requirements: Who's At Risk? Health Affairs Blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20170412.059575/full/

demonstration were already meeting the terms of the community engagement requirement or would qualify for an exemption from it. This makes it challenging for community engagement requirements to produce any meaningful impact on employment outcomes by incentivizing behavioral changes in a small fraction of beneficiaries, all the while risking substantial coverage losses among those subject to the requirements.

Arkansas, Michigan, and New Hampshire, three states where a community engagement requirement as a condition of Medicaid eligibility was in effect, provide some early evidence on potential enrollment impacts.[12,13] Experience from these states indicates that large portions of the beneficiaries subjected to these states' community engagement requirements failed to comply with the community engagement reporting requirements or became disenrolled once the requirements were implemented. In Arkansas, for instance, before the court halted the community engagement requirement, the state reported that from August 2018 through December 2018, 18,164 individuals were disenrolled from coverage for "noncompliance with the work requirement."[14] During these five months, the monthly rate of coverage loss as a percentage of those who were required to report work and community engagement activities fluctuated between 20 and 47 percent.[15] In New Hampshire, almost 17,000 beneficiaries (about 40 percent of those subject to the requirement) were set to be suspended for non-compliance with the requirement and lose Medicaid coverage within the span of just over a month when that state's community engagement requirement was in effect.[16,17,18] Based on that early data, another study projected that between 30 and 45 percent of New Hampshire beneficiaries subject to the community engagement requirement would have been disenrolled within the first year of implementation.[19] And in Michigan, before the policy was vacated by the courts, 80,000

[12] Utah and Indiana also briefly implemented the community engagement requirement that was part of these states' section 1115 demonstrations, but the program designs in these states did not require beneficiaries subject to the community engagement requirement to comply with reporting minimum-hours requirement within the period the requirement was in effect in each state.

[13] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts

[14] Arkansas Department of Human Services (DHS). (2018 & 2019). Arkansas Works Section 1115 Demonstration Annual Reports. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf; https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-annl-rpt-jan-dec-2019.pdf

[15] Arkansas Department of Human Services (DHS). (2018). Arkansas Works Section 1115 Demonstration Annual Report: January 1, 2018 – December 31, 2018. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf

[16] Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[17] New Hampshire Department of Health and Human Services. (2019). DHHS Community Engagement Report: June 2019. Retrieved from https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf

[18] Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results

[19] The Commonwealth Fund Blog. (2019). New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage. Retrieved from https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss

beneficiaries—representing nearly 33 percent of individuals subject to the community engagement requirement—were at risk of suspension, if not loss of coverage, for failing to report compliance with the community engagement requirement.[20]

Despite state assurances in the demonstration's Special Terms and Conditions that Wisconsin would provide the necessary outreach to Medicaid beneficiaries, experience from other states with similar community engagement requirements shows that despite similar assurances, lack of awareness of and administrative barriers associated with community engagement requirements create serious challenges for beneficiaries, which could result in significant coverage losses.[21] In fact, there was evidence of widespread confusion and lack of awareness among demonstration beneficiaries regarding the community engagement requirements[22] in the states where the requirements were implemented. For example, many beneficiaries in New Hampshire reportedly did not know about the community engagement reporting requirement or received confusing and often contradictory notices about whether they were subject to the requirement.[23,24] Moreover, in Arkansas, Michigan, and New Hampshire, evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements.[25] Beneficiaries also reported barriers to obtaining exemptions from the community engagement requirement. For example, beneficiaries with physical and behavioral health conditions reported that their providers were resistant to signing forms needed to establish that the beneficiary was unable to work so that the beneficiary could qualify for an exemption.[26]

Losing health care coverage undoubtedly has negative consequences for affected beneficiaries down the road. For example, according to Sommers et al. (2020), in Arkansas, those ages 30–49 who had lost Medicaid or Marketplace coverage in the prior year experienced significantly higher medical debt and financial barriers to care, compared to similar Arkansans who

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[20] Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[21] Margo Sanger-Katz. (2018). Hate Paperwork? Medicaid Recipients Will Be Drowning in It. New York Times. Retrieved from https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html.

[22] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts.

[23] Solomon, D. (2019). Spreading the Word on Medicaid Work Requirement Proves Challenging. Union Leader. Retrieved from https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html

[24] Moon, J. (2019). Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect. New Hampshire Public Radio. Retrieved from https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0

[25] Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[26] Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results

maintained coverage.[27] Specifically, 50 percent of Arkansans affected by disenrollment in that age group reported serious problems paying off medical bills; 56 percent delayed seeking health care and 64 percent delayed taking medications because of cost considerations.[28] These rates were all significantly higher than among individuals who retained coverage in Medicaid or Marketplace all year. Evidence also indicates that those with chronic conditions were more likely to lose coverage,[29] which could lead to worse health outcomes in the future.

In all states, consistent and stable employment is often out of reach for beneficiaries who might be subject to a community engagement requirement. Many low-income beneficiaries face a challenging job market, which often offers only unstable or low-paying jobs with unpredictable or irregular hours, sometimes resulting in spells of unemployment, particularly in seasonal work.[30,31,32] The Wisconsin BadgerCare Reform demonstration's rigid requirement for reporting 80 or more hours every month is a concern even for low-income adults who are working. For example, 46 percent of this group nationally, as well as 25 percent of those working as many as 1,000 hours during a year (which would be sufficient for meeting the 80-hour monthly requirement) could be at risk of losing coverage for one or more months because they would not meet the 80-hour minimum requirement in every month.[33,34]

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) indicates that such requirements generally have only modest and temporary effects on employment, failing to increase long-term

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[27] Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs, 39(9), 1522-1530. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538

[28] Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs, 39(9), 1522-1530. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538

[29] Chen, L. & Sommers, B.D. (2020). Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018. American Journal of Public Health, 110, 1208-1210. DOI https://doi.org/10.2105/AJPH.2020.305697

[30] Butcher, K. & Schanzenbach, D. (2018). Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in

[31] Center on Budget and Policy Priorities. (2020). Taking Away Medicaid for Not Meeting Work Requirements Harms Low-Wage Workers. Retrieved from https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-low-wage-workers

[32] Gangopadhyaya, A., Johnston, E., Kenney, G. & Zuckerman, S. (2018). Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees? Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf

[33] Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed

[34] Aron-Dine, A., Chaudhry, R. & Broaddus, M. (2018). Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements. Retrieved from https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements

employment or reduce poverty.[35,36,37] Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after controlling for changes in unemployment and poverty levels.[38] In fact, evidence suggests that there were large and rapid caseload losses in selected areas after SNAP work requirements went into effect, similar to what early data from Arkansas show, and what appeared would likely to happen in New Hampshire and Michigan after these states began implementing community engagement requirements, if those states' community engagement requirements had been implemented long enough to reach the scheduled suspensions or disenrollments.

Therefore, existing evidence from states that have implemented community engagement requirements through Medicaid demonstrations, evidence from other public programs with work requirements, and the overall work patterns and job market opportunities for the low-income adults who would be subject to such requirements all highlight the potential ineffectiveness of community engagement requirements at impacting employment outcomes for the target population. And while there are variations in the design and implementation of community engagement requirements in each state that has implemented such a requirement, as well as differences in employment and economic opportunities, findings from the states that implemented community engagement requirements point in the general direction of coverage losses among individuals subject to such requirements.

Thus, CMS is not aware of any reason to expect that the community engagement requirement as a condition of eligibility in Wisconsin's Medicaid demonstration project would have a different outcome in the future than what was observed during the initial implementation of such a requirement in other states. Accordingly, there is risk that Wisconsin's demonstration project, as extended and amended in October 2018, will lead to substantial coverage losses, a risk that is exacerbated by the ongoing COVID-19 public health emergency and its likely aftermath.

Impact of COVID-19 and its Aftermath

The COVID-19 pandemic and the uncertainty surrounding the long-term effects on economic activity and opportunities across the nation exacerbate the risks associated with tying a community engagement requirement to eligibility, making Wisconsin's community engagement requirement infeasible under the current circumstances. There is a substantial risk that the COVID-19 pandemic and its aftermath will have a negative impact on economic opportunities

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[35] Katch, H., Wagner, J. & Aron-Dine, A. (2018). Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce

[36] Danziger, S.K., Danziger, S., Seefeldt, K.S. & Shaefer, H.L. (2016). From Welfare to a Work-Based Safety Net: An Incomplete Transition. Journal of Policy Analysis & Management, 35(1), 231-238. DOI: https://doi.org/10.1002/pam.21880

[37] Pavetti, L. (2016). Work Requirements Don't Cut Poverty, Evidence Shows. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows

[38] Ku, L., Brantley, E. & Pillai, D. (2019). The Effects of SNAP Work Requirements in Reducing Participation and Benefits From 2013 to 2017. American Journal of Public Health 109(10), 1446-1451. DOI: https://doi.org/10.2105/AJPH.2019.305232. Retrieved from https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305232

for Medicaid beneficiaries. If employment opportunities are limited, Medicaid beneficiaries may find it difficult to obtain paid work in the aftermath of the COVID-19 pandemic.[39,40]
As discussed above, prior to the pandemic, most adult Medicaid beneficiaries who did not face a barrier to work were working full or part-time.[41] However, one in three working adult Medicaid beneficiaries was doing only part-time work prior to the COVID-19 public health emergency, often due to fewer opportunities for full-time employment. The pandemic is expected to only have aggravated the challenges of finding full-time employment, along with causing greater obstacles from lack of childcare options or increased caregiving responsibilities.[42]

Moreover, during the pandemic, the different sectors of the economy have seen disparate levels of disruption, which has affected labor market outcomes for certain populations more than the others. While the national employment rate[43] declined by 10.2 percent from January 2020 to January 2021, employment rates for workers in the bottom wage quartile decreased by a larger percentage than for workers in the highest wage quartile across that time period (28.7 percent vs. 1.7 percent).[44] In Wisconsin, employment rates for low-wage earners (i.e., annual wages under $27,000) declined by 25 percent, compared to virtually no change in employment rates for high-wage earners (i.e., wages above $60,000 per year) from January 2020 to January 2021.[45]

Further, declines in employment have been much higher for Black and Hispanic women and for workers in several low-wage service sectors, such as hospitality and leisure, while workers in other sectors, such as financial services, have seen virtually no change.[46] In April 2020, the estimated unemployment rates (including individuals who were employed but absent from work and those not in the workforce but who wanted employment) for the Black and Hispanic populations were as high as 32 and 31 percent, respectively, compared to 24 percent for the White population.[47] Hispanic populations specifically are more likely to be affected due to their

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[39] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[40] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[41] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[42] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[43] Not seasonally adjusted.

[44] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[45] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[46] Rouse, C. (2021). The Employment Situation in February. The White House Briefing Room. Retrieved from https://www.whitehouse.gov/briefing-room/blog/2021/03/05/the-employment-situation-in-february/

[47] Fairlie, R., Couch, K. & Xu, H. (2020). The Impacts of COVID-19 on Minority Unemployment: First Evidence from April 2020 CPS Microdata. National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w27246/w27246.pdf

disproportionate representation in industries such as hospitality and construction, which have been most affected by the pandemic-related layoffs.[48,49,50]

Moreover, pandemic-related job and income losses have been more acute among the low-income population—those with the least wherewithal to withstand economic shocks, and who are disproportionately enrolled in Medicaid.[51] In fact, 52 percent of lower income adults (annual income below $37,500) live in households where someone has lost a job or taken a pay cut due to the pandemic.[52] Understandably, households with a job or income loss were two–to-three times more likely to experience economic hardship than those who did not experience such a loss.[53,54] Fifty-nine percent of lower-income adults said they worry every day or almost every day about paying their bills.[55] There are also racial and ethnic disparities in the likelihood of reporting hardships; for example, compared to White households, Black households reported significantly higher chances of putting off filling prescriptions and difficulties making housing and other bill payments. Also, Hispanic households were more likely to experience food insecurity compared to White households.[56,57]

Existing disparities in access to computers and reliable internet may also exacerbate issues in finding and maintaining employment during the pandemic. For example, 29 percent of adults in households with annual incomes below $30,000 did not own a smartphone, and 44 percent did

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[48] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[49] Industries like health care and transportation have been less affected by the pandemic, and that has provided some cushion for black workers. See Despard et al. (2020).

[50] Krogstad, J.M., Gonzalez-Barrera, A. & Noe-Bustamante, L. (2020). U.S. Latinos among hardest hit by pay cuts, job losses due to coronavirus. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2020/04/03/u-s-latinos-among-hardest-hit-by-pay-cuts-job-losses-due-to-coronavirus/

[51] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[52] Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

[53] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[54] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[55] Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

[56] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[57] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

not have home broadband services in 2019.[58] Moreover, fewer than 8 percent of Americans with earnings below the 25th percentile have the capabilities to work remotely.[59] These disparities will result in fewer opportunities for beneficiaries to satisfy a community engagement requirement, particularly as more jobs have shifted to telework or "work from home" during the public health emergency. Therefore, implementation of the community engagement requirement approved in this demonstration increases the risk of coverage loss for these low-income individuals.[60,61]

The pandemic also has disproportionately impacted the physical and mental health of racial and ethnic minority groups, who already experience disparities in health outcomes. Racial minorities and people living in low-income households are more likely to work in industries that are considered "essential services," which have remained open during the pandemic.[62] Additionally, occupations with more frequent exposure to COVID-19 infections, and that require close proximity to others (such as personal care aides and bus drivers) employ Black individuals at higher rates than White individuals.[63] As a result, Black people may be at higher risk of contracting COVID-19 through their employment. The pandemic's mental health impact also has been pronounced among populations experiencing disproportionately high rates of COVID-19 cases and deaths. Specifically, Black and Hispanic adults have been more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.[64]

Since the start of the pandemic, individuals have delayed or postponed seeking care, either due to concerns with out-of-pocket expenses or to avoid risk of contact with infected individuals in health care settings. For example, one study showed that screenings for breast, colon, prostate, and lung cancers were between 56 and 85 percent lower in April 2020 than in the previous year.[65] Results of another survey-based study show that 40 percent of respondents canceled

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[58] Anderson, M. & Kumar, M. (2019). Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

[59] Maani, N., Galea, S. (2020). COVID-19 and Underinvestment in the Health of the US Population. The Milbank Quarterly. Retrieved from https://www.milbank.org/quarterly/articles/covid-19-and-underinvestment-in-the-health-of-the-us-population/

[60] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[61] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[62] Raifman, M.A., & Raifman, J.R. (2020). Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income. American Journal of Preventive Medicine, 59(1), 137–139. https://doi.org/10.1016/j.amepre.2020.04.003

[63] Hawkins, D. (2020). Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity. American Journal of Industrial Medicine, 63(9):817-820. DOI: 10.1002/ajim.23145

[64] Panchal, N., Kamal, R., Cox, C. & Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[65] Patt, D., Gordan, L., Diaz, M., Okon, T., Grady, L., Harmison, M., Markward, N., Sullivan, M., Peng, J., Zhau, A. (2020). Impact of COVID-19 on Cancer Care: How the Pandemic Is Delaying Cancer Diagnosis and Treatment for American Seniors. JCO Clinical Cancer Informatics, 4, 1059-1071. DOI: 10.1200/CCI.20.00134. Retrieved from https://ascopubs.org/doi/full/10.1200/CCI.20.00134

upcoming health care appointments due to the pandemic, and another 12 percent reported they needed care but did not schedule or receive services.[66] These unmet health care needs may lead to substantial increases in subsequent mortality and morbidity.[67] In addition to the health consequences associated with delaying care, pandemic-related delays in seeking care are estimated to increase annual health care costs nationwide by a range of $30 to $65 billion.[68]

The impact of the COVID-19 public health emergency on the economy has been significant, and, importantly, experience with previous recessions suggests the impact is likely to persist for an extended period of time. The unemployment rate went up from 3.5 percent in February 2020, prior to when the pandemic hit, to 14.8 percent in April 2020, and has subsequently fallen to 6.2 percent in February 2021.[69] The labor force participation rate (i.e., the percentage of the civilian noninstitutional population age 16 or older who are working or actively seeking work during the prior month) likewise dipped from 63.3 percent in February 2020 to 60.2 percent in April 2020 only to recover somewhat to 61.4 percent in February 2021.[70] Compared to pre-pandemic conditions, these data suggest that the labor force is still down by approximately 4.24 million individuals.[71]

Evidence shows that losing a job can have significant long term effects on an individual's future earnings. Studies have found that workers who lose their jobs in mass layoffs still earn 20 percent less than similar workers who kept their jobs, 15 to 20 years after the layoff, and the impacts are greater for individuals who lose their jobs during a recession. On average, men lost 2.8 years of pre-layoff earnings when the mass layoff occurred in a time when the unemployment rate was above eight percent.[72] Further, workers who enter the labor market during a recession also face long-term consequences for their earnings.[73] Additionally, non-White individuals and individuals with lower educational attainment have experienced larger and more persistent earning losses than other groups who enter the labor market during recessions.[74]

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[66] McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#

[67] Chen, J. & McGeorge, R. (2020). Spillover Effects Of The COVID-19 Pandemic Could Drive Long-Term Health Consequences For Non-COVID-19 Patients. Health Affairs Blog, DOI: 10.1377/hblog20201020.566558. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20201020.566558/full/

[68] McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#

[69] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/cps/

[70] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/cps/

[71] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/web/empsit/cpseea08b.pdf

[72] Davis, S.J. & von Wachter, T. (2011). Recessions and the Costs of Job Loss. Brookings Papers on Economic Activity. Retrieved from https://www.brookings.edu/wp-content/uploads/2011/09/2011b_bpea_davis.pdf

[73] Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from https://www.nber.org/papers/w25141

[74] Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from https://www.nber.org/papers/w25141

Layoffs can also impact an individual's mortality and morbidity risks.[75] For example, workers experienced mortality rates that were 50-100 percent higher than expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.[76] Furthermore, workers experiencing layoff have reductions in health care utilization, especially among those who lose coverage, which suggests that access to coverage, and continuity of care, could be important in alleviating the long-term ill effects of layoffs on mortality.[77]

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for Medicaid beneficiaries, which have been aggravated further by challenges around shifting childcare and caregiving responsibilities as well as constraints on public transportation during the pandemic, heightens the risks of attaching a community engagement requirement to Medicaid eligibility for continued coverage. In addition, the uncertainty regarding the lingering health complications of COVID-19 infections exacerbates the risk of potential coverage losses for Medicaid beneficiaries. The likely ramifications of losing timely access to necessary health care also can be long lasting. As such, CMS believes that the potential for coverage loss among Medicaid beneficiaries—especially from a requirement that is difficult for beneficiaries to understand and administratively complex for states to implement—would be particularly harmful in the aftermath of the pandemic, and makes the community engagement requirement impracticable.

Withdrawal of Community Engagement Requirement in the October 31, 2018 Extension of the BadgerCare Reform Demonstration

Based on the foregoing, and pursuant to our obligation under section 1115 of the Act to review demonstration projects and ensure they remain likely to promote the objectives of Medicaid, CMS has determined that, on balance, the extension approval authorizing Wisconsin to implement a community engagement requirement as a condition of eligibility is not likely to promote the objectives of the Medicaid program. At a minimum, in light of the significant risks and uncertainties described above about the adverse effects of the pandemic and its aftermath, the information available to CMS does not provide an adequate basis to support an affirmative judgment that the community engagement requirement is likely to assist in promoting the objectives of Medicaid. Accordingly, pursuant to our authority and responsibility under applicable statutes and regulations to maintain ongoing oversight of whether demonstration projects are currently likely to promote those objectives, we are hereby withdrawing approval of that portion of the October 31, 2018 extension that permits the state to require work and community engagement as a condition of eligibility under the BadgerCare Reform

[75] Banks, J., Karjalainen, H. & Propper, C. (2020). Recessions and Health: The Long-Term Health Consequences of Responses to the Coronavirus. Journal of Applied Public Economics. DOI: 10.1111/1475-5890.12230. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/1475-5890.12230

[76] Sullivan, D. & von Wachter, T. (2009). Job Displacement and Mortality: An Analysis Using Administrative Data. Quarterly Journal of Economics. Retrieved from http://www.econ.ucla.edu/tvwachter/papers/sullivan_vonwachter_qje.pdf

[77] Schaller, J., Stevens, A. (2015). Short-Run Effects of Job Loss on Health Conditions, Health Insurance, and Health Care Utilization. Journal of Health Economics, 43, 190-203. DOI: 0.1016/j.jhealeco.2015.07.003. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629615000788

demonstration. The provisions of our letter approving the October 31, 2018 extension and the corresponding provisions of the expenditure authorities and Special Terms and Conditions that authorize the community engagement requirement are withdrawn.

The withdrawal of these authorities is effective on the date that is thirty days after the date of this letter, unless the state timely appeals, as discussed below. The waivers, expenditure authorities, and Special Terms and Conditions reflecting this change are attached to this letter and will govern the BadgeCare Reform demonstration from the effective date of the withdrawal of the community engagement authorities until the demonstration expires on December 31, 2023.

As indicated in CMS's February 12, 2021 letter, CMS is also reviewing the other authorities that CMS previously approved in the Wisconsin BadgerCare Reform demonstration. That review remains ongoing. The state and CMS will work together to update the evaluation design, as needed, to reflect all the key policies that are implemented during the approval period. The current established timeline for the interim and summative evaluation reports will remain in effect. CMS looks forward to continuing to work with the state on the evaluation design, interim and summative evaluation reports.

Procedure to Appeal This Decision

In accordance with Special Terms and Conditions ¶ 11 and 42 C.F.R. § 430.3, the state may request a hearing to challenge CMS's determination prior to the above-referenced effective date by appealing this decision to the Departmental Appeals Board (DAB or Board), following the procedures set forth at 45 C.F.R. part 16. This decision shall be the final decision of the Department unless, within 30 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written notice of appeal to the DAB.

A notice of appeal may be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. The Board will notify the state of further procedures. If the state faxes its notice of appeal (permitted only if the notice of appeal is under 10 pages), the state should use the Appellate Division's fax number, (202) 565-0238.

To use DAB E-File to submit your notice of appeal, the state's Medicaid Director or its representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, https://dab/efile.hhs.gov/; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, the state's Medicaid Director or its representative should login to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

Due to the COVID-19 public health emergency, the DAB is experiencing delays in processing documents received by mail. To avoid delay, the DAB strongly encourages the filing of materials through the DAB E-File system. However, should the state so choose, written requests for appeal should be delivered or mailed to U.S. Department of Health and Human Services, Departmental Appeals Board MS 6127, Appellate Division, 330 Independence Ave., S.W., Cohen Building Room G-644, Washington, DC 20201. Refer to 45 C.F.R. Part 16 for procedures of the Departmental Appeals Board.

The state must attach to the appeal request, a copy of this decision, note its intention to appeal the decision, a statement that there is no dollar amount in dispute but that the state disputes CMS's withdrawal of certain section 1115 demonstration authorities, and a brief statement of why the decision is wrong. The Board will notify the state of further procedures. If the state chooses to appeal this decision, a copy of the notice of appeal should be mailed or delivered (the state should use registered or certified mail to establish the date) to Judith Cash, Acting Deputy Director, Center for Medicaid and CHIP Services at 7500 Security Blvd, Baltimore, MD 21244.

If you have any questions, please contact Judith Cash at (410) 786-9686.

Sincerely,



Elizabeth Richter
Acting Administrator

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform**

AWARDEE: **Wisconsin Department of Health Services**

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the affected populations, as described for the demonstration project from October 31, 2018 through December 31, 2018, as these two waivers will sunset on December 31, 2018.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the state plan requirements contained in section 1902 of the Act are granted in order to enable Wisconsin to implement the Wisconsin BadgerCare Reform Medicaid section 1115 demonstration.

1. Provision of Medical Assistance Eligibility

Section 1902 (a)(8)
Section 1902(a)(10)

To the extent needed to enable the state to enforce premium payment requirements under the demonstration by not providing medical assistance for a period of three months for adults that qualify for Medicaid only under section 1925, or sections 1902(e)(1) and 1931(c)(1), of the Act whose eligibility has been terminated as a result of not paying the required monthly premium.

2. Premiums

Section 1902(a)(14) insofar as it incorporates section 1916
Section 1902(a)(52)

To the extent needed to permit the state to impose monthly premiums based on household income on individuals that qualify for Medicaid only under Transitional Medical Assistance (TMA). This waiver allows the state to apply premiums to TMA Adults with income above 133 percent of the federal poverty level (FPL) starting from the date of enrollment, and to TMA Adults with income from 100-133 percent of the FPL starting after the first six calendar months of TMA coverage.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform Section 1115 Demonstration**

AWARDEE: **Wisconsin Department of Health Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this demonstration, shall be regarded as expenditures under the state's title XIX plan.

The following expenditure authority shall enable the state to operate its BadgerCare Reform section 1115 Medicaid demonstration beginning October 31, 2018 through December 31, 2023.

1. **Childless Adults Demonstration Population.** Expenditures for health care-related costs for eligible non-pregnant, uninsured adults ages 19 through 64 years who have family incomes up to 95 percent of the federal poverty level (FPL) (effectively 100 percent of the FPL including the five percent disregard), who are not otherwise eligible under the Medicaid State plan, other than for family planning services or for the treatment of Tuberculosis, and who are not otherwise eligible for Medicare, Medical Assistance, or the State Children's Health Insurance Program (CHIP).

2. **Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Wisconsin or tribe in such other state on the date of attaining 18 years of age (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid on that date, and are now applying for Medicaid in Wisconsin.

3. **Residential and Inpatient Treatment Services for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Childless Adults Demonstration Population beginning October 31, 2018, through December 31, 2023.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to require enrollment of eligible individuals in managed care organizations.

2. Premiums **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**

To the extent necessary to the state to charge an $8 monthly premium to the childless adult population with household incomes over 50 percent of the FPL, up to and including 100 percent of the FPL.

3. Comparability **Section 1902(a)(17)/Section 1902(a)(10)(B)**

To the extent necessary to enable the state to vary monthly premiums for the childless adult population based on health behaviors and health risk assessment completion.

To the extent necessary to enable the state to establish a non-emergency use of the emergency department copayment of $8 for the childless adult population.

4. Eligibility **Section 1902(a)(10) and 1902(a)(52)**

To the extent necessary to enable the state to deny eligibility and prohibit reenrollment for up to six months for the childless adults population who are disenrolled for failure to pay premiums.

To the extent necessary to enable the state to deny eligibility for the childless adults population who does not complete a health risk assessment.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00293/5

TITLE: Wisconsin BadgerCare Reform

AWARDEE: Wisconsin Department of Health Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) to enable Wisconsin (state) to operate the Badger Care Reform section 1115(a) BadgerCare demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and amendments and the state's obligations to CMS related to this demonstration and amendments. The STCs are effective October 31, 2018 and the BadgerCare Reform demonstration is approved through December 31, 2023.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits
VI. Cost Sharing (Premiums, Copays, and Healthy Behavior Incentive)
VII. Delivery System
VIII. General Reporting Requirements
IX. General Financial Requirements
X. Monitoring Budget Neutrality for the Demonstration
XI. Evaluation of the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A. Summary of Cost-sharing for TMA Adults Only
Attachment B. Substance Use Disorder Implementation Plan Protocol
Attachment C. Substance Use Disorder Monitoring Protocol
Attachment D. Developing the Evaluation Design
Attachment E Preparing the Interim and Summative Evaluation Reports
Attachment F. Evaluation Design
Attachment G. Monitoring Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

With the implementation of the Affordable Care Act provisions, that will provide federally-funded subsidies to help individuals and families purchase private health insurance, Wisconsin saw the BadgerCare Reform amendment as an opportunity to reduce the uninsured rate and encourage beneficiaries to access coverage in the private market.
The Wisconsin BadgerCare Reform amendment provided state plan benefits, other than family planning services and tuberculosis-related services, to childless adults who had effective family incomes up to 100 percent of the Federal Poverty Level (FPL) (effective income is defined to include the five (5) percent disregard), and permitted the state to charge premiums to adults who were only eligible for Medicaid through the Transitional Medical Assistance eligibility group (hereinafter referred to as "TMA Adults") with incomes above 133 percent of the FPL starting from the first day of enrollment and to TMA Adults from 100-133 percent of the FPL after the first six (6) calendar months of TMA coverage.

The BadgerCare Reform amendment allowed the state to provide health care coverage for the childless adult population at or below an effective income of 100 percent of the FPL with a focus on improving health outcomes, reducing unnecessary services, and improving the cost-effectiveness of Medicaid services. Additionally, the amendment enabled the state to test the impact of providing TMA to individuals who were paying a premium that aligned with the insurance affordability program in the Marketplace based upon their household income when compared to the FPL.

In accordance with CMS' November 21, 2016 CMCS Informational Bulletin (CIB), *Section 1115 Demonstration Opportunity to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the BadgerCare Reform demonstration was amended in December 2017 to add coverage of former foster care youth defined as individuals under age 26 who were in foster care in another state or tribe of such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid at that time or at some point while in such foster care, and are now applying for Medicaid in Wisconsin. With the addition of this population, Wisconsin has a new demonstration goal to increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

The 2017 amendment request was prompted by the Wisconsin 2015-2017 Biennial Budget (Act 55), which required the Wisconsin Department of Health Services (DHS) to request an amendment to the BadgerCare Reform amendment in order to apply a number of new policies to the childless adult population. Act 55 requirements included: establishing monthly premiums, establishing lower premiums for members engaged in healthy behaviors, requiring completion of a health risk assessment, limiting a member's eligibility to no more than 48 months, and requiring as a condition of eligibility that an applicant or member complete a drug screening, and if indicated, a drug test and treatment; however, a drug test as a condition of eligibility and a 48-month limit are not part of this approval. Policies not required by Act 55, but included in the amendment request in order to meet the program objectives involve charging an increased copayment for non-emergent use of the emergency department utilization for childless adults, and providing full

coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, and meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as well as a modified allotment neutrality worksheet as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, Evaluation Design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP, whether administrative or service-based expenditures, will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An explanation of the public process used by the state consistent with the requirements of STC 13; and,

    d. If applicable, a description of how the Evaluation Design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in

accordance with the timelines contained in statute. Otherwise, no later than twelve months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

   a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and how the state incorporated the received comment into the revised transition and phase-out plan.

   b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

   c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.

   d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration

activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the demonstration authority expiration plan.

d. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

    The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.
    The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

14. **Federal Financial Participation (FFP).** No federal matching for expenditures, both administrative and service, for this demonstration will take effect until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or

alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

16. **State Plan Eligibility Groups Affected By the Demonstration.** The state plan populations affected by this demonstration are outlined in Table 1, which summarizes each specific group of individuals and specifies the authority under which they are eligible for coverage and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed.

17. **Demonstration Expansion Eligibility Groups.** Table 1 summarizes the specific groups of individuals, and specifies the authority under which they are eligible for coverage. Table 1 also specifies the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed. Demonstration Population 2 in Table 1 is made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration. Coverage of Demonstration Population 2 is subject to Medicaid laws and regulations (including all enrollment requirements described in paragraph b. below) unless otherwise specified in the "Title XIX Requirements Not Applicable to the Demonstration Population" section of the expenditure authorities document for this demonstration.

Table 1: Eligibility Groups Affected by the Demonstration			
Medicaid State Plan Mandatory Groups	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Population 1. Parents and caretaker relatives who are non-pregnant, those who do not qualify for Medicaid on the basis of disability, and whose effective family income is above 100 percent FPL and who qualify for TMA under section 1925 of the Act	Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1925 of the Act or 1931(c)(1) of the Act.	Title XIX	TMA Adults
Demonstration Expansion Groups	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting

Population 2. Non-pregnant childless individuals Age 19 through 64 with an effective monthly income that does not exceed 100 percent FPL	• Ages 19 through 64 • Effective monthly income at or below 100 percent of the FPL • Not pregnant • Do not qualify for any other full-benefit Medicaid or CHIP eligibility group • Are not receiving Medicare • Childless adults may have children, but do not qualify as a parent or caretaker relative (e.g., either the children are not currently living with them or those children living with them are 19 years of age or older) • Fully complete a Health Risk Assessment (HRA)	Title XIX	BC Reform Adults
Population 3. Former Foster Care Youth ("FFCY") from Another State	• Individuals under age 26, who we were in foster care under the responsibility of a state other than Wisconsin or a tribe in such other state when they turned 18 or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid at that time or at some point while in such foster care, are now applying for Medicaid in Wisconsin, and are not otherwise eligible for Medicaid.	Title XIX	FFCY

V. BENEFITS

18. Wisconsin BadgerCare Demonstration. All enrollees in this demonstration (as described in Section IV) will receive benefits as specified in the Medicaid state plan, to the extent that such benefits apply to those individuals. Beneficiaries in Demonstration Population 2 will not receive family planning services or tuberculosis-related services. In addition, beneficiaries in the Demonstration Population 2 will not receive pregnancy related services, but instead must be administratively transferred to the pregnant women group in the state plan if they are

pregnant. Refer to the state plan for additional information on benefits. Former foster care youth from another state receive full Medicaid State Plan benefits.

19. **Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program**. Effective upon CMS' approval of the SUD Implementation Protocol, the demonstration benefit package for all Wisconsin Medicaid recipients will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matched expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Wisconsin Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Wisconsin will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 21 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

    The coverage of OUD/SUD treatment services and withdrawal management during short term residential and inpatient stays in IMDs will expand Wisconsin's current SUD benefit package available to all Wisconsin Medicaid recipients as outlined in Table 2. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as impatient facilities under section 1905(a) of the Act.

Table 2: Wisconsin OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefits	Wisconsin Medicaid Authority	Expenditure Authority
Outpatient Services	State Plan	n/a
Intensive Outpatient Services	State Plan	n/a
Medication Assisted Treatment	State Plan (Individual services covered)	Services provided to individuals in IMDs
Residential Treatment Services	State Plan (Individual services covered)	Services provided to individuals in IMDs
Inpatient Services	State Plan (Individual services covered)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State Plan	Services provided to individuals in IMDs

20. **SUD Implementation Plan Protocol.** The state must submit a SUD Implementation Plan Protocol within ninety (90) days after approval of the SUD program under this demonstration approval. The state may not claim FFP for services provided in IMDs until CMS has approved the SUD Implementation Plan Protocol. Once approved, the Implementation Plan Protocol will be incorporated into the STCs, as Attachment B, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Plan Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Plan Protocol or failure to obtain CMS approval will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such,

would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in funding deferral. At a minimum, the SUD Implementation Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD program in this demonstration:

a. Access to Critical Levels of Care for OUD and other SUDs: Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

b. Use of Evidence-based SUD-specific Patient Placement Criteria. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. Patient Placement. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

d. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities. Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Wisconsin administrative code. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

e. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

f. Standards of Care. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval.

g. Sufficient Provider Capacity at each Level of Care, including Medication Assisted Treatment for OUD. An assessment of the availability of providers in the key levels of

care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval.

h. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

i. SUD Health IT Plan**.** Implementation of the milestones and metrics as detailed in STC 32.

j. Improved Care Coordination and Transitions between levels of care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

21. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within one hundred fifty (150) calendar days after approval of the SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment C. At a minimum, the SUD Monitoring Protocol will include reporting of the average length of stay for residential treatment and reporting relevant to each of the program implementation areas listed in STC 20. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 38 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the SUD Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

22. Mid-Point Assessment. The state must conduct an independent mid-point assessment of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones

and targets not yet met and about the risk of possibly missing those milestones and performance targets. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report. For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Plan Protocol and SUD Monitoring Protocols for ameliorating these risks subject to CMS approval.

23. **SUD Evaluation.** The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections VIII General Reporting Requirements and XII Evaluation of the Demonstration of the STCs.

24. **SUD Evaluation Design.** The state must submit, for CMS review and approval, a revision to the Evaluation Design to include the SUD program, no later than one-hundred-and-eighty (180) calendar days after the effective date of these amended STCs. Failure to submit an acceptable and timely Evaluation Design along with any required monitoring, expenditure, or other evaluation reporting will subject the state to a $5 million deferral. The state must use an independent evaluator to design the evaluation.

    a. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

    b. Evaluation Questions and Hypotheses Specific to SUD Program. The state must follow the general evaluation questions and hypotheses requirements as specified in guidance provided in Attachment D (Developing the Evaluation Design) of the STCs. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this section 1115 demonstration, to include, but is not limited to: initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of

Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

25. **SUD Health Information Technology (Health IT).** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be submitted as a component of the State Medicaid Health IT Plan (SMHP), and included as a section of the state's "Implementation Plan" to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

    a. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them (see Attachment B).

    b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

    c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

    d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

    e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[2] *Ibid*.

f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]

g. In developing the Health IT Plan, states should use the following resources.

   i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

   ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

   iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state will include in its Monitoring Protocol (see STC 21) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 38).

j. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

k. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

l. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

26. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

VI. COST SHARING (PREMIUMS, COPAYS, AND HEALTHY BEHAVIOR INCENTIVE)

27. Cost sharing. For all enrollees in this demonstration, cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies and be reflected in the state plan, except for premiums for Demonstration Population 1 (TMA Adults), and except for copayments for non-emergency use of the ED for Demonstration Population 2.

a. Premiums for Demonstration Population 1 (TMA Adults). TMA Adults with income of 133 percent of the FPL or greater are subject to monthly premiums based on the sliding scale as outlined in Attachment A from the date of enrollment. TMA Adults with effective income over 100 percent but less than 133 percent of the FPL are subject to monthly premiums based on a sliding scale starting six calendar months after the date of enrollment. There will be a 30-day grace period for non-payment of the monthly premium before being disenrolled. Eligibility and enrollment for TMA will be terminated for a maximum period of three months for demonstration participants who fail to make a required premium payment before the end of the grace period. However, a participant may re-enroll at any point during this three -month period by paying owed premiums. After the three-month period of non-eligibility, TMA Adults must be reenrolled in TMA on request, even if they have an outstanding unpaid premiums, provided their respective 12-month TMA period has not yet expired. The three-month period of non-eligibility does not toll the 12-month TMA period. If section 1925 of the Act sunsets or is otherwise inapplicable and TMA is then available only for a four month extension, Demonstration Population 1 individuals may not re-enroll in TMA. No premium may be charged during the three-month period of non-eligibility, and nonpayment of premiums that remain unpaid from a prior TMA enrollment period may not be used as a basis for terminating a beneficiary's enrollment during a subsequent period of TMA enrollment after the three-month period of non-eligibility.

i. Premiums for TMA Adults whose income changes after time of application (i.e., decreases or increases, including an increase in which the individual's income increases to 200 percent of the FPL or more), but before his/her annual redetermination, will be recalculated after the individual has reported the change. Once the state has calculated an individual's new monthly premium amount based on the sliding scale outlined in Attachment A, the state will provide the individual with at least a 10-day notice prior to effectuating the new monthly premium amount. If income increases to 133 percent FPL or more for TMA demonstration

enrollees who had income under 133 percent FPL when their TMA began, premiums will be due immediately after the 10-day notice.

ii. Consistent with 42 CFR 447.56, American Indians and Alaska Natives (AI/AN) who are eligible to receive or who have received an item or services furnished by an Indian health care provider or through referral under contract health services are exempt from the premium amounts outlined above.

iii. TMA adults may be disenrolled for failure to pay premiums after a 30-day grace period. Once they are disenrolled, they will be restricted from re-enrollment during a three month period of non-eligibility. They may enroll in Medicaid under another eligibility group if they become eligible under such other eligibility group during the three-month non-eligibility period. At any point during this three-month period, they may pay the owed premiums to re-enroll in TMA for the remainder of the 12-month TMA extension period and be re-enrolled. After the three-month period, they may re-enroll for TMA for the remainder of the 12-month TMA extension period, if requested, even if they have an outstanding unpaid premiums from the prior TMA enrollment period. In this case, nonpayment of premiums that remain unpaid from the prior TMA enrollment period may not be used as a basis for terminating the beneficiary's enrollment during the subsequent period of TMA enrollment.

STC 27(a) will sunset on December 31, 2018 and demonstration premiums will no longer be charged to the TMA adults after this date.

b. Premiums for Demonstration Population 2. For individuals in demonstration population 2, a monthly premium payment is required for those with monthly household income above 50 percent of the FPL. Monthly premium amounts are divided into the following two income tiers:

Table 3: Income Tiers for Monthly Premiums for Demonstration Population 2	
Monthly Household Income	**Monthly Premium Amount**
0 to 50 percent of the FPL	No premium
Above 50 percent of the FPL	$8 per household

i. Beneficiaries with household income up to 50 percent of the FPL are exempt from paying monthly premiums. AI/AN who are eligible to receive or who have received an item or services furnished by an Indian health care provider or through referral under contract health services are also exempt from the monthly premiums outlined above, consistent with section 1916(j) of the Act and with 42 CFR 447.56.

ii. Beneficiaries in Demonstration Population 2 may be disenrolled for failure to pay premiums only at annual redetermination. The state will notify beneficiaries who have unpaid premium amounts for the coverage year and provide a reasonable opportunity for the beneficiary to pay before disenrolling the beneficiary for the next coverage year. If a beneficiary is disenrolled at annual redetermination for

failure to pay premiums who would have continued to have a premium requirement during the next coverage year if not disenrolled, the beneficiary will be subject to a period of non-eligibility for up to six months. Such a beneficiary may reenroll at any time prior to the end of the six-month period if he or she pays all owed premiums, or if his or her situation changes such that he or she would no longer be subject to a premium requirement. After the six-month period, the beneficiary may be re-enrolled in BadgerCare upon request, if he or she meets all program rules, even if he or she continues to have unpaid premiums from the prior period of enrollment.

c. The state will monitor and include in the quarterly report information related to disenrollments from the demonstration, including due to nonpayment of premiums.

28. **Healthy Behavior Incentives.** Beneficiaries enrolled in Demonstration Population 2 who are subject to a premium requirement will have their household premium requirement reduced by up to 50 percent if they demonstrate that they do not engage in behaviors that increase health risks ("health risk behaviors"). For beneficiaries who do not demonstrate that they do not engage in health risk behaviors, but attest to actively managing their behavior(s) and/or that they have a health condition that causes them to engage in one or more health risk behaviors, the premium will also be reduced by up to half. For beneficiaries who do not demonstrate that they do not engage in health risk behaviors and do not attest that they are actively managing their behavior(s) and/or that they have a health condition that causes them to engage in one or more health risk behaviors, the standard premium will apply. Beneficiaries will have the opportunity to update and self-attest to any changed health risk behavior or conditions that affect health risk behaviors at a minimum on an annual basis, when eligibility is re-determined. Health risk behaviors include, but are not limited to, excessive alcohol consumption, failure to engage in dietary, exercise, and other lifestyle (or "healthy") behaviors in attempt to attain or maintain a healthy body weight, illicit drug use, failure to use a seatbelt, and tobacco use. To identify beneficiaries who are engaging in health risk behaviors, individuals will be asked to complete a Health Risk Assessment (HRA) when applying for coverage under the demonstration or, for current beneficiaries, no sooner than 12 months after waiver approval. Beneficiaries will also use the HRA to self-attest to their active management of a health risk behavior and/or to having an underlying health condition that causes them to engage in one or more health risk behaviors, if either of these is applicable.

    Because health risk is assessed at an individual level, a married couple may include one beneficiary who qualifies for a premium reduction and one beneficiary who does not. If this happens, the household premium would be reduced by 25 percent. If both beneficiaries qualify for a premium reduction, the household's premium would be reduced by 50 percent.

    Beneficiaries enrolled in Demonstration Population 2 must fully complete a HRA to be determined eligible for coverage at application and renewal. If an individual fails to answer all questions on the HRA, eligibility for the demonstration will be denied, but there is no period of non-eligibility and that individual can re-apply at any time.

29. **Copayments for Use of the Emergency Department.** Individuals in Demonstration Population 2 are required to pay a copayment for each non-emergent use of the emergency

room (ER). This copayment shall be charged consistent with 1916A(e)(1) of the Act and 42 CFR 447.54.

a. Under the provisions of section 1916A(e) of the Act, the state has the authority to impose a copayment for services received at a hospital emergency room if the services are not emergency services.

b. As provided under 42 CFR 447.54, the amount of this co-pay will be $8 for each non-emergent use of the emergency department.

c. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.

d. Providers cannot refuse treatment for nonpayment of the co-payment.

e. AI/AN who are currently receiving or who have ever received an item or services furnished by an Indian health care provider or through referral under contract health services are exempt from the copayment requirements outlined above, consistent with section 1916(j) of the Act and 42 CFR 447.56.

VII. DELIVERY SYSTEM

30. General. Demonstration Populations 1 and 2 will be enrolled in the managed care organizations (MCO) that are currently contracted to provide health care services to the existing Medicaid and BadgerCare programs in most of the state to serve persons eligible under this demonstration. Demonstration enrollees will be required to join a MCO as a condition of eligibility, as long as there is at least one MCO available in their county of residence, and the county has been granted a rural exception under Medicaid State plan authority. The state may mandate enrollment into the single MCO in the counties that have been granted the rural exception by CMS. If the county has not been granted a rural exception, the state must offer the option of either MCO enrollment or Medicaid fee-for-service. All demonstration eligible beneficiaries must be provided a Medicaid card, regardless of MCO enrollment. MCOs may elect to provide a MCO specific card to MCO enrollees as well. The state must comply with the managed care regulations published at 42 CFR §438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of sixty (60) days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

VIII. GENERAL REPORTING REQUIREMENTS

31. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by

these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

    i. CMS may decline the extension request.

    ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

    iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

32. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

33. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

34. General Financial Requirements. The state must comply with all general financial requirements under title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section X of these STCs.

35. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XI of these STCs.

36. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than one hundred fifty (150) calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment G.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 38(b)), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g, operational updates as described in STC 38(a)), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

37. Tribal Consultation Plan. The state must consult with federally recognized tribal governments and with Indian health care providers, and through consultation, identify any tribal concerns. The plan and timeline are due to CMS within 60 calendar days after approval of this demonstration and will be incorporated into the STCs, as Attachment I. CMS will work with the state if we determine changes are necessary to the state's submission, or if issues are identified as part of the review.

38. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS's framework. The performance metrics will reflect all components of the state's demonstration, and may include, but are not limited to, measures associated with eligibility and coverage. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation

hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

39. **Corrective Action.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

40. **Close-Out Report.** Within 120 days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

    a. The draft report must comply with the most current guidance from CMS.

    b. The state will present to and participate in a discussion with CMS on the Close-Out report.

    c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

    d. The final Close-Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

    e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 31.

41. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

    a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

    b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

    c. The state and CMS will jointly develop the agenda for the calls.

42. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

43. Transformed Medicaid Statistical Information Systems Requirements (T-MSIS). The state shall comply with all T-MSIS milestones and associated timelines indicated below. Failure to meet these milestones on the below timeline will result in a deferral, as described in STC 31:

a. By December 31, 2018 state will address and correct all post go-live corrective actions (except waiver population reporting).

b. By January 31, 2019, state will achieve and maintain currency in T-MSIS data reporting.

c. By June 30, 2019 state will implement corrective action for waiver reporting.

IX. GENERAL FINANCIAL REQUIREMENTS.

This project is approved for title XIX services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

44. Quarterly Financial Reports. The state must provide quarterly title XIX expenditure reports using Form CMS-64, to separately report total title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section XI of the STCs.

45. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit, including baseline data and member months, must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Using specific medical status codes, the state has the capacity to use its MMIS system to stratify manufacturer's rebate revenue that should be assigned to net demonstration expenditures for BC Reform Adults. The state will generate a demonstration-specific rebate report to support the methodology used to assign rebates to the demonstration. The state will report the portion of rebate revenue assigned to BC Reform Adults on the appropriate Forms CMS-64.9 WAIVER. This revenue will be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid. Budget neutrality will reflect the net cost of prescriptions.

e. Federally Qualified Health Center Settlement Expenses. Using specific medical status codes, the state will assign FQHC settlement expenses to claims covered under the demonstration for BC Reform Adults and will report these costs on the appropriate Forms CMS-64.9 WAIVER. The state will be able to generate reports using MMIS data to show the assignment of these settlement payments to demonstration expenditures.

f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. These amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

g. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration (Section XI of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:

    i. "BC Reform Adults"

    ii. "TMA Adults"

    iii. "FFCY"

iv. "SUD"

h. Demonstration Year Definition. The Demonstration Years (DYs) will be defined as follows:

January 1, 2014 through December 31, 2014	Demonstration Year 1 (DY1)
January 1, 2015 through December 31, 2015	Demonstration Year 2 (DY2)
January 1, 2016 through December 31, 2016	Demonstration Year 3 (DY3)
January 1, 2017 through December 31, 2017	Demonstration Year 4 (DY4)
January 1, 2018 through December 31, 2018	Demonstration Year 5 (DY5)
January 1, 2019 through December 31, 2019	Demonstration Year 6 (DY6)
January 1, 2020 through December 31, 2020	Demonstration Year 7 (DY7)
January 1, 2021 through December 31, 2021	Demonstration Year 8 (DY8)
January 1, 2022 through December 31, 2022	Demonstration Year 9 (DY9)
January 1, 2023 through December 31, 2022	Demonstration Year 10 (DY10)

46. Administrative Costs. The state must track administrative costs for state-approved workforce programs under Section V. Administrative costs, including state-approved workforce programs under Section V, will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs ("ADM").

47. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

48. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 38, the actual number of eligible member months for BadgerCare Reform Demonstration adults and separately the actual number of eligible member months for former foster care youth (i.e. FFCY). The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member months to the total. Two individuals who are eligible for two (2) months each contribute two (2) eligible member months to the total, for a total of four (4) eligible member months.

49. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

50. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section X of these STCs:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

51. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be

addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding, including up to date responses to the CMS standard funding questions

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

52. State Certification of Funding Conditions. The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

53. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

54. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in Section IV, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

55. **Calculation of the Budget Neutrality Limit.** For the purpose of calculating the overall budget neutrality limit for the demonstration, an annual budget limit will be calculated for each DY on a total computable basis. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 56 below.

    The demonstration expenditures subject to the budget neutrality limit related to Demonstration Population 2 as described in STC 17 are those reported under the following Waiver Name: BC Reform Adults. The demonstration expenditures subject to the budget neutrality limit related to Demonstration Population 3 as described in STC 17 are those reported under the following Waiver Name: FFCY. The demonstration expenditures subject to the budget neutrality limit related to SUD as those reported under the following Waiver Name: SUD.

    For each DY, separate annual budget limits of demonstration service expenditures will be calculated based on projected PMPM expenditures for BC Reform Adults, Former Foster Care Youth, and SUD. The PMPM amounts for BC Reform Adults, Former Foster Care Youth, and SUD are shown on the table below.

MEG	TREND RATE	2018 DY 5 – PMPM	2019 DY 6 - PMPM	2020 DY 7 PMPM	2021 DY 8 – PMPM	2022 DY 9 – PMPM	2023 DY 10 PMPM
BC Reform Adults	4.7%	$710.95	$744.36	$779.35	$815.98	$854.33	$894.48

Former Foster Care Youth	3.7%	$2,538.20	$2,632.11	$2,729.50	$2,830.49	$2,935.22	$3,043.82
SUD	4.6%	$5,561	$5,816.81	$6,084.38	$6,364.26	$6,657.02	$6,963.24

56. **Hypothetical Eligibility Group.** BC Reform Adults (as related to Demonstration Population 2 defined under STC 17), SUD, and Former Foster Care Youth (Demonstration Population 3) are considered to be a hypothetical populations for budget neutrality. BC Reform Adults consist of individuals who could have been added to the Medicaid program through the state plan, but instead are covered through demonstration authority.

    Former Foster Care Youth from Another State are individuals that were or would have been eligible for state plan coverage as described in the January 22, 2013 CMS notice of proposed rulemaking that permitted the option to cover formerly out-of-state former foster care youth up to age 26 pursuant to section 1902(a)(10)(A)(i)(IX) of the Act. This coverage is now only permissible under the authority of this section 1115 demonstration as outlined in the November 21, 2016 CIB on transition coverage for Former Foster Care Youth.

    As part of the SUD initiative, the state may receive FFP for the continuum of services specified in Table 2 to treat OUD and other SUDs that are provided to Medicaid beneficiaries in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the services listed in Table 2 that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality "savings" from these services. Therefore, a separate expenditure cap is established for SUD services.

    The budget neutrality expenditure limits for these populations reflect the expected costs for these populations and there is no requirement that the state produce savings from elsewhere in its Medicaid program to offset hypothetical population costs. States may not accrue budget neutrality "savings" from hypothetical populations.

57. **Composite Federal Share Ratio.** The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual expenditures for BC Reform Adults during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

58. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy

interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

59. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap on a PMPM basis by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition on a PMPM basis	Percentage
DY 1	Cumulative budget neutrality limit plus:	1 percent
DY 2	Cumulative budget neutrality limit plus:	0.75 percent
DY 3	Cumulative budget neutrality limit plus:	0.5 percent
DY 4	Cumulative budget neutrality limit plus:	0.25 percent
DY 5	Cumulative budget neutrality limit plus:	0 percent
DY 6	Cumulative budget neutrality limit plus:	0 percent
DY 7	Cumulative budget neutrality limit plus:	0 percent
DY 8	Cumulative budget neutrality limit plus:	0 percent
DY 9	Cumulative budget neutrality limit plus:	0 percent
DY 10	Cumulative budget neutrality limit plus:	0 percent

60. **Exceeding Budget Neutrality.** If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XI. EVALUATION OF THE DEMONSTRATION

61. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data

and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 31.

62. **Independent Evaluator.** Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

63. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than one hundred eighty (180) calendar days after approval of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

    The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

    a. Attachment D (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a draft Evaluation Design.

64. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval, the approved Evaluation Design will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the evaluation design in monitoring reports.

65. **Evaluation Questions and Hypotheses.** Consistent with Attachments D and E (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could

include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS' measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

66. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

67. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

    d. The state must submit a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.

    e. The Interim Evaluation Report must comply with Attachment E (Preparing the Interim and Summative Evaluation Reports) of these STCs.

68. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment E (Preparing the Interim and Summative Evaluation Reports) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

b. Upon approval from CMS, the final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

69. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

70. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the summative evaluation.

71. **Public Access.** The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, Approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

72. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Attachment B: CMS Comments and UW/DHS Responses

Wisconsin's BadgerCare Reform Section 1115 Demonstration
CMS COMMENTS ON THE REVISED EVALUATION DESIGN

June 22, 2021

I. Introduction

The Centers for Medicare & Medicaid Services (CMS) has reviewed the revised evaluation design resubmitted on February 22, 2021 for Wisconsin's section 1115 BadgerCare Reform demonstration extension against CMS's comments on the state's earlier draft evaluation design, provided in March and September 2020, the demonstration's Special Terms and Conditions (STC) (Number 11-W-00293/5), as updated on April 6, 2021,[1] and CMS's evaluation design guidance for eligibility and coverage and substance use disorder (SUD) demonstrations.

CMS is sincerely appreciative of the state's commitment to a comprehensive and rigorous evaluation of the BadgerCare Reform demonstration. The revisions to the evaluation design were responsive to most of CMS's comments and the state has increased the strength of its design. In particular, CMS appreciates more detailed information on survey and data collection activities, the survey instrument, and the groups of beneficiaries to be surveyed. The state also plans to field an additional wave of the beneficiary survey and provided more information about their power calculations in response to CMS comments from March 2020. Finally, the state has addressed most of CMS's comments related to the COVID-19 pandemic through adjustments to its empirical approach.

In the recommendations below, we provide a few areas for the state to further strengthen the evaluation design as the state finalizes the document per the current set of STCs, dated April 6, 2021. In consultation with the state, CMS would like to establish a feasible timeline for the state to update the evaluation design to address the recommendations outlined below and preferably, in accordance with STC #64, receive from the state the revised evaluation design no later than 60 days after the state receives these comments.

II. Updated CMS recommendations

1. Update evaluation design components to reflect the currently authorized STCs.

On April 6, 2021, CMS sent a letter[2] to the state updating the STCs for this demonstration. Please update the list of provisions, hypotheses, and research questions—and commensurate design elements—to reflect these changes.

2. Estimate annual demonstration impacts for each year in the intervention period in difference-in-differences analyses.

In the state's difference-in-differences specification (p. 7), the demonstration impact is estimated across all years in the intervention period. The state should consider a difference-in-differences

[1] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wi-badgercare-reform-ca2.pdf
[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wi-badgercare-reform-ca2.pdf

specification that allows for a different impact for each year in the intervention period. For example, if the baseline period is 2019 and the intervention period is 2021–2023 (and 2020 is excluded from the analysis), the state could estimate separate treatment effects for 2021, 2022 and 2023. This would allow the state and CMS to observe the impact of the demonstration in years during or right after COVID-19 and in later years when the pandemic has further subsided.

3. Control for local area time trends in difference-in-differences analyses.

As CMS noted in its comments from September 23, 2020, demonstration impacts could be confounded by the pandemic even in 2021 and beyond. To control for these and other factors, the state could consider adding county-by-year fixed effects to beneficiary-level difference-in-differences models. This can account for the fact that COVID-19 severity and recovery may vary across areas and over time and help isolate the demonstration impact from the confounding effects of COVID-19 and other potential confounding factors.

4. Add sensitivity analyses using a constant analytic sample.

In its comments, CMS noted that the pandemic may affect the pool of beneficiaries who enter Medicaid, making it difficult to isolate the demonstration impact from changing characteristics of Medicaid beneficiaries. The state should consider sensitivity analyses that keep the analytic sample constant before and after the start of the pandemic. This approach is similar to the sensitivity check the state proposed to account for a changing Medicaid population due to the availability of SUD services when evaluating provision 5.

5. Clarify how 2020 will be treated as part of the baseline period under the evaluation of provision 3.

For most hypotheses that will be examined using a difference-in-differences approach, the state will exclude 2020 from the baseline period. However, for the evaluation of provision 3, the baseline period for the difference-in-difference analyses is set to "prior to March 2020" (p. 57) and it is unclear whether the remainder of 2020 is excluded from the analysis or is part of the intervention period. The state should clarify why the approach for provision 3 differs from the other provisions and ensure that the evaluation results for provision 3 are robust to excluding all of 2020 from the analysis.

6. Ensure that the supporting text aligns with tables for changed and excluded research questions.

In its revised evaluation design, the state changed question 4.6.a, included an additional primary research question 4.7, and excluded research question 3.1.b. However, the surrounding text occasionally refers to the previous numbering and questions. For example, the Hypothesis & Research Questions section for provision 4 still refers to question 4.6a from the previous version of the evaluation design and question 4.7 is not mentioned (pp. 65–66). Under provision 3, the Data Sources & Outcomes Measures (p. 62), Analytic Methods (p. 63) and Methodological Limitations (p. 64) sections have not been updated to reflect that research question 3.1.b from the previous version of the evaluation design has been dropped and the research questions have been

re-numbered. The state should ensure that the surrounding text and tables are fully updated to reflect the updated list of primary research questions.

Institute for Research on Poverty
UNIVERSITY OF WISCONSIN–MADISON

Wisconsin's Medicaid CMS § Waiver 2019-2023
CMS Review and Recommendations and UW Evaluation Team Response

CMS recommendation in Times New Roman font
UW Evaluation Team response in Calibri font

The UW Evaluation Team appreciates the feedback received from CMS on the most recent version of the design report. We have summarized our responses below.

In addition, CMS has previously indicated that they welcome all opportunities to provide feedback on data collection instruments. Given the tight timelines we typically face between instrument development and implementation, and the desire for flexibility in the face of uncertainty, we would welcome a streamlined way to conduct this conversation. For example, planning for the second beneficiary survey will begin Q4 2021 and data collection will begin Q2 2022. We would be glad to engage the CMS team for a consultation conversation on the survey concepts if given the opportunity, including through a direct connection between the evaluation team and CMS's designated representative as appropriate.

I. Updated CMS recommendations

1. Update evaluation design components to reflect the currently authorized STCs.

On April 6, 2021, CMS sent a letter[1] to the state updating the STCs for this demonstration. Please update the list of provisions, hypotheses, and research questions—and commensurate design elements—to reflect these changes.

The updated STCs mean that further evaluation of what was Provision 2, the community engagement requirements, will no longer be required, thus Hypotheses 2.1-2.4 along with Primary Research Questions (and related subquestions) 2.1-2.4 will be eliminated. A few survey questions intended to measure the effects of Provision 2 can be excised from future surveys, although some questions in the employment domain are still relevant to other provisions. In addition, administrative data on beneficiaries' community engagement activities will not be collected and thus no longer utilized. Because many design elements and data sources were common to multiple hypotheses, these are the only elements of the evaluation design that have been eliminated. We have made these edits accordingly in the document. Because the community engagement requirement did exist, even though it was never implemented, and part of the waiver population received communications referring to it and/or were exposed to news coverage about it, we have retained a description of it and its fate in the narrative portion of the design report.

[1] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wi-badgercare-reform-ca2.pdf

2. Estimate annual demonstration impacts for each year in the intervention period in difference-in-differences analyses.

In the state's difference-in-differences specification (p. 7), the demonstration impact is estimated across all years in the intervention period. The state should consider a difference-in-differences specification that allows for a different impact for each year in the intervention period. For example, if the baseline period is 2019 and the intervention period is 2021–2023 (and 2020 is excluded from the analysis), the state could estimate separate treatment effects for 2021, 2022 and 2023. This would allow the state and CMS to observe the impact of the demonstration in years during or right after COVID-19 and in later years when the pandemic has further subsided.

We agree that allowing for treatment effect heterogeneity is appropriate. We have edited the text to reflect this as an additional specification.

3. Control for local area time trends in difference-in-differences analyses.

As CMS noted in its comments from September 23, 2020, demonstration impacts could be confounded by the pandemic even in 2021 and beyond. To control for these and other factors, the state could consider adding county-by-year fixed effects to beneficiary-level difference-in-differences models. This can account for the fact that COVID-19 severity and recovery may vary across areas and over time and help isolate the demonstration impact from the confounding effects of COVID-19 and other potential confounding factors.

We agree that studying robustness to geographic differences may be appropriate in some cases. The feasibility of this suggestion generally depends on the underlying data used for analysis; for example, whether the analytic sample is constant, whether the data include county information, and whether the sample size is sufficient to support the inclusion of a large number of fixed effects. We have added language to reflect this.

4. Add sensitivity analyses using a constant analytic sample.

In its comments, CMS noted that the pandemic may affect the pool of beneficiaries who enter Medicaid, making it difficult to isolate the demonstration impact from changing characteristics of Medicaid beneficiaries. The state should consider sensitivity analyses that keep the analytic sample constant before and after the start of the pandemic. This approach is similar to the sensitivity check the state proposed to account for a changing Medicaid population due to the availability of SUD services when evaluating provision 5.

We agree that this may be appropriate depending on the analysis and the time of implementation for the provisions. We have added language reflecting this.

5. Clarify how 2020 will be treated as part of the baseline period under the evaluation of provision 3.

For most hypotheses that will be examined using a difference-in-differences approach, the state will exclude 2020 from the baseline period. However, for the evaluation of provision 3, the baseline period for the difference-in-difference analyses is set to "prior to March 2020" (p. 57) and it is unclear whether the remainder of 2020 is excluded from the analysis or is part of the intervention period. The state should clarify why the approach for provision 3 differs from the other provisions and ensure that the evaluation results for provision 3 are robust to excluding all of 2020 from the analysis.

We have changed the wording in the description for this provision to mirror that used for other provisions. The intent was not for the approach to differ.

6. Ensure that the supporting text aligns with tables for changed and excluded research questions.

In its revised evaluation design, the state changed question 4.6.a, included an additional primary research question 4.7, and excluded research question 3.1.b. However, the surrounding text occasionally refers to the previous numbering and questions. For example, the Hypothesis & Research Questions section for provision 4 still refers to question 4.6a from the previous version of the evaluation design and question 4.7 is not mentioned (pp. 65–66). Under provision 3, the Data Sources & Outcomes Measures (p. 62), Analytic Methods (p. 63) and Methodological Limitations (p. 64) sections have not been updated to reflect that research question 3.1.b from the previous version of the evaluation design has been dropped and the research questions have been re-numbered. The state should ensure that the surrounding text and tables are fully updated to reflect the updated list of primary research questions.

We have made these edits. Please note that due to the elimination of provision 2, all hypotheses have been re-numbered.

Attachment C: Independent Evaluator Assurance of No Conflict

INDEPENDENT EVALUATOR: ASSURANCE AND "NO CONFLICT" STATEMENT

The Wisconsin Department of Health Services assures that the independent evaluator, the University of Wisconsin Institute for Research on Poverty and its subcontracting investigators, will conduct a fair and impartial evaluation, prepare an objective and robust evaluation report, and there will be no conflict of interest.

The selected independent evaluator has a record of providing high-quality, independent evaluations for multiple organizations across Wisconsin. The independent evaluator also conducted the independent evaluation of the previous 1115 waiver approved in 2008, 2012, and 2014 as well as numerous other Medicaid initiatives in Wisconsin. Key research staff who participated in the 2014 BadgerCare Reform waiver evaluation and who are familiar with the state's Medicaid Eligibility Groups and data sources will be continuing their research efforts on this waiver evaluation.

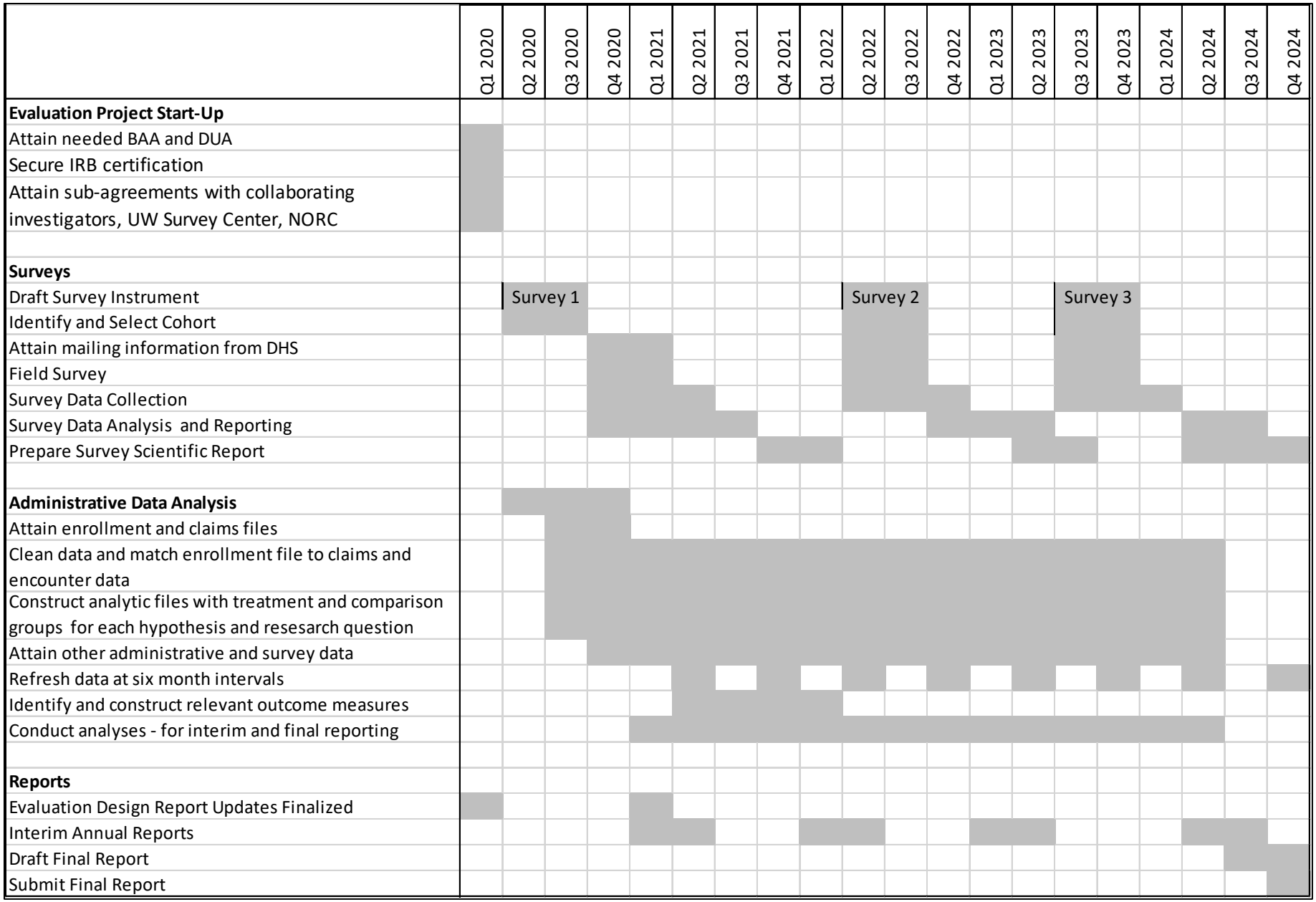
The independent evaluator was screened to assure independence and freedom from conflict of interest. A series of interviews with the independent evaluator revealed that the entity has no conflicts of interest or preconceived notions about what they might find in terms of outcomes related to the new waiver provisions for childless adults. The state assures that the independent evaluator will be able to conduct the evaluation freely and without interference from the state or other outside parties connected to the state.

The state encourages the independent evaluator to address any potential conflict of interest in an open and honest manner at any stage of the evaluation process at which it may arise so that it does not diminish its capacity for impartiality and undermine the evaluation outcome. The state also encourages the independent evaluator to report on any pressures or interferences encountered during the evaluation process that did affect, or could have affected, the evaluator's independence or objectivity. The state is committed to fostering transparency throughout the evaluation process by ensuring that necessary data is easily accessible to the independent evaluator.

Any conflicts of interest that may arise during the evaluation process will be required to be disclosed in the evaluation report. In reviewing draft evaluation reports, the state and independent evaluator will agree to follow procedures designed to improve the probability of organizational independence and protection from interference.

Confirmation Statement: The evaluator, the University of Wisconsin Institute for Research on Poverty submits this evaluation design report under its institutional letterhead and, in doing so, confirms no conflict of interest in serving as an independent evaluator on this project.

Attachment D: Timelines of Major Evaluation Milestones


Q1 2020
Q2 2020
Q3 2020
Q4 2020
Q1 2021
Q2 2021
Q3 2021
Q4 2021
Q1 2022
Q2 2022
Q3 2022
Q4 2022
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Q1 2024
Q2 2024
Q3 2024
Q4 2024
Evaluation Project Start-Up
Attain needed BAA and DUA
Secure IRB certification
Attain sub-agreements with collaborating investigators, UW Survey Center, NORC
Surveys
Draft Survey Instrument
Survey 1
Survey 2
Survey 3
Identify and Select Cohort
Attain mailing information from DHS
Field Survey
Survey Data Collection
Survey Data Analysis and Reporting
Prepare Survey Scientific Report
Administrative Data Analysis
Attain enrollment and claims files
Clean data and match enrollment file to claims and encounter data
Construct analytic files with treatment and comparison groups for each hypothesis and resesarch question
Attain other administrative and survey data
Refresh data at six month intervals
Identify and construct relevant outcome measures
Conduct analyses - for interim and final reporting
Reports
Evaluation Design Report Updates Finalized
Interim Annual Reports
Draft Final Report
Submit Final Report

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ATTACHMENT 2: 2024 MEDICAID BENEFICIARY SURVEY

MEDICAID OR BADGERCARE
CURRENT AND FORMER MEMBER SURVEY

Thank you for taking the time to answer the questions on the following pages. This survey is about your current or former health care coverage through Wisconsin Medicaid or BadgerCare. Your answers will help the Wisconsin Department of Health Services understand how changes to these programs affect your health and health care.

When answering questions, please only include your experiences and opinions about your current or former Medicaid or BadgerCare health care coverage. If you have Medicaid or BadgerCare, you likely have a card that looks like the example below:



When you have completed the survey, please place the survey into the postage-paid envelope provided, and put it in the mail.

If you have questions about the survey, you can contact either of the following people at the University of Wisconsin:

Bob Cradock (608-265-9885, cradock@ssc.wisc.edu)
Tim Connor (608-261-1578, tim.connor@wisc.edu)

Thank you again for your help!

A. MEDICAID RENEWAL PROCESS

1. The Wisconsin Department of Health Services (DHS) is in the process of renewing everyone's Medicaid health coverage if they are still eligible. The DHS has notified some people about their opportunity to renew their health coverage and will be notifying the rest in the next few months.

Which of the following best describes the status of your Medicaid or BadgerCare renewal process in the last year?

- ○ Your coverage was automatically renewed by the State DHS
- ○ You were able to renew your coverage on your own
- ○ You tried to renew, but you were not successful
- ○ You are still waiting to be notified about when to renew your coverage
- ○ You opted not to renew your coverage
- ○ You are not sure whether or not your coverage has been renewed

2. Please tell us how much you agree or disagree with the following statements about the Medicaid renewal process.

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not applicable
a. Messages sent to you about renewal were easy to understand.	○	○	○	○	○
b. You had plenty of notice that you would need to renew your coverage.	○	○	○	○	○
c. The renewal process was easy for you to complete.	○	○	○	○	○
d. You are confident that you can successfully complete your renewals in the future.	○	○	○	○	○
e. You were able to get the help you needed.	○	○	○	○	○
f. You understood what eligibility information was needed and how to submit it.	○	○	○	○	○

B. YOUR HEALTH CARE COVERAGE

3. In the past 12 months, how many months did you have some kind of health care coverage?

- ○ No health care coverage during the last 12 months
- ○ 1 to 2 months of health care coverage
- ○ 3 to 5 months of health care coverage
- ○ 6 to 8 months of health care coverage
- ○ 9 to 11 months of health care coverage
- ○ Covered for all of the last 12 months → **Go to Question 5 on page 2**

4. If you did not have health care coverage in some or all of the past 12 months, what are the reasons you did not have coverage?

Was it because…

	Yes	No
a. …you did not qualify for Medicaid or BadgerCare anymore?	○	○
b. …you could not afford payments to remain on Medicaid or BadgerCare?	○	○
c. …you were not offered health care coverage from an employer?	○	○
d. …you were not able to afford the health care coverage an employer offered?	○	○
e. …you did not have access to any health care coverage?	○	○
f. …you did not want health care coverage?	○	○
g. …you did not know how to find information on available health care coverage options?	○	○
h. …you did not have the time to get health care coverage?	○	○
i. …of some other reason?	○	○

5. Which of the following types of health care coverage do you currently have?

Are you currently covered by...

	Yes	No
a. …Wisconsin Medicaid or BadgerCare?	○	○
b. …your employer or a family member's employer?	○	○
c. …a private plan you pay for yourself?	○	○
d. …a health plan from Healthcare.gov, the federal Marketplace?	○	○
e. …some other type of health care coverage?	○	○
f. …no current coverage?	○	○

C. MEDICAID OR BADGERCARE EXPERIENCES

Please answer these questions only if you are <u>currently enrolled</u> in Medicaid or BadgerCare. If you are NOT currently enrolled in Medicaid or BadgerCare, skip to Question 14 on page 4.

6. A health insurance co-pay is the amount you or a family member pays each time you receive health care, for example, if Medicaid or BadgerCare requires you to pay anything for a doctor visit or prescription drugs.

In the past 12 months, did you or your family ever pay a co-pay for services covered by Medicaid or BadgerCare?

○ Yes
○ No

7. To the best of your knowledge, which of these is true for your visits to the emergency room?

○ You never need to pay a co-pay
○ You only need to pay a co-pay for care that the doctor determines was not an emergency
○ You always need to pay a co-pay

8. **In the last 12 months, have you ever been so worried about a co-pay amount that you have not gone to the emergency room?**

   ◯ Yes
   ◯ No

9. **In the last 12 months, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay premiums or co-pays?**

   ◯ Yes
   ◯ No

10. **Some people find information about health care coverage confusing. Please tell us how much you agree or disagree with the following statements about your health care coverage using Medicaid or BadgerCare.**

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not applicable
a. You understand the letters you receive about your health care coverage from the Medicaid or BadgerCare program.	◯	◯	◯	◯	◯
b. You understand what payments are required.	◯	◯	◯	◯	◯
c. You understand who is eligible for health care coverage using Medicaid or BadgerCare.	◯	◯	◯	◯	◯
d. You understand how changes to your health care coverage through Medicaid or BadgerCare might affect you.	◯	◯	◯	◯	◯

11. **Starting in January 2024, Wisconsin will give certain adults an optional health survey called the BadgerCare Plus Health Survey when they enroll or renew their Medicaid or BadgerCare coverage. How much have you heard or read about the BadgerCare Plus Health Survey?**

    ◯ A lot
    ◯ A little
    ◯ Nothing at all

12. **In the past 12 months, have you taken the BadgerCare Plus Health Survey from Medicaid or BadgerCare?**

    ◯ Yes
    ◯ No

13. Residential treatment is a place where people stay overnight to receive alcohol or drug treatment. To your knowledge, does your insurance provide coverage for residential treatment for alcohol or drug use?

◯ Yes
◯ No
◯ Don't know

D. EXPERIENCES AFTER MEDICAID

Please answer these questions if you <u>are not currently enrolled</u> in Medicaid or BadgerCare. If you are currently enrolled in Medicaid or BadgerCare, skip to Question 17 below.

14. When you lost your Medicaid or BadgerCare coverage did a caseworker or health insurance navigator help you find a new source of insurance?

◯ Yes
◯ No

15. When you lost Medicaid or BadgerCare, did any of the following happen to you?

	Yes	No
a. You had to stop taking medications that had been prescribed to you.	◯	◯
b. You had to cancel medical appointments that you had planned to attend.	◯	◯
c. You avoided going to the doctor to get assessed for a new health problem.	◯	◯
d. You paid out of pocket for medical expenses that Medicaid used to pay for.	◯	◯

16. Do you expect to apply for Medicaid or BadgerCare again in the next 12 months?

◯ Yes
◯ No
◯ Not sure

E. YOUR HEALTH CARE

17. The next few questions ask about your health care experiences.

Is there a place you usually go for your health care?

◯ Yes
◯ No

18. In the last 12 months, did you get all the health care you needed?

◯ Yes
◯ No
◯ You did not need any health care in the last 12 months

19. Was there a time in the last 12 months when you needed prescription medication?

- ◯ Yes
- ◯ No

20. In the last 12 months, did you get all the prescription medications you needed?

- ◯ Yes
- ◯ No
- ◯ You did not need prescription medications in the last 12 months

21. How long has it been since you last visited a dentist or a dental care provider for any reason? Include visits to dental specialists, such as orthodontists.

- ◯ Less than 12 months ago
- ◯ Between 1 and 5 years ago
- ◯ More than 5 years ago
- ◯ You have never visited a dentist or dental care provider
- ◯ Not sure

22. In the last 12 months, not including hospital or emergency room visits or dental care, about how many times did you visit a doctor's office, an urgent care or walk-in clinic, or other health care provider in-person to get care for yourself? If you are not sure, please give your best guess.

- ◯ 0 times
- ◯ 1 to 3 times
- ◯ 4 to 8 times
- ◯ 9 or more times

23. Do any of your health care providers offer telephone or video appointments, so that you don't need to visit the office or building in person? Telephone or video visits are sometimes referred to as "telehealth visits," "virtual check-ins," or "e-visits."

- ◯ Yes
- ◯ No
- ◯ Don't know

24. In the last 12 months, how many times did you go to an emergency room to get care for yourself? Please give your best guess.

○ 0 times → **Go to Question 26 below**
○ 1 to 3 times
○ 4 or more times

25. Which of these apply to your last emergency room visit?

Did you visit the emergency room because...

	Yes	No
a. …you did not have another place to go for care?	○	○
b. …your health provider advised you to go?	○	○
c. …the problem was too serious for the doctor's office or clinic?	○	○
d. …you get most of your care at the emergency room?	○	○
e. …or some other reason?	○	○

26. In the last 12 months, did you ever stay in a hospital overnight? Do not include hospital stays to deliver a baby.

○ Yes
○ No

27. In the past 12 months, did you have problems paying any medical bills, including bills for doctors, dentists, hospitals, therapists, medical equipment, nursing home, or home care?

○ Yes
○ No

28. In the last 12 months, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?

○ Yes
○ No

29. How satisfied or dissatisfied are you with the following aspects of your current health care coverage?

	Very satisfied	Somewhat satisfied	A little satisfied	Very dissatisfied
a. The range of health care services available	○	○	○	○
b. The choice of doctors and other providers	○	○	○	○
c. Your health care costs	○	○	○	○
d. Your current or most recent health care coverage	○	○	○	○

F. YOUR HEALTH

30. How often do you use seat belts when you drive or ride in a car?

- ◯ Always
- ◯ Nearly always
- ◯ Sometimes
- ◯ Seldom
- ◯ Never
- ◯ Never drive or ride in a car
- ◯ Don't know / Not sure

31. Thinking back over the past 4 weeks, in how many weeks did you participate in physical activities on at least 2 days and for at least 3 hours total during the week? Physical activity is defined as walking, dancing, running, strenuous work or sports.

- ◯ 0 weeks
- ◯ 1 week
- ◯ 2 weeks
- ◯ 3 weeks
- ◯ 4 weeks
- ◯ Don't know / Not sure

32. How would you rate your overall habits of eating healthy foods?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

33. This question is about your physical health. Physical health includes physical illness and injury.

In general, would you say your <u>physical</u> health is…

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

34. This question is about your mental health. Mental health includes stress, depression, and problems with emotions.

In general, would you say your <u>mental</u> health is…

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

35. About how long has it been since you last had your blood cholesterol checked?

- ◯ Within the last 12 months
- ◯ More than 12 months ago
- ◯ Never

36. In the past 12 months, have you had either a flu vaccine that was sprayed in your nose or a flu shot injected in your arm?

- ◯ Yes
- ◯ No

37. Do you currently smoke cigarettes every day, some days, or not at all?

- ◯ Every day
- ◯ Some days
- ◯ Not at all → **Go to Question 40 below**

38. In the past 12 months, have you stopped smoking for more than one day because you were trying to quit smoking?

- ◯ Yes
- ◯ No

39. In the past 12 months, has a doctor, dentist, or other health professional advised you about ways to stop smoking or prescribed medication to help you quit?

- ◯ Yes
- ◯ No

40. Do you use e-cigarettes or other electronic vaping products every day, some days, or not at all?

- ◯ Every day
- ◯ Some days
- ◯ Not at all

41. Does a physical, mental, or emotional condition now limit your ability to work at a job?

- ◯ Yes
- ◯ No

42. Over the past two weeks, how often have you been bothered by having little interest or pleasure in doing things?

- ◯ Not at all
- ◯ A few times
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Don't know

43. Over the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?

- ◯ Not at all
- ◯ A few times
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Don't know

44. In the last 12 months, have you ever drank or used drugs more than you meant to?

- ◯ Yes
- ◯ No

45. In the last 12 months, have you felt you wanted or needed to cut down on your drinking or drug use?

- ◯ Yes
- ◯ No

If you answered "YES" to either Question 44 or Question 45, then please continue to Question 46.

If you answered "NO" to both Question 44 and Question 45, then skip to Question 51 on page 11.

46. In the past 12 months, did you want or need treatment or counseling for your alcohol or drug use?

- ◯ Yes
- ◯ No ⟶ **Go to Question 51 on page 11**

47. In the past 12 months, did you receive treatment or counseling for alcohol or drug use?

○ Yes → **Go to Question 49 below**

○ No

48. Which of these statements explain why you did not get the treatment or counseling you needed or wanted for your alcohol or drug use?

	Yes	No
a. You had no health care coverage and you couldn't afford the cost.	○	○
b. You did have health care coverage, but it didn't cover treatment for alcohol or drug use, or didn't cover the full cost.	○	○
c. You had no transportation to treatment or counseling, or the treatments or counseling were too far away, or the hours were not convenient.	○	○
d. You didn't find the type of treatment or counseling you wanted.	○	○
e. There were no appointments available for the treatment or counseling provider you wanted to see.	○	○
f. You were not ready to stop using alcohol or drugs.	○	○
g. There were no openings in the treatment or counseling programs.	○	○
h. You did not know where to go to get treatment or counseling.	○	○
i. You were concerned that getting treatment or counseling might cause your neighbors or community to have a negative opinion of you.	○	○
j. You were concerned that getting treatment or counseling might have a negative effect on your job.	○	○
k. Some other reason or reasons.	○	○

If you did not receive treatment for alcohol or drug use in the past 12 months, skip to Question 51 on page 11.

49. If you received treatment in the past 12 months, at which of the following settings did you receive treatment for alcohol or drug use?

Did you receive treatment at …

	Yes	No
a. …a hospital?	○	○
b. …a residential drug or alcohol rehab facility?	○	○
c. …an outpatient mental health treatment center?	○	○
d. …an outpatient drug or alcohol treatment center?	○	○
e. …a doctor's office?	○	○
f. …a jail or prison?	○	○
g. …some other place?	○	○

50. If you received treatment in the past 12 months, please tell us how much you agree or disagree with these statements about your last experience with substance use treatment:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not applicable
a. The program was a comfortable and safe place to get treatment.	○	○	○	○	○
b. The level of care and the range of services was suitable for your needs.	○	○	○	○	○
c. The staff had enough training and knowledge to meet your needs.	○	○	○	○	○
d. You could have received the care you needed in a different setting.	○	○	○	○	○
e. The treatment was long enough to meet your needs.	○	○	○	○	○
f. The requirements of the program were a burden to you.	○	○	○	○	○

G. ABOUT YOU

51. The next few questions are about you.

How would you describe your gender?

○ Male
○ Female
○ You prefer to describe yourself as ☐

52. What is your current age?

☐ Years

53. Are you currently employed or self-employed?

○ Yes, employed by someone else
○ Yes, self-employed
○ Not currently employed → **Go to Question 55 on page 12**
○ Retired → **Go to Question 55 on page 12**

54. About how many hours per week, on average, do you work at your current job(s)?

○ You work less than 20 hours per week
○ You work 20 to 29 hours per week
○ You work 30 or more hours per week

55. In 2022, including any cash assistance or unemployment benefits you may have received, and the income of all members of your household, what was your total annual household income before taxes? If you are not sure, please give your best guess.

- ○ Less than $5,000
- ○ $5,000 to $9,999
- ○ $10,000 to $14,999
- ○ $15,000 to $19,999
- ○ $20,000 to $29,999
- ○ $30,000 to $49,999
- ○ $50,000 or higher

56. In the past 12 months, did you or any member of your household receive benefits from FoodShare or SNAP (the Supplemental Nutrition Assistance Program) using your Quest card? Do NOT include WIC, the School Lunch Program, or assistance from food banks.

- ○ Yes
- ○ No

57. In the past 12 months, did you or any member of your household receive benefits from the Wisconsin's Temporary Assistance for Needy Families Program, also known as Wisconsin Works, or W-2?

- ○ Yes
- ○ No

58. Are you Hispanic, Latino, or of Spanish origin?

- ○ Yes
- ○ No

59. Check all of the following that describe your race:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other ⟶ Please tell us: _____

60. What is the highest level of education you have completed? Select one answer only.

- ○ Less than high school
- ○ High school diploma or General Education Development (GED) certificate
- ○ Vocational training or 2-year degree
- ○ Some college but no degree
- ○ A 4-year college degree or more

61. Do you currently live…

- ◯ …alone?
- ◯ …with your partner or spouse?
- ◯ …with your parents?
- ◯ …with other relatives, including children?
- ◯ …with friends or roommates?
- ◯ …in some other situation?

62. Of the family members living in your home, how many are under age 19?

☐ family member(s) in my home are under age 19

63. Do you have any children under age 19 who you financially support, but who do not live in your home?

- ◯ Yes
- ◯ No

Thank you for participating. When you have finished your survey, please place it in the included postage-paid envelope and drop it in the mail.

ATTACHMENT 3: 2024 MEDICAID BENEFICIARY SURVEY DATA TABLES

Attachment 3 includes the frequency distributions for all questions administered through the 2024 Medicaid Beneficiary Survey for the BadgerCare Reform demonstration. Question wording is abbreviated in the tables below, but the full question wording can be found in the survey in **Attachment 2**. Full details on the survey methodology can be found in the Methods section of the main report.

The survey was administered to all groups of participants in the demonstration including childless adults (CLAs), the comparison group of parents, a disenrolled group, and additional adult Medicaid members with a probable substance use need in the Medicaid claims data. The disenrolled group includes individuals who had been enrolled as CLAs during the preceding year. When questions were not applicable to a group of participants, they were instructed to skip those questions. Thus, the number of responses varies across the data tables within this attachment.

The survey question numbers are provided to help reference the survey in Attachment 2 if needed. The data tables are organized by topic and do not necessarily follow the question sequence in the survey, but all question results are included.

Frequencies are weighted to account for differential survey non-response by demographic groups. P-values represent pairwise t-test or chi-squared test results between CLAs, parents, and the disenrolled group.

Table A1. Medicaid Renewal Process

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
1. Status of Medicaid renewal process in the last year					
Coverage was automatically renewed by the state DHS.	28.9%	30.1%	0.464	5.2%	<0.001
Were able to renew your coverage on your own.	39.5%	43.6%		8.6%	
Tried to renew, but you were not successful.	3.1%	2.5%		34.9%	
Still waiting to be notified about when to renew your coverage.	10.0%	8.1%		2.4%	
Opted not to renew your coverage.	2.5%	0.6%		31.7%	
Not sure whether or not your coverage has been renewed.	16.1%	15.2%		17.2%	
2. Do you agree with these statements about Medicaid renewal process?					
a. Messages sent to you about renewal were easy to understand					
Strongly agree	30.5%	38.4%	0.172	24.7%	0.014
Agree	53.7%	49.9%		57.0%	
Disagree	6.0%	4.2%		10.7%	
Strongly disagree	2.5%	3.5%		4.0%	
Not applicable	7.3%	4.1%		3.6%	
b. You had plenty of notice that would need to renew coverage					
Strongly agree	32.6%	40.2%	0.146	28.8%	0.007
Agree	48.5%	48.3%		50.1%	
Disagree	9.1%	4.9%		15.1%	
Strongly disagree	4.0%	3.3%		4.5%	
Not applicable (if volunteered)	5.9%	3.2%		1.4%	
c. Renewal process was easy to complete					
Strongly agree	26.8%	35.5%	0.082	16.7%	<0.001
Agree	51.5%	46.3%		41.5%	
Disagree	8.8%	10.1%		19.4%	
Strongly disagree	2.7%	2.6%		8.7%	
Not applicable (if volunteered)	10.2%	5.5%		13.7%	
d. You are confident you can successfully complete renewals in the future					
Strongly agree	29.7%	37.1%	0.152	25.3%	0.047
Agree	53.9%	50.4%		49.4%	
Disagree	8.0%	6.5%		13.0%	
Strongly disagree	1.9%	3.1%		3.6%	
Not applicable (if volunteered)	6.5%	2.9%		8.6%	
e. You were able to get the help you needed					
Strongly agree	28.2%	39.6%	0.106	19.5%	<0.001
Agree	51.2%	43.0%		43.6%	

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
Disagree	7.0%	5.3%		17.7%	
Strongly disagree	2.1%	2.4%		6.5%	
Not applicable (if volunteered)	11.6%	9.6%		12.7%	
f. Understood eligibility information needed and how to submit it					
Strongly agree	25.6%	36.0%	0.039	23.6%	0.127
Agree	53.2%	50.5%		53.7%	
Disagree	10.6%	5.9%		14.6%	
Strongly disagree	3.2%	3.4%		4.4%	
Not applicable (if volunteered)	7.4%	4.2%		3.6%	

Note: Responses about the Medicaid renewal process were collected during the February-August 2024 survey response period.

Table A2. Health Care Coverage

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
3. Health care coverage in prior 12 months					
No health care coverage during last 12 months	2.8%	0.0%	0.072	5.0%	<0.001
1 to 2 months of health care coverage	2.1%	0.8%		5.4%	
3 to 5 months of health care coverage	1.3%	0.0%		5.7%	
6 to 8 months of health care coverage	2.2%	1.8%		11.0%	
9 to 11 months of health care coverage	5.0%	1.9%		14.1%	
Covered for all of last 12 months	86.8%	95.5%		58.8%	
5. Current health care coverage					
Wisconsin Medicaid or BadgerCare	100.0%	100.0%		0.0%	<0.001
Employer or a family member's employer	11.0%	6.9%	0.134	35.0%	<0.001
A private plan	3.9%	1.0%	0.025	17.3%	<0.001
Health plan from Health Care.gov	8.7%	1.9%	<0.001	15.4%	<0.001
Some other type of health care coverage	6.5%	6.4%	0.969	17.5%	<0.001
No current coverage	0.0%	0.0%		45.8%	<0.001

Table A3. Reasons for Not Having Health Care Coverage

	CLA (N=144)	Parents (N=27)		Disenrolled (N=162)	
	%	%	*p* value	%	*p* value
4. Reasons for not having coverage					
Did not qualify for Medicaid anymore	38.6%	7.7%	0.051	66.7%	0.004
Could not afford payments to remain on Medicaid	36.3%	17.1%	0.366	19.7%	0.055
Were not offered coverage from an employer	35.2%	55.5%	0.339	39.7%	0.648
Not able to afford the health care coverage	33.3%	8.5%	0.114	35.1%	0.866
Did not have access to any health care coverage	34.7%	49.9%	0.500	37.0%	0.826
Did not want health care coverage	10.8%	6.8%	0.679	15.4%	0.475
Did not know how to find information on available coverage	41.4%	15.0%	0.124	31.9%	0.328
Did not have the time to get health care coverage	34.3%	0.0%	0.094	26.6%	0.428
Some other reason	36.2%	63.1%	0.235	40.5%	0.635

Note: Responses were only collected from beneficiaries who reported having less than 12 months coverage in Question 3.

Table A4. Knowledge of Program Requirements

	CLA (N=995)	Parents (N=299)	
	%	%	*p* value
7. Which is true of visits to the emergency room?			
Never need to pay a co-pay	81.3%	86.1%	0.309
Pay a co-pay only if doctor determines it was not an emergency	11.5%	6.5%	
Always need to pay a co-pay	7.2%	7.4%	
11. How much heard about the BadgerCare Plus Health Survey?			
A lot	5.5%	3.5%	0.626
A little	21.2%	19.3%	
Nothing at all	73.4%	77.1%	
12. Taken the BadgerCare Plus Health Survey from Medicaid in last 12 months?	8.8%	6.7%	0.451
13. Does insurance provide coverage for residential treatment for alcohol or drug use?	14.2%	14.6%	0.937
10. Level of agreement with statements about health care coverage using Medicaid?			
a. You understand the letters about health care coverage from Medicaid			
Strongly agree	27.0%	32.6%	0.399
Agree	59.6%	53.1%	
Disagree	8.6%	10.4%	
Strongly disagree	3.2%	3.3%	
Not applicable	1.7%	0.5%	
b. You understand what payments are required			
Strongly agree	20.9%	30.9%	0.022
Agree	58.7%	55.3%	
Disagree	12.7%	6.7%	
Strongly disagree	2.9%	4.1%	
Not applicable	4.9%	3.1%	
c. You understand who is eligible for health care coverage using Medicaid			0.199
Strongly agree	24.2%	34.0%	
Agree	60.7%	52.1%	
Disagree	10.4%	10.0%	
Strongly disagree	3.7%	3.3%	
Not applicable	1.0%	0.6%	
d. You understand how changes to health coverage through Medicaid might affect you			
Strongly agree	21.3%	27.6%	0.332
Agree	53.9%	51.9%	
Disagree	19.0%	15.1%	
Strongly disagree	4.9%	5.1%	
Not applicable	1.0%	0.3%	

Note: Disenrolled individuals are not included in the table because they were not asked questions about Medicaid program requirements. Only “yes” responses reported for Questions 12–13.

Table A5. Experiences with the Emergency Room

	CLA (N=995)	Parents (N=299)	
	%	%	*p* value
In the last 12 months…….			
6. Ever paid a copay for Medicaid or BadgerCare	37.1%	21.6%	<0.001
8. Avoided emergency room due to copay	8.9%	8.4%	0.853
9. Borrowed money or had trouble paying bills due to premiums or copay	6.7%	7.4%	0.798
24. Number of times went to the emergency room (ER) in last 12 months			
0 times	55.5%	51.5%	0.102
1–3 times	38.1%	37.4%	
4 or more times	6.4%	11.2%	
Of those who had an ER visit in Question 24……	**(N=359)**	**(N=128)**	
25. Reason for most recent ER visit (choose all that apply):			
a. Did not have another place to go	30.5%	41.6%	0.108
b. Your health provider asked you to go	35.2%	44.2%	0.192
c. The problem was too serious for doctor's office or clinic	72.6%	72.8%	0.973
d. You get most of your care at the ER	26.8%	29.5%	0.709
e. Other reason for most recent ER visit	45.9%	44.1%	0.803

Note: Disenrolled individuals are not included in the table because they were not asked questions about Medicaid experiences. Only "yes" responses reported for Questions 6, 8, and 9.

Table A6. Experiences After Disenrolling from Medicaid

	Disenrolled (N=381) %
14. Did caseworker help you find a new source of insurance?	15.4%
16. Expect to apply for Medicaid again in the next 12 months?	31.1%
15. When lost Medicaid, did any of the following happen to you:	
a. Had to stop taking medications	32.8%
b. Had to cancel medical appointments had planned to attend	42.6%
c. Avoided going to the doctor for a new health problem	49.3%
d. Paid out of pocket for medical expenses that Medicaid used to pay	49.5%

Note: Only “yes” responses reported for all questions.

Table A7. Access to Care and Recent Health Care Use

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
17. Has usual place to go for health care	90.4%	89.9%	0.873	83.0%	0.006
18. Got all needed health care in last 12 months	82.8%	80.7%	0.845	66.1%	<0.001
19. Needed prescription medication in last 12 months	82.3%	82.7%	0.901	73.6%	0.008
20. Got all needed prescription medications in last 12 months	78.9%	75.6%	0.146	58.4%	<0.001
21. Time since last dental visit					
Less than 12 months ago	45.3%	46.8%	0.551	43.9%	0.012
Between 1 and 5 years ago	30.7%	31.5%		39.3%	
More than 5 years ago	18.6%	17.8%		15.0%	
Never visited a dental care provider	1.7%	2.5%		1.0%	
Not sure	3.7%	1.4%		0.9%	
22. In-person outpatient visits in last 12 months					
0 visits	15.1%	10.3%	0.190	19.9%	0.133
1 to 3 visits	43.5%	45.9%		45.0%	
4 to 8 visits	24.4%	22.2%		23.8%	
9 or more visits	17.1%	21.6%		11.3%	
23. Any health care providers offer telephone or video visits as options	49.3%	61.2%	0.015	60.0%	<0.001
26. Stayed in hospital overnight in last 12 months	13.6%	14.1%	0.862	8.2%	0.027
27. Had problems paying medical bills in last 12 months	13.9%	17.4%	0.252	27.0%	<0.001
28. Had treatment refused due to overdue medical bills in last 12 months	1.9%	2.4%	0.714	2.8%	0.400

Note: Only “yes” responses reported for Questions 17–20 and 23–28.

Table A8. Satisfaction with Current Health Care Coverage

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
29a. Range of health care services available					
Very satisfied	52.9%	51.0%	0.951	32.4%	<0.001
Somewhat satisfied	35.8%	37.5%		42.2%	
Somewhat dissatisfied	8.1%	7.7%		17.2%	
Very dissatisfied	3.2%	3.9%		8.1%	
29b. Choice of doctors and other providers					
Very satisfied	51.9%	46.7%	0.681	35.8%	0.006
Somewhat satisfied	34.7%	38.7%		45.6%	
Somewhat dissatisfied	10.1%	10.5%		15.5%	
Very dissatisfied	3.4%	4.2%		3.1%	
29c. Health care costs					
Very satisfied	66.2%	67.5%	0.763	25.1%	<0.001
Somewhat satisfied	23.3%	24.7%		32.2%	
Somewhat dissatisfied	6.3%	4.4%		20.1%	
Very dissatisfied	4.3%	3.4%		22.6%	
29d. Current or most recent health care coverage					
Very satisfied	60.5%	63.4%	0.872	25.1%	<0.001
Somewhat satisfied	31.3%	29.8%		41.5%	
Somewhat dissatisfied	5.3%	5.0%		22.0%	
Very dissatisfied	2.8%	1.8%		11.5%	

Note: The “somewhat dissatisfied” category was used in the follow up phone survey. However, “a little satisfied” was erroneously used in the mail survey. The phone and mail survey responses are combined as “somewhat dissatisfied” in the results.

Table A9. Physical Health Status

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
33. Self-rated physical health					
Excellent	5.5%	7.6%	0.007	7.7%	0.061
Very good	22.7%	18.2%		28.3%	
Good	32.9%	46.5%		35.8%	
Fair	28.9%	20.6%		21.3%	
Poor	10.0%	7.1%		7.0%	
32. Self-rated habit for eating healthy foods					
Excellent	9.5%	9.0%	0.490	8.7%	0.082
Very good	19.7%	20.2%		20.1%	
Good	38.4%	44.9%		29.2%	
Fair	24.5%	19.2%		32.3%	
Poor	7.9%	6.6%		9.7%	
31. Number of weeks in the past 4 weeks involving physical activity					
0 weeks	15.9%	14.2%	0.041	9.3%	<0.001
1 weeks	9.6%	6.9%		5.4%	
2 weeks	10.5%	6.4%		9.0%	
3 weeks	7.3%	10.4%		5.4%	
4 weeks	48.0%	57.5%		66.7%	
Don’t know	8.7%	4.5%		4.2%	
35. How long since last blood cholesterol check?					
Within the last 12 months	67.6%	52.3%	0.001	56.7%	0.005
More than 12 months ago	21.8%	31.7%		32.3%	
Never	10.6%	15.9%		11.0%	
36. Had flu vaccine in past 12 months	38.0%	28.0%	0.013	28.8%	0.011
30. How often do you use seat belts?					
Always	81.8%	85.8%	0.076	86.0%	0.404
Nearly always	10.9%	9.7%		7.2%	
Sometimes	3.0%	4.1%		2.9%	
Seldom	2.0%	0.0%		1.7%	
Never	1.7%	0.4%		2.3%	
Never drive or ride in a car	0.2%	0.0%		0.0%	
Don’t know/ not sure	0.3%	0.0%		0.0%	
41. Does physical, mental, or emotional condition limit ability to work?	43.4%	32.8%	0.012	20.6%	<0.001

Note: Only “yes” responses reported for Questions 35 and 41.

Table A10. Mental Health Status

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
34. Self-rated mental health					
Excellent	8.0%	9.2%	0.870	11.8%	0.111
Very good	19.7%	21.1%		13.2%	
Good	32.4%	33.8%		31.0%	
Fair	27.4%	23.5%		31.2%	
Poor	12.4%	12.3%		12.8%	
42. Little interest or pleasure in doing things in last 2 weeks					
Not at all	29.7%	35.8%	0.109	31.5%	0.707
A few times	39.6%	33.1%		41.6%	
More than half the days	14.6%	10.5%		13.2%	
Nearly every day	14.0%	17.6%		12.8%	
Don't know	2.0%	3.0%		1.0%	
43. Feeling down, depressed, or hopeless in last 2 weeks					
Not at all	36.4%	39.3%	0.225	36.4%	0.466
A few times	38.7%	34.9%		40.5%	
More than half the days	12.7%	8.7%		8.9%	
Nearly every day	10.9%	15.0%		13.3%	
Don't know	1.3%	2.0%		0.9%	
PHQ2 score (calculated based on responses to Questions 42–43)					
Not likely to have major depressive disorder	67.5%	70.1%	0.519	70.0%	0.504
Likely to have major depressive disorder	32.5%	29.9%		30.0%	

Table A11. Tobacco Use Status

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
37. Currently smoke cigarettes					
Every day	17.5%	17.7%	0.597	15.0%	0.703
Some days	9.9%	7.6%		10.5%	
Not at all	72.7%	74.8%		74.5%	
40. Currently use e-cigarettes or other vaping products					
Every day	6.0%	6.0%	0.712	9.2%	0.031
Some days	8.5%	6.8%		13.0%	
Not at all	85.5%	87.2%		77.7%	
Among individuals who smoke identified in Question 37……..	**(N=270)**	**(N=73)**		**(N=94)**	
38. Stopped smoking for more than one day while trying to quit in past 12 months	48.9%	70.8%	0.003	57.4%	0.280
39. Advised by health professional about ways to stop smoking in past 12 months	56.9%	66.4%	0.207	54.1%	0.716

Table A12. Identification of Substance Use Needs

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
44. In the last 12 months, have you ever drank or used drugs more than you meant to?					
Yes	11.5%	6.8%	0.045	13.0%	0.568
No	88.5%	93.2%		87.0%	
45. In the last 12 months, have you felt you wanted or needed to cut down on your drinking or drug use?					
Yes	13.4%	7.0%	0.023	16.5%	0.270
No	86.6%	93.0%		83.5%	

Table A13. Substance Use Treatment Status

	Any Adult With a SU Need
	(N=282)
46. Wanted or needed treatment for drugs or alcohol in past 12 months	41.9%
	(N=99)
47. Received treatment for alcohol or drugs in past 12 months	74.0%
	(N=23)
48. Reasons for not receiving treatment or counseling when needed/wanted	
a. No health care and couldn't afford the cost	50.3%
b. Health care didn't cover treatment for SUD	34.0%
c. No transportation to treatment or hours were inconvenient	50.8%
d. Didn't find the type of treatment wanted	54.1%
e. No appointments available for desired provider	19.3%
f. Not ready to stop using alcohol or drugs	41.0%
g. No openings in the treatment programs	24.6%
h. Did not know where to go to get treatment	59.2%
i. Concerned about community having a negative opinion of you	32.2%
j. Might have a negative effect on your job	23.9%
k. Other reason	52.5%
	(N=76)
49. Settings where treatment for alcohol/drug use was received in past 12 months	
a. At hospital	29.4%
b. Residential rehabilitation facility	30.6%
c. Outpatient mental health treatment center	51.0%
d. Outpatient drug or alcohol treatment center	68.4%
e. Doctor's office	39.5%
f. Jail or prison	7.5%
g. Some other place	21.9%

Notes: Only "yes" responses reported for all questions. "Any Adult with a SU Need" is defined as any respondent replying "yes" to Question 44 or 45 in Table A12. Only respondents who answered "yes" to Question 46 were asked Question 47 about receiving SU treatment. Only respondents who answered "no" to Question 47 were asked Question 48 about why they did not receive SU treatment. Only respondents who answered "yes" to Question 47 were asked Question 49 about the setting for their SU treatment.

Table A14. Satisfaction with Substance Use Treatment

	Any Adult With a SU Need (N=282)
Level of agreement with statements about experience with SUD treatment in past 12 months	
50a. Program was comfortable and a safe place	
Strongly agree	41.4%
Agree	40.0%
Disagree	8.1%
Strongly disagree	8.7%
Not applicable (if volunteered)	1.9%
50b. Level of care/range of services were suitable	
Strongly agree	31.3%
Agree	36.5%
Disagree	20.5%
Strongly disagree	9.8%
Not applicable (if volunteered)	1.9%
50c. Staff had enough training and knowledge	
Strongly agree	34.2%
Agree	27.3%
Disagree	21.3%
Strongly disagree	12.8%
Not applicable (if volunteered)	4.3%
50d. Could have received the care needed in a different setting	
Strongly agree	21.5%
Agree	43.5%
Disagree	25.1%
Strongly disagree	5.3%
Not applicable (if volunteered)	4.6%
50e. Treatment was long enough to meet needs	
Strongly agree	17.3%
Agree	50.1%
Disagree	11.7%
Strongly disagree	10.2%
Not applicable (if volunteered)	10.6%
50f. Requirements of the program were a burden	
Strongly agree	9.8%
Agree	13.5%
Disagree	54.5%
Strongly disagree	17.8%
Not applicable (if volunteered)	4.4%

Notes: “Any Adult with a SU Need” is defined as any respondent replying “yes” to Question 44 or 45 in Table A12.

Table A15. Respondent Demographic Characteristics

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
51. Gender					
Male	51.2%	18.3%	<0.001	50.4%	0.831
Female	47.1%	80.8%		48.4%	
Other (open specify)	1.7%	0.8%		1.2%	
52. Age					
18–29	23.4%	14.7%	<0.001	30.5%	<0.001
30–39	20.7%	39.0%		31.8%	
40–49	15.3%	36.9%		15.0%	
50–59	22.5%	8.2%		12.3%	
60–65	16.2%	0.4%		8.6%	
66+	1.8%	0.8%		1.7%	
58. Hispanic, Latino, or Spanish origin					
Yes	14.9%	18.3%	0.383	20.8%	0.104
No	85.1%	81.7%		79.2%	
59. Race					
White	59.7%	59.3%	0.843	55.7%	0.080
Black	18.9%	18.6%		17.1%	
Asian	2.5%	2.3%		3.7%	
Native American	2.4%	3.9%		5.8%	
Native Hawaiian	0.1%	0.3%		0.9%	
Other	16.3%	15.6%		16.8%	
60. Highest education level completed					
Less than high school diploma	14.8%	10.9%	0.329	8.8%	0.001
High school diploma/GED certificate	38.7%	36.2%		29.1%	
Vocational training or 2-year degree	12.0%	12.7%		12.7%	
Some college but no degree	19.2%	25.4%		25.4%	
A 4-year college degree or more	15.3%	14.8%		23.9%	
53. Currently employment status					
Employed by someone else	39.4%	30.1%	<0.001	68.1%	<0.001
Self-employed	10.2%	18.5%		10.9%	
Not currently employed	42.6%	49.8%		17.7%	
Retired	7.8%	1.7%		3.3%	
54. Hours worked per week					
Less than 20 hours per week	30.6%	25.3%	0.190	6.5%	<0.001
20 to 29 hours per week	23.2%	17.6%		11.4%	
30 or more hours per week	46.3%	57.1%		82.1%	
55. Total 2022 household income before taxes					
Less than $5,000	26.1%	30.7%	<0.001	15.0%	<0.001
$5,000 to $9,999	15.5%	10.3%		5.9%	
$10,000 to $14,999	19.4%	9.1%		12.1%	

	CLA (N=995)	Parents (N=299)		Disenrolled (N=381)	
	%	%	*p* value	%	*p* value
$15,000 to $19,999	10.9%	6.4%		10.4%	
$20,000 to $29,999	12.7%	13.5%		18.4%	
$30,000 to $49,999	10.0%	15.7%		20.2%	
$50,000 or higher	5.4%	14.3%		18.0%	
56. Foodshare or SNAP recipient in past 12 months	52.5%	60.8%	0.051	28.778	<0.001
57. Temporary Assistance for Needy Families (TANF) recipient in past 12 months	1.5%	6.9%	<0.001	0.976	0.471
61. Current living situation					
Alone	26.1%	5.4%	<0.001	29.6%	0.318
With partner or spouse	27.8%	34.0%	0.092	32.8%	0.156
With parents	19.9%	5.5%	<0.001	12.3%	0.009
With other relatives	9.3%	42.3%	<0.001	13.0%	0.116
With friends or roommates	8.4%	2.7%	0.005	4.4%	0.019
In some other situation	7.7%	7.8%	0.978	6.4%	0.555
62. Family members under 19 living in household					
0	86.4%	5.4%	<0.001	75.9%	0.035
1	6.6%	33.9%		11.2%	
2	3.4%	30.3%		8.6%	
3	2.1%	16.3%		2.6%	
4	1.6%	7.4%		0.5%	
5 or more	0.8%	6.8%		1.2%	
63. Financially supporting children under 19 living outside the household	7.6%	13.0%	0.046	10.4%	0.273

ATTACHMENT 4: 2022 QUALITATIVE INTERVIEW REPORT ON THE EMERGENCY DEPARTMENT COPAYMENT POLICY

A Report on the Results of the 2022-2023 BadgerCare In-depth Interview Study



Prepared for:
Institute for Research on Poverty
University of Wisconsin-Madison

Prepared by:
University of Wisconsin Survey Center
University of Wisconsin–Madison
September 2023

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SECTION 1: OVERVIEW

Introduction

This report presents the results of qualitative interviews with people who had participated in Wisconsin's BadgerCare (Medicaid) health insurance program. The purpose of the interviews was to evaluate their experiences with emergency department usage and opinions about program policy options. The report was requested by Tim Connor of the University of Wisconsin–Madison Institute for Research on Poverty and Brendan Saloner of the Johns Hopkins Bloomberg School of Public Health Department of Health Policy and Management (collectively referred to below as the client).

The interviews and the analysis in this report were carried out by the University of Wisconsin Survey Center (UWSC). A department in the College of Letters & Science of the University of Wisconsin–Madison, the UWSC assists researchers by providing high-quality survey and qualitative research services. Professor Jennifer Dykema is the director of the UWSC. Kelly Elver is the associate director. Karen Zoladz is the project management director. Senior Project Director Robert Cradock carried out the interviews and prepared this report, with assistance from Senior Project Director Kenneth Croes Ph.D. UWSC's Tracing, Coding, and Transcription Department Supervisor Tom Francis oversaw transcription. The UWSC project number for this project is p1646.

The study team thanks the respondents who shared their experiences and perspectives in the interviews.

Study Objectives

The objectives of the interviews were to gather information about BadgerCare members':

1. Access to and use of routine care and emergency department care.
2. Knowledge of BadgerCare program policies.
3. Opinions about possible BadgerCare policy changes regarding emergency department care.

Interview Question Guide Development

The UWSC worked collaboratively with the client to develop the interview question guide. Development took place in October-November 2022. The first 2 interviews, in mid-November 2022, were initially treated as a pilot. Small revisions were made to the question guide after

those first two interviews. Due to the minor changes involved, the first 2 interviews were included in the overall body of interviews analyzed. Appendix 1 shows a copy of the question guide.

Respondent Selection and Contact

This in-depth interview project was an extension of a mail and telephone survey of BadgerCare members (UWSC p1533). Persons who completed the mail or telephone questionnaire were asked whether they would be willing to be contacted for possible participation in the follow-up in-depth interview.

Eligibility criteria for the follow-up interview were as follows:

- The respondents must have been childless adults, according to BadgerCare definitions, when they were selected for the original sample.
- They must have completed the questionnaire.
- They must have visited an emergency department to get care for themselves within a 12-month period before they completed the questionnaire.

Due to the differing structure of the mail and telephone questionnaires, there were two filtering processes for determining follow-up eligibility. All those who completed a mail questionnaire were invited to volunteer for the in-depth interviews, via a pre-printed item at the end of the questionnaire. After data entry of those mail questionnaires, eligible respondents were identified from their self-reported answers. For those who completed a telephone survey interview, data collected by the computer-assisted telephone interviewing (CATI) system identified eligible respondents in real time as they answered questions. At the end of the telephone interview, those eligible were offered the chance to volunteer for the in-depth interviews. Both the mail and the telephone invitations included an offer of $50 for completing a follow-up interview, if eligible.

Volunteers provided either an email address, a telephone number, or both, for follow-up contacts. A total of 53 eligible mail and telephone respondents volunteered. The project director attempted to contact eligible volunteers for in-depth interview scheduling as their eligibility data became available. Up to 5 phone attempts were made for each case, although cases where respondents invited additional calls may have had more than 5, and cases unresolved at the end of the study may have had fewer. Up to 2 unsolicited email messages were sent to respondents who provided an email address.

The project had a goal of 24 completed interviews. After 24 interviews were completed, no further contact attempts occurred.

Each in-depth interview respondent was assigned the same case ID number that they had been assigned for the initial survey. After the completion of each interview, UWSC mailed a check for $50 to the respondent.

Field Report

Interviews ranged in length from 12 to 36 minutes, with a median length of 14 minutes.

SAMPLE OUTCOMES	N
Complete	24
Refused	6
Ineligible	2
No-show for scheduled interview	3
No response to contact attempts	17
Contact information provided was not valid	1
TOTAL	**53**

Analysis and Reporting

Interviews were audio recorded with the permission of respondents, and the audio recordings were transcribed verbatim. Qualitative analysis was conducted on the transcripts using NVivo software (Release 1.7).

A combination of inductive and deductive coding was used for developing the thematic analysis. Inductive codes were derived from respondents' answers. After inductive codes were established, codes for a few questions were revised and recategorized deductively in the following ways. Chronic medical condition codes were revised by a member of the client's team. Reasons for emergency department choices were revised in consultation with the client based on decision-making factors identified in another analysis of emergency department use (Uscher-Pines Lori, Pines J, Kellermann A, Gillen E, Mehrotra AP. Emergency department visits for nonurgent conditions: systematic literature review. Am J Manag Care. 2013;19(1), 47-59.).

Whenever possible, text segments were included in a response code such that their reason for inclusion is self-evident – i.e., one can read a quoted text segment and its response code and see the correspondence. However, respondents sometimes used terms in vague or unique ways.

Report Format

This report presents thematic coding of the exit interviews to facilitate further analysis by subject matter experts on the study team.

Each section of the report begins with a question as it appeared in the question guide. The question guide contained closed-ended and open-ended questions. The responses in closed-ended tables add up to the number of respondents (24), when a question was asked of everyone. The responses in open-ended tables do not add up to the same totals, however, because respondents could make as many points as they wished in their responses, and each point was coded separately.

Beneath each open-ended question, and beneath some closed-ended questions, there is an analytic description of responses to that question, usually using codes applied to the responses and selected excerpts of coded text. Not every open-ended response, and not every code, appears in the analysis, due to redundancies and responses with minimal content.

Section 3 shows all open-ended responses grouped by question and code.

Open-ended responses were lightly edited for clarity and concision but otherwise appear verbatim in italics. Where dialogue between an interviewer and a respondent is needed to convey context or meaning, the interviewer's words are shown in parentheses and are marked with "I:" Each open-ended response ends with a case ID number indicating the UWSC project number and the case number (e.g., p1646-4231).

The terms "emergency room / ER" instead of "emergency department / ED" were used during question development for ease of respondent understanding, and respondents used "emergency room / ER" in their answers. Coding derived from respondents' answers uses the terms that respondents did. Those instances of "emergency room / ER" are reported as-is here, although "emergency department / ED" is used in analytic descriptions.

Executive Summary

Prospective respondents for the BadgerCare in-depth follow-up interviews were selected because they had completed a mail or phone questionnaire for the previous portion of the 2022 BadgerCare study (UWSC p1533), they had visited an emergency department to get care for themselves in the previous twelve months, and they were childless adults as defined by the BadgerCare program. Twenty-four respondents completed the in-depth interviews, with a median interview time of fourteen minutes.

Respondents tended to have primary care access (23/24) and usage in the past twelve months (18/24), and also tended to have urgent care access (19/24). Most (20/24) knew which emergency department they would choose if required to. They generally reported being satisfied with their emergency care experiences, and only one had been told by emergency medical staff that they should have sought care elsewhere.

One-third of those interviewed (8/24) had previously avoided going to an emergency facility while in a health situation that they believed was an emergency. Reasons given by multiple respondents for that avoidance included expected delay or lack of treatment, prior bad ED experience, and thinking that the problem would resolve on its own.

No respondents had been required to pay ED copayments by BadgerCare, although two had received bills about which they were unsure. None were aware of recent changes to BadgerCare's coverage of emergency care, and none thought that BadgerCare members currently have to pay for ED services.

When asked about choosing a particular ED in a future hypothetical emergency, the most common reasons were based on their good opinions of care at that ED, either from first- or secondhand experiences. Another frequent type of reason for choosing a specific ED was convenience of access.

In response to another question about previous emergency department use, respondents explained why they had chosen an ED versus other non-emergency facilities. The ED's availability in terms of time of day or distance was the most common reason, and better access to care within the ED also came up in multiple interviews. The next most prevalent type of reasons for making that choice was perceived severity of their health condition.

Respondents were asked about their beliefs and attitudes about using emergency departments for non-emergency care. Most (17/24) thought that people often use an ED for routine care. Some respondents based that belief on personal knowledge of that action, while others described the thought processes that they believed those ED users would employ. Most respondents also thought that it is often difficult for patients to tell emergency from non-emergency health problems (19/24).

A proposed eight-dollar fee for BadgerCare members who visit emergency departments for non-emergency care seemed reasonable to most (21/24) respondents. Frequent reasons for agreement invoked the fee's affordability, its low amount compared to hospital costs, and its low cost relative to what others might pay. Some felt that the fee would be a deterrent to non-emergency use of ED services.

All respondents thought that an eight-dollar fee would not change their decision-making about ED use. Similar to answers about the reasonableness of the fee, many explanations for this response involved the low cost of the fee in absolute or relative terms. A frequent variation on the low cost aspect compared it to the high value of improved health outcomes.

In a final question that invited respondents to add other thoughts on the topics in the interview, respondents expressed satisfaction with the BadgerCare program, and also offered suggestions for how to make potential emergency health care situations work better for patients.

SECTION 2: INTERVIEW QUESTIONS, ANSWERS, AND ANALYSIS

Topic 1: Respondent Self-Description

The interview began with demographic questions about the respondents and their households, and about their insurance status. Since the pool of potential respondents was self-selected by mail & phone survey completers volunteering for the follow-up interview, and since the number of interviews is small, comparisons to Wisconsin's overall demographics are not feasible.

1011. How old are you?

RESPONSE CODES	N
20-29	6
30-39	7
40-49	2
50-59	4
60 or older	5
TOTAL	**24**

1012. What is the race that you identify with?

RESPONSES	N
Black	3
White	21
TOTAL	**24**

1013. What is the gender that you identify with?

RESPONSES	N
Male	12
Female	12
TOTAL	**24**

1014. What county do you live in?

RESPONSES	N
Adams	1
Burnett	1
Columbia	1
Dane	3
Dodge	1
Eau Claire	1
Jefferson	1
La Crosse	1
Milwaukee	5
Outagamie	2
Polk	1
Portage	1
Racine	1
Rock	1
Sauk	1
Sawyer	1
Waukesha	1
TOTAL	**24**

1014. County RUCC (Rural Urban Continuum Code) score

RESPONSE CODES	N
1	6
2	4
3	6
4	4
5	0
6	1
7	1
8	2
TOTAL	**24**

At the client's request, UWSC assigned a Rural Urban Continuum Code to each county, indicating its degree of urbanization. A code of 9 would indicate the most rural category, and a code of 1 would indicate the most urban.

1015. Do you live with other adults or children?

RESPONSES	N
Yes	16
No	8
TOTAL	**24**

1016. Who else do you live with?

RESPONSES	N
No one	8
Child(ren)	2
Parent(s)	6
Roommate, including siblings	4
Spouse/partner, including their children	4
TOTAL	**24**

Most respondents shared a household with other family members.

1017. Do you currently work?

RESPONSES	N
Yes	15
No	9
TOTAL	**24**

1018. What is your occupation?

RESPONSES	N
Accounts receivable	1
Artist	1
Auto parts store sales and installation	1
Baker	1
CNC operator in factory	1
Convenience store stocker	1
Customer care rep	1
Job coach	1
Landscaper	1
Scientist	1
Store manager	1
Utility worker	1
Waiter	1
Window cleaner	1
Writer	1
Not applicable	9
TOTAL	**24**

Nearly two-thirds of respondents were employed, with a wide variety of occupations.

1019. Who in your household is covered by BadgerCare?

RESPONSES	N
Self	21
Self & child	1
Self & parent	1
Child	1
TOTAL	**24**

All respondents were covered by BadgerCare, except for one who said that she had recently left the program. That respondent was still eligible for both the mail/phone and in-depth interview portions of the study, since she had been a BadgerCare member at the time of selection.

1020. What other health insurance do people in your household have?

RESPONSES	N
BadgerCare	1
Employer-provided	5
Medicaid	1
Medicare	2
Other provider	1
Don’t know	5
Not applicable	9
TOTAL	**24**

The most common source of health insurance for other members of the household was an employer.

Topic 2: Chronic Health Problems

The next set of questions focused on chronic medical conditions. Respondents could report as many conditions as they wanted.

1021. Do you have any chronic health problems that require ongoing medical attention by a medical provider, or that require regular medication?

RESPONSES	N
Yes	19
No	5
TOTAL	**24**

1022. What are those chronic health problems?

RESPONSE CODES	N
ADHD	3
Cancer	2
Cardiovascular disease	4
Chronic disease not otherwise specified	2
Chronic kidney disease	2
Chronic pain	4
Endocrine disorder	4
Gastrointestinal illness	3
Mental health disorder	7
Neurological disorder	1
Respiratory illness	4
Rheumatic disease	1
Substance use disorder	1

A member of the client's team provided categorical groupings for the reported conditions.

Topic 3: Primary, Urgent, and Preventive Care

The following group of questions covered respondents' access to and use of medical care: primary, urgent, and emergency.

1030. Do you have a place you regularly go to for primary care, such as a doctor's office or clinic?

RESPONSES	N
Yes	23
No	1
TOTAL	**24**

1032. What is the type of place?

RESPONSE CODES	N
Clinic	11
Community health care center	4
Doctor's office	7
Undetermined	1
N/A not asked	1
TOTAL	**24**

1034. Is it difficult to get appointments there?

RESPONSE CODES	N
Not difficult to get appointments	13
Not difficult to get appointments - telehealth	1
Yes - difficult to get appointments	3

Most respondents reported that they had a place for primary care, and said that getting appointments was not difficult. One said that telehealth was helpful for appointments. A few reported difficulty with getting appointments.

> *R: No. The telehealth has been extremely helpful as I moved, and so even though I'm like 45 minutes from there now, I can still meet with my primary doctor, who knows everything, and I don't have to switch. (I: Okay. Thinking about that clinic, is that a place that you'd go to for in-person care as well? You mentioned it's 45 minutes—) R: I still do. (p1646-2607)*

> *My primary care, if I have an illness, like strep throat or something, sometimes I can't get in for, you know, like three or four days, which, when you're sick, it's a long time. (p1646-3231)*

1040. Is there an urgent care location you can go to (if your doctor's office or clinic cannot see you)?

RESPONSE CODES	N
Don't know whether urgent care is available	4
No urgent care location	1
Yes - but urgent care location is far away	2
Yes - have urgent care option	17

Most respondents reported having an urgent care option, including some whose urgent care was at the same location as a primary care clinic or emergency department. Two considered their urgent care location to be available but far away. A few were unsure.

> *There's actually an Urgent Care at the same building as well. (p1646-3077)*

> *There is, but it's probably 40 miles. (p1646-3133)*

> *Honestly, I haven't— That's a good question. I should probably look into that. I think so. I should probably know. (p1646-2607)*

1050. Over the past twelve months, have you received any preventive care such as a checkup, recommended screenings, or a flu shot?

RESPONSES	N
Yes	18
No	6
TOTAL	**24**

RESPONSE CODES	N
No preventive care in past 12 months	6
Yes - checkup	5
Yes - COVID vaccine	4
Yes - flu vaccine	5
Yes - general mention	8

Three-fourths of respondents had received preventive care in the past twelve months. Some reported more than one type of preventive care.

All of the above. (p1646-3231)

I believe they gave me the flu shot last time I was in the doctor's office. (p1646-2580)

No, aside from a health risk assessment at work, but I don't think that qualifies. (p1646-2769)

1052. Did you want to get preventive care, but were you unable to get it?

RESPONSE CODES	N
No - R did not want preventive care	3

All of the respondents who reported receiving no preventive care, and who were asked about wanting preventive care, said that they had not sought it. One reported having been told to make an appointment for care, but not making it.

I was supposed to have made an appointment, but I haven't made one (p1646-3157)

1054. What preventive care were you unable to get?

No respondents were eligible to be asked this question.

1056. Did your doctor or clinic recommend preventive care, but you did not end up getting it?

RESPONSE CODES	N
No - provider did not recommend preventive care	1
Yes - provider recommended checkup	1

Only one respondent reported that their provider had recommended preventive care.

A whole physical and all that. (p1646-3157)

Topic 4: Emergency Department Experiences and Attitudes

The interview proceeded to ask respondents about their experiences with emergency department care, including current potential choices for ED care. In addition, there were questions about decision-making for instances of seeking – as well as not seeking – emergency care.

1060. If you were to have a medical emergency at your residence, do you know which emergency room you would likely go to, if you were given the choice?

RESPONSE CODES	N
Yes - know which ER to choose	20
No - do not know which ER to choose	4

A large proportion of respondents knew which emergency department they would choose, although some were guessing based on location or insurance network.

> *Being in Milwaukee, I'm unfamiliar with the area, so I would hope it's [redacted] (p1646-3077)*

> *since I have [redacted] Healthcare, it would probably end up being [redacted] (p1646-3583)*

Most of the respondents who did not know which ED they would choose attributed that to lack of knowledge after a recent move.

> *No. I should probably look into that. I haven't actually thought about it. When I was in Sun Prairie, I knew, but I, moving, haven't actually thought about it. (p1646-2607)*

> *No. I haven't. I don't have my plan B. I should have that. I know there's something nearby. There's so many satellite medical facilities everywhere around here. I'm very impressed with it. So I just haven't googled it. Isn't that funny? (p1646-3600)*

1062. How far away is it?

RESPONSE CODES	N
Shorter distance - 0-9 miles or 0-19 minutes	11
Longer distance - 10+ miles or 20+ minutes	9

Some respondents replied with distance estimates and others with time estimates for the nearest ED. At the client's direction, responses were grouped into shorter and longer categories.

1064. Why would you choose to go there?

RESPONSE CODES	N
Access or availability - speed of care	2
Attentive staff	1
Convenience - easier to navigate facility	1
Convenience - location	8
Cost - insurance coverage	1
Feel comfortable there	1
Good behavioral health team	1
Good opinion of care	7
Previous experience	9
Staff know my conditions	1

Reasons for choosing that particular ED in a hypothetical emergency covered a wide range of topics. In broad terms, there were factors outside of the emergency department itself (convenience and cost, typically using that facility for routine care) as opposed to factors related an ED's operations (staff functioning, speed of care, respondent experience or opinion of care quality).

Convenience of getting to the ED on one's own made a difference to several respondents. Some focused on the time to travel to the ED, and one spoke about the ease of getting to the ED once parked at the facility.

> *An immediate emergency because it's the nearest facility. (p1646-2769)*
>
> *I guess it's convenient. I guess the location is pretty convenient. (p1646-2364)*
>
> *It's not as confusing. … Easier parking. (p1646-3583)*

One respondent would choose the ED based on insurance coverage.

> *the obvious, clear answer would be because of my insurance (p1646-3583)*

Some respondents said that they would choose a particular emergency department because they were used to, and liked, receiving non-emergency care there.

> *That's where I typically (have) been going for my regular healthcare (p1646-3133)*
>
> *I also have history there, gave birth to both my children at that hospital. (p1646-3134)*
>
> *that's where I've been getting all my medical attention, and I really like it there. (p1646-3473)*

When providing reasons that applied to the ED itself, many respondents spoke of their good opinions of care and their general comfort level at that ED, either from their own experience or that of others.

> *I've been in this community for a while, and it's a reputable hospital (p1646-3134)*
>
> *I feel comfortable there (p1646-2011)*
>
> *I like the care they give (p1646-2876)*
>
> *I'm familiar and it was a good experience (p1646-2570)*

Factors inherent to that ED's functioning included speed of care and qualities of the staff.

> *The care I received there was also very quick, so that would also be a factor. (p1646-2769*

But the one at [redacted-1], I waited for over four hours, and I was still fifth in line, and I was having chest pains. So my mom actually came and picked me up and took me over to [redacted-2], and they got me in right away. (p1646-3231)

They're more attentive than the emergency room at [redacted]. (p1646-3231)

Because they have a good behavioral health team. (p1646-2570)

I think the doctors there know my condition well enough (p1646-2011)

1070a. Tell me about the most recent time you went to the emergency room. What was your health issue?

RESPONSE CODES	N
Asthma	1
Bladder infection	1
Childbirth	1
COVID	2
Cramps	1
Dehydration	1
Dizziness	1
Esophagus problem	1
Eye problem	2
Fracture	3
Gastrointestinal problem - general	2
Gastrointestinal problem - pancreatitis	1
Hand injury	1
Heart problem - general	4
Infection	1
Mental health problem	2
Overdose - prescription medication	1

The health conditions that brought respondents to the ED varied widely. Some were situations where a patient's chronic condition became acute, while others were ad hoc occurrences. For one respondent, the ED visit resulted in his chronic condition's diagnosis.

> *I went in because I was experiencing, I have asthma, so I wasn't able to breathe, and it was causing chest problems as well. (p1646-3092)*

> *I had a hard time swallowing. … I was supposed to see a doctor, and I couldn't wait to see the doctor, so I went into the emergency room. And that's when I found out I had cancer in my esophagus. (p1646-3473)*

> *I broke my ankle (p1646-3352)*

1070b. Were they able to successfully treat the issue or transfer you to another health care provider who could?

RESPONSE CODES	N
Yes - Treatment was successful	21
No - Treatment was unsuccessful	3

Most respondents reported that their treatment in the ED was successful, although some qualified their answers.

> *Yes, I would be able to curb my manic episode. (p1646-2570)*

> *Well, they did the best they could. (p1646-3157)*

> *Yeah. I mean, they should have been able to treat it sooner, I would think. But maybe they were just busy, but yeah. (p1646-2364)*

A few respondents said that there was no successful treatment or transfer.

> *They neglected to see that it was dislocated and sent me home. (p1646-3600)*

> *(I: Did they refer you to another provider? Were there any referrals they gave you then?) R: No. I had to wait like 6 days to see my primary doctor, and then he's the one that put in a referral to mental health. (p1646-3077)*

1070c. Were you satisfied with the experience?

RESPONSE CODES	N
Not satisfied - competence of staff	2
Not satisfied - ER staff considered visit non-emergency	2
Not satisfied - no clear diagnosis	1
Satisfied - care was efficient	1
Satisfied - competence of staff	3
Satisfied - friendly staff	2
Satisfied - satisfied - general	15
Satisfied - speed of care	1

Although most respondents expressed satisfaction with the ED experience, some complained about factors that left them unsatisfied. Competence of the staff, lack of a clear diagnosis, and ED staff determination that the situation was not an emergency played a part in various respondents' dissatisfaction.

> *They didn't do their job the first time. Of course, I was going to go right back to where they screwed it up. You know, they didn't fix it. They needed to fix it. And they should not have student doctors doing whatever they did to me. (p1646-3600)*

> *Just not able to get a confirmed answer as to what the underlying problem was. I didn't know if I had a persistent heart problem, if I didn't have, or if it was caused by asthma. I never got a solid answer as to if it was going to be something that could happen in the future and what I could do in the future to prevent it, if it's just something that like, you know, my albuterol inhaler would be able to fix. (p1646-3092)*

> *the physician told me, they're there for emergencies. So they didn't see me being in an emergency situation, so, therefore, they suggested to me to go back to my primary. (p1646-2972)*

The reasons that respondents gave for being satisfied tended to involve either the speed and efficiency of the care or the conduct of the medical staff.

> *Yeah, it was very efficient (p1646-3362)*

I was satisfied with the care I received. It was late at night, and I know they were a little understaffed, so the care was as adequate as they could provide at the time. (p1646-3092

it seemed like everybody that I interacted with was friendly (p1646-2769)

1080. In your most recent time going to the emergency room, did you make the choice to go or did someone else make it?

RESPONSE CODES	N
Family member made R go	1
Joint decision	1
Respondent chose	17
Telehealth staff told R to go to ER	5

All of the decisions to go to the ED were ultimately the respondents' (i.e., none were incapacitated seriously enough that ambulance staff or others decided in place of the respondent), but several respondents mentioned influences on their decision from either family members or telehealth advice.

I didn't want to go, but my partner made me go. (p1646-2364)

I made it pretty quick myself. (p1646-2607)

It was my girlfriend's choice, but I decided— we both decided to go because I was having trouble breathing. (p1646-2580)

It was very clear to all of us I needed to go to the hospital (p1646-3600)

Respondents tended to characterize the telehealth advice that led them to visit an ED as a recommendation, to varying degrees.

I called the doctor's office that I was supposed to go to for the check-up or whatever. And they told me I might as well just go right to the emergency room. (p1646-3473)

I called my primary care. They told me I could come in the next day, and I should probably just go to the ER to get it looked at. (p1646-3097)

I guess I made it. You know, they recommended that I go in, not wait anyway. (p1646-3133)

The [name of organization redacted] nurse line told me that I needed to go. (p1646-3231)

1082. Different people have different reasons for going to the emergency room. Why did you choose to go to the emergency room instead of some other place?

RESPONSE CODES	N
Access or availability - distance to facility	4
Access or availability - ER was only option certain to be open at the time	12
Access or availability - more doctors available	1
Access or availability - speed of care in ER	5
Advice - telehealth staff advised visiting ER	2
Cost - Insurance would cover care	1
Doctors are more experienced	1
Friendly staff	1
Medical history	1
Not accustomed to urgent care	1
Perceived severity - concern about health	2
Perceived severity - pain	3
Perceived severity - situation required emergency care	8

Most of the reasons that respondents chose emergency departments over other options were related to the perceived severity of the situation and the ability to access care quickly.

Availability of care was the most commonly mentioned type of factor. Some respondents' answers in this category involved travel time to a facility or the time of day when the ED was the only available facility.

I just knew that it was within a two-minute drive. And I faint when I see blood, so I didn't want to drive far and then have the blood leak out and then me collapse while I'm driving. So just to keep a safety aspect, I just went to the closest possible place. (p1646-2607)

Well, at that time of night there was no urgent care or nothing like that open. (p1646-3157)

I just knew that the emergency room was going to be open. (p1646-2607

Well, it was at night. The doctor's office was closed. (p1646-3352)

A related set of answers focused on the relative availability of care within the ED setting, either referring to staffing or speed.

more doctors (p1646-3157)

The wait time to see some kind of behavioral health professional. (p1646-2570)

So I could be treated immediately. (p1646-3157)

I figured the emergency room would be the fastest solution to the problem, my problem. (p1646-3134)

The perceived severity of the health condition was a motivating factor for several respondents, whether it was the severity of their pain or the situation in general.

Because I was in such massive pain I couldn't take it anymore. And I was, you know, going to make sure that everything was okay and truly hoped it, in hopes that maybe they could find something. (p1646-2972)

Well, because I was scared. I didn't know what in the world was going on. So I was kind of just scared. And I wanted to make sure everything was okay. (p1646-2869)

literally couldn't call urgent cares or anything because I was bleeding so much. I didn't have, I just went to the nearest emergency room. I didn't have time to google or call around if there were clinics open. (p1646-2607)

R: Because I just needed fluids bad. I could barely even walk because I was so lightheaded. (I: Okay. So it was serious enough that you needed to go to the emergency room for that.) R: Yeah. I pretty much knew that's the only place to go. (p1646-2941)

As discussed earlier, telehealth advice was the reason that some respondents chose the ED.

I called the doctor's office that I was supposed to go to for the check-up or whatever. And they told me I might as well just go right to the emergency room. (p1646-3473)

Expectations about ED medical staff were mentioned by some respondents.

Well, they're more experienced (p1646-3157)

the doctors there are usually friendly in my town (p1646-3044)

I mean, he knows my past with my pancreas issues, (p1646-2364)

Other reasons came up as well.

It was a place that I knew would be covered by my insurance (p1646-3097)

I was born in the '80s, and so kind of used to— I'm not really used to Urgent Care centers, and so I don't know the process applying to the Urgent Care facility and actually utilizing it. (p1646-3134)

1084. Did you ever consider going to another place, or was it just very clear that the emergency room was the only place that you should have gone?

RESPONSE CODES	N
Yes - considered different option	1
No - ER was clear choice	19

Nearly all the respondents said that it was clear that the ED was the only choice.

That was the only place I even thought of. (p1646-2607)

No, I never even thought of it at the time. I probably could have went to Urgent Care. But I just didn't think of it at the time. (p1646-2869)

At that time, on a Saturday night, that's the only place to go. (p1646-3133)

Well, I asked the nurse line if I could wait until the morning, but they said that it said that I needed to be seen within four hours. (p1646-3231)

The sole respondent who reported considering another option seemed to have difficulty comprehending the question, and did not elaborate on the reason.

> *(I: Okay. One more way for me to ask this is, did you ever consider waiting and going to, say, Urgent Care, rather than going to the emergency room?) R: Yes. (p1646-3092)*

1086. Beyond your health condition, was there another reason you chose to go to the emergency room instead of another place?

RESPONSE CODES	N
No - only health-related reasons	15

All respondents who answered this question said that their reasons for choosing an ED were solely health-related. Some noted the seriousness of the condition, and others reported that the ED was the only health care option available at the time.

> *I felt that I needed to get the treatment as soon as possible. (p1646-3092)*

> *I didn't really have another option. (p1646-3600)*

> *I was instructed by my doctor that if the clinic wasn't open, to go to the emergency. (p1646-3362)*

1088. What were those other reasons for choosing to go to the emergency room?

No respondents were eligible to be asked this question.

1090. In any of your recent times going to the emergency room, was there ever a situation when the doctor at the emergency room -- or other emergency room staff -- told you that you should have gone somewhere else?

RESPONSE CODES	N
No - never told that R should have gone elsewhere	22
Yes - staff told R to self-treat mental health problem	1

Almost none of the respondents reported an experience of being told by ED staff that they should have gone elsewhere. Only one of those respondents in the "no" category elaborated on his overall ED attitude in that regard.

> *No. I grew up in a "You do not go to the emergency room unless you're dying," kind of household. And so if I'm at the emergency room, I've never been told I shouldn't be there. (p1646-2607)*

> *I have actually never ran into that, no. (p1646-2769)*

1092. Tell me about what happened. At what point of your visit were you told (that you should have gone somewhere else)? Who told you that? Did they refer/send you to another provider?

The single respondent who did have a "should have gone elsewhere" experience offered a lot of detail about the situation.

> *Yeah. When I went in there about my anxiety, they said, well, all I can say is take a deep breath, drink water, I mean, get a hold of mental health. And I said, you know, I did call mental health. I'm on a 6-month waiting list. They said, well, you got to follow protocol. I'm sorry, but there's definitely something they could have done about it that they didn't feel like doing or were worried about lawsuits. (p1646-3077)*

> *(I: Mm-hmm. At what point in your visit were you told that you should have gone somewhere else or you should have done those other things?) R: When the doctor actually came into the room and seen me. (I: Okay. So the doctor told you that at that point?) R: Yes. (I: Okay. Did they refer you to another provider? Were there any referrals they gave you then?) R: No. I had to wait like 6 days to see my primary doctor, and then he's the one that put in a referral to mental health. (I: So for that appointment with your*

primary doctor, did you make that yourself, or did the emergency room refer you to them?) R: I made that myself. (p1646-3077)

1100. Are there any situations since you've been on BadgerCare where you have avoided going to the emergency room, even though you believed you were experiencing an emergency?

1102. Tell me about why you avoided going to the emergency room.

RESPONSE CODES	N
No - R never avoided ER in emergency	16
Yes - Did not want to be separated from family	1
Yes - Expected lack of treatment	2
Yes - Expected wait time	1
Yes - Prior bad ER experience	2
Yes - Thought problem would go away on its own	3

Most respondents said that they had not had any situations (while on BadgerCare) where they avoided visiting an ED when they believed that they were having an emergency.

No, not since I've been on BadgerCare. (p1646-2769)

No. I listen to my body and try to take care of it. (p1646-3077)

Among those who did avoid an ED in that kind of self-assessed emergency situation, most gave reasons related to expecting a bad or unproductive ED experience. For some, that expectation was based on prior experience.

Well, it appears that I go through bouts with my stomach. And after going through that one, and having the results that I did, it would be futile for me to go. It's not effective for the cost, for the time, and for the results. (p1646-2972)

I guess I didn't want to deal, you know, with having to wait there for hours at a time, (p1646-2364)

I felt like I was having an emergency, but I chose not to go to a place because of how I was treated previously. (p1646-2011)

once I was shoveling snow, and I kind of twisted or hurt something in my back. And I probably should have went, but I didn't go just because of prior experiences that I've had in the ER. (p1646-2364)

Another reason that several respondents gave for this avoidance was that they thought that the situation would improve on its own. The interview protocol did not allow for the interviewer to probe to determine whether the situation that those respondents had subjectively described as an emergency would fit an objective definition of emergency. One respondent told of a hybrid situation of not-going/going, avoiding the ED for one day but visiting it on the next.

Yeah. I just figured I could, it would pass, and I would get over it. (p1646-2570)

Once within the last 6 months. I was trying to avoid it to see if the pain would go away by morning, but the following day it was not going away at all. So I went in. (p1646-2580)

1104. What was the health problem that you were experiencing, in that situation where you avoided going to the emergency room?

RESPONSE CODES	N
Back injury	1
Bacterial meningitis	1
Gastrointestinal problem	1
Head injury	1
Heart problem	1
Mental health medication reaction	1

The self-assessed emergency situations where respondents avoided going to the ED involved a varied set of health conditions, with some respondents describing conditions that might have needed urgent treatment or evaluation.

I hit my head, and I thought that maybe I had a slight concussion. (p1646-3134)

Well, it was after I got out of the inpatient, I was put on some meds, and I had a bad reaction to one of them and wasn't able to get a prescription but felt like in the moment like I needed to get some immediate treatment. (p1646-2570)

1106a. Earlier, you mentioned that you had some chronic health conditions. How do those conditions affect the ways that you require medical care in general?

RESPONSE CODES	N
Frequent appointments	4
Multiple facilities required	1
Prescription difficulties	1
Some providers handle chronic conditions better	1
Specialized equipment required	1

When describing general medical care required by their chronic conditions, most respondents brought up a need for frequent appointments. One person's experience of that was compounded by the need to visit multiple facilities.

I go quite regularly to quite a few different doctors and specialists. (p1646-2364)

I need slightly more medical care, medical treatment than I would say the average person because, yeah, with addiction counseling and the medication treatment I receive. (p1646-3092)

They can't all be handled at one facility, so I transfer between multiple facilities. (p1646-3092)

There were a variety of other healthcare-utilization effects of the chronic conditions.

I've had trouble with getting prescriptions filled. So I've had to change pharmacies. (p1646-3092)

I have found some doctors and hospitals that I'd rather go to more than others just because of the way they, you know, treat the patients and their knowledge and expertise and other things. (p1646-2364

R: I live in a town where there's a walk-in clinic. And because they don't have certain equipment that they would need for my particular condition, I have to go to a certain

one. (I: Okay. So your condition means you have to go to a clinic with more equipment there.) R: The equipment, yep. (p1646-2011)

1106b. (Earlier, you mentioned that you had some chronic health conditions.) How have those conditions affected your use of the emergency room?

RESPONSE CODES	N
Chronic conditions become acute and need ER care	4
ER staff dismiss patient concerns about condition	1
Psychiatric facility access procedure required ER visit	1

As previously mentioned, acute symptoms arising from chronic conditions were a factor in bringing respondents to an ED.

because my bone density is so depleted, there are times that I have had to go to the ER because of fractures. (p1646-2972)

R: I would just simply say it's been a lot more than I ever would have. (I: Visit emergency rooms more than you ever would have?) R: Yeah. (p1646-2011)

Like I said, it was an urgent matter one time, and that's why I had to get in there. (p1646-2570)

Difficulties with staff or bureaucracy also came up as ED-related consequences of respondents' chronic conditions.

they seem to just want to dismiss everything or say it's in your head, you know, and not like what you're feeling isn't about illness or pain or something like that. (p1646-2364)

If I have suicidal ideations, which doesn't happen very often, like I haven't had that for years. But I did happen to have it last February. And [name of organization redacted] is the only place that has, at least that I was told, it has a psychiatric facility, a patient facility. And so you have to go through the emergency room to be admitted for that. (p1646-3231)

1110. In any of your recent trips to the emergency room, was there ever a time when BadgerCare made you pay a copayment?

RESPONSE CODES	N
Never charged BadgerCare ER co-pay	21
Received bill, unsure whether it was from BadgerCare	2

The vast majority answered (with varying degrees of certainty) that BadgerCare had not made them pay a copayment.

> *No, I had no copayment. I was shocked. (p1646-3352)*

> *No, I don't remember paying. (p1646-2869)*

Two people initially described receiving bills after ED treatment, but they were not sure whether those were for BadgerCare copayments. After interviewer probing, it appears unlikely that those were the kinds of payments of interest for this question, but those responses are coded and reported separately for possible future analysis.

> *R: I'm not sure if that would be a no. Just because, I've went to the emergency room but at the time of the visit I didn't have to pay. But then later, I got billed for services. And, well, yeah, I think that was when I was participating in a plan with BadgerCare. (I: Okay. So the services that you got billed for, was that a bill from the BadgerCare program, from the hospital directly or?) R: The hospital. (I: The hospital, okay. So they billed you in that situation. Okay. So we got down that it wasn't a BadgerCare copayment. It was a hospital bill for that.) (p1646-2011)*

> *(I: What I want to ask you here is in that situation, you got that bill from the hospital. Did you get a bill for a copay from the BadgerCare program itself? Do you remember whether that occurred then?) R: No. I have to say, they all come through the online portal. (I: That's the MyChart portal?) R: Yes. So they can come from several different places, so I can't answer precisely where it came from. (p1646-3600)*

1112. Tell me what happened (in your recent trips to the emergency room, when BadgerCare made you pay a copayment).

The two respondents who had uncertainty about bills and BadgerCare copayments were not asked this detailed follow-up question, since it did not appear relevant to their situations.

Topic 5: BadgerCare Program Knowledge

Next came two questions gauging respondents' knowledge about changes to policies of the BadgerCare program.

1122. Since you've been on BadgerCare, has the program's coverage of treatment in the emergency room changed in any way that you are aware of?

RESPONSE CODES	N
Not aware of BadgerCare ER coverage change	22

No respondents reported being aware of ED treatment coverage changes in the BadgerCare program. Some were more certain than others.

As long as I've been on with BadgerCare, no, it hasn't. (p1646-3134)

to my knowledge, it has not changed (p1646-3583)

I don't know. I don't actually know anything about it. (p1646-2607)

I do not remember what was in that letter. (p1646-3097)

1124. To the best of your knowledge, do BadgerCare members ever have to pay for services in the emergency room?

RESPONSE CODES	N
No - BadgerCare members do not pay for ER services	10
Maybe BadgerCare members need to pay ER co-pay for non-emergency visits	1
Unsure - Don't know whether BadgerCare members pay for ER services	6

Most respondents believed that BadgerCare members do not have to pay for ED services, although some were more certain than others. One thought that maybe there was a policy to that effect. Several stated that they did not know one way or the other.

As far as I know, no, but I've never looked at a bill yet that I've received from the hospital (p1646-2941)

I don't think so. (p1646-3001)

Generally don't (p1646-3362)

R: I was told that, I don't remember, but that if you were seen in the emergency room and it was deemed not an emergency, that you could have to pay a copay. (I: Do you know whether that's a policy that's in place now?) R: I believe that it is, but I don't know for sure. (p1646-3231)

Topic 6: Opinions about BadgerCare and Emergency Care

The final set of questions presented respondents with a series of statements about emergency care, then asked them to agree or disagree with the statements. Follow-ups to each agree/disagree question probed for the respondents' reasons for choosing the answer that they did.

1130. We are almost done. Before we finish, I want to get your opinion on a few statements. After I read each statement, please tell me whether you agree or disagree, and what reasons you have for agreeing or disagreeing. There aren't any right or wrong answers, we just want to hear what you think.

1131. Many people go to the emergency room for routine medical problems that are not emergencies.

RESPONSES	N
Agree	17
Disagree	4
Unsure	3
TOTAL	**24**

1132. (Many people go to the emergency room for routine medical problems that are not emergencies.) Why do you feel that way?

RESPONSE CODES	N
Agree - lack of awareness of non-ER options leads to ER non-emergency use	1
Agree - people go to ER due to lack of health insurance	1
Agree - people mistake routine problems for emergencies	2
Agree - people seek drugs in ER	1
Agree - people want to be seen immediately	2
Agree - people who have been uninsured in the past have a habit of using ER for primary care	1

Agree - routine facilities are often full	1
Agree - sometimes people go to ER when care could wait	8
Agree - stress can make patients think conditions are more serious	1
Disagree - non-emergency ER use is not common	4
Unsure - Don't know whether many people use ER for non-emergency events	2

Only a few respondents disagreed with this statement that many people use an ED for routine care. Of those who disagreed, some directly addressed the question of whether the event is common.

> *One time. I can only think of one instance in my entire life that someone could have waited and just gone to the doctor or urgent care without being in the emergency room. (p1646-2607)*

> *I would disagree. I don't think it's common. I think it happens, but it's not common. (p1646-2607)*

Other respondents explained their disagreement by placing themselves in the decision-making shoes of a potential ED-user.

> *No, I would say I disagree with that. I would think that, again, why would people want to go there unless it was a state of emergency? (p1646-2972)*

> *Because they figure it's an emergency, so it's an emergency. Like usually, if you stub your toe, you don't go to the emergency room, but if you see bruising, and it like swells, and you can't walk on it, then you know to go to the emergency room, even though you just bumped your toe. So I think like it just depends on the person and their opinion of what an emergency is. (p1646-3134)*

Agreeing with the statement was much more common. Several people based their agreement on first- or secondhand observations.

> *when you go to the emergency room, you can see the people there that are doing it. (p1646-3001)*

> *I've met quite a few people that seem to treat the ER as the first choice of medical care. (p1646-2769)*

> *R: Yeah. I've had friends with young children that have like maybe an ear infection or throat or something that it could either wait until like the next day, or not an ER. Were you talking about ER or urgent care? (I: ER is what we're talking about here.) R: Yeah. Like more geared towards urgent care or their primary doctor. (p1646-2364)*

I agree. And my reasoning is because I know people that that went to the emergency room for no reason, pretty much. It's kind of ridiculous. (p1646-2941)

As the disagreeing respondents did, many agreeing respondents also backed up their answer by describing the reasoning that they believed would occur in the minds of non-emergency ED patients.

I mean, I come from Racine, and I'm well aware that there are people that go in there just for drug-seeking reasons. (p1646-3077)

some people are just entitled and think they should be seen immediately, even if it's not actually an emergency. (p1646-3097)

Because people think that things are emergencies that turn out aren't (p1646-3097)

I just think there's some people out there that probably, you know, their condition needs that degree of attention. I'm not saying a lot of people do it. It's probably like a margin, but I could see where some people would feel the stress enough to seek treatment in an emergency room rather than (routine appointments with) professionals. (p1646-2570)

Other respondents agreed with the statement, and followed up with explanations that posited more structural or knowledge-based factors in patients' lives leading to this kind of ED use.

most of the time, local facilities are booked up, and you don't have a chance to get there. (p1646-3133)

the timing is not right to get something taken care of, expedited as soon as possible. (p1646-3133)

I agree. I think they do that because they don't have health insurance. (p1646-3077)

people (who) have been uninsured in the past, don't have primary or dental and have primary care physicians, tend to use the emergency room more often. (p1646-3231)

people, without having a primary care doctor or realizing that urgent care is available or without people being aware that there are other places they could go before they go to an ER, that they just go to the ER first. So I think that that's a lack of education and a lack of awareness on a lot of people's parts that that's their choice. (p1646-3600)

I agree. Sometimes— well, I'm sure people don't realize how serious things are. I know I've been myself don't realize how serious something is until you find out what's really serious to go to an emergency room or what isn't. (p1646-3473)

1133. It is reasonable for BadgerCare to require members to pay a fee of eight dollars, if they go to the emergency room for care that the doctor determines is not an emergency

RESPONSES	N
Agree	21
Disagree	3
Unsure	0
TOTAL	**24**

1134. (It is reasonable for BadgerCare to require members to pay a fee of eight dollars, if they go to the emergency room for care that the doctor determines is not an emergency) Why do you feel that way?

RESPONSE CODES	N
Agree - care costs money	5
Agree - fee is affordable	9
Agree - fee is low compared to ER treatment costs	2
Agree - fee will discourage non-emergency use of ER	7
Agree - general agreement	3
Agree - if fee is in the rules then patients should pay it	2
Agree - other people pay more	1
Disagree - treat without payment if patient thinks situation was emergency	3
Undecided - R cannot answer yes or no	1

A large majority of respondents thought that the proposed fee was reasonable. Some respondents just agreed generally with the statement without elaborating.

> *I Because we should, you know. We should. No other really reason for it. I just think we should. (p1646-3001)*

I agree. I think if it's not serious, you could pay a little something. (p1646-3473)

Many of the specific reasons for agreement were related to the low cost of the fee relative to other costs or benefits. The fact that medical care has a cost in money and time came up frequently.

I think the doctor's time is important too. So, there should be some sort of fee that is involved. (p1646-2570)

you got to pay something. You can't have everything for free. You know, you got to pay for some things. (p1646-2869)

it acknowledges that the patient has been there and taken the doctor's time. (p1646-3600)

It's just a small fee for the amount that, you know, an emergency visit costs. (p1646-2364)

Many respondents considered the fee to be reasonable because the amount was affordable.

it's not like it would break the bank or anything. (p1646-2364)

That is not a life-changing amount of money. I agree. (p1646-2607)

$8 is not an unreasonable amount given that, aside from chronic hypochondriacs, for most people that wouldn't be an event that occurred more than once or twice a year at most. (p1646-3097)

it's also not bleeding the poor people dry. $8 is a lovely fee to pay. I'd be thrilled to get a bill like that if I had ended up in the wrong place because I wasn't aware of where else I should go. (p1646-3600)

One person compared the fee to what other people would pay.

I mean, a lot of people have to pay a lot more. (p1646-2580)

Some responses had a more policy-based orientation, including having the fee act as a deterrent to non-emergency use of an ED.

if BadgerCare says that no matter what, the trip to the emergency room costs $8, and you feel the need to go to the emergency room, you should be conscious enough to know that that's going to cost $8. (p1646-3077)

I guess I would agree because it's like important for those people to sort of get with the program and the fee is like a punishment, I guess. (p1646-2570)

Yes, I would agree with that. I think that's something that should be— maybe not necessarily punished, but it should be discouraged, certainly. (p1646-2769)

Just because it prevents people from overusing the emergency room and using it and taking up resources that would be utilized, you know, better elsewhere, or just someone else who's actually having an emergency. (p1646-3092)

In contrast, some respondents disagreed about the fee being reasonable.

just to charge people depending on whether the doctor thinks it's an emergency? No, that's not right. You choose to treat the people. (p1646-3134)

Because I feel like if you go into the emergency, and you feel like it's an emergency, they kind of just treat everybody the same based on what your needs are or what your problems are. (p1646-3362)

1135. It is often difficult for patients to know whether some health problem is an emergency, versus a problem that could be treated at a doctor's office or a clinic.

RESPONSES	N
Agree	19
Disagree	4
Unsure	1
TOTAL	**24**

1136. (It is often difficult for patients to know whether some health problem is an emergency, versus a problem that could be treated at a doctor's office or a clinic.) Why do you feel that way?

RESPONSE CODES	N
Agree - conditions might vary over time	1
Agree - different people experience symptoms differently	3
Agree - general agreement that it is difficult to distinguish emergencies and non-emergencies	2
Agree - lots of people are in and out of ER	1
Agree - patients don't know how to identify serious symptoms	8
Agree - patients go to ER if they are overwhelmed or scared	1
Agree - reluctance to go to or pay for ER might lead patients to discount symptoms	1
Agree - some people overestimate seriousness	2
Disagree - patients can distinguish emergencies from non-emergencies	3
Unsure - Don't know whether people have difficulty telling emergencies from non-emergencies	5

Most respondents agreed that distinguishing emergencies from routine problems was often difficult for people. Some respondents agreed with the statement in a general way, while others were more specific. The specific reasons for that perceived emergency-assessment difficulty fell broadly into two categories: factors related to the condition or situation, and factors related to patients' choices or knowledge.

General agreement included the belief that some people have difficulty assessing emergency conditions, as well as personal experiences with that difficuloty.

> *Yes, they probably do. There's a lot of people in and out of the ER. (p1646-2580)*

> *I think in some cases, it could be difficult. (p1646-2570)*

> *We were looking after a dog one time. He got oral surgery, and that turned into septic shock, and the dog ended up passing away. We just thought it was a result of the surgery and, you know, didn't expect infection. (p1646-2570)*

The answers that were based on the situation or condition took into account variations over time or across people's experience.

> *They might think … they got to get there right away. But really, they could wait until the next morning or something like that. (p1646-2364)*

> *R: I think people have different, like when you're in pain, you might have, somebody else might have pain, and they feel different about it. I don't know. It's hard to explain. (I: Sounds like you're saying different people might have different ways of being able to evaluate that pain when they're in pain?) R: Right, yeah. (p1646-2364)*

Patients' knowledge of and ability to assess serious symptoms was a frequent reason that came up.

> *I think if you just educate the public, it would be a lot better. Most people don't know what's serious and what's not, and that's not their fault. (p1646-2607)*

> *Because most people are not medical professionals. They might have experienced some kind of discomfort that they can very easily mistake for serious symptoms. And conversely, they might have serious symptoms that they brush off because they don't realize it's actually serious. (p1646-3097)*

> *if you stub your toe, you think you stubbed it in such a way that now, all of a sudden, your toe is black and blue, and it feels, it's really horribly painful, you don't know if you broke it or didn't break it. And you might consider that an emergency. And so you go to the ER thinking that you just broke your toe. And then they come back and say, no, you just stubbed it, here's an ice pack and this $8 fee. You're going to be like, well, wait, how would I have known that it was just a stubbed toe? (p1646-3583)*

Being overwhelmed or scared might affect someone's decision.

> *if I'm just having some like pain or whatever— or on occurring pain, I will just go into emergency just because I get like overwhelmed with it or scared, versus calling the doctor first or making an appointment. (p1646-3362]*

Attitudes toward ED use in general, and toward its cost, could affect decision-making.

> *I come from a family that you don't go to the emergency room unless you're actually dying. And it can lead to people not getting the emergency care room that they need. I have to kind of check myself too sometimes because I'm so adamant that I'm not going to go to the emergency room that, you know, when I had a kidney infection and I was like two days from dying, like I almost didn't go because I was taught not to go. This is*

the idea with some of the people, that you just, you can't afford it. You can't afford the emergency room, so you wait. And then sometimes they don't make it. (p1646-2607)

Overestimating the seriousness of conditions was a thought pattern that some respondents ascribed to some ED patients.

I think a lot of people tend to exaggerate the discomfort of what they're experiencing or seem to overreact to illness or pain. And I think that it's that that really leads to people kind of frivolously using the ER as opposed to a doctor because they deal with the initial kind of shock reaction as opposed to trying to think it through more rationally, you know, trying to, you know, treat things on your own before resorting to the medical system. (p1646-2769)

R: Well, some people go on WebMD or Google, and they freak themselves out. And then sometimes they're embarrassed to bring it up to their primary, whatever it is, so they go to the ER to try to get it dealt with, they think it's going to be dealt with faster. Then they end up sitting for 3 hours. … For some people, it might be an itch, and the other person, they could think it's killing them. They freak out and go to the ER because you think emergency room, and they instantly correlate with you thinking you have an emergency. More like a psychological thing. (p1646-3077)

Alternatively, respondents who disagreed with the statement thought that patients do (or should) have the ability to sort out emergency and routine situations.

No, it shouldn't be difficult, no, I think the emergency rooms were designed for just that - emergency. So if you slice your finger and you need stitches, that's an emergency. If you're going to have your heart checked or, you know, blood pressure or something that a doctor's office can facilitate, I would believe people would go there versus an ER. (p1646-2972)

I don't think so. I think people know what's wrong with them. (p1646-3001)

I think that it's pretty clear what you should be using each facility for and what they're there for. I mean, emergency room has in its name, it's for an immediate emergency that can't be treated elsewhere. (p1646-3092)

1137. A fee of eight dollars will not change my decision-making process for using an emergency room.

RESPONSES	N
Agree	24
Disagree	0
Unsure	0
TOTAL	**24**

1138. (A fee of eight dollars will not change my decision-making process for using an emergency room.) Why do you feel that way?

RESPONSE CODES	N
Agree - fee is low compared to ER treatment costs	6
Agree - fee is low enough not to matter to me	3
Agree - fee is worth it for benefit to health	10
Agree - general agreement that fee will not change my decision process	2
Agree - I follow provider advice about whether to go to ER	2
Agree - if fee is in rules, then I will pay it	2
Agree - other people pay more	1

All respondents agreed that a hypothetical fee of eight dollars would not change their process for making decisions about seeking emergency care. Most of the reasons for agreement had to do with the low cost of the fee, either in absolute terms or comparatively (many answers were similar to those at question 1134 about the reasonableness of the fee).

Several responses compared the fee favorably to the hospital's cost of providing treatment.

> *I think $8 is a small price to pay for the services that are provided. (p1646-2972)*

> *Well, the emergency rooms do provide a service. And, you know, it costs a lot more to run hospitals. But, you know, they do profit too. But $8 is not a big deal. (p1646-3352)*

if … the doctor sees you and says, no, you don't need to be here, you should go someplace else, to only be charged $8 instead of $1,200? Wow, it's a no-brainer. It's a wonderful, wonderful, wonderful thing for BadgerCare to do instead of charging them the whole fee. And not everybody has insurance. You know, I don't even know what it costs to go to the ER if you don't have insurance, thousands probably. So $8 is a gift. (p1646-3600)

Another perspective considered the fee low enough to be affordable.

Because if I'm wrong, I can eat $8. (p1646-3097)

I agree. I mean, that's less than most people make an hour. So if you can't use an hour of your wages to go to the emergency room, then I don't know. … it's less than what I make in an hour at work, so it's really nothing. (p1646-2941)

Most commonly, respondents weighed the fee favorably against the health benefits that they would receive from emergency care. Some described the fee in the manner of an eight-dollar wager that they would place, with their winnings being improved health.

Because your health is more important than $8. (p1646-2876)

If I'm paying $8, you know, if I have to go have a visit at the ER, then maybe that $8 could or could not save my life, whether or not I had to pay it. (p1646-2580)

Because it's just an emergency, and I think as an emergency, it's worth $8 that, you know, is maybe being necessary if the doctor tells me at a later time that it wasn't actually an emergency. (p1646-3134)

I wouldn't want to die or regret going, then have it be something that gets worse, and I'd have to live with worse symptoms the rest of my life or something. (p1646-2011)

One person contrasted the eight-dollar fee to costs that other patients would be paying.

there's a lot of people out there that are paying a lot more for, you know— even just medication alone, they're paying $200, $300 a month just for their medication. (p1646-2580)

The reason that some respondents gave for their ED decision being unaffected by the potential fee was that their decision would be guided by telehealth advice.

I would agree because I, I almost always talk to the nurse line before I, if I'm even thinking of going to the emergency room. (p1646-3231)

I would agree with it. It would not change my decision. If I'm going to an ER for what my doctor tells me to do, I'm going to be doing that. It's not going to change my decision otherwise. … Obviously, they're thinking that this could be something serious, and so if they think it's something, could be something serious, then, obviously, I'm going to listen to them. (p1646-3583)

Still other respondents focused on taking the fee into account as a required element of the ED procedures.

(if) it's in the contract of being on BadgerCare that you have to pay, they tell you to pay the $8 to go to the ER. You bite the bullet, and you pay the $8. (p1646-3077)

$8 for me would be something that I would have to do no matter what, I guess. If it has to happen, it has to happen. (p1646-3133]

Topic 7: Other responses

After the last of the data collection questions, the interviewer invited respondents to add any other thoughts that they might have about the subjects that the interview had touched on.

9999. Thank you. That's the last question that I have, but are there any final thoughts you want to share about any of the topics we've discussed today, or anything else I might have missed?

RESPONSE CODES	N
BadgerCare is helpful	2
Frustration with BadgerCare wait time for specialty care	1
If telehealth responses were faster, then patients might not need to go to ER	1
Participants should be grateful for BadgerCare	1
Patient advocates would help with care and billing difficulties	1

A few of the responses to this question dealt with issues related to emergency department use.

> *BadgerCare is already providing so many people with, you know, a service that they can't afford. So I mean, they should be grateful for how much they do. I mean, BadgerCare saved my life. If I didn't have it, I don't know what would have happened after my accident. (p1646-3077)*

> *like the LiveWell or MyChart app, where you can message them on there. I mean, generally, when you message them, you don't get a response for a day or two or three. But I mean, if you explain to the nurse what's going on in the LiveWell app, and you got an answer right away, the nurse or doctor might be able to settle your nerves and make you realize, "Oh, okay, I'll wait for my appointment". (p1646-3077)*

> *That was my first experience with a traumatic injury in an ER. And I was so out of it with pain that it was really, really, really hard for me to advocate for myself. And my daughter and her husband that were there with me, I don't think any of us had ever experienced anything quite like that. And it would have been really helpful to have a patient advocate. (p1646-3600)*

SECTION 3: OPEN-ENDED RESPONSES AND CODES

1022. Chronic health problems	
ADHD	*ADHD (p1646-2570)* *I have ADHD (p1646-2607)* *ADHD (p1646-3097)*
Cancer	*I'm receiving a BadgerCare treatment for colon cancer. (p1646-3133)* *I got diagnosed with cancer in March, and I went through chemo and radiation (p1646-3473)*
Cardiovascular disease	*I'm currently in stage three heart failure (p1646-2011)* *high blood pressure (p1646-2869)* *I have had some heart stuff going on, and it hasn't been diagnosed yet. (p1646-3231)* *I had a bypass done last year or a year ago (p1646-3473)*
Chronic disease not otherwise specified	*Yes. (p1646-2580)* *Yes (p1646-3077)*
Chronic kidney disease	*chronic kidney disease (p1646-3231)* *I have chronic kidney disease (p1646-3600)*
Chronic pain	*I have chronic pain issues. I see a pain specialist. I have a lot of problems with my, like my back and hips and knees and stuff, so I see a orthopedic doctor regularly. (p1646-2364)* *I have fibromyalgia (p1646-2972)* *I have chronic back disease (p1646-3157)* *I also have peripheral neuropathy not related to diabetes (p1646-3231)*

Endocrine disorder	*I have chronic pancreatitis (p1646-2364)* *I take medicine for my thyroid. (p1646-2869)* *I do, yeah. I'm a diabetic, high blood pressure. I take insulin. (p1646-2869)* *I have hyperparathyroid (p1646-3231)* *I have a thyroid issue that I've had for a quarter of a century. It's not a big deal, but I do need to have blood work done every year, couple of years, to make sure that my arm or thyroid medicine is the right dosage. (p1646-3600)*
Gastrointestinal illness	*I have colitis (p1646-2570)* *I have a stomach issue. So I don't know how you would put that, a gastrointestinal issue. (p1646-2972)* *I have some pancreas issues that's endocrine— sorry, that's already a bunch— enzyme insufficiency, I mean, that could be chronic enzyme insufficiency, (p1646-3231)*
Mental health disorder	*I see a psychiatrist. (p1646-2364)* *generalized anxiety disorder (p1646-2607)* *I don't know if it's chronic, but it's like bipolar disorder. (p1646-3001)* *Anxiety (p1646-3092)* *depression (p1646-3092)* *depression (p1646-3097)* *anxiety disorder (p1646-3097)* *Mental illness. (p1646-3134)* *anxiety (p1646-3231)* *I have depression that's treatment resistant (p1646-3231)*
Neurological disorder	*I have epilepsy (p1646-3352)*

Respiratory illness	*I have multiple, or had multiple blood clots in my lungs, so it's something called CTEPH, chronic thromboembolic pulmonary hypertension. (p1646-2011)* *asthma (p1646-2941)* *asthma (p1646-3157)* *I also have asthma (p1646-3231)*
Rheumatic disease	*I have rheumatoid arthritis. I have osteoporosis. (p1646-2972)*
Substance use disorder	*I was going through the [redacted] Community Clinic for addiction health, so all of it pertains to like Suboxone prescriptions and, yeah, that's an ongoing treatment that I receive. (p1646-3092)*

1030. Primary care - have a place to go	
No primary care location	*No. I have not actually had a primary care physician since I was 17. For whatever reason, my day-to-day health is extraordinary. I rarely, if ever, get sick in any, you know, incapacitating way. (p1646-2769)*
Yes - have primary care location	*Yes, I do. (p1646-2011)* *Yeah, I go to a clinic. (p1646-2364)* *Yeah (p1646-2570)* *Right now it's at [redacted] in Racine or Mount Pleasant. (p1646-2580)* *Yes. (p1646-2607)* *Yeah, [name of organization redacted]. (p1646-2869)* *Yes (p1646-2876)* *Yep (p1646-2941)* *I do (p1646-2972)* *Yeah (p1646-3001)* *Yeah (p1646-3044)*

	Yes (p1646-3077) *Yes (p1646-3092)* *Yes (p1646-3097)* *Usually [name of organization redacted] (p1646-3133)* *Yes (p1646-3134)* *The [redacted] Clinic. (p1646-3157)* *I go to [name of organization redacted]. (p1646-3231)* *[redacted organization name] (p1646-3352)* *I just go to [redacted] (p1646-3362)* *Yeah (p1646-3473)* *Yes (p1646-3583)* *Yes (p1646-3600)*

1032. Primary care - type of place	
Clinic	*Yeah, I go to a clinic. (p1646-2364)* *[redacted] Clinic (p1646-2570)* *R: Clinic, just like a normal clinic. (I: Okay. Is it part of your HMO? Is it a community health center or some other type of place?) R: I'm not really sure. They accept BadgerCare, so I've been going there. But it's like through [redacted] Health. (p1646-2607)* *Well, it's a clinic. (p1646-2869)* *it's like a primary care clinic. (p1646-3077)* *It is a clinic that is part of [hospital] (p1646-3097)* *R: I go to [name of organization redacted]. (I: Okay, so you go to a clinic.) (p1646-3231)* *(I: Okay. Would that be a clinic associated with your HMO that you're, that you go to for primary care?) R: Yes (p1646-3352)* *[redacted] Clinic. (p1646-3473)*

	I guess this like a clinic (p1646-3600)
Community health center	*It's a community health center (p1646-2941)* *Community Clinics (p1646-3092)* *Community health center (p1646-3134)* *Community health center (p1646-3157)*
Doctor's office	*It would be a doctor's office. (p1646-2011)* *R: Well, I just recently started going to that doctor's office. My next appointment is on December 7th. (I: Okay. Got it. So that's a place that does regular appointments. It's not an Urgent Care facility that we're thinking of here.) R: It's both. I mean, I went there for the emergency room, but I went to the same place for the doctor's visit afterwards. (I: Okay, same location for the emergency room and the doctor visits. (p1646-2580)* *Doctor's office (p1646-2876)* *it's a doctor's office (p1646-2972)* *the doctor's clinic (p1646-3001)* *Doctor's office (p1646-3044)* *Doctor's office (p1646-3133)* *I think it would be considered a doctor's office (p1646-3583)*

1034. Primary care - difficult to get appointments	
Not difficult to get appointments	*No. (p1646-2011)* *Not really, no. (p1646-2364)* *No (p1646-2570)* *No. (p1646-2869)* *No, no. I've had to do it before. I got in the same day. (p1646-2941)*

	No (p1646-2972) *No, it's not (p1646-3001)* *No (p1646-3097)* *No (p1646-3133)* *No (p1646-3157)* *No (p1646-3352)* *I guess actually, no (p1646-3583)* *No (p1646-3600)*
Not difficult to get appointments - telehealth	*R: No. The telehealth has been extremely helpful as I moved, and so even though I'm like 45 minutes from there now, I can still meet with my primary doctor, who knows everything, and I don't have to switch. (I: Okay. Thinking about that clinic, is that a place that you'd go to for in-person care as well? You mentioned it's 45 minutes—) R: I still do. (p1646-2607)*
Yes - difficult to get appointments	*Yes (p1646-3044)* *My primary care, if I have an illness, like strep throat or something, sometimes I can't get in for, you know, like three or four days, which, when you're sick, it's a long time. (p1646-3231)* *Yep (p1646-3362)*

1040. Urgent care - have a place to go	
Don't know whether urgent care is available	*Honestly, I haven't— That's a good question. I should probably look into that. I think so. I should probably know. (p1646-2607)* *R: I believe there are some Urgent Care clinics around the area. I don't know specifically what company they're with, but the last time I tried to use one, they did not actually accept BadgerCare. But that may— that probably wasn't an Urgent Care specific but a similar sort of care clinic. (p1646-2769)* *I do not know (p1646-3097)*

	I don't know (p1646-3352)
No urgent care location	*No, not really (p1646-3044)*
Yes - but urgent care location is far away	*R: Well, the place in my city, in [city], they used to, but they don't take my insurance anymore, so I have to go to another community, like [city] or [city]. (I: Okay. So if you needed to get a visit, do an urgent care visit, could you go to a [city] location for that then?) R: Yes. (I: Okay. And that's in your insurance network then, right?) R: Right, yeah. (p1646-2364)* *There is, but it's probably 40 miles. (p1646-3133)*
Yes - have urgent care option	*Yes. (p1646-2011)* *Yeah (p1646-2570)* *I believe, yeah, [redacted] Urgent. (p1646-2580)* *There's one near me house, Urgent Care. (p1646-2869)* *Yes (p1646-2876)* *Yep (p1646-2941)* *there is (p1646-2972)* *Yes (p1646-3001)* *Yeah. There's actually an Urgent Care at the same building as well. (p1646-3077)* *Yeah (p1646-3092)* *Yes (p1646-3134)* *Yes (p1646-3157)* *Yes (p1646-3231)* *Yep (p1646-3362)* *Yeah (p1646-3473)* *Yes (p1646-3583)* *there's an urgent care and an ER here. (p1646-3600)*

1050. Preventive care - received in past 12 months	
No preventive care in past 12 months	*No, aside from a health risk assessment at work, but I don't think that qualifies. (p1646-2769)* *No (p1646-3001)* *No (p1646-3134)* *No (p1646-3157)* *No (p1646-3473)* *R: Yeah. So I'm trying to think, actually, like just that, I have my— oh, there it is. Let me just see here. Nope, nope, all of the COVID shots were in 2021. (I: Okay, so nothing in the past 12 months.) (p1646-3583)*
Yes - checkup	*Yeah, I had a checkup (p1646-2570)* *Yes. I do my annual health screening checkup (p1646-2607)* *Oh, I have that all since COVID shot and all that stuff. (p1646-2869)* *Wellness check or whatever you want to call it. (p1646-3133)* *I have been for a wellness check (p1646-3600)*
Yes - COVID vaccine	*my COVID (p1646-2607)* *COVID shot (p1646-2869)* *I got my COVID shot (p1646-3352)* *I've gotten all four of the COVID shots (p1646-3600)*
Yes - flu vaccine	*I believe they gave me the flu shot last time I was in the doctor's office. (p1646-2580)* *flu boosters (p1646-2607)* *Oh, I have that all since COVID shot and all that stuff. (p1646-2869)* *Flu shots (p1646-3044)* *I've received a flu shot (p1646-3097)*

Yes - general mention	*Yeah. (p1646-2011)* *Yes. (p1646-2364)* *Yep (p1646-2941)* *Yes (p1646-2972)* *Yes (p1646-3077)* *Yeah (p1646-3092)* *All of the above. (p1646-3231)* *Yeah (p1646-3362)*

1052. Preventive care - wanted but could not get	
No - R did not want preventive care	*No (p1646-3001)* *I was supposed to have made an appointment, but I haven't made one (p1646-3157)* *No (p1646-3583)*

1056. Provider recommended preventive care but R did not get	
No - provider did not recommend preventive care	*No (p1646-3001)*
Yes - provider recommended checkup	*A whole physical and all that. (p1646-3157)*

1060. ER - know which to choose	
No - do not know which ER to choose	*No. I should probably look into that. I haven't actually thought about it. When I was in Sun Prairie, I knew, but I, moving, haven't actually thought about it. (p1646-2607)* *Not really. (p1646-3157)*

	I do not know, honestly. I do not know the hospitals out here. (p1646-3352) *No. I haven't. I don't have my plan B. I should have that. I know there's something nearby. There's so many satellite medical facilities everywhere around here. I'm very impressed with it. So I just haven't googled it. Isn't that funny? (p1646-3600)*
Yes - know which ER to choose	*Yes. (p1646-2011)* *[Name of organization redacted] in [city]. (p1646-2364)* *The University Hospital (p1646-2570)* *It would be [redacted] (p1646-2580)* *Like for an immediate emergency, I would go to [redacted]. (p1646-2769)* *Probably [name of organization redacted]. (p1646-2869)* *Yes (p1646-2876)* *Yep (p1646-2941)* *Yes (p1646-2972)* *Yes (p1646-3001)* *Yeah (p1646-3044)* *Being in Milwaukee, I'm unfamiliar with the area, so I would hope it's [redacted] (p1646-3077)* *Yeah (p1646-3092)* *Yes (p1646-3097)* *Well, there's probably [name of organization redacted], I guess. (p1646-3133)* *Yes (p1646-3134)* *Probably [name of organization redacted] (p1646-3231)* *Yeah (p1646-3362)* *Yeah (p1646-3473)*

	since I have [redacted] Healthcare, it would probably end up being [redacted] (p1646-3583)

1062. ER - how far	
Shorter distance - 0-9 miles or 0-19 minutes	*eight miles. (p1646-2011)* *Seventeen minutes (p1646-2570)* *A couple miles, if that. (p1646-2580)* *I want to say it's about 3 or 4 miles from me. (p1646-2769)* *Probably, I don't know, maybe three miles, four miles. (p1646-2869)* *nine miles (p1646-3001)* *Four miles (p1646-3044)* *It's about 13 minutes. (p1646-3077)* *It's five or six miles maybe (p1646-3231)* *I'd say about maybe three miles or less. (p1646-3362)* *I would say about 15, 20-minute drive. (p1646-3583)*
Longer distance - 10+ miles or 20+ minutes	*Like 12 miles. (p1646-2364)* *Twenty minutes (p1646-2876)* *Twenty-five minutes (p1646-2941)* *40 minutes (p1646-2972)* *Fifteen miles (p1646-3092)* *I could not tell you in miles. It's about a 30-minute drive. (p1646-3097)* *It's approximately 50 miles. (p1646-3133)* *About 30 minutes (p1646-3134)* *33 miles (p1646-3473)*

1064. ER - why choose that ER	
Access or availability - speed of care	*The care I received there was also very quick, so that would also be a factor. (p1646-2769)* *But the one at [name of organization redacted], I waited for over four hours, and I was still fifth in line, and I was having chest pains. So my mom actually came and picked me up and took me over to [name of organization redacted], and they got me in right away. (p1646-3231)*
Attentive staff	*They're more attentive than the emergency room at [name of organization redacted] . (p1646-3231)*
Convenience - easier to navigate facility	*it's not as confusing. (p1646-3583)* *Easier parking. (p1646-3583)*
Convenience - location	*I guess it's convenient. I guess the location is pretty convenient. (p1646-2364)* *An immediate emergency because it's the nearest facility. (p1646-2769)* *[city], I think, would be the fastest. (p1646-2869)* *Because that is the closest one (p1646-2972)* *Just because it's closest. (p1646-3001)* *It's closest (p1646-3044)* *It's closest to me (p1646-3092)* *It is the closest one. (p1646-3097)*
Cost - insurance coverage	*the obvious, clear answer would be because of my insurance (p1646-3583)*
Feel comfortable there	*I feel comfortable there (p1646-2011)*
Good behavioral health team	*Because they have a good behavioral health team. (p1646-2570)*
Good opinion of care	*I like the care they give there (p1646-2364)* *I guess they do really good work there, I don't know. (p1646-2580)* *Well, I like the hospital. (p1646-2869)*

	I like the care they give (p1646-2876) *Because it's the best one in the area who are known for their work (p1646-2941)* *I feel the care there is adequate (p1646-2972)* *I've been in this community for a while, and it's a reputable hospital (p1646-3134)*
Previous experience	*Previous visits (p1646-2011)* *I've been there before, and I know a lot of people (p1646-2364)* *I probably went to it before (p1646-2570)* *I'm familiar and it was a good experience (p1646-2570)* *That's just where I've been going (p1646-2580)* *I've been there before. (p1646-2869)* *Somehow, [redacted] managed to professionally and carefully make sure that I have a life to look forward to. (p1646-3077)* *I have had good experiences there in the past, and my family has (p1646-3097)* *Because I've always went there. (p1646-3362)* *I've had a little bit better care at the [redacted] than the [redacted-2] Hospital. (p1646-3583)*
Staff know my conditions	*I think the doctors there know my condition well enough (p1646-2011)*
Use that facility for routine care	*That's where I typically, [name of organization redacted] is where I've been going for my regular healthcare (p1646-3133)* *I also have history there, gave birth to both my children at that hospital. (p1646-3134)* *I've always gotten the best service there. (p1646-3362)* *that's where I've been getting all my medical attention, and I really like it there. (p1646-3473)*

1070a ER - most recent visit health issue	
Asthma	*I went in because I was experiencing, I have asthma, so I wasn't able to breathe, and it was causing chest problems as well. (p1646-3092)*
Bladder infection	*I had a— What do you call it? A scope, where they looked inside my bladder, and I got a bladder infection from it. And they told me to, it was after hours, and I had a fever, and they told me to go to the emergency room. (p1646-3133)*
Childbirth	*I was in labor (p1646-3362)*
COVID	*I had COVID. (p1646-3157)* *I was COVID positive (p1646-3231)*
Cramps	*I had a track of cramps through the whole body, and I was in a lot of pain. (p1646-2869)*
Dehydration	*I was low on fluids. I was puking for like four days, and so I had to get IV and medicine at the emergency room. (p1646-2941)*
Dizziness	*I was having severe dizziness (p1646-3231)*
Esophagus problem	*I had a hard time swallowing. And I was going to see a— I was supposed to see a doctor, and I couldn't wait to see the doctor, so I went into the emergency room. And that's when I found out I had cancer in my esophagus. (p1646-3473)*
Eye problem	*R: I had something in my eye, and they, I couldn't get it out, couldn't get it out. They had to remove it. (I: All right. All right. Did they tell you what particular problem you were having with your eye, besides something being in there, was it just a foreign object or anything else?) R: Yeah, it was just a foreign object. (p1646-3001)* *I was having trouble with my contact lenses. I washed my hair with my contact lenses in my eyes, and there was some irritation to my eyes. (p1646-3134)*
Fracture	*The most recent time, I had been in a car collision myself. I was on a bicycle. And the end result of it was I had— my ankle had been shattered. (p1646-2769)*

	I broke my ankle (p1646-3352) *I had shattered my elbow and dislocated it as well. (p1646-3600)*
Gastrointestinal problem - general	*I have a gastrointestinal issue that's been ongoing for 12 years. I became very sick from it, so that's what prompted me to go to the ER. (p1646-2972)* *I had like a stomach infection of some sort. I don't remember what they said it was. It was like a, I think it was just like the stomach flu, but it was not fun, and they gave me some meds for that, so. (p1646-3044)*
Gastrointestinal problem - pancreatitis	*Okay. So I have chronic pancreatitis, and I had like a flare-up attack. And, you know, the pain was like excruciating. I can't even explain it. And so I went in. (p1646-2364)*
Hand injury	*I sliced my hand open pretty good with a— I was cutting a lime, and I cut my thumb deep, deep. (p1646-2607)*
Heart problem - general	*my chest got real tight. I got real dizzy, started sweating really bad, got nauseous, and my heart felt like it was fluttering (p1646-2011)* *Pericarditis. (p1646-2580)* *my heart rate was dropping down to like 49 (p1646-3231)* *I started having pain in my chest. And I looked online like to look at my symptoms. And all of the symptoms were matching up to a potential like heart attack. (p1646-3583)*
Infection	*Infection (p1646-2876)*
Mental health problem	*When I was going through a manic episode (p1646-2570)* *I'm having a hard time breathing. I haven't been sleeping. I have bad anxiety. (p1646-3077)*

Overdose - prescription medication	*I had mixed up my medication bottles with an old bottle of one of my former ADHD prescriptions. So I essentially accidentally double-dosed on ADHD medication, which are stimulants. And I had been feeling tightness in my chest of the kind that when you go back on a medication, they recommend you look out for. I called my primary care. They told me I could come in the next day, and I should probably just go to the ER to get it looked at. (p1646-3097)*

1070b ER - successful treatment or transfer	
No - Treatment was unsuccessful	*R: No. (I: Okay. Would, did they transfer you to another healthcare provider for treatment for it?) R: No. They told me to check back with my primary. (p1646-2972)* *(I: Okay. Did they refer you to another provider? Were there any referral they gave you then?) R: No. I had to wait like 6 days to see my primary doctor, and then he's the one that put in a referral to mental health. (p1646-3077)* *They neglected to see that it was dislocated and sent me home. (p1646-3600)*
Yes -Treatment was successful	*Yeah (p1646-2011)* *R: They, it took them a little while to figure stuff out. I mean, and they knew all my history because I've been there so many times in the past, which is kind of weird. But they, you know, gave me pain medicine and got me settled down. And, you know, after a while, it passed. But I don't know. I don't really know what else you want to know. (I: Okay. Would you say that they were able to successfully treat your issue there?) R: Yeah. I mean, they should have been able to treat it sooner, I would think. But maybe they were just busy, but yeah. (p1646-2364)*

R: When I was going through a manic episode. It was inpatient. (I: Okay. So, you got admitted as an inpatient from the emergency room then?) R: Yeah. (I: Would you say that they were able to successfully treat the issue there?) R: Yes, I would be able to curb my manic episode. (p1646-2570)

No, they did it there, and then they gave me indomethacin and colchicine. (p1646-2580)

(I: Okay. Were they able to successfully treat the issue there at the emergency room? Did they refer you to somewhere else for a follow-up?) R: Nope, they were able to super glue it back because the spot it was in, they didn't want to do stitches. And the super glue held it together. And I just had like a wrap around my finger for a while. (p1646-2607)

They were able to take care of everything on site. By the time I left, my leg was in a support boot, not a cast. But, yep, I had crutches and everything. I mean, as far as pain relief goes, I tend to make a point of not asking for or accepting opioids unless it's absolutely necessary. So realistically, I just went home, and started taking ibuprofen every day. (p1646-2769)

Everything turned out to be okay. (p1646-2869)

Yes (p1646-2876)

Yeah (p1646-2941)

They treated me right there. (p1646-3001)

I'd say it worked, yeah. (p1646-3044)

yeah, they were able to treat it (p1646-3092)

Yes (p1646-3097)

Yes (p1646-3133)

Yes (p1646-3134)

Well, they did the best they could. (p1646-3157)

Yeah. They said it was, it was part of COVID. (p1646-3231)

	I don't like the boot they gave me because it wasn't all necessary. (p1646-3352) *Yep (p1646-3362)* *They provided the medication that I needed, and that's when I had the radiation and chemo. (p1646-3473)* *Yes (p1646-3583)*

1070c ER - satisfied with experience	
Not satisfied - competence of staff	*R: No. They're terrible. I wouldn't recommend anybody go there. (I: Okay. That's definitely the kind of thing that we'll be asking about as we go along here. I just want to ask you, in general, how satisfied would you say you were with the experience for that visit?) R: Like a one to ten? (I: Sure. You could describe it if you feel like giving us—) R: Yeah, I wasn't happy at all. They're, I mean, I was, you know, poked, trying to get blood work, and they can't get it, and they got to bring different people in. They just don't seem like they're, they know what they're doing. (p1646-2364)* *They didn't do their job the first time. Of course, I was going to go right back to where they screwed it up. You know, they didn't fix it. They needed to fix it. And they should not have student doctors doing whatever they did to me. (p1646-3600)*
Not satisfied - ER staff considered visit non-emergency	*the physician told me, they're there for emergencies. So they didn't see me being in an emergency situation, so, therefore, they suggested to me to go back to my primary. (p1646-2972)* *I'm sorry, but there's definitely something they could have done about it that they didn't feel like doing or were worried about lawsuits. (p1646-3077)*

Not satisfied - no clear diagnosis	*Just not able to get a confirmed answer as to what the underlying problem was. I didn't know if I had a persistent heart problem, if I didn't have, or if it was caused by asthma. I never got a solid answer as to if it was going to be something that could happen in the future and what I could do in the future to prevent it, if it's just something that like, you know, my albuterol inhaler would be able to fix. (p1646-3092)*
Satisfied - care was efficient	*Yeah, it was very efficient (p1646-3362)*
Satisfied - competence of staff	*R: Yeah. I mean, for me, it seemed like everybody that I interacted with was friendly and competent. So that's a big thing to me is— a previous time that I had to stay at an ER and was an extended stay, and I interacted with a lot of doctors that I was very surprised they graduated high school or practicing medical. (I: Are you talking youth or competence?) R: So, yeah, they all seemed competent. And, you know, they did the job, and that's really what I look for in a hospital is getting the right kind of care the right way at a good pace. (p1646-2769)* *I was satisfied with the care I received. It was late at night, and I know they were a little understaffed, so the care was as adequate as they could provide at the time. (p1646-3092)* *Yeah. The doctor was very good. He explained things very well. (p1646-3231)*
Satisfied - friendly staff	*Yeah. I mean, for me, it seemed like everybody that I interacted with was friendly (p1646-2769)* *they were good, really nice, and helpful. (p1646-2869)*
Satisfied - satisfied - general	*Yes. (p1646-2011)* *Yes. (p1646-2570)* *Yeah. (p1646-2580)* *Yes. (p1646-2607)*

	Oh, oh, yeah, absolutely. (p1646-2769) *Yep (p1646-2941)* *yeah (p1646-3001)* *Yes (p1646-3044)* *Yes (p1646-3097)* *Yes (p1646-3133)* *Yes (p1646-3134)* *Yes (p1646-3157)* *Yeah (p1646-3352)* *Yes (p1646-3473)* *Yes (p1646-3583)*
Satisfied - speed of care	*Well, I stated before, it was quick care. They got me in and out far faster than I've ever gotten out of the ER. (p1646-2769)*

1080. ER - whose choice to go	
Family member made R go	*I didn't want to go, but my partner made me go. (p1646-2364)*
Joint decision	*It was a joint decision (p1646-2570)*
Respondent chose	*Yeah. So I felt like it was important to go, and I called and spoke to a nurse. (p1646-2011)* *It was my girlfriend's choice, but I decided— we both decided to go because I was having trouble breathing. (p1646-2580)* *No, I made it pretty quick myself. (p1646-2607)* *I made the choice to go (p1646-2769)* *I made the choice. (p1646-2869)* *I did (p1646-2876)* *I did (p1646-2941)* *I did (p1646-2972)* *I made it (p1646-3001)* *I made it (p1646-3044)*

	I made the choice to go. (p1646-3077) *I made the choice (p1646-3092)* *I made the decision (p1646-3134)* *Yeah (p1646-3157)* *I made the choice to go (p1646-3352)* *I made the choice to go in (p1646-3362)* *It was very clear to all of us I needed to go to the hospital (p1646-3600)*
Telehealth staff told R to go to ER	*I called my primary care. They told me I could come in the next day, and I should probably just go to the ER to get it looked at. And in the event of—Just to have them give me a quick checkup on my heart. (p1646-3097)* *I made the choice to go on the recommendation of my primary care (p1646-3097)* *I guess I made it. You know, they recommended that I go in, not wait anyway. (p1646-3133)* *The [name of organization redacted] nurse line told me that I needed to go. (p1646-3231)* *I called the doctor's office that I was supposed to go to for the check-up or whatever. And they told me I might as well just go right to the emergency room. (p1646-3473)* *first I called my doctor's office and talked to the nurse there, explained the symptoms. And she's like, "Yeah, we would definitely not recommend you coming here." Because that's where I was first thinking of, you know, going. And she's like, "We would not recommend you coming here. We would recommend you going to the hospital immediately." And so I ended up going there. (p1646-3583)*

1082. ER - why R chose ER vs other place

Access or availability - distance to facility	*I guess it was close, (p1646-2364)* *I just knew that it was within a two-minute drive. And I faint when I see blood, so I didn't want to drive far and then have the blood leak out and then me collapse while I'm driving. So just to keep a safety aspect, I just went to the closest possible place. (p1646-2607)* *Because it was fairly close. (p1646-3097)* *Because it was convenient. (p1646-3134)*
Access or availability - ER was only option certain to be open at the time	*I just knew that the emergency room was going to be open. (p1646-2607)* *Because it was like 8:00 or 9:00 at night (p1646-2607)* *Because it was at midnight or like 1:00 in the morning (p1646-2876)* *at that time of day, that was my only option (p1646-2972)* *It was 2:00 in the morning. There was no urgent cares open. (p1646-3001)* *The time of day. Urgent Care was not open at the time, and it was something that I couldn't make an appointment for because it was an emergency. (p1646-3092)* *There was nowhere else really that I knew where to go (p1646-3097)* *At that time, on a Saturday night, that's the only place to go. (p1646-3133)* *Well, at that time of night there was no urgent care or nothing like that open. (p1646-3157)* *Because we don't have, that I know of anyway, an urgent care that's open. Because this was late in the evening, and we don't have, as far as I know anyway, an urgent care in this area that was open that late. (p1646-3231)* *Well, it was at night. The doctor's office was closed. (p1646-3352)*

	I went to the emergency on January 25th because the clinic wasn't open (p1646-3362) *I didn't really have another option. You know, I knew, I don't know where else I would have gone. (p1646-3600)*
Access or availability - more doctors available	*more doctors (p1646-3157)*
Access or availability - speed of care in ER	*he wanted to get me somewhere as soon as possible. (p1646-2364)* *Because of how soon it needed to be addressed (p1646-2570)* *The wait time to see some kind of behavioral health professional. (p1646-2570)* *I just thought it would be faster (p1646-3044)* *I figured the emergency room would be the fastest solution to the problem, my problem. (p1646-3134)* *So I could be treated immediately. (p1646-3157)*
Advice - telehealth staff advised visiting ER	*I called the doctor's office that I was supposed to go to for the check-up or whatever. And they told me I might as well just go right to the emergency room. (p1646-3473)* *It's because I was told by my doctor's office to go to the emergency room. (p1646-3583)*
Cost - insurance would cover care	*It was a place that I knew would be covered by my insurance (p1646-3097)*
Doctors are more experienced	*Well, they're more experienced (p1646-3157)*
Friendly staff	*the doctors there are usually friendly in my town (p1646-3044)*
Medical history	*I mean, he knows my past with my pancreas issues, (p1646-2364)*
Not accustomed to urgent care	*I was born in the '80s, and so kind of used to— I'm not really used to Urgent Care centers, and so I don't know the process applying to the Urgent Care facility and actually utilizing it. (p1646-3134)*

Perceived severity - concern about health	*Well, because I was scared. I didn't know what in the world was going on. So I was kind of just scared. And I wanted to make sure everything was okay. (p1646-2869)* *Just an immediately high fever, I guess. (p1646-3133)*
Perceived severity - pain	*I was in a lot of pain (p1646-2364)* *I didn't know what else to do to make the pain stop. (p1646-2580)* *Because I was in such massive pain I couldn't take it anymore. And I was, you know, going to make sure that everything was okay and truly hoped it, in hopes that maybe they could find something. (p1646-2972)*
Perceived severity - situation required emergency care	*R: Because I felt like it was an emergency. (I: Okay. Anything else?) R: No, I was just scared. (p1646-2011)* *I guess it was probably the best decision to go there. It could be, a lot of the things could have happened (p1646-2364)* *I literally couldn't call urgent cares or anything because I was bleeding so much. I didn't have, I just went to the nearest emergency room. I didn't have time to google or call around if there were clinics open. (p1646-2607)* *at the time, I just kind of knew I needed care. And I really— you know, it was just my first instinct. Call 911, tell them what happened, and be like, I got to get somewhere. (p1646-2769)* *R: Because I just needed fluids bad. I could barely even walk because I was so lightheaded. (I: Okay. So it was serious enough that you needed to go to the emergency room for that.) R: Yeah. I pretty much knew that's the only place to go. (p1646-2941)* *(I: Okay. Was there a time-of-day issue at all? Was it when other things would have been closed?) R: No, it was just the doctor's office, nowhere else*

	has the medicine, like the IV medicines and stuff like the emergency room does. (p1646-2941) *Because I couldn't breathe. I was having a panic attack worse than I ever have. (p1646-3077)* *The condition was getting to the point where I realized I shouldn't wait. It needed to be addressed immediately. (p1646-3092)* *Because I knew my ankle was broken, and ER was the only one that could really take care of it. (p1646-3352)*

1084. ER - ever consider going elsewhere	
No - ER was clear choice	*I felt like that was the place I should have gone. (p1646-2011)* *Yeah, it was clear I needed to go there. (p1646-2364)* *That was the only place I should have gone (p1646-2570)* *No (p1646-2580)* *That was the only place I even thought of. (p1646-2607)* *I had not particularly considered it. I had a feeling that my, you know, at that point, I had a pretty good idea that my foot was broken. And I don't have my own vehicle or too many people with transportation in my life. So I kind of just called 911, and, you know, I assumed they would take me to an ER. I didn't necessarily consider Urgent Care would have been an option going that route. If I were— if I had a vehicle or somebody that could have driven me, then I may have considered going to an Urgent Care because I know they typically cost less. (p1646-2769)*

No, I never even thought of it at the time. I probably could have went to Urgent Care. But I just didn't think of it at the time. (p1646-2869)

The only place. (p1646-2941)

at that time of day, that was my only option (p1646-2972)

I just couldn't handle it no more. : I tried to wait as long as I could. (p1646-3001)

I'm fairly certain it's the only place I could have gone in that situation because it was, yeah, kind of short notice. You don't really get a lot of time to prepare when you get sick. (p1646-3044)

At that time, on a Saturday night, that's the only place to go. (p1646-3133)

Emergency room. (p1646-3157)

Well, I asked the nurse line if I could wait until the morning, but they said that it said that I needed to be seen within four hours. (p1646-3231)

That's the only place I could have gone (p1646-3352)

No, it was just clear that that's where I should have went. (p1646-3362)

Yeah, they told me to go right to the emergency room (p1646-3473)

It was just very clear to go to the emergency room. (p1646-3583)

I knew I had something that required ER care. (p1646-3600)

Yes - considered different option	*(I: Okay. So in this case, you chose the Hayward emergency room. And the alternative you're talking about would have been another emergency room in Spooner?) R: Yes. (I: Okay. For this question, we ask people to think a little bit differently about this. Was there— did you ever consider not going to the emergency room or going to a different type of place?) R: Yes. (I: Okay. And can you tell me about the place that you considered?) R: I considered going to the Spooner emergency room just because they provide better, more attentive care. And I feel like they have more resources there. (I: Okay. One more way for me to ask this is, did you ever consider waiting and going to, say, Urgent Care, rather than going to the emergency room?) R: Yes. (p1646-3092)*

1086 & 1088. ER - non-health reason for choosing	
No - only health-related reasons	*No (p1646-2011)* *No, just basically that. (p1646-2364)* *Timing, that was my biggest thing. Like if it's after 8:00, I assume all the urgent care places are closed. (p1646-2607)* *No. (p1646-2869)* *No (p1646-2941)* *No (p1646-2972)* *No, because, like I said, it was just the time of the day. (p1646-3001)* *No (p1646-3044)* *R: I felt that I needed to get the treatment as soon as possible. (I: Okay. So the urgency of your health condition is what you're talking about there.) R: Yeah. (p1646-3092)* *Not particularly (p1646-3097)*

	It was pretty evident that that would work fine. And it had been recommended to me, so. (p1646-3097) *No (p1646-3133)* *No (p1646-3231)* *I was instructed by my doctor that if the clinic wasn't open, to go to the emergency. (p1646-3362)* *No (p1646-3583)* *I didn't really have another option. (p1646-3600)*

1090 & 1092. ER - doctor ever said R should have gone elsewhere	
No - never told that R should have gone elsewhere	*No. (p1646-2011)* *No. (p1646-2364)* *No (p1646-2570)* *No. I grew up in a "You do not go to the emergency room unless you're dying," kind of household. And so if I'm at the emergency room, I've never been told I shouldn't be there. (p1646-2607)* *I have actually never ran into that, no. (p1646-2769)* *No, they didn't say anything like that. (p1646-2869)* *No (p1646-2876)* *No (p1646-2941)* *No (p1646-2972)* *No (p1646-3001)* *No (p1646-3044)* *No (p1646-3092)* *No (p1646-3097)* *No (p1646-3133)* *No (p1646-3134)*

	No (p1646-3157) *No (p1646-3231)* *No (p1646-3352)* *No (p1646-3362)* *No, not really. (p1646-3473)* *No (p1646-3583)* *never (p1646-3600)*
Yes - staff told R to self-treat MH problem	*Yeah. When I went in there about my anxiety, they said, well, all I can say is take a deep breath, drink water, I mean, get a hold of mental health. And I said, you know, I did call mental health. I'm on a 6-month waiting list. They said, well, you got to follow protocol. I'm sorry, but there's definitely something they could have done about it that they didn't feel like doing or were worried about lawsuits. (p1646-3077)* *(I: Mm-hmm. At what point in your visit were you told that you should have gone somewhere else or you should have done those other things?) R: When the doctor actually came into the room and seen me. (I: Okay. So the doctor told you that at that point?) R: Yes. (I: Okay. Did they refer you to another provider? Were there any referrals they gave you then?) R: No. I had to wait like 6 days to see my primary doctor, and then he's the one that put in a referral to mental health. (I: Okay. So for that appointment with your primary doctor, did you make that yourself, or did the emergency room refer you to them?) R: I made that myself. (p1646-3077)*

1100 & 1102. R avoided ER despite thinking it was emergency - reason	
No - R never avoided ER in emergency	*No, not since I've been on BadgerCare. (p1646-2769)* *No. (p1646-2869)* *No (p1646-2876)*

	No (p1646-2941) *No (p1646-3001)* *No (p1646-3044)* *No. I listen to my body and try to take care of it. (p1646-3077)* *No (p1646-3092)* *No (p1646-3097)* *No (p1646-3133)* *No (p1646-3157)* *No (p1646-3231)* *No (p1646-3352)* *No (p1646-3473)* *No (p1646-3583)* *No (p1646-3600)*
Yes - Did not want to be separated from family	*I didn't want to be separated from my girlfriend (p1646-2570)*
Yes - Expected lack of treatment	*they probably wouldn't have treated it, so, you know, very well anyway. So I just treated myself. (p1646-2364)* *Because, again, I knew there was probably nothing that they would do for me. So I just suffered through it. (p1646-2972)* *Well, it appears that I go through bouts with my stomach. And after going through that one, and having the results that I did, it would be futile for me to go. It's not effective for the cost, for the time, and for the results. (p1646-2972)*
Yes - Expected wait time	*I guess I didn't want to deal, you know, with having to wait there for hours at a time, (p1646-2364)*
Yes - Prior bad ER experience	*I felt like I was having an emergency, but I chose not to go to a place because of how I was treated previously. (p1646-2011)*

	Yeah. I guess once I was shoveling snow, and I kind of twisted or hurt something in my back. And I probably should have went, but I didn't go just because of prior experiences that I've had in the ER. (p1646-2364)
Yes - Thought problem would go away on its own	*Yeah. I just figured I could, it would pass, and I would get over it. (p1646-2570)* *I just thought that I was going to be able to sleep it off maybe, that I would— the inflammation would go down on its own, but it didn't. (p1646-2580)* *Once within the last 6 months. I was trying to avoid it to see if the pain would go away by morning, but the following day it was not going away at all. So I went in. (p1646-2580)* *I didn't go in because I figured it would just go away, I don't know. (p1646-3134)*

1104. R avoided ER - health problem	
Back injury	*once I was shoveling snow, and I kind of twisted or hurt something in my back. (p1646-2364)*
Bacterial meningitis	*bacterial meningitis. (p1646-2011)*
Gastrointestinal problem	*R: Well, it appears that I go through bouts with my stomach. And after going through that one, and having the results that I did, it would be futile for me to go. It's not effective for the cost, for the time, and for the results. (I: Okay. So this is after that August visit for the gastrointestinal issue.) R: Right, correct. (I: Okay. And so you had more recent gastrointestinal pain with that. (p1646-2972)*
Head injury	*I hit my head, and I thought that maybe I had a slight concussion. (p1646-3134)*
Heart problem	*(I: What kind of things were going on with you then? Was that also the pericarditis?) R: Yeah. (p1646-2580)*

Mental health medication reaction	*Well, it was after I got out of the inpatient, I was put on some meds, and I had a bad reaction to one of them and wasn't able to get a prescription but felt like in the moment like I needed to get some immediate treatment. (p1646-2570)*

1106a Chronic conditions - effect on health care needs	
Frequent appointments	*I go quite regularly to quite a few different doctors and specialists. (p1646-2364)* *Well, yeah, all I know is that I have to be seen because of my conditions. (p1646-2972)* *I need slightly more medical care, medical treatment than I would say the average person because, yeah, with addiction counseling and the medication treatment I receive. (p1646-3092)* *It seems like I am always doctoring for something. Like it just, my appointments are just kind of spread out, or it seems like I have one every week or two. (p1646-3231)*
Multiple facilities required	*They can't all be handled at one facility, so I transfer between multiple facilities. (p1646-3092)*
Prescription difficulties	*I've had trouble with getting prescriptions filled. So I've had to change pharmacies. (p1646-3092)*
Some providers handle chronic conditions better	*I have found, you know, some doctors that, and hospitals that like I'd rather go to more than others just because of the way they, you know, treat the patients and their knowledge and expertise and other things. (p1646-2364)*
Specialized equipment required	*R: I live in a town where there's a walk-in clinic. And because they don't have certain equipment that they would need for my particular condition, I have to go to a certain one. (I: Okay. So your condition means you have to go to a clinic with more equipment there, okay.) R: The equipment, yep. (p1646-2011)*

1106b Chronic conditions - effect on ER use	
Chronic conditions become acute and need ER care	*R: I would just simply say it's been a lot more than I ever would have. (I: Okay. Visit emergency rooms more than you ever would have?) R: Yeah. (p1646-2011)* *In the past, I've had to go for issues, you know, like with my back or hips and knees. (p1646-2364)* *Like I said, it was an urgent matter one time, and that's why I had to get in there. (p1646-2570)* *because my bone density is so depleted, there are times that I have had to go to the ER because of fractures. So does that answer it? (p1646-2972)*
ER staff dismiss patient concerns about condition	*they seem to just want to dismiss everything or say it's in your head, you know, and not like what you're feeling isn't about illness or pain or something like that. (p1646-2364)*
Psychiatric facility access procedure required ER visit	*If I have suicidal ideations, which doesn't happen very often, like I haven't had that for years. But I did happen to have it last February. And [name of organization redacted] is the only place that has, at least that I was told, it has a psychiatric facility, a patient facility. And so you have to go through the emergency room to be admitted for that. (p1646-3231)*

1110 & 1112. BadgerCare charged co-pay for ER visit	
Never charged BadgerCare ER co-pay	*No (p1646-2570)* *No. (p1646-2580)* *I don't think so. (p1646-2607)* *No, I have not paid any copayments. (p1646-2769)* *No, I don't remember paying. (p1646-2869)* *No (p1646-2876)*

	No (p1646-2941) *No (p1646-2972)* *No (p1646-3001)* *No (p1646-3044)* *No, not once. (p1646-3077)* *No (p1646-3092)* *No (p1646-3097)* *No (p1646-3133)* *No (p1646-3134)* *No (p1646-3157)* *No (p1646-3231)* *No, I had no copayment. I was shocked. (p1646-3352)* *I haven't had to (p1646-3362)* *No (p1646-3473)* *no (p1646-3583)*
Received bill, unsure whether it was from BadgerCare	*R: I'm not sure if that would be a no. Just because, I've went to the emergency room but at the time of the visit I didn't have to pay. But then later, I got billed for services. And, well, yeah, I think that was when I was participating in a plan with BadgerCare. (I: Okay. So the services that you got billed for, was that a bill from the BadgerCare program, from the hospital directly or?) R: The hospital. (I: The hospital, okay. So they billed you in that situation. Okay. So we got down that it wasn't a BadgerCare copayment. It was a hospital bill for that. (p1646-2011)*

	(I: What I want to ask you here is in that situation, you got that bill from the hospital. Did you get a bill for a copay from the BadgerCare program itself? Do you remember whether that occurred then?) R: No. I have to say, they all come through the online portal. (I: That's the MyChart portal?) R: Yes. So they can come from several different places, so I can't answer precisely where it came from. (p1646-3600)

1122. Has BadgerCare coverage for ER changed	
Not aware of BadgerCare ER coverage change	*No. (p1646-2011)* *No (p1646-2570)* *No. (p1646-2580)* *I don't know. I don't actually know anything about it. (p1646-2607)* *Not so far as I know, no. (p1646-2769)* *Not that I know. (p1646-2869)* *No (p1646-2876)* *Nope (p1646-2941)* *No (p1646-2972)* *No (p1646-3001)* *Not that I'm aware of, no (p1646-3044)* *No. It's all been very simple. (p1646-3077)* *No, not that I'm aware of (p1646-3092)* *I do not remember what was in that letter. (p1646-3097)* *Not that I'm aware of, no (p1646-3133)* *As long as I've been on with BadgerCare, no, it hasn't. (p1646-3134)* *No (p1646-3157)* *Not that I'm aware of. (p1646-3231)*

	No (p1646-3352) *No (p1646-3362)* *No (p1646-3473)* *to my knowledge, it has not changed (p1646-3583)*

1124. Do BadgerCare members have to pay for ER services	
Maybe BadgerCare members need to pay ER co-pay for non-emergency visits	*R: I was told that, I don't remember, but that if you were seen in the emergency room and it was deemed not an emergency, that you could have to pay a copay. (I: Okay. Do you know whether that's a policy that's in place now?) R: I believe that it is, but I don't know for sure. (p1646-3231)*
No - BadgerCare members do not pay for ER services	*R: I don't believe you have to. (I: Okay.) R: There's different types of BadgerCare programs but not what I'm on, I guess. (I: Okay. So from your experience, that's a no then, all right.) R: Right. (p1646-2364)* *No (p1646-2570)* *As far as I know, no, but I've never looked at a bill yet that I've received from the hospital (p1646-2941)* *I don't think so (p1646-3001)* *No, not that I know of, I don't think so. (p1646-3092)* *Not to my knowledge. (p1646-3097)* *No (p1646-3352)* *Generally don't (p1646-3362)* *to my knowledge, for me, no. (p1646-3583)* *I don't think so. (p1646-3600)*
Unsure - Don't know whether BadgerCare members pay for ER services	*Yeah, I don't know. I never really questioned it. (p1646-2607)* *I don't know. (p1646-2869)*

	I don't know the answer to that (p1646-2972) *I'm not entirely sure about that. (p1646-3044)* *I don't know. (p1646-3133)* *No, I don't. (p1646-3157)*

1131 & 1132. Many people go to ER for routine problems	
Agree - lack of awareness of non-ER options leads to ER non-emergency use	*people, without having a primary care doctor or realizing that urgent care is available or without people being aware that there are other places they could go before they go to an ER, that they just go to the ER first. So I think that that's a lack of education and a lack of awareness on a lot of people's parts that that's their choice. (p1646-3600)*
Agree - people go to ER due to lack of health insurance	*I agree. I think they do that because they don't have health insurance. (p1646-3077)*
Agree - people mistake routine problems for emergencies	*Because people think that things are emergencies that turn out aren't, (p1646-3097)* *I agree. Sometimes— well, I'm sure people don't realize how serious things are. I know I've been myself don't realize how serious something is until you find out what's really serious to go to an emergency room or what isn't. (p1646-3473)*
Agree - people seek drugs in ER	*I mean, I come from Racine, and I'm well aware that there are people that go in there just for drug-seeking reasons. (p1646-3077)*
Agree - people want to be seen immediately	*some people are just entitled and think they should be seen immediately, even if it's not actually an emergency. (p1646-3097)* *the timing is not right to get something taken care of, expedited as soon as possible. (p1646-3133)*

Agree - people who have been uninsured in the past have a habit of using ER for primary care	*I feel like people have been uninsured in the past, don't have primary or dental and have primary care physicians, tend to use the emergency room more often. (p1646-3231)*
Agree - routine facilities are often full	*most of the time, local facilities are booked up, and you don't have a chance to get there. (p1646-3133)*
Agree - sometimes people go to ER when care could wait	*R: Oh, I've been at the emergency room before, and somebody has been there and has a cough. It's not really productive. There's no fever. There's no coughing up blood. I mean, even though it should be something that could have been treated at home. Or, you know, they could have called and spoken to like a nurse on call or their 24-hour online clinic. I know some places have that as well available at night. I feel like a lot of stuff could be treated at home, even, well, yeah, more so before the pandemic, but. (I: Okay. So that's your experience being a patient in the emergency room for your emergency and seeing other patients who were there for non-emergency stuff.) R: Correct. (p1646-2011)* *R: Yeah. I've had friends with young children that have like maybe an ear infection or throat or something that it could either wait until like the next day, or not an ER. Were you talking about ER or urgent care? (I: ER is what we're talking about here.) R: Yeah. Like more geared towards urgent care or their primary doctor. (p1646-2364)* *yeah, I've met quite a few people that seem to treat the ER as the first choice of medical care. (p1646-2769)* *I agree. And my reasoning is because I know people that that went to the emergency room for no reason, pretty much. It's kind of ridiculous. (p1646-2941)* *when you go to the emergency room, you can see the people there that are doing it. (p1646-3001)* *That's generally true. (p1646-3044)*

	I believe so, yeah. I think people overuse the emergency room for things that definitely could be taken care of by an urgent care or by a doctor's appointment that would be a scheduled visit. (p1646-3092) *well, like I stated, is because there are people that, even though it's routine and so should be going to a doctor's office, they feel that the ER is more suited in treating said routine situation. (p1646-3583)*
Agree - stress can make patients think conditions are more serious	*I just think there's some people out there that probably, you know, their condition needs that degree of attention. I'm not saying a lot of people do it. It's probably like a margin, but I could see where some people would feel the stress enough to seek treatment in an emergency room rather than professionals. (p1646-2570)*
Disagree - non-emergency ER use is not common	*One time. I can only think of one instance in my entire life that someone could have waited and just gone to the doctor or urgent care without being in the emergency room. (p1646-2607)* *I would disagree. I don't think it's common. I think it happens, but it's not common. (p1646-2607)* *R: No, I would say I disagree with that. (I: Okay. Can you tell me why you disagree?) R: Well, I would think that, again, why would people want to go there unless it was a state of emergency? (p1646-2972)* *Because they figure it's an emergency, so it's an emergency. Like usually, if you stub your toe, you don't go to the emergency room, but if you see bruising, and it like swells, and you can't walk on it, then you know to go to the emergency room, even though you just bumped your toe. So I think like it just depends on the person and their opinion of what an emergency is. (p1646-3134)* *if it's a routine thing, most people have appointments for those things and don't need to go to the emergency. (p1646-3362)*

Unsure - Don't know whether many people use ER for non-emergency events	*I can't speak for everybody. I don't know. (p1646-2869)* *I don't know. I don't know what other people do. (p1646-2876)*

1133 & 1134. Reasonable for BadgerCare to charge $8 for non-emergency ER care	
Agree - care costs money	*Yeah. I think the doctor's time is important too. So, there should be some sort of fee that is involved. (p1646-2570)* *The hospital has got to, you know, pay their bills too. (p1646-2580)* *Well, yeah, you got to pay something. You can't have everything for free. You know, you got to pay for some things. (p1646-2869)* *Just because it's a non-emergency and just wasting emergency room time, I guess. (p1646-3133)* *it acknowledges that the patient has been there and taken the doctor's time. (p1646-3600)*
Agree - fee is affordable	*I think, you know, if you go and that's the case, that it's not like it would break the bank or anything. (p1646-2364)* *Eight dollars is not much. (p1646-2570)* *So I think $8 is— you know, that's kind of feasible. (p1646-2580)* *It's only $8. (p1646-2580)* *I agree. That is not a life-changing amount of money. I agree. (p1646-2607)* *because $8 is not an unreasonable amount given that, aside from chronic hypochondriacs, for most people that wouldn't be an event that occurred more than once or twice a year at most. (p1646-3097)*

	Well, if it wasn't, then the $8 shouldn't be no problem. (p1646-3157) *I think that's a more than reasonable fee or expectation for that. (p1646-3231)* *Well, I'll tell you what, they could charge a lot more. But if you're on a fixed income or you don't have the money, and you do have $8 in your pocket, I think that's reasonable. (p1646-3352)* *Yeah, $8 is not bad. In fact, it's really good. (p1646-3352)* *But it's also not bleeding the poor people dry. $8 is a lovely fee to pay. I'd be thrilled to get a bill like that if I had ended up in the wrong place because I wasn't aware of where else I should go. (p1646-3600)*
Agree - fee is low compared to ER treatment costs	*It's just a small fee for the amount that, you know, an emergency visit costs. (p1646-2364)* *I would think that $8 isn't that much for the services that are provided. (p1646-2972)*
Agree - fee will discourage non-emergency use of ER	*I guess I would agree because it's like important for those people to sort of get with the program and the fee is like a punishment, I guess. (p1646-2570)* *I grew up that you don't go to the emergency room unless it's an actual emergency because if we have people going to the emergency room that shouldn't be there, or they're not emergencies, people that are actually in need of like emergency care can't get in, you know. Like you're already going to have to wait, and some people just can't wait. So if you can like go to a clinic or somewhere that's not emergency room, you should do it. (p1646-2607)* *Yes, I would agree with that. I think that's something that should be— maybe not necessarily punished, but it should be discouraged, certainly. (p1646-2769)*

	if you could wait or go to your doctor, and you're just choosing to go to the emergency room, but like I said before, I don't know why someone would do that. It's an $8 fee. If it was during the day, and you went to the emergency room instead of your doctor, yeah, I agree with the $8 fee then. (p1646-2876) *I'll agree just because you shouldn't be wasting resources and time of the emergency people if you don't have to be, if somebody else could use it more. It could be more important to somebody else. (p1646-2941)* *Just because it prevents people from overusing the emergency room and using it and taking up resources that would be utilized, you know, better elsewhere, or just someone else who's actually having an emergency. (p1646-3092)* *I think the emergency room should be utilized for emergencies as well. (p1646-3231)*
Agree - general agreement	*Because we should, you know. We should. No other really reason for it. I just think we should. (p1646-3001)* *Oh, yeah, it's reasonable (p1646-3044)* *I agree. I think if it's not serious, you could pay a little something. (p1646-3473)*
Agree - if fee is in rules then patients should pay it	*No. I mean, if BadgerCare says that no matter what, the trip to the emergency room costs $8, and you feel the need to go to the emergency room, you should be conscious enough to know that that's going to cost $8. (p1646-3077)* *I agree with it because I believe that is standard procedure, so yeah. (p1646-3092)*
Agree - other people pay more	*I mean, a lot of people have to pay a lot more. (p1646-2580)*

Disagree - treat without payment if patient thinks situation was emergency	*I guess no because I mean, if the patient felt like it was an emergency or they experienced, you know, previous symptoms that they're having now that could have been part of their condition, they're having a condition that their symptoms make it feel like it's, I don't know, worse. I mean, if it was me, I would go. (p1646-2011)* *just to charge people depending on whether the doctor thinks it's an emergency. No, that's not right. You choose to treat the people. (p1646-3134)* *Because I feel like if you go, if you go into the emergency, and you feel like it's an emergency, they kind of just treat everybody the same based on what your needs are or what your problems are. (p1646-3362)*
Undecided - R cannot answer yes or no	*so I would, that's why I'm like kind of hemming and hawing on this yes or no question because, you know what I mean, because like you're saying that it's okay for the doctors to say, for BadgerCare to charge $8 if the doctor is saying it was not a medical emergency. But if the person is, the patient is thinking it's an actual medical emergency because of the symptoms they're having, and it's come to find out that, "Oh, this is actually this, not that," it's actually not an emergency, and you're charged the $8, that's something that you're not expecting. So then, I guess, but see, I want to say no because if you're expecting like a yes or no question about that, then it would be a no. (p1646-3583)*

1135 & 1136. Often difficult for people to know whether problem is emergency	
Agree - conditions might vary over time	*They might think it's, you know, they got to get there right away. But really, you know, they could wait until the next morning or something like that. (p1646-2364)*

Agree - different people experience symptoms differently	*R: Yeah. I think, you know, people have different, like when you're in pain, you might have, somebody else might have pain, and they feel, you know, different about it. I don't know. It's hard to explain. (I: Sounds like you're saying different people might have different ways of being able to evaluate that pain when they're in pain?) R: Right, yeah. (p1646-2364)* *To be honest, I'm going to like, it probably is hard to tell differences because people experience things differently. (p1646-3044)* *Because a lot of people— like I said, their opinion of what an emergency is or isn't. (p1646-3134)*
Agree - general agreement that it is difficult to distinguish emergencies and non-emergencies	*I think in some cases, it could be difficult. (p1646-2570)* *Yeah. We were looking after a dog one time. He got oral surgery, and that turned into septic shock, and the dog ended up passing away. We just thought it was a result of the surgery and, you know, didn't expect infection. (p1646-2570)* *Yeah, a lot of times (p1646-3352)*
Agree - lots of people are in and out of ER	*Yes, they probably do. There's a lot of people in and out of the ER. (p1646-2580)*
Agree - patients don't know how to identify serious symptoms	*(I: Do you think that kind of uncertainty is something that a lot of people would have if they were faced with something that was a difficult health situation?) R: Yeah, uneducated people as well, yeah, something that they haven't experienced before. Yeah, I would think so. (p1646-2011)*

Yeah. Like I said, again, with my issue, I at first thought it, you know, might have been anxiety or really bad heartburn. And I just, I didn't know whether or not to make the decision to go. But because of my previous health stuff, that was more of an indicator for me to go in because, you know, the nurse said that she thought it would be a good idea, better to be safe than sorry than to get checked out. (p1646-2011)

I think if you just educate the public, it would be a lot better. Most people don't know what's serious and what's not, and that's not their fault. (p1646-2607)

But in my experience, people generally seem to be lacking in knowledge or understanding of what kind of treatment you can get at the doctor's office versus the ER, like when it's urgent to do one or the other. (p1646-2769)

People probably, you know— like I said, we're not doctors, so we wouldn't know what was considered, you know, sometimes things seem minor, and then it ended up being something really major. You should have went, you know. (p1646-2876)

Because most people are not medical professionals. They might have experienced some kind of discomfort that they can very easily mistake for serious symptoms. And conversely, they might have serious symptoms that they brush off because they don't realize it's actually serious. (p1646-3097)

Because a lot of times, people don't realize what is actually wrong with them or what's causing the problems that they're having. (p1646-3133)

	R: Yeah, I would agree. That's what I was talking about. Sometimes you just don't know if it's serious or not. (I: Okay. Anything else you can tell us about why you agree with that?) R: Well, I've had things that I probably should have gone to a hospital instead of waiting or seeing a doctor because sometimes when you go to like a primary doctor, they just send you to another doctor anyhow. (p1646-3473) *if you stub your toe, you think you stubbed it in such a way that now, all of a sudden, your toe is black and blue, and it feels, it's really horribly painful, you don't know if you broke it or didn't break it. And you might consider that, that's considered, you know, an emergency. And so you go to the ER thinking that you just broke your toe. And then they come back and say, no, you just stubbed it, here's an ice pack and this $8 fee. You're going to be like, well, wait, how would I have known that it was just a stubbed toe? (p1646-3583)*
Agree - patients go to ER if they are overwhelmed or scared	*Sometimes like, I mean, personally, if I'm just having some like pain or whatever— or on occurring pain, I will just go into emergency just because I get like overwhelmed with it or scared, versus calling the doctor first or making an appointment. (p1646-3362)*
Agree - reluctance to go to or pay for ER might lead patients to discount symptoms	*I come from the understanding that, I come from a family that you don't go to the emergency room unless you're actually dying. And it can lead to people not getting the emergency care room that they need. I have to kind of check myself too sometimes because I'm so adamant that I'm not going to go to the emergency room that, you know, when I had a kidney infection and I was like two days from dying, like I almost didn't go because I was taught not to go. This is the idea with some of the people, that you just, you can't afford it. You can't afford the emergency room, so you wait. And then sometimes they don't make it. (p1646-2607)*

Agree - some people overestimate seriousness	*I think a lot of people tend to exaggerate the discomfort of what they're experiencing or seem to overreact to illness or pain. And I think that it's that that really leads to people kind of frivolously using the ER as opposed to a doctor because they deal with the initial kind of shock reaction as opposed to trying to think it through more rationally, you know, trying to, you know, treat things on your own before resorting to the medical system. (p1646-2769)* *R: Well, some people go on WebMD or Google, and they freak themselves out. And then sometimes they're embarrassed to bring it up to their primary, whatever it is, so they go to the ER to try to get it dealt with, they think it's going to be dealt with faster. Then they end up sitting for 3 hours. (I: Okay. Anything else that you think of as a reason why you'd agree that it's difficult for patients to know whether things are emergencies?) R: Whether those things are emergencies— maybe just new symptoms, something new comes up. For some people, it might be an itch, and the other person, they could think it's killing them. They freak out and go to the ER because you think emergency room, and they instantly correlate with you thinking you have an emergency. More like a psychological thing. (p1646-3077)*
Disagree - patients can distinguish emergencies from non-emergencies	*R: No, it shouldn't be difficult, no. (I: Okay. Can you tell me more about why you would disagree with that statement?) R: Again, I think the emergency rooms were designed for just that, emergency. So, you know, if you slice your finger and you need stitches, that's an emergency. If you're going to have your heart checked or, you know, blood pressure or something that a doctor's office can facilitate, I would believe people would go there versus an ER. (p1646-2972)* *I don't think so. I think people know what's wrong with them. (p1646-3001)*

	I think that it's pretty clear what you should be using each facility for and what they're there for. I mean, emergency room has in its name, it's for an immediate emergency that can't be treated elsewhere. Urgent Care is along the same lines, but it's, you know, for not as emergent problems that still need to be handled as quickly as possible. (p1646-3092)
Unsure - Don't know whether people have difficulty telling emergencies from non-emergencies	*I don't know. (p1646-2869)* *They should have an easy time, but they make it difficult. (p1646-2941)* *It all depends. It's just like people who have chest pains, then it could be gas, and they might take it for having a problem, having a heart attack or something. (p1646-3157)* *Sometimes. There's not a yes or a no for that. (p1646-3231)* *Well, I mean, if something is going wrong with inside of your body and you don't know, you don't know, you know. Sometimes people just don't know. I don't know what else to say. (p1646-3600)*

1137 & 1138. Fee of $8 will not change my decision process for using ER	
Agree - fee is low compared to ER treatment costs	*if I'm getting emergency care, it's like a small amount, you know, for pain, for getting that care. (p1646-2364)* *I think I agree with that. I think $8 is not a lot. (p1646-2570)* *I think $8 is a small price to pay for the services that are provided. (p1646-2972)*

	Because I feel that the fee is low enough where, I mean, if you're going in there and it's not an emergency, for the amount of resources that you'd be utilizing, that's on the very low end of the spectrum. (p1646-3092) *Well, the emergency rooms do provide a service. And, you know, it costs a lot more to run hospitals. But, you know, they do profit too. But $8 is not a big deal. (p1646-3352)* *if you don't know what's wrong with you and you go to the emergency room thinking that's the level of care you might need, and it turns out that the doctor sees you and says, no, you don't need to be here, you should go someplace else, to only be charged $8 instead of $1,200? Wow, it's a no-brainer. It's a wonderful, wonderful, wonderful thing for BadgerCare to do instead of charging them the whole fee. And not everybody has insurance. You know, I don't even know what it costs to go to the ER if you don't have insurance, thousands probably. So $8 is a gift. (p1646-3600)*
Agree - fee is low enough not to matter to me	*R: I agree. I mean, that's less than most people make an hour. So if you can't use an hour of your wages to go to the emergency room, then I don't know. (I: Okay, sure. So thinking about your own personal opinion on whether it would change your decision making, is there anything else that would make you agree—) R: Oh, no, it wouldn't change my mind. (I: Okay. Can you give me your reasoning for why it would not change your decision-making process?) R: Same reason, it's less than what I make in an hour at work, so it's really nothing. (p1646-2941)* *And that's honestly not too much money anyways. (p1646-3044)* *Because if I'm wrong, I can eat $8. (p1646-3097)*
Agree - fee is worth it for benefit to health	*I, you know, wouldn't want to die or regret going then have it be, or something that gets worse, and I'd have to live with worse symptoms the rest of my life or something, I don't know. (p1646-2011)*

Yeah, it's $8, and, you know, if that helps me get my problem taken care of, then I would be more than willing to do that. (p1646-2580)

If I'm paying $8, you know, if I have to go have a visit at the ER, then maybe that $8 could or could not save my life, whether or not I had to pay it. (p1646-2580)

$8 to me is not enough to make me question whether or not I need to go to the emergency room. That amount of money I could pay and feel comfortable paying, that if a doctor was like, "This is actually not an emergency," I'd be like, "Oh, well, okay, here's my $8." It would not deter me. (p1646-2607)

even if there was a fee of $8 on something like that, it wouldn't necessarily dissuade me because if I'm at the point that I'm considering going to the ER, I would be in some severely— severe or immense discomfort. (p1646-2769)

Because your health is more important than $8. (p1646-2876)

Because it's only $8. And if you're dying or something is really seriously wrong with you, I don't see why, it's $8. It's not like a million bucks or something. I think it's not that big of a deal. If you're in that much pain, you should be able to cover the $8. (p1646-3001)

I'd, honestly, I agree because I'd pay money like that if I had to go if it was something like that. But your own health should be important, so. (p1646-3044)

Because it's just an emergency, and I think as an emergency, it's worth $8 that, you know, is maybe being necessary if the doctor tells me at a later time that it wasn't actually an emergency. (p1646-3134)

Because it's only $8. If I would have to borrow it, either way it goes, as long as I was covered for the procedure then instead of getting billed, it wouldn't matter. (p1646-3157)

	Because if I feel like, personally, I don't care to go to the doctor or the emergency. But if I feel that I need to, I don't care about what it costs. I'd just rather make sure I'm okay. (p1646-3362)
Agree - general agreement that fee will not change my decision process	*Yeah. (p1646-2869)* *The $8 would not change my mind on going to the emergency room. I mean, if I thought I needed to go, I'd probably still go. (p1646-3473)*
Agree - I follow provider advice about whether to go to ER	*I would agree because I, I almost always talk to the nurse line before I, if I'm even thinking of going to the emergency room. (p1646-3231)* *R: I would agree with it. It would not change my decision. If I'm going to, if I'm going to an ER for what my doctor tells me to do, I'm going to be doing that. It's not going to change my decision otherwise. (I: Okay. Anything else that might factor into you saying you agree that the $8 wouldn't change your decision?) R: Nope, just basic, if I my doctor tells me to go to the ER, I'm going to go to the ER. Obviously, they're thinking that this could be something serious, and so if they think it's something, could be something serious, then, obviously, I'm going to listen to them. (p1646-3583)*
Agree - if fee is in rules then I will pay it	*Like I said before, it's in the contract of being on BadgerCare that you have to pay, they tell you to pay the $8 to go to the ER. You bite the bullet, and you pay the $8. (p1646-3077)* *$8 for me would be something that I would have to do no matter what, I guess. If it has to happen, it has to happen. (p1646-3133)*
Agree - other people pay more	*It's just, you know, like I said earlier, there's a lot of people out there that are paying a lot more for, you know— even just medication alone, they're paying $200, $300 a month just for their medication. (p1646-2580)*

9999 Anything else	
BadgerCare is helpful	*I mean, my experience with BadgerCare has been really good. (p1646-2011)* *now that I am working, I will be getting off of it soon, but BadgerCare has really helped me with therapy. It has given me— I got laid off a week before COVID, so that's how I got on BadgerCare, and I didn't have to worry about, "Was I going to lose my house, everything I worked for?" Having that, just knowing that if something bad happened, I'd be okay, has been such a blessing. And I think that this program does a really great job on many aspects. I think I'm really happy that you guys do so much with therapy because a lot of poor people can't afford therapy. It's expensive. And some people need it. (p1646-2607)* *I do counseling too, through BadgerCare, which has been exceptionally helpful. That has been really an amazing thing that I'm very grateful for. And I have been doing counseling for about a year now to help with that, and it has been a wonderful experience. And I don't have to worry about, "Can I afford to go? Am I going to get a random bill in the mail?" And being able to regulate some of those things without medication is nice. (p1646-2607)*

Frustration with BadgerCare wait time for specialty care	*I'm very grateful that BadgerCare was available to me. However, it was very frustrating for me, being a person with multiple health issues and having primary and specialty doctors that were not in network, and I had to literally wait six months to see that specialty doctor, which advanced my condition. So that part was frustrating. So what I did at the beginning of the year, I sought out my own healthcare plan so I could get back into the people that have been caring for me for the last 20 years. Now I understand, you know, I'm on Western Wisconsin, so I'm close to Minnesota. And that's why I say that. It just was frustrating. Because it's the same distance for me to travel to my primary doctor as it is to go to Amery or Barron or any of the facilities around here. So that part was just frustrating. And again, please don't misunderstand me, I'm very grateful for the program. (p1646-2972)*
If telehealth responses were faster, then patients might not need to go to ER	*faster to like the LiveWell or MyChart app, where you can message them on there. I mean, generally, when you message them, you don't get a response for a day or two or three. But I mean, if you explain to the nurse what's going on in the LiveWell app, and you got an answer right away, the nurse or doctor might be able to settle your nerves and make you realize, Oh, okay, I'll wait for my appointment. (p1646-3077)*
Participants should be grateful for BadgerCare	*BadgerCare is already providing so many people with, you know, a service that they can't afford. So I mean, they should be grateful for how much they do. I mean, BadgerCare saved my life. If I didn't have it, I don't know what would have happened after my accident. (p1646-3077)*
Patient advocates would help with care and billing difficulties	*That was my first experience with a traumatic injury in an ER. And I was so out of it with pain that it was really, really, really hard for me to advocate for myself. And my daughter and her husband that were there with me, I don't think any of us had ever experienced anything quite like that. And it would have been really helpful to have a patient advocate. (p1646-3600)*

APPENDIX 1: INTERVIEW QUESTION GUIDE

Interview Question Guide

CaseID: _____ IDI Date: _____

Interviewer: _____ IDI Mode: _____

Mail/Phone Survey Completion Date: _____

General notes

- Do not interview respondents who are driving or in other potentially unsafe situations, regardless of hands-free devices.
- Indicate Yes/No answers where indicated. After the interview, transfer those values to the data table.
- Write in response values where indicated. After the interview, transfer those values to the data table.

Introduction

Thank you for agreeing to be part of this interview project about BadgerCare.

[IF ER VISIT ELIGIBILITY IS ALREADY CONFIRMED, SKIP PAST THE ELIGIBLITY QUESTION.]

First, we need to ask when was the last time you went to an emergency room to get care for yourself? _____

[IF ER VISIT DATE IS WITHIN 12 MONTHS OF SURVEY DATE, THEN CONTINUE. OTHERWISE, EXPLAIN INELIGIBILITY.]

I want to talk to you today about your health care use, and particularly your experiences using the emergency room. Your feedback will help the BadgerCare program to meet the needs of people like you, and could influence future policies of the program. There are no right or wrong answers in this conversation. We are most interested in getting your perspective. If we come to any question that you prefer not to answer, please let me know and I will move on in the conversation. You may end the conversation at any time you like. Your decision to participate in this interview and what you tell me will not affect any benefits or services that you receive now or in the future from the BadgerCare program.

(consent information continues on next page)

Any information you provide will not be shared in a way that would allow you to be personally identified.

I would like to audio record this interview. The study team will make transcripts of the audio recordings. After the transcripts are made, the audio recordings will be permanently deleted. The recordings and transcripts of interviews will be secured on password-protected computers and only the study team will have access. Please let me know if you would like me to pause the recorder or turn it off at any time.

Do you have any questions?

Do you consent to participate in the interview?

May I audio record the interview? [START RECORDER]

Item	Question	Notes/Probes
1010	I want to start with some quick questions about you and your family.	
1011	How old are you? ____	(Note age)
1012	What is the race that you identify with? _____	(Note race information) (Include all race categories that R mentions)
1013	What is the gender that you identify with? _____	(Note gender)
1014	What county do you live in? _____	(Note county)
1015	Do you live with other adults or children? Yes ___ No ___	
1016	Who else do you live with? _____ _____ _____	(Note household members)
1017	Do you currently work? Yes ___ No ___	
1018	What is your occupation? _____	(Note occupation)
1019	Who in your household is covered by BadgerCare? _____ _____ _____	
1020	What other health insurance do people in your household have?	

1021	Do you have any chronic health problems that require ongoing medical attention by a medical provider, or that require regular medication? Yes ___ No ___ [IF 1021 = NO, SKIP TO 1030, ELSE CONTINUE TO 1022]	(Probe: "regular ongoing medical attention" can be defined as at least a couple of times a year)
1022	What are those chronic health problems?	(Make note of R's conditions for later questions)
1030	Do you have a place you regularly go to for primary care, such as a doctor's office or clinic? Yes ___ No ___ [IF 1030 = NO, SKIP TO 1040, ELSE CONTINUE TO 1032]	
1032	What is the type of place?	(Probe: is it a doctor's office, a community health center, or some other place?)
1034	Is it difficult to get appointments there? Yes ___ No ___	
1040	Is there an urgent care location you can go to (if your doctor's office or clinic cannot see you)? Yes ___ No ___	(If R does not have a primary care location, omit the "if your doctor …" text.) ("Can go to" means it is near the person and their insurance is accepted.) (Urgent care is a clinic that is separate from the hospital emergency room, where you can walk in and be seen for time-sensitive health concerns that are not life threatening)

1050	Over the past twelve months, have you received any preventive care such as a checkup, recommended screenings, or a flu shot? Yes ___ No ___ [IF 1050 = YES, SKIP TO 1060, ELSE CONTINUE TO 1052]	(COVID shot is preventive care. Screening examples: colonoscopy for older adults, prostate cancer screening for men, or mammogram for women.)
1052	Did you want to get preventive care, but were you unable to get it? Yes ___ No ___ [IF 1052 = NO, SKIP TO 1061, ELSE CONTINUE TO 1053]	
1054	What preventive care were you unable to get?	
1056	Did your doctor or clinic recommend preventive care, but you did not end up getting it?	
1060	If you were to have a medical emergency at your residence, do you know which emergency room you would likely go to, if you were given the choice? Yes ___ No ___ [IF 1060 = NO, SKIP TO 1070, ELSE CONTINUE TO 1062]	
1062	How far away is it? _____	(Probe: either distance or time estimate is OK)
1064	Why would you choose to go there?	(Example answers: it is the nearest, it has the lowest wait times, it takes my insurance.)

1070	Tell me about the most recent time you went to the emergency room.	(Probes: What was your health issue? Were they able to successfully treat the issue or transfer you to another health care provider who could? Were you satisfied with the experience?)
1080	In your most recent time going to the emergency room, did you make the choice to go or did someone else make it? (IF SOMEONE ELSE CHOSE: Who made the choice: was it a family member or friend; or was it an EMT, paramedic, or first responder?) Patient/family/friend ___ EMT/first responder ____ [IF EMT/FIRST RESPONDER CHOSE THE ER, SKIP TO 1090, ELSE CONTINUE TO 1082]	(If R's personal doctor advised R to go to ER, but R ultimately got to make the decision, then it was R's own decision, not the doctor's.)
1082	Different people have different reasons for going to the emergency room. Why did you choose to go to the emergency room instead of some other place?	(Example answers: issue was too serious to be treated elsewhere, doctor's office was closed, the staff at the emergency room are very attentive and helpful, R was unsure what the problem was.)
1084	Did you ever consider going to another place, or was it just very clear that the emergency room was the only place that you should have gone? Yes, considered other place ___ No, did not consider other place ____	

1086	Beyond your health condition, was there another reason you chose to go to the emergency room instead of another place? Yes ___ No ___ [IF 1086 = NO, SKIP TO 1090, ELSE CONTINUE TO 1088]	
1088	What were those other reasons for choosing to go to the emergency room?	
1090	In any of your recent times going to the emergency room, was there ever a situation when the doctor at the emergency room -- or other emergency room staff -- told you that you should have gone somewhere else? Yes ___ No ___ [IF 1090 = NO, SKIP TO 1100, ELSE CONTINUE TO 1092]	
1092	Tell me about what happened. At what point of your visit were you told (that you should have gone somewhere else)? Who told you that? Did they refer/send you to another provider?	(Probe: If R mentions having to pay a bill, probe what happened.)
1100	Are there any situations since you've been on BadgerCare where you have avoided going to the emergency room, even though you believed you were experiencing an emergency? Yes ___ No ___ [IF 1100 = NO, SKIP TO 1110, ELSE CONTINUE TO 1102]	
1102	Tell me about why you avoided going to the emergency room.	(Probes: You were worried about the cost, you didn't think it was serious enough, you were worried about being treated poorly.)
1104	What was the health problem that you were experiencing, in that situation where you avoided going to the emergency room?	

1106	[SKIP 1106 IF R DID NOT MENTION CHRONIC CONDITIONS AT 1022] Earlier, you mentioned that you had some chronic health conditions. How do those conditions affect the ways that you require medical care in general? How have those conditions affected your use of the emergency room?	
1110	In any of your recent trips to the emergency room, was there ever a time when BadgerCare made you pay a copayment? Yes ___ No ___ [IF 1110 = NO, SKIP TO 1120, ELSE CONTINUE TO 1112]	
1112	Tell me what happened.	(Probes: Was that unexpected to you? Why do you think you ended up getting a bill?)
1120	We've been hearing that some BadgerCare members are confused about how the program covers care in the emergency room. We just wanted to hear more about what you understand about the current program requirements.	
1122	Since you've been on BadgerCare, has the program's coverage of treatment in the emergency room changed in any way that you are aware of? Yes ___ No ___	
1124	To the best of your knowledge, do BadgerCare members ever have to pay for services in the emergency room? Yes ___ No ___	

1130	We are almost done. Before we finish, I want to get your opinion on a few statements. After I read each statement, please tell me whether you agree or disagree, and what reasons you have for agreeing or disagreeing. There aren't any right or wrong answers, we just want to hear what you think.	
1131	Statement 1: Many people go to the emergency room for routine medical problems that are not emergencies. Agree ____ Disagree ____	(Note agree/disagree answer)
1132	Why do you feel that way? (Anything else?) (Can you give me an example of a time that you've known of that happening (even just one or two instances)?)	
1133	Statement 2: It is reasonable for BadgerCare to require members to pay a fee of eight dollars, if they go to the emergency room for care that the doctor determines is not an emergency. Agree ____ Disagree ____	(Note agree/disagree answer)
1134	Why do you feel that way? (Anything else?)	
1135	Statement 3: It is often difficult for patients to know whether some health problem is an emergency, versus a problem that could be treated at a doctor's office or a clinic. Agree ____ Disagree ____	(Note agree/disagree answer)
1136	Why do you feel that way? (Anything else?)	
1137	Statement 4: A fee of eight dollars will not change my decision-making process for using an emergency room. Agree ____ Disagree ____	(Note agree/disagree answer)
1138	Why do you feel that way? (Anything else?)	
1140	Thank you. That's the last question that I have, but are there any final thoughts you want to share about any of the topics we've discussed today, or anything else I might have missed?	

		(After recording the answers to the final question, turn off the recorder, then confirm the respondent's name and address for sending the incentive check.)