WILLIAM PENTERMAN

STATE REPRESENTATIVE • 37TH ASSEMBLY DISTRICT

(608) 237-9137
Toll-Free: (888) 534-0037
Rep.Penterman@legis.wisconsin.gov

P.O. Box 8953
Madison, WI 53708-8953

April 12, 2023
Assembly Committee on Health, Aging and Long-Term Care
Testimony from Rep. William Penterman in favor of AB 148

Chairman Moses and members of the Assembly Committee on Health, Aging and Long-Term Care:

According to the Centers for Medicare and Medicaid Services, improper payments under the Medicaid Assistance program (MA) are estimated at $85 billion annually. This issue has only gotten worse as enrollment has expanded due to the effects of COVID-19.

During the COVID-19 pandemic, the federal government adopted enhanced reimbursements for each state's MA program. States were prohibited from removing existing participants in their MA program in return for these additional resources. This has led to many ineligible individuals remaining on the MA program.

With this in mind, AB 148 would make needed changes to our BadgerCare Plus program to help protect valuable taxpayer resources. The bill prohibits the automatic renewal of benefits for BadgerCare Plus recipients. It would require eligibility to be redetermined every six months, if approved by the federal government, and would require information to be cross referenced between state agencies that collect financial data related to public assistance programs. DHS would be required under the bill to promptly remove all ineligible individuals. In addition, individuals that fail to report to DHS any change that may affect their eligibility under BadgerCare Plus would be removed from the program for six months.

This common sense bill is intended to protect the integrity of Wisconsin's Medicaid Assistance Program. It is a redraft of the 2021-2022 legislative session bill AB 934. I encourage the members of the committee to support this bill.

Thank you.

William Penterman
State Representative
37th Assembly District

ROB STAFSHOLT

STATE SENATOR • 10th SENATE DISTRICT

(608) 266-7745
Toll Free: (800) 862-1092
Sen.Stafsholt@legis.wi.gov

P.O. Box 7882
Madison, WI 53707-7882

DATE: April 12, 2023

RE: Testimony on Assembly Bill 148

TO: Members of the Assembly Committee on Health, Aging and Long-Term Care

FROM: Senator Rob Stafsholt

Thank you Chairman Moses and members of the Assembly Committee on Health, Aging and Long-Term Care for hearing Assembly Bill 148 relating to disenrollment of ineligible individuals from and redeterminations of eligibility for the BadgerCare Plus program and database confirmation for public assistance program eligibility.

Recently, the federal government adopted enhanced reimbursements for each state's Medical Assistance program. States were prohibited from removing existing participants in their Medical Assistance program in return for these additional resources. This has led to countless ineligible individuals remaining on the Medical Assistance program and an abundance of fraud, waste and abuse of this program's dollars.

This bill requires that the Department of Health Services, as soon as allowable, to remove all ineligible participants from the BadgerCare Plus program. It also increases the eligibility determination from annually to bi-annually and improves eligibility crosschecks between agencies. Due to current federal law, eligibility checks can only be done once every 12 months. This bill also requires DHS to request a federal waiver to allow the bi-annual determination.

This is a simple, common sense bill to ensure program integrity for our most vulnerable populations that really need this resource by eliminating the free ride for those that are ineligible.

Again, thank you for allowing me to submit testimony on Assembly Bill 148. I would also like to thank Representative Penterman for his work on this bill in the Assembly. I would appreciate your support on this piece of legislation.

State of Wisconsin
Department of Health Services
Tony Evers, Governor
Kirsten L. Johnson, Secretary

TO: Members of the Assembly Committee on Health, Aging, and Long-Term Care

FROM: HJ Waukau, Legislative Director

DATE: April 12, 2023

RE: Assembly Bill 148, relating to: disenrollment of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility

The Wisconsin Department of Health Services (DHS) would like to thank the Committee for the opportunity to submit written testimony for information only on Assembly Bill 148 (AB 148), regarding changes to how DHS would process eligibility and reenrollments of Medicaid members. Under the provisions of AB 148, Medicaid members would be required to renew benefits every six months and DHS would be prohibited from automatically renewing a member's eligibility or utilizing pre-populated renewal forms. AB 148 would also impose a six-month disenrollment penalty on Medicaid members who fail to report changes that could affect eligibility. Additionally, AB 148 would require DHS to enter into data sharing agreements with any agency that maintains a database of financial or personal information of Wisconsin residents, confirm applicant information within said database, and require DHS to share data for the purpose of confirming eligibility. AB 148 also requires DHS to terminate a member's enrollment upon receipt of information that they are ineligible for Medicaid benefits. Further, DHS would be required to audit and submit quarterly reports to the legislature on the number of individuals who are ineligible for Medicaid but are receiving benefits.

An almost identical bill was put forward last session (2021 AB 934). In analyzing that bill, DHS estimated that the eligibility provisions would have significant negative fiscal impacts for the state. DHS estimated that implementing the bill could risk all of the federal funding Wisconsin receives for the Medicaid program with an estimated annualized impact of $7.0 billion in lost federal funding. Wisconsin would also risk losing federal match on administrative costs associated with the Medicaid program of over $300 million in federal funding. DHS is working on developing updated estimates; however, an updated analysis in unable to be provided as of the date of this hearing due to the incredibly limited timeframe between when DHS received a request for analysis (April 10, 2023) and the hearing date of AB 148.

Wisconsin's Medicaid and BadgerCare Plus programs provide consistent, reliable, and affordable coverage to our state's most at-risk populations. Through its programs Wisconsin Medicaid and BadgerCare Plus currently provide coverage to over 1.6 million Wisconsinites.[1] While this number is expected to decline due to the end of continuous coverage made available under the Families First Coronavirus Response Act (FFCRA), a significant number of Wisconsinites will still maintain eligibility. Prior to the COVID-19 pandemic Medicaid and BadgerCare Plus had an average monthly enrollment of 1.1 million members, with a significant number of those enrollees being children. With the end of the continuous enrollment provisions created by the Consolidated Appropriations Act (CAA) 2023 (P.L. 117-328), and the initiation of the unwinding, Wisconsin is focused on ensuring people are informed about the process of renewal and are able to maintain access to coverage and care. Creating additional confusion for those navigating the post-pandemic environment, which requires the return to routine operations, is not helpful. Recent studies have shown that the continuous eligibility provisions for FFCRA

[1] ForwardHealth, "Health Care Enrollment," last accessed April 10, 2023, https://www.forwardhealth.wi.gov/wiportal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage. Utilizing March 2023 enrollment data.

reduced Medicaid "churn."[2] Lower rates of churn are often associated with lower administrative costs, more predictable state expenditures, and lower monthly costs. Lowering the rates of churn would be especially impactful for Wisconsin as pre-pandemic analyses showed that Wisconsin experienced some of the highest rates of churn in the nation.[3]

Under 42 CFR §§ 435.916(a)(1) and 457.343, states are prohibited from conducting Medicaid and BadgerCare Plus renewals more often than once every 12 months. States are also required under the same regulations to complete administrative renewals whenever possible. State Medicaid agencies are required to make eligibility determinations without requiring additional information from the program participant if able to do so based on reliable information contained in the individual's account or other more current information available to the agency through electronic data exchanges under 42 CFR § 435.916(a)(2). This includes comparing a given member's information provided by the State Wage Income Collection Agency (SWICA), Equifax, Social Security, and unemployment insurance databases, among others. And if it is not possible, or if the state cannot make a renewal determination on its own, states are required to send the program participant a prepopulated renewal form that contains the information that is currently available to the agency that would be needed to renew eligibility under 42 CFR § 435.916(a)(3). States are also prohibited under 42 CFR § 435.952(d) from terminating eligibility on the basis of information received directly from data exchanges.

Coinciding with the aforementioned federal rules, regulations from the Centers for Medicare and Medicaid Services (CMS) do not permit the state to add disenrollment penalties as an extra eligibility requirement under Wisconsin's existing state plan for Medicaid. Further, the provisions of AB 148 regarding 6-month eligibility redeterminations, prohibitions on automatic renewals, use of pre-populated forms, and prompt removal of people from the Medicaid/BadgerCare Plus programs, are out of compliance with the provisions contained within the CAA. As such, the provisions of AB 148 are out of compliance with current federal regulations and would jeopardize Wisconsin's ability to draw down both regular and enhanced federal funds for the Medicaid program. In addition, CMS has said that states are expected to be in full compliance with all renewal and redetermination requirements no later than 2 years after the end of a state's unwinding period. Failure to do so risks all of the enhanced funding under the CAA.

Most importantly in terms of fiscal impacts, imposing the provisions in AB 148 that require more frequent renewals and a 6-month penalty for a failure to provide information on families with children would result in the loss of all federal funding for Medicaid and the Children's Health Insurance Program (CHIP). The maintenance of eligibility (MOE) requirements under sections 1902(gg) and 2105(d)(3) of the Social Security Act, prohibit states from enacting any eligibility standards, methodologies, or procedures affecting children under any state plan or waiver that are more restrictive than those that were in place on March 23, 2010. The MOE requirement for children is in effect until September 30, 2029. In other words, under federal law, CMS couldn't approve a state plan or even a waiver to enact the provisions of AB 148.

Additionally, under AB 148 major systems changes would be required and would have significant costs for DHS, as it would double the income maintenance workload related to Medicaid eligibility determinations. Based on the analysis for 2021 AB 934, the annual impact on Milwaukee Enrollment Services would be at least $10.4 million GPR annually and necessitate the creation of 138.5 additional FTE positions. The impact on the 10 Income Maintenance Consortia would be $35.1 million GPR annually, and the impact for tribal Income Maintenance

---

[2] S Sugar et al. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy Issue Brief, April 12, 2021, last accessed April 10, 2023, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199881/medicaid-churning-ib.pdf.

[3] MACPAC, "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP," Issue Brief October 2021, last accessed April 10, 2023, https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

agencies is estimated to be $702,000 GPR. Further, the administrative burden of the renewals would be much more time intensive without the use of pre-printed renewal forms. Such efforts would be further complicated by the unwinding of the public health emergency with current members already having their eligibility status redetermined. AB 148 does not provide any funding for DHS for these purposes and DHS would be unable to absorb these costs under its existing budget.

Regarding the data sharing agreements under the bill DHS already uses several data sharing agreements with state and federal agencies in accordance with state and federal law, and in conjunction with its Client Assistance for Re-employment and Economic Support (CARES) system. Existing data exchanges include regular, automated data exchanges with the Social Security Administration, Equifax, and SWICA, which provides employment and income verification wages, unemployment compensation, child support, and Wisconsin's Vital Records, which furnish dates of death and result in automatic termination of benefits for members who have passed away. It is unclear what utility or function would be added by requiring additional data sharing agreements and may likely increase unnecessary administrative burden and complexity between state agencies.

DHS thanks the Committee for the opportunity to provide written testimony for information only and offers itself as a resource for any questions or follow up the Committee may have.

April 12, 2023

Representative Clint Moses, Chairman
Assembly Committee on Health, Aging and Long-Term Care
Re: Opposition Testimony on Assembly Bill 148

Dear Chairman Moses and Members of the Committee:

On behalf of the 103 people diagnosed with cancer every day in Wisconsin and more than 285,000 survivors we represent, the American Cancer Society Cancer Action Network (ACS CAN) opposes AB 148 - a bill that would require Medicaid enrollees prove eligibility and re-apply every six months. Cancer patients and survivors – as well as those with other complex chronic conditions – could be seriously disadvantaged and find themselves without Medicaid coverage due to changes to continuous eligibility and an increase in red tape to maintain enrollment.

Eliminating continuous eligibility will create additional barriers and requirements for enrollees, very likely reducing the number of Wisconsinites who can access essential health care, including cancer prevention and treatment. Requiring such frequent re-application and re-determinations of Medicaid eligibility is burdensome on enrollees as well as the Department. Terminating individuals' eligibility if they are not able to keep up with these onerous requirements could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals in active cancer treatment.

Federal Medicaid rules require that states attempt to renew members' coverage using other available data sources[1] because this is one of the most efficient and cost-effective ways to keep people covered. Where the state already has information on file about an enrollee's qualifications, requiring more frequent redetermination is an unnecessary waste of taxpayer resources. Just as this data can be used to determine that someone is now ineligible for a means tested program, it should also be trusted to confirm eligibility.

Frequent re-determinations could result in loss of access to health care coverage due to small – often temporary – fluctuations in income, making it difficult or impossible for those with cancer to continue treatment. The American Cancer Society Cancer Action Network urges the members of the state legislature to reject this legislation and instead, increase income eligibility for our BadgerCare program. The most cost-effective solution to the issue of minor income fluctuations that interrupt Medicaid eligibility is to fully expand income eligibility for our state's Medicaid program.

ACS CAN wants to ensure that cancer patients and survivors in Wisconsin will have coverage under BadgerCare program, and that program requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. For cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival.

The American Cancer Society Cancer Action Network urges the members of the state legislature to reject this legislation and instead, increase income eligibility for our state's Medicaid program. The most cost-effective solution to the issue of minor income fluctuations that interrupt Medicaid eligibility is full expansion of Medicaid up to 138% FPL.

Sincerely,

Sara Sahli
Wisconsin Government Relations Director
American Cancer Society Cancer Action Network

1 435.916(a)(2) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under §§ 435.948, 435.949 and 435.956.

WISCONSIN CATHOLIC CONFERENCE

TO: Members, Assembly Committee on Health, Aging and Long-Term Care

FROM: Barbara Sella, Executive Director Barbara Sella

DATE: April 12, 2023

RE: Assembly Bill 148 BadgerCare Plus Continuing Eligibility

On behalf of the Catholic bishops of Wisconsin, we respectfully urge you to oppose Assembly Bill 148, which limits access to health care, especially for those who most need it.

Public assistance programs exist to aid vulnerable individuals and families whose situation prevents them from being able to meet basic needs. Frequently, those who most need Medicaid benefits are facing a myriad of challenges, some of which may be lifelong. Addiction, trauma, illness, accidents, and the loss of family, housing, or employment can all stymie efforts to build stability. The goal of these public assistance programs is to accompany vulnerable individuals so they can move out of poverty.

Health care is a basic human right and access to health care for all has been a policy goal of the U.S. bishops since 1919. It is important to remember that those who currently receive Medicaid are individuals who have disabilities, are pregnant, with chronic conditions or diseases, children and their parents, and individuals living in poverty. By definition, they are in need of services and do not have the resources necessary to receive treatment and medications without Medicaid. These are individuals and families who are likely struggling to meet home and transportation expenses, as well as meeting the basic needs of their loved ones. They frequently must transition from one home to another, as well as from one employment situation to another, changing addresses, phone numbers, and earnings along the way.

AB 148 would require that the Wisconsin Department of Health Services (DHS) determine an individual's eligibility every six months. Currently, most Medicaid recipients must complete a program renewal at least once a year to determine ongoing program eligibility. While renewal is necessary and important, a six-month renewal will be burdensome on the state and individuals, and likely result in individuals not having access to care when they most need it. The requirement will lead to missed deadlines, appointments, treatments, and medications, rather than a meaningful path towards self-improvement. Many may not even realize that their coverage has lapsed until care is needed.

The bill also states that a failure to disclose information in a timely manner can result in a six-month suspension from the Medicaid program. We think this is draconian. It does not distinguish between a person who makes an innocent mistake and one who knowingly withholds information.

106 E. Doty Street • Suite 300 • Madison, WI 53703
Tel 608/257-0004 • Fax 608/257-0376 • Website http://www.wisconsincatholic.org

Finally, it is important to note the impact this bill will have on private charitable actors. Depriving the poorest among us of health care will only shift the burden to the hundreds of private charities, Catholic and other, which are already overwhelmed. While as Catholics we stand ready to serve the common good, we cannot be expected to serve more with less.

In conclusion, reforming public assistance programs to reduce poverty and dependency requires the involvement of government and the private sector working cooperatively. Reforms must ensure that people in poverty do not become targets, but rather that they receive the support and services appropriate to their needs. Self-sufficiency and self-determination require that those in poverty be listened to and respectfully engaged. Overly bureaucratic and punitive measures to reduce fraud and encourage responsibility all too often have the opposite effect of increasing burdens and further impoverishing the most vulnerable. The problem of poverty requires a holistic approach, something that our Catholic Charities agencies and Society of St. Vincent de Paul councils are adept at doing. Everyone has an interest in improving health and encouraging labor force participation. We urge you not to tie the hands of our state's most vulnerable individuals, but instead to work together to improve the health of all of Wisconsin's residents.

For all these reasons, we urge you to oppose this bill. Thank you.

KIDS FORWARD

Every Kid. Every Family. Every Community.

DATE: April 12, 2023

TO: Assembly Committee on Health, Aging, and Long-term Care

FR: William Parke-Sutherland, Senior Health Policy Analyst

RE: Opposition to AB 148 – prohibiting automatic renewals and increasing redeterminations

Chairperson Moses and committee members,

Kids Forward is submitting testimony on Assembly Bill 148, which we strongly oppose because it will create harmful barriers to Medicaid participation reducing access to health care among Medicaid-eligible children, parents, and other adults, and would exacerbate racial inequities in access to health care and coverage.

Kids Forward aspires to make Wisconsin a place where every child thrives by advocating for effective, long-lasting solutions that break down barriers to success for children and families, notably children and families of color and those furthest from opportunity. Using research and a community-informed approach, Kids Forward works to help every kid, every family, and every community thrive.

AB 148 would prohibit DHS from automatically renewing health care benefits for those covered by BadgerCare Plus, would require eligibility to be verified every six months (instead of annually), and disallow the use of pre-populated forms. It would also require that people lose their coverage for six months if they fail to report (in a timeframe established by the state) any change that may impact their eligibility. The bill also appears to require DHS to disenroll people who are found ineligible through data matching efforts.

Through increased renewals, prohibiting automatic renewals, disallowing DHS from using best practices for renewals, such as pre-populating forms, this bill would greatly increase administrative burdens, which would likely worsen inequality and health disparities. A 2021 report from the Office of Management Budget found that barriers making it harder for people to access public benefits worsen inequity. This bill would require someone on BadgerCare to fill out more paperwork, answer more notices and phone calls, submit more verification and documentation, and have more interactions with income maintenance workers. All of this additional work would fall hardest on those who have the least amount of time and resources.

Because of long-term systemic employment and economic discrimination, Black, Indigenous, and People of Color are more likely to be in lower-paying jobs, have less access to insurance, and more likely to face barriers such as lack of access to transportation, connectivity, and financial instability. For example, the report notes that during the *great recession Black and Hispanic workers were less likely to receive unemployment insurance benefits than White workers.* Increasing administrative burdens by implementing this proposal would likely disproportionately harm Black, Indigenous, and People of Color in Wisconsin. Assembly Bill 148 would perpetuate and exacerbate racial inequity.

Automatic renewals are one of the best ways that states can ensure those who are eligible for coverage remain covered without adding administrative burdens and red tape like verification and renewal forms. Forms can get lost in the mail, processed incorrectly, sent to the wrong address, not returned in a timely manner, and be misunderstood by beneficiaries. All of these can lead to people losing their coverage and can result in increased health costs and worse health outcomes for people who need regular access to health care services.

Renewals are important to make sure that people who are enrolled are Medicaid eligible, but they are also the way people are most likely to lose their coverage, even if they are eligible. AB 148, which would make state staff process twice as many renewals as they do currently, would cause more children and families to fall through the cracks and become uninsured even though they are still eligible. Further, it is unclear how many people would actually be required to renew coverage semi-annually. Federal regulations state that renewals for individuals whose Medicaid eligibility is based on modified adjusted gross income (MAGI) methods may not be done more frequently than every 12 months[1]. This section of the bill would likely not apply for the vast majority of children, parents, adults without dependent children and pregnant people covered by BadgerCare Plus.

According to an October 2021 report by the Medicaid and CHIP Payment and Access Commission (MACPAC), Wisconsin already has some of the highest rates of churn in the country. More than 12 percent of enrollees are disenrolled and then re-enroll within 12 months. According to that same report, Black enrollees are more likely to be impacted by churn and needlessly lose coverage than their white counterparts, so increasing the administrative burden could have an inequitable impact on Black Wisconsinites. Language accessibility barriers when using websites, reading communications, and interacting with income maintenance workers could also make it more likely that people in families who speak a language other than English would be impacted by increased renewals and needlessly lose coverage.

Federal Medicaid rules require that states attempt to renew members' coverage using other available data sources[2] because this is one of the most efficient and cost-effective ways to keep people insured. States are required to use data sources the state determines useful. By requiring data checks for ineligibility and creating six-month sanctions, the bill is trying to have it both ways. If the data is good enough to prove someone is ineligible, then it is good enough to confirm that person's eligibility. For these reasons, it is likely that the proposed prohibition is inconsistent with federal law.

Doubling the number of renewals would also mean tremendous increases in administrative costs and staffing needs, which this bill doesn't acknowledge or allocate funding for. An April 2021 HHS study estimated the cost of processing a single instance of disenrollment and re-enrollment at between $400 and $600.[3]

---

[1] § 435.916 Periodic renewal of Medicaid eligibility.

[2] 435.916(a)(2) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under §§ 435.948, 435.949 and 435.956.

[3] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf

Please oppose this bill because it would prohibit one of the best ways of keeping eligible Wisconsinites covered, increase rates of churn where people are needlessly going without care and coverage exacerbating health inequities. It would also needlessly create substantial administrative burdens for staff and balloon administrative costs.

Please feel free to contact me at wparkesutherland@kidsforward.org with questions, follow up, or requests for more information. Thank you.

OPEN ARMS FREE CLINIC
CLINICA GRATUITA

Telephone: 262-379-1401 / Fax: 262-379-1271 / Email: info@openarmsfreeclinic.org
Clinic Location: 205 E. Commerce Ct. Elkhorn, WI 53121 / Correspondence: PO Box 678, Elkhorn, WI 53121

DATE: April 12, 2023

TO: Committee on Health, Aging and Long-Term Care

FROM: Sara Nichols, MPH, Executive Director, Open Arms Free Clinic, Inc.

REFERENCE: AB 148 relating to disenrollment of ineligible individuals regarding BadgerCare and public assistance programs

---

On behalf of the community served at Open Arms Free Clinic, Inc. in Walworth County, Wisconsin, I am writing not in favor of the current language written in proposed AB 148.

Since 2012, Open Arms Free Clinic (OAFC) has been an access point for Walworth County residents who are otherwise unable to receive medical care. Open Arms is focused on providing equitable access to healthcare for the most vulnerable people living in Walworth County, Wisconsin. The mission is to better understand and serve with compassion the health and wellness needs of low-income, uninsured, and underinsured residents of Walworth County. As the first free medical and supportive care clinic in the county, Open Arms has provided over 40,000 patient visits in the areas of primary medical, dental, vision, behavioral health, lab, and medication dispensary.

As a result of the COVID-19 pandemic, there was an 84% growth in new patients comparing 2019 to 2022 intake records. Open Arms has created new access points to underserved communities as evidence of the telehealth services and mobile medical services delivered in remote communities within the county. Open Arms services are delivered to individuals of all ages at no cost to the patient, and the intake process is simple without complex burden to the patient. Other than dental services that accept Medicaid, all services are targeted for low-income and uninsured adult and child residents of Walworth County. For persons who need to access a health home, the community health workers provide the guidance for patients to receive care at the main Open Arms clinic located in Elkhorn. Open Arms has continued to expand the service capacity as there has been an increase in new patients annually for the last ten years. The clinic is staffed with professional medical volunteers and paid staff with a majority representation of people of color and native Spanish-speaking. Concerted effort has

OPEN ARMS FREE CLINIC
CLINICA GRATUITA

Telephone: 262-379-1401 / Fax: 262-379-1271 / Email: info@openarmsfreeclinic.org
Clinic Location: 205 E. Commerce Ct. Elkhorn, WI 53121 / Correspondence: PO Box 678, Elkhorn, WI 53121

been in place to have hired and volunteer staff reflect the patient population for the purpose of developing trusting relationships and optimizing positive health outcomes.

The primary service location is at a stand-alone medical office in the center of Walworth County - 205 E. Commerce Court, Elkhorn, Wisconsin. In 2022, we had over 936 new patients and recorded **7,258 patient visits.** In addition, our electronic medical record system did not account for the approximately 500 individuals we reached with our mobile medical clinic, nor the 2345 children we cared for in the oral health Seal-A-Smile program. As we are meeting people where they are in the community, we are engaging many more people into our trusted healthcare home. Already in the first quarter of 2023, we have had over 250 new patients seek care with Open Arms, and much of this increase includes children with Medicaid insurance needing dental care. With the unwinding of the public health emergency funding, we estimate that we will serve over 2000 unique patients this year alone, thus we will need more clinic hours and stable support staff to ensure quality care.

In AB 148, there are two concepts in the statute that are harmful to low-income persons. The first is the concept of immediately disenrolling recipients with shared databases. The patients served at our free clinic are the working engines of the county's economy: tourism, hospitality and service workers. Individuals work 2-3 jobs throughout the year and their income fluctuates greatly each season. For a person with chronic disease such as heart disease or diabetes, not accessing 3 months of labs and medications can be life-threatening. Churning on and off health insurance increases the stress of maintaining their medical care. How this bill would directly affect personal and community health can be illustrated with the rate of heart disease is 3 times higher in Walworth County compared to the rest of the state. Ambulatory emergencies related to heart attacks and stroke are the #1 cause for medical debt for both households and hospitals to lose income for uncompensated medical care. **Immediately disenrolling persons from Medicaid due to data sharing increases stress and trust in health care systems that would exacerbate the preventative and planned care model primary care centers strive so hard to maintain.**

The second concept that is not ethical nor cost effective is the 6-month penalty of no coverage for failure to report requalification. Most Medical Assistance benefits are applied to women and children living in poverty. Housing, food, employment, childcare, and basic human needs are already in constant stress for survival. Many single parents who do not have a case manager supporting them do not have the mental, physical, nor emotional capacity to maintain mail, phone apps, or other mechanisms of state communication. In

OPEN ARMS FREE CLINIC
CLINICA GRATUITA

Telephone: 262-379-1401 / Fax: 262-379-1271 / Email: info@openarmsfreeclinic.org
Clinic Location: 205 E. Commerce Ct. Elkhorn, WI 53121 / Correspondence: PO Box 678, Elkhorn, WI 53121

addition, as it is humans maintaining the qualification criteria, there is also human error that occurs where failure to notify the Medical Assistance benefactor exists.

We witness how the problem exacerbates health issues illustrated at our dental clinic. Since September 2022, we have cared for over 2500 children with the oral health prevention program, Seal-A-Smile in the school-based settings. Over 55% of these children in grades 4k – 8 have needed further dental care due to cavities or severe dental decay. Open Arms Free Clinic is the only dental provider in Walworth County that accepts Medical Assistance and low-income patients with no health insurance. Families need to access our dental program so that their children can be relieved of dental pain and be able to eat and participate in school. Open Arms receives $0.35 to the dollar of the cost of care, and while that is not much, it supports the sustainability of our program. We utilize case managers, legal assistance, and insurance navigators to help our families sustain benefits that they are eligible for. Fear of losing benefits, unknowingly believing individuals have benefits, or realizing they are not eligible for benefits even temporarily initiates a chain of administrative burden that is not cost effective, nor dignified for the individual already vulnerable.

We believe that all members of our community have intrinsic dignity. This means that a program to support individuals with health and other supportive benefits is to maintain dignity. Immediately disqualifying benefits due to shared databases or creating a 6-month disqualification measure due to lack of effective communication is contrary to dignity-focused actions. Thank you for your time and consideration for my testimony.

Wisconsin BPDD
WISCONSIN BOARD FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

April 12, 2023

Representative Clint Moses
Assembly Committee on Health, Aging and Long-Term Care (Chair)
State Capitol, Room 12 West
Madison, WI 53708

Dear Rep. Moses and members of the committee:

The Wisconsin Board for People with Developmental Disabilities' (BPDD) analysis of AB 148 finds this proposal will negatively and disproportionately impact people with disabilities and their families.

This proposal would needlessly double the administrative burden, make it more difficult to complete required forms, and would penalize administrative and reporting mistakes with the loss of health care coverage.

BadgerCare is the only source of health care for some people with Intellectual and Developmental Disabilities (I/DD) and many family caregivers. Disability and disability adjacent populations within BadgerCare include:

- People with I/DD who do not meet the nursing home level of care criteria required for Family Care or IRIS programs.
- People waiting for a disability determinacy, which may take two or more years.
- People with diagnosis of serious and persistent mental illness
- People with chronic or intermittent conditions or disabilities
- Family caregivers of people with disabilities, many of whom have been forced to leave the workforce or cut work hours to take on caregiving responsibilities because of an inadequate paid caregiver workforce.

AB 148 would require people in BadgerCare to reapply every six months, doubling the amount of paperwork needed to keep their health care coverage. It also requires applicants to start from scratch every time, refilling the same information into blank forms. Any errors could mean no health care for six months.

BadgerCare participants with I/DD are more likely to be non-readers, have disabilities that interfere with reading comprehension and cognitive processing, have limited or no access to internet, and be non-drivers. Clerical errors will likely cost people with I/DD their health care coverage. Tracking deadlines, requiring repetitive re-entering of existing information, and the understanding and complying with complex instructions are challenging for people with I/DD. The punitive measures in this bill could result in disrupted prescriptions, treatments, therapy and other important health care simply

Wisconsin BPDD
WISCONSIN BOARD FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

because of paperwork mistakes. Should people with I/DD lose coverage for six months, the challenges of understanding how to reapply could result in many continuing to remain uninsured.

Family caregivers of adults with I/DD provide daily care and support to help family members be as independent and productive as possible. Many family caregivers reduce their participation or leave the workforce entirely to meet care needs and often at the expense of their own financial futures. BadgerCare is critical for family caregivers who need to take care of their own health to care for others in their family.

Navigating Medicaid administrative requirements and paperwork is already difficult, mentally and emotionally taxing, and burdensome for family caregivers who are often already doing daily care coordination, making medical and other appointments, coordinating and transporting people with I/DD, and navigating multiple complex systems. Adding another high stakes administrative task with serious consequence for their own health coverage makes already complicated lives harder and is likely to only result in more crisis for already stressed families.

Not all people with disabilities in BadgerCare have a family or other support network to help them navigate and submit paperwork. The effect the bill will be to require people without families or other support systems living with significant health conditions that limit mobility and cognitive ability to figure out complex administrative requirements on their own or lose the health care and supports that help them live independently. Many will be unable to do so successfully, with disastrous results.

BPPD notes the provision to require eligibility redetermination every six months appears to conflict with federal law. We understand there are already data sharing agreements that are used to confirm financial eligibility, and existing processes—temporarily suspended during the public health emergency—remove ineligible participants from the BadgerCare rolls.

BPDD is charged under the federal Developmental Disabilities Assistance and Bill of Rights Act with advocacy, capacity building, and systems change to improve self-determination, independence, productivity, and integration and inclusion in all facets of community life for people with developmental disabilities[1].

Thank you for your consideration,

Beth Swedeen

Beth Swedeen, Executive Director,
Wisconsin Board for People with Developmental Disabilities

[1] More about BPDD https://wi-bpdd.org/wp-content/uploads/2018/08/Legislative_Overview_BPDD.pdf .

Providing quality coverage to nearly 3 million Medicaid and private sector enrollees in Wisconsin.

To:	Chairperson Clint Moses Members, Assembly Committee on Health, Aging and Long-Term Care
From:	R.J. Pirlot, Executive Director Caty McDermott, Lobbyist (MA Policy)
Date:	April 12, 2023
Re:	Oppose Assembly Bill

The Alliance of Health Insurers (AHI) is a nonprofit state advocacy organization created to preserve and improve upon consumer access to affordable health insurance in Wisconsin, both via the private sector and public programs. AHI health plans (HMOs) provide managed care to roughly two-thirds of the participants in Wisconsin's Medical Assistance program (BadgerCare and SSI program participants).

Under Wisconsin's managed care model, the Department of Health Services (DHS) makes preset, actuarily sound, per member/per month capitation payments to the managed care HMOs and in exchange, the HMOs are at financial risk for the Medicaid services specified in their contracts. Because DHS presets the capitation payments, if a member utilizes costlier services, the HMO assumes the additional expense. Studies have demonstrated that Medicaid managed care health plans provide savings of up to 20 percent compared to fee-for-service programs.[i] This saves taxpayers money and leads to better patient outcomes and better quality of care for program participants.

AB 148 prohibits DHS from automatically renewing an individual's Medicaid eligibility and requires DHS to determine eligibility every six months – instead of the current 12-month timeline. The bill provides that if an individual fails to "timely report" a change that may impact their Medicaid eligibility, they will remain ineligible for Medicaid for the following six months after the department discovers the failure to report. AB 148 also prevents DHS from using any prepopulated form with information from the recipient, except their name and address. In addition, the bill requires DHS to enter into broad data sharing agreements with other state agencies providing public benefits to confirm Medicaid eligibility.

AHI appreciates the legislature's interest in ensuring individuals that are on the Medicaid program are indeed eligible. AHI shares that interest. Currently, managed care HMOs work collaboratively with the state to ensure members are well-informed of redetermination requirements and timelines. However, AHI opposes this legislation due to the harmful impacts to eligible Medicaid members and the several policies included in AB 148 that are against federal law and directives. To help better understand the full implications of AB 148, AHI requests the committee to consider the following adverse items:

1. **Federal Law and "Unwinding" Impacts -** Federal law (42 CFR § 435.916) provides a recipients' Medicaid benefits "must be renewed once every 12 months, and no more

10 East Doty Street, Suite 500 • Madison, WI 53703 • 608-258-9506
R.J. Pirlot, Executive Director, pirlot@hamilton-consulting.com
www.allianceofhealthinsurers.com

frequently than once every 12 months." AHI cautions the committee to consider the federal law requirements prior to advancing this legislation.

The 12-month redetermination period is especially critical for the state's Medicaid unwinding process. Since March 2020, states have been operating under the PHE, and have received an additional 6.2 percentage point increase in federal Medicaid matching funds. In exchange for the additional federal match, states must meet certain conditions, including continuous eligibility through the end of the month in which the public health emergency ends. The easing of these rules was intended to prevent people with Medicaid and CHIP nationwide from losing health coverage during the pandemic.

The federal spending bill passed in December 2022 ended the connection between the ongoing COVID-19 public health emergency (PHE) and continuous coverage for Medicaid. Even though the PHE remains in place, Wisconsin has now begun to "unwind" its temporary continuous eligibility Medicaid rules related to the emergency, and DHS will restart Medicaid and CHIP eligibility reviews. The formal end of the continuous coverage policy is March 31. The department will begin the process of redetermining the eligibility of individuals on the program between June 2023 and May 2024.

For the last year, Wisconsin – and the AHI HMOs – have actively been gearing up and dedicating resources for this "unwinding" period[ii] in which Medicaid eligibility will need to be redetermined for Medicaid recipients. This effort requires coordinated outreach to ensure that Medicaid members that continue to meet eligibility requirements can remain on Medicaid and individuals that are no longer eligible can transition to another form of health care coverage (e.g., employer sponsored or via a plan purchased on the exchange).

The federal government has provided states with a 12-month timeline to "unwind" the Medicaid program. Renewals are required no more than once per year for MAGI populations (e.g., children, pregnant women, parents/caretaker relatives of children under 19, childless adults) and at least once per year for non-MAGI populations (e.g., people with disabilities). The only time redetermination occurs more than once per year for MAGI populations is when the state sets up agreements with third party vendors to accept data throughout the year that informs the agency of potential changes in circumstances and then the state will act on it (CMS requires states to act on information it receives).

AHI strongly supports the 12-month timeline both generally and for this unwinding period to limit program churn, transition Medicaid ineligible individuals to the exchange, and appropriately manage administrative costs for the significant renewal process.

2. **Autorenewals –** AB 148 restricts DHS' use of prepopulated eligibility forms (except for name and address) which could impede state efforts to streamline the Medicaid renewal process. Under the Affordable Care Act, "states must seek to verify eligibility criteria based on electronic data matches with reliable sources of data."[iii] The federal Centers for Medicare and Medicaid Services (CMS) requires states to do ex parte (passive) renewals when information is available, and to send prepopulated forms when information needs to be requested from the enrollee.

AB 148 includes a 6-month lock-out for enrollees failing to inform the agency of information that affects their eligibility (most enrollees do not proactively report changes in circumstance). Lock outs are prohibited unless CMS grants the state waiver approval to implement it. Only a handful of states have waivers in place for lock outs in Medicaid and those waivers are for expansion adults or people at higher FPL levels for failing to pay small premiums and the lockout is shorter (two months, etc), both of which are not applicable to Wisconsin's Medicaid program.

To streamline this process, Wisconsin and 46 other states have moved towards "real-time" Medicaid eligibility determinations. Technology and improved third-party data sources have been assets in not only allowing for administrative renewals, but to verify member income and work status, which helps identify individuals who are not providing accurate employment records to the Income Maintenance agencies. In general, Medicaid managed care HMOs support efforts to use these technologies to avoid redundant data entry, manage the workload and budgets for the Income Maintenance consortia.

3. **Data Sharing Limitations** – The bill requires DHS to enter into data sharing agreements with other state agencies that maintain databases of Wisconsin resident's personal and financial information. While AHI appreciates the intent to utilize data to ensure that those on Medicaid are eligible, development of a system like this could be a significant cost for the state, and there are limitations for the various IT systems to be cross referenced. Also, there may be privacy implications – both for Protected Health Information and other information, which could require additional state resources to appropriately manage. AHI urges the committee to quantify the fiscal impact of this policy.

AHI appreciates the committee's considerations of these items. AHI is dedicated to delivering affordable, high-value care to the state's Medicaid population and welcome the opportunity to work together with the legislature on these issues.

Thank you for your consideration.

---

[i] The Lewin Group, "Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies" March 2009
[ii] Wisconsin Department of Health Services, COVID-19 Emergency "Unwinding" Partner Toolkit, January 2022
[iii] KFF, Medicaid Eligibility Determinations, Applications, and Online Accounts, January 2020

April 11, 2023

American Lung Association.
Wisconsin

Testimony of the American Lung Association
Opposing Assembly Bill 148
Assembly Committee on Health, Aging and Long-Term Care

Dear Chair Moses and members of the committee,

The American Lung Association represents thousands of patients and families with lung disease in Wisconsin and are committed to ensuring that BadgerCare provides adequate, affordable, and accessible health care coverage. Medicaid's robust healthcare coverage is critical for low-income children, adults, seniors, and people with disabilities. However, Assembly Bill 148 would jeopardize coverage for patients who remain eligible for Medicaid. The Lung Association urges Wisconsin lawmakers to oppose this bill.

Assembly Bill 148 would prohibit state agencies from automatically renewing people's Medicaid benefits, require eligibility to be verified every six months (instead of annually), and would lock patients out of coverage for six months if they fail to report any change that may impact their eligibility. It also prohibits using prepopulated forms to help streamline enrollment. This bill will lead to administrative chaos and massive disenrollment, including of enrollees who are eligible but lose coverage due to administrative red tape. Low-income individuals who qualify for Medicaid may move frequently and not receive notices about their eligibility, therefore not realizing they have lost their Medicaid coverage until they show up at a hospital, physician's office, or pharmacy. This loss of coverage would likely lead to delays in accessing needed care.

The evidence is clear that policies that increase administrative red tape for patients lead to coverage losses for individuals with serious and chronic health conditions, including lung disease. For example, when Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[i] Additionally, a recent report found that 1.6 million individuals lost their Medicaid coverage in 2018, including 744,000 children, with the largest coverage losses in states that had burdensome redetermination processes.[ii] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

AB 148 would also require Medicaid enrollees' to timely report change of employment or wages or be locked out of coverage for six months. Low-income individuals' wages and housing situations often fluctuate due to the nature of hourly wages and income insecurity. The Medicaid agency should be reviewing this information at the 12-month redetermination check. Doing so more frequently will result in more churn in the Medicaid program, more gaps in coverage, worse health outcomes and ultimately higher healthcare costs.

The American Lung Association strongly opposes proposals to increase the administrative burden on individuals in the Medicaid program and lock patients out of coverage, which will decrease the number of individuals with quality, affordable healthcare. Adding this burden is especially dangerous at this time as Wisconsin will already need to devote resources to processing hundreds of thousands of eligibility redeterminations at the end of the COVID-19 continuous coverage requirements. This is not a responsible use of tax dollars because it will

mean increased costs for the administration, higher medical bills for those who are forced to go without coverage, and more red tape for patients who should be focused on their health.

If Wisconsin lawmakers want to strengthen the health of the workforce, they could agree to expand Medicaid which would mean people could earn more while maintaining their health care coverage. It would also qualify our state for more than $1 billion in savings which could be used to bolster work supports. There are, in fact, many alternative policies that Wisconsin could pursue to ensure patients who remain eligible for Medicaid coverage maintain their access to care and we would be very happy to serve as a resource to develop ideas to strengthen this program. The American Lung Association urges Wisconsin lawmakers to reject these proposals and instead focus on policies that promote affordable, accessible, and adequate health care coverage in Wisconsin.

---

[i] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[ii] https://familiesusa.org/sites/default/files/product_documents/Return_of_Churn_Analysis.pdf

WISCONSIN COUNTIES ASSOCIATION

22 EAST MIFFLIN STREET, SUITE 900
MADISON, WI 53703
TOLL FREE: 1.866.404.2700
PHONE: 608.663.7188
FAX: 608.663.7189
WICOUNTIES.ORG

MEMORANDUM

TO: Honorable Members of the Assembly Committee on Health, Aging & Long Term Care

FROM: Chelsea Shanks, Government Affairs Associate

DATE: April 12, 2023

SUBJECT: Opposition of Assembly Bill 148

Assembly Bill 148 prohibits DHS from automatically renewing the eligibility of a recipient for Medical Assistance (MA) program benefits. DHS must determine an individual's eligibility every six months under the bill. Additionally, any recipient of MA benefits that fails to timely report to DHS or its designee any change that may affect eligibility is ineligible for benefits for six months. The bill also requires DHS to promptly remove from eligibility for the MA program any individual who has been determined to be ineligible for the program, and requires quarterly reports on eligibility status if the bill's implementation affects enhanced federal financial participation.

With the exception of cases in Milwaukee County, all of the eligibility work required in AB 148 will be conducted by our 10 county-operated income maintenance (IM) consortia and the workload increases associated with the bill is significant. For example, the bill requires MA eligibility to be determined every six months, as opposed to every 12 months under current law. That provision alone doubles the eligibility work associated with the MA program. If quarterly reports must be submitted to DHS, that workload could actually quadruple. Counties raised concerns about the increased costs associated with FSET work requirements and drug testing when those provisions were first proposed.

AB 148 fails to recognize the workload increases on IM consortia and in so doing, fails to provide the resources IM consortia will need to implement the program changes contained in this bill.

The state provides the 10 IM consortia with funding to perform eligibility determinations for Wisconsin's economic support programs through the IM administration allocation (IMAA). Historically, IMAA funding levels have not kept pace with the work involved in processing and managing FoodShare and MA cases. In fact, county levy invested in economic support programs is greater than the state's GPR investment - in 2017, the state invested $17.7 million GPR while county levy investment was over $30 million. The 2021-23 state biennial budget proposed by

the Governor contained increased funding for the IM consortia to cover projected workload increases due to significantly increasing caseloads. Unfortunately, the Legislature rejected the Governor's increase, causing IM consortia to bear an even greater percentage of costs. Counties simply do not have the levy capacity to fund the increased costs associated with these three bills.

The 2023-25 budget proposed by the Governor recommends adjusting funding to reflect a reestimate of the caseload and updated program requirements for the IM consortia: $1,506,800 GPR/FED in FY24 and $2,278,500 GPR/FED in FY25. The Wisconsin Counties Association supports this budget recommendation.

The Wisconsin Counties Association respectfully requests your opposition to Assembly Bill 148. Thank you for your consideration.

Contact: Chelsea Shanks, Government Affairs Associate
608.663.7188
shanks@wicounties.org

WISCONSIN INSTITUTE
FOR LAW & LIBERTY

Testimony in Support of Assembly Bill 148
Assembly Committee on Health, Aging, and Long-Term Care
Wednesday, April 12, 2023

Chairman Moses, Vice Chair Rozar and members of the committee,

Thank you for the opportunity to submit testimony in support of Assembly Bill 148. This legislation, by prohibiting automatic renewal, requiring eligibility redetermination, removal of ineligible recipients, and data sharing among other agencies, will get our state back to normal operations and make Medicaid more efficient and secure moving forward.

During the COVID-19 public health crisis, the federal government increased the Medicaid match rate by 6.7%. In return for this enhanced match, states were prohibited from removing existing participants from the program, regardless of whether they were still eligible for assistance. However, the federal government is phasing out this match increase by the end of this year and is now allowing states to disenroll ineligible recipients. Earlier this year, the Center for Medicaid Services (CMS) required each state to submit an unwinding plan detailing the state's plans for disenrolling ineligible Medicaid recipients. Disenrollment is expected and inevitable the growth of the Medicaid rolls without undergoing this process is unsustainable.

Over the course of the pandemic, almost 210,000 people were added to Medicaid rolls in Wisconsin with continuous coverage. The childless adult population increased by 96% between March 2020 to February 2023. By comparison, children on Medicaid increased by 5% and parents/caretakers grew by 20%. It also worth noting that pregnant women have grown by 99% because women who are even two years post-partum are still enrolled. Undoubtably, a number of people may have fallen on hard times during the height of the pandemic, but many have no doubt improved their situation since then

We can look at the work done in Iowa to illustrate the improved circumstances of some of their Medicaid recipients. Over the course of the pandemic, Iowa continued to conduct eligibility redetermination without disenrolling anyone. This not only kept all enrollee information up to date, but they were able to uncover that over 36,000 enrollees were dual enrolled in Medicaid and private insurance. This becomes problematic when the state continues paying for a Medicaid enrollee that is not using their benefits. This is very likely to be the case in Wisconsin as well. Our Forward Health program pays monthly capitated rates to health management organizations that provide enrollees with their benefits and continues to pay whether the enrollee uses the benefits or not. State resources should be reserved for truly needy individuals, not those enrolled in private insurance plans.

The bill would also require DHS to verify eligibility every 6 months, instead of annually. This will improve program integrity and ensure that benefits are reserved for those that are truly in need. While this provision would require submittal of a waiver request to CMS, continually pushing the federal government for flexibility in administering state programs is a worthwhile endeavor.

This bill will also make Medicaid programs more efficient by requiring data sharing crosschecks with other state agencies that also administer programs that have financial eligibility requirements. Wisconsin's various public assistance programs often operate in separate silos. Data sharing will ensure that each agency has the most up to date financial eligibility information for public assistance recipients

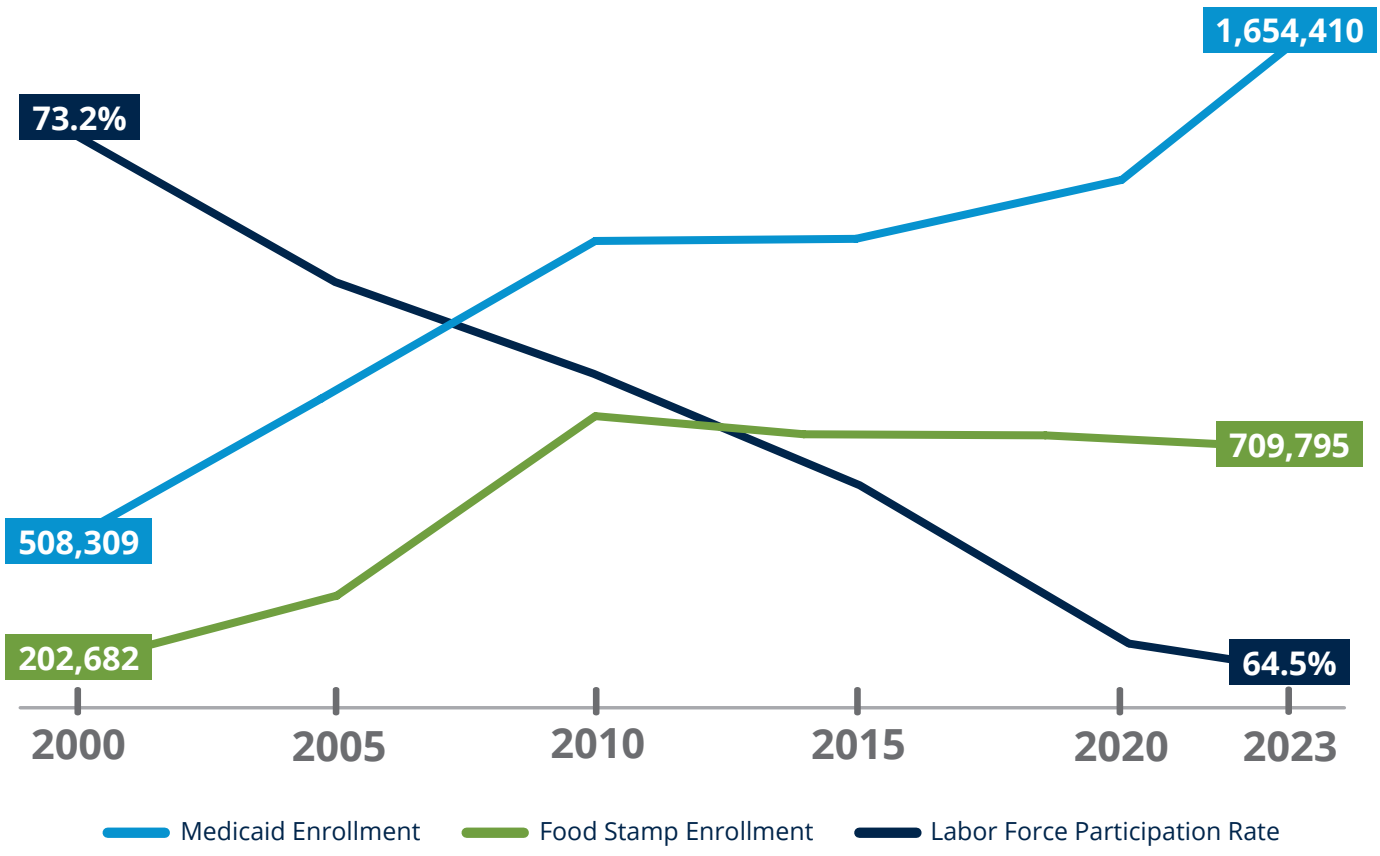
and ensure that benefits are reserved for those who need them most. The U.S. Department of Health and Human Services Administration for Children and Families (ACF) and Centers for Medicare & Medicaid Services (CMS) have released guides for data sharing between programs, and data sharing has been successfully implemented in multiple states such as Indiana and Massachusetts.

AB 148 is a necessary step forward in the maintenance and improvement of our Medicaid system and ensure its benefits are directed to those that truly need it. I strongly encourage this committee to support this bill. Thank you again for the opportunity to submit testimony and for your time.

Kyle Koenen
Policy Director
Wisconsin Institute for Law & Liberty

Wisconsin's Economic Comeback is Being Stalled by the Worker Shortage

Medicaid and Food Stamp Enrollment Skyrocket As Labor Force Participation Plummets



LEGAL ACTION OF WISCONSIN

Providing free legal services to low-income Wisconsin clients since 1968 • Proporcionando servicios legales gratuitos a clientes de bajos ingresos en Wisconsin desde 1968

TO:	**Assembly Committee on Assembly Committee on Health, Aging and Long-Term Care**
FROM:	**Abby Bar-Lev Wiley, Legislative Director, Legal Action of Wisconsin**
RE:	**Impact of AB 148 on Legal Action's Clients**
DATE:	**April 12, 2022**

Thank you for the opportunity to provide feedback on AB 148. Legal Action of Wisconsin (LAW) is the largest non-profit law firm providing high-quality, free civil legal aid to low-income Wisconsinites. Our broad reach and expertise mean that we see what poverty looks like over a wide swath of the state, from urban to rural areas, from farmworkers to service workers.

We appreciate value underlying AB 148, which is to get people back into family-sustaining jobs and ensure that no one is using Medical Assistance who does not need it. Legal Action shares the value that good, family-sustaining jobs is a critical component of helping people to escape poverty and achieve economic security, and consequently to improve the economy and save the state money on important state services, like Medical Assistance. We are concerned that the unintended consequences of AB 148 could mean that deserving people are nonetheless left without access to healthcare—in turn costing the state more money—and could create significant administrative burden on an already overworked system.

Medicaid churn leads to greater costs and likely to lead to lead to increased reliance on state services

At Legal Action, we agree that it is important that only qualified and needy individuals are utilizing Medical Assistance, and that it is important for the state to save money where it can. However, we are concerned that this bill could actually end up costing the state money due to Meidcaid "churn." DHS is already reviewing every individual's eligibility every 12 months, which, for our clients, is a timeline that is easy to anticipate and gives enough time to gather the necessary information, therefore reducing unnecessary gaps in coverage. Studies have found that states with more Medicaid "churn"—people moving in and out of Medicaid eligibility—see higher administrative costs, less predictable state expenditures, and higher monthly health care costs. For example, "one study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month in 2021 after adjusting for inflation) than those with six months of coverage ($583/month) or only three months of coverage ($799/month)."[1] People who experience coverage disruptions are "more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits."[2] Therefore, it is likely that in trying to encourage individuals to get off Medical Assistance who don't need it, this

[1] Sarah Sugar, et. al, Health & Human Services, Asst. Secretary for Planning & Evaluation, Issue Brief, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (Apr. 12, 2021), *available at* https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.
[2] *Id.*

Administrative Office

633 West Wisconsin Avenue
Suite 2000
Milwaukee, WI 53203

Office 855.947.2529
Fax 414.662.4080

www.legalaction.org

funded in part by:
LSC America's Partner for Equal Justice
LEGAL SERVICES CORPORATION

bill would instead simply delay coverage for many qualified low-income folks, creating gaps in coverage that the state ends up filling with expensive emergency services.

AB 148 could make local agencies' more burdensome, leading to gaps in coverage even for those who have done everything right

AB 148 would prohibit automatic renewals for reenrollment in Medical Assistance. Were this bill to become law, it would require a significant influx of funds to local agencies for the process imagined in the bill to run smoothly. The purpose of automatic renewals is to lessen the administrative burden on local agencies, who would need significant funding increases to manage enrollment if they were no longer able to engage in automatic renewals where appropriate. Automatic renewals only occur in instances when the agency can obtain the information to determine eligibility data exchanges, in which relevant information is readily available to the agency. Therefore, automatic renewals have been happening for years without any evidence to our knowledge that the process results in more improper certifications of Medical Assistance than non-automatic renewals.

Under the bill, county agencies, or income consortium agencies, would bear the burden of trying to manage the extreme increase in workload the bill proposes. By requiring eligibility checks every six months instead of every year, AB 148 would essentially double county agencies' workload, and then add the prohibition on automatic renewals on top of that. They would need more funding and staffing to send out all the additional notices, process the influx of documents necessary to check eligibility, and more.

When the local agencies' burden is increased and a time-saving tool is removed, it is nearly certain to result in delays in coverage, including for those qualified individuals who have done everything right.

Qualified individuals may see gaps in coverage

AB 148 would require DHS to determine an individual's eligibility for Medical Assistance every six months. If someone is determined to have failed to report any change that may impact their eligibility, that individual would be excluded from the program for six months. While such a change would not be a problem for individuals or families in stable housing and employment, it is actually quite onerous on our clients who move often and are frequently in crisis.

An annual determination of income makes the most sense for our clients. Low-income adults who are able to work often experience income instability because they work multiple low-wage, hourly jobs, with little or no paid time off, and with hours and wages that fluctuate based on the employer's determination. Lack of stable income means that our working clients move frequently, whether because they can no longer afford rent, are facing housing instability, or any other unforeseen crisis that struggling families face. Because people with low incomes move frequently, many might not receive notices from DHS regarding their eligibility. Tragically, they

might not discover they have lost their health care coverage until they show up at the hospital or the doctor's office in need of care. This heart-sinking moment would require them to decide: do they get the care they need, or do they pay the rent, the bills, or buy groceries for their children? How do they manage their health moving forward?

We are concerned that the bill could also have an unintended negative impact on some of Wisconsin's most vulnerable residents, including for the elderly and people with disabilities whose situations do not typically change throughout the year. While gathering and updating information on one's financial situation every six months may not be difficult for many Wisconsinites, it would prove very difficult for the elderly and disabled individuals we serve, likely leading to significant gaps in coverage for folks that the legislature did not intend.

Thank you again for taking Legal Action's feedback as you consider this bill. We greatly appreciate the opportunity to provide input.

Administrative Office

633 West Wisconsin Avenue
Suite 2000
Milwaukee, WI 53203

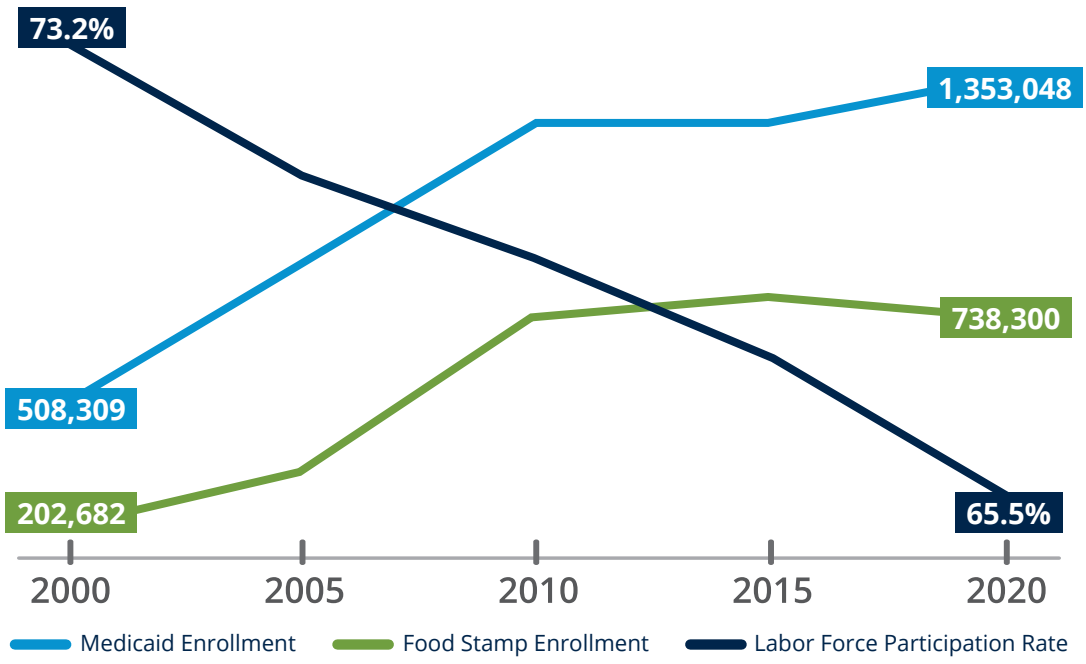
Office 855.947.2529
Fax 414.662.4080

www.legalaction.org

funded in part by:
LSC America's Partner for Equal Justice
LEGAL SERVICES CORPORATION

Wisconsin's Economic Comeback is Being Stalled by the Worker Shortage

Medicaid and Food Stamp Enrollment Skyrocket As Labor Force Participation Plummets



Government Programs	
Premium Tax Credits	$1,004
Unemployment Insurance	$940
Child Tax Credits *(pending)*	$600
Earned Income Tax Credit (EITC)	$452
Food Stamps	$429
Cost-Sharing Subsidies	$308
MONTHLY TOTAL	**$3,733**

Based on a low-income Wisconsinite with two children under age six.

	Earnings from Work	Monthly Cash Benefits to Stay Home	Percent Difference
Monthly Earnings of a Full-Time Wisconsin Worker Earning Minimum Wage	$1,257	$3,733	197%
Median Monthly Earnings of a Full-Time Wisconsin Worker	$3,430	$3,733	21%

How much does it pay to not work?

$22 per hour

$44,801 per year

TheFGA.org | @TheFGA

To:	Chairperson Clint Moses Members, Assembly Committee on Health, Aging and Long-Term Care
From:	R.J. Pirlot, Executive Director, Alliance of Health Insurers (AHI) Caty McDermott, Lobbyist (MA Policy), AHI Tim Lundquist, Senior Director of Government and Public Affairs, Wisconsin Association of Health Plans (WAHP)
Date:	April 12, 2023
Re:	Oppose Assembly Bill 148

The Alliance of Health Insurers (AHI) and the Wisconsin Association of Health Plans (WAHP) are nonprofit state advocacy organizations dedicated to promoting consumer access to affordable health insurance in Wisconsin, both via the private sector and public programs. AHI and WAHP member health plans (HMOs) provide managed care to participants in Wisconsin's Medical Assistance program (BadgerCare and SSI program participants).

Under Wisconsin's managed care model, the Department of Health Services (DHS) makes preset, actuarially sound, per member per month capitation payments to the managed care HMOs and in exchange, the HMOs are at financial risk for the Medicaid services specified in their contracts. Because DHS presets the capitation payments, if a member utilizes costlier services, the HMO assumes the additional expense. Studies have demonstrated that Medicaid managed care health plans provide savings of up to 20 percent compared to fee-for-service programs.[i] This saves taxpayers money and leads to better patient outcomes and better quality of care for program participants.

AB 148 prohibits DHS from automatically renewing an individual's Medicaid eligibility and requires DHS to determine eligibility every six months – instead of the current 12-month timeline. The bill provides that if an individual fails to "timely report" a change that may impact their Medicaid eligibility, they will remain ineligible for Medicaid for the following six months after the department discovers the failure to report. AB 148 also prevents DHS from using any prepopulated form with information from the recipient, except their name and address. In addition, the bill requires DHS to enter into broad data sharing agreements with other state agencies providing public benefits to confirm Medicaid eligibility.

AHI and WAHP appreciate the legislature's interest in ensuring individuals that are on the Medicaid program are indeed eligible. AHI and WAHP share that interest. Currently, managed care HMOs work collaboratively with the state to ensure members are well-informed of redetermination requirements and timelines. However, AHI and WAHP oppose this legislation due to the harmful impacts to eligible Medicaid members and the several policies included in AB 148 that are against federal law and directives. To help better understand the full implications of AB 148, AHI and WAHP request the committee to consider the following adverse items:

1. **Federal Law and "Unwinding" Impacts -** Federal law (42 CFR § 435.916) provides a recipients' Medicaid benefits "must be renewed once every 12 months, and no more

frequently than once every 12 months." AHI and WAHP caution the committee to consider the federal law requirements prior to advancing this legislation.

The 12-month redetermination period is especially critical for the state's Medicaid unwinding process. Since March 2020, states have been operating under the COVID-19 public health emergency (PHE), and have received an additional 6.2 percentage point increase in federal Medicaid matching funds. In exchange for the additional federal match, states must meet certain conditions, including continuous eligibility through the end of the month in which the public health emergency ends. The easing of these rules was intended to prevent people with Medicaid and CHIP nationwide from losing health coverage during the pandemic.

The federal spending bill passed in December 2022 ended the connection between the ongoing PHE and continuous coverage for Medicaid. Even though the PHE remains in place, Wisconsin has now begun to "unwind" its temporary continuous eligibility Medicaid rules related to the emergency, and DHS is on the cusp of restarting Medicaid and CHIP eligibility reviews. The formal end of the continuous coverage policy was March 31, and the Department will redetermine the eligibility of individuals on the program between May 2023 and May 2024.

For more than a year, Wisconsin – and the Medicaid HMOs – have actively been gearing up and dedicating resources for this "unwinding" period[ii] in which Medicaid eligibility will need to be redetermined for Medicaid recipients. This effort requires coordinated outreach to ensure that Medicaid members who continue to meet eligibility requirements can remain on Medicaid and individuals who are no longer eligible can transition to another form of health care coverage (e.g., employer sponsored or via a plan purchased on the exchange).

The federal government has provided states with a 12-month timeline to "unwind" the Medicaid program. Renewals are required no more than once per year for MAGI populations (e.g., children, pregnant women, parents/caretaker relatives of children under 19, childless adults) and at least once per year for non-MAGI populations (e.g., people with disabilities). The only time redetermination occurs more than once per year for MAGI populations is when the state sets up agreements with third party vendors to accept data throughout the year that informs the agency of potential changes in circumstances and then the state will act on it (the federal Centers for Medicare and Medicaid Services (CMS) requires states to act on information it receives).

<u>AHI and WAHP strongly support the 12-month timeline both generally and for this unwinding period to limit program churn, transition Medicaid ineligible individuals to the exchange, and appropriately manage administrative costs for the significant renewal process.</u>

2. **Autorenewals –** AB 148 restricts DHS' use of prepopulated eligibility forms (except for name and address) which could impede state efforts to streamline the Medicaid renewal process. Under the Affordable Care Act, "states must seek to re-determine eligibility at renewal using electronic data matches with reliable sources of data prior to requiring enrollees to complete a renewal form or submit documentation."[iii] CMS requires states to do

ex parte (also referred to as administrative or passive) renewals when information is available, and to send prepopulated forms when information needs to be requested from the enrollee.

AB 148 includes a 6-month lock-out for enrollees failing to inform the agency of information that affects their eligibility (most enrollees do not proactively report changes in circumstance). Lock-outs are prohibited unless CMS grants the state waiver approval to implement it. Only a handful of states have waivers in place for lock-outs in Medicaid and those waivers are for expansion adults or people at higher FPL levels for failing to pay small premiums and the lock-out is shorter (two months, etc), both of which are not applicable to Wisconsin's Medicaid program.

To streamline the renewal process, Wisconsin and 46 other states have moved towards "real-time" Medicaid eligibility determinations. Technology and improved third-party data sources have been assets in not only allowing for administrative renewals, but to verify member income and work status, which helps identify individuals who are not providing accurate employment records to the Income Maintenance agencies. In general, Medicaid managed care HMOs support efforts to use these technologies to avoid redundant data entry, and manage the workload and budgets for the Income Maintenance consortia.

3. **Data Sharing Limitations –** The bill requires DHS to enter into data sharing agreements with other state agencies that maintain databases of Wisconsin resident's personal and financial information. Development of a system like this could be a significant cost for the state, as there are limitations for the various IT systems to be cross referenced. Also, there may be privacy implications – both for Protected Health Information and other information, which could require additional state resources to appropriately manage. AHI and WAHP urge the committee to quantify the fiscal impact of this policy.

AHI and WAHP appreciate the committee's consideration of these items. AHI and WAHP member health plans are dedicated to delivering affordable, high-value care to the state's Medicaid population and welcome the opportunity to work together with the legislature on these issues.

Thank you for your consideration.

---

[i] The Lewin Group, "Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies" March 2009
[ii] Wisconsin Department of Health Services, Keeping Wisconsin Covered & COVID-19 Emergency "Unwinding" Partner Toolkit, April 2023
[iii] KFF, Medicaid Eligibility Determinations, Applications, and Online Accounts, January 2023

Wisconsin

Welfare Program Integrity Bill

Adam Gibbs
Opportunity Solutions Project

Good morning. I'm Adam Gibbs. I live right here in Madison, and I'm the Communications Director at the Foundation for Government Accountability and I'm testifying in my capacity as a Visiting Fellow at Opportunity Solutions Project, a non-partisan, non-profit organization founded with one clear goal—getting more Americans into the workforce to achieve the American Dream.

To that end, I really appreciate the opportunity to speak today to support the intent behind this welfare reform bill, to encourage this committee to support this bill, and to humbly offer ideas for how to strengthen it further.

This bill is confirmation that this legislature is getting serious about a serious problem—waste and fraud across welfare, particularly in BadgerCare, our state's Medicaid program, where the improper payment rate is more than 20 percent.[1]

Now, for better or worse, Wisconsin is about average on that metric. But we can do better than average. Michigan is at about 14 percent. Blue states like New Mexico, purple states like Virginia, and red states like Wyoming all have improper payment rates of about half of Wisconsin's 20 percent.[2]

20 percent. That means that in our state's single biggest program, more than one in every five dollars is spent improperly. What drives Wisconsin's improper payment rate?

It's actually pretty simple. More than 80 percent of improper payments are caused by eligibility errors.[3] Meaning cash going out the door for individuals who aren't eligible for coverage and, for the many Badgers on managed care plans, that means cash going out the door month after month after month even if they're not using services.

We spend about $5 billion every year in *state* money for Medicaid[4]—again just in state money—so that means we're wasting about $1 billion every year on improper payments in BadgerCare.

Imagine what this legislature could do with $1 billion more dollars to spend without raising taxes—the investments that could be made in infrastructure, in schools, in public safety. Not to mention making BadgerCare more generous for the truly needy—for the folks actually eligible for Medicaid.

Those are the stakes.

So what does this bill do and what doesn't it do? Well, first, here's what it doesn't do—it doesn't remove anyone who is eligible for BadgerCare from Badgercare. The goal here is clear—reserving Medicaid for Badgers who are actually eligible for Medicaid.

Now, what does it do and what should it do?

Section 1 requires the department to "remove promptly" anyone found ineligible on Medicaid. The goal here is common-sense. We would suggest that this would be stronger with clear deadlines.

In particular, as Wisconsin unwinds the current restrictions on removing ineligible enrollees who only remain enrolled due to the federal public health emergency, it would be clearer and better if Wisconsin did what states like Arkansas, Arizona, and Idaho are doing—setting clear deadlines for when the rolls must be clean.

Arizona provides a strong example for Wisconsin. In Arizona, the Republican legislature passed and the Democratic Governor signed a bill requiring the agency to move faster than required and finish

redeterminations for individuals thought to be ineligible by the end of this year, rather than waiting even longer. This bill is an opportunity to do something similar.

Section 2 has a handful of reforms. It requires the agency to submit four waivers to the federal government to 1) end auto-renewals; 2) end pre-populated forms; 3) implement biannual redeterminations instead of annual redeterminations; and 4) implement a fraud lockout.

Each one is important for different reasons but they all have a common purpose—verifying eligibility for benefits, plain and simple.

Current regulations require Wisconsin to provide pre-populated forms on behalf of enrollees when they are due to renew in Medicaid.[5] This facilitates waste and fraud by making it difficult to detect. Another regulation restricts Wisconsin from redetermining Medicaid eligibility more often than once every 12 months.[6] And Medicaid recipients in Wisconsin who fail to report changes in their income or other household changes in a timely manner have limited or no penalties and likely will not even be disenrolled when the failure to report is discovered.

This bill requires the agency to submit waivers to stop these practices.

With approval of these waivers, applicants and enrollees must complete and update their own information when they apply for new or extended coverage; applicants will be redetermined more often than once per year to ensure their continued eligibility, and those who fail to report changes will be disenrolled for six months. States like Kentucky have submitted waivers along these lines and received approval.[7]

There are opportunities to strengthen this section though.

First, regarding the fraud lockout, the bill currently includes all Medicaid beneficiaries in every eligibility category. Wisconsin is probably better off following Kentucky's lead and only applying that restriction to able-bodied adults which, in Wisconsin, means the parent/caretaker category.

Second, still on the fraud lockout, instead of requiring enrollees to report changes in a "timely" manner, without defining what that means, the bill should clarify it with a specific timeline. 10 days would be our suggested deadline.

Sections 3 and 4 are very promising. This section requires some quarterly cross-checks with other state-owned data-sets to ensure eligibility.
But, compared to other states which have codified cross-checks, this section is vague and incomplete. The concept is simple: Wisconsin already has prison records, death records, wage and employment records, lottery and gaming winnings, and out-of-state EBT card spending. And it has access to federal pension data, new hire and child support data, earnings data, and fleeing felon data.

BadgerCare—and other welfare programs—should be required to cross-check all of those databases on a monthly or quarterly basis.

Moving to the last Section, Section 5, we would recommend clarifying that if federal approval is rejected or withdrawn for any of the waivers submitted under the bill, the waiver must be resubmitted every 24 months until approved—it shouldn't be a one-time thing.

The last thing that's worth mentioning here is that there are other welfare program integrity reforms that do not require waivers that aren't in this bill. This committee should consider adding them. For instance, BadgerCare uses some loose standards in eligibility verification by choice—not because it is required to do under regulations.

For example, state residency, caretaker status, and, especially, household composition are all critical factors in determining whether or not an applicant is eligible for Medicaid. But Wisconsin currently

accepts an applicant's statement at face value without any additional verification through so-called "self attestation."[8]

This means, to a large degree, BadgerCare eligibility is run on the honor system. Using such loose standards prioritizes dependency over self-sufficiency and debt over solvency. Wisconsin can and should close those loopholes by statute in this bill by simply requiring that those conditions of eligibility must be verified—and no federal waiver is required.

All that said, this bill is a big step in the right direction on a critical issue for Wisconsin. And I strongly encourage this committee to support this bill and build on these efforts.

Thank you for the opportunity to testify and I'd be happy to answer any questions.

---

[1] https://thefga.org/research/ineligible-medicaid-enrollees-costing-taxpayers-billions/
[2] Ibid.
[3] Ibid.
[4] https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b7500fca152d64c2/UploadedImages/SER%20Archive/2022_State_Expenditure_Report_-_S.pdf
[5] 42 C.F.R. 435.916(a), https://www.govinfo.gov/app/details/CFR-2010-title42-vol4/CFR-2010-title42-vol4-sec435-916.
[6] Centers for Medicare and Medicaid Services, "Medicaid program: Eligibility changes under the Affordable Care Act of 2010," Federal Register 77(57): 17,144-217 (2012), https://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf.
[7] Centers for Medicare and Medicaid Services, "Letter approving Kentucky's 1115 waiver request," United States Department of Health and Human Services (2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.
[8] Centers for Medicare and Medicaid Services, "Wisconsin MAGI-Based Eligibility Verification Plan," U.S. Department of Health and Human Services (2020)https://www.medicaid.gov/sites/default/files/2019-12/wisconsin-updated-verification-plan-template.pdf