WILLIAM PENTERMAN

STATE REPRESENTATIVE • 38th ASSEMBLY DISTRICT

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P.O. Box 8953
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Assembly Committee on Public Benefit Reform
Testimony in Support of Assembly Bill 163
April 10, 2025

Chair Knodl and members of the Assembly Committee on Public Benefit Reform, thank you for holding a public hearing on Assembly Bill 163 (AB 163) relating to redeterminations of eligibility for the Medical Assistance (MA) program and database confirmation for public assistance program eligibility.

During the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA), enacted in March 2020, included a "continuous coverage" requirement, which mandated that states maintain Medicaid enrollment for individuals enrolled as of March 18, 2020 and prohibited disenrollment until the end of the Public Health Emergency (PHE). In return, states received a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP). As a result, enrollment numbers grew unchecked.

However, the Consolidated Appropriations Act enacted on December 29, 2022, amended this requirement by delinking it from the PHE. Specifically, Section 5131 of the Act terminated the continuous enrollment condition effective March 31, 2023, allowing states to resume Medicaid coverage terminations starting April 1, 2023. It is time to reassess and restore integrity to the system by ensuring that only those who truly qualify continue receiving benefits.

As of February 2025, approximately 1,165,000 individuals were enrolled in Wisconsin's MA programs. In our 2023-25 Budget, MA programs were about $8.67 billion - roughly 18% of our general fund appropriations – making it third-largest expenditure. It is only fair that these funds be directed to the Wisconsinites who need them most.

AB 163 appropriately emphasizes personal responsibility, requiring recipients to report changes that may affect their eligibility—a fair and reasonable expectation. This bill strikes an important balance: preserving a strong safety net for our most vulnerable residents while curbing inappropriate, long-term reliance on public assistance.

Assembly Bill 163 is a pragmatic, common-sense reform that prioritizes accountability without losing compassion. It helps ensure Wisconsin's public assistance programs remain sustainable, trustworthy, and targeted toward those who need them most.

Thank you for your time and consideration.

ROB STAFSHOLT

STATE SENATOR • 10th SENATE DISTRICT

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

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

DATE: April 10, 2025

RE: Testimony on Assembly Bill 163

TO: Members of the Assembly Committee on Public Benefit Reform

FROM: Senator Rob Stafsholt

Thank you, Chairman Knodl and members of the Assembly Committee on Public Benefit Reform for hearing Assembly Bill 163 relating to redeterminations of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility.

During the COVID-19 outbreak, the federal government adopted enhanced reimbursements for each state's Medical Assistance program and prohibited states from removing existing participants in their Medical Assistance program in return for these additional resources. This has since 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 remove all ineligible participants from the Medical Assistance program. It also increases the eligibility determination from annually to bi-annually and improves eligibility crosschecks between agencies by requiring relevant agencies to share applicable data. Due to current federal law, eligibility checks can only be done once every 12 months, so this bill also requires DHS to request a federal waiver to allow the bi-annual determination.

This is a common-sense bill to ensure program integrity and preserve allotted tax dollars for our most vulnerable populations that really need this resource by eliminating the free ride for those that are ineligible. I look forward to receiving input from the public on this proposed legislation.

Thank you for allowing me to submit testimony on Assembly Bill 163. I would also like to thank Representative Penterman for his work on this bill. 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 Public Benefit Reform

FROM: Arielle Exner, Legislative Director

DATE: April 10, 2025

RE: Assembly Bill 163, relating to: redeterminations of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility

The Wisconsin Department of Health Services (DHS) appreciates the opportunity to submit written testimony for information only on AB 163, which proposes significant changes to the way eligibility is determined and maintained for Wisconsin Medicaid members. This legislation would require DHS to redetermine member eligibility every six months, prohibit the Department from automatically renewing members' eligibility when possible, prohibit the use of prepopulated forms, impose a six-month disenrollment penalty for failure to report changes affecting eligibility, mandate new data-sharing agreements with agencies that maintain personal and financial data on Wisconsin residents, and require DHS to complete a redetermination of eligibility for all Medicaid members and immediately remove any ineligible recipients.

AB 163 contains provisions similar to those included in 2023 Assembly Bill 148 and 2021 Assembly Bill 934. As in prior sessions, the Department estimates this legislation would have significant negative fiscal impacts for the state. For AB 163, the known one-time costs are estimated at $2,500,100 all funds ($250,000 GPR and $2,250,100 FED), the known annual ongoing costs are estimated at over $60.5 million all funds ($20,716,900 GPR and $39,855,100 FED) and the bill is anticipated to require 119 additional full-time employees.

Wisconsin Medicaid provides access to health care and long-term care to more than 1.3 million Wisconsin residents who are elderly, have a disability, or have low income. Medicaid programs serve medical needs of low-income individuals and families, as well as offer long-term support and services for older adults and Wisconsinites of all ages with disabilities. This legislation would impact BadgerCare Plus and the Childless Adult Demonstration members, which represents approximately 905,000 monthly enrollees. The Department is committed to providing access to care for some of the most vulnerable Wisconsinites and using the technology and resources available to increase efficiency while protecting the integrity of the program.

Automatic renewals and the use of prepopulated forms are required practices by federal Medicaid regulations, which the bill prohibits. Prohibiting the Department from utilizing these practices would increase the administrative burden for both Medicaid enrollees and our staff, potentially complicating renewal processes that could result in gaps of coverage. As previously mentioned, Medicaid serves some of the state's most vulnerable populations, and disrupting constituents' coverage could result in negative health impacts.

Another significant provision of the bill introduces penalties for recipients who fail to report eligibility changes within ten days of such a change, which is also inconsistent with federal Medicaid policy. The bill requires DHS to complete eligibility redeterminations for all Medical Assistance recipients by January 1, 2026, which would duplicate efforts already in place. These changes would necessitate extensive administrative adjustments, including new data exchanges, additional workload, and system upgrades, resulting in substantial upfront and ongoing costs. The increased number of renewals and the elimination of automatic processes could overwhelm the system and reduce the efficiency of benefit administration.

Federal regulations at 42 CFR § 435.916 limit Medicaid eligibility redeterminations to once every 12 months and require states to use administrative data to automatically renew members' eligibility whenever possible. States must also provide prepopulated renewal forms when eligibility cannot be confirmed through existing data. In addition, the Maintenance of Effort provisions under the Social Security Act prohibit states from implementing more restrictive eligibility standards for children than were in place on March 23, 2010. These protections remain in place through September 30, 2029 and cannot be waived by CMS.

If enacted, the proposed changes would require extensive modifications to DHS systems and processes. It would more than double the number of renewals processed annually and eliminate streamlined tools that currently reduce workload and promote member retention. Updating the Client Assistance for Re-employment Economic Support system to allow for biannual eligibility redeterminations alone would cost $2,500,100 all funds ($250,000 GPR and $2,250,100 FED). The workloads and costs for county Income Maintenance (IM) agencies and Milwaukee Enrollment Services would increase significantly; effectively doubling the workload associated with eligibility renewals and would require an increase of 119 FTEs. These costs would be incurred in addition to significant staffing increases and would not be covered under the Department's existing budget. Eliminating pre-printed forms would also dramatically increase the time required to complete each renewal. Without funding to support these changes, DHS would be unable to absorb the resulting workload.

DHS already operates a number of data-sharing agreements and automated data exchanges with state and federal agencies to confirm program eligibility. These include regular access to data from the Social Security Administration, the Department of Corrections, the Department of Workforce Development – the State's Wage Income Collection Agency (SWICA), Equifax, and Wisconsin's Vital Records. These tools help DHS identify changes in member circumstances and take action, such as terminating benefits when a member is deceased and investigating discrepancies when income in for a members Medicaid eligibility does not match wage information reported by the employer to DWD. However, federal rules at 42 CFR § 435.952 prohibit DHS from terminating coverage solely based on data from exchanges, except in specific cases like death. While data from tax records could be helpful in fraud investigations, sharing tax information would require additional safeguards under Wisconsin law due to confidentiality provisions.

The proposed policies would also introduce risks to program access for eligible individuals. Requiring more frequent renewals, removing automatic renewals, and penalizing members for reporting issues would increase coverage loss among eligible individuals, especially those with language barriers, unstable housing, or lack of access to digital tools. These changes not only reduce coverage continuity and care quality but raise overall costs to the healthcare system by increasing reliance on emergency care and other uncompensated services.

DHS remains committed to program integrity and ensuring that public funds support those who meet eligibility requirements. However, that commitment must align with federal law and practical implementation capacity. As written, this bill would introduce substantial costs and administrative complexity while decreasing efficiency and undermining the stability of programs that are essential to the health and well-being of hundreds of thousands of Wisconsinites. Thank you for the opportunity to provide testimony.

Wisconsin BPDD
Wisconsin Board for People With Developmental Disabilities

April 8, 2025

Assembly Committee on Public Benefit Reform
Representative Knodl, Chair
State Capitol, Room 221 N
Madison, WI 53708

Dear Representative Knodl and committee members:

The Wisconsin Board for People with Developmental Disabilities' (BPDD) analysis of AB 163 finds this proposal will negatively and disproportionately impact people with disabilities and their families.

People with disabilities are in all of Wisconsin's more than 20 Medicaid programs. Many unpaid caregivers who have had to leave the workforce to provide care for people with disabilities or older adults also rely on Medicaid for health care coverage.

This proposal would needlessly double the existing administrative burden by requiring redetermination every six months (instead of 12), and prohibit automatic renewal for people whose eligibility has not changed, increase the likelihood of administrative mistakes by prohibiting prepopulated forms (except name and address), and would penalize administrative and reporting mistakes with the loss of health care and/or long-term care coverage.

Are people in Medicaid who shouldn't be? Not in Wisconsin.

Wisconsin already has a rigorous process to ensure all people who apply or renew their Medicaid coverage prove they are eligible for the program.

Currently, people applying to get into a Medicaid program must provide proof of identity, income, assets, and other items like disability status to apply. This proof must be independently verified before a person can be enrolled into a Medicaid program. Proof is verified by:

- Contacting employers to confirm people don't have an insurance option though work and how much they make.
- Contacting financial institutions to make sure people don't have more money that is allowed.
- Checking federal benefit databases to make sure they are citizens, are who they say, and aren't getting benefits in other states.

Wisconsin has 1400 workers who check every application and renewal using Wisconsin's CARES system. Workers independently verify information using Wisconsin's CARES system. CARES is connected to more than 20 federal and state data sources that check information to confirm identity, immigration and citizenship status, birth and death records, earnings reports, employment records, and asset information.

Wisconsin already checks and rechecks routinely to make sure Medicaid beneficiaries are still eligible

Every year, everyone in Medicaid must renew and provide verifiable proof they still meet the criteria to be in Medicaid. All 1.2 million people currently in Wisconsin's Medicaid programs meet the financial and

other criteria needed to be allowed in and they must keep proving they meet the criteria to stay in. The only people who are in Wisconsin's Medicaid programs are people who have proven their eligibility. **Wisconsin has a near zero eligibility error rate.**

More paperwork, more deadlines, more mistakes that can cost eligible people their health care and/or long term care coverage.

Many people with disabilities and families find the current requirements to prove and re-prove they meet eligibility criteria time-consuming and complex.

- More paperwork, steps that are hard for people to understand or do, and time-sensitive deadlines have led to people losing health care.
- Mistakes can be hard to correct and take a lot of time. People can lose their health care while they are trying to fix mistakes.
- People who do not have technology, don't drive, who are ill or alone, or need plain language and clear steps to follow to complete tasks correctly could be more at risk of losing health care.

This proposal increases the already high mental and emotional burden of unpaid family caregivers who consistently describe navigating Medicaid program administrative requirements and paperwork as difficult, mentally taxing, and burdensome. Adding yet another high stakes task to complete on an even more frequent basis makes lives which are already hard much harder.

Not all Medicaid participants have families to help them navigate the already complex Medicaid system. These populations are more likely to be non-drivers, have little or no access to internet connection, and have conditions which may interfere with cognition, reading comprehension, and following complex instructions or tasks.

This bill requires 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, and under this bill they will lose health and/or long-term care supports for six months.

Additional paperwork could put vulnerable populations' care at risk

More than 83,600 frail elders, people with physical disabilities, and people with I/DD get health care and supports to help them live and work in Wisconsin communities through Wisconsin's institution diversion programs (Family Care, IRIS, and CLTS). These long-term care programs are designed to help people stay in their own homes and stay out of Medicaid-funded institutions, like nursing homes.

In addition to meeting income and asset limit requirements, Family Care, IRIS, and CLTS participants must meet the criteria for nursing home level of care, and already undergo an annual functional screen administered by ADRCs. Requiring reapplication for Medicaid eligibility every 6 months instead of annually doubles the administrative cost and burden for ADRCs conducting functional screens, as well as participants and families who would now be required to complete the same paperwork twice or risk losing all care.

Wisconsin BPDD
WISCONSIN BOARD FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

People who meet nursing home level of care generally continue to do so because the need for supports and functional limitations are the result of a permanent lifelong disabilities—like cerebral palsy, autism, Down Syndrome--or age-related declines. This population can be medically fragile, have ongoing conditions, and often need daily assistance to get basic care needs (getting out of bed, toileting, eating) and other supports to keep them living independently and safely at home. Disenrollment can literally mean life or death.

The same concerns impact the 31,500 people with disabilities in the MAPP program, 26,000 children with disabilities in the CLTS program and the 11,000 children with disabilities in the Katie Beckett program.

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 .

1952 hrs

That is how many hours I have spent on paperwork and evaluations to determine my children's disability and current 'status' of disability.

Good morning ladies and gentlemen,

My name is Sandra Lomeli. I am here to share my family's story regarding the time commitment and paperwork involved to obtain Medicaid services in Wisconsin. We hope that by sharing our story you will see why it is imperative to vote NO to AB 163.

To put 1952 hours into context, it is almost 3 full months (no rest – no break). That is ¼ of a Year!!! Just to complete paperwork and have evaluations to prove and 'reprove' that my children a disabled.

Attached you will find a breakdown of the stages of their lives to date where we have had to various entities evaluate them and our family. Some of which can be so intrusive they are nothing short humiliating.

Currently, in order to maintain eligibility a participant is required to:

- have an annual screen by their FEA as well as their IC
- If they require personal care that is an annual screen & evaluation as well
- must meet and complete any necessary documentation with their IC every 3 months
- again, if they have personal care they must meet with their pc nurse every 3 months as well
- Annual application for Forward Health Insurance.

That is more than 54 hrs are annual at this point.

This data NOT include:

- time for phone calls / record keeping
- drive time to / from appointments / meetings
- follow-up documentation or conversations for accuracy / changes to things like primary physician or dentist
- data that must all be kept up to date / accurate in order to maintain benefits
- time and resources need to help re-regulate my children from the distress from the evaluations
- various other services and supports that require verification / validation of disability such as DVR services, therapeutic supports, etc.

All this while trying to maintain employment, being a full-time caregiver for my children and attempting to provide them with a fulfilling life. AB 163 is asking me to double that and impose more than 108 hrs annually. An additional 54 hours that would take away from my ability to provide the necessary care for my family that gives the quality of life they deserve.

108 hours just to prove what has already been proven many times. All by several independent professionals of which the 'Medicaid' system has dictated to conduct the screens / evaluations.

The data I have enclosed is only in reference to the impact on me and my family. This does not include the hours / resources needed by the various DHHS departments and Medicaid services entities that need to process these additional screens that are being proposed. We should not be looking to increase this administrative burden to families and agencies that are currently being cut. But rather look at ways to streamline it, make it more efficient and less redundant.

If you have questions, I would be happy to sit with any of you to discuss my testimony, data I'm providing. All of which I can validate with meeting invites, minutes, physical paperwork, etc. I wholeheartedly believe that if impacted stakeholders such as the self-advocates and their families were involved in the development of such bills we would be able to establish a system that is not only efficient and less redundant but potentially cost saving to the state.

I urge you to vote NO to AB 163

Thank you for your time today.

Annual' paperwork /hours - since 3 yrs old				x2 children				all 'sheets'	x2 children
Program	**Hours**	**Sessions**	**Total Hrs**	**Total Hrs**	**# of sheets**	**Sessions**	**Total # of Sheets**	**dbl sided**	**# of sheets**
Birth to 3 (Eval & Paperwork)	20	4	80	160	24	4	96	192	384
IEP (Mtg & Paperwork)	14	36	504	1008	32	36	1152	2304	4608
Primary Doc Ref Req (appt & paperwork)	8	1	8	16	12	1	12	24	48
CHW (Eval & Paperwork)	16	6	96	192	45	6	270	540	1080
Xray (appt & paperwork)	2	1	2	4	4	1	4	8	16
MRI (appt & paperwork)	2	1	2	4	4	1	4	8	16
EEG (appt & paperwork)	2	1	2	4	4	1	4	8	16
CHW Psych Eval / Autism 'test'	60	1	60	120	50	1	50	100	200
Katie Becket / Childrens Waiver Program (Paperwork / Eval)	10	1	10	20	8	1	8	16	32
Katie Becket Yearly Eligibility Screen (paperwork & mtg)	6	8	48	96	8	8	64	128	256
SSI Application & Screen	12	1	12	24	30	1	30	60	120
SSI 3 yr Eval (paperwork & screen)	12	4	48	96	14	4	56	112	224
SSI 6yr Psych Eval & Screen	12	2	24	48	14	2	28	56	112
Initial LTC Paperwork & Eval	20	1	20	40	36	1	36	72	144
Forward Health Application / Eval	6	1	6	12	4	1	4	8	16
Annual WI Access (Forward Health / food share)	2	1	2	4	4	1	4	8	16
Yearly LTC Eligibility Screen (paperwork & mtg)	10	1	10	20	24	1	24	48	96
Yearly LTC PC Eligibility Screen (paperwork & mtg)	10	1	10	20	12	1	12	24	48
3 mo LTC / IC Mtg	3	4	12	24	12	4	48	96	192
3 mo LTC / PC Nurse Mtg	3	4	12	24	6	4	24	48	96
Yearly LTC IC Screen (paperwork & mtg)	4	1	4	8	12	1	12	24	48
Yearly LTC PC Screen (paperwork & mtg)	4	1	4	8	6	1	6	12	24
Total			976	**1952**	365		1948	730	**1460**

Current 'Annual' paperwork /hours				x2 children				all 'sheets'	x2 children
Program	**Hours**	**Sessions**	**Total Hrs**	**Total Hrs**	**# of sheets**		**Total Hrs**	**dbl sided**	**# of sheets**
Annual WI Access (Forward Health / food share)	2	1	2	4	4	1	4	8	16
Yearly LTC Eligibility Screen (paperwork & mtg)	10	1	10	20	24	1	24	48	96
Yearly LTC PC Eligibility Screen (paperwork & mtg)	10	1	10	20	12	1	12	24	48
3 mo LTC / IC Mtg	3	4	12	24	12	4	48	96	192
3 mo LTC / PC Nurse Mtg	3	4	12	24	6	4	24	48	96
Yearly LTC IC Screen (paperwork & mtg)	4	1	4	8	12	1	12	24	48
Yearly LTC PC Screen (paperwork & mtg)	4	1	4	8	6	1	6	12	24
Total			54	**108**	76		130	260	**520**

Please oppose Assembly Bill 163; please oppose doubling the paperwork for Medicaid. My name is Erin Miller and I'm autistic. I use Forward Health card, through Badger Care, which is a Medicaid program. I work but neither of my jobs provide health insurance. Because of my disability, it is impossible for me to do the paperwork. My mother helps me with that. Right now, the paperwork is already hard to understand. Mistakes are already hard to correct. There are time sensitive deadlines. If we get it wrong, that means doing the same form over again. —which takes more time. Even if we get it right, we are doing the same form, again and again and again--and that takes even *more* time in a time crunch. In the time it takes to repeat all my information, I could lose my health coverage trying to fix mistakes.

Under this new system, renewing two times a year instead of once, making people apply every time--even if nothing has changed. (Yes, I'm pretty sure I'll still be autistic next year too.)—and if you miss the deadline, you have no health care for the next 6 months. Because you made a simple mistake. Once. There is a HUGE difference between fraud and a mistake. The actual logistics of defrauding DHS is so small & hard to calculate accurately because everything is all lumped together. Anyone I have EVER met that uses these programs has no energy or motive to try and get away with anything. People want to get it right, because they need those services to survive. Adding more paperwork on top of us and our families heads seems just cruel.

Erin Miller
St Francis WI
Erinmiller777@gmail.com

Testimony in OPPOSITION to AB 163
10 April 2025

To the members of the Assembly Committee on Public Benefit Reform:

My name is Joanne Juhnke, and I'm a proud parent of Miriam Oakleaf, in the picture below.

Miriam will turn 21 next month, so this is her last semester of public education. Her transition into adult life is well underway, such that she is on the UW-Madison payroll and works three morning shifts doing kitchen support at the Pyle Center, fully supported by an aide. Given her genetic differences, including epilepsy and autism, she needs someone with her at all times, so it makes sense for part of the supported time to include assisting Miriam to work and earn a real wage.

Miriam uses the IRIS program, which is part of Wisconsin's home and community-based programming funded via Medicaid.

Since the beginning of 2025, we've had three in-person home visits, each with a different official, each of whom needed to lay eyes on Miriam and ask a bunch of questions to make sure that we were in bounds with our Medicaid funding.

Then, since she will be transitioning from school to adult services, we are preparing to adjust her Medicaid-funded budget to match. Since we won't have the school district coverage after the semester ends, we have had a huge volume of communication around trying to craft a sufficient budget amendment that is also respectful of resource use. So far in 2025, I count one in-person meeting, two Zoom meetings, three phone consultations, and over seventy emails (counting my own and those of various paid providers).

This is all just about **funding**, and doesn't count any of the rest of the communication that it takes to support Miriam on a regular basis, such as team meetings, health and mood updates, medical appointments, prescription renewals, timesheets, troubleshooting and strategizing. Then factor in that someone has to be with Miriam at all times, and while I wrote this testimony that someone was me. Multi-tasking is the name of the game in our home, and it is incessant.

And now here comes AB 163 saying that it's not enough, and implying that my daughter might somehow secretly shed her disability and start cheating if the government doesn't pay someone to come in and ask all the soul-sucking questions one extra time a year, so we can prove yet again all the things that my daughter cannot do.

Please don't do this to your budget, and please don't do this to my family and all the other families who share this experience with us.

Thank you for the opportunity to present this testimony.

Joanne Juhnke
430 Oak Crest Ave.
Madison, WI 53705
joannethatsme@yahoo.com
608-320-6165

Committee Testimony Against State Bill AB 163

My name is Chelsea Peck, and I'm a mom to two boys with Sanfilippo syndrome, a rare genetic disease that is a form of childhood dementia. Owen passed away last year at age 9, and Caleb is 7.

Caleb, like 8,000 children in the state of Wisconsin, qualifies for Katie Beckett Medicaid coverage and the Children's Long Term Support Program because of the intellectual disability caused by Sanfilippo syndrome. Raising a child with a disability is incredibly expensive. Katie Beckett and CLTS help cover some of the additional costs for us including: care from medical specialists, surgeries, dental care, medical and incontinence supplies, physical therapy, occupational therapy, feeding therapy, speech therapy, equipment like communication devices, wheelchairs, bath chair, home and vehicle modifications, and respite care. All of these are examples of things that have made it possible for us to care for our children with disabilities at home, but this represents thousands upon thousands of dollars of expenses that would have largely come out of our pockets without Katie Beckett or CLTS. This bill is designed to make it harder for children like ours to keep their benefits and obtain some of these services. If this bill is passed, how many children will wait an extra year for a surgery, or a communication device, or a wheelchair?

In our family, and many families like ours, one parent is unable to work full time because of the need to care for and manage the care of a child. As a parent of children with disabilities, the volume of meetings, appointments, MyChart messages, phone calls, and paperwork is huge. This bill seeks to double the volume of paperwork or meetings required for a child to keep their Katie Beckett coverage. Why is this additional paperwork necessary for already overburdened parents? The vast majority of those 8,000 children will not have their disability status change throughout their life. My son Caleb has Sanfilippo syndrome, and he's not going to stop having Sanfilippo syndrome in 6 months or 6 years. If we really want to make our government more efficient, let's not create extra paperwork for Medicaid.

Here are some things that I have spent my time doing to care for my children with disabilities instead of additional Medicaid paperwork: changed countless diapers, filled out paperwork for a wheelchair conversion to our minivan, took my child to speech therapy so they can learn to use a communication device, pureed meals for my child who was losing his ability to swallow, attended an IEP meeting to advocate for accommodations at school, made phone calls to find out why supplies weren't being delivered, toilet trained my 7 year old who is still in diapers, cleaned hearing aids, sent a MyChart message to doctors who are coordinating multiple specialties for a surgery, filled out a seizure plan for school.

Finally, like many of your constituents, I am a Christian who believes life is valuable and precious no matter how young or how disabled a person is. My son Owen lost his ability to speak and walk on his own and was never able to read or hold a job, but he brought light and joy into those around him with his laugh and affection. If you truly want to stand for life, support the families like ours who are caring for the least of these. Children with disabilities deserve to live, and they deserve to be supported with medical care and services and equipment that make their lives manageable.

Chelsea Peck
(515) 999-6080
chelsea.k.peck@gmail.com

disabilityrights WISCONSIN
Protection and advocacy for people with disabilities.

To: Assembly Committee on Public Benefit Reform
From: Disability Rights Wisconsin (Contact: Lisa Hassenstab, Public Policy Manager, lisah@drwi.org)
Date: April 10, 2025
Re: AB163, Relating to: redeterminations of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility

Disability Rights Wisconsin (DRW) is the federally mandated Protection and Advocacy system for the State of Wisconsin, charged with protecting the rights of individuals with disabilities, investigating systemic abuse and neglect, and ensuring access to supports and services, so that all Wisconsinites can learn, work, and live full lives in their community. With this charge, DRW opposes AB163.

AB163 would increase the likelihood that eligible individuals will lose health care coverage through Wisconsin's Medicaid Assistance program, including people with disabilities and individuals with mental health needs. The requirements of the bill would double the administrative burden put on already overburdened administering agencies while providing little to no benefit to recipients or to the system in general. The eligibility process is already stringent and time-consuming, which presents barriers to many people with disabilities and individuals with mental health needs as the system currently stands. AB163 would unnecessarily increase these barriers.

The provision in this bill that would impose six months of ineligibility for recipients who don't report a change that may impact their eligibility within 10 days of that change is drastic and would be harmful. There are many reasons why an individual would be unable to report a change in that timeframe, and the burden of such a short timeframe would likely disproportionately impact people with disabilities and individuals with mental health need. This provision would also very likely increase the likelihood that people without access to ongoing treatment during ineligibility periods will find themselves in the emergency room or acute care psychiatric facilities. These scenarios would not only significantly increase costs for our health care system but would also impose significant costs on the health and well-being of individuals left without access to care.

Continuity of health care, including mental health care, is critical for all of us. But it is particularly so for individuals with chronic and/or lifelong conditions which require

consistent treatment, medication, and management. For many individuals, their diagnosis and/or eligibility for Wisconsin's Medicaid program will never change; requiring them to go through the eligibility redetermination process even more frequently than they already do would be an undue, unnecessary, and costly burden.

As others will likely point out, provisions in this bill would violate federal law 42 CFR 435.916 (b). This law is in place to ensure that excessive "churn" doesn't happen when individuals inappropriately lose their Medicaid eligibility and then have to must go through an extensive process to get back into the program, and to save costs.

Thank you for your consideration, and please don't hesitate to reach out with questions.

WISCONSIN CATHOLIC CONFERENCE

TO: Members, Assembly Committee on Public Benefit Reform

FROM: David Earleywine, Associate Director

DATE: April 10, 2025

RE: Opposition to Assembly Bill 163, Redeterminations of Eligibility for Medical Assistance

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On behalf of the Catholic bishops of Wisconsin, we respectfully urge you to oppose Assembly Bill 163, which limits access to health care, especially for those who most need it.

AB 163 is intended to prevent improper Medical Assistance (Medicaid) payments by:

- Prohibiting the automatic renewal of benefits for Medicaid recipients
- Requiring redetermination of eligibility every six months, if approved by the federal government
- Requiring information to be cross referenced between state agencies that collect financial data related to public assistance programs
- Requiring prompt removal of all ineligible individuals
- Removing individuals from the program for six months if they fail to report to any change that may change their Medicaid eligibility

We oppose this bill, as we have done in the past, because it would unfairly burden vulnerable individuals who are in need of health care. Public assistance programs exist to aid individuals and families whose situation prevents them from being able to meet basic needs.

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, have chronic conditions or diseases, and are children or adults 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 individuals and families struggle to meet basic housing, transportation, and other expenses. Out of necessity, they frequently must move from one home to another, as well as from one job to the next, changing addresses, phone numbers, and earnings along the way. By and large these individuals are trying to make ends meet, not defraud the government.

We are most concerned that AB 163 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

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eligibility. While renewal is necessary and important, a six-month renewal will be burdensome on the state and on 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 greater health.

AB 163 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 unjust because it does not distinguish between a person who makes an innocent mistake and one who knowingly withholds information.

Finally, it is important to note the impact this bill will have on private charities. Depriving the poorest among us of health care will only shift the burden to private charities, Catholic and others. The Catholic Church is the largest private charity in the United States. But private charity cannot substitute for what only the public sector can do. Private charity cannot make up for the State's abdication of responsibility to assist the most poor and vulnerable.

In conclusion, reforming public assistance programs to reduce poverty, dependency, and inefficiency is a laudable goal. However, any program reforms must ensure that people in need do not become targets. Overly bureaucratic and punitive measures to ostensibly reduce fraud and encourage responsibility all too often have the opposite effect of increasing burdens and further impoverishing the most vulnerable. We urge that any changes to Medicaid prioritize access to quality care so that everyone can live a dignified life.

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

April 9, 2025

To the Committee on Public Benefit Reform,

My name is Heather Murray and I live in Waunakee. I have a son Cameron, who is 19, autistic and disabled. Cameron is enrolled in the IRIS program in Wisconsin and because of that receives Medicaid. I am writing this today in opposition to bill AB163.

Wisconsin already has a rigorous process to be enrolled in Medicaid. Cameron just transitioned from the Katie Beckett program to Medicaid when he turned 19 this last year. During this process, I had to make several phone calls and send several emails because they kept telling me I didn't provide proof of disability for Cameron. Even though Cameron was in the CLTS program and had been declared disabled by the state of Wisconsin for several years. I finally acquired the correct signatures and paperwork and Cam was declared disabled and was able to move into the adult Medicaid program. This was a complicated process for me to complete and I have been navigating these systems and Cam's paperwork his whole life.

I explain all of that to you because raising a child with a disability is not easy and the system is already hard to navigate. Now you want to make us do this twice a year for our people that we support?

Disabled people who don't drive, are alone, or need clear steps to follow the already rigorous process could be more at risk for losing their health care. So these people who rely on workers (which already are pretty non existent) to help them navigate are penalized if they miss any steps or mailings? How is this helping anyone?

Also, what is the price tag on having the DHS do a redetermination for all 1.2 million people on Medicaid by January of 2026. This is a waste of time and funds to find fraud. Almost all fraud is known to be with Medicaid providers not the ones who need this health care to survive.

This bill deliberately targets one of the most vulnerable populations in the state of Wisconsin, people who are disabled. If you are looking for fraud it isn't within the disabled community. The people in the disabled community just want to live their fullest lives in their communities of their choosing. In our abled world they need support from their communities to do just that.

Please stop wasting time with this terrible targeted legislation. You were elected to create legislation that helps our communities and the people in it. This does neither.

Please concentrate on things the people of Wisconsin are telling you that they want. Try funding our public schools. Finally get Wisconsin's Special Education funding to level that meets inflation. Expand postpartum Medicaid coverage. Make sure families have accessible and affordable childcare. These things would make Wisconsin have a stronger economy, a better place to live and a place where people want to raise a family.

As a Mother with a child with a disability, all of this makes me tired. But I will be here every time pushing back on legislation that harms my child or the disability community.

Heather Murray
603 Omalley Street
Waunakee, WI 53597

TO: Assembly Committee on Public Benefit Reform
FROM: Ellen Aubuchon
DATE: 4/10/2025
RE: AB 163

My name is Ellen Aubuchon. I am a resident of Stoughton Wisconsin and a mother to three wonderful boys aged 8 and younger. My eldest son has a disability and qualifies for CLTS and Katie Beckett through the state. I am writing to strongly oppose these efforts to impose stricter requirements for accessing and maintaining eligibility for the CLTS program. As the program stands we have monthly check-ins with his case manager and have required meetings every six months in person, as well as yearly functional screens to assess his eligibility for these programs. Stricter requirements would not only create unnecessary bureaucratic hurdles for families already under stress, but could also result in children losing access to life-changing care. Many families struggle to navigate complex systems; adding more red tape only widens disparities and risks pushing the most vulnerable out of the support systems designed to help them. I struggle to navigate the system as it stands currently even though I am a college educated nurse that is well versed with the healthcare system. I am concerned this bill will limit access to the much needed resources for children and those with disabilities. I feel obligated to advocate for those who may not be able to do so for themselves. The CLTS waiver is crucial for many families in Wisconsin and they provide essential services like respite care, therapies, adaptive equipment and in-home support. These are critical to the children in the program and should not be limited by the passing of this bill.

As a mom and healthcare provider I have seen how imperative early intervention is for children with disabilities. Providing these resources with less barriers saves the state money by investing in children early when they are developing so they are able to be more independent later in life.

Instead of proposing and sponsoring bills to limit access to resources and programs the legislature should be working to strengthen and expand access to CLTS. We should want our children with disabilities to thrive and be supported by their communities. This bill does the opposite of that. Children and families should not fear losing support due to unnecessary barriers that are being proposed in AB 163 .

I work outside the home and our lives are very busy filled with activities for all three children and maintaining our house. I already struggle to stay on top of all of the needs of my children and I worry with the passing of AB 163 that the stricter requirements would create more barriers to those with disabilities to access the care that they need. It is appalling to me that the sponsors of this bill find it to be a good use of time and resources that are already thinly spread to add more ways to deny help to those with disabilities. If this bill passes it creates more work and stress, especially to mothers who are generally the ones burdened with the paperwork and meetings involved with the process of maintaining eligibility for medicaid programs. As a nurse it makes me so sad to see these sponsors trying to create more barriers to help and support for those with disabilities. I have a strong feeling that none of the sponsors of this bill have children with disabilities, nor have they ever had to fill out the mountains of paperwork required or made sure they stay on top of the requirements so that their child can stay eligible. The case managers with CLTS are already overworked and overwhelmed and this bill would create even more work for them and increase the risk of an error that could lead to the termination of benefits to a very well deserving individual. I would have loved to attend the hearing today to face all the sponsors of this bill to ask them face to face why they want to make life harder for individuals with disabilities. As a society we owe it to our more vulnerable populations to support and lift them up. I am struggling to understand why the sponsors of this bill find it necessary to make individuals with disabilities and families who have children with disabilities jump through more hoops to be able to have access to resources to enrich their lives. As a caretaker at work and at home I am so ashamed that I even have to write this statement. I was raised to have empathy and to care

for those who can't help themselves. I struggle to understand how anyone in good conscience can support this bill. I appreciate you taking the time to listen to my concerns and sincerely ask that you think about these implications that I have outlined before you support this bill.

Thank you again!

Ellen Aubuchon

4-10-25

TO: Committee on Public Benefit Reform
Re: AB 163

Dear Committee Members,

I am writing to register my opposition to AB 163, regarding rule changes for Medicaid.

I am not on Medicaid, but my mom was before her death in 2019. Medicaid was an important source of help for her. She was legally blind and also suffered some cognitive impairment. She relied on me to complete her Medicaid forms annually.

Requiring a 6-month renewal probably doesn't sound onerous for committee members. But I assure you it will be for some people.

Not everyone has a family member who can help with these forms. They may not open their mail regularly; they may not be able to see or write well enough to complete the forms; they may struggle to gather the data; they may not be able to get help completing the forms since so many of our aid organizations are facing severe federal cuts.

The penalty for failure to complete a form every six months will also be a huge burden for beneficiaries and for state staff.

Have you considered unintended consequences of this punitive provision?

- More people may become homeless or die without MA
- People who have an addiction and receive suboxone may relapse, overdose and die.
- People who have a serious mental illness and are unable to cope with MA forms, may be forced off of needed medications, become homeless, and end up in jail. \
- All of this places more burdens on counties.
- State staff will be required to process TWICE AS MANY forms as currently. Is there adequate staffing? If not will current staff have higher rates of errors in denying people assistance?

Finally, making things more difficult for our most vulnerable citizens doesn't help. It makes things worse for affect people, their families and our state in the long run. Consider the long-term unintended consequences that will cause more suffering and cost Wisconsin taxpayers more in the long run.

I ask you to listen to people with lived experience and oppose this misguided bill.

Thank you for your consideration.

Annette Czarnecki
Madison, WI

Testimony in opposition of AB-163:

Good morning, and thank you for this opportunity

My name is Cary Chaney, and I'm writing this today not just as a constituent, but as someone whose life—and whose health—depends on Wisconsin's Medicaid programs. I want to share what it really means to navigate the state's Medicaid eligibility and renewal process, because too often, the voices of those directly affected are missing from these policy conversations.

Every year, I have to prove—again and again—that I am still poor enough, sick enough, or disabled enough to qualify for the very programs that keep me alive and functioning. Programs like CLTS,BadgerCare, IRIS, Family Care, and the ForwardHealth card aren't luxuries for me. They are lifelines. They help me and my family afford medication, see doctors, get personal care support, and live with dignity.

But the process to apply or renew is exhausting. It's confusing. It's invasive. And sometimes, it feels designed to wear you down.

The paperwork is overwhelming, with requirements that are hard to understand even if you don't have a disability or chronic condition. I've had to send the same documents multiple times, track down verification from doctors, banks, and employers, and spend hours on hold trying to get answers—often with no resolution. One wrong form, one missed deadline, and I risk losing everything.

And let's be clear: people like me don't just bounce back if coverage gets interrupted. We don't just "go without care for a few weeks." We end up in crisis. We end up in hospitals. We end up in situations that cost the state more in emergency care than if we had just been allowed to stay enrolled in the first place.

It's not that we're not eligible. It's that the system is so burdensome that even eligible people fall through the cracks.

I know the state wants to ensure that Medicaid dollars go to those who truly qualify. We agree on that. But what's happening now is that the process itself has become a barrier to care—especially for families with kids, people with disabilities, and those living on the margins.

I urge lawmakers to listen to people who live this every day. We need a simpler, more humane process—one that recognizes our humanity, our time, and our right to health care.

Thank you.

Cary Chaney

"We're "normal" people trying our bests"

People First Wisconsin

See Our disAbility

To: The Assembly Committee on Public Benefit Reform

From: Cindy Bentley, Executive Director

Date: April 10, 2025

Re: Opposition to Assembly Bill 163

I am sorry that I cannot be there in person to testify. There was too short of notice for this public hearing. I have a medical procedure today that has been on the calendar for three months and could not change it. People with disabilities use Medicaid for health care insurance coverage, as well as, to meet their long-term care needs. Medicaid Home and Community Based waivers, such as IRIS, Family Care, and Children's Long-term Support, keep people with disabilities in their homes in the community and out of the more costly state centers or nursing homes. Participants in any Medicaid program in Wisconsin already have a lot of paperwork to prove and maintain eligibility and the process can be very overwhelming for participants and their family members. Wisconsin's screening and recertification process keeps incidents of fraud or abuse very low. The annual functional screen process is thorough and participants have to share very private information. I was born with a disability and it will not go away. I have an intellectual disability and autism. Many of our members have lifelong disabilities like me. To make people go through this screen twice each year feels cruel and it would be a total waste of resources, time, and money. Please do not make life more difficult.

The changes proposed in AB 163, will make things very confusing and even more overwhelming. Many people with disabilities may not have access to technology and do not drive. There is a caregiver crisis already and more paperwork cuts into the time people need for their daily care and support. Documents are not always in plain language and if people cannot follow the complex steps to complete tasks correctly, they could make mistakes that put them at risk of losing health care and long-term care. When people do not get the health care they need in a timely manner, it puts them at risk of illness, hospitalization, and even death. When they do not get the long-term care services they need, they could lose everything- their health, homes, and jobs and end up in costly institutions. Please do not move forward with this bill. Trust the process you already have in place and trust the people you represent.

People First Wisconsin is a statewide self-advocacy organization run by and for people with disabilities.

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WISCONSIN COUNTIES ASSOCIATION

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MEMORANDUM

TO: Honorable Members of the Assembly Committee on Public Benefit Reform

FROM: Chelsea Shanks, Government Affairs Associate

DATE: Thursday, April 10, 2025

SUBJECT: Opposition of Assembly Bill 163

Assembly Bill 163 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 report any change that may affect their eligibility within ten days 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 monthly data matches.

With the exception of cases in Milwaukee County, all of the eligibility work required in AB 163 will be conducted by our 10 county-operated income maintenance (IM) consortia, creating significant workload increases. 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.

AB 163 fails to recognize the workload increases on IM workers 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 IM agencies in Wisconsin with funding to perform eligibility determinations for Wisconsin's economic support programs through the IM administration allocation (IMAA). Since 2012, counties operate IM programs including Medicaid and FoodShare (SNAP) through 10 multi-county consortia.

Since the counties began operating these consortia, the state share of 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 2023, the state invested $15.1 million GPR while county levy investment was about $29 million.

Counties simply do not have the levy capacity to fund the increased costs associated with this legislation. The IMAA funding is used primary for IM workers that determine eligibility and manage cases. Staff wages and benefit compensation costs increase every year and IM agencies must add staff when workloads increase. Additionally, benefit administration is highly automated so IM agencies must also continually invest in computer and telecommunications equipment.

The 2025-27 budget proposed by the Governor recommends adjusting funding by providing $2.7 million all funds to reflect a reestimate of the caseload and updated program requirements for the IM consortia. The Wisconsin Counties Association supports this budget recommendation to help these agencies with their current caseloads. As it relates to AB 163, WCA recommends further investment in IMAA beyond the Governor's recommendation.

For these reasons the Wisconsin Counties Association respectfully requests your opposition to Assembly Bill 163. Thank you for your consideration.

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

Wisconsin Association of Health Plans

AHI ALLIANCE OF HEALTH INSURERS

To:	Chairperson Dan Knodl Members, Assembly Committee on Public Benefit Reform
From:	R.J. Pirlot, Executive Director, AHI Abbey Rude, Legislative & Policy Director, AHI Caty McDermott, Lobbyist (MA Policy), AHI John Nygren, Executive Director, WAHP Kyle Caudill, Director of Government Affairs, WAHP
Date:	April 10, 2025
Re:	Oppose Assembly Bill 163

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, 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 163 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 163 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 163 that are against federal law and directives. To help understand the full implications of AB 163, AHI and WAHP requests the committee to consider the following adverse items:

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R.J. Pirlot, Executive Director, pirlot@hamilton-consulting.com
www.allianceofhealthinsurers.com

1. **Federal Law and 12-Month Renewal Requirement** – Federal law (42 CFR § 435.916) provides that Medicaid benefits *must be renewed once every 12 months, and no more frequently than once every 12 months.* While the bill under consideration would require federal government approval to implement a 6-month renewal period, we caution against pursuing this change. More frequent redeterminations could increase administrative costs, contribute to program churn, and risk coverage disruptions for individuals who remain eligible but face procedural barriers to renewal.

   The 12-month redetermination period is a critical tool for maintaining program stability. It helps limit churn, ensures that eligible individuals maintain continuous coverage, and allows those who are no longer eligible to transition smoothly to other forms of health insurance, such as employer-sponsored plans or coverage through the exchange.

   Federal rules require that renewals occur no more than once per year for MAGI populations (e.g., children, pregnant women, parents/caretaker relatives, childless adults), and at least annually for non-MAGI populations (e.g., people with disabilities). In addition, there is a CMS requirement that once a child is determined eligible, they have 12 months continuous coverage, regardless of if family income changes (with some exceptions). States may act on verified data indicating a change in circumstances, but the once-per-year redetermination remains the standard for program integrity and efficiency.

   AHI and WAHP strongly support maintaining the 12-month renewal timeline to promote stability, reduce churn, and ensure a manageable administrative process for Medicaid in Wisconsin.

2. **Autorenewals & Fiscal Impact–** AB 163 restricts the Department of Health Services (DHS) from using prepopulated Medicaid renewal forms, except for name and address fields. This change could significantly disrupt efforts to streamline eligibility renewals and reduce administrative burdens. Under the Affordable Care Act, states are required to verify eligibility criteria using electronic data from reliable sources. The Centers for Medicare and Medicaid Services (CMS) mandates that states use *ex parte* (passive) renewals when possible and send prepopulated forms only when additional information from the enrollee is needed.

   Additionally, AB 163 would impose a six-month lock-out for enrollees who fail to report changes affecting their eligibility provision that is not currently permitted under federal law unless CMS grants a waiver. Only a few states have received such waivers, and those are narrowly tailored (e.g., for expansion populations at higher income levels or for failure to pay modest premiums). These conditions do not apply to Wisconsin's Medicaid program, making it unlikely that a similar waiver would be granted.

   Wisconsin, along with 46 other states, has invested in technology to enable real-time Medicaid eligibility determinations. These improvements support administrative renewals and reduce manual processing by leveraging third-party data to verify income and employment status. This not only improves accuracy but also helps manage the workload

and operational costs for the county- and tribal-based Income Maintenance (IM) consortia. Medicaid managed care organizations broadly support the use of these technologies to promote efficiency and cost control.

By limiting the use of prepopulated forms and requiring more manual processing, AB 163 would reverse much of this progress, driving up administrative workload and costs at both the state and county levels and increasing the administrative burden on our associations' Medicaid HMOs.

The fiscal impact of AB 163 is substantial for the state and IM consortia. According to DHS' fiscal estimate of the 2023 AB 148 (the same bill from last session), the bill would result in: a one-time cost of $225,700 GPR, ongoing state costs of $19.2 million GPR and 125 FTEs for DHS/MiLES operations, and an annual cost of $35.1 million GPR to the county-based IM consortia, and an additional $702,000 GPR impact to tribal IM agencies.

These increased costs come at a time when the state Medicaid program is projected to end the fiscal year with only a modest $1.2 million GPR surplus, underscoring the risk of enacting costly administrative changes proposed under AB 163.

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 and WAHP appreciate 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 and WAHP urge the committee to quantify the fiscal impact of this policy.

Our organizations appreciate the committee's considerations of these items. AHI and WAHP 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.

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[i] [i]The Lewin Group, "Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies" March 2009

April 10, 2025

To: Assembly Committee on Public Benefit Reform
From: The American Cancer Society Cancer Action Network
Re: Testimony in Opposition to Assembly Bill 163 - redeterminations of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility

On behalf of the estimated 82 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) is writing to express opposition to AB 163 - 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.

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 committee to reject this legislation.

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.

Testimony in Support of Assembly Bill 163

Presented to

Wisconsin Assembly Committee on Public Benefit Reform

April 10, 2025

Kaitlyn Finley, *Visiting Fellow*
FGA Action

Chairman Knodl and members of the committee, thank you for the opportunity to submit testimony on behalf of FGA Action in support of Assembly Bill 163.[1]

This bill addresses a significant but often overlooked issue that quietly imposes a substantial financial burden on Wisconsin: fraud, abuse, and eligibility errors within the Medicaid program.

Wisconsin spends about $5 billion annually in state money alone on Medicaid.[2] And according to the latest reliable federal audit, the state's improper payment rate is 21 percent.[3] This equates to nearly $1 billion each year in state funds directed toward ineligible recipients.

According to federal data, more than 80 percent of improper Medicaid payments are due to eligibility issues.[4] These are not minor administrative errors but systemic gaps in determining and maintaining eligibility.

This level of waste is fiscally unsustainable and fundamentally unfair—to both the taxpayers who fund the program and the individuals who genuinely depend on it for access to care.

That's why Wisconsin needs AB 163. This bill takes a smart, responsible approach. It doesn't change who qualifies for Medicaid, but it does ensure agencies do a better job checking and verifying eligibility. It strengthens oversight by requiring the state to use data it already has, including wage records, death records, and lottery winnings, to help verify eligibility and catch red flags that might otherwise be missed.[5]

Additionally, AB 163 would eliminate pre-populated renewal forms, ensuring eligibility verification is based on current and accurate information rather than passive affirmation.[6] The legislation would also require eligibility reviews to occur twice annually rather than once, recognizing that significant changes in income, household composition, or residency can happen quickly.[7] More frequent checks help catch those changes sooner, which means fewer improper payments and more accurate enrollment.

To ensure these improvements are carried out, the bill requires the Department of Health Services to seek federal approval through waivers where needed.[8]

The goal of this bill is simple: Keep the program strong for the people who need it and stop the waste and abuse that undermine public trust in the program. Improving Medicaid program integrity could lead to savings that may be redirected toward other state priorities such as roads, education, and public safety.

AB 163 isn't about cutting care; it's about protecting it. It's about ensuring taxpayer dollars are doing what they're supposed to: supporting the people who genuinely need help, not covering those who don't qualify.

[1] Wisconsin AB 163 (2025), https://docs.legis.wisconsin.gov/2025/related/proposals/ab163.pdf.
[2] 2024 National Association of State Budget Officers State Expenditure Report, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2024_SER/2024_State_Expenditure_Report_S.pdf.
[3] Hayden Dublois and Jonathan Ingram, "Ineligible Medicaid Enrollees Are Costing Taxpayers Billions." Foundation for Government Accountability (2022), https://thefga.org/research/ineligible-medicaid-enrollees-costing-taxpayers-billions/.
[4] Hayden Dublois and Jonathan Ingram, "Ineligible Medicaid Enrollees Are Costing Taxpayers Billions." Foundation for Government Accountability (2022), https://thefga.org/research/ineligible-medicaid-enrollees-costing-taxpayers-billions/
[5] Wisconsin AB 163 (2025), https://docs.legis.wisconsin.gov/2025/related/proposals/ab163.pdf.
[6] Ibid.
[7] Ibid.
[8] Ibid.

My name is Krisjon Olson of 1008 Beloit Court Madison, WI 53705. I am a researcher, person with a disability, and parent to a child born with a disability with over two decades of experience advancing health equity. Some of my current work examines Medicaid coverage and continuity of care for youth with complex conditions in Wisconsin. I also participate in an extensive annual renewal process for a Medicaid Waiver on behalf of my daughter. I'm writing in strong opposition to AB 163. This bill would require Medicaid enrollees to renew eligibility twice a year and penalize paperwork errors with a six-month loss of coverage. These changes will disproportionately harm individuals with disabilities, youth in transition, older adults, and families already navigating complex systems. I've seen how administrative burdens already push eligible people off coverage. AB 163 would make this worse—leading to coverage gaps, delayed care, and higher costs for the state. Wisconsin should be working to simplify Medicaid processes, not make them more punitive. I urge you to vote NO on AB 163 and educate your fellow members. This statement does not represent an official position or endorsement of my employer and represents my personal perspective.

O'Keeffe, David

From: Nancy Gapinski <nancy.gapinski@gmail.com>
Sent: Thursday, April 10, 2025 12:21 PM
To: Rep.Knodl; Rep.Maxey; Rep.Neylon; Allen, Scott; Rep.Clancy; Phelps, Christian
Cc: Sen.Drake; Rep.Madison
Subject: Opposition to AB 163

Dear Representatives,
My name is Nancy Gapinski. I am writing to oppose AB 163. I am the parent of a son with autism who is a Children's Long Term Care Medicaid Waiver participant and is eligible for Medicaid through the Katie Beckett Program.

During the last few years of my mom's life, after we had exhausted her resources and she was in need of long-term care services to stay at home, she was found eligible for Medicaid and utilized the IRIS program to meet her needs. Because of Medicaid, we were able to support her at home and keep her out of a nursing home. She died peacefully at home surrounded by her family.

I can tell you as a family caregiver that life is hard enough to meet the daily support needs of a loved one. The annual requirements to prove financial and functional eligibility are overwhelming. The functional screen in particular is an intrusive and anxiety-producing process. It is so depressing to share intimate details with a stranger and relive the worst moments of the worst days in order to ensure that a participant's true support needs are captured.

Wisconsin already has protections in place and very low incidents of fraud and abuse. Doubling the requirements and burdens on people who are already overwhelmed, increases the likelihood of mistakes. These become dangerous mistakes because people could lose their health care and long term care support.

One of the early thoughts I had after my mom died was, "at least we never have to go through another long-term care functional screen." The fact that this went through the mind of a grieving daughter should tell you how difficult the steps already are. Doubling the burden is mean and unrealistic for the participants, the people who support them, and the workers administering the Medicaid programs.

Please vote no to this terrible amendment.
Sincerely,
Nancy Gapinski
2615 W Hunter Circle
Glendale, WI 53209

April 10, 2025

American Lung Association.
Wisconsin

Testimony of the American Lung Association
Opposing Assembly Bill 163
Assembly Committee on Public Benefit Reform

Dear Chair Knodl 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 163 would jeopardize coverage for patients who remain eligible for Medicaid. The Lung Association urges Wisconsin lawmakers to oppose this bill.

Assembly Bill 163 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 163 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. 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.

Please contact me if you have any follow up questions.

Molly Collins
Advocacy Director for Wisconsin
262-395-1700
Molly.Collins@lung.org

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[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

KIDS FORWARD

DATE: April 10, 2025

TO: Assembly Committee on Public Benefit Reform

FR: William Parke-Sutherland, Government Affairs Director

RE: Opposition to AB 163 – redeterminations of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility.

Chairperson Knodl and committee members,

Kids Forward strongly opposes Assembly Bill 163. It will create harmful barriers to Medicaid participation, reduce access to health care among Medicaid-eligible children, parents, people with disabilities, and would worsen racial disparities in access to care and coverage.

Kids Forward aspires to make Wisconsin a place where every child thrives. We advocate for effective, long-lasting solutions that break down barriers to success for children and families of color and children and families in rural communities. Using research and a community-informed approach, Kids Forward works to help every kid, every family, and every community thrive.

AB 163 would prohibit DHS from automatically renewing coverage for Medicaid enrollees, 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, within 10 days, 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.

Doubling renewals, prohibiting automatic renewals, disallowing DHS from using best practices for renewals, such as pre-populating forms, would all significantly increase administrative burdens. More people would become uninsured, and it would exacerbate health disparities. A report from the Office of Management Budget found that barriers making it harder for people to access public benefits worsen health disparities. AB 163 would require someone enrolled in one of the state's many Medicaid programs (like BadgerCare Plus or Family Care) 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 this additional work would fall hardest on those who have the least amount of time and resources.

Because of long-term employment and economic discrimination, Black, Brown, and Indigenous people are more likely to have lower-paying jobs, less access to insurance, and more likely to face transportation and connectivity barriers and financial instability. 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 and Brown people in Wisconsin.

Automatic renewals help states ensure those who are eligible for coverage remain covered without adding costly administrative burdens and red tape like over-verification and redundant renewal forms. Forms can get lost in the mail, processed incorrectly, sent to the wrong address, not returned in a timely manner, poorly translated into languages other than English, and be misunderstood by beneficiaries (regardless of what language the form is in). All of these can lead

to people losing their coverage despite being eligible and can result in increased health costs and worse health outcomes for people who need regular access to health care services.

Renewals help the state ensure that people who are enrolled are Medicaid eligible, but they are also when people are most likely to lose coverage, even if they are eligible. AB 163, which would make state staff process twice as many renewals as they do currently, would cause more Medicaid-eligible children, families, and people with disabilities to fall through the cracks and become uninsured. Further, it is unclear how many people could 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]. For most children, parents, adults without dependent children and pregnant people covered by BadgerCare Plus this section of the bill would likely not apply.

According to a 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 were disenrolled and then re-enrolled within 12 months. According to that same report, Black enrollees are more likely to be impacted by churn needlessly losing coverage more often than their white counterparts. Increasing administrative burdens could have a disproportionate impact. Further, language barriers for websites, communications, and interacting with income maintenance workers make it likely that people who speak a language other than English would be disproportionately impacted needlessly losing coverage despite being eligible.

Doubling the number of renewals would also mean tremendous increases in state costs and staffing needs, which this bill doesn't acknowledge or allocate funding for. An HHS study estimated the cost of processing a single instance of disenrollment and re-enrollment at between $400 and $600.[2]

Federal Medicaid rules require that states attempt to renew members' coverage using other available data sources[3] 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.

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 losing care and coverage, and exacerbate health disparities. 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.

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[1] § 435.916 Periodic renewal of Medicaid eligibility.

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

[3] 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.