Wisconsin needs to work to reduce the number of people who lose their Medicaid coverage during the PHE unwinding period because of administrative burden, despite being eligible.

Our Process

- ABC uses a detailed and comprehensive client services approach we call Precision Patient Advocacy. This includes a weekly case meeting with Advocates, Counselors, and Attorneys as well as 2x daily stand-ups to check in on cases and load balance work
- We developed a decision support tool called FirstCheck WI as a "big picture sort," a high-altitude data collection and screening tool
- Widespread and significant Medicaid program and process knowledge barriers cross the spectrum of Income Maintenance (IM) workers, assisters, and enrollees.
- Medicaid programs in Wisconsin need a credible, cohesive system of checks and balances that helps to catch IM worker or system error.

We identified recommendations for improvement as the state reevaluates Medicaid and BadgerCare Plus eligibility for individuals, broken into several categories based on process, program, or population.

Administrative/Ex-Parte Renewals

1. **Review data on total enrollees eligible for administrative renewal because of the "earned income extension" policy. Separate out individuals for ex parte renewal, do not evaluate based on household**
   - **a.** We expect that Wisconsin should use Ex-Parte renewals more frequently. We see little reason why any parent who was enrolled during the PHE would not be automatically renewed regardless of income because of earned income extension provisions for parents and therefore their children
   - **b.** In practice, "over income" parents are mailed a renewal packet, and only upon application submission are they evaluated for an extension. *They should have been automatically renewed.*
   - **c.** Please separate out the individual whose renewal should have been automatic; do not only evaluate "households" for ex parte renewals. Currently, if one member of a house "fails" for administrative renewal, everyone in the house must submit a renewal packet, even those who should have been administratively renewed.
   - **d.** Easy targets for increased administrative renewals are people on SSDI or SSR, or EBD Medicaid. They only need to verify their assets and many banks participate in data-matching. This population is on a set income, so they are usually unlikely to go over their asset limits.
   - **e.** Overall, individuals most likely to be administratively renewed are those with traditional employment, whose employers are participating in data-matching programs. These tend to not be workers in the cash economy or those who have little to no earned income. It exposes an apparent health equity/racial disparity in the process.
2. **Data is needed from the state on administrative renewals.**

"IC-Only" Population Errors:

1. **Many in the "IC-Only" group were prematurely terminated. Their renewal dates should match to a child's.**
   - a. An email to Consortia leads instructed that (assuming there was as birth relating to the pregnancy) a post-pregnant person enrolled in BadgerCare Prenatal during the PHE should be added to their child's BadgerCare Plus renewal date.
   - b. There is no source material for this we can share with consumers or with Consortia when calling.

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c. IM Consortia workers do not process this correctly. As a result, many people have been prematurely terminated from coverage.
d. Escalation to a supervisor is not always successful. In disappointing cases, we left a message for a supervisor who never returned our call.
e. It's not clear why this same flexibility wasn't granted to other parents with limited benefit program coverage, like EMA BC+ coverage. This is a population with a child in the home, who should be considered to have a renewal date that matches their child.

2. **Enrollees were eligible to maintain coverage through the PHE.**
   a. We suspect certain enrollees were moved into the "IC Only" category upon worker error, and therefore had a premature end date to coverage, not a renewal date. (Frequent example: Someone reported an income change for FoodShare during the PHE and incorrectly got notice their BadgerCare was ending. When we called to get continuous coverage reinstated, that was done manually, and we were told this person was now in the IC Only group.)

Emergency Services Medicaid (EMA):

1. **Consortia need training on this limited benefit program.**
   a. Applicants are frequently prompted to provide "verification of immigration status" documentation when none is required for this program. One IM worker said the "system would not let her advance" until immigration was verified.
2. **We expect more EMA enrollees to get coverage extensions to a renewal date, not terminated at the end of the PHE.**
   a. We maintain this type of coverage should also be extended via continuous eligibility rules, however, staff observed that cases where IM workers open a limited period of coverage that was only in backdated months, instead of continuous coverage.
   b. It's not clear where this population is showing up on the unwinding data page as some will have BadgerCare Plus-related coverage, some have Elderly, Blind, or Disabled (EBD)-related coverage.

Online "Access.Wi.Gov" Challenges:

1. **Access needs additional enhancements to be a viable substitute for calling a Consortia, such as the ability to ask questions or get more clarity on an eligibility question.**
   a. The online accounts have limited functionality for end-user input, especially from advocate helpers on the case.
   b. Access lacks Opportunities to submit clarifying question– the only way to get a question answered is by calling or going in person.
   c. Access presents challenges for certain populations: technology literacy barriers, internet barriers, access to devices like computer/smart phone, lack of rural internet or stable connection.
   d. Provide easier portal access for Advocates, Navigators or Assisters to help on a case in Access.
   e. Provide stronger language in Access about renewal timing – to find a renewal date or language to not renew too early is too many clicks.
2. **Access needs better decision support technology, to help distinguish application pathways based on the program being sought.**
   a. An application for benefits asks more questions than are required. For example, people applying for BadgerCare are asked for asset information even though it may be irrelevant.
3. **Applicants are not appropriately assessed for sub-programs, like MAPP.**
   a. Access is not accurate when evaluating for subprograms, like the Medical Assistance Purchase Plan (MAPP)

Language Barriers:

1. **Improve language accessibility.**
   a. Non-English speakers face equity and information barriers to IM Consortia. Non-English speakers – largely Spanish-speaking in our experience, are not getting equitable services and may abandon a renewal or application because of this administrative shortcoming.
   b. Hold times for Spanish lines are generally longer.
   c. Availability for Spanish speaking IM workers is very limited – generally understaffed – some consortia have none.
   d. We have been noticing calls being "dropped" seemingly more frequently for people who need an interpreter than calls being dropped generally.
   e. Consortiums have options for English or Spanish line – the English line then has several options to select based on what you need help with (Child Care Assistance, EBD MA, BC+, etc.) The Spanish line does NOT have sub-options.
   f. People who don't speak English are more likely going to need to call IM for assistance with renewing, because the materials sent are mainly in English and they'll need help understanding what to do.
2. **Limit transfers of a non-English speaker.**
   a. ABC staff have experience extensive hold times on a Spanish line, only to have an English speaker pick up OR have an attendant pick up who says they "don't specialize in the Medicaid feature" we're asking about, and that they will transfer us to that department – where either an English speaker picks up or the call is dropped in the transfer.

Phone Issues:

1. **Improve phone system call triage and assign call-backs.**
2. **Allow for overflows from busy consortia to lower-volume consortia.**
3. **Allow for appointment scheduling for certain vulnerable populations.**
   a. Vulnerable, high-need consumers should have the ability to schedule an appointment. The state has insisted that this is a "first come, first served" process of renewals and applications. That is not only unrealistic, but also inequitable for those with enhanced need, like those working agricultural jobs away from a phone or computer for long stretches; those only granted short breaks during the day not able to sit on hold for several hours; those with disabilities or mental/behavioral health challenges that make a phone-in or online process difficult, etc.

Application Packets:

1. **Shorten the application/renewal packet to the bare minimum. Seek additional information based on answers provided with an efficient follow-up, when needed.**
   a. The complexity of the application itself is a barrier to renewal or application, especially for families with children.
   b. The BadgerCare Plus packet is 61 pages. The relevant sections are really only 8 pages.
   c. The Elderly, Blind, or Disabled (EBD) Medicaid application packet is 52 pages. The relevant pieces make up 16 pages.
2. **Ask about annual income to assess for all coverage availability (using gap filler features).** The paper application does not ask annual income unless you are self-employed. Annual income is needed in order to screen for gap filler.
3. **Improve the EBD application for children.** For a minor child as an EBD applicant, there is **not** a way to fill out this application in a way that makes sense – there's no place to put a child's information.

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Verifying Information upon Application or Renewal:

1. **Improve verification notices.**
   a. Forward Health generated notices are lengthy and poorly organized and applicants or enrollees often lack proper notice of agency/system expectations. For example, a verification letter begins with an introductory page saying there's "been a change to your benefits." There is no change – once you turn multiple more pages, you learn that the notice is actually seeking a verification document.
   b. For people with employers enrolled in data-matching programs, verifications are more streamlined than for people working in the gig or cash economy, exposing an equity issue.
2. **Improve level of IM assistance for verification process and accepting "best available information."**
   a. In fact, policy requires the IM worker **to help** the enrollee/applicant obtain documentation or otherwise verifying items, including income. We have yet to see a worker offer such assistance.
   b. The IM worker must accept the "**Best Available information**," as a verification item, if the suggested proof is not available. We have had to insist that an item of proof is the best available after best efforts trying to produce an item, and that it must be accepted.
3. **Stop over verification.**
   a. We identified cases where IM workers insisted on more verification than is required. This over-verification is often for those self-employed, working for cash, or working multiple jobs. For example, a member submitted a tax return as a verification item. The IM worker insisted that "a letter from a tax preparer vouching that the tax return was accurate" was required. This was an inappropriate, improper over-verification request.
4. **Improve processes for those with employers not in the data-matching systems.**

Disability Cases:

1. **Improve training to reduce knowledge barriers of IM workers processing applications to alleviate the exclusion of disability populations from timely renewals/appropriate application processing.**
   a. When an applicant requires a disability determination as part of the eligibility review, it takes a very long time to complete. IM workers generally don't understand this process well, and cases seem to get lost in the shuffle between the two agencies, the IM Consortia and the Disability Determination Bureau (DDB).
   b. Workers often provide wrong information – like the common, incorrect statement "that applicants need to apply for SSDI first" in order to be screened for disability
   c. This is unwinding related because of overextended IM agencies/staff pay less attention to the more complex cases – negatively impacting people with disabilities.

Waiver Medicaid:

1. **Provide a handbook, policy, and source material for the "Waiver Medicaid" program.**
   a. In our experience, we have seen a child being "opened" for "Waiver Medicaid" to keep their Children's Long Term Support Program (CLTS) waiver program enrollment. During Medicaid unwinding, a child may have Medicaid terminated but still require CLTS services, and the state has instructed counties waiver agencies to simply "open" the child for "Waiver Medicaid" to thus keep CLTS.
   b. There is no public guidance, policy manual, or handbook on Waiver Medicaid. More guidance is needed.

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