WISCONSIN HOSPITAL ASSOCIATION

The Valued Voice

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High Risk Pools Could Help Stabilize Individual Insurance Market if Done Right

WHA analysis says federal reform bills should include sufficient funding, allow flexibility for states, and not penalize Wisconsin

As concerns about the sustainability of the individual insurance market continue to mount, high risk pools, if properly structured, funded and focused on preserving coverage for individuals with higher cost chronic conditions, can help bring relative stability to the individual insurance market.

That's according to comments submitted July 12 by the Wisconsin Hospital Association (WHA) in response to the federal Department of Health and Human Services (HHS) request for information about how to stabilize the insurance market. Among several recommendations, WHA says the Centers for Medicare and Medicaid Services (CMS) should support high risk pools and work with Congress to develop and fund pools to meet states' needs. (See WHA's comments at www.wha.org/pdf/WHAComment-HHS-RFI-Improving-Health-Insurance-Options7-12-17.pdf.)

Wisconsin's former high risk pool program, the Health Insurance Risk Sharing Plan (HIRSP), has been touted both here and in Washington as an example of a successful high risk pool and potential model as Congress grapples with ways to stabilize volatile individual insurance markets.

WHA's comments to HHS are based on its own analysis of the impact and effectiveness of Washington-crafted high risk pools in Wisconsin. The report (see at www.wha.org/pdf/WHAReport-High-Risk-Pools-and-the-AHCA-BCRA-SummaryRecommendationsAnalysis7-12-17.pdf) draws on Wisconsin's extensive

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Obamacare Replacements Continue to Shortchange Wisconsin

Wisconsin estimated to come up $37 billion short compared to expansion states

The Senate Republicans' newest proposal to replace Obamacare, released July 13, again falls far short of ensuring access to affordable care, stabilize the insurance markets, and protect Wisconsin's Medicaid program, according to the Wisconsin Hospital Association (WHA).

The most recent version of the U.S. Senate's Better Care Reconciliation Act (BCRA) keeps the same tax credit structure as the previous draft, which was first unveiled June 21. Under the Senate plan, tax credits would increase for older Americans and would be eliminated for those making 350-400 percent of the federal poverty level (FPL). The plan also phases out the cost sharing subsidies that have helped reduce out-of-pocket costs for many at the lowest income levels.

And the newest version of the bill makes few changes to how Medicaid would be funded, thus maintaining the disparities between expansion and non-expansion states. An analysis by the Missouri Hospital Association and five other hospital associations including WHA, estimates that, under the BCRA, the 19 states that opted out of the Affordable Care Act's full expansion for Medicaid, including Wisconsin, will have foregone $737 billion over 10 years compared to the 31 states that expanded Medicaid under the ACA. Wisconsin's share of that is estimated to be at least $37 billion over 10 years. See the analysis at www.mhanet.com/mhaimages/advocacy/PolicyBrief_BCRA_0717.pdf.

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Political Action Spotlight

Wisconsin Hospitals State PAC & Conduit at $175,000

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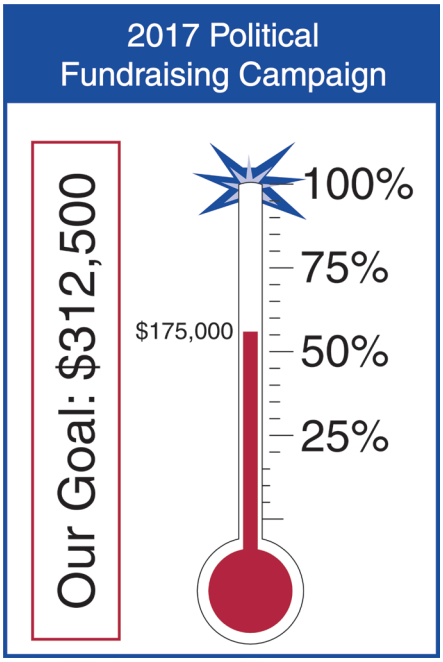

As of July 14, the Wisconsin Hospitals PAC and Conduit is just shy of $175,000 in contributions from 183 individuals. This puts the 2017 campaign at 56 percent of its goal of raising $312,500. The average contribution per individual is $956 with over $6,200 contributed each week.

In 2016, the Wisconsin Hospitals State PAC & Conduit launched three contributor levels beginning at $1,500 and up: Leaders Circle, Platinum Club and the Gold Club. There are 61 individuals who have contributed at one of these levels. All contributions, large or small, are appreciated.

Take a look at the full 2017 contributor list on page 8 to see who made the list.

To ensure your name is on future contributor lists, make your personal contribution today at www.whconduit.com or contact WHA's Jenny Boese at 608-268-1816 or *jboese@wha.org* or Nora Statsick at 608-239-4535 or *nstatsick@wha.org*.

WHA Comments to CMS on Medicaid Waiver Proposal

Recommends additional funding, suggests improvements

On July 14, WHA submitted comments (see at www.wha.org/pdf/2017WHALetter-CMS-Section1115Waiver7-14.pdf) to the Centers for Medicare & Medicaid Services (CMS) on Wisconsin's draft waiver amendment to the state's Medicaid childless adult demonstration project. WHA recommends CMS consider enhanced funding for Wisconsin's program and suggests modifications to proposed emergency department copayments, premiums, work requirements and drug testing. The DHS proposal also includes a change to the federal policy that limits services in Institutes for Mental Disease (IMD).

The Wisconsin Department of Health Services (DHS) submitted the waiver amendment proposal to CMS in June after receiving stakeholder feedback on an earlier draft. In order to implement the changes, DHS needs CMS approval. In May, WHA submitted comments to the State and was pleased DHS made some modifications to the earlier draft. Nevertheless, WHA calls for additional modifications, particularly to the funding and the emergency department copayment provisions.

The original waiver for providing services to the childless adult population was approved in late 2013 and allowed the state to expand eligibility to childless adults with income up to the poverty line (100 percent FPL). This was considered a "partial expansion" by the previous federal administration, and thus Wisconsin was not eligible for the higher level of federal funding available to states that expanded coverage to adults with income up to 133 percent of the federal poverty level (FPL). WHA has been advocating for equitable funding for Wisconsin's partial Medicaid expansion compared to states that fully expanded Medicaid under the Affordable Care Act.

In its comments, WHA recommends that CMS consider and approve enhanced federal matching funds for the partial expansion. In doing so, WHA describes Wisconsin as a model for avoiding gaps in coverage and notes other states are now considering changes to their programs that align with Wisconsin. In

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Arkansas, for example, recently passed legislation that requires the state modify its current Medicaid waiver to reduce the income threshold for coverage from 133 percent FPL to 100 percent FPL, like Wisconsin's program. Arkansas is an expansion state and is expected to ask the federal government to maintain the higher match it currently receives.

"As states seek flexibility for their programs, including as expansion states seek ways to reform their programs and reduce costs for their Medicaid programs, the principle that Medicaid should be a safety net for all in poverty can resonate if states are assured of enhanced funding," wrote Eric Borgerding, WHA president/CEO.

In addition to the funding question, WHA also provided comments about the implementation of other policies included in the waiver proposal. WHA noted in particular the state's commitment to increasing treatment options for individuals with substance use disorders. WHA also expressed support for the intention of the overall proposal to engage participants in maintaining and improving their overall health and incenting the efficient use of health care resources.

At the same time, WHA expressed concern about some provisions that would result in a person's disenrollment from the Medicaid program. The imposition of premiums is an example.

"WHA's members are the health care safety net," wrote Borgerding. "Individuals who fail to pay their premium and are disenrolled will still seek care at their doors, and our members will continue to serve them. Unfortunately, this will mean more uncompensated care."

The draft waiver proposal also includes copayments for emergency department utilization. The copayment would be $8 for all emergency visits, with providers being responsible for collecting the copayments. In its comments, WHA notes individuals with income below poverty likely will not be able to pay, and this will essentially result in a provider rate cut, increasing the Medicaid shortfall even more. Instead, WHA recommends the copayment be collected directly by DHS. WHA also believes the proposal as drafted could discourage appropriate use of the emergency room and recommends the proposal be narrowed to non-emergent use only.

The waiver proposal includes a 48-month time limit and work requirements. Any month in which the participant does not meet the work requirement would apply to the 48-month limit, and once a person meets the 48-month limit he/she would be disenrolled for six months. DHS proposes to limit the application of these policies to people age 19-49, and would allow for exemptions for individuals with mental illness, disabilities and other circumstances. WHA encourages CMS to consider additional exemptions for people with medical conditions that might prevent them from being able to meet the work requirement.

WHA believes health risk screenings are a positive practice and helpful if used appropriately to address care needs. WHA also supports the provision to waive the current limits on services provided by IMDs. With respect to the substance use provisions, WHA remains concerned about significant gaps in availability of treatment. While Wisconsin has made gains in the past several years in expanding substance abuse treatment resources, considerable additional investments are still needed. WHA has been and will continue to partner with and support efforts to combat substance abuse and increase access to and the availability of substance abuse treatment for individuals suffering from addiction.

Grassroots Spotlight

Rep. Kind Visits Richland Hospital and Medical Center

Rep. Ron Kind recently visited Richland Hospital and Richland Medical Center in Richland Center to discuss key health care issues, including the American Health Care Act and the Better Care Reconciliation Act, federal legislation aimed at repealing and replacing the Affordable Care Act. The group discussed provisions of concern including reduced access to insurance coverage, cuts to Medicaid funding and Medicaid funding inequity for Wisconsin.

The group also discussed the substance abuse crisis, the need for AODA resources and mental health care professionals, the importance of primary care, and ensuring access to care in rural communities.

Representatives of the Richland Hospital and the Richland Medical Center meet with Rep. Kind, middle.

CMS Releases 2018 OPPS/ASC and Physician Payment Proposed Rules

On July 13, the Centers for Medicare & Medicaid Services (CMS) released 2018 proposed rules regarding the Outpatient Prospective Payment System (OPPS) and the physician fee schedule. The following is a brief synopsis of the key points in the rules.

The OPPS rule proposes to update payment rates by 1.75 percent in calendar year 2018 compared to CY 2017. The rule also would drastically cut Medicare payment for drugs that are acquired under the 340B Drug Pricing Program. Specifically, CMS proposes to pay separately payable, non pass-through drugs (other than vaccines) purchased through the 340B program at the average sales price (ASP) minus 22.5 percent, rather than ASP plus 6 percent.

The OPPS rule also proposes changes to site-neutral policies under Section 603 of the Bipartisan Budget Act of 2015. Section 603 requires that, with the exception of dedicated emergency department services, services furnished in off-campus provider-based departments that began billing under the OPPS on or after November 2, 2015 no longer be paid under the OPPS, but under another applicable Part B payment systems. Under the physician fee schedule proposed rule, those services would now be paid at 25 percent rather than 50 percent of the OPPS rate for non-excepted services in 2018.

The OPPS proposed rule would also reinstate for CYs 2018 and 2019 the moratorium on enforcement of the direct supervision policy for outpatient therapeutic services for critical access hospitals and small rural hospitals with 100 or fewer beds. In addition, CMS proposes to delay implementation of the outpatient and ASC CAHPS survey-based measures in the Outpatient Quality Reporting (OQR) program

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until further notice. The rule also would remove six quality measures from the OQR. CMS does not propose relief from the Stage 3 reporting requirements that begin on January 1, 2018.

The rule on the physician fee schedule for calendar year 2018 proposes an estimated 0.31 percent increase in physician payment rates for 2018 compared to 2017, after applying a 0.5 percent payment increase required by the Medicare Access and CHIP Reauthorization Act of 2015 and a misvalued code adjustment required under the Achieving a Better Life Experience Act of 2014. CMS proposes to pay for new telehealth services, including psychotherapy for crisis, health risk assessments and care planning for chronic care management. In addition, the rule would delay until January 1, 2019, the appropriate use criteria program for advanced diagnostic imaging services; and establish payment to rural health clinics and federally qualified health clinics for regular and complex chronic care management services, general behavioral health integration services and psychiatric collaborative care model services.

While data submission for the CY 2018 Physician Quality Reporting System has passed, CMS proposes to retroactively lower the number of required measures from nine to six to more closely align the program with the new Merit-based Incentive Payment System that will affect payment starting in CY 2019. CMS also proposes to lower the maximum amount of payment at risk under the CY 2018 value modifier program from 4.0 percent to 1.0 percent for individual clinicians and groups of under 10 clinicians, and to 2.0 percent for groups of 10 or more clinicians.

Both proposed rules have comment due dates of September 11. WHA will put out a more detailed summary and will comment on the rules, concentrating on the problematic areas regarding the 340B program and the site neutral payment changes.

eNLC, Regulatory Reform Top Agenda at WHA Workforce Development Council

With 25 states already taking the step to enact the enhanced Nurse Licensure Compact (eNLC), it is likely it will go into effect before the end of this year, according to Ann Zenk, WHA vice president, workforce and clinical practice. The enhanced compact will be enacted the earlier of either December 31, 2018, or when 26 states join.

In a presentation to the WHA Workforce Development Council July 13, Zenk said that similar to the current compact, of which Wisconsin was an inaugural member in 2000, the eNLC allows nurses holding a license issued by another state participating in the compact to continue to utilize a voluntary, alternative and expedited process to receive a privilege to practice nursing in Wisconsin.

WHA, along with the Wisconsin Organization of Nurse Executives and the Wisconsin Board of Nursing, are in support of Wisconsin adopting the eNLC. WHA will work with state lawmakers to adopt the eNLC to ensure Wisconsin will continue to benefit from the expedited licensure process provided through the Compact.

Zenk also presented an update on WHA's development of a package of reforms to Wisconsin regulations and statutes intended to help WHA's members further advance emerging integrated and team-based models of care. Assembly Bill 146, Wisconsin Act 20, was signed into law June 21, 2017. It enables dental hygienists to provide dental hygiene care in hospitals and clinics without supervision by a dentist. Expanding the settings in which this care can occur may ultimately lead to a reduction in emergency department visits for preventable dental conditions—an effective use of hospital and health systems' workforce to improve outcomes and lower cost.

WHA Senior Vice President of Government Relations Kyle O'Brien joined the meeting to provide a budget and legislative update. O'Brien discussed the current status of the state budget and several WHA accomplishments, including the additional investment of funds to support new rural clinical training

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experiences for advanced practice clinicians, allied health professionals and graduate medical education for physicians.

O'Brien also updated the Council on recent proposals put forward by management and labor representatives of the Worker's Compensation Advisory Council. The Department of Workforce Development said worker's compensation premium rates for Wisconsin businesses will drop 8.46 percent in 2017.

The WHA Workforce Report is in progress, and council members shared their experiences with how they use the data and recommendations in the report and made suggestions on what they believe policymakers can do to improve the supply of and training for Wisconsin's health care workforce. The 2017 report is slated for release in October.

Registration Now Available for WCMEW Fall Conference

This fall, the Wisconsin Council on Medical Education & Workforce (WCMEW) will host a statewide conference focusing on Wisconsin health care workforce issues. At the full-day event September 27 in Wisconsin Dells, participants will engage in topics ranging from public policy to provider retention and training clinicians for evolving models of care delivery. The conference is designed to bring stakeholders from across Wisconsin's business, government, and non-profit areas together to look toward the future, recognizing the urgent demand for creative and cross-sector solutions to health care workforce challenges. The event will feature a keynote by Michael Munger, MD, president-elect of the American Academy of Family Physicians.

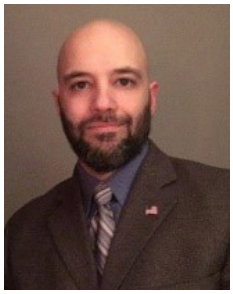
Panels and breakout sessions will feature discussions by Wisconsin leaders including: Ann Zenk, WHA vice president, workforce and clinical practice; Bruce Palzkill, deputy administrator, Department of Workforce Development; Jim Wood, strategic counsel, Competitive Wisconsin; Rep. Mike Rohrkaste (R-Neenah); Peter Sanderson, medical director, informatics and ambulatory regulation, Ascension Wisconsin; Nancy Nankivil, director, practice transformation and professional satisfaction, American Medical Association; Charisse Oland, CEO, Rusk County Memorial Hospital; and Marilyn Frenn, director, PhD nursing program, Marquette University.

Registration for the conference is now available at www.cvent.com/d/85qxys. If you have questions, contact George Quinn, executive director, WCMEW, at *gquinn@wcmew.org* or 608-516-5189. The full conference brochure is included in this week's packet and is also available at www.wha.org/education/2017wcmew9-27.pdf.

WHA Offers Active Shooter Response Training September 20

International Risk Communications Expert Vincent Covello will also keynote event

Christopher Sonne



Billy Castellano

It is a reality in today's world that hospitals must be prepared to respond to the threat of an active shooter on their campus. On September 20, the Wisconsin Hospital Association is sponsoring the "WHA Emergency Preparedness Conference: *Ready to Respond."* This important, one-day conference will feature Chris Sonne and William Castellano, both of HSS EM Solutions, who will share best practices and lessons learned from live active shooter scenarios, as well as direct tabletop exercises and a practical, scenario-based training exercise, during a special afternoon session focused on preparing for an active shooter. ***(continued on page 7)***

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Hospitals are encouraged to take advantage of this in-state training opportunity designed for hospital emergency preparedness directors, emergency department directors and physicians, infection prevention staff, department directors, public relations professionals and public information officers.

The conference will also feature national experts who will share communication and preparedness lessons learned from real world events and focus on current threats facing health care organizations, including workplace and community violence and highly infectious diseases. Attendees will have the opportunity to collect strategies to enhance their current emergency management programs, practice them through interactive exercises, and integrate those preparedness and communication strategies into daily operations.

Vincent Covello, PhD, will keynote the conference and offer a deep-dive session in the afternoon specifically for public information officers and health care public relations professionals.

Covello is a nationally and internationally recognized trainer, researcher, consultant and expert in crisis, conflict, change and risk communications. Over the past 25 years, he has held numerous positions in academia and government. Covello was a senior scientist at the White House Council on Environmental Quality in Washington, D.C., a study director at the National Research Council/National Academy of Sciences and the director of the risk assessment program at the National Science Foundation. Covello has authored or edited more than 25 books and published over 75 articles on risk assessment, management and communication. Covello will share principles, strategies and practical tools for communicating effectively in a high stress situation.

Additional sessions include a look at infectious disease outbreaks and what hospitals can do to better prepare; as well as the role of governmental agencies, including the Department of Health Services and the Department of Public Health during an emergency.

This conference is September 20 at the Sheraton Hotel in Madison. The registration fee is $225 per person. The full agenda and online registration are available at www.cvent.com/d/b5qw08. An event brochure is also included in this week's packet. Seating is limited—WHA highly recommends registering early.

WI-Trac Bed Management System Used in Emergency, Non-Emergency Events

A hospital's ability to communicate—whether internally or externally with other hospitals and health care partners—is essential, especially in the event of an emergency. The Wisconsin Tracking Resources and Communication System (WI-Trac) is an internet-based hospital bed management platform that has been provided free of charge since the mid-2000s by the Wisconsin Healthcare Emergency Preparedness Program (WHEPP). WHEPP is a program administered by the Wisconsin Department of Health Services in partnership with WHA and other stakeholders to support hospital emergency preparedness planning and response to mass casualty incidents and other emergencies.

WI-Trac allows hospitals to alert and communicate with each other and with their emergency response partners in emergency and non-emergency events alike. The WI-Trac dashboard provides inpatient open bed capacity as well as information about important diagnostic and intervention capabilities such as CT scanner, cardiac catheterization lab and stroke intervention availability. Additionally, WI-Trac allows users to issue many types of alerts, including a mass casualty incident (MCI) alert that polls hospitals in real-time on their emergency department surge capacity. Michael Clark, MD, emergency and EMS physician and WHEPP medical advisor, explains, "During an MCI event, the MCI alert function allows hospitals to update their receiving capacity as often as they need and allows hospitals to communicate the changes region-wide with a single action rather than multiple phone calls. Both MCI capacity and bed capacity allow for assessment of regional capacity and status for individual facilities and area or regional coordination centers."

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WI-Trac may also be used during non-emergency events, including when trying to place or transfer a patient. Clark explains, "WI-Trac allows hospitals to share the availability of inpatient beds to assist in patient transfers and assessment of regional bed status. Knowing in advance how likely another facility is to have a bed may reduce the number of facilities a physician needs to call to find an accepting facility."

For more information or to schedule WI-Trac training for your facility, contact your local health care coalition coordinator or Andrew Brenton, WHA assistant general counsel, at *abrenton@wha.org* or 608-274-1820.

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Turkal, Nick	Aurora Health Care

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experience and cautions that market dynamics have changed since HIRSP sunset in December 2013, including the potential impacts of new insurance market policies contained in both the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA).

"We had a good experience with our high risk pool in Wisconsin, in large part because it was actually administered by a separate board of directors that included provider, insurer and patient representatives who understood its singular purpose," said WHA President/CEO Eric Borgerding. "What we know from the Wisconsin experience is that to be successful, these pools must be adequately funded, but as important, the population in the pool must be stable so the care can be well coordinated and effective. If there is a lot of jumping in and out, a lot of churn in these pools caused by other provisions in the BCRA, that could lead to instability and unsustainability."

While many are pointing to high risk pools as the solution to concerns about pre-existing conditions and waivers of essential health benefits, the report describes why creating risk pools solely to address those concerns could be unsustainable. Certain elements of both the AHCA and BCRA could incent individuals to enroll in a high risk pool for a short-term or specific need, and revert back to the individual market. As a result, this "churn" could cause the pool to become less manageable and unstable.

"What we know from Wisconsin's experience is that if adequately resourced and properly focused and structured, risk pools can help address some of the instability now threatening the individual market," Borgerding said. "But saying and doing are two different things when it comes to sustaining high risk pools; the details really matter here."

The WHA report notes the individual market has historically faced challenges in maintaining stability. Risk pools could be created to take some of the higher costs and volatility out of the individual market, thus lowering premiums across the board. That risk, however, would have to be subsidized. While the AHCA and BCRA include some funding for high risk pools, neither includes sufficient resources for states to establish risk pools that can be sustained.

While the BCRA is largely silent about how funding is distributed among states, WHA says the AHCA's funding formula for the largest block of funding—the Patient Safety and Stability Fund—would penalize states like Wisconsin and exacerbate concerns about state equity that are increasingly surfacing in the Obamacare repeal debate. The formula distributes funding based on incurred claims, on the number of uninsured with income below 100 percent of the federal poverty level (FPL), and it gives more funding to states that have fewer than three insurers in the exchange.

"The funding formula should be revamped," Borgerding said. "Wisconsin is nationally known for its high-quality care, which results in lower overall utilization. Distributing funding based on incurred claims disadvantages states like Wisconsin that have lower utilization." Wisconsin has a low uninsured rate for those below the FPL, largely due to Wisconsin's hybrid approach to Medicaid expansion. Wisconsin also has a very competitive insurance market. All of these factors will actually work to Wisconsin's disadvantage when it comes to distributing funding for high risk pools under the AHCA and BCRA.

"In other words, Wisconsin would be penalized for having high-quality care, providing coverage to those with income below 100 percent and having a competitive insurance market," Borgerding said. "Everywhere we turn in these two bills, Wisconsin is essentially being penalized."

Over the past several months, WHA has advocated for premium tax credits based on income rather than age and to ensure cost sharing reduction subsidies are maintained. WHA says their analysis on risk pools does not change their recommendations in this area. WHA continues to advocate that the bills recognize states like Wisconsin for "partial" Medicaid expansions.

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"The BCRA continues to perpetuate the funding inequities between expansion and nonexpansion states," according to WHA President/CEO Eric Borgerding. "It is absolutely unacceptable that the bills being proposed to replace Obamacare are financially punishing states that rejected Obamacare."

In a letter to the Wisconsin Congressional Delegation July 13 (see at www.wha.org/pdf/2017WHADelegationLetterDSH7-13-17.pdf), Borgerding noted both the House and Senate bills recognize the need for the Medicaid Disproportionate Share Hospital (DSH) program. But, he added, as drafted, the provisions would have no substantive impact in Wisconsin. As such, both bills fail to alleviate the significant funding disparity between Wisconsin and expansion states.

Under the federal DSH program, each state has a cap on its federal DSH funding. The BCRA would allow for non-expansion states to have a higher cap or "allotment." It takes state dollars at the regular Medicaid matching rate to draw down those federal DSH funds.

"Increasing Wisconsin's DSH allotment alone is meaningless since Wisconsin would have to spend an additional $59 million in state dollars each year just to draw down the allotment we currently have," said Borgerding. "A real solution would instead be to allow a higher match rate for nonexpansion states for DSH funding or recognize Wisconsin's partial expansion population."

Wisconsin's "Partial" Medicaid Expansion, a $280 Million Annual Cost to State Budget

Gov. Scott Walker expanded Medicaid by adding 130,000 people below the poverty level to the program. But Wisconsin's version of expansion didn't meet the Obama administration's definition of "expansion." That means Wisconsin spends $280 million per year to cover the exact same population that, under the ACA and now the American Health Care Act/BCRA, an expansion state would spend 1/10 of, roughly $28 million, to cover.

"That's a difference of nearly a quarter-billion dollars annually we could use to train more primary care doctors and nurses, improve access in underserved rural and urban areas or reduce Medicaid cost shifting to employers and families—*right here in Wisconsin*," Borgerding said.

Additionally, under the ACA, Wisconsin hospitals are taking billions of dollars in Medicare cuts to pay for coverage expansion, including for Medicaid in those states that are getting more federal dollars for full expansion. Under the BCRA, those cuts continue, and Wisconsin keeps paying, according to Borgerding.

"The unique Wisconsin model of coverage has worked to reduce our uninsured rate by an estimated 38 percent, and we can be proud to say that everyone in poverty is covered under Medicaid," said Borgerding. "Unfortunately, funding disparities baked into the BCRA would place our state at a significant disadvantage."

WHA continues to urge Wisconsin's two U.S. Senators, Ron Johnson and Tammy Baldwin, to fight for Wisconsin and ensure Medicaid funding equity under any proposals acted upon by the Senate.