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Budget Adjustment Bill Approves Sweeping Shift in Authority for Medicaid Policymaking

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The amended budget adjustment bill signed by the Governor on March 11 includes provisions that will give the Department of Health Services (DHS) extremely broad authority to change Medicaid and BadgerCare. (Note that even though the bill has now been given an Act number – 2011 Act 10 – it doesn't formally become law until it has been published, and publication has been enjoined by a judge's ruling, pending review of challenges based on alleged missteps in the legislative process.)

The final bill authorizes DHS to write rules that will supersede any conflicting portions of state Medicaid and BadgerCare statutes and could adversely affect many of the more than 1.1 million state residents served by Wisconsin's Medicaid-related programs. The only limits on the department's options for rewriting the state's public health care benefits are federal requirements, and the bill requires DHS to seek a waiver exempting the state from the federal restrictions.

This paper summarizes the Medicaid related portions of the new law. It includes an appendix summarizing the "maintenance of effort" (MOE) standards in federal law, which the Walker Administration seeks to circumvent by a federal waiver.

A. Exempting Wisconsin from Federal Requirements

The final bill contains provisions that give DHS much broader latitude in its ability to change Medicaid-related programs in Wisconsin by exempting our state from current federal requirements contained in the Affordable Care Act (ACA) and other federal statutes.

DHS is required to seek a waiver exempting the state from federal maintenance of effort (MOE) standards, which are described in Appendix 1. Such a waiver could allow the state to makes changes like reducing income limits for eligibility, tightening non-income eligibility standards, increasing premiums or other cost-sharing and changing procedures for enrollment and renewal of eligibility.

Act 10 also directs DHS to either submit a Medicaid-plan amendment or seek a federal waiver, to the extent necessary to permit any of the DHS rule changes described in Section D, below. Such changes could go beyond eligibility issues by including such things as the scope of services required, reimbursement policies, and "supporting responsibility and choice of medical assistance providers."

B. Reducing Income Eligibility Limits

To the extent allowed by federal law or a federal waiver, Act 10 authorizes DHS to promulgate rules that reduce income eligibility. The new law creates two alternative triggers for putting into effect rules that tighten current eligibility standards, methodologies and procedures:

1. The department receives a waiver from federal maintenance of eligibility requirements in the ACA; or
2. if the state does not receive a waiver from MOE requirements by December 31, 2011, the act directs DHS to reduce eligibility for adults (other than pregnant women and people with disabilities) to 133 percent of the poverty level, beginning on July 1, 2012.

According to the Legislative Fiscal Bureau, reducing eligibility to 133 percent of the poverty level change could end insurance coverage for 70,000 adults – about 63,200 parents and about 6,800 adults without dependent children. As Appendix I describes, federal law allows the state to reduce eligibility of adults (other than pregnant women and people with disabilities) to the 133 percent level;[1] however, Act 10 retains the current statutory standard of 200 percent for parents and childless adults until one of the two triggers noted above permits the department to adopt tighter eligibility rules.

A reduction in eligibility of adults to 133 percent of the poverty level would disqualify a single person working a full-time job at minimum wage and would end coverage for parents in a family of three or four that has two people working full time at the minimum wage. (Appendix 2 shows the annual, monthly and hourly incomes at different percentages of the federal poverty level and for different family sizes.)

As with the other changes that Act 10 allows, the income eligibility changes could be made by DHS without any vote by the full legislature explicitly approving the reduced income ceiling.

An amendment recommended by the Joint Finance Committee and included in the final bill makes a small change by providing that a reduction in income eligibility would revert to the previous level in January 2015, unless the legislature makes a statutory change codifying the lower income limit.

C. DHS Study of Medicaid Changes

Section 99 of the new law directs DHS to study potential changes in Wisconsin's Medical Assistance state plan and in the current federal waivers the state has received, in order to achieve any of the following purposes:

1. Increasing the cost effectiveness and efficiency of care and care delivery
2. Limiting switching from private health insurance to Medical Assistance programs.
3. Ensuring the long−term viability and sustainability of Medical Assistance programs.
4. Advancing the accuracy and reliability of eligibility for Medical Assistance programs and claims determinations and payments.
5. Improving the health status of individuals who receive benefits under a Medical Assistance program.
6. Aligning Medical Assistance program benefit recipient and service provider incentives with health care outcomes.
7. Supporting responsibility and choice of medical assistance recipients.

[1] That change is allowable now for childless adults, and could be made beginning on July 1, 2011 for parents.

D. Using Rulemaking to Change Current State Law

Act 10 authorizes DHS to adopt rules that make policy changes intended to accomplish any of the permissible goals of the planning process noted above. However, the final version of the bill dropped the original proposal to allow the changes to be made with emergency rules that could last until January 2015. The Conference Committee amended the bill so DHS must use the usual rulemaking process, which provides somewhat more opportunity for public input.

The rules may change Wisconsin's Medicaid programs in any of the following ways, subject only to federal restrictions:

1. Require cost sharing from program benefit recipients up to the maximum allowed by federal law or a waiver of federal law.
2. Allow providers to deny care or services if an enrollee is unable to share costs.
3. Modify existing benefits or establish different benefit packages for different recipients.
4. Revise provider reimbursement models for particular services.
5. Mandate that program benefit recipients enroll in managed care.
6. Restrict or eliminate presumptive eligibility.
7. Impose restrictions on providing benefits for non-citizens.
8. Set standards for establishing and verifying eligibility requirements.
9. Develop methods to assure accurate eligibility determinations and renewals.
10. Reduce income eligibility ceilings to the extent allowed by federal law or waiver.

Because the legislation delegates so much authority to DHS, it removes the vast majority of legislators from responsibility for setting Medicaid and BadgerCare policies on issues like eligibility standards, premiums, benefits, reimbursement, and enrollment procedures. As the next section of this summary indicates, the new rules adopted by DHS may conflict with and supersede the state statutes relating to Medicaid and BadgerCare Plus.

E. Exemptions from Existing Statutes

The final bill amends the statutes in at least 24 places to permit the rules adopted by the department to conflict with those statutes. In general, these provisions allow the department's rulemaking authority to supersede the statutes relating to any of the 10 potential subjects of rules noted above. However, the exemptions from the statutes also include some other options for the department, such as the following:

- Allowing DHS to alter the share of Medicaid funding the state pays to schools from the federal Medicaid reimbursement for health care services the schools provide.
- Permitting DHS to change the eligibility of non-citizens for Medicaid benefits, which means that the department could end the eligibility of lawfully residing children and pregnant women, as well as the prenatal care provided through the "unborn child" coverage for undocumented non-citizens.
- Reducing the range of people eligible for family planning services, or Medicaid eligibility of women diagnosed with breast or cervical cancer.
- Eliminating presumptive eligibility for pregnant women – a change that could prevent some women from getting cost-effective prenatal care early in their pregnancy.

The language allowing rules to conflict with and supersede the statutes is not inserted in every section of the Medicaid law. For example, it is not included in the parts of the statutes relating to financial eligibility standards and cost-sharing requirements for SeniorCare and Family Care. The Fiscal Bureau summary says that even though some of the general language in Act 10 appears to allow changes in those programs, the Legislative Reference Bureau interprets the legislation to mean that DHS could not issue rules that conflict with those aspects of SeniorCare and Family Care. We are still studying the new law to see if there are other significant aspects of current Medicaid law that cannot be superseded by rule

F. Redeterminations of Eligibility

Act 10 allows the state to review the eligibility of enrollees more frequently than is now the practice. In contrast to most other changes that the new law permits, Section 149 of the legislation authorizes this policy to be altered without amending the administrative rules, "if there is no conflicting provision of state law."

Under current state law, DHS regularly reviews the eligibility of each Medicaid enrollee every 12 months. However, the preexisting statutes also give the department the authority to make investigations of eligibility whenever there is reasonable ground to believe that an applicant or enrollee may not be eligible. As a result of that authority, DHS can and often does remove enrolled individuals or families before their annual review, if their income rises or they gain access to employer-sponsored insurance.

One effect of Section 149 would be to allow DHS to require a periodic review every 6 months (or more frequently) instead of annually. Most states have been moving away from semiannual reviews of eligibility because that system increases administrative expense and the review process creates churning in coverage by frequently knocking eligible families from subsidized coverage, at least for a brief while. Increasing the frequency of reviews would appear to be allowed without even making a change in state rules, if the state gets a waiver from maintenance of effort requirements.

Federal law gives states the option of providing a 12-month period of "continuous eligibility" for pregnant women and children. Like nearly all the other states, Wisconsin uses continuous eligibility for pregnant women and newborns because of the importance of continuity of care for those populations. However, other children and adults in Wisconsin are not continuously eligible – in contrast to about 22 states that have 12-months continuous eligibility for all children on Medicaid and/or CHIP-funded coverage.

Although we are seeking further clarification of the effects of this part of the bill, it appears that it would allow DHS to end 12-months continuous eligibility for infants and pregnant women.

Cost Savings

The Medicaid changes described above are not expected to yield any savings in the 2010-11 fiscal year, and the Legislative Fiscal Bureau concluded that this portion of the bill constitutes "non-fiscal policy" (which the Joint Finance Committee typically strips from budget bills at the outset of the budget process).

The biennial budget bill that was unveiled on March 1 cuts the state share of Medicaid funding by $500 million below the level that would be required to maintain current programs, but provides little indication of how the savings will be achieved. Aside from a cut in Family Care

funding and a cost-saving change in the SeniorCare program, the bill does not propose any significant changes to achieve the proposed spending reductions. We might not get a good idea of how spending will be cut until DHS develops the plan required by Act 10 and submits its waiver request to federal officials.

Conclusion

The recently-passed budget adjustment bill delegates sweeping power to the Department of Health Services to make changes relating to Medicaid and BadgerCare Plus eligibility, services, cost-sharing, enrollment procedures, and provider reimbursement. Until January 2015, those policy choices, formerly the responsibility of state legislators and the Governor, have been handed over to an unelected official, the DHS Secretary.

Concerns about the extraordinary power being granted to an administrative agency have been raised by many advocacy groups. Those concerns are echoed by the words of the attorney in the nonpartisan Legislative Reference Bureau who drafted the Medicaid provisions. She cautioned in her drafter's note that "the request would allow DHS to change any Medical Assistance law, for any reason, at any time, and potentially without notice or public hearing."

The final version of the bill addressed one of those problems by requiring DHS to use the usual rulemaking options, rather than the proposed emergency rule option that had been approved by both houses of the legislature before the bill stalled. That change will provide somewhat more opportunity for public input, but it does little to remedy the concern that DHS can rewrite state law without the involvement of the vast majority of state legislators. The new law strips from Wisconsin citizens our right to hold state legislators accountable for the policy changes that could affect hundreds of thousands of Wisconsinites.

The biennial budget bill that was proposed by the Governor in early March proposes a cut of $500 million from the level of state funding needed to fully finance Medicaid and BadgerCare. In the coming weeks and months, the Walker Administration will contend that it either needs to get a waiver of federal maintenance of effort (MOE) requirements in order to make broad changes in eligibility standards and procedures, or it will have to reduce income limits for adults in BadgerCare Plus. At least until the 2011-13 budget bill passes, many advocates and providers will resist the notion that those are the only two choices.

Under Republican and Democratic governors, BadgerCare has delivered the care Wisconsin families need at a price they can afford. Now, during the worst economy in generations, the health and economic stability BadgerCare and Medicaid deliver is even more important. In the biennial budget, legislators should work with the Governor and with the involvement of the general public to find ways to balance the state's budget while protecting the health of Wisconsin families and most vulnerable citizens.

Jon Peacock, research director

Appendix 1: Federal Restrictions on State Changes to Medicaid Eligibility in Wisconsin (including BadgerCare Plus)

Federal laws currently contain restrictions on the authority of states for reducing eligibility standards for participation in Medicaid-funded programs. These restrictions, known as "maintenance of eligibility" or "maintenance of effort" (MOE) requirements, derive from two federal laws:

- **The American Recovery and Reinvestment Act** (ARRA) prevents states from reducing eligibility for Medicaid-related programs before July 1, 2011 – while the states are receiving the enhanced Medicaid reimbursement provided by that Act. However, this limitation applies only to coverage in effect on July 1, 2008, which means that it doesn't apply to BadgerCare Plus Core coverage for childless adults, which didn't begin until July 2009.
- **The Affordable Care Act** (ACA) requires states to maintain current eligibility standards for children until September 30, 2019. States that currently provide Medicaid-funded coverage of adults over 133 percent of the federal poverty level may reduce eligibility to that level, if they certify that they are facing a deficit, but may not reduce eligibility of pregnant women or people with disabilities prior to January 1, 2014.

A recent letter from Secretary Sebelius to state governors about state flexibility in administering their MA-related programs indicates that the federal Department of Health and Human Services is reviewing whether it has authority to waive the MOE requirements.

The following table reflects the effect in Wisconsin of the overlapping maintenance of eligibility requirements in ARRA and the ACA.

Effects of Current Maintenance of Eligibility Requirements for Wisconsin

<table>
<tr><th></th><th>Until 6/30/11[i]</th><th>7/1/11 – 12/31/13 [ii]</th><th>2014 or later</th></tr>
<tr><td>Children</td><td colspan="2">Can't change eligibility before 2019</td><td rowspan="7">MA coverage to 133% required, above that it's optional [iii]</td></tr>
<tr><td>Pregnant women</td><td colspan="2" rowspan="2">Can't change before 2014</td></tr>
<tr><td>People with disabilities</td></tr>
<tr><td>Parents/caretakers</td><td>Can't change</td><td>Could lower the income ceiling to 133% of FPL</td></tr>
<tr><td>Childless adults over 133% of federal poverty level (FPL)</td><td colspan="2">Could eliminate,[iv] but the state must still meet the cost neutrality requirement</td></tr>
<tr><td>Childless adults up to 133% of FPL</td><td colspan="2">Can't change [v]</td></tr>
<tr><td>Childless adults in BC+ Basic</td><td colspan="2">This isn't part of Medicaid, so they aren't protected by federal law.</td></tr>
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Appendix 2 – 2011 Federal Poverty Levels
Income at Different Percentages of the Federal Poverty Level

Annual Income Levels

Group Size	100%	133%	150%	200%	300%
One	$10,890	$14,484	$16,335	$21,780	$32,670
Two	14,710	19,564	22,065	29,420	44,130
Three	18,530	24,645	27,795	37,060	55,590
Four	22,350	29,726	33,525	44,700	67,050
Five	26,170	34,806	39,255	52,340	78,510
Six	29,990	39,887	44,985	59,980	89,970

For each additional person, add $3,820/yr. ($318/month or $1.84/hr) for families at 100% of poverty.

Monthly Income Levels

Group Size	100%	133%	150%	200%	300%
One	$908	$1,207	$1,361	$1,815	$2,723
Two	1,226	1,630	1,839	2,452	3,678
Three	1,544	2,054	2,316	3,088	4,633
Four	1,863	2,477	2,794	3,725	5,588
Five	2,181	2,901	3,271	4,362	6,543
Six	2,499	3,324	3,749	4,998	7,498

Hourly Income Levels

(Assumes 2080 hours per year)

Group Size	100%	133%	150%	200%	300%
One	$5.24	$6.96	$7.85	$10.47	$15.71
Two	7.07	9.41	10.61	14.14	21.22
Three	8.91	11.85	13.36	17.82	26.73
Four	10.75	14.29	16.12	21.49	32.24
Five	12.58	16.73	18.87	25.16	37.75
Six	14.42	19.18	21.63	28.84	43.25

Note: Significance of Indicated Poverty Levels:

100% is the point where small co-pays begin to apply to children in BadgerCare Plus.

133% is the ceiling for mandatory coverage of parents and childless adults, beginning in 2014, and it is the level to which states with more generous adult coverage can reduce that coverage (as described in Appendix 1). The Governor's bill directs DHS to exercise the option to reduce coverage to that level in July 2012 if the state doesn't get a federal waiver.

150% is the income level at which premiums are now required for parents in BadgerCare Plus (BC+), and "crowd-out" policies restrict BC+ eligibility for people who have access to employer-sponsored insurance.

200% is the top income for parents in BadgerCare Plus (BC+) and for family planning services, as well as for child care eligibility for families qualifying initially at or below 185%, and it's where premiums begin for kids in BC+.

300% is the maximum income level for pregnant women in BadgerCare Plus and is the point at which premiums for kids in BadgerCare Plus are based on the f

[i] While states are receiving the enhanced federal match rate for Medicaid (scheduled to end on 7/1/2011), they are required to maintain their Medicaid "eligibility standards, methodologies, and procedures" as in effect on July 1, 2008. BadgerCare Plus Core coverage for childless adults didn't begin until July 2009 and isn't affected by the maintenance of eligibility (MOE) requirement relating to the enhance Medicaid funding.

[ii] States that certify that they have a deficit can reduce their eligibility ceiling for adults (except for pregnant women, the elderly and people with disabilities) to 133% of the federal poverty level (FPL).

[iii] If the state doesn't continue MA or BC+ coverage for these adults, they will be eligible for subsidized coverage through the exchanges (but that coverage will have higher cost-sharing and tougher crowd-out restrictions).

[iv] In contrast to parent coverage, the Core Plan for childless adults isn't protected by the Recovery Act MOE provisions, which don't apply to expansions effective after July 1, 2008. Any reductions to eligibility must still meet the cost neutrality requirements of the federal waiver.

[v] The MOE provisions in the ACA apply to waivers and require states to maintain coverage of adults to 133 percent of poverty. In addition, the cost neutrality provisions of the state's federal waiver require the state to maintain spending.