

Budget Bill Approves Sweeping Shift in Authority for Medicaid Policymaking

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The amended budget bill recommended by the Joint Finance Committee and approved by the full Legislature incorporates provisions from the budget repair bill (Act 10) giving the Department of Health Services (DHS) sweeping authority to change state laws relating to Medicaid and BadgerCare. Like Act 10, the bill authorizes DHS to make policy changes that supersede conflicting portions of state Medicaid and BadgerCare statutes, and it 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.

The final budget bill repeals all the Medicaid language from Act 10 and incorporates nearly all of it into the biennial budget. However, it removes the rule-making provisions, thereby eliminating the only requirement for public hearings on fundamental policy changes relating to Medicaid and BadgerCare. The amended bill added language requiring DHS to submit policy changes to the Joint Finance Committee if those changes would conflict with state statutes. That change provides a small degree of legislative oversight, but most legislators will be absolved of any responsibility for policy decisions that may substantially rewrite current law.

This paper describes the new Medicaid and BadgerCare policymaking procedures contained in the final version of the budget bill. It includes an appendix the budget bill's provisions with those in Act 10, and another appendix summarizes 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 budget bill approved by the Legislature incorporates provisions from Act 10 that seek to 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 request a waiver exempting the state from federal maintenance of effort (MOE) standards, which are described in Appendix 2. Such a waiver could allow the state to make 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.

The amended budget bill 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 policy 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

Like Act 10, the amended budget bill authorizes DHS to adopt policies that reduce income eligibility – to the extent allowed by federal law or a federal waiver. The bills both create 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 latest Legislative Fiscal Bureau estimate, reducing eligibility to 133 percent of the poverty level could end insurance coverage for 60,000 adults. As Appendix 2 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, the revised budget bill 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 3 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 the revised budget bill allows, the income eligibility changes could be made by DHS without any vote by the full legislature explicitly approving the reduced income ceiling. A reduction in income eligibility would revert to the previous level in January 2015, unless the Legislature and Governor enact a statutory change codifying the lower income limit.

C. DHS Study of Medicaid Changes

Like Act 10, the budget bill 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.

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

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.

D. Adopting Policies That Change Current State Law

The amended budget bill authorizes DHS to make policy changes intended to accomplish any of the permissible goals of the planning process noted above. These changes, which may conflict with state statutes (see section E, below) and are subject only to federal restrictions, may include:

1. Requiring cost sharing from program benefit recipients up to the maximum allowed by federal law or a waiver of federal law.
2. Allowing providers to deny care or services if an enrollee is unable to share costs.
3. Modifying existing benefits or establishing different benefit packages for different recipients.
4. Revising provider reimbursement models for particular services.
5. Mandating that program benefit recipients enroll in managed care.
6. Restricting or eliminating presumptive eligibility.
7. Imposing restrictions on providing benefits for non-citizens.
8. Setting standards for establishing and verifying eligibility requirements.
9. Developing methods to assure accurate eligibility determinations and renewals.
10. Reducing 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 policies adopted by DHS may conflict with and supersede the state statutes relating to Medicaid and BadgerCare Plus.

E. Preempting Existing Statutes – Without Public Involvement

The budget bill amends the statutes in at least 24 places to permit the new policies adopted by the department to conflict with those statutes. In general, these provisions allow the department's policy-making 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 new policies 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 the revised budget bill 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.

Appendix 1 compares the Medicaid policymaking changes in the final budget bill with those that were in Act 10. The biggest difference is that the budget bill deletes the requirement that the policy changes that conflict with state statutes must be promulgated as rules. That change eliminates public hearings and also could minimize public notification of important policy changes. The nonpartisan attorney in the Legislative Reference Bureau who drafted the Medicaid portions of the bill cautions that *“there is no requirement for publication of whatever changes DHS makes to the program, including changes in benefits and eligibility for Medical Assistance Programs. This creates a practical problem, and I have not researched whether there are any constitutional issues arising from the lack of notice or access to information.”*

F. Joint Finance Committee’s Passive Review of Proposed Policy Changes

The rulemaking requirement in Act 10 would have yielded a modest degree of legislative involvement because rules get referred to a standing committee in each house of the Legislature for review. That would have allowed legislators on the health care committees to have a small role in the approval of policy changes that supersede the statutes. However, that role would be removed by the biennial budget bill, since it eliminates the rulemaking requirement.

The amended version of the biennial budget contrasts with Act 10 by substituting a different type of legislative oversight. It provides that before implementing a policy that conflicts with a statute and prior to applying to the federal government to make that change, DHS must submit the plan to the Joint Finance Committee for a 14 day passive review. This would provide a small degree of legislative involvement, though only 16 of the legislature’s 132 members would have a role. Also, it should be noted the Finance Committee doesn’t generally have as much expertise in health care issues as the health committees, and it’s the most lopsided committee in the Legislature from a partisan perspective (currently 12 Republicans and 4 Democrats).

G. Redeterminations of Eligibility

Like Act 10, the revised budget bill allows the state to review the eligibility of enrollees more frequently than is now the practice.

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 this part of the bill 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.

It appears that this portion of the budget bill would allow DHS to end 12-months continuous eligibility for infants and pregnant women.

H. Cost Savings

The Legislature’s version of the budget bill, like the Governor’s proposal, includes what the Fiscal Bureau refers to as “unspecified cuts” to medical assistance, totaling about \$467 million (in combined state and federal spending). That figure reflects the savings that the bill assumes DHS will achieve with the broad latitude it is being granted to rewrite Medicaid policy.

Although we don’t know specifically how DHS will achieve that level of cuts (and nothing in the bill or Act 10 would stop the agency from cutting more), the department has provided a general description of the types of changes it intends to pursue, including: enrolling more MA recipients in the benchmark plan, increasing cost-sharing requirements, increasing the frequency of reviews of eligibility, and seeking to require certain groups of individuals to enroll in other available plans prior to enrolling in MA. We might not get a better idea of how spending will be cut until DHS develops the plan required by the revised budget bill and submits to the Joint Finance Committee (for the passive review process) any proposals that conflict with state statutes.

I. Conclusion

The recently passed budget bill delegates sweeping power to the Department of Health Services to make changes relating to Medicaid and BadgerCare Plus eligibility, services, cost-sharing, and enrollment procedures. 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.

The only limits on the department’s options for rewriting the state’s public health care benefits are federal restrictions, and the bill requires DHS to seek a waiver exempting the state from the federal constraints.

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 for the budget repair bill 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 budget repair bill (Act 10) would have addressed one of those problems by requiring DHS to use the usual rulemaking procedure, rather than the proposed emergency rule option initially recommended by the Governor. However, the amended biennial budget bill eliminates the rulemaking requirement and gives the DHS Secretary unprecedented authority to make policy changes that supersede state statutes without so much as a public hearing.

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. Legislators, DHS and the Governor should continue to work together to protect BadgerCare and should actively involve the public – with a goal of finding cost-savings and efficiencies that don't cause an increase in the uninsured and in the cost-shifting that results from an increase in uncompensated care.

Jon Peacock, research director

Appendix 1: Comparison of Medicaid Policymaking Changes in Act 10 and the Biennial Budget Bill

Thanks to the Supreme Court’s June 14th ruling, Act 10 is now taking effect and grants the Department of Health Services (DHS) sweeping power to change Medicaid and BadgerCare policies – even if the policy changes conflict with state statutes. However, after the Governor signs the biennial budget bill and it becomes law, the Medicaid policymaking changes that Act 10 created will be repealed, and similar provisions in the budget bill will take effect.

The table below compares the Medicaid decision-making authority granted to DHS by Act 10 with the provisions of the biennial budget bill. In most respects the two pieces of legislation are the same, but one extremely important difference is that Act 10 requires DHS policy changes conflicting with the statutes to be made by rule, which would provide public notice, public hearings and citizen involvement in the process. The budget bill would eliminate the rulemaking requirement in Act 10, thereby eliminating the only opportunity for a public hearing and testimony.

The other difference is in the role of legislators in the process. Under Act 10, members of the health committee in each house would have had a chance to review the DHS rules described above. The budget bill repeals that rulemaking process and adds a requirement that policies conflicting with the statutes be submitted to the Joint Finance Committee (JFC) before DHS seeks federal approval for such changes. If the JFC notifies DHS within 14 days that it is scheduling a meeting, the proposal can only be submitted for federal review after it has been approved by the committee.

Provision	Act 10	Amended Budget Bill
Transfer legislative authority for changes to Medicaid to DHS, until January 2015.	Yes	Yes
Require a vote of the entire legislature when policy changes conflict with state statutes.	No	No
Require rule-making when policy changes conflict with state statutes.	Yes	No -- repeals the rulemaking requirement in Act 10
Provide opportunity for legislative oversight by health committees.	Yes – proposed rules would be referred to a standing committee in each house for review.	No
Provide opportunity for oversight by Joint Finance Committee when policy changes conflict with state statutes.	No – instead requires rule-making process for changes superseding state statutes	Yes – Joint Finance 14 day passive review process
Provide public hearings on policy changes conflicting with state statutes.	Yes	No
Direct DHS to seek waivers that allow the state to make changes that conflict with federal law, including a waiver of “Maintenance of Eligibility” (MOE) requirements.	Yes	Yes
Require DHS to reduce eligibility of adults to 133% of the federal poverty level in July 2012 if DHS doesn’t get an MOE waiver by 12/31/11	Yes	Yes

Appendix 2: 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 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

	Until 6/30/11 ⁱ	7/1/11 – 12/31/13 ⁱⁱ	2014 or later
Children	Can’t change eligibility before 2019		
Pregnant women	Can’t change before 2014		MA coverage to 133% required, above that it’s optional ⁱⁱⁱ
People with disabilities			
Parents/caretakers	Can’t change	Could lower the income ceiling to 133% of FPL	
Childless adults over 133% of federal poverty level (FPL)	Could eliminate, ^{iv} but the state must still meet the cost neutrality requirement		
Childless adults up to 133% of FPL	Can’t change ^v		
Childless adults in BC+ Basic	This isn’t part of Medicaid, so they aren’t protected by federal law.		

**Appendix 3 – 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.