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Medical Assistance Cost-to-Continue Estimate (Health Services -- Medical Assistance -- Eligibility and Benefits)

[LFB 2023-25 Budget Summary: Page 233, #2]

CURRENT LAW

The medical assistance (MA) program, also known as "Medicaid," provides health care coverage to adults and children in families with household income below certain levels, and to elderly, blind or disabled individuals who have limited resources. Certified healthcare providers provide a wide range of services to program recipients. The Department of Health Services (DHS) administers the program under a framework of state and federal law through a state plan approved by the federal Centers for Medicare and Medicaid Services (CMS), and several federal waiver agreements.

The program has two primary components -- elderly, blind, and disabled (EBD) Medicaid and BadgerCare Plus. EBD Medicaid provides coverage to individuals who are elderly, blind, or disabled who meet the program's income and asset standards. Individuals may receive services provided under the state's long-term care waiver programs, such as Family Care and IRIS (Include, Respect, I Self-Direct), as well as acute care services, including physician services, prescription drugs, and inpatient and outpatient hospital services. Many individuals enrolled in EBD Medicaid also qualify for Medicare benefits. For these "dual eligible" individuals, the state's MA program pays for services not otherwise covered under Medicare, as well as Medicare's cost-sharing requirements.

BadgerCare Plus provides coverage to individuals and families that meet the program's income standards. In general, children and pregnant women in households with income up to 300% of the federal poverty level (FPL), and non-pregnant, non-disabled adults in households with income up to 100% of the FPL, qualify for Badger Care Plus. Enrollees primarily receive acute

care services, such as hospital and physician services, prescription drugs, and maternity and prenatal care coverage.

MA also provides full benefit coverage to other individuals based on categorical status, rather than level of income or assets, or disability status. The largest group of individuals who are categorically eligible for Medicaid include individuals who qualify for benefits under the federal supplemental security income (SSI) program. Other categorically eligible groups include foster children and children for whom subsidized adoption assistance agreements are in effect. Under the well woman program, MA provides full coverage to woman who have been diagnosed with breast or cervical cancer and do not have other insurance.

Finally, MA has subcomponents that provide partial benefits, including Medicare cost sharing assistance (for individuals with limited assets and income who are Medicare eligible but do not meet the income and asset criteria for full MA benefits), family planning only services, emergency services only, and tuberculosis coverage.

MA benefits are funded from the following sources: (a) state general purpose revenue (GPR); (b) federal matching funds (FED); (c) program revenues (PR), primarily rebate revenue provided by drug manufacturers; and (d) segregated revenues (SEG), primarily from the MA trust fund.

DISCUSSION POINTS

1. The MA "cost-to-continue" estimate establishes the program's budget for the upcoming biennium under a scenario in which no changes are made to program benefits, eligibility, or provider reimbursement rates. The estimate is based on assumptions for dozens of parameters, but these assumptions generally fall into a few key categories: (a) average monthly enrollment for each of the MA eligibility groups; (b) utilization and cost of services provided on a fee-for-service basis; (c) managed care capitation rates; (d) enrollment in long-term care programs, such as Family Care and IRIS; and (d) federal policy and formula changes, including changes to the federal matching percentage and Medicare premiums for dually-eligible MA members.

2. Table 1 shows the funding change to the appropriation base, by fund source, under the cost-to-continue estimate included in AB 43/SB 70.

TABLE 1

Medical Assistance Cost-to-Continue Change to Base, AB 43/SB 70

Fund	2023-24	2024-25	Biennium
GPR	$119,124,000	$261,743,800	$380,867,800
FED	633,051,500	443,601,100	1,076,652,600
PR	46,004,200	-59,598,400	-13,594,200
SEG	281,844,100	-14,270,500	267,573,600
TOTAL	$1,080,023,800	$631,476,000	$1,711,499,800

3. This paper presents a cost-to-continue reestimate for the 2023-25 biennium. The reestimate is generally based on updated data and projections from the Department of Health Services, but makes certain modifications to the Department's assumptions. The revisions to the cost-to-continue estimate assumptions discussed in this paper result in an decrease of $26.7 million to the GPR funding for MA benefits over the biennium, and a total decrease of $14.5 million from all fund all sources over the biennium, relative to the AB 43/SB 70 estimates. Relative to the MA base, GPR funding for MA would increase by $354.2 million GPR over the biennium and by $1,697.0 million from all fund sources. Table 2 shows the funding adjustments made under the resulting cost-to-continue reestimate, expressed both as a change to the appropriation base and a change to the Administration's original estimate. Following the table is a description of the major contributing factors and assumptions for the cost-to-continue reestimate.

TABLE 2

MA Cost-to-Continue Reestimate, By Fund Source

	Change to Base			Change to AB 43/SB 70		
	2023-24	2024-25	Biennium	2023-24	2024-25	Biennium
GPR	$113,687,700	$240,502,500	$354,190,200	-$5,436,300	-$21,241,300	-$26,677,600
FED	618,648,900	326,565,800	945,214,700	-14,402,600	-117,035,300	-131,437,900
PR	82,458,000	38,064,300	120,522,300	36,453,800	97,662,700	134,116,500
SEG	298,691,500	-21,588,100	277,103,400	16,847,400	-7,317,600	9,529,800
Total	$1,113,486,100	$583,544,500	$1,697,030,600	$33,462,300	-$47,931,500	-$14,469,200

Medical Assistance Enrollment

4. Over the past three years, state Medicaid programs have been operating under a "continuous eligibility" policy, meaning that any person who was enrolled in the program as of March 18, 2020, or who later became eligible for coverage, could not be disenrolled even if changes to their household income, age, or household situation would have otherwise made them ineligible for

coverage. This policy, which was a condition of receiving enhanced federal matching rate under the federal Families First Coronavirus Response Act of 2020 (FFCRA), resulted in steady enrollment increases for all states over the past three years. To illustrate this impact on Wisconsin's Medical Assistance program, the following table shows a comparison of enrollment for the full benefit eligibility categories in January of 2020 and April of 2023.

TABLE 3

Enrollment Comparison by Full Benefit Category

Eligibility Category	January 2020	April 2023	Change
Elderly	32,783	40,979	8,196
Disabled	206,204	230,619	24,415
Children	446,325	590,451	144,126
Parents	158,055	251,936	93,881
Childless Adults	151,020	297,014	145,994
Pregnant Women	18,256	37,916	19,660
Foster Care/Subsidized Adoption	20,704	29,065	8,361
Other Full Benefit	988	957	-31
Well Woman MA	488	508	20
Total	1,034,823	1,479,445	444,622

5. The continuous eligibility policy ended on March 31, 2023, meaning that any person enrolling after that date has been subject to standard eligibility and disenrollment policies. For persons enrolled in the program prior to that date, eligibility will be redetermined on a rolling basis under a process that has come to be called "Medicaid unwinding." In preparation for the unwinding, DHS established a twelve-month eligibility redetermination schedule. However, although renewals are initiated mid-month on this 12-month schedule, since the renewal or coverage termination occurs 45 days after the renewal is initiated, the time between the first renewal notices being sent and the final renewals or terminations will extend for a total of about 14 months, from mid-April, 2023, to the end of May, 2024.

6. In general, the redetermination schedule was developed to distribute the workload for county and state eligibility determination staff over the 12-month unwinding period, as well as to maintain an even monthly renewal workload in future years. Although federal policies would have permitted the unwinding period to be completed in a shorter period of time, most states, like Wisconsin, have elected to use a 12-month unwinding timeline, largely due to the same or similar logistical considerations. According to a survey of state Medicaid agencies conducted by the Kaiser Family Foundation, 43 states are using a 12-month schedule.

7. For the purpose of scheduling redeterminations, DHS grouped individuals so that all members of a household will be reviewed at the same time. In addition, for individuals who are enrolled in other programs, such as FoodShare, the eligibility reviews for all programs were scheduled to coincide to reduce the need to undergo repeated application processes. Finally, the Department

considered the length of time since the most recent coverage renewal. In general, about 68,000 to 72,000 households are scheduled for eligibility redetermination in each month.

8. There is considerable uncertainty about what proportion of currently enrolled individuals will be disenrolled during the unwinding period, in large part because there is no precedent for the current situation, or even a comparable period in the program's history. According to the Kaiser Family Foundation survey cited earlier, state estimates of the rate of disenrollment range from 7% to 33% (as a percentage of the total Medicaid population). The U.S. Department of Health and Human Services' (DHHS) Office of Health Policy has estimated that 17.4% of all enrollees would be disenrolled, although this represents a national-level estimate that may not reflect individual states' experiences.

9. The rate of disenrollment will be affected, in part, by the number of individuals who lose eligibility for administrative reasons, rather than for reasons of program eligibility. An administrative disenrollment occurs when coverage is terminated--for a person who would otherwise meet eligibility criteria--due to a failure to correctly complete the application process by the deadline. Although DHHS is encouraging (or, in some cases, requiring) that states adopt measures to limit unintentional disenrollment, the Office of Health Policy estimates that 45% of all disenrollments will be for administrative, rather than eligibility, reasons.

10. Complicating the overall caseload estimates further, the regular process of enrollment and subsequent disenrollment of new enrollees (including due to births, deaths, and moves in and out of the state) will proceed as normal, which could either add to or subtract from the number of individuals who are disenrolled at the time of their unwinding redetermination. This may be affected by changes in economic conditions, particularly the unemployment and underemployment rates.

11. Under the assumptions used for the Administration's cost-to-continue estimate for AB 43/SB 70, total enrollment would decline by 27% from the beginning to the end of the unwinding period. However, the rate of decrease would vary by subgroup, from 46% for childless adults, 36% for parents, 24% for children, and 2% for enrollees in the EBD groups. By the end of the biennium, the Administration projects that the number of children, parents, and pregnant women will be at, or close to, the number who were enrolled in these categories in March of 2020. The number of childless adults is projected to be about 5% higher and the number of elderly and disabled beneficiaries will be 3% higher than in March of 2020, reflecting the net effect of unwinding disenrollment and the underlying enrollment trends.

12. The Administration's assumptions regarding enrollment in EBD Medicaid are based on the assumption that growth in the elderly and disabled enrollee categories will continue at a rate that is similar to recent years, largely mirroring growth rates in the state's elderly population. Since enrollment in EBD categories was not as affected by continuous eligibility policies as for the BadgerCare Plus groups, the unwinding process will not be as significant of a factor in determining EBD enrollment. Enrollment in elderly and disabled adults and children will decline slightly during the first year, before continuing a more typical growth pattern. Although these estimates are, by their nature, somewhat uncertain, the cost-to-continue estimate presented in this paper retains these assumptions for the EBD caseload.

13. The Administration's assumptions regarding BadgerCare Plus enrollment generally reflect the expectation that caseloads will mostly return to the levels that prevailed prior to the implementation of the continuous eligibility policy in early 2020. This would be consistent with an expectation that the economic indicators that are correlated with BadgerCare Plus enrollment, such as the household poverty rate, will not be substantially different during the biennium than they were prior to 2020. However, the enrollment projections used for the reestimate presented in this paper use a slightly lower rate of disenrollment for nonelderly adults during unwinding. This is largely to account for the possibility of coverage extensions granted for certain parents and children under current law transitional medical assistance provisions, as well as for the possibility that a higher proportion of childless adults who are eligible for coverage will remain enrolled during unwinding due to efforts to limit administrative disenrollments. Table 4 shows average monthly enrollment projections by eligibility category for the 2023-25 biennium, as well as actual and projected enrollments for 2021-22 and 2022-23.

TABLE 4

Actual and Projected Monthly Average Enrollment by Group, Cost-to-Continue Reestimate

	Actual	Projected	Estimates	
	2021-22	2022-23	2023-24	2024-25
Elderly, Blind, Disabled MA				
Elderly	84,089	88,015	87,268	87,502
Non-Elderly Disabled Adults	151,437	153,460	153,571	153,755
Disabled Children	34,741	35,893	35,805	35,834
EBD Total	270,266	277,368	276,645	277,092
BadgerCare Plus				
Children	553,511	583,790	581,419	493,102
Parents	224,548	245,079	236,494	184,982
Childless Adults	257,860	286,213	221,016	179,069
Pregnant Women	32,545	36,642	25,962	19,078
BadgerCare Plus Total	1,068,464	1,151,724	1,064,891	876,231
Other Full Benefit				
Foster Care/Subsidized Adoption	25,616	27,533	23,926	21,765
Well Woman	518	540	502	479
Total Full Benefit	1,364,864	1,457,165	1,365,964	1,175,567
Limited Benefit Groups				
Family Planning Only	45,649	49,017	41,434	36,407
Medicare Cost Sharing	16,244	15,589	16,212	16,663
Total Enrollment	1,426,757	1,521,771	1,423,610	1,228,637

Long-Term Care Programs

14. In addition to overall caseload projections, the cost-to-continue estimate takes into consideration enrollment and cost trends in MA's long term care programs, such as Family Care and IRIS, as well as nursing home utilization by individuals not enrolled in Family Care. Collectively,

although these programs typically account for around 8% of total MA enrollment, they typically account for around 40% of MA costs, and so trends in these program can have a significant bearing on the cost-to-continue estimate.

15. The reestimate as described in this paper adopts the Department's assumptions regarding enrollment in both Family Care and IRIS. Specifically, DHS estimates that average monthly enrollment in Family Care will be approximately 53,100 in 2022-23 (a 2.8% increase from 2021-22 enrollment), and increase to approximately 54,300 in 2023-24 and 55,600 in 2024-25 (increases of 2.3% and 2.4% over the prior year, respectively). For IRIS, the Department estimates that average monthly enrollment will be approximately 25,100 in 2022-23 (a 6.4% increase from 2021-22 enrollment), and increase to approximately 26,900 in 2023-24 and 28,700 in 2024-25 (increases of 7.2% and 6.7%, respectively). Both of these assumptions appear consistent with recent enrollment trends, when considering the elimination of the waiting list for adults eligible for long-term care services in the spring of 2021.

16. The Department indicates the Medicaid program has experienced a long-term trend of declining nursing home utilization, driven by two underlying factors: (1) a reduction in the total number of individuals using nursing home services over time; and (2) a decrease in the average length of a nursing home stay. Specifically, DHS projects that the monthly average census of Medicaid fee-for-service nursing home residents will decline from around 6,530 in 2022-23 to 5,950 by 2023-24 and 5,400 by 2024-25. As such, total fee-for-service patient bed days are anticipated to decline by approximately 9% annually.

17. Prior to the 2021-23 biennium, DHS estimated that 17% of nursing home patient days were attributable to managed care. However, that trend has been updated, based on the decrease in fee-for-service patient days and the increase in long-term managed care enrollment, resulting in an associated increase in nursing home services utilization under managed care. As such, it is estimated that 50.2% of nursing home patient days are attributable to managed care annually in 2023-25. The reestimate as described in this paper adopts the Department's assumptions regarding nursing home utilization in the 2023-25 biennium.

18. It is expected that approximately 19,800 children will be enrolled in the children's long term support (CLTS) waiver program by the end of 2022-23. However, on average, only 89% of CLTS enrollees are estimated to experience monthly program costs, an average of 16,300 per month in 2022-23. The administration's cost-to-continue estimate assumes that enrollment in the program will increase to 21,200 by June, 2024, and 21,700 by June, 2025 (of which 19,600 and 20,500, respectively, will experience monthly program costs).

19. Like in previous biennia, the Department's assumptions include funding sufficient to cover the full cost of CLTS services without maintenance of a waiting list. It is currently projected CLTS will experience average monthly enrollment growth of 150 individuals per month in 2023-24 and 75 individuals per month in 2024-25, and that the share of monthly enrollees with costs in the program will grow from an average of 91% per month in 2023-24 to 93% per month in 2024-25.

Home and Community-Based Services Enhancement Plan

20. A provision of the American Rescue Plan Act included federal incentives for states to improve their home and community-based services programs (HCBS) for elderly and disabled individuals. Under the provision, states received a 10.0 percentage point increase in their standard federal matching percentage for base HCBS expenditures during a 12-month period from April 1, 2021 to March 31, 2022. States are required to spend the state savings resulting from the enhanced federal matching rate to improve HCBS programs over a two-year period, from April 1, 2022, through March 31, 2024 (subsequently extended to March 31, 2025). States were required to submit a plan to the Centers for Medicare and Medicaid Services (CMS) with an expenditure plan for HCBS enhancements. For Wisconsin, the enhanced federal matching percentage resulted in state savings of $405.5 million.

21. Under Wisconsin's expenditure plan, the Department currently estimates that $101.9 million of this savings will be spent for HCBS initiatives in the 2021-23 biennium, leaving $303.6 million for expenditure through March 31, 2025. The Department intends to leave an unexpended surplus in the MA trust fund of $303.6 million at the end of the 2021-23 biennium, in order to carry over the funding needed for the remaining plan expenditures into the 2023-25 biennium. The Administration's cost-to-continue estimate includes the anticipated HCBS plan expenditures in the overall calculation of MA funding needs for 2023-24, which results in the carry-over funds being appropriated as SEG in the program. In addition to this SEG funding increase, the cost-to-continue item includes a FED increase of $191.2 million in 2023-24, to reflect the matching funds for the portion of HCBS plan expenditures that are eligible for federal financial participation. In total, this HCBS plan spending accounts for 29% of the biennial appropriation increase in the cost-to-continue reestimate.

HMO Capitation Rates and Payments

22. The Administration's cost-to-continue estimate assumed 2.0% annual increases to the 2024 and 2025 calendar year capitation rates for BadgerCare Plus and SSI HMOs, which is consistent with capitation estimates developed for prior biennial budgets. The reestimate presented in this paper retains those assumptions as a reasonable approximation of HMO and MCO costs. Actual capitation rates are established each year based on service utilization data submitted by HMOs.

23. Although it is assumed that HMO capitation rates will increase by 2.0% annually from 2023 levels, these rates will still be at or below capitation rates paid in 2022, because capitation rates decreased in 2023, from the 2022 rates. For BadgerCare Plus standard (parents and children), HMO monthly capitation rates declined by an average of 3.5%, for childless adults, the rates decreased by an average of 11.6%, and for SSI HMOs, the capitation rates declined by 3.2%. These decreases can be attributed, in large part, to lower average acuity levels (better health and lower service utilization) as enrollment has expanded with the continuous eligibility policy. That is, in comparison with HMO enrollees prior to 2020, the program currently enrolls more individuals with lower health care needs. In addition, enrollees are more likely to have other sources of coverage, such as employer-sponsored plans, which are billed for services instead of MA, further reducing average MA costs. As enrollment decreases during the unwinding period, the average cost can be expected to increase again, as the health care needs of those remaining in the program will be higher, and the likelihood of beneficiaries

have other insurance coverage is lower. This will eventually put upward pressure on capitation rates. However, since the unwinding process will be gradual, and there is some time lag in the data used to set capitation rates, the 2.0% annual growth rate remains a reasonable estimate for these rates for the 2023-25 biennium.

24. Beginning with the 2021 plan year, the Department has included risk corridor payment and recoupment provisions in HMO and long-term care managed care organization (MCO) contracts, in part to account for increased uncertainties regarding service utilization during the COVID-19 pandemic and the enrollment changes brought on by the continuous eligibility policy. Under these risk corridor provisions, HMOs and MCOs are required to make payments back to the program if the sum of their payments for contract services exceeds their total capitation revenues by a certain percentage. Conversely, HMOs and MCOs are entitled to receive an additional payment from the program if they suffer losses (contract payments in excess of capitation revenue) that exceed certain specified percentages. For the 2021 contracts, HMOs and MCOs experienced surplus revenue, in aggregate, and so will be required to make payments back to the program under the risk corridor provisions. These payments, which are expected to occur in the fall of 2023, have not been finalized, but the Department estimates that they will total approximately $182.0 million. The Administration's cost-to-continue estimate reflects the impact of these risk corridor recoupment payments in 2023-24, which reduces the amount needed for HMO and MCO payments in that year by $182.0 million, ($70.0 million GPR and $112.0 million FED).

25. The Administration's cost-to-continue estimate does not include any risk corridor recoupment payments for the 2022 plan year, since it is too early to determine whether the HMOs and MCOs realized surpluses of a sufficient magnitude to trigger payments. Nevertheless, there are at least some preliminary indications that 2022 was profitable for the MA HMOs and MCOs, although possibly not as profitable as 2021. Some of the circumstances that lead to lower 2023 capitation payments--lower average acuity and higher proportion of alternative coverage associated with the expanded enrollment--continued throughout 2022. On the other hand, these favorable conditions may have been somewhat offset by rebounding service utilization, following a year in which COVID-19 restrictions suppressed some types of service usage.

26. On balance, it is reasonable to assume some recoupments for the 2022 plan year, payable in 2024-25. For the purposes of the reestimate presented in this paper, it is assumed that recoupments will be one-third of the estimate for 2021, as a percentage of total capitation payments. These payments would offset HMO and MCO payments by an estimated $69.4 million ($27.3 million GPR and $42.1 million FED).

Fee-For-Service Utilization

27. For servicers delivered on a fee-for-service (FFS) basis, the cost-to-continue estimate typically relies on recent trends in claims data by service category and eligibility group to estimate service utilization for the upcoming biennium. For most FFS categories, the estimate projects costs on a per member-per month basis, and inflates or deflates those amounts based on recent trends. The FFS categories that are estimated in this way and that have the greatest impact on the overall cost-to-continue estimate are typically prescription drugs, inpatient hospital services, and personal care services.

28. The estimate presented in this paper uses updated information from the Department of Health Services for FFS utilization. In general, the reestimate for many categories is lower than the projections used for AB 43/SB 70, due to revised estimates of the baseline expenditures for 2022-23. For the same reason that HMO capitation rates were lowered in 2023, FFS utilization is now projected to be somewhat lower in some of the major service categories in 2022-23 than earlier projections due to a caseload that is, on average, healthier than in the past.

Federal Medicare Premiums and Part D Clawback

29. MA pays the Medicare Part A and Part B premiums and, in some cases, deductibles and coinsurance for certain enrollees who are dually-eligible for Medicaid and Medicare. The Administration's cost-to-continue estimate was based on projections for these premiums for 2024 and 2025 included in the 2022 annual report of the Medicare Board of Trustees. The number of dually-eligible beneficiaries eligible for Part A premium payments is expected to remain relatively constant throughout the biennium, at approximately 7,200 per month, while the number eligible for Part B premium payments is projected at about 139,000 per month. The reestimate presented in this paper accepts the Administration's estimates of the dually eligible beneficiaries eligible for Part A and Part B premiums, but uses updated premium projections from the 2023 Medicare Trustees report, which are slightly lower than the 2022 projections. Total Part A and Part B premium payments are estimated at $330.3 million ($127.1 GPR and $203.2 million FED) in 2023-24 and $348.6 million ($137.0 million GPR and $211.5 million FED) in 2024-25.

30. Since 2006, state Medicaid programs have been required to make a payment each year to fund a portion of the costs of the federal Medicare Part D program, in recognition that Part D results in state Medicaid program savings on drugs for dually-eligible enrollees. The amount of this "clawback" payment is based on a formula that is intended to equal 75% of each state's estimated savings. Year-to-year payments change based on the number of dually-eligible MA beneficiaries, the change in per capita drug spending under Part D, and the state's FMAP. The reestimate in this paper updates the Administration's estimate of dually-eligible enrollees, but updates the estimate using the most recent projections of changes to per capita drug costs included in the 2023 Medicare Trustees report. Total clawback payments are estimated at $357.9 million GPR in 2023-24 and $405.7 million GPR in 2024-25.

Federal Medical Assistance Percentage (FMAP)

31. The FMAP determines the federal matching rate for Medicaid benefit expenditures. The FMAP formula is based on the state's per capita personal income in relation to the national average. Historically, Wisconsin's FMAP has typically ranged between 58% to 62%, although it was increased by 6.2 percentage points during the past three years, under provisions of the federal Families First Coronavirus Response Act (FFCRA). That enhanced rate is now being phased down over the course of calendar year 2023, returning to the standard formula, beginning in 2024. Under the phase-out schedule, states receive a 5.0 point increase in the second quarter of 2023 (April 1 to June 30), a 2.5 point increase in the third quarter, and a 1.5 point increase in the fourth quarter.

32. Table 5 below shows the actual and projected FMAP rates applicable to MA benefit expenditures in each fiscal year from 2022-23 through 2024-25. The rates shown for 2024-25 have

been decreased slightly from the Administration's cost-to-continue estimate, reflecting the most recent projections. As shown in the table, the FMAP is projected to decline from 2022-23 through the end of the biennium, reflecting the phase-out of the enhanced rate received under FFCRA. In addition to the FMAP for regular Medicaid (Title 19 of the federal Social Security Act), the table also shows the higher rate applicable to expenditures for children eligible under the Children's Health Insurance Plan (CHIP or Title 21).

TABLE 5

Federal Medical Assistance Percentage (FMAP) Rates
By State Fiscal Year

State Fiscal Year	Title 19 (Most MA Services)	Title 21 (Children's Health Insurance Plan)
2022-23		
State	34.06%	23.84%
Federal	65.95	76.16
2023-24		
State	38.48%	26.94%
Federal	61.52	73.06
2024-25		
State	39.31%	27.52%
Federal	60.69	72.48

33. Although the state's FMAP will be lower in the 2023-25 biennium without the enhanced formula, in comparison to the 2021-23 biennium, this does not significantly impact the cost-to-continue adjustment to GPR appropriations. This is because the 2021-23 budget for MA was established with the expectation that the enhanced rate would already have expired by 2022-23. Thus, the current appropriation base for MA reflects the assumption that the FMAP would be 60.32% in that year under the standard formula. In comparison to that rate, the current FMAP projections for the two state fiscal years of the 2023-25 biennium (61.52% and 60.69%) are actually somewhat higher. Consequently, in isolation, the FMAP has a slight negative effect on GPR appropriation adjustments, relative to the GPR appropriation base for the program.

Medical Assistance Trust Fund Revenue

34. The medical assistance trust fund (MATF) is a segregated fund used for the nonfederal share of MA benefits, offsetting an equal amount of GPR. In a typical biennium, most revenues to the trust fund are collected from provider assessments, such as the nursing home bed assessment and the hospital assessment (although, in that case, indirectly through a transfer from the hospital assessment fund). The 2021-23 budget included two changes to MATF revenues that are notable. First, MATF revenues included transfers from the general fund of $174,665,900 in 2021-22 and $527,783,700 in 2022-23. Second, all revenues received by the state under terms of the Master Tobacco Settlement

and deposited in the permanent endowment fund are annually transferred to the MATF. Previously, the MATF received $50,000,000 annually from permanent endowment fund, but the remaining revenues in that fund were deposited in the general fund.

35. The transfers from the general fund and the increase in the transfer from permanent endowment fund result in higher SEG appropriations for MA, and an equivalent reduction in GPR appropriations and available general fund revenues. Because the reduction in GPR appropriations is equal to the reduction general fund revenues, these changes have no net change to the use of general fund resources for the program.

36. The MATF transfer measures were included in the 2021-23 budget act as part of an initiative to reduce statewide GPR expenditures as a means to reduce the state's obligations under a federal maintenance of effort provision for state education spending. Those maintenance of effort provisions no longer apply for the 2023-25 biennium.

37. Recognizing that the maintenance of effort provision would only apply for the 2021-23 biennium, the transfer from the general fund to the MATF was made on nonrecurring basis. For the 2023-25 budget, therefore, the SEG and GPR changes that were made in the appropriation base as a part of this transfer provision are reversed. However, the change to the permanent endowment fund was an ongoing change.

38. The 2021-23 budget change to the permanent endowment fund transfer has introduced a source of uncertainty into the MA cost-to-continue estimate that was not there previously. Most sources of MATF revenues are fixed or can be estimated with reasonable certainty. Thus, prior to the permanent endowment fund change, the SEG appropriation from the MATF, which is sum certain, could be established by the budget to match expected revenues. Tobacco settlement payments, however, are not known with as much certainty as the traditional MATF revenues, since they can vary based on tobacco sales, the receipt of disputed payments from prior years, and other factors.

39. To illustrate the uncertainty of tobacco settlement payments, the 2021-23 budget assumed that the amount of proceeds deposited in the MATF would be $97.3 million in 2021-22 and $103.6 million in 2022-23. However, in part because the state received disputed payments from prior years, the total amount received was $126.8 million in 2021-22 and $133.4 million in 2022-23. Furthermore, because the SEG appropriation is set to match MATF revenue estimates set during the budget, the program does not have authority to spend this additional MATF revenue received to offset GPR spending. Previously, since the amount of tobacco proceeds deposited in the MATF was fixed at $50,000,000 annually, the relative shares of SEG and GPR funding in the program could be known with greater certainty.

40. The cost-to-continue reestimate presented in this paper assumes that the state will receive $101,523,900 in 2023-24 and $95,817,200 in 2024-25, which is the same assumption used for the cost-to-continue estimate included in AB 43/SB 70. These estimates are developed by the National Association of Attorneys General.

41. In the event that the state receives tobacco settlement payments in excess of the amounts included in the cost-to-continue estimate (and all else being equal), the MA program will not be able

to spend this amount, and would instead spend more from the GPR appropriation for the program than would otherwise be the case. To reduce this source of uncertainty in the estimate, the Committee could consider returning to the previous policy of transferring $50,000,000 annually from the permanent endowment fund to the MATF annually, and depositing the remainder in the general fund. Relative to the cost-to-continue estimate, this would have no net effect on the general fund balance since it would increase general fund revenues by amounts equal to increases in the GPR appropriation MA ($51,523,900 in 2023-24 and $45,817,200 in 20024-25). The MATF SEG appropriation would be reduced by corresponding amounts. [Alternative B1]

Summary

42. The Medicaid program, in Wisconsin as well as nationally, will be undergoing significant enrollment changes during the 2023-25 biennium, as the program returns to normal operations following the COVID-19 public health emergency. Since the unwinding process is just now beginning, the caseload projections used for the cost-to-continue estimate are subject to a greater degree of uncertainty than is typically the case. Moreover, in addition to the magnitude of the enrollment changes, there is additional uncertainty related to how the unwinding process will change the average costs of those who remain enrolled.

43. With limited exceptions, the medical assistance program is required by state and federal law to pay for the cost of all medically necessary services for program enrollees. If the amount of funding provided in the biennial budget is insufficient to fund these costs, the Department's options to administratively reduce costs are somewhat limited. In the event of a budget shortfall in MA, the Committee or the full Legislature may be required to act, either by increasing the MA appropriations or making statutory program changes to reduce costs. For this reason, the cost-to-continue reestimate presented in this paper the estimate presented in this paper adopts an overall cautious approach that allows for the possibility that MA costs will increase above recent trends. However, the estimate cannot account for all contingencies, including a significant recession, which could result in deficit in the MA GPR appropriation.

44. In addition to adopting the cost-to-continue reestimate, as shown in the table under Part A of the alternatives, the Committee could consider changes to the treatment of permanent endowment fund transfers to the medical assistance trust fund under Part B.

ALTERNATIVES

A. MA Cost-to-Continue Reestimate

Adopt funding changes to the medical assistance appropriation base as shown in the following table.

Medical Assistance Cost-to-Continue Change to Base, Reestimate

Fund	2023-24	2024-25	Biennium
GPR	$113,687,700	$240,502,500	$354,190,200
FED	618,648,900	326,565,800	945,214,700
PR	82,458,000	38,064,300	120,522,300
SEG	298,691,500	-21,588,100	277,103,400
Total	$1,113,486,100	$583,544,500	$1,697,030,600

B. Transfer of Permanent Endowment Fund Revenue to the Medical Assistance Trust Fund

1. Specify that the amount to be transferred from the permanent endowment fund to the medical assistance trust fund shall be $50,000,000 in each fiscal year, and that any other amounts in the permanent endowment fund from tobacco settlement payments shall be transferred to the general fund in each fiscal year. Increase the GPR appropriation for MA benefits by $51,523,900 GPR in 2023-24 and $45,817,200 GPR in 20024-25 and increase estimated general fund revenues by corresponding amounts. Decrease the SEG appropriation from the medical assistance trust fund for MA benefits by $51,523,900 SEG in 2023-24 and $45,817,200 SEG in 20024-25 and decrease estimated trust fund revenues by corresponding amounts.

ALT B1	**Change to Base**	
	Revenue	Funding
GPR	$ 97,341,100	$ 97,341,100
SEG	-97,341,100	-97,341,100
Total	$0	$0

2. Take no action.

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