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December 2011

An Evaluation

Medical Assistance Program

Department of Health Services

2011-2012 Joint Legislative Audit Committee Members

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Response

From the Department of Health Services

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Joe Chrisman
State Auditor

December 20, 2011

Senator Robert Cowles and
Representative Samantha Kerkman, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Cowles and Representative Kerkman:

We have completed a review of the Department of Health Services' (DHS's) Medical Assistance program, as requested by the Joint Legislative Audit Committee. Total Medical Assistance expenditures increased from $5.0 billion in fiscal year (FY) 2006-07 to $7.5 billion in FY 2010-11, primarily because the number of recipients increased from 870,201 in January 2007 to 1.2 million in January 2011.

DHS has increasingly relied on vendors to provide administrative support to the program, and vendor payments increased from $66.2 million in FY 2006-07 to $114.8 million in FY 2010-11. DHS has not always adequately assessed costs before contracting with vendors, and its extensive reliance on vendors raises concerns about DHS's ability to provide adequate program oversight. We include recommendations for DHS to improve its contracting and oversight practices.

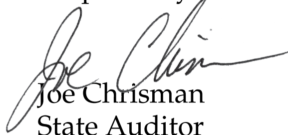
Most recipients receive services through subprograms, such as BadgerCare Plus, which are often provided through managed care arrangements. It is widely believed that providing services through such arrangements is cost-effective. However, an estimated $3.6 billion, or 51.2 percent of all Medical Assistance expenditures, were incurred on a fee-for-service basis in FY 2009-10. We include a recommendation for DHS to consider enrolling recipients in managed care plans more quickly.

DHS's budgeting and financial management practices have not kept pace with the growth and increasing complexity of the Medical Assistance program, and DHS has not been able to readily produce the type of management information that is desired by legislators and needed for effective management. For example, DHS does not include all Medical Assistance expenditures as part of the program's budget or record them as the program's expenditures. In addition, it neither budgets nor routinely accounts for expenditures on a subprogram basis, which is typically how legislators and others deliberate the program. We include recommendations for DHS to better account for all Medical Assistance expenditures and to budget and track these expenditures by subprogram.

The federal Patient Protection and Affordable Care Act will impact Medical Assistance funding and participation, but its overall effects are difficult to predict because many provisions of the Act will not become effective until 2014. We include a recommendation for DHS to report to the Joint Legislative Audit Committee by January 2013 when more will be known about the likely effects of the Act.

We appreciate the courtesy and cooperation extended to us by DHS, health care providers, and other groups in completing this evaluation. DHS's response follows the appendices.

Respectfully submitted,



Joe Chrisman
State Auditor

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Report Highlights ▪

Wisconsin's Medical Assistance recipients totaled 1.2 million in January 2011.

Medical Assistance expenditures increased from $5.0 billion in FY 2006-07 to $7.5 billion in FY 2010-11.

DHS paid vendors $411.9 million for administrative support services from FY 2006-07 through FY 2010-11.

From FY 2006-07 through FY 2010-11, at least 8,975 investigations of potential recipient fraud were conducted.

Additional efforts are needed to budget for and record Medical Assistance expenditures.

The Department of Health Services (DHS) administers the State's Medical Assistance program, which is also known as Medicaid. The program uses state and federal revenue to fund health care subprograms for individuals with low and moderate incomes. Periods of economic recession and the expansion of the types of individuals who are eligible to participate in the program have increased both program costs and the number of recipients. In fiscal year (FY) 2010-11, Medical Assistance expenditures totaled $7.5 billion.

Concerns had been raised about growth in program expenditures and the number of recipients; the quality, usefulness, and availability of management information; and the effects federal health care reforms may have on the program. Therefore, at the request of the Joint Legislative Audit Committee, we reviewed:

- trends in the number of Medical Assistance recipients, by subprogram;
- trends in program expenditures, by funding source, type, and subprogram;
- alternatives for providing services in a more cost-effective manner;
- how Wisconsin's Medical Assistance costs and benefits compare to those of other midwestern states, as well as how states have attempted to control these costs; and

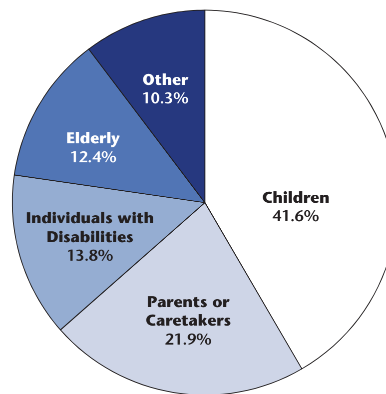
- the potential effects of changes in federal law on the provision of Medical Assistance-funded benefits.

Program Recipients

The total number of recipients in Wisconsin's Medical Assistance program increased from 870,201 in January 2007 to 1.2 million in January 2011. Children were the largest group of Medical Assistance recipients, as shown in Figure 1.

Figure 1

Medical Assistance Recipients, by Type
January 2011



DHS delivers Medical Assistance services through three primary arrangements: managed care, fee-for-service, and contracts with county governments. Most recipients receive services through managed care arrangements, including care provided by health maintenance organizations (HMOs). However, 445,425 recipients, or 37.7 percent of the total, received care exclusively on a fee-for-service basis in January 2011.

Program Expenditures

Total Medical Assistance expenditures increased from $5.0 billion in FY 2006-07 to $7.5 billion in FY 2010-11. However, 87.0 percent of this increase was funded with federal revenue. Expenditures of state funds increased from $2.1 billion to $2.4 billion during the same period.

The increase in expenditures is largely the result of an increase in the number of Medical Assistance recipients precipitated by the economic downturn and changes in state law that expanded eligibility by an estimated 100,000 recipients from FY 2006-07 through FY 2010-11. Increases in the rates paid to certain providers, such as inpatient hospitals and nursing homes, also contributed to the increase.

Based on limitations in the State's accounting systems, we spent a large portion of our audit effort compiling basic information on expenditures, participation, and service costs in a format that would be useful to legislators and other policymakers. We found that expenditures for acute and primary care subprograms, such as BadgerCare Plus, increased 75.4 percent from $916.1 million in FY 2006-07 to $1.6 billion in FY 2009-10. In addition, expenditures for long-term care subprograms, such as Family Care, increased 50.5 percent from $948.7 million in FY 2006-07 to $1.4 billion in FY 2009-10.

Administrative Services

DHS relies heavily on vendors to help it administer the Medical Assistance program. From FY 2006-07 through FY 2010-11, DHS paid vendors $411.9 million for administrative support services associated with the Medical Assistance program. We found that vendor oversight and contract monitoring could be improved. For example, DHS has not consistently ensured that adequate funding was available before authorizing additional contract work or that services were obtained at a competitive price.

The number of contract staff working on the Medical Assistance program for the single largest administrative service vendor increased from 598.5 full-time equivalent (FTE) positions in December 2008 to 1,127.5 FTE positions in June 2011. In contrast, DHS had 364.6 FTE positions performing Medical Assistance functions in June 2011. Vendor services will continue to be needed in the future, and it will be important for DHS to retain adequate flexibility in determining how administrative services are best provided. However, DHS's increasing reliance on vendors may also potentially hamper its ability both to effectively provide guidance to the large number of contracted staff and to maintain adequate administrative oversight.

Managing Service Delivery

Numerous studies completed nationally and in Wisconsin support the use and expansion of managed care in providing health care services, because the coordination of recipients' ongoing health care

needs can reduce unnecessary services and encourage the provision of preventative care.

Despite efforts to increase the use of managed care providers, we found that the Medical Assistance program still incurs significant fee-for-service expenditures, which totaled $3.6 billion in FY 2009-10. This includes $421.2 million in fee-for-service expenditures for care provided to 297,909 BadgerCare Plus recipients before their enrollment in an HMO. To further enhance the coordination of recipients' care, DHS could require these recipients to enroll in HMOs more quickly.

Confirming Eligibility

The reported number of investigations of potential recipient fraud declined from 2,166 in FY 2006-07 to 1,424 in FY 2010-11, largely because of a reduction in state funding for fraud investigation activities.

State law generally requires Medical Assistance recipients to be United States citizens and reside in Wisconsin. Lawfully admitted adults who have resided in the United States for less than five years and all other undocumented adult aliens are limited to receiving emergency services for life-threatening conditions or services related to a pregnancy. From FY 2006-07 through FY 2010-11, Medical Assistance services were provided to 1,225 of these individuals at a total cost of $10.7 million. We found that the services provided to them were appropriately limited to those related to emergencies and pregnancy.

Future Considerations

The State's budgeting and financial management practices have not kept pace with growth in the size and complexity of the Medical Assistance program. We found that DHS neither includes all Medical Assistance costs in its budget nor records them as the program's expenditures. In addition, DHS neither budgets nor routinely accounts for Medical Assistance expenditures on a subprogram basis. This type of information is crucial because subprograms, such as BadgerCare Plus, are often the focus of proposed programmatic changes.

DHS is attempting to reduce costs by $554.4 million during the 2011-13 biennium. In November 2011, the Joint Committee on Finance approved the portion of DHS's plan that required its approval, including proposals to save $119.6 million in general purpose revenue (GPR) through modifications to Medical Assistance eligibility rules, premiums, and benefits. DHS estimates these changes will eliminate

coverage for 42,200 current recipients; lead to the voluntary disenrollment of 22,500 individuals due to increased premiums; and reduce benefits for an additional 263,000 recipients. The effectiveness of DHS's current efforts to reduce Medical Assistance expenditures depends on the extent to which the federal government approves DHS's proposed eligibility rule modifications, as well as how implementation of the federal Patient Protection and Affordable Care Act will affect future costs and funding.

Recommendations

We recommend that DHS report to the Joint Legislative Audit Committee by July 2, 2012, on its efforts to:

- ☑ develop separate accounting codes for administrative expenditures for the Medical Assistance and FoodShare programs *(p. 36);*
- ☑ ensure it has adequate funding for contractual services before authorizing expenditures *(p. 36)*;
- ☑ use bids to solicit the most appropriate and effective administrative services at the most competitive price *(p. 36);*
- ☑ review existing contracted services to identify whether cost savings could be achieved by using state employees *(p. 36);*
- ☑ consider the potential benefits of enrolling recipients into HMOs in a more timely manner *(p. 45);*
- ☑ account for all Medical Assistance expenditures in determining total program costs *(p. 57);* and
- ☑ develop a more detailed biennial budget request and financial reporting structure to allow it to routinely budget and account for all Medical Assistance costs by subprogram *(p. 57).*

In addition, we recommend that DHS report to the Joint Legislative Audit Committee by January 14, 2013, on how implementation of the federal Patient Protection and Affordable Care Act will affect both participation and costs in Wisconsin's Medical Assistance program *(p. 69).*

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Introduction ■

Since 1965, states and the federal government have funded health care services for certain low-income individuals through the federal Medical Assistance program. The range of health care benefits available to recipients is comprehensive and includes both primary and long-term care services. Within parameters set by the federal government, states have flexibility in determining some of the services to be provided, as well as who is eligible to receive services based on income and asset levels. States may also require some recipients to make copayments or pay monthly premiums as a means of sharing program costs, and they may require recipients to comply with certain other requirements for continued eligibility, such as participating in periodic eligibility reviews with a case worker.

Federal law requires states to provide Medical Assistance coverage to certain individuals.

The federal government requires states to provide Medical Assistance coverage for specific groups of individuals, including:

- Supplemental Security Income (SSI) recipients;
- certain Medicare beneficiaries;
- individuals who meet the eligibility requirements for a state's Aid to Families with Dependent Children program in effect on July 16, 1996;
- children under age six and pregnant women with household incomes below 133 percent of the federal poverty level;

- all children born after September 30, 1983, who are under age 19 and have household incomes up to 100 percent of the federal poverty level; and
- recipients of adoption or foster care assistance under Title IV of the Social Security Act.

States may also extend coverage to additional groups, such as adults without dependent children, by receiving waivers of existing requirements from the federal government.

Recipients must be citizens or qualified aliens, Wisconsin residents, and have or apply for a Social Security number.

To be eligible for the Medical Assistance program, applicants must meet certain nonfinancial requirements, which include being a United States citizen or a qualified alien, a Wisconsin resident, and typically having or applying for a Social Security number. For certain long-term care programs, recipients must typically be 65 years of age or older or have a documented developmental or physical disability.

Applicants must also meet certain financial eligibility requirements, which vary based on the type of Medical Assistance benefits they are seeking or on their personal health conditions. For example, individuals who are elderly or disabled must typically have assets of no more than $2,000 and must meet certain monthly income limits, which can vary based on a variety of criteria, such as whether they are retired, unemployed, living with a spouse, or receiving federal Medicare benefits. For otherwise healthy children and adults who are seeking acute and primary care services, there is no asset limit and applicants may be eligible for Medical Assistance benefits based on income limits, which vary from 133 percent to 300 percent of the federal poverty level. For 2011, the annual income of a family of four at 133 percent of the federal poverty level is $29,726, or $2,477 per month.

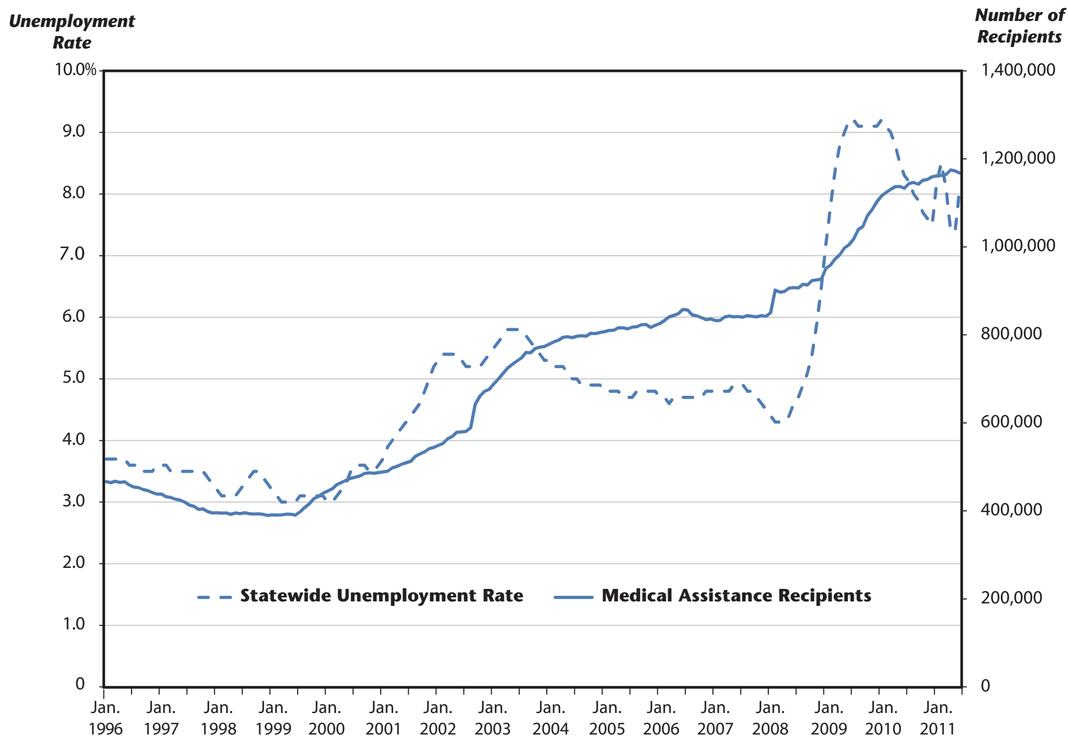
Federal law mandates specific services be provided to Medical Assistance recipients.

Federal law mandates specific services be provided to all Medical Assistance recipients, such as inpatient and outpatient hospital care, nursing home care, and physician services. In addition, federal law identifies additional services that states may provide with Medical Assistance funds at their discretion, such as prescription drugs, vision and dental services, and preventative and rehabilitative services. Appendix 1 provides additional information on mandatory and optional Medical Assistance services.

As shown in Figure 2, the number of individuals receiving Medical Assistance benefits in Wisconsin has increased substantially during the past 15 years, from 466,700 in January 1996 to almost 1.2 million in June 2011, or by more than 150 percent.

Figure 2

Number of Medical Assistance Recipients



Expansion of eligibility and periods of economic recession have increased the number of Medical Assistance recipients.

The increase in the number of recipients is largely the result of two factors: periods of economic recession and the passage of state legislation to expand eligibility, which increased the number of individuals qualified for benefits. Official measures of the nation's economic condition indicate two recent periods of economic recession: from March 2001 through November 2001 and from December 2007 through June 2009. Figure 2 indicates that the increases in Wisconsin's unemployment rate generally coincided with increases in the number of Medical Assistance recipients. What is less clear is why the number of recipients increased from January 2004 through January 2006 while the unemployment rate declined over this period.

Table 1 summarizes key legislation related to the Medical Assistance program. Notably, 2007 Wisconsin Act 20, the 2007-09 Biennial Budget Act, created the BadgerCare Plus subprogram, which expanded Medical Assistance-funded benefits for children, pregnant women, and families. It also authorized the creation of the BadgerCare Plus Core subprogram, which expanded eligibility to some adults without dependent children.

Table 1

Summary of Selected Legislation Related to the Medical Assistance Program

Legislation	Date Enacted	Description
2005 Wisconsin Act 25	July 2005	Expanded eligibility for prenatal care and child delivery services to certain immigrants and incarcerated women. Allowed an additional 500 children with autism to participate in the Children's Long-Term Supports subprogram.
2007 Wisconsin Act 20	October 2007	Expanded eligibility through creation of the BadgerCare Plus subprogram to include: ▪ full benefits for families and pregnant women whose household incomes do not exceed 200 percent of the federal poverty level; ▪ full benefits for adults aged 18 through 20 who were in out-of-home care when they reached 18 years of age; ▪ limited benefits for families and pregnant women whose household incomes are between 200 percent and 300 percent of the federal poverty level; and ▪ limited benefits for all children whose household incomes exceed 300 percent of the federal poverty level, if the entire benefit cost is paid by the family. Expanded eligibility through the creation of the BadgerCare Plus Core subprogram for adults without dependent children with incomes that do not exceed 200 percent of the federal poverty level. Authorized statewide expansion of the Family Care subprogram.
2009 Wisconsin Act 2	March 2009	Created a Hospital Assessment Fund to collect fees from hospitals to increase federal Medical Assistance matching funds. Funds are used to increase reimbursement rates paid to hospitals and fund other Medical Assistance costs.

Data systems and budgetary practices limit the availability of basic information needed to effectively manage and oversee the program.

In analyzing program expansion and other aspects of Medical Assistance funding, we found that DHS's electronic data systems, budgetary practices, and reporting procedures currently in place have typically not provided the type of management information desired by legislators to exercise program oversight or to facilitate effective management of a large, complex collection of health care subprograms by DHS. Therefore, we spent a large portion of our audit effort compiling basic information on expenditures, participation, and service costs in a form that would be more useful to legislators and other policymakers.

Program Recipients

Children and their parents or caretakers accounted for approximately 60 percent of all Medical Assistance recipients.

As shown in Table 2, children are the largest group of Medical Assistance recipients, followed by the parents or caretakers of children. Combined, these two categories represent approximately 60 percent of all Medical Assistance recipients in both January 2007 and January 2011. Childless adults, who were not eligible for Medical Assistance benefits until January 2009, represented 3.8 percent of all recipients in January 2011.

Table 2

Medical Assistance Recipients, by Type

	January 2007		January 2011	
Recipient Type	Number	Percentage	Number	Percentage
Children	353,139	40.6%	490,755	41.6%
Parents or Caretakers	157,144	18.1	258,917	21.9
Individuals with Disabilities	140,162	16.1	162,880	13.8
Elderly[1]	157,267	18.1	146,269	12.4
Childless Adults	–	–	45,039	3.8
Pregnant Women	11,164	1.3	20,788	1.8
Other[2]	51,325	5.9	56,381	4.8
Total	**870,201**	**100.0%**	**1,181,029**	**100.0%**

[1] Includes 102,759 SeniorCare recipients in January 2007 and 90,559 SeniorCare recipients in January 2011.

[2] Includes individuals who received limited benefits, such as those related to cancer screening and family planning.

Medical Assistance recipients are provided with services through one of 16 subprograms, which we grouped into three broad categories.

Eligible individuals are entitled to receive services related to their medically necessary acute, primary, and long-term care needs. Most individuals receive services through 1 of 16 Medical Assistance-funded subprograms. To better conceptualize the types and range of subprograms supported by Medical Assistance funds, we grouped them into three broad categories:

- acute and primary care subprograms, which provide hospital, clinic, and dental care, primarily to children, their parents or caretakers, and working adults;
- long-term care subprograms, which provide medical and behavioral care to elderly individuals and people with disabilities in their homes or in community-based settings; and
- limited-benefit subprograms, which provide selected services, such as prescription drugs.

Some recipients are not enrolled in a subprogram, such as elderly and disabled individuals who reside in nursing homes and other long-term care institutions. These individuals receive services on a fee-for-service basis, which are commonly referred to as "card services" because recipients typically access health care services using plastic cards issued to them.

The number of acute and primary care subprogram recipients increased by 57.0 percent from January 2007 to January 2011.

As shown in Table 3, the number of recipients in acute and primary care subprograms increased by 57.0 percent from January 2007 to January 2011, while the number in long-term care subprograms increased by 19.2 percent. Overall, the number of recipients in limited-benefit subprograms remained largely unchanged. Appendix 2 provides a profile of each Medical Assistance-funded subprogram.

Table 3

Medical Assistance Recipients, by Subprogram

	January 2007	January 2011	Percentage Change
Acute and Primary Care Subprograms			
BadgerCare Plus, Family Medical Assistance, and Healthy Start[1]	516,673	766,342	48.3%
BadgerCare Plus Core	–	45,039	–
SSI Managed Care	19,996	30,978	54.9
Subtotal	536,669	842,359	57.0
Long-Term Care Subprograms			
Family Care	10,336	31,461	204.4
Children's Long-Term Supports	2,277	4,583	101.3
Community Integration Program (CIP)	15,992	4,122	(74.2)
Family Care Partnership	2,313	3,619	56.5
Community Options Program (COP)	10,948	3,415	(68.8)
Include, Respect, I Self-Direct (IRIS)	–	3,057	–
Program for the All-Inclusive Care for the Elderly (PACE)	770	865	12.3
Brain Injury Waiver	336	92	(72.6)
Subtotal	42,972	51,214	19.2
Limited-Benefit Subprograms			
SeniorCare	102,759	90,559	(11.9)
Family Planning Waiver	54,432	59,345	9.0
Qualified Medicare Beneficiaries	8,287	15,382	85.6
Children Come First and Wraparound Milwaukee	692	997	44.1
Subtotal	166,170	166,283	0.1
Not in a Subprogram[2]	124,390	121,173	(2.6)
Total	**870,201**	**1,181,029**	35.7

[1] BadgerCare, Family Medical Assistance, and Healthy Start subprograms were merged to create the BadgerCare Plus subprogram in February 2008.

[2] Includes recipients who are not in a subprogram but instead exclusively receive card services on a fee-for-service basis.

Delivering Services

DHS delivers Medical Assistance services through three primary arrangements.

DHS delivers Medical Assistance services through three primary arrangements:

- managed care, in which DHS typically pays a fixed monthly amount, known as a capitated payment, to an HMO or a managed care organization (MCO) for each recipient who is enrolled;
- fee-for-service, in which health care providers bill DHS for the services they render and are reimbursed based on rates established by DHS; and
- contracts with county governments to oversee the provision of in-home or community-based care to individuals who are elderly or have developmental or physical disabilities.

To assist in limiting costs, federal rules allow states to require some recipients to enroll in an HMO to receive Medical Assistance services on a managed care basis. However, federal rules also stipulate that certain groups of people must be allowed to receive services on a fee-for-service basis if they choose to do so, including:

- recipients who are also eligible for Medicare;
- most Native Americans who are members of federally recognized tribes; and
- certain groups of children under the age of 19, including those eligible for SSI and children who are in out-of-home placements, such as foster care.

DHS does not require recipients in acute and primary care subprograms to enroll in an HMO under certain circumstances. For example, participation in a BadgerCare Plus HMO is generally mandatory for recipients in 62 of Wisconsin's 72 counties. In the remaining 10 counties, including all of Florence, Menominee, and Polk counties, and portions of Ashland, Buffalo, Marinette, Pepin, Pierce, Richland, and Sauk counties, recipients are permitted to receive care on a fee-for-service basis because only one or no HMO provides services in these areas. DHS also allows those with certain health conditions or those who are pregnant when they become eligible for Medical Assistance to obtain an exemption to continue receiving services on a fee-for-service basis from their current health care providers.

In January 2011, 61.3 percent of recipients received services through a managed care arrangement.

In January 2011, 723,392 Medical Assistance recipients, or 61.3 percent, received services through a managed care arrangement, as shown in Table 4. However, 445,425 recipients received services exclusively on a fee-for-service basis, primarily because they were either not required to enroll with an HMO or because they had not yet selected an HMO. For example, BadgerCare Plus applicants who are determined eligible for services must enroll with an HMO within four weeks but may receive services on a fee-for-service basis until they are enrolled. The number of recipients receiving services through a managed care arrangement in January 2011 is approximately 50,000 less than is typical because DHS had temporarily suspended HMO enrollments while it renegotiated contracts with the HMOs.

Appendix 3 identifies the HMOs and MCOs with which DHS contracts to administer BadgerCare Plus, SSI Managed Care, Family Care, Family Care Partnership, and the Program for the All-Inclusive Care for the Elderly (PACE) subprograms. Appendix 4 identifies the counties with which DHS contracts to administer the Brain Injury Waiver, Children's Long-Term Supports, the Community Integration Program (CIP), and the Community Options Program (COP) subprograms.

Table 4

Primary Service Delivery Arrangement, by Subprogram
January 2011

	Number of Recipients		
	Managed Care	Fee-for-Service	County Contract
Acute and Primary Care Subprograms			
BadgerCare Plus, Family Medical Assistance, and Healthy Start[1]	623,326	143,016[2]	–
BadgerCare Plus Core	29,089	15,950[2]	–
SSI Managed Care	30,978	–	–
Subtotal	683,393	158,966	–
Long-Term Care Subprograms			
Family Care	31,461	–	–
Children's Long-Term Supports	–	–	4,583
Community Integration Program (CIP)	–	–	4,122
Family Care Partnership	3,619	–	–
Community Options Program (COP)	–	–	3,415
Include, Respect, I Self-Direct (IRIS)	3,057	–	–
Program for the All-Inclusive Care for the Elderly (PACE)	865	–	–
Brain Injury Waiver	–	–	92
Subtotal	39,002	–	12,212
Limited-Benefit Subprograms			
SeniorCare	–	90,559	–
Family Planning Waiver	–	59,345	–
Qualified Medicare Beneficiaries	–	–	–
Children Come First and Wraparound Milwaukee	997	–	–
Subtotal	997	149,904	–
Not in a Subprogram[3]	–	136,555[4]	–
Total	**723,392**	**445,425**	**12,212**

[1] BadgerCare, Family Medical Assistance, and Healthy Start subprograms were merged to create the BadgerCare Plus subprogram in February 2008.

[2] The number of BadgerCare Plus and BadgerCare Plus Core recipients receiving care on a fee-for-service basis was unusually high in January 2011 because DHS had temporarily suspended HMO enrollments in August 2010 while it renegotiated contracts with HMOs and created a single region to serve Kenosha, Milwaukee, Ozaukee, Racine, Sheboygan, Walworth, and Waukesha counties. As of September 2011, 107,575 BadgerCare Plus and BadgerCare Plus Core recipients received care on a fee-for-service basis.

[3] Includes those recipients who were not in a subprogram but instead received services exclusively on a fee-for-service basis.

[4] Includes Qualified Medicare Beneficiaries for whom DHS pays Medicare premiums but provides no other services.

Program Expenditures ▪

In recent years, Medical Assistance expenditures have increased. Much of the increase was offset through receipt of additional federal funds, but the availability of enhanced federal funding ended in June 2011. Using available data, we estimated expenditures for all Medical Assistance subprograms and identified causes for the overall growth in expenditures.

Overall Medical Assistance Expenditures

Medical Assistance expenditures increased from $5.0 billion in FY 2006-07 to $7.5 billion in FY 2010-11.

As shown in Table 5, the State's Medical Assistance expenditures increased from $5.0 billion in FY 2006-07 to $7.5 billion in FY 2010-11. However, 87 percent of the $2.5 billion increase in expenditures was funded with federal revenue, largely because of the additional federal funds that were provided through the American Recovery and Reinvestment Act (ARRA) of 2009 as enhanced federal funding for Medical Assistance expenditures. Even though the amount of GPR declined over this period, it still funded the largest portion of the State's share of Medical Assistance expenditures. In addition, the amount of segregated revenue that was spent increased by more than 400 percent, in part because of the creation of the Hospital Assessment Fund in 2009.

Table 5

State Medical Assistance Expenditures, by Funding Source
(in millions)

	FY 2006-07	FY 2010-11	Percentage Change
Federal Revenue	$2,913.1	$5,131.1	76.1%
State Revenue			
General Purpose Revenue	1,868.0	1,578.9	(15.5)
Segregated Revenue	127.3	673.5	429.1
Program Revenue	58.7	133.2	126.9
Subtotal	2,054.0	2,385.6	16.1
Total	**$4,967.1**	**$7,516.7**	51.3

The amount of federal funds that states receive under Medical Assistance is based on the federal Medical Assistance percentage (FMAP), which is used to calculate the amount of federal matching funds that will be provided to support a state's Medical Assistance benefit expenditures. Each state's FMAP is calculated annually by comparing a three-year average of a state's per capita income to the national average per capita income. In recent years, Wisconsin's FMAP has been approximately 60 percent, but it increased to as much as 70 percent for several months during the period from October 1, 2008, through June 30, 2011, because of additional funding made available under ARRA. With the expiration of enhanced federal reimbursement under ARRA, Wisconsin's FMAP returned to approximately 60 percent in July 2011. In addition, states receive a fixed amount of matching funds for administrative expenditures ranging from 50 percent for most activities to 90 percent for developing new information systems.

Segregated revenue and program revenue funded a growing share of all Medical Assistance expenditures.

Over the past five years, Wisconsin has increasingly relied on segregated revenue and program revenue to fund the State's share of Medical Assistance benefit expenditures. In FY 2010-11, segregated revenue came from several sources:

- $454.6 million from the Medical Assistance Trust Fund, which was created by 2001 Wisconsin Act 13 as a non-lapsable trust fund to support the State's Medical Assistance program, primarily with revenue from nursing home bed assessments and excess revenue from assessments on hospitals;

- $215.5 million from the Hospital Assessment Fund, which was created by 2009 Wisconsin Act 2, the 2007-09 Budget Adjustment Act, to receive revenue from annual assessments on hospitals—excluding critical access hospitals, institutions for mental disease, and general psychiatric hospitals—to be used, in part, to provide higher reimbursement rates to hospitals for services provided to Medical Assistance recipients; and

- $3.4 million from the Critical Access Hospital Assessment Fund, which was established by 2009 Wisconsin Act 190 to receive revenue from annual assessments on critical access hospitals to provide higher reimbursement rates to these hospitals and provide additional revenue for the Medical Assistance Trust Fund.

DHS collects revenue for the Hospital Assessment Fund by assessing a fee on most hospitals. The fee is a percentage of a hospital's gross patient revenues and is set at the level needed to collect an amount specified by the Legislature annually. 2009 Wisconsin Act 28, the 2009-11 Biennial Budget Act, established the amount to be collected at $378.7 million for FY 2009-10 and $414.5 million for FY 2010-11. This assessment allows the State to claim additional federal revenue to pay for services without having to use additional GPR. Assessment amounts collected in excess of the statutorily designated amounts are transferred to the Medical Assistance Trust Fund to support general Medical Assistance services.

Program revenue comes from a variety of sources, including premiums, prescription drug rebates, and required county contributions for long-term care programs, such as Family Care.

Benefit costs represented 96.2 percent of total expenditures in both FY 2006-07 and FY 2010-11.

As shown in Table 6, recipients' benefits accounted for the vast majority of total program expenditures. Benefit costs represented 96.2 percent of all expenditures in both FY 2006-07 and FY 2010-11 and increased at the same rate as administrative costs.

Table 6

State Medical Assistance Expenditures, by Type
(in millions)

	FY 2006-07	FY 2010-11	Percentage Change
Benefit Costs	$4,778.0	$7,230.6	51.3%
Administrative Costs	189.1	286.1	51.3
Total	**$4,967.1**	**$7,516.7**	51.3

Administrative Expenditures

DHS contracts extensively with vendors for help administering the Medical Assistance program.

While DHS directly administers some aspects of the Medical Assistance program, it contracts extensively with vendors, which are primarily private companies, for help in some areas. It also pays counties and tribal governments to make eligibility determinations and provide case management services, which are collectively referred to as income maintenance functions. In 2009, DHS assumed direct responsibility for income maintenance functions in Milwaukee County in response to a lawsuit.

As shown in Table 7, expenditures for vendor contracts increased by 73.4 percent from FY 2006-07 through FY 2010-11, and they accounted for the largest share of administrative expenditures in both years. The largest area of expenditure growth was in Aging and Disability Resource Centers, which assist elderly and disabled individuals in locating appropriate care options. Expenditures for the Centers increased by $34.4 million from FY 2006-07 through FY 2010-11, largely because of the expansion of the Family Care subprogram to most counties in the state. DHS includes some nonemergency transportation as an administrative expense because it does not meet the federal requirements needed to obtain the higher reimbursement rate that is provided for all other benefit expenditures. This is because DHS has not been able to provide data on the origin and destination of all Medical Assistance-funded trips.

Table 7

State Medical Assistance Administrative Costs[1]
(in millions)

Description	FY 2006-07	FY 2010-11	Percentage Change
Contracts with Vendors	$ 66.2	$114.8	73.4%
Local Medical Assistance Administration[1]	44.0	52.8	20.0
Aging and Disability Resource Centers	5.8	40.2	593.1
DHS Staff Salaries and Fringe Benefits	21.7	27.6	27.2
Nonemergency Transportation[2]	23.8	18.8	(21.0)
CARES Mainframe Costs[3]	14.8	14.2	(4.1)
Supplies, Travel, Facilities, and Other Information Technology	7.1	12.1	70.4
Other	5.7	5.6	(1.8)
Total	**$189.1**	**$286.1**	51.3

[1] Administrative expenditures funded by GPR are estimated because DHS does not separately record Medical Assistance and FoodShare administrative expenditures.

[2] DHS records some payments for nonemergency transportation as an administrative cost because it does not maintain adequate trip data to claim the higher reimbursement rate that is provided for all other Medical Assistance services.

[3] The Client Assistance for Reemployment and Economic Support (CARES) electronic system is used to determine eligibility for Medical Assistance and other public assistance programs.

Nonemergency transportation expenditures recorded as administrative costs declined by $5.0 million from FY 2006-07 through FY 2010-11 because nonemergency transportation services for BadgerCare Plus recipients in Milwaukee County were provided by HMOs beginning in January 2009. As a result, the State is currently receiving a higher federal reimbursement rate for these expenditures. In addition, 2009 Wisconsin Act 28, the 2009-11 Biennial Budget Act, directed DHS to establish a "transportation broker" to coordinate nonemergency transportation costs for some other Medical Assistance recipients not served by HMOs in Milwaukee County. The data collected and reported by the broker are expected to allow DHS to claim the higher federal reimbursement rate for these trips. DHS had projected that implementing this method of coordinating transportation services would save approximately $9.2 million in GPR funds during the 2009-11 biennium. However, these savings were not realized at that time because the broker did not begin providing services under contract with DHS until July 2011, after the biennium had ended.

DHS had an estimated 364.6 FTE positions performing Medical Assistance functions in June 2011.

Because much of the program is administered by counties and tribal governments, and because DHS contracts with vendors for additional administrative functions, costs associated with the salaries and benefits of DHS staff totaled $27.6 million in FY 2010-11 and represented only 9.6 percent of total administrative expenditures. DHS had an estimated 364.6 FTE positions performing Medical Assistance functions in June 2011.

Subprogram Benefit Expenditures

Neither the State's nor DHS's accounting systems contain expenditures by subprogram.

Neither WiSMART, which is the State's central accounting system, nor DHS's own internal accounting system contains expenditure information that can be separated by subprogram. Therefore, we estimated subprogram expenditures using information from several sources, including data provided by the State's Medical Assistance fiscal agent, Hewlett-Packard (HP) Enterprise Services, LLC, and various documents compiled by DHS staff. These amounts differ from those reported in WiSMART, as well as those shown in Table 5 and Table 6 of this report, because they are produced on a cash basis rather than a budgetary basis, do not represent final expenditures, and do not include rebates from pharmaceutical manufacturers for prescription drugs or recoveries of provider overpayments. Because of the significant work effort associated with estimating expenditures by subprogram, and because final expenditures for FY 2010-11 were not available until September 2011, we were able to analyze these data only through FY 2009-10.

As shown in Table 8, expenditures for most subprograms increased from FY 2006-07 through FY 2009-10. The largest growth occurred in acute and primary care subprograms, largely because of the increase in BadgerCare participation when eligibility was expanded in February 2008 primarily for children, families, and pregnant women, and in January 2009 for adults without dependent children. The largest growth in a single subprogram was in Family Care, which increased by 242.0 percent, or $631.5 million, largely because of the expansion of the program to most counties in the state. The increase in Family Care expenditures was partially offset by decreased expenditures for the Community Options Program and the Community Integration Program, because these subprograms are eliminated in each county when Family Care is implemented.

Expenditures for card services increased from $2.8 billion in FY 2006-07 to $3.6 billion in FY 2009-10.

Those who are not in a subprogram and those who require additional services not provided by their subprogram receive card services, which increased from $2.8 billion in FY 2006-07 to $3.6 billion in FY 2009-10. These expenditures reflect payments made on a fee-for-service basis to institutional providers, such as nursing homes and inpatient hospitals, as well as to non-institutional providers, such as pharmacies, physicians, and dentists.

Table 8

Estimated Medical Assistance Benefit Expenditures, by Subprogram[1]
(in millions)

	FY 2006-07	FY 2009-10	Percentage Change
Acute and Primary Care Subprograms			
BadgerCare Plus, Family Medical Assistance, and Healthy Start[2]	$ 732.5	$1,308.2	78.6%
SSI Managed Care	183.6	235.1	28.1
BadgerCare Plus Core	–	63.1	–
Subtotal	916.1	1,606.4	75.4
Long-Term Care Subprograms			
Family Care	260.9	892.4	242.0
Community Integration Program (CIP)	376.0	179.4	(52.3)
Family Care Partnership and Program for the All-Inclusive Care for the Elderly	115.6	173.2	49.8
Children's Long-Term Supports	43.4	61.7	42.2
Include, Respect, I Self-Direct (IRIS)	–	35.9	–
Community Options Program (COP)	135.0	78.7	(41.7)
Brain Injury Waiver	17.8	6.8	(61.8)
Subtotal	948.7	1,428.1	50.5
Limited-Benefit Subprograms			
Qualified Medicare Beneficiaries	215.8	272.9	26.5
SeniorCare	119.4	96.9	(18.8)
Family Planning Waiver	14.5	27.9	92.4
Children Come First and Wraparound Milwaukee	13.3	20.9	57.1
Subtotal	363.0	418.6	15.3
Medical Assistance Card Services[3]	2,754.5	3,624.0	31.6
Total	**$4,982.3**	**$7,077.1**	42.0

[1] Estimates are produced on a cash basis rather than a budgetary basis, do not represent final expenditures, and do not include rebates from pharmaceutical manufacturers for prescription drugs or recoveries of provider overpayments. In addition, the fee-for-service costs for individuals who also receive services through a subprogram are included in card services because these costs could not be readily separated by subprogram.

[2] BadgerCare, Family Medical Assistance, and Healthy Start subprograms were merged to create the BadgerCare Plus subprogram in February 2008.

[3] Includes fee-for-service expenditures for all recipients regardless of whether they are in a subprogram.

Information on expenditures by service type was readily available only for card services. As shown in Table 9, nearly half of the $3.6 billion in FY 2009-10 expenditures were payments to institutional providers, such as nursing homes and inpatient and outpatient hospitals. The remaining expenditures were payments to non-institutional providers, such as pharmacies and physicians.

Table 9

Estimated Medical Assistance Card Services Expenditures, by Service Type
FY 2009-10
(in millions)

Service Type	Amount	Percentage
Institutional Fee-for-Service Providers		
Nursing Home and Long-Term Care Facilities	$1,057.6	29.2%
Inpatient Hospitals	486.1	13.4
Outpatient Hospitals	163.5	4.5
Subtotal	1,707.2	47.1
Non-Institutional Fee-for-Service Providers		
Pharmacies	569.2	15.7
Home Health and Personal Care	238.3	6.6
Physicians and Clinics	209.6	5.8
Federally Qualified Health Centers	129.1	3.6
Mental Health and Substance Abuse Services	103.2	2.8
School-based Services	52.3	1.4
Laboratory and X-Ray	50.0	1.4
Durable Medical Equipment and Supplies	48.7	1.3
Dentists	45.6	1.3
Mental Health Services	44.2	1.2
Other[1]	426.6	11.8
Subtotal	1,916.8	52.9
Total	**$3,624.0**	**100.0%**

[1] Includes expenditures for other non-institutional services, such as hospice care, ambulance services, specialized medical vehicles, chiropractic services, vision services, and county-administered services for which detailed information was unavailable.

More than one-third of Medical Assistance expenditures in FY 2009-10 were payments to HMOs and MCOs.

As noted, the State does not pay for individual services provided by HMOs and MCOs, but instead pays a capitated rate for each recipient enrolled to cover health care services and the provider's administrative costs. In FY 2009-10, $2.7 billion, or more than one-third of all Medical Assistance expenditures, were capitation and other payments to HMOs and MCOs. As shown in Table 10, capitation rates varied considerably in 2011, largely because of differences in the type and amount of services provided by each subprogram. Acute and primary care subprograms, such as BadgerCare Plus, have lower capitation rates because recipients in these subprograms are generally younger and healthier. In contrast, long-term care subprograms have higher capitation rates, largely because recipients' medical and behavioral needs require both more frequent and more costly care. DHS contracts with PricewaterhouseCoopers, LLP, to calculate capitation rates for each of the subprograms in which services are provided through managed care arrangements.

Table 10

Monthly Capitation Rates per Recipient, by Subprogram
2011

	Monthly Capitation Rates
Acute and Primary Care Subprograms[1]	
BadgerCare Plus	$49 to $338
BadgerCare Plus Core	$88 to $286
SSI Managed Care[2]	$33 to $1,484
Long-Term Care Subprograms[3]	
Family Care	$607 to $3,766
Family Care Partnership and Program for the All-Inclusive Care for the Elderly (PACE)	$2,958 to $3,638
Limited-Benefit Subprograms	
Children Come First	$2,231
Wraparound Milwaukee	$1,844

[1] Rates vary based on the age and gender of the recipient, as well as the region where a person receives services.

[2] The capitation payments for individuals who are eligible for both Medicare and Medical Assistance are primarily paid by the Medicare program, including those whose Medical Assistance capitation payments are less than $200 per month.

[3] Rates vary based on whether recipients are elderly or disabled and whether they require an intermediate- or nursing home-level of care.

Growth in Medical Assistance Expenditures

The 51.3 percent increase in expenditures from FY 2006-07 through FY 2010-11 is largely due to an increase in the number of recipients.

We found that the 51.3 percent increase in total Medical Assistance expenditures from FY 2006-07 through FY 2010-11 is largely because of an increase in the number of individuals served by the program. As noted, some of the increase in the number of Medical Assistance recipients is the result of program expansion, which we estimate resulted in approximately 100,000 additional recipients through FY 2010-11 who would not otherwise have been eligible. Additional growth occurred due to the economic downturn, as individuals lost their jobs and became eligible to receive Medical Assistance benefits.

The factors leading to Medical Assistance expenditure growth are not unique to Wisconsin. An October 2011 report issued by the Kaiser Commission on Medicaid and the Uninsured found that the primary factor contributing to Medical Assistance spending growth for 49 states was the economy and increases in the number of individuals receiving Medical Assistance benefits because of high unemployment rates.

In addition to growth in the number of recipients, we identified several other factors that contributed to expenditure increases using additional revenue generated through assessments on hospitals and nursing homes, including:

- an increase in inpatient hospital rates from an average of $4,059 per admission in FY 2006-07 to $4,578 per admission in FY 2010-11;

- the creation of "access payments," which are supplemental payments to hospitals to ensure access of Medical Assistance recipients to hospital-provided services. These payments began in FY 2009-10 and totaled $672.0 million in FY 2010-11; and

- an increase in nursing home rates from an average of $130 per recipient per day in FY 2006-07 to $165 per recipient per day in FY 2010-11.

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Contracting for Administrative Services ■

DHS contracts extensively with numerous vendors to help administer the Medical Assistance program. The scope of services performed under contract is broad and includes fiscal agent services, maintenance of electronic systems, actuarial services, quality of care assessments, and assistance in enrolling some recipients in HMOs.

Scope of Contracting

From FY 2006-07 through FY 2010-11, DHS paid vendors a total of $411.9 million for administrative services.

In FY 2010-11, payments to vendors represented $114.8 million of $286.1 million in total Medical Assistance administrative costs. Because DHS's payments to vendors represented the single largest category of administrative costs, we reviewed these payments from FY 2006-07 through FY 2010-11. As shown in Table 11, payments to vendors for administrative services totaled $411.9 million over this period. In addition, of the more than 70 vendors with which DHS contracted, 24 were paid at least $200,000. Two vendors—HP Enterprise Services and Deloitte Consulting, LLP—accounted for three-fourths of these expenditures. HP Enterprise Services acts as the fiscal agent for the Medical Assistance program, and Deloitte Consulting maintains the electronic system used to determine applicants' eligibility for services.

Table 11

DHS Payments to Vendors for Administrative Services
(in millions)

Vendor	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	Total
Electronic Data Systems/ HP Enterprise Services, LLC[1]	$44.6	$55.4	$45.8	$37.6	$ 64.7	$248.1
Deloitte Consulting, LLP	9.9	11.5	13.8	12.5	13.6	61.3
All Other Vendors	11.7	13.1	13.0	28.2	36.5	102.5
Total	**$66.2**	**$80.0**	**$72.6**	**$78.3**	**$114.8**	**$411.9**

[1] HP Enterprise Services purchased Electronic Data Systems in 2008.

In 2008, HP Enterprise Services purchased Electronic Data Systems, which had been the State's fiscal agent since the 1970s. From FY 2006-07 through FY 2010-11, these vendors were paid $248.1 million and accounted for 60.2 percent of total vendor payments over this period. Although contracting is not required, all states must designate a fiscal agent that is responsible for enrolling certain recipients, certifying health care providers, and paying providers for Medical Assistance services. A competitive solicitation process was last conducted in 2004. The current contract with HP Enterprise Services will expire in November 2013 unless DHS and HP Enterprise Services extend the contract by exercising up to five annual renewal options by mutual agreement.

Contract costs associated with a new claims processing system were $27.9 million more than initially projected.

Development of the electronic system for processing health care claims, which is known as ForwardHealth interChange, first began in January 2005 and was initially expected to be completed in January 2007 at a contracted cost of $27.5 million. The system was not completed until November 2008 and contract costs totaled $55.4 million, which is $27.9 million more than was initially projected. DHS attributed the additional time and resources needed for completion to the unanticipated expansion of the project's scope, such as extending coverage to all children in the state in February 2008. Federal funds covered $49.9 million, or 90 percent, of the project's contracted costs.

The second largest vendor, Deloitte Consulting, was paid $61.3 million over the past five years, primarily to maintain the State's CARES system, which is used to determine eligibility for Medical Assistance and other public assistance programs. Deloitte Consulting was paid for the number of hours of service it provided

at a negotiated rate, which was $90 per hour in 2009 and 2010 and $104 per hour in 2011. In addition, it currently receives $170,000 per month for its facility and equipment costs.

Although DHS does not guarantee a minimum number of hours, its contract with Deloitte Consulting anticipates approximately 75,500 hours annually for the Medical Assistance program. DHS paid the vendor increased amounts for Medical Assistance-related services in recent years because the number of staff hours charged under the contract increased from 76,700 in FY 2006-07 to 126,800 in FY 2010-11. DHS attributed the increased hours to the establishment of new Medical Assistance subprograms and the need to interface the CARES system with the new ForwardHealth interChange system.

Three other vendors were each paid more than $10.0 million from FY 2006-07 through FY 2010-11:

- The Management Group, Inc., was paid $24.2 million to provide services for several long-term care programs, such as Include, Respect, I Self-Direct (IRIS); the Community Integration Program; the Brain Injury Waiver; and Children's Long-Term Supports;

- Automated Health Systems, Inc., was paid $23.1 million to assist in determining eligibility for all adults without dependent children and serve as an HMO enrollment broker to assist Medical Assistance recipients in selecting an HMO in areas of the state where multiple HMOs provide Medical Assistance services; and

- MetaStar, Inc., was paid $12.9 million to assess the quality of care provided to Medical Assistance recipients and determine whether services are medically necessary, adequately documented, and appropriate.

Additional information on payments to vendors for Medical Assistance administrative services is provided in Appendix 5.

Improving Vendor Oversight

Given the extent to which DHS contracts for administrative services, effective oversight is needed to ensure contracted services are cost-effective, adequate, and completed in a timely manner and within budget. During the course of our review we assessed concerns

communicated to us through our Fraud, Waste, and Mismanagement Hotline, and we identified several areas in which oversight and monitoring of vendor contracts should be improved.

DHS is unable to easily identify expenditures associated with specific contracted activities or which subprograms funded specific contract payments.

First, DHS is unable to easily identify expenditures associated with specific contracted activities or determine which Medical Assistance subprograms funded specific contract payments. This is because the accounting codes used are not sufficiently detailed and payments to vendors are frequently transferred from one funding source to another at year-end, based on the availability of funds from a given source.

DHS could improve the transparency of its budgeting practices and provide more useful information if it accounted for the administrative costs of the Medical Assistance and FoodShare programs separately. Although they are separate programs, provide different services, and are funded through different federal agencies, they are currently part of a single GPR appropriation in the State's budget. Because DHS does not consistently establish separate internal coding for these costs, as it does with federal appropriations, it cannot distinguish between certain GPR expenditures associated with the Medical Assistance program and other GPR expenditures associated with the FoodShare program.

DHS has not always considered its available spending authority when making contracting decisions.

Second, we found that DHS did not consistently track additional services requested from its vendors or communicate these additional services and their related costs to its budget, accounting, and procurement staff to ensure that proper procedures were used and that any additional payments made were appropriate and within budget. For example, DHS was authorized $42.0 million in additional administrative spending authority by 2011 Wisconsin Act 13, largely to help offset an estimated $54.8 million in unbudgeted contractual commitments DHS had made with its fiscal agent from FY 2006-07 through FY 2010-11. These unbudgeted contractual commitments included $22.5 million to assist DHS in determining eligibility for low-income adults without dependent children, $16.5 million to help implement cost-savings measures for the Medical Assistance program, and $15.8 million for additional services requested by DHS.

We identified similar concerns with DHS's oversight of other contracts. For example, from FY 2006-07 through FY 2010-11, DHS paid its actuary—PricewaterhouseCoopers, LLP—$1.5 million more than the initially contracted amount to conduct work associated with the expansion of Medical Assistance services to new recipient groups. However, not until August 2010 did DHS begin requesting that PricewaterhouseCoopers, LLP, estimate the cost of any additional work before authorizing the vendor to proceed with it. This is especially significant given that actuarial service costs were

nearly 26.9 percent higher than the initially contracted amounts in FY 2009-10 and 17.1 percent higher in FY 2010-11.

Subsequent to our review, DHS indicated that it began to formally track all contract amendments for the Medical Assistance program in August 2011. In addition, it now also attempts to identify specific funding sources for all services requested, and it communicates relevant information on proposed contract amendments to its budget, accounting, and procurement staff before authorizing additional services. However, it is important that DHS formalize this process to ensure that these procedures continue to be routinely performed on an ongoing basis.

DHS has not always conducted a bidding process to determine whether some services could be provided at a lower cost.

Third, DHS has frequently chosen to expand existing contracts with HP Enterprise Services and Deloitte Consulting without first conducting a bidding process to determine whether other vendors could effectively provide comparable services at a lower cost. In addition, we found that DHS procurement staff were seldom consulted about whether additional services should be considered for a separate bid. DHS officials believe the broad nature of DHS's existing contracts provided the authority needed to request additional services without conducting new bidding processes and that doing so was both more efficient and timely because the services were needed quickly to address significant expansion of the Medical Assistance program.

Moreover, DHS indicated that contracting was often viewed as the only practical option to address staffing needs because it was unable to increase state employee staffing levels based on a state employee hiring freeze in place from January 2008 through December 2010 and on a requirement that most state employees take 16 days of unpaid leave during the 2009-11 biennium. These policies resulted in a significant number of vacancies in state agency positions and reduced the amount of work existing employees could complete.

To address staffing needs, DHS relied on the flexibility of its contract with HP Enterprise Services to provide more than 500 additional staff. The contract provides for services in 14 broad administrative areas, such as claims processing, electronic system maintenance, financial services, quality assurance, program integrity, and policy planning. Standard billing rates were established for 180 position types, currently ranging from $21.96 per hour for customer service staff to $323.15 per hour for actuarial services.

Contracted staffing levels for HP Enterprise Services nearly doubled in recent years and totaled 1,127.5 FTE positions in June 2011.

Staffing levels under HP Enterprise Services' contract with DHS nearly doubled from 598.5 FTE positions in December 2008 to 1,127.5 FTE positions in June 2011, as shown in Figure 3. Of the 529 additional positions:

- 410 were assigned to the Enrollment Services Center, which administers public assistance programs for low-income adults without dependent children. We issued a report on the Enrollment Services Center in June 2011 as the first phase of our evaluation of the Medical Assistance program;

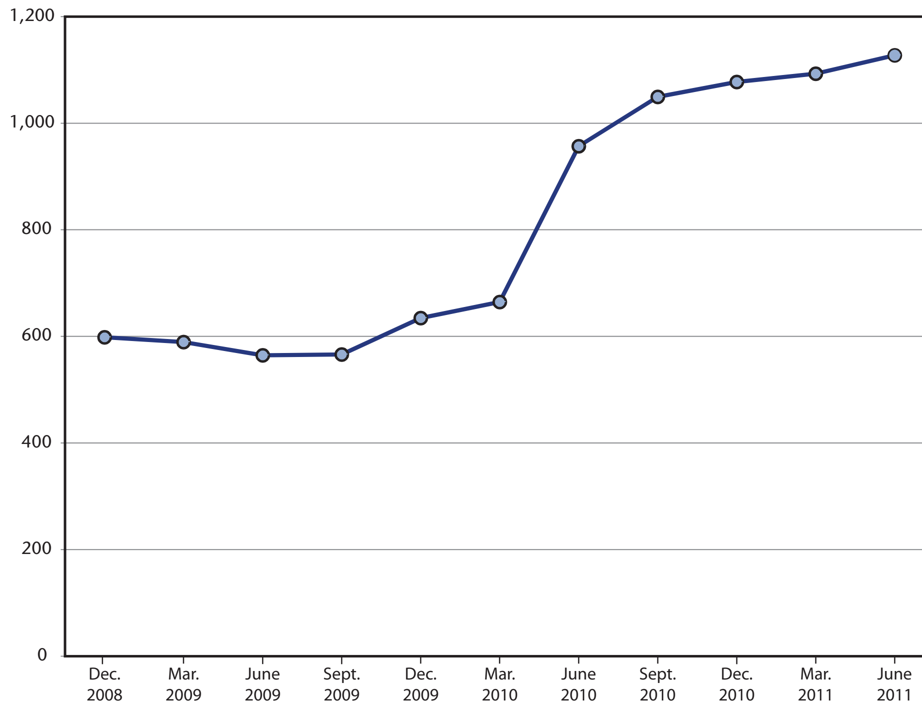
- 68 were assigned to implement cost-savings proposals developed by DHS for the Medical Assistance program; and

- 51 were assigned to supplement DHS's own staff and meet various other program needs in administering the Medical Assistance program.

DHS began its cost-savings initiative, referred to as "rate reform," in March 2009, in large part to address a requirement in 2009 Wisconsin Act 28, the 2009-11 Biennial Budget Act, to identify $633.0 million in Medical Assistance cost savings. DHS advanced 72 cost-savings proposals for implementation, and we identified 11 contract amendments between DHS and HP Enterprise Services to increase contract staff to a maximum of 107.0 FTE positions in September 2010 at a cost of $12.2 million in order to implement these cost-saving proposals. Examples of the types of contract work that resulted from these proposals included increasing audit and collection activities and revising provider payment rates in DHS's electronic systems.

Figure 3

Hewlett-Packard Enterprise Services Contract Staff FTE Positions



Some contracted staff perform ongoing administrative responsibilities that have been typically performed by state employees.

DHS has also contracted with HP Enterprise Services to supplement its own staff, including requesting contracted staff to perform ongoing administrative responsibilities that have been typically performed by state employees, including:

- assisting with ongoing testing of the ForwardHealth interChange system;
- providing general administrative support to DHS officials, including answering telephone calls; and
- providing services to address a range of other needs, such as assisting pregnant BadgerCare Plus recipients in southeastern Wisconsin in finding physicians.

DHS has historically relied on vendors to provide administrative support for the Medical Assistance program. These services will continue to be needed in the future, and it will be important for DHS to

retain adequate flexibility in determining how administrative services are best provided. However, DHS's increasing reliance on vendors may also potentially hamper its ability both to effectively provide guidance to the large number of contracted staff and to maintain adequate administrative oversight of the program.

☑ Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by July 2, 2012, on its efforts to:

- *develop separate accounting codes for administrative expenditures funded with general purpose revenue for the Medical Assistance and FoodShare programs;*
- *formalize the process for overseeing its contractual commitments by ensuring adequate funding will be available before authorizing expenditures for additional administrative services;*
- *develop a process to adequately solicit bids to ensure that the most appropriate and effective administrative services are purchased at the most competitive price; and*
- *review existing contracted services to identify whether cost savings could be achieved by using state employees rather than vendors for some functions.*

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Managing Service Delivery ■

Within parameters established by state and federal law, DHS has the authority to manage the type and amount of services provided to Medical Assistance recipients, as well as the manner in which those services are provided. In an attempt to limit costs, increase access, and improve the quality of care, DHS has increasingly relied on managed care arrangements to provide services. We reviewed the current approaches for providing health care services to program recipients and identified options that may further limit costs.

Approaches to Providing Services

Health care services are generally paid on either a fee-for-service or managed care basis.

The two main approaches to paying for health care services through government-funded health care programs, such as Medical Assistance, are fee-for-service and managed care. Under a fee-for-service arrangement, health care providers are generally paid a fee for each service they provide, such as an office visit or a diagnostic test, and payments are provided as reimbursements. Because the care provided is not managed with the intent of limiting costs and because a provider's payment generally depends solely on the amount of care provided, paying for services on a fee-for-service basis may create an incentive for providers to deliver more services than necessary.

Managed care providers have a financial incentive to reduce the cost and use of services.

Under managed care, it is typical for health insurers, such as HMOs and MCOs, to either contract with or directly employ physicians and other health care providers to care for their members at reduced costs. Organizations that operate under a managed care

arrangement have a financial incentive to reduce the cost and use of services because they are paid a fixed amount monthly for each individual they serve. Under managed care, capitation payments typically exceed the cost of providing services to some recipients and are lower than the cost of providing services to others. Therefore, HMOs and MCOs assume the financial risk for any costs of care that exceed the capitated payments they receive.

Nationally, two-thirds of Medical Assistance recipients were enrolled in some form of managed care in October 2010.

Managed care is widely considered to be a more cost-effective method of delivering health care services, because it can coordinate recipients' ongoing health care needs to reduce unnecessary or duplicative services, divert recipients from high-cost services to lower cost services that are medically appropriate, and encourage preventative care to help avoid the development of costly health problems. The Kaiser Commission on Medicaid and the Uninsured reported that two-thirds of Medical Assistance recipients nationally were enrolled in some form of managed care in October 2010.

Numerous studies have been completed by academic institutions, private research firms, and state agencies to determine whether delivering Medical Assistance services through managed care arrangements is more cost-effective than fee-for-service arrangements. A 2009 review of Medical Assistance programs in 24 states completed by the Lewin Group, a private research firm that specializes in health care research, found that providing services through a managed care arrangement resulted in savings, largely by reducing the cost and use of inpatient hospital visits and prescription drugs. However, the review found that savings varied widely—from 0.5 percent to 20.0 percent—largely because the types of benefits included under managed care arrangements differed among the 24 states.

In addition, DHS contracted for a study completed in 2002, which estimated that providing acute and primary care services to children and their caretakers in what is now the BadgerCare Plus subprogram saved $35.1 million in 2001 and would save $56.3 million in 2002, compared to providing these services to a comparable group of recipients on a fee-for-service basis. Similarly, a 2005 study completed by APS Healthcare, Inc., a health services consulting firm under contract with DHS, estimated that providing long-term care services to Family Care recipients cost $452 less per recipient per month than providing these services to a comparable group of non–Family Care recipients in the Medical Assistance program.

Managed care arrangements are considered to be more cost-effective than fee-for-service arrangements.

Attempting similar comparisons at the present time is much more challenging because it is difficult to find similar groups of recipients who are served across managed care and fee-for-service arrangements. However, based on previous studies completed in Wisconsin and other states, it appears that managed care arrangements are generally more likely to provide cost-effective

services to Medical Assistance recipients than providing services on a fee-for-service basis. However, we found that Wisconsin's Medical Assistance program still incurs significant fee-for-service expenditures, both for recipients who are not enrolled with a managed care provider and for recipients who are enrolled with a managed care provider but also receive additional care on a fee-for-service basis.

As noted, total fee-for-service expenditures were $3.6 billion in FY 2009-10, which was 51.2 percent of all Medical Assistance expenditures in that year. We analyzed data maintained by DHS to determine the types of recipients who received services on a fee-for-service basis. In FY 2009-10, the largest categories of fee-for-service expenditures included:

- $1.9 billion for recipients who were elderly or disabled and received services exclusively on a fee-for-service basis;

- $530.5 million for children and their parents, pregnant women, and adults without dependent children who received services exclusively on a fee-for-service basis because they had not yet enrolled in a managed care plan when the services were provided, or because they were exempted from having to enroll; and

- $468.1 million for individuals of all ages and types who were enrolled in a managed care plan but received additional health care services on a fee-for-service basis because not all services, such as prescription drugs and dental services, are provided through a managed care arrangement.

Elderly and Disabled Recipients

In FY 2009-10, 190,711 elderly and disabled individuals received services exclusively on a fee-for-service basis, including 110,156 individuals known as "dual-eligibles" because they were recipients of both Medicare and Medical Assistance. These individuals typically have more complex health needs that require skilled nursing care, and federal rules allow them to receive services on a fee-for-service basis.

In FY 2009-10, DHS spent $1.9 billion for services to elderly and disabled recipients on a fee-for-service basis.

As shown in Table 12, in FY 2009-10, DHS spent $1.9 billion for services to elderly and disabled recipients under a fee-for-service arrangement, including $1.3 billion for institutional services and $576.1 million for non-institutional services.

Table 12

Fee-for-Service Expenditures for Elderly and Disabled Recipients[1]
FY 2009-10
(in millions)

Service Type	Amount	Percentage
Institutional Services		
Nursing Home and Long-Term Care Facilities	$ 939.3	49.0%
Inpatient Hospitals	279.4	14.6
Outpatient Hospitals	120.7	6.3
Subtotal	1,339.4	69.9
Non-Institutional Services		
Professional Services	253.7	13.2
Home Health and Personal Care	157.9	8.2
Prescription Drugs	153.8	8.0
Dental Care	10.7	0.6
Subtotal	576.1	30.1
Total	**$1,915.5**	**100.0%**

[1] Includes elderly and disabled recipients who received services exclusively on a fee-for-service basis.

Dual-eligible recipients accounted for a disproportionate amount of expenditures for three types of services provided to elderly and disabled recipients, including:

- $866.7 million for institutional care, or 92.3 percent of total institutional care expenditures;
- $118.0 million for home health and personal care, or 74.7 percent of total home health and personal care expenditures; and
- $7.5 million for dental care, or 70.1 percent of total dental care expenditures.

Children, Parents, and Other Adults

In FY 2009-10, 324,592 children and their parents or caretakers, pregnant women, and adults without dependent children received $530.5 million in health care services exclusively on a fee-for-service

basis. As shown in Table 13, expenditures for inpatient hospitalizations and professional services represented nearly three-fourths of the total.

Table 13

Fee-for-Service Expenditures for Children, Parents, and Other Adults[1]
FY 2009-10
(in millions)

Service Type	Amount	Percentage
Inpatient Hospitals	$210.9	39.8%
Professional Services	172.6	32.5
Outpatient Hospitals	78.0	14.7
Prescription Drugs	56.9	10.7
Dental Care	7.7	1.5
Home Health and Personal Care	3.8	0.7
Other[2]	0.6	0.1
Total	**$530.5**	**100.0%**

[1] Includes children, parents, and other adults who received services exclusively on a fee-for-service basis because they had not yet enrolled in a managed care plan when the services were provided.

[2] Includes institutional care not provided by a hospital.

The State's Medical Assistance rules allow some recipients to receive services exclusively on a fee-for-service basis.

In FY 2009-10, $109.3 million was spent for services to 26,683 recipients who had been granted exemptions by DHS to obtain services on a fee-for-service basis rather than participate in the BadgerCare Plus subprogram and receive services through an HMO. State Medical Assistance rules require DHS to offer exemptions to certain recipients who wish to receive services exclusively on a fee-for-service basis, such as when the recipient is:

- pregnant and chooses to use certified midwives or nurse practitioners, or is in the third trimester of pregnancy at the time of eligibility determination;
- receiving services from a federally qualified health center that is not affiliated with an HMO in the recipient's geographic region;
- diagnosed with mental health or substance abuse issues, such as children diagnosed with severe emotional issues and adults with complex physical or psychiatric conditions;

- a family member of someone receiving Medical Assistance services on a fee-for-service basis;
- diagnosed with HIV or AIDS;
- a recipient of an organ transplant that is considered to be experimental; or
- under age three and has developmental disabilities or receives services through the Birth-to-Three program, which provides early intervention support for infants and toddlers with developmental delays and disabilities.

DHS believes that allowing recipients with certain health conditions to obtain exemptions is necessary because their specialized health or behavioral care needs may be more costly than what could be adequately provided by HMOs under current capitation rates. Recipients granted exemptions based on their long-term health care needs are monitored by DHS annually to determine whether the original health conditions that justified the exemption remain.

For recipients without an exemption, DHS policies generally require that they select an HMO within four weeks of being determined eligible for the Medical Assistance program. Recipients who do not make a selection within four weeks are automatically enrolled in an HMO by DHS. During this four-week period, recipients may obtain services on a fee-for-service basis.

In FY 2009-10, fee-for-service costs totaled $421.2 million for 297,909 recipients before their enrollment in HMOs.

We found that $421.2 million of the $530.5 million in FY 2009-10 fee-for-service expenditures for this group was for care provided to 297,909 recipients before their enrollment in HMOs. DHS attributed the high level of expenditures to substantial service utilization by recipients during their first month of program eligibility in order to address their previously unmet health care needs, including women experiencing complications during pregnancy.

Services Not Covered through Managed Care Arrangements

Some services are paid on a fee-for-service basis because they are not available through managed care plans.

Some covered Medical Assistance services are not available from HMOs or MCOs through a managed care plan. Instead, DHS pays for these services on a fee-for-service basis. In FY 2009-10, DHS incurred $468.1 million in fee-for-service expenditures for 636,474 recipients of all ages and types who were enrolled in a managed care plan but received additional health care services not included in their managed care plans. As shown in Table 14, $338.5 million, or 72.3 percent of the total, was for prescription drugs.

Table 14

Fee-for-Service Expenditures for Care Provided to Recipients Enrolled in Managed Care Subprograms[1]
FY 2009-10
(in millions)

Service Type	Amount	Percentage
Prescription Drugs	$338.5	72.3%
Professional Services	86.0	18.4
Dental Care	34.1	7.3
Outpatient Hospitals	8.1	1.7
Inpatient Hospitals	1.2	0.3
Other	0.2	<0.1
Total	**$468.1**	**100.0%**

[1] The subprograms providing services through a managed care arrangement in January 2011 are shown in Table 4.

States can obtain rebates from pharmaceutical manufacturers for drugs prescribed through their Medical Assistance programs. Historically, prescription drugs were typically excluded from the services that HMOs and MCOs were required to provide to recipients through their managed care contracts because until March 2010 federal rules prohibited states from obtaining rebates from pharmaceutical manufacturers on drugs prescribed through a managed care arrangement.

DHS believes it can negotiate greater cost savings by separating prescription drug coverage from managed care coverage.

DHS indicated that by continuing to pay for prescription drugs on a fee-for-service basis it can negotiate greater rebates with pharmaceutical manufacturers than HMOs or MCOs could obtain by negotiating separately. For example, since 2006 Wisconsin has participated with seven other states to negotiate rebates on a set of preferred drugs. Provider Synergies, LLC, a pharmaceutical management consulting firm, administers the program. In FY 2009-10, DHS obtained $329.4 million in rebates for prescription drugs.

Increasing the Coordination of Care

DHS has proposed initiatives to coordinate care for recipients who receive services exclusively on a fee-for-service basis.

To help limit the growth in Medical Assistance expenditures, DHS has proposed several initiatives to coordinate care for recipients who receive services exclusively on a fee-for-service basis. 2011 Wisconsin Act 32, the 2011-13 Biennial Budget Act, requires DHS to provide quarterly updates to the Joint Committee on Finance on the estimated savings of these and other initiatives.

Beginning in July 2012, DHS plans to implement a pilot program—the Virtual Program for the All-Inclusive Care of the Elderly—in four regions of the state. DHS reports that it will contract with an independent entity to coordinate the long-term and acute and primary care needs of recipients who are dual-eligibles, including the elderly and those who have a developmental or physical disability, to ensure they receive appropriate care that is delivered in a timely manner. DHS expects this effort to better coordinate care will reduce the frequency and duration of both hospitalizations and the amount of time recipients spend in institutional care settings. The vendor chosen by DHS will be paid on a capitated basis for each enrollee. DHS is seeking authority from federal officials to use both Medicare and Medical Assistance funds to operate the program. If established, DHS estimates the program will serve approximately 20,000 people and will save up to $3.4 million in GPR in FY 2012-13, largely through better coordination of acute and primary care services.

In addition, beginning in January 2012, DHS plans to implement "medical home" initiatives to serve six types of Medical Assistance recipients, including those who:

- are in foster care;
- are pregnant;
- have been diagnosed with HIV or AIDS;
- have diagnosed mental health needs;
- are leaving the criminal justice system; and
- have two or more chronic conditions, such as diabetes and hypertension.

While these individuals are typically eligible for BadgerCare Plus, they may obtain waivers to receive services on a fee-for-service basis, or HMOs may request that they do so in certain cases, such as when their networks of providers are insufficient to serve these recipients' particular needs. DHS anticipates that the medical home initiatives will save a total of $5.2 million in GPR through June 2013.

There is evidence to suggest that coordinating the medical care of fee-for-service recipients is effective in reducing costs.

There is evidence to suggest that coordinating the medical care of fee-for-service recipients can be effective in reducing costs. For example, the Marshfield Clinic, which operates more than 50 clinics throughout Wisconsin, was one of ten physician groups that participated in a five-year federal demonstration project managed by the federal Centers for Medicare and Medicaid Services. The project began in 2005 as an effort to encourage the coordination of care for Medicare recipients and reduce costs. As an incentive to coordinate care, physician groups were given bonus payments, which were in addition to standard Medicare reimbursement rates, if the total cost of care they provided to all participants in the demonstration project was at least 2.0 percent less than the cost of all services provided to a control group of Medicare recipients whose care was not coordinated. The physician groups could increase their bonus payments if they met certain other performance targets, such as providing specific services to individuals diagnosed with diabetes or congestive heart failure. The Marshfield Clinic reported that it was annually awarded bonuses totaling more than $56 million over the five years of the demonstration project.

To ensure greater continuity of care and better control expensive fee-for-service costs, DHS could require recipients to enroll in HMOs more quickly.

To further enhance the coordination of recipients' care, DHS could require BadgerCare Plus recipients to enroll with HMOs more quickly. As noted, for those BadgerCare Plus recipients who live in an area that is served by more than one HMO, DHS allows recipients up to four weeks to select the HMO in which they would like to enroll. To ensure greater continuity of care for those with ongoing health needs and better manage expensive fee-for-service costs, such as high-cost pregnancies and inpatient hospitalizations, DHS could require BadgerCare Plus recipients to enroll in an HMO at the time of eligibility determination, or reduce the four-week period recipients are currently given to select an HMO.

☑ Recommendation

We recommend the Department of Health Services consider the potential benefits of enrolling Medical Assistance recipients into health maintenance organizations in a more timely manner and report to the Joint Legislative Audit Committee by July 2, 2012, on its determination.

▪ ▪ ▪ ▪

Confirming Eligibility ▪

County and tribal agencies conduct fraud prevention activities to ensure that only eligible recipients receive Medical Assistance benefits, identify those who have obtained benefits inappropriately, and recover benefit costs from recipients later found to be ineligible. We reviewed their recovery efforts. In addition, we reviewed available data on recipients who previously resided outside of Wisconsin, including the length of time they lived in Wisconsin before receiving benefits, and assessed the appropriateness of services provided to certain noncitizens, whose eligibility for Medical Assistance services is greatly restricted.

Local Fraud Prevention Efforts

Fraud prevention activities are undertaken by both state and local agencies.

Fraud prevention activities are undertaken by DHS, the Wisconsin Department of Justice (DOJ), and county and tribal agencies. For example, DHS reviews claims paid to Medical Assistance providers to ensure that services have actually been delivered and are allowable, medically necessary, and adequately documented. If it identifies improper payments, it attempts to recover the funds, which are used to offset the costs of the Medical Assistance program. In addition, federal law requires states to operate units that investigate allegations of fraud associated with receipt of Medical Assistance payments and prosecute those providers believed to have committed crimes. Wisconsin's Medicaid Fraud Control Unit is operated by DOJ. Because we reviewed the fraud prevention efforts of DHS and DOJ in our December 2008 evaluation of

Medical Assistance Program Integrity (report 08-15), we reviewed efforts that are primarily undertaken by county and tribal governments.

Counties and tribes are required to undertake efforts to prevent fraud.

DHS requires counties and tribes to conduct fraud prevention activities, such as matching information provided by applicants, including Social Security numbers, to national and state data exchanges in order to confirm their identities and verify their income and employment status. Counties may perform fraud prevention activities independently using their own staff, join a consortium of counties, or participate in a statewide contract that, when implemented, will be overseen by DHS. As of September 2011:

- 59 counties had joined one of four consortia that generally contract with vendors to conduct investigations of potential recipient fraud in the Medical Assistance and FoodShare programs;
- 12 counties performed these functions either directly or by contracting with private vendors without joining a consortium; and
- 1 county—Milwaukee County—was waiting to participate in the state contract that has yet to be finalized by DHS.

Local agencies are required to identify the circumstances under which applicants' information should receive additional verification.

An investigation of possible program violations or fraud may be initiated at any time and can occur during either the initial application or the eligibility renewal process, which is typically required every 12 months. For example, county and tribal agencies are required to create a list of circumstances under which an applicant's information should receive additional verification, including when the applicant has submitted questionable or contradictory documentation of Wisconsin residency or income. Investigations may also be initiated based on referrals made to fraud investigators, eligibility determination staff, or fraud hotlines.

In 2011, the Department of Children and Families (DCF), which maintains county-reported data on the number of investigations and financial recoveries for Medical Assistance and other public assistance programs, began requiring counties to report on all of the investigations they conduct and all amounts they recover. DCF staff noted that previously not all counties had been consistently recording these data in the State's centralized system. Therefore, the number of investigations and amounts recovered before 2011 are likely underreported.

As shown in Table 15, at least 8,975 investigations were conducted from FY 2006-07 through FY 2010-11, including 4,220 reviews of eligibility at the time of initial application or recertification, known as "front-end verifications," and 4,755 fraud investigations, which can be conducted at any time. Front-end verifications are typically initiated when insufficient or contradictory information is provided by an applicant at initial application or during eligibility recertification. Fraud investigations are generally initiated when sufficient evidence exists to suggest that a recipient withheld or misrepresented information in an attempt to obtain Medical Assistance benefits inappropriately, such as by making false or misleading statements, concealing facts, failing to report changes in income, or violating program rules.

Table 15

Reported Investigations of Medical Assistance Recipient Eligibility[1]

Fiscal Year	Front-End Verification	Fraud Investigations	Total
2006-07	965	1,201	2,166
2007-08	805	1,224	2,029
2008-09	1,140	927	2,067
2009-10	696	593	1,289
2010-11	614	810	1,424
Total	**4,220**	**4,755**	**8,975**

[1] The number of investigations conducted is likely underreported because counties did not consistently record all investigations they conducted before 2011.

The number of investigations that were conducted declined from 2,166 in FY 2006-07 to 1,424 in FY 2010-11, largely as a result of a decline in state funding for county and tribal fraud investigation activities. State funding for local Medical Assistance fraud prevention activities declined from $602,500 in FY 2007-08 to $85,500 in FY 2010-11.

From FY 2006-07 through FY 2010-11, $2.9 million in Medical Assistance services provided to ineligible recipients was recovered.

DHS does not maintain data on how many of the 4,220 front-end verifications found that applicants were ineligible and prevented them from receiving services. However, information on financial recoveries from benefits that were provided to ineligible recipients is tracked. As shown in Table 16, financial recoveries resulting from fraud investigations and other administrative actions totaled $2.9 million from FY 2006-07 through FY 2010-11.

Table 16

Reported Financial Recoveries of Medical Assistance Costs for Ineligible Recipients[1]
(as of June 30, 2011)

Fiscal Year	Amount[2]
2006-07	$ 930,502
2007-08	609,417
2008-09	617,125
2009-10	391,893
2010-11	396,441
Total	**$2,945,378**

[1] Recoveries are recorded in the year the recovery was initiated, not in the year payment was issued.

[2] Amounts are likely underreported because counties did not consistently record all amounts they recovered before 2011.

It is difficult to determine the extent to which total financial recoveries will decline from FY 2006-07 through FY 2010-11, because recovered funds are recorded in the year the recovery was initiated, rather than in the year payment was issued. Consequently, it is likely that some recoveries for the most recent years remain outstanding. Nevertheless, the decline in the number of investigations noted during this period suggests that the amount of funds eventually recovered will also decrease.

Recipients Previously Residing Outside of Wisconsin

Questions have also been raised about the extent to which individuals may choose to move to Wisconsin to receive Medical Assistance and other public assistance benefits. To determine the number of Medical Assistance recipients who were previously from outside of Wisconsin, we analyzed data obtained by county and state staff who are responsible for determining applicants' eligibility for the Medical Assistance program. Because it is not required for eligibility determination purposes, neither state nor county staff systematically record the date on which Medical Assistance applicants moved to Wisconsin, or their previous state or country of residence. Therefore, these data likely underestimate the number of recipients who previously resided elsewhere. It should also be noted that people move for many reasons, including to be closer to family members, and no data are collected by state and county staff on the reasons people move to Wisconsin.

From FY 2006-07 through FY 2010-11, at least 88,632 individuals who enrolled in the Medical Assistance program, or 6.5 percent of the total, had previously resided in another state or country, as shown in Table 17. A total of 38,570 individuals, or 43.5 percent of these individuals, were 18 years old or younger.

Table 17

New Medical Assistance Recipients Who Previously Resided Outside of Wisconsin[1]

Fiscal Year	Total New Recipients	Number Who Previously Resided Outside of Wisconsin	Percentage of New Recipients
2006-07	187,576	12,464	6.6%
2007-08	228,365	16,193	7.1
2008-09	248,303	14,515	5.8
2009-10	336,289	19,494	5.8
2010-11	354,167	25,966	7.3
Total	**1,354,700**	**88,632**	6.5

[1] Includes individuals for whom information on a prior residence was recorded.

Almost two-thirds of those moving to Wisconsin resided in the state for more than 12 months before receiving Medical Assistance benefits.

From FY 2006-07 through FY 2010-11, 57,449 recipients, or 64.8 percent of those who moved to Wisconsin, had resided in the state for more than 12 months before they received Medical Assistance benefits, as shown in Table 18. This suggests that obtaining Medical Assistance benefits was likely not a motivating factor in the decision of most recipients to move to Wisconsin. In contrast, 18,338 individuals (20.7 percent) received benefits within their first month of residence.

Table 18

Length of Wisconsin Residency before Receipt of Medical Assistance Benefits[1]
FY 2006-07 through FY 2010-11

	Number	Percentage
Up to 1 month	18,338	20.7%
More than 1 month up to 3 months	4,335	4.9
More than 3 months up to 6 months	2,141	2.4
More than 6 months up to 12 months	2,473	2.8
More than 12 months	57,449	64.8
Unknown	3,896	4.4
Total	**88,632**	**100.0%**

[1] Includes those individuals who reported or were determined to have previously resided in another state or country.

In addition, we reviewed where recipients had resided before they moved to Wisconsin. As shown in Table 19, 85.5 percent of those who enrolled in Medical Assistance within their first three months of moving to Wisconsin came from other states, including 6,083 individuals who previously resided in Illinois and 1,648 individuals who previously resided in Minnesota. An additional 3,046 recipients came from other countries.

Table 19

State or Country of Prior Residence[1]
FY 2006-07 through FY 2010-11

	Number	Percentage
Other States and United States Territories		
Illinois	6,083	26.8%
Minnesota	1,648	7.3
Puerto Rico	1,070	4.7
Texas	958	4.2
Michigan	832	3.7
Other	8,788	38.8
Subtotal	19,379	85.5
Other Countries		
Myanmar (formerly Burma)	918	4.0
Somalia	496	2.2
Iraq	253	1.1
Thailand	215	0.9
Mexico	174	0.8
Other	990	4.4
Subtotal	3,046	13.4
Unknown	248	1.1
Total	**22,673**	**100.0%**

[1] Includes only those individuals who became Medical Assistance recipients within three months of moving to Wisconsin.

Services Provided to Noncitizens

State law generally requires Medical Assistance recipients to be United States citizens and reside in Wisconsin.

DHS 103, Wis. Adm. Code, generally requires Medical Assistance recipients to be United States citizens and reside in Wisconsin. Citizens may apply for and obtain Medical Assistance benefits on the same day they arrive in the state if they meet other eligibility requirements. Under federal and state Medical Assistance rules, naturalized citizens are eligible for full benefits under the Medical Assistance program, as are certain noncitizens such as:

- permanent residents who have lived in the United States for five years or more;
- individuals from Cuba or Haiti, regardless of their United States citizenship status;
- refugees or asylum seekers from certain countries, such as Iraq and Somalia; and
- undocumented individuals who are elderly, blind, disabled, or under 18 years of age.

Undocumented adult aliens may receive only emergency services or services related to a pregnancy.

Certain lawfully admitted adults who have resided in the United States for less than five years and all undocumented adult aliens, such as those who have never obtained documentation to reside in the country or whose visa or other documentation has expired, may receive only emergency services for a life-threatening health condition or services related to a pregnancy. Therefore, we reviewed all care provided to undocumented adult aliens and lawfully admitted adult noncitizens who had resided in the United States for less than five years to determine whether the care provided to them was exclusively related to emergencies or pregnancy.

From FY 2006-07 through FY 2010-11, $10.7 million in emergency and pregnancy-related services were provided to adult non-citizens.

From FY 2006-07 through FY 2010-11, 1,225 individuals, including 1,026 undocumented aliens and 199 lawfully admitted individuals who had resided in the United States for less than five years, had at least one Medical Assistance claim. Services provided to these recipients totaled $10.7 million during this period, of which $9.0 million was for pregnancy-related services and $1.7 million was for emergency services. To prevent paying for claims unrelated to an emergency or pregnancy, DHS's claims processing system is programmed to deny any claim for undocumented adult aliens and lawfully admitted adult noncitizens that is not for specific types of emergency or pregnancy-related procedures. We did not identify any claims that appeared unrelated to an emergency or a pregnancy.

Future Considerations ■

The size and complexity of the Medical Assistance program have increased substantially. In order for DHS and the Legislature to effectively manage and oversee the program, improvements in program budgeting and financial management are needed. In an effort to reduce Medical Assistance expenditures, DHS has developed and implemented a variety of cost-containment initiatives. DHS currently plans to reduce benefits and restrict eligibility for some low-income adults and children if it receives federal approval to do so. In addition, DHS will need to closely monitor the implementation of the federal Patient Protection and Affordable Care Act in Wisconsin to ensure the health care needs of low-income individuals are met in a cost-effective manner.

Improving Program Budgeting and Financial Management Information

The size and complexity of the Medical Assistance program have increased substantially over the past decade, but the State's budgeting and financial management practices have not kept pace with these changes. As noted, DHS has not been able to readily produce the type of information that would be useful in managing a large, complex collection of health care programs and is desired by legislators in overseeing the program.

Not all Medical Assistance-funded expenditures are included as part of the Medical Assistance budget or recorded as the program's expenditures.

We identified two primary budgeting and financial management issues that we believe need improvement. First, not all Medical Assistance-funded expenditures are included in the Medical Assistance budget or recorded as Medical Assistance expenditures. For example, some GPR funding and expenditures associated with both the Community Options Program and the Community Integration Program are not currently included in Medical Assistance budgets or expenditure reporting. While federal matching funds spent on these subprograms are recorded as Medical Assistance expenditures, we identified an estimated $62.7 million in GPR expenditures for FY 2006-07 and $12.0 million for FY 2010-11 for which federal matching funds were claimed but were neither used in estimating the program's overall budget nor reported as Medical Assistance expenditures. DHS indicated this occurred, in part, because the Community Options Program began as a state-initiated program and only later became eligible for federal reimbursement under the Medical Assistance program through receipt of a waiver.

Second, DHS neither budgets nor routinely accounts for Medical Assistance expenditures on a subprogram basis. Instead, DHS uses a complex process to calculate the overall program budget by estimating the number and type of Medical Assistance recipients to be served, as well as the corresponding expenditures for the types and amounts of services they are likely to receive. In published budget documents, this information is often summarized as two numbers: an adjusted program base and additional funds needed to continue program operations.

Data in the State's accounting systems were insufficient to apportion $2.0 billion in Medical Assistance expenditures among the various subprograms in FY 2009-10.

Neither the State's accounting system nor the internal accounting system used by DHS contain sufficient information to apportion all Medical Assistance expenditures by subprogram. Specifically, neither accounting system could identify on which subprograms $2.0 billion in Medical Assistance funds, including over $1.4 billion in federal funds and $551 million in GPR, was spent in FY 2009-10. As noted, we had to rely on expenditure estimates from HP Enterprise Services and other sources to allocate estimated costs among the various Medical Assistance subprograms.

Enhancing the process by which budgets for the Medical Assistance program are developed and expenditures are tracked could help address long-standing concerns about the availability and quality of data on the Medical Assistance program. We believe the best way to accomplish this is by establishing separate subprogram appropriations within the State's budget. This would provide members of the Legislature, the Governor, fiscal staff in both the Department of Administration and the Legislative Fiscal Bureau, and the public with better information about how funds are likely to

be spent among subprograms and whether assumptions made in developing budgeted estimates are reasonable. It would also create the means to account for Medical Assistance expenditures by subprogram in both the State's accounting system and the internal accounting system used by DHS. This type of information is crucial because the Medical Assistance program is typically considered in terms of its various subprograms, which are also often the basis for proposed programmatic changes.

☑ Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by July 2, 2012, on its plans to:

- *account for all expenditures for which the State receives federal Medical Assistance matching funds as expenditures under the Medical Assistance program; and*
- *develop a more detailed biennial budget request and financial reporting structure for the Medical Assistance program that includes establishing separate appropriations for each subprogram and routinely reporting expenditures on a subprogram basis, including any additional costs that would be incurred to implement this initiative.*

Comparisons with Other States

Michigan generally has the strictest income eligibility limits for Medical Assistance recipients among the six midwestern states we reviewed.

In conducting our review, we compared Wisconsin's Medical Assistance program to those of five other midwestern states based on income eligibility, enrollment, expenditures, and premiums and copayments charged to recipients. As shown in Table 20, Michigan has the strictest income eligibility limits for all Medical Assistance recipients other than for the elderly and for individuals with disabilities. Michigan is also 1 of 33 states that do not offer Medical Assistance benefits to parents with incomes up to 100 percent of the federal poverty level. While five of the six midwestern states provided Medical Assistance benefits to adults without dependent children, Illinois is 1 of 26 states that do not provide this coverage. As of September 2011, Indiana, Michigan, and Wisconsin have capped the number of adults without dependent children that will be covered by their respective Medical Assistance programs, largely for budgetary reasons.

Table 20

Maximum Income Eligibility Limits for Medical Assistance Recipients
(as a percentage of the 2011 federal poverty level)

	Children	Parents or Caretakers	Pregnant Women	Adults without Dependent Children	Elderly and Disabled[1]
Illinois	Up to 300%	Up to 200%	Up to 200%	Not Covered	Up to 100%
Indiana	250	200	200	Up to 200%	83
Iowa	300	250	300	250	83
Michigan	200	Varies[2]	185	35	100
Minnesota	275	275	275	250	100
Wisconsin	300	200	300	200	94

[1] Some recipients with incomes above eligibility limits are eligible for services after meeting income "spend-down" requirements.

[2] The base level for Medical Assistance eligibility is 33 percent of the federal poverty level. However, parents or caretakers with incomes greater than 33 percent of the federal poverty level may qualify for certain benefits, but they are required to pay a deductible for all services that increases with the families' incomes.

As shown in Table 21, the number of Medical Assistance recipients in each of the six states increased from June 2006 to June 2010, the most recent year for which comparable information was readily available for all six states. Illinois had the largest percentage increase (35.9 percent) among the midwestern states we reviewed, while Minnesota had the smallest percentage increase (21.7 percent). Variation in the number of recipients resulted from multiple factors, such as differences in who is eligible, how eligibility criteria have changed over time, and localized economic effects.

Total Medical Assistance expenditures also increased from federal fiscal year (FFY) 2005-06 through FFY 2009-10. As shown in Table 22, Illinois had the largest percentage increase (48.2 percent) in expenditures during this time period, while Indiana had the lowest percentage increase (6.7 percent). Data on the reasons for this disparity were not readily available.

Table 21

Medical Assistance Enrollment in Selected Midwestern States

	June 2006	June 2010	Percentage Change
Illinois	1,805,100	2,453,900	35.9%
Wisconsin	856,800	1,133,300	32.3
Iowa	316,400	407,300	28.7
Michigan	1,460,400	1,870,000	28.0
Indiana	779,400	964,500	23.7
Minnesota	585,600	712,700	21.7

Source: Enrollment totals for states other than Wisconsin were obtained from the Kaiser Foundation's *State Health Facts* website.

Table 22

Medical Assistance Expenditures in Selected Midwestern States
(in billions)

	FFY 2005-06	FFY 2009-10	Percentage Change
Illinois	$11.0	$16.3	48.2%
Wisconsin	4.9	6.9	40.8
Michigan	8.9	12.2	37.1
Minnesota	5.8	7.9	36.2
Iowa	2.7	3.2	18.5
Indiana	6.0	6.4	6.7

Source: Federal Centers for Medicare and Medicaid Services.

States may use premiums and copayments paid by recipients to help offset total Medical Assistance costs.

States may use premiums and copayments collected from recipients to help offset total Medical Assistance costs, but federal rules require total out-of-pocket expenses for recipients be limited to no more than 5.0 percent of an individual's or family's monthly or quarterly income. To compare monthly premium amounts across midwestern states, we calculated the total monthly premium for a family of three—an adult caretaker and two children—with an annual family income at 175 percent of the federal poverty level, which is $32,428

in 2011. As shown in Table 23, the amount of monthly premiums paid by Medical Assistance recipients in midwestern states varies widely. Michigan requires a monthly premium of $10, while Minnesota requires a monthly premium of $124 for this three-member family.

Table 23

Medical Assistance Monthly Premiums for Families at 175 Percent of the Federal Poverty Level
2011

	Premium for a Family of One Adult and Two Children
Michigan	$ 10[1]
Illinois	30
Iowa	47
Wisconsin	68
Indiana	87
Minnesota	124

[1] Includes monthly premium amount for children only; adults are excluded from premium calculations.

We also reviewed available data on recipient copayments. Unlike premiums that are paid monthly regardless of whether a recipient uses health care services, copayments are charged only when a service is used. We analyzed the extent to which midwestern states required copayments for nine Medical Assistance services that had high total annual expenditures, a rapid increase in expenditures during the past five years in Wisconsin, or were more susceptible to fraud or abuse by providers or recipients. The nine service types we analyzed were chiropractic, dental, durable medical equipment and supplies, emergency room visits for nonemergency services, home health and personal care services, inpatient hospitalization, outpatient hospitalization, prescription drugs, and nonemergency medical transportation.

As shown in Table 24, Illinois required Medical Assistance recipients to make copayments for eight of the nine services, while Minnesota required copayments for three of them. All six midwestern states require copayments for prescription drugs, varying from $3 in Iowa, Michigan, Minnesota, and Wisconsin, to $10 in Indiana. In addition,

all states except for Wisconsin charged copayments for emergency room visits when used for nonemergency services, and these ranged from $3 in Indiana, Iowa, Michigan, and Minnesota to $25 in Illinois.

Table 24

Maximum Allowable Copayments for Selected Medical Assistance Services[1]
(amount is per service or per admission unless otherwise noted)

Service Type	Illinois[2,4]	Indiana[4]	Iowa[3]	Michigan[3]	Minnesota[3]	Wisconsin[4]
Chiropractic	$ 5.00	–	$1.00	–	–	$3.00
Dental	5.00	–	3.00	$ 3.00	–	3.00
Durable Medical Equipment and Medical Supplies	5.00	–	3.00	–	–	3.00
Emergency Room Visits[5]	25.00	$ 3.00	3.00	3.00	$3.00	–
Home Care Services	5.00	–	–	–	–	–
Inpatient Hospital	5.00	–	–	50.00	–	3.00[6]
Outpatient Hospital	5.00	1.00	3.00	1.00	3.50	3.00
Prescription Drugs	5.00	10.00	3.00	3.00	3.00	3.00
Transportation	–	10.00	2.00	–	–	2.00

[1] Based on BadgerCare Plus Standard Plan recipients and similar programs in other midwestern states.

[2] Illinois caps annual copayments at a total of $100 per family for all services.

[3] Recipients under 21 years old are exempt from copayments.

[4] Recipients under 18 years old are exempt from copayments.

[5] Copayment applies only when emergency rooms are used for nonemergency services.

[6] Represents the copayment charged per day. Total copayment is limited to $75 per admission.

Although copayments have been established for many services, they may not be routinely collected by health care providers.

While Wisconsin requires copayments for certain Medical Assistance services, it allows providers to waive copayments if they believe collecting them would be too burdensome. During our fieldwork, providers and their representatives reported that it was common for copayments to be waived because they do not believe it is cost-effective to attempt to collect them from recipients, in part, because they believe some recipients cannot afford to pay them or are reluctant to do so. Similar conditions may also be true in other states, but we were not able to confirm this. Because some copayments are not routinely collected, DHS is not receiving all revenue available to it, and the potential effect that copayments may have in discouraging some unnecessary utilization of services is diminished.

Approaches to Controlling Costs

Finding ways to control Medical Assistance expenditures is complex and requires consideration of the effects that proposed changes in eligibility, benefits, and provider reimbursements are likely to have on the availability and adequacy of care. In addition, some proposed changes to Wisconsin's Medical Assistance program will require approval by the federal government.

There are several potential strategies that could be employed to better control Medical Assistance costs.

There are several potential strategies that could be employed to better control Medical Assistance costs, including:

- modifying financial eligibility rules, such as income and asset limits;
- modifying non-financial eligibility rules, such as eliminating eligibility for childless adults;
- placing restrictions or caps on the number of recipients a particular subprogram may serve;
- limiting the types or amounts of services that recipients can receive;
- increasing the amount recipients share in the cost of their health care services by modifying premium and copayment requirements;
- reducing payments to health care providers;
- enhancing efforts to recover improper payments;
- streamlining methods of service delivery, such as through managed care arrangements or other strategies intended to seek administrative efficiencies; and
- implementing preventative measures, such as blood pressure screenings, immunizations, and promoting healthy lifestyles.

However, the effects of any of these changes will depend on a variety of factors, including their scope, duration, and the willingness of providers to continue to provide services.

Many states have sought to identify cost-savings strategies for their Medical Assistance programs.

Concerns about the growth in Medical Assistance costs are not new, but have been exacerbated by recent economic downturns. Many states, including Wisconsin, have sought to identify cost-savings strategies by hiring contractors to provide suggestions, asking state employees to develop initiatives, and seeking public input on

possible approaches. To date, states have taken a variety of approaches, including some that have been controversial or rejected by the federal government. For example:

- In a decision that raised substantial public concern, Arizona discontinued Medical Assistance coverage for certain high-cost transplants of the heart, liver, lung, pancreas, and bone marrow beginning in October 2010. Arizona officials estimated these reductions would save approximately $4.5 million per year. However, Arizona reversed its decision, in part as a result of media reports detailing the deaths of two Medical Assistance recipients who had been denied transplants, and in April 2011 began covering almost all of the transplants that had previously been excluded.

- In January 2011, Illinois enacted initiatives estimated to save $774 million over five years. One notable initiative requires 50 percent of its Medical Assistance recipients who currently receive services on a fee-for-service basis to enroll in "coordinated care" by January 1, 2015. Earlier this year, the federal Centers for Medicare and Medicaid Services notified Illinois that three of its initiatives related to income and residency verification violate federal law because they include changes to Medical Assistance eligibility criteria.

- In April 2011, New York enacted 78 cost-savings initiatives as part of the state's budget that it anticipates will reduce Medical Assistance spending by an estimated $2.2 billion in the current fiscal year, such as by reducing the rates paid to all Medical Assistance providers by 2.0 percent, placing a 4.0 percent cap on total program growth, and initiating a three-year transition to managed care for all Medical Assistance recipients. It appears that some of these initiatives, including transitioning all recipients to managed care, will require federal approval before they can be implemented.

- In July 2011, Florida enacted initiatives that are anticipated to save an estimated $1.1 billion during the first year, such as expanding managed care to most recipients and allowing certain recipients to use Medical Assistance funds to

purchase health care from private insurers through an exchange developed by the state. Florida is currently awaiting federal approval of these state-enacted changes before implementing them.

An October 2011 report issued by the Kaiser Commission on Medicaid and the Uninsured included the results from a survey of all 50 states. It reported that provider rate restrictions was the most frequently cited cost-containment strategy being implemented nationally, with 39 states freezing or reducing provider reimbursement rates in FY 2010-11 and 46 states planning to do so in FY 2011-12. Another commonly reported strategy was the expansion of managed care services, primarily by expanding the geographical areas and the types of recipients covered by managed care plans. In FY 2010-11, 17 states reported they expanded their use of managed care arrangements for Medical Assistance recipients, while 24 states indicated they planned to do so in FY 2011-12.

DHS achieved $222.2 million less in Medical Assistance savings than required by 2009 Wisconsin Act 28.

In Wisconsin, 2009 Wisconsin Act 28, the 2009-11 Biennial Budget Act, required DHS to identify a total of $633.0 million in savings to offset growing Medical Assistance expenditures, as noted. From FY 2009-10 through FY 2010-11, DHS operated a rate reform project to generate cost-savings strategies from its staff, contractors, and advisory groups. DHS developed a total of 88 initiatives that it believed would allow it to save $525.1 million. As shown in Table 25, DHS implemented 80 of the 88 initiatives and projected total savings of $410.8 million, which is $222.2 million less than was required by the Act.

Table 25

Projected Savings from the Rate Reform Project in Wisconsin
FY 2009-10 through FY 2010-11
(in millions)

	Number of Initiatives	Reported Savings[1]
Payment Reductions and Modifications	38	$267.9
Modification to the Type or Amount of Services Provided	25	111.9
Other Savings	17	31.0
Total	**80**	**$410.8**

[1] Includes projected savings of both federal and state funds.

DHS reported that several initiatives that it implemented generated considerable savings, including:

- $115.1 million through prescription drug initiatives, such as increasing the use of generic prescription drugs, using uniform prescription drug lists, and limiting the number of times a prescription may be refilled;
- $106.5 million through reducing administrative costs, such as reducing payments to the HMOs that provide services to recipients in the BadgerCare Plus subprogram and competitively rebidding HMO contracts to provide services to BadgerCare Plus recipients in several southeastern Wisconsin counties; and
- $22.0 million by accelerating payments to HMOs and MCOs in order to obtain additional federal matching funds.

DHS plans to identify savings totaling $554.4 million for the 2011-13 biennium.

2011 Wisconsin Act 32, the 2011-13 Biennial Budget Act, required DHS to identify additional Medical Assistance savings to remain within budgeted levels for the 2011-13 biennium. Based on the most recent projections, DHS estimates that it will need to identify a total of $554.4 million in savings, including $334.9 million in federal funds and $219.5 million in state funds. Act 32 also requires DHS to submit quarterly reports to the Joint Committee on Finance that:

- describe the changes DHS has made to the Medical Assistance program;
- estimate the amounts that will be saved because of the programmatic changes it implements; and
- project total Medical Assistance benefit expenditures during the biennium compared to budgeted amounts.

Some of the changes DHS intends to make to the Medical Assistance program have raised concerns among recipients and their advocates.

In September 2011, DHS delivered its first report, which identified 38 cost-savings initiatives. Some of the changes DHS intends to make to the Medical Assistance program have raised concerns among recipients and their advocates. This is not surprising, given that the proposed changes may affect some individuals' access to health care and the type and amount of benefits recipients receive. DHS originally projected that it would save $229.3 million in GPR if all 38 initiatives were implemented, which DHS believed would be sufficient to meet its overall goal of $554.4 million in total savings.

Five of these initiatives were projected to save $143.5 million, or 62.6 percent of the total, including:

- $54.4 million from changes to Medical Assistance eligibility rules, such as increasing recipients' premiums and making ineligible those individuals who have access to health insurance through an employer, if an employee's contribution is less than 9.5 percent of the household's income;
- $45.0 million from the federal government, because DHS believes it was incorrectly required to pay for services to certain recipients that were covered by other federal programs, such as Medicare;
- $19.2 million from changing how DHS obtains federal matching funds for certain home and community-based services funded under the Medical Assistance program;
- $14.9 million by adding 10.0 FTE auditors to identify improper payments to providers and using "extrapolation audits," which analyze a sample of paid claims and project the amount that is potentially recoverable from all claims. We recommended that DHS adopt this methodology in our December 2008 report on Medical Assistance program integrity efforts (report 08-15); and
- $10.0 million by providing fewer services to children and adults with incomes above 100 percent of the federal poverty level, or $22,350 per year for a family of four.

The federal government informed the State that it will not receive $45.0 million in additional federal funds that DHS had anticipated.

In October 2011, the federal government informed the State that it will not receive the additional $45.0 million in federal funds for Medical Assistance services DHS believes should have been covered under other federal programs.

DHS is also required by s. 49.45(2m)(d), Wis. Stats, to submit to the Joint Committee on Finance for review those initiatives that conflict with certain statutes, such as those related to eligibility for Medical Assistance benefits or that require submitting a Medical Assistance waiver or amendment to the federal Centers for Medicare and Medicaid Services. In October 2011, DHS submitted to the Joint Committee on Finance for its review a proposal detailing three initiatives totaling $119.6 million in GPR savings, which is a subset of the items contained in the cost-savings plan required by the

2011-13 Biennial Budget Act, as previously noted, but with revised savings projections, including:

- $88.2 million from changes to Medical Assistance eligibility rules;
- $26.2 million from changes reducing benefit levels for some recipients; and
- $5.2 million by coordinating the care of recipients who receive services exclusively on a fee-for-service basis.

DHS estimates its proposed changes will eliminate coverage for 42,200 current recipients and reduce benefits for 263,000 others.

DHS estimates these changes will eliminate coverage for 42,200 current recipients, including approximately 15,000 children; lead to the voluntary disenrollment of 22,500 individuals due to increased premiums; and reduce benefits for an additional 263,000 recipients.

In November 2011, the Joint Committee on Finance approved DHS's proposal. However, in order to implement any changes to Medical Assistance eligibility rules currently in effect, DHS must obtain a waiver from the federal government. If the waiver is not approved by December 31 of this year, 2011 Wisconsin Act 32, the 2011-13 Biennial Budget Act, requires DHS to reduce the income eligibility limits for non-disabled, non-pregnant adults to 133 percent of the federal poverty level, which DHS estimates would allow it to exclude from the program approximately 53,000 current Medical Assistance recipients. However, under restrictions imposed by the federal Patient Protection and Affordable Care Act, DHS may do so only if the State certifies to the federal government that it has or is projected to have a budget deficit in FY 2011-12.

In December 2011, the federal Centers for Medicare and Medicaid Services notified DHS that its request to modify Medical Assistance eligibility rules remains under review. However, it granted DHS approval to implement those proposals that are consistent with the federal Patient Protection and Affordable Care Act. For the BadgerCare Plus and BadgerCare Plus Core subprograms, DHS may:

- exclude adults who are neither pregnant nor disabled and have household incomes above 133 percent of the federal poverty level, if they can access health insurance through their employers and their share of insurance premiums would be less than 9.5 percent of their incomes;
- suspend for a period of one year adult recipients who are neither pregnant nor disabled and have household incomes above 133 percent of the federal poverty level if they fail to pay their subprogram premiums;

- increase subprogram premiums for adults who are neither pregnant nor disabled by up to 5.0 percent of household income if they have incomes above 150 percent of the federal poverty level; and

- discontinue paying for services for adults and children 10 days after their eligibility ends. Currently, recipients may continue to receive services through the end of the month in which their eligibility ends.

The federal Patient Protection and Affordable Care Act requires Wisconsin and other states to develop and administer health care "exchanges."

It will also be necessary to consider how the federal Patient Protection and Affordable Care Act, which became law in March 2010, will affect the range of potential cost-savings options. Beginning in January 2014, the Act expands Medical Assistance coverage to some individuals who are not currently eligible and requires United States citizens and legal residents who are not covered by Medical Assistance or Medicare to purchase health insurance or to pay a penalty for not doing so. Individuals may purchase insurance through state-administered health care "exchanges," which are expected to be competitive insurance marketplaces in which individuals can purchase private or public health insurance plans. Currently, DHS and the Office of the Commissioner of Insurance are researching the exchange requirements.

In addition, 2011 Senate Bill 273 would establish a health care exchange in Wisconsin by January 1, 2014, that would provide qualified health plans to individuals based on the criteria established in the Patient Protection and Affordable Care Act. The bill focuses on health plans for employers with no more than 100 employees. Under the proposal, one of the duties of the health care exchange would be to inform individuals of eligibility requirements for Medical Assistance and assist eligible individuals to enroll in the program.

The federal Patient Protection and Affordable Care Act expands eligibility nationally to most individuals with incomes up to 133 percent of the federal poverty level.

The Act also affects the provision of Medical Assistance benefits in two significant ways. First, beginning in January 2014, the Act requires all states to enroll in their Medical Assistance programs all non-Medicare eligible individuals under age 65, including children, pregnant women, parents, and adults without dependent children, who have incomes up to 133 percent of the federal poverty level. Individuals who are uninsured and have household incomes between 133 percent and 400 percent of the federal poverty level may receive federal tax credits to purchase private insurance through the health care exchanges or may be enrolled in the Medical Assistance program.

Second, from January 2014 through December 2016 the federal government will reimburse 100 percent of the health care costs for some adult recipients who were not previously receiving services through the Medical Assistance program. Federal reimbursement decreases to 95 percent in 2017 and continues to decline until it reaches 90 percent in 2020 and all subsequent years. However, a 23 percentage point increase in federal matching funds will be provided for services to children beginning in October 2015.

Overall, the effects of the federal Patient Protection and Affordable Care Act on the State's Medical Assistance expenditures are difficult to predict, in part because the federal government has not finalized regulations implementing the Act and portions of the Act remain subject to judicial review. Whether there will be a significant change in the number of recipients served by Wisconsin's Medical Assistance program after January 2014 is currently unknown. However, the Act will provide additional federal funding to cover some additional Medical Assistance costs, especially for children.

Implementation of the federal Patient Protection and Affordable Care Act will have to be closely monitored by DHS.

In addition, it will be important for DHS to consider how Medical Assistance enrollment will change as a result of the Act's implementation. If the federal government approves DHS's waiver request to eliminate coverage for certain individuals, some of these individuals will likely become eligible for Medical Assistance services again beginning in 2014, such as adults with access to employer-sponsored health insurance, while others will likely purchase health care coverage through an exchange. At present, it is unclear how Wisconsin's Medical Assistance program will be affected by these changes. However, because the Act could have substantial effects on Wisconsin's Medical Assistance expenditures, and because federal reimbursement amounts will continually change from 2014 through 2020, its implementation will have to be closely monitored by DHS.

☑ Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by January 14, 2013, on how implementation of the federal Patient Protection and Affordable Care Act will affect both participation and costs in Wisconsin's Medical Assistance program.

▪ ▪ ▪ ▪

Appendix 1

Mandatory and Optional Medical Assistance Services

Mandatory Services

- Nursing facility services for individuals aged 21 or older, other than services provided in an institution for mental disease
- Inpatient hospital services
- Outpatient hospital services
- Physician and clinic services
- Rural health clinic services
- Laboratory and x-ray services
- Early periodic screening, diagnosis, and treatment for children
- Nurse practitioner services
- Family planning services
- Prenatal care and delivery services

Optional Services[1]

- Nursing facility services operated by religious nonmedical institutions or facilities located on an Indian reservation
- Inpatient hospital, nursing facility, and intermediate care facility services for individuals aged 65 or older who reside in institutions for mental disease
- Inpatient psychiatric services for individuals under the age of 21
- Intermediate care facilities
- Private duty nursing services
- Medical and remedial care authorized by state statute, such as transportation and emergency hospital services
- Certain medical services recommended by a physician that diagnose illness or injury, detect disease, prevent disease and disability, and rehabilitate individuals to the best possible functional level

Optional Services[1] *(continued)*

- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Dental services
- Prescription drugs
- Vision and eyeglasses
- Prosthetic devices and dentures
- Personal care services
- Case management services
- Home and community-based services
- Respiratory care for ventilator-dependent individuals

[1] Wisconsin's Medical Assistance program provides all optional services. However, the type and amount of services provided by each subprogram varies. States that provide optional services must obtain approval from the federal Centers for Medicare and Medicaid Services to discontinue providing the services.

Appendix 2

Medical Assistance Subprogram Profiles

BadgerCare Plus

BadgerCare Plus Core

Brain Injury Waiver

Children Come First and Wraparound Milwaukee

Children's Long-Term Supports

Community Integration Program (CIP)

Community Options Program (COP)

Family Care

Family Care Partnership

Family Planning Waiver

Include, Respect, I Self-Direct (IRIS)

Program for the All-Inclusive Care for the Elderly (PACE)

Qualified Medicare Beneficiaries

SeniorCare

SSI Managed Care

BadgerCare Plus

Date Implemented: February 2008

Eligibility: Recipients receive services through one of two plans. BadgerCare Plus Standard plan provides health care services to:

- children under age 19, parents and caretakers, and pregnant women with household incomes of up to 200 percent of the federal poverty level; and
- individuals aged 18 through 20 who are leaving foster care and were 18 on or after January 1, 2008, regardless of household income.

Badger Care Plus Benchmark plan provides health care services to:

- children under age 19 with household incomes greater than 200 percent of the federal poverty level;
- pregnant women with household incomes from 201 percent to 300 percent of the federal poverty level; and
- certain self-employed parents with household incomes of up to 200 percent of the federal poverty level.

The BadgerCare Plus Standard plan provides all acute and primary care services authorized under the Medical Assistance plan and certain services may require copayments of up to $3. The BadgerCare Plus Benchmark plan provides limited acute and primary care services and may require higher copayment amounts.

Parents or caretakers with incomes from 151 percent of the federal poverty level to 200 percent of the federal poverty level are required to pay monthly premiums ranging from $10 to $268. Premiums for children whose family incomes are greater than 200 percent of the federal poverty level range from $10 to $98.

Covered Services: Acute and primary care services, such as inpatient and outpatient hospitalization, physician and clinic visits, laboratory and x-ray services, and medical equipment and supplies.

Service Delivery Model: Managed care

Service Area: Statewide

Enrollment in January 2011: 766,342

Estimated Expenditures in FY 2009-10: $1.3 billion. Does not include expenditures for certain services, such as prescription drugs, that are not included in the managed care plan and are paid for on a fee-for-service basis.

BadgerCare Plus Core

Date Implemented: January 2009

Eligibility: Recipients must be adults with no dependent children and have incomes up to 200 percent of the federal poverty level. Recipients must pay an annual enrollment fee of $60 and complete a comprehensive physical exam within the first year of enrollment.

Covered Services: Acute and primary care services, such as inpatient and outpatient hospitalization, physician and clinic visits, laboratory and x-ray services, and medical equipment and supplies.

Service Delivery Model: Managed care

Service Area: Statewide

Enrollment in January 2011: 45,039

Estimated Expenditures in FY 2009-10: $63.1 million. Does not include expenditures for certain services, such as prescription drugs, that are not included in the managed care plan and are paid for on a fee-for-service basis.

Brain Injury Waiver

Date Implemented: January 1995

Eligibility: Recipients must be diagnosed with a brain injury and be receiving or be eligible to receive post-acute rehabilitation services in a nursing home or hospital designated as a special unit for brain injury rehabilitation by DHS. Individuals must also have less than $2,000 in assets and may be required to pay a deductible if their monthly incomes exceed an established limit, which was $592 as of January 2011.

Covered Services: Long-term care, including assistance with the tasks of daily living, such as eating, bathing, dressing, medication management, and transportation. Services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: County contract

Service Area: Statewide

Enrollment in January 2011: 92

Estimated Expenditures in FY 2009-10: $6.8 million. Does not include expenditures for certain services, such as prescription drugs, that are paid for on a fee-for-service basis.

Children Come First and Wraparound Milwaukee

Date Implemented: Children Come First began in April 1993 and Wraparound Milwaukee began in March 1997

Eligibility: Recipients must be under age 18, have severe mental health issues, and be either in out-of-home care or at risk of admission to a psychiatric hospital, placement in a residential care center, or incarceration at a juvenile corrections facility.

Covered Services: Mental health and substance abuse services, which are provided as an alternative to inpatient care for children with emotional or mental health needs.

Service Delivery Model: Managed care

Service Area: Children Come First operates in Dane County and Wraparound Milwaukee operates in Milwaukee County.

Enrollment in January 2011: 997

Estimated Expenditures in FY 2009-10: $20.9 million. Does not include expenditures for certain services, such as prescription drugs, that are not included in the managed care plan and are paid for on a fee-for-service basis.

Children's Long-Term Supports

Date Implemented: January 2004

Eligibility: Recipients must be under age 22 and have a developmental or physical disability or severe mental health issues. Parents' incomes are not considered for eligibility determination. In general, children may not have incomes greater than $2,022 per month or assets greater than $2,000.

Covered Services: Long-term care, including assistance with the tasks of daily living, such as eating, bathing, dressing, medication management, and transportation. Services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: County contract

Service Area: Statewide

Enrollment in January 2011: 4,583

Estimated Expenditures in FY 2009-10: $61.7 million. Does not include expenditures for certain services, such as prescription drugs, that are paid for on a fee-for-service basis.

Community Integration Program (CIP)

Date Implemented: January 1996

Eligibility: Recipients must be adults with developmental disabilities that are long-term and irreversible and be determined to need assistance to safely or appropriately perform basic daily living skills. Individuals must also have less than $2,000 in assets and may be required to pay a deductible if their monthly incomes exceed an established limit, which was $592 as of January 2011.

Covered Services: Long-term care, including assistance with the tasks of daily living, such as eating, bathing, dressing, medication management, and transportation. Services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: County contract

Service Area: The subprogram is administered in the 15 counties that do not administer the Family Care subprogram.

Enrollment in January 2011: 4,122

Estimated Expenditures in FY 2009-10: $179.4 million. Does not include expenditures for certain services, such as prescription drugs, that are paid for on a fee-for-service basis.

Community Options Program (COP)

Date Implemented: January 1990

Eligibility: Recipients must be elderly or adults with physical disabilities that are long-term and irreversible and be determined to need assistance to safely or appropriately perform basic daily living skills. Individuals must also have less than $2,000 in assets and may be required to pay a deductible if their monthly incomes exceed an established limit, which was $592 as of January 2011.

Covered Services: Long-term care, including assistance with the tasks of daily living, such as eating, bathing, dressing, medication management, and transportation. Services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: County contract

Service Area: The subprogram is administered in the 15 counties that do not administer the Family Care subprogram.

Enrollment in January 2011: 3,415

Estimated Expenditures in FY 2009-10: $78.7 million. Does not include expenditures for certain services, such as prescription drugs, that are paid for on a fee-for-service basis.

Family Care

Date Implemented: February 2000

Eligibility: Recipients must be elderly or have a developmental or physical disability that is long-term and irreversible and be determined to need assistance to safely or appropriately perform basic daily living skills. Individuals must have less than $2,000 in assets and may be required to pay a deductible if their monthly incomes exceed an established limit, which was $592 as of January 2011.

Covered Services: Long-term care, including assistance with the tasks of daily living, such as eating, bathing, dressing, medication management, and transportation. Services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: Managed care

Service Area: The subprogram is administered in 57 counties. As of July 1, 2011, statewide expansion of Family Care was suspended pending DHS's review of the financial sustainability of the subprogram.

Enrollment in January 2011: 31,461

Estimated Expenditures in FY 2009-10: $892.4 million. Does not include expenditures for certain services, such as prescription drugs, that are not included in the managed care plan and are paid for on a fee-for-service basis.

Family Care Partnership

Date Implemented: October 1998

Eligibility: Recipients must be elderly or have a physical disability that is long-term and irreversible and be determined to need assistance to safely or appropriately perform basic daily living skills. Individuals must have less than $2,000 in assets and may be required to pay a deductible if their monthly incomes exceed an established limit, which was $592 as of January 2011.

Covered Services: Both acute and primary care, such as inpatient and outpatient hospitalization, physician and clinic visits, laboratory and x-ray services, and medical equipment and supplies, and long-term care including assistance with the tasks of daily living such as eating, bathing, dressing, medication management, and transportation. Long-term care services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: Managed care

Service Area: The subprogram is administered in 19 counties.

Enrollment in January 2011: 3,619

Estimated Expenditures in FY 2009-10: $173.2 million, which also includes expenditures for the Program for the All-Inclusive Care for the Elderly (PACE) because DHS does not record the expenditures for the subprograms separately.

Family Planning Waiver

Date Implemented: January 2003

Eligibility: Recipients include females and males aged 15 through 44 in families with incomes up to 300 percent of the federal poverty level.

Covered Services: Contraceptive supplies, tests, and treatment for sexually transmitted diseases, and other family planning services.

Service Delivery Model: Fee-for-service

Service Area: Statewide

Enrollment in January 2011: 59,345

Estimated Expenditures in FY 2009-10: $27.9 million

Include, Respect, I Self-Direct (IRIS)

Date Implemented: July 2008

Eligibility: Recipients must be elderly or have a developmental or physical disability that is long-term and irreversible and be determined to need assistance to safely or appropriately perform basic daily living skills. Individuals must also have less than $2,000 in assets and may be required to pay a deductible if their monthly incomes exceed an established limit, which was $592 as of January 2011.

Covered Services: Long-term care, including assistance with the tasks of daily living, such as eating, bathing, dressing, medication management, and transportation. Services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: Recipients purchase long-term care services using a monthly budget established by DHS, based in part on the severity of their needs.

Service Area: This subprogram is administered in 57 counties.

Enrollment in January 2011: 3,057

Estimated Expenditures in FY 2009-10: $35.9 million. Does not include expenditures for acute and primary care services, such as prescription drugs, that are paid for separately on a fee-for-service basis.

Program for the All-Inclusive Care for the Elderly (PACE)

Date Implemented: January 1995

Eligibility: Recipients must be elderly individuals and be determined to need assistance to safely or appropriately perform basic daily living skills. Individuals must have less than $2,000 in assets and may be required to pay a deductible if their monthly incomes exceed an established limit, which was $592 as of January 2011.

Covered Services: Both acute and primary care, such as inpatient and outpatient hospitalization, physician and clinic visits, laboratory and x-ray services, and medical equipment and supplies, and long-term care including assistance with the tasks of daily living such as eating, bathing, dressing, medication management, and transportation. Long-term care services are delivered in recipients' homes or in community-based settings.

Service Delivery Model: Managed care

Service Area: The subprogram is administered in two counties.

Enrollment in January 2011: 865

Estimated Expenditures in FY 2009-10: $173.2 million, which also includes expenditures for Family Care Partnership because DHS does not record the expenditures for the subprograms separately.

Qualified Medicare Beneficiaries

Date Implemented: March 1993

Eligibility: Recipients include individuals in the Medical Assistance program who also receive or are eligible to receive Medicare, including individuals who have:

- incomes that do not exceed 100 percent of the federal poverty level and assets less than $6,680;
- enrolled in Medicare Part A, which covers inpatient hospital care, skilled nursing facility care, hospice, and home health care, and have incomes between 100 percent and 120 percent of the federal poverty level or between 120 percent and 135 percent of the federal poverty level with assets less than $6,680; or
- disabilities and qualified for but lost Medicare eligibility because they returned to work and have income less than 200 percent of the federal poverty level and assets less than $4,000.

Covered Services: Part or all of Medicare Part A or B premiums

Service Area: Statewide

Enrollment in January 2011: 15,382

Estimated Expenditures in FY 2009-10: $272.9 million

SeniorCare

Date Implemented: September 2002

Eligibility: Recipients must be 65 years of age or older. In addition, recipients must pay an annual enrollment fee of $30 and additional expenses depending on their annual income.

Covered Services: Prescription drugs only

Service Delivery Model: Fee-for-service

Service Area: Statewide

Enrollment in January 2011: 90,559

Estimated Expenditures in FY 2009-10: $96.9 million

SSI Managed Care

Date Implemented: March 2005

Eligibility: Recipients must be adults who are determined as disabled by DHS and eligible to receive Supplemental Security Income (SSI) because of a physical or developmental disability. Recipients of SSI cash assistance are automatically covered under Wisconsin's Medical Assistance program. An individual must have less than $2,000 in assets to qualify for SSI and a monthly income that does not exceed the maximum allowable SSI cash benefit amount, which was $674 as of January 2011.

Covered Services: Acute and primary care services, such as inpatient and outpatient hospitalization, physician and clinic visits, laboratory and x-ray services, and medical equipment and supplies.

Service Delivery Model: Managed care

Service Area: The subprogram was administered in 60 counties as of May 2011.

Enrollment in January 2011: 30,978

Estimated Expenditures in FY 2009-10: $235.1 million. Does not include expenditures for certain services, such as prescription drugs, that are not included in the managed care plan and are paid for on a fee-for-service basis.

Appendix 3

Medical Assistance Subprograms Administered by Health Maintenance Organizations and Managed Care Organizations

October 2011

Health Maintenance Organizations

	BadgerCare Plus[1]	SSI Managed Care
Children's Community Health Plan	■	
CommunityConnect Health Plan	■	
Compcare	■	■
Dean Health Plan	■	
Group Health Cooperative of Eau Claire	■	■
Group Health Cooperative of South Central Wisconsin	■	
Gundersen Lutheran Health Plan	■	
Health Tradition Health Plan	■	
iCare		■
Managed Health Services	■	■
MercyCare Insurance Company	■	
Molina Healthcare	■	■
Network Health Plan	■	■
Physicians Plus Insurance Corporation	■	
Security Health Plan	■	
UnitedHealthcare Community Plan	■	■
Unity Health Plan	■	

[1] Includes BadgerCare Plus and BadgerCare Plus Core subprograms.

Managed Care Organizations

	Family Care	Family Care Partnership	Program for the All-Inclusive Care of the Elderly
Care Wisconsin First, Inc.	■	■	
Community Health Partnership, Inc.	■		
Community Care of Central Wisconsin	■		
Community Care, Inc.	■	■	■
iCare		■	
Lakeland Care District	■		
Milwaukee County Department of Family Care	■		
NorthernBridges	■		
Partnership Health Plan		■	
Southwest Family Care Alliance	■		
Western Wisconsin Cares	■		

Appendix 4

Medical Assistance Subprograms Administered by Counties

October 2011

Subprogram	Availability
Brain Injury Waiver	Statewide
Children's Long-Term Supports	Statewide
Community Integration Program[1]	Adams, Brown, Dane, Door, Florence, Forest, Kewaunee, Marinette, Menominee, Oconto, Oneida, Rock, Shawano, Taylor, and Vilas
Community Options Program[1]	Adams, Brown, Dane, Door, Florence, Forest, Kewaunee, Marinette, Menominee, Oconto, Oneida, Rock, Shawano, Taylor, and Vilas

[1] Includes counties not participating in the Family Care program.

Appendix 5

Vendor Payments for Medical Assistance Administrative Services

Vendor	Description	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	Total
Electrical Data Systems/ Hewlett-Packard Enterprise Services, LLC	In 2008, Hewlett-Packard Enterprise Services, LLC, purchased Electronic Data Systems, which had served as the State's fiscal agent since the 1970s. Current fiscal agent responsibilities include: assisting with application processing for certain participants, maintaining information systems, certifying health care providers, paying providers for health care provided to Medical Assistance recipients, and other activities as requested by DHS.	$44,572,400	$55,372,400	$45,831,500	$37,637,100	$64,717,000	$248,130,400
Deloitte Consulting, LLP	Maintains the Client Assistance for Reemployment and Economic Support (CARES) system, which determines eligibility for Medical Assistance and other public assistance programs.	9,911,000	11,500,600	13,815,000	12,480,700	13,619,100	61,326,400
The Management Group, Inc.	Since 2000, The Management Group, Inc., has provided quality assurance services for several long-term care Medical Assistance subprograms, including the Community Integration Program, the Brain Injury Waiver, and Children's Long-Term Supports. In 2008, it also began establishing a statewide network of consultants to assist recipients in the Include, Respect, I Self-Direct (IRIS) subprogram manage their benefit budgets.	1,960,700	1,772,800	1,938,900	5,634,400	12,895,000	24,201,800
Automated Health Systems, Inc.	Assisted DHS in determining Medical Assistance eligibility during 2009 and 2010 for all adults without dependent children, and since the 1990s has assisted Medical Assistance recipients select an HMO in which to enroll in areas of the state where more than one HMO operates.	2,634,000	2,841,300	3,147,900	8,747,600	5,706,800	23,077,600
MetaStar, Inc.	Provides statewide surveillance and utilization reviews of care provided to Medical Assistance recipients. The vendor assists DHS in meeting federal requirements to safeguard against unnecessary procedures and costs, as well as assess the quality of health care services. MetaStar, Inc., is certified by the federal Centers for Medicare and Medicaid Services to conduct the reviews.	1,960,700	2,289,600	1,939,400	3,330,100	3,376,100	12,895,900

Vendor	Description	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	Total
Department of Administration	Conducts hearings of appeals filed by recipients contesting Medical Assistance benefit decisions.	$ 1,275,600	$ 1,127,700	$ 935,200	$ 1,319,200	$ 1,366,000	$ 6,023,700
University of Wisconsin-Oshkosh	Provides quality assurance reviews of eligibility determinations and FoodShare benefit calculations completed by local staff. In addition, UW-Oshkosh employees identify participants who may not be eligible for public assistance benefits and provide training to county staff. In September 2011, DHS received authorization from the Legislature's Joint Committee on Finance to hire state employees instead of renewing this contract, which expires in December 2011.	1,121,100	1,330,000	768,200	566,200	1,878,400	5,663,900
University of Wisconsin-Madison	Provides periodic evaluations of program issues. Examples include analyses of pharmacological services and assessments of enrollment and claims data.	508,900	122,800	542,800	3,089,700	1,376,400	5,640,600
Public Consulting Group	Responsible for identifying strategies to increase federal funding and reduce program costs. Maximus, Inc., completed these services prior to 2008.	–	187,500	682,800	1,068,600	3,066,000	5,004,900
Pricewaterhouse-Coopers, LLP	Provides actuarial services for developing managed care capitation payment rates for all Medical Assistance subprograms.	632,900	1,317,900	861,600	896,200	831,100	4,539,700
Sally Mather Associates	Sally Mather Associates contracts with eight agencies throughout the state to complete assessments of children with severe disabilities to determine their eligibility for care provided in a home setting.	627,300	555,000	486,600	662,100	801,900	3,132,900
Board on Aging and Long Term Care	Provides ombudsman services for individuals over the age of 60 who participate in long-term care subprograms, including Family Care.	253,900	242,600	590,900	599,000	492,500	2,178,900
Milwaukee Center for Independence	Serves as the IRIS program financial services agency by performing caregiver background checks and by providing payroll processing and other financial support to participants who directly employ personal care staff.	–	–	98,700	404,800	1,425,300	1,928,800

Vendor	Description	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	Total
Disability Rights Wisconsin, Inc.	Provides ombudsman and advocacy services for Family Care, IRIS, and SSI Managed Care recipients. Services include mediation, investigating participants' complaints, and assisting participants with filing appeals.	$ –	$ 3,300	$ 115,700	$ 544,700	$ 1,099,000	$ 1,762,700
Maximus, Inc.	Previously provided revenue maximization and cost avoidance services similar to those now provided by Public Consulting Group.	71,600	850,700	–	–	–	922,300
Marci Katz and Associates, LLC	Provides strategic planning services intended to increase use of managed care arrangements for recipients who are elderly, blind, or disabled.	–	140,800	129,800	277,700	275,600	823,900
Wisconsin Health Information Organization	Provides a data repository for Medical Assistance and private insurance claims that DHS accesses in order to analyze cost and quality of care among various health insurance programs.	–	–	167,100	219,100	112,300	498,500
Centers for Medicare and Medicaid Services	Identifies Medical Assistance recipients who are also eligible for Medicare in order to reduce health care claims funded by Medical Assistance subprograms.	53,700	59,600	60,700	126,000	153,100	453,100
Fox Systems, Inc.	Assisted DHS in completing a federally required information technology assessment and plan.	–	–	–	–	425,200	425,200
Coleman and Williams, Ltd	Performs federally required annual audits of hospitals receiving disproportionate share hospital payments.	–	–	–	204,600	206,600	411,200
Developmental Disabilities Network, Inc.	Provides health benefit counselors to assist individuals during the Medical Assistance application process.	–	14,500	141,800	54,800	181,200	392,300
Employment Resources, Inc.	Provides a health and employment counseling program for high-functioning developmentally disabled individuals.	66,400	72,200	68,000	81,100	78,300	366,000
Oregon Health Sciences	Provides information on prescription drugs, which DHS uses to establish provider payment rates.	84,900	83,400	63,000	124,300	–	355,600

Vendor	Description	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	Total
Wisconsin Statewide Health Information Network, Inc.	DHS is one of several entities funding an effort to develop an interoperable network of statewide health information. DHS used federal grant funds to make payments of approximately $2.3 million since FY 2006-07, and in FY 2010-11 it began using Medical Assistance funds to support the network.	$ –	$ –	$ –	$ –	$ 223,900	$ 223,900
All other vendors with payments totaling less than $200,000		451,200	141,800	206,300	213,000	528,600	1,540,900
Total		**$66,186,300**	**$80,026,500**	**$72,591,900**	**$78,281,000**	**$114,835,400**	**$411,921,100**

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

December 13, 2011

Joe Chrisman, State Auditor
Wisconsin Legislative Audit Bureau
22 East Mifflin Street, Suite 500
Madison, WI 53703

Dear Mr. Chrisman:

This letter is in response to the Legislative Audit Bureau's (LAB) review of the Medical Assistance program. I appreciate the opportunity to comment and discuss our plans to stabilize the program and achieve sustainability for the program in the future.

The Department of Health Services would like to thank LAB for the significant time and effort devoted to its review of this very complex program and its many components. We appreciate their thoroughness, insightful comments, and the cooperation they extended to Department staff.

Enrollment in the Medicaid program has risen steadily in the last 20 years, from roughly 420,000 in 1990 to over 1.1 million in fall 2011. During that period, the total population of Wisconsin has increased 16 percent, but Medicaid enrollment has jumped 160 percent. The program provides coverage to one of every five residents, including one of every three children. As the review notes, expenditures rose by 42% from FY 07 through FY 10, to over $7 billion, driven by eligibility expansion, recession-fueled enrollment growth, and rate increases supported by provider taxes.

The Department of Health Services recognizes that this rate of growth is not sustainable. In the 2011-13 biennial budget, the Governor and Legislature needed to inject $1.2 billion of state GPR funds to maintain health care coverage for low income families, seniors, and people with disabilities, at the expense of other state agencies' priorities through the biennial budget process. As directed by the Governor and Legislature, the Department is pursuing a number of efficiency measures to achieve savings in the program. These include aligning Medicaid coverage more closely with private coverage, improving the effectiveness of service delivery to enrollees with complex care needs, and reforming payment methods to providers.

Administration
We concur with LAB's analysis of the significant growth in Medicaid administrative expenses that occurred prior to 2011. We understand that being frugal with our operations costs is just as important as improving the cost effectiveness of benefit expenditures. Toward that goal:

- Consistent with the LAB recommendations, the Department has implemented a new process by which the Division of Enterprise Services will review all administrative contract amendments for funding availability and to ensure compliance with procurement rules. DHS is formalizing this process in its Accounting Policies and Procedures Manual.

- Over the last 10 months, we have been conducting a thorough review of all existing Medicaid administrative contracts in the Division of Health Care Access and Accountability to assess their ongoing value and relevance.

- As directed by the Governor and Legislature in Act 32, we are working with counties to implement a regionalized, more efficient, income maintenance program for determining Medicaid and FoodShare eligibility. As part of that process, DHS is phasing down the Enrollment Services Center.

The Department must rely on the expertise of partner vendors to design and implement state of the art care delivery systems, to comply with federal quality assurance and rate setting requirements, and to strengthen the integrity and customer service performance of our eligibility and payment processes. Our goal is to procure such technical assistance, when necessary, at the best price, to improve the overall performance of the program.

As LAB recommends, we will continue to explore opportunities for savings by using state employees in place of vendors for some functions. At its September 14, 2011, s. 13.10 meeting, the Joint Committee on Finance approved the Department's request to create 10.5 FTE to replace a contract with UW-Oshkosh for eligibility training and quality assurance activities. The change will generate an estimated $402,800 AF ($201,400 GPR) per year in savings.

Managing Service Delivery
The Department agrees with LAB on the importance of expanding care coordination for people currently served in the fee for service system. Approximately half of all Medicaid expenditures are made on behalf of enrollees with complex care needs comprising 5% of total enrollment. Redesigning the service delivery system and realigning provider incentives is the path to real savings and true health care reform.

LAB recommends that we consider allowing new Medicaid members to select and enroll in HMOs faster than the current average one month enrollment time. The Department is developing a "real time" eligibility process, which will allow applicants who apply online or over the phone to receive an immediate determination of eligibility. Several data exchange tools will able to accurately and instantly verify information, such as citizenship, identity, and income. The new system will allow applicants to choose their HMO online also, replacing the current paper-based manual system and shortening the period of fee for service coverage significantly. The Department expects to implement the first phase of the new system by October 2012.

As noted by LAB, the Department is pursuing several medical home initiatives for individuals currently served in the fee for service system, including foster children, pregnant women, individuals diagnosed with HIV/AIDS, individuals with mental illness, individuals exiting the criminal justice system, and individuals who have one or more chronic conditions. Medical homes focus on coordinating care to ensure that the benefits and services provided meet the individual's needs. Medical homes are a key part of the Department's overall goal of changing Medicaid's service delivery and reimbursement structure from a volume based model to one based on value and health outcomes.

Fraud
I appreciate LAB's discussion of local fraud prevention efforts. I would like to underscore the high priority the Department places on fraud prevention and enforcement activities. We recently created a new Office of Inspector General which will coordinate and reinvigorate program integrity efforts across the Department. Act 32 appropriated $2 million and 19 FTE beginning in FY 13 to strengthen these efforts.

Future Considerations
LAB makes a number of recommendations regarding accounting and budgeting for Medicaid expenditures. The Department is committed to providing the Legislature with any information it needs or requests to manage and oversee this very large and complex program. It is important to clarify that the Department has an extensive Medicaid management information system, with large data warehouses and extensive analytical capabilities. It uses these resources on a daily basis for budgeting, forecasting, federal claiming, managed care rate setting, program integrity, program design and improvement, and other purposes.

For each biennial budget, the Department prepares and shares with the State Budget Office and the Legislative Fiscal Bureau a large and detailed spreadsheet that re-estimates the program for the coming two years. We also share with them monthly reports showing expenditures by service category and eligibility group, as well as caseload.

For the first time, Act 32 directs the Department to report to the Joint Committee on Finance on the status of the Medicaid program on a quarterly basis and to seek approval from the committee for any program changes that would conflict with current statutes. I fully support these provisions.

I have some concerns regarding the LAB recommendation to create appropriations for each Medicaid "subprogram." Creating separate appropriations in Chapter 20 would limit the Department's flexibility to manage expenditure fluctuations in the program during the fiscal year. It would also require DHS to reconcile client level expenditure data between MMIS and the state accounting system, which would extend the time period for fiscal year closeout significantly. In addition, there are many interdependencies among service expenditures within the program. For example, expenditures for nursing home services are affected by Family Care and home and community based waiver enrollment. As LAB notes, DHS directly manages prescription drug reimbursement for both managed care and fee for service enrollees. For these reasons, it is difficult to divide the program cleanly into a finite number of subdivisions.

I would also invite the Legislature's guidance regarding treatment of the Community Options Program (COP) appropriation. LAB notes that counties use a portion of COP funds as match for Medicaid services and asks why that portion is not included within the Medicaid appropriation structure. The Department allocates COP funds from the legislatively designated COP appropriation, and counties choose to use the funds for Medicaid and non-Medicaid services, based on the care needs of their residents in any given year. Dividing the funds into Medicaid and non-Medicaid appropriations would provide more clarity to Medicaid expenditures, but would limit county flexibility to meet client needs.

At the same, I am very interested in working with LAB and the Legislature to improve the program's transparency. The Department is committed to submitting a detailed Medicaid biennial budget request for future budgets and making our budget projections as accurate as possible. We will also plan to resume preparing a report of expenditures by service category at year end. We are working to restore sound management practices that had been discontinued in 2009 and 2010. We appreciate the importance of LAB's finding that the savings targets in the previous biennium were not achieved.

Lastly, I agree with LAB's recommendation to monitor and report on the impact of the federal Patient Protection and Affordable Care Act (PPACA) on the Medicaid program. Much uncertainty surrounds PPACA, as it currently is being challenged in federal court, while the federal government continues to issue implementation rules. If upheld, PPACA will have profound impact both on Medicaid and the private health insurance market in Wisconsin.

Again, we appreciate the time, effort, and professionalism of the LAB Audit Team in preparing the review. Thank you for considering our comments.

Sincerely,

Dennis G. Smith
Secretary