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An Evaluation:

Medical Assistance
Eligibility Determination

September 2004

Report Highlights

Both enrollment and benefit costs have increased substantially in recent years.

Eligibility requirements vary among midwestern states.

Worker errors led to inappropriate eligibility decisions in some instances.

Some applicants were inappropriately denied Medical Assistance coverage.

County efforts to prevent fraud and abuse have been limited in recent years.

In Wisconsin, government-funded health care is available to individuals who meet the financial and non-financial criteria of:

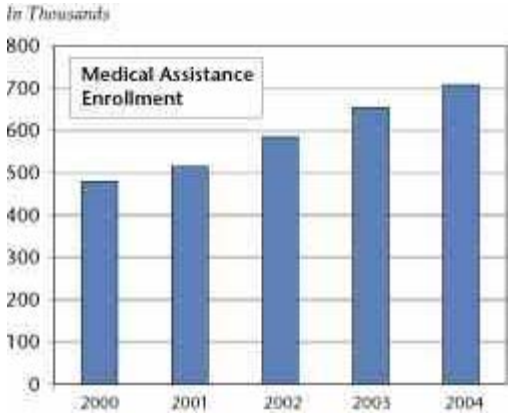
- the federal Medical Assistance program for low-income elderly, blind, and disabled individuals;
- family Medical Assistance, which is available for pregnant women and children under the age of 19 and their parents or caretaker relatives; and
- BadgerCare, a separate component of the Medical Assistance program that was implemented in July 1999 to provide health insurance for low-income working families.

The Department of Health and Family Services (DHFS) administers Wisconsin's Medical Assistance program, while county and tribal agencies determine eligibility and provide case management services. In fiscal year (FY) 2004-05, the program's budget is $4.3 billion: 60.7 percent of these costs are federally funded; the remaining 39.3 percent is funded with general purpose revenue (GPR), segregated fund revenue, and program revenue.

Eligibility requirements changed significantly when families with assets but limited incomes became eligible for program benefits in July 2000. Further changes occurred in 2001, when the application process no longer required supporting documentation for wages and other information used to establish eligibility, unless the information provided was questionable. These changes, as well as increases in caseloads and program costs, have raised concerns about eligibility determinations. Therefore, at the direction of the Joint Legislative Audit Committee, we analyzed program enrollment and expenditures; compared Wisconsin's eligibility criteria and verification requirements to those of other states; tested the accuracy of eligibility approvals and denials; and reviewed efforts to prevent fraud and abuse and to recover overpayments.

Enrollment and Costs

From 2000 through 2004, enrollment in Medical Assistance programs, including BadgerCare, increased by 47.7 percent, or approximately 229,000 recipients, Program costs have increased as a result.



Expenditures for program benefits grew 48.6 percent in the past five fiscal years, from $2.9 billion in FY 1999-2000 to $4.3 billion in FY 2003-04. Administrative expenditures increased 2.1 percent in the most recent five-year period for which data were available during the course of our review, reaching $169.6 million in FY 2002-03.

Key Facts and Findings

$4.3 billion is budgeted for Medical Assistance for FY 2004-05.

From 2000 to 2004, enrollment increased by 229,000 individuals, or by 47.7 percent.

Among midwestern states, only Michigan and Wisconsin do not require documentation of income.

Workers made errors affecting eligibility in 6.5 percent of the cases we reviewed.

In January 2004, an estimated 1,100 individuals were inappropriately denied benefits.

Wisconsin provides less

Eligibility Requirements

Within parameters set by the federal government, states have the flexibility to design their Medical Assistance programs to provide coverage for certain groups of individuals based on their incomes and assets.

States may share program costs with some recipients by requiring co-payments or monthly premiums, and they may establish requirements for continued eligibility, such as an annual review by a case worker.

In Wisconsin, the initial income eligibility requirement for those enrolled in BadgerCare is 185 percent of the federal poverty level. While BadgerCare covers parents with higher incomes than any other midwestern state except Minnesota, Wisconsin's income requirements for pregnant women, infants, and children under family Medical Assistance are more restrictive than those of other midwestern states.

Like Indiana, Minnesota, and Ohio, Wisconsin does not permit continuous eligibility for Medical Assistance. Instead, recipients are required to promptly report changes in their employment, household composition, or other circumstances that may affect eligibility.

Wisconsin is one of only 12 states that does not require applicants to provide documentation of income, such as pay stubs. Instead, computerized databases are used to verify applicant information. However, some of these databases contain outdated or inaccurate information, and information is not available for all applicants or for all sources of income.

Errors and Discrepancies

funding for program integrity than many surrounding states.

Statutes and DHFS policies are inconsistent and may hinder program integrity efforts.

County workers generally make correct eligibility determinations. However, both worker errors and discrepancies between estimated and actual income can result in inaccurate eligibility determinations. These errors can have significant effects on applicants and on program costs.

Worker errors affected the outcome of eligibility determinations for 13 of the 200 cases we reviewed in which someone in the household was receiving Medical Assistance benefits. We found that:

- recipients benefited from the errors in seven cases when they were incorrectly provided with Medical Assistance benefits that should have been denied;
- recipients were incorrectly denied benefits in four cases; and
- in two cases, recipients were not affected but the State was harmed because it paid a portion of costs that would have been paid by the federal government if eligibility determinations had been made correctly.

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Discrepancies between estimates of future income, which are used to determine eligibility for program benefits, and the actual incomes recipients earned, were fairly common. Using information that was not available to county workers during initial eligibility determinations, we found that 10 of the 200 cases we reviewed had income discrepancies that would have affected eligibility.

If this information had been available at the time of eligibility determination, recipients would have been considered ineligible or would have been required to pay a premium in six cases. In three cases, there would have been no effect on recipients, but costs would have shifted from the federal government to the State. In the remaining case, recipients would not have been required to pay premiums they were charged.

Application methods appear to affect the accuracy of income estimates. In-person interviews were most accurate. Of the 140 eligibility determinations made through in-person interviews, 27.1 percent had income discrepancies of $100 or more per month, compared to 32.6 percent for the 43 determinations made from mail-in applications and 41.7 percent for determinations made from 12 telephone interviews. However, because of the fairly small sample size, additional analysis by DHFS may be beneficial.

Denied Benefits

We reviewed 101 cases in which eligibility for Medical Assistance was denied. In 13 cases, the denials were inappropriate. In four of the cases, worker error was the primary cause; in the remaining nine cases the primary cause was a programming problem or limitation with the Client Assistance for Re-employment and Economic Support (CARES) system, the State's computerized processing system used for a number of public assistance and employment programs.

Written guidance provided to county workers to manually compensate for the main programming problem was not effective, and the

programming error in CARES was not corrected until July 2004, after we had raised the issue with DHFS staff during the course of our fieldwork. We estimate that in January 2004, the month we reviewed, this error resulted in approximately 1,100 individuals being inappropriately denied benefits, almost all of whom were children.

Ensuring Program Integrity

Efforts to ensure program integrity by correcting errors and preventing fraud and abuse have been limited in recent years. For example, in any given year between 1998 and 2003, approximately one-third of counties did not attempt to recover any benefits that were granted inappropriately.

Several factors contribute to the low level of effort, including decreased funding and inconsistencies in state laws and program policies. We make a number of recommendations to address these issues.

Recommendations

Our recommendations address the need for DHFS to:

- report to the Legislature regarding CARES programming changes that could reduce the possibility of eligibility determination errors *(**p. 32**);*
- make a number of changes to the mail-in application form to improve its ability to collect complete and accurate information, and to better inform applicants of their responsibility to report required changes in their circumstances *(**p. 37**);*
- clarify policies regarding when county eligibility determination workers can request documentation of income, and grant them greater discretion in requesting such documentation when they believe it is needed *(**p. 37**);*
- revise its program integrity policies to be consistent with state statutes *(**p. 55**);* and
- report to the Legislature regarding its plans to address program integrity needs *(**p. 56**).*

We also recommend the Legislature:

- revise state statutes to make the circumstances under which benefit overpayments may be recovered from recipients consistent with the statutory definition of Medical Assistance fraud *(**p. 55**).*

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