Report 04-11
September 2004

An Evaluation

Medical Assistance Eligibility Determinations

Department of Health and Family Services

2003-2004 Joint Legislative Audit Committee Members

Senate Members:

Carol A. Roessler, Co-chairperson
Robert Cowles
Alberta Darling
Jeffrey Plale
Julie Lassa

Assembly Members:

Suzanne Jeskewitz, Co-chairperson
Samantha Kerkman
Dean Kaufert
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State Auditor - Janice Mueller

Audit Prepared by

Paul Stuiber, Director and Contact Person
Kellie Monroe Aquino
Bradley Carl
Melinda Gustafson
Shelby McCulley
Ben Monty
Robert Sommerfeld

CONTENTS

Letter of Transmittal 1

Report Highlights 3

Introduction 9

- Enrollment and Expenditures 11

Program Requirements 15

- Eligibility Criteria 15
  - Non-financial Criteria 15
  - Financial Criteria 16
  - Time Periods for Eligibility 19
  - Cost-Sharing Requirements 20
- Verification Requirements and Application Methods 21
  - Automated Data Exchange Systems 23

Approvals of Eligibility 27

- Sampling Methodology 27
- Worker Errors 29
- Income Discrepancies 32

Denials of Eligibility 39

- Sampling Methodology and Findings 39
  - Family Fiscal Unit Testing 42

Ensuring Program Integrity 45

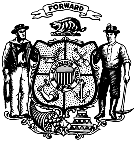
- Components of Program Integrity 45
- Level of Program Integrity Efforts 48
- Improving Program Integrity Efforts 50
  - Administration and Funding 50
  - Statutes and Department Policies 53
- Future Considerations 55

Appendices

Appendix 1—2004 Income Maintenance Contracts
Appendix 2—Medical Assistance Eligibility Requirements by Program
Appendix 3—Asset and Income Limits by Program
Appendix 4—Selected Automated Data Exchanges

Response

From the Department of Health and Family Services



State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
STATE AUDITOR

22 E. MIFFLIN ST., STE. 500
MADISON, WISCONSIN 53703
(608) 266-2818
FAX (608) 267-0410
Leg.Audit.Info@legis.state.wi.us

September 28, 2004

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

As requested by the Joint Legislative Audit Committee, we have completed an evaluation of Wisconsin's process for determining eligibility for Medical Assistance program benefits, including BadgerCare. The State's Medical Assistance program is administered by the Department of Health and Family Services (DHFS), which contracts with counties to determine eligibility and provide case management services. A total of $4.3 billion in state and federal funds is budgeted for Medical Assistance benefits in fiscal year (FY) 2004-05.

Concerns have been raised about the accuracy of the eligibility determination process, in part because applicants are no longer required to provide supporting documentation for wages and other information used to establish eligibility. We found that eligibility determinations are generally correct. However, in 6.5 percent of the 200 cases we reviewed, worker errors affected program eligibility. In addition, improving the mail-in application and allowing workers greater discretion in requesting documentation of income may improve the accuracy of eligibility determinations.

In 12.9 percent of an additional 101 cases we reviewed, individuals had been inappropriately denied benefits. Moreover, we estimate that approximately 1,100 individuals were inappropriately denied benefits in January 2004, the month we reviewed, because a longstanding computer system problem was not resolved until July 2004, only after we had raised the issue with DHFS staff during the course of our fieldwork.

Although we found limited evidence of recipient fraud, program integrity efforts to prevent fraud and abuse are important program functions. We found that program integrity efforts vary substantially across counties and that Wisconsin appears to be unusual in relying on benefit recoveries to fund these efforts. County officials have raised concerns about the nature and level of program integrity funding and are concerned about the sustainability of these efforts. We include a recommendation for DHFS to report to the Joint Legislative Audit Committee on its plans to address program integrity needs.

We appreciate the courtesy and cooperation extended to us by DHFS and county staff. DHFS's response follows the appendices.

Sincerely,

Janice Mueller
State Auditor

JM/PS/ss

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

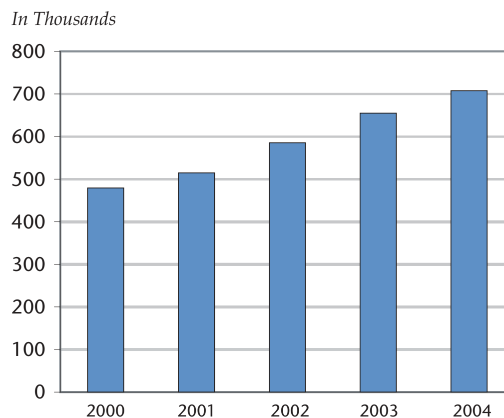
about eligibility determinations. Therefore, at the direction of the Joint Legislative Audit Committee, we analyzed program enrollment and expenditures; compared Wisconsin's eligibility criteria and verification requirements to those of other states; tested the accuracy of eligibility approvals and denials; 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. Figure 1 shows the growth in enrollment. Program costs have increased as a result.

Figure 1

Medical Assistance Enrollment



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.

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

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.

We did not find any instances in our sample of non-citizens or non-Wisconsin residents receiving benefits inappropriately.

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).*

Introduction ■

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

Since 1965, states and the federal government have funded health care services for low-income individuals through the federal Medical Assistance program. The State's $4.3 billion program budget for the current fiscal year includes $2.6 billion in federal funds, as well as $1.5 billion in GPR. 2004 contracts with counties and tribes, which include funds for local administration of Medical Assistance, food stamps, and child care, totaled $54.6 million. Contract amounts for each county and tribe are listed in Appendix 1. Appendix 2 includes a complete listing of eligibility requirements for Medical Assistance for the elderly, blind, and disabled; family Medical Assistance; BadgerCare; and two other smaller program components. In addition, a number of other smaller groups are covered.

County and tribal governments' eligibility determination and case management activities are supported by the Client Assistance for Re-employment and Economic Support (CARES) system, a computerized processing system used for a number of public assistance and employment programs, including food stamps, child care, and Wisconsin Works (W-2). Based on data entered by county workers, CARES estimates applicants' future incomes; cross-checks wages and other information against a number of databases; assists in determining eligibility; and electronically enrolls the applicant in the Medical Assistance program if he or she is found to be eligible.

Wisconsin has made significant changes to the eligibility determination process in recent years.

Recent changes to eligibility requirements and the application processes for Medical Assistance occurred, in part, as a result of Wisconsin's efforts to satisfy federal Medical Assistance waiver requirements for BadgerCare, the program that extends Medical Assistance coverage to adults and children in low-income working families. As of January 2004, Wisconsin was one of only six states to have extended Medical Assistance coverage to adults in these families. The most significant changes included:

- the July 2000 elimination of an asset test for families receiving Medical Assistance, which expanded eligibility to families who may have assets but little income;
- the July 2001 implementation of a mail-in application process that can be used by most Medical Assistance recipients; and
- in conjunction with the mail-in application process, implementation of a policy that does not require supporting documentation for wage and other information used to establish eligibility for program benefits, unless the information provided is questionable based on DHFS policies.

As a result of these eligibility changes, as well as a downturn in the state's economy, the number of individuals served by Wisconsin's Medical Assistance and BadgerCare programs has increased substantially over the past five years.

In January 2004, the Legislative Fiscal Bureau projected a Medical Assistance shortfall of approximately $401 million in GPR for the 2003-05 biennium. In February 2004, 2003 Wisconsin Act 129 restructured the State's debt obligations, thereby reducing the Medical Assistance shortfall to $277.5 million. Subsequently, 2003 Wisconsin Act 318 transferred an additional $53.2 million in GPR to the Medical Assistance program by reallocating Community Aids funds, in order to draw down additional federal funds. Finally, at a June 2004 meeting of the Joint Committee on Finance, an additional $2.0 million was allocated to help fund Medical Assistance benefits. However, an existing shortfall of $222.3 million remains.

In response to concerns about the accuracy of eligibility determinations and the State's ability to meet future funding needs, and at the direction of the Joint Legislative Audit Committee, we analyzed:

- program enrollment and expenditures;
- Wisconsin's eligibility criteria, verification requirements, and determination policies and practices, including how they compare with those of other states;
- eligibility approvals and denials, including the extent to which they are made correctly, including whether individuals were mistakenly found ineligible for assistance;
- strategies for improving the accuracy of the eligibility determination process; and
- program integrity activities, including efforts to prevent fraud and abuse and recover benefits in the case of overpayment.

In completing this evaluation, we reviewed Medical Assistance caseloads and expenditures from FY 1999-2000 through FY 2003-04 and analyzed trends in the funds allocated by the State to counties and tribes for eligibility determination and case management services. We also reviewed a sample of more than 300 eligibility determinations made for Medical Assistance applicants statewide and interviewed officials and staff of DHFS, staff in 15 counties who oversee eligibility determinations, advocates for the economically disadvantaged, and staff at hospitals and clinics who assist individuals in applying for the Medical Assistance program.

A subsequent report will present our findings related to eligibility determinations for SeniorCare, the State's prescription drug program for the elderly, which was also requested by the Joint Legislative Audit Committee.

Enrollment and Expenditures

From 2000 to 2004, Medical Assistance enrollments increased 47.7 percent.

As shown in Table 1, Medical Assistance enrollment has increased substantially over the past five years. From June 2000 to June 2004, the increase was 47.7 percent, from 479,167 recipients to 707,723 recipients.

Table 1

Medical Assistance/BadgerCare Enrollment
(For June of Each Year)

Program	2000	2001	2002	2003	2004	Percentage Change
Family Medical Assistance	233,307	252,795	302,967	358,291	408,078	74.9%
BadgerCare	65,147	80,859	97,195	109,158	108,634	66.8
Elderly, Blind, and Disabled	156,758	156,072	159,414	163,627	166,994	6.5
Miscellaneous[1]	23,955	24,932	25,729	23,844	24,017	0.3
Total	**479,167**	**514,658**	**585,305**	**654,920**	**707,723**	47.7

[1] Includes individuals covered through foster care, subsidized adoption, Family Care, the Well Woman Program, the tuberculosis program, and qualified Medicare beneficiaries.

Medical Assistance expenditures have increased by 48.6 percent over the past five years.

Enrollment growth has been coupled with increases in program benefit costs. Expenditures increased from $2.9 billion in FY 1999-2000 to $4.3 billion in FY 2003-04, or by 48.6 percent, as shown in Table 2. Growth averaged 10.4 percent annually over this period.

Administrative expenditures for the Medical Assistance program have not increased at rates similar to those for benefits. As shown in Table 3, administrative expenditures increased by 2.1 percent, or $3.4 million, from FY 1998-99 through FY 2002-03. Federal funds paid for 56.1 percent of administrative expenditures over this period.

Table 2

Expenditures for Medical Assistance Benefits
(In Millions)

Expenditure Type	FY 1999-2000	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04
General[1]					
GPR	$ 993.3	$1,034.7	$1,109.2	$1,078.0	$ 717.3
Segregated Fund Revenues[2]	0.0	0.0	204.9	361.5	735.0
Program Revenues	3.3	3.3	6.2	6.2	7.0
Federal Revenues	1,810.3	$1,937.3	2,095.5	2,351.6	2,591.3
Subtotal	$2,806.9	$2,975.2	$3,415.9	$3,797.3	$4,050.6
BadgerCare					
GPR	$ 21.9	$ 46.2	$ 43.8	$ 60.8	$ 64.8
Segregated Fund Revenues	0.0	0.0	0.5	1.0	0.0
Program Revenues	0.8	1.4	4.4	4.1	6.1
Federal Revenues	35.7	81.4	92.4	124.5	134.7
Subtotal	$58.4	$ 129.0	$ 141.1	$ 190.4	$ 205.6
Total[3]	**$2,865.3**	**$3,104.3**	**$3,557.0**	**$3,987.8**	**$4,256.3**

[1] Includes expenditures for all areas of Medical Assistance other than BadgerCare, including Family Medical Assistance and care for the elderly, blind, and disabled.
[2] Represents expenditures made from the Medical Assistance Trust Fund.
[3] Totals may not add due to rounding.

Table 3

Expenditures for Medical Assistance Administration

	1998-99	1999-2000	2000-01	2001-02	2002-03[1]	Percentage Change
Federal	$ 92,460,178	$ 92,305,223	$ 94,176,430	$ 98,207,133	$ 96,741,674	4.6%
State and Local[2]	73,671,781	73,091,048	74,516,072	76,859,884	72,809,657	-1.2
Total	**$166,131,959**	**$165,396,271**	**$168,692,502**	**$175,067,017**	**$169,551,331**	2.1

[1] Includes SeniorCare administration costs, which could not readily be separated from other administrative costs.
[2] Available data did not allow us to determine the specific type or mix of state and local expenditures made for program administration. However, the majority were made from GPR.

Program Requirements ▪

Recipients must meet a number of financial and non-financial conditions to qualify for health care coverage. However, states have considerable discretion in developing eligibility and application requirements for their own Medical Assistance programs. Unlike most midwestern states, Wisconsin does not require applicants to document their income to qualify for program services, unless information submitted is judged questionable under DHFS policies.

Eligibility Criteria

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 income and asset levels. States may also require co-payments or monthly premiums as a means of sharing program costs with some recipients, and they may require recipients to comply with certain other requirements for continued eligibility, such as completion of an annual review with a case worker.

Non-financial Criteria

Recipients of Medical Assistance benefits must meet several non-financial criteria, including:

- being residents of Wisconsin;

- being United States citizens or having qualifying alien status;
- providing, or applying for, a Social Security number, unless they are illegal or non-qualifying aliens who are seeking benefits only for children who are United States citizens and who have Social Security numbers; and
- being a child; a pregnant woman; the parent or caretaker of a dependent child; or eligible on the basis of age, disability, blindness, or certain medical diagnoses, such as tuberculosis.

Financial Criteria

To receive federal matching funds for Medical Assistance, states are required to cover specific groups of individuals who meet certain financial criteria, including Supplemental Security Income (SSI) recipients and certain Medicare beneficiaries. For family Medical Assistance coverage, which includes children, pregnant women, and parents or other caretaker relatives, states must cover:

- individuals who meet the requirements for the Aid to Families with Dependent Children program in effect in their state on July 16, 1996;
- children under age 6 and pregnant women with family incomes below 133 percent of the federal poverty level;
- all children born after September 30, 1983, who are under age 19 and have family incomes at or below the federal poverty level; and
- recipients of adoption or foster care assistance under Title IV of the Social Security Act.

In addition, states may provide Medical Assistance for optional groups with characteristics similar to the mandatory groups. For example, infants up to age one and pregnant women with family incomes of not more than 185 percent of the federal poverty level who are not covered under the mandatory program may be covered as an optional group, as they are in Wisconsin.

States also provide health care coverage to the children of working, low-income families through the State Children's Health Insurance Program (SCHIP), which is a federally established program that allows states to provide health care coverage to children in families with incomes above the limit for Medical Assistance eligibility. Wisconsin's BadgerCare program was established in this manner. States may provide the same or different benefits to individuals enrolled in SCHIP as they do to individuals in Medical Assistance. Wisconsin provides the same benefits to those who receive health care coverage through BadgerCare as it does to those enrolled in the Medical Assistance program.

As of January 2004, Wisconsin was one of only six states to have expanded coverage to the adults of working, low-income families through a federal waiver. Five states—Arizona, Minnesota, New Jersey, Rhode Island, and Wisconsin—expanded coverage to include groups of parents and children who are not covered under Medical Assistance. Arizona also used its waiver to expand coverage to childless adults. In contrast, Colorado used its waiver to expand coverage only to pregnant women. Because their approaches differ, the extent of medical coverage provided by these states varies considerably. For example, Colorado reported serving only 1,423 adults in federal fiscal year 2003, while New Jersey reported covering 123,700, which is more than any other state. Wisconsin reported covering 123,400 adults in BadgerCare during this period, almost as many as New Jersey.

Income-related eligibility criteria are linked to the federal poverty level.

Income-related eligibility criteria are linked to the federal poverty level, which is adjusted annually. Federal poverty limits for 2004 are shown in Table 4.

Table 4

2004 Annual Federal Poverty Levels

Family Size	100 Percent of the Federal Poverty Level	185 Percent of the Federal Poverty Level
1	$ 9,310	$ 17,224
2	12,490	23,107
3	15,670	28,990
4	18,850	34,873
5	22,030	40,756
6	25,210	46,639

As shown in Table 5, Wisconsin determines initial eligibility at 185 percent of the federal poverty level for all groups in its family Medical Assistance and BadgerCare programs. Other midwestern states cover infants and children with incomes up to at least 200 percent of the federal poverty level. However, Wisconsin covers parents with a higher level of income than most other midwestern states. Only Minnesota provides more generous coverage to parents than Wisconsin.

Table 5

Income Eligibility Levels for Family Medical Assistance and SCHIP
As of August 2004
(As a Percentage of the Federal Poverty Level)

State	Infants to Age 1	Children Ages 1-19	Parents[1]	Pregnant Women
Illinois	200[2]	200	90	200
Indiana	200	200	30	150
Iowa	200	200	102	200
Michigan	200	200	61	185
Minnesota	280	275	275	275
Ohio	200	200	100	150
Wisconsin[3]	185	185	185	185

[1] Illinois, Indiana, Iowa, and Michigan have lower income eligibility levels for parents who are not working.
[2] Illinois covers infants in families with income at or below 200 percent of the federal poverty level who are born to mothers enrolled in Medical Assistance. Infants born to mothers not enrolled in Medical Assistance are covered in families with incomes at or below 133 percent of the federal poverty level.
[3] Wisconsin determines initial income eligibility for BadgerCare at 185 percent of the federal poverty level, and recipients may remain eligible until their income increases above 200 percent of the federal poverty level.

Income eligibility levels for other Medical Assistance groups, such as the elderly, the blind, and the disabled also vary from state to state. As shown in Table 6, Wisconsin's income eligibility limits for medically needy individuals—those who generally have higher incomes but qualify for Medical Assistance because of high health care costs—are the highest among the midwestern states we reviewed, and Wisconsin's income eligibility limits for SSI recipients and medically needy married couples are the second highest.

Table 6

Income Eligibility Requirements for Elderly, Blind, and Disabled Medical Assistance Groups in Selected Midwestern States
As of March 2004
(As a Percentage of the Federal Poverty Level)

State	Medically Needy Individuals	Medically Needy Married Couples	SSI Recipients
Illinois	38%	37%	41%[1]
Indiana	NA[2]	NA[2]	76[1]
Iowa	65	48	74
Michigan	55	54	74
Minnesota	64	60	70[1]
Ohio	NA[2]	NA[2]	64[1]
Wisconsin	79	59	74

[1] These states use their 1972 financial and non-financial standards instead of the federal SSI standards to determine eligibility for the disabled individuals. Because of this, these states have to allow disabled individuals to "spend down" into Medical Assistance eligibility by deducting incurred medical expenses from income.
[2] Indiana and Ohio do not have programs for the medically needy.

Some states also limit the value of assets a Medical Assistance recipient may have, although most states, including Wisconsin, have eliminated asset tests for family Medical Assistance recipients. Wisconsin, however, does have asset limits for elderly, blind, and disabled recipients. Additional information on asset and income limits for these groups is provided in Appendix 3.

Time Periods for Eligibility

Some midwestern states allow for continuous eligibility, but Wisconsin does not.

Family Medical Assistance and SCHIP benefits may either be provided on a continuous eligibility basis, in which a recipient is eligible for a particular period of time regardless of changes in income or other relevant criteria, or on a contingent basis, which requires a recipient to report income or other changes that may affect continued eligibility. Generally, continuous eligibility is only applied to children. As shown in Table 7, Indiana, Minnesota, Ohio, and Wisconsin do not allow continuous eligibility for anyone, while Illinois, Iowa, and Michigan allow it for children. States vary in the length of time between required reviews. Most midwestern states, including Wisconsin, require annual review and redetermination. Retroactive eligibility, or coverage for past medical expenses incurred during a set time period before application, is offered by some states. Wisconsin allows retroactive eligibility for its Medical Assistance program, but not for BadgerCare.

Table 7

Eligibility Periods in Selected Midwestern States
(As of March 2004)

State	Continuous Eligibility Period	Frequency of Eligibility Determination	Retroactive Eligibility
Illinois	12 months	12 months	Limited[1]
Indiana	Not allowed	12 months	Limited[1]
Iowa	12 months	12 months	Limited[1]
Michigan	12 months	12 months	Limited[1]
Minnesota	Not allowed	12 months[2]	Limited[1]
Ohio	Not allowed	6 months	Up to 3 months
Wisconsin	Not allowed	12 months	Limited[1]

[1] In general, retroactive eligibility does not apply to Medical Assistance expansion programs, such as Wisconsin's BadgerCare program.
[2] Starting October 1, 2004, Minnesota will determine eligibility every six months.

Cost-Sharing Requirements

There are two basic types of cost-sharing requirements for Medical Assistance and BadgerCare recipients: premiums and co-payments. Under federal law, the amount of cost sharing cannot exceed 5.0 percent of a family's annual income, and states may not impose cost-sharing requirements on children.

Some BadgerCare recipients are required to pay premiums.

In Wisconsin, premiums are charged to some BadgerCare recipients. Families with incomes of at least 150 percent of the federal poverty level are required to pay a monthly premium. Originally, the premium amount was approximately 3 percent of total family income; as of January 2004, the monthly premium was raised to 5 percent of total family income. In June 2004, 15.1 percent of BadgerCare enrollees paid premiums.

Wisconsin also charges co-payments ranging from $0.50 to $3.00 for some goods and services. Co-payments are placed on benefits such as prescription drugs, medical supplies, dental services, and x-rays. However, certain categories of goods and services, such as emergency services, are exempt from co-payments. In addition, certain groups of recipients, including children under 18, individuals in nursing homes, and those receiving care from a managed care provider, such as a Health Maintenance Organization,

are exempt from co-payments. As of May 2004, approximately two-thirds of family Medical Assistance and BadgerCare recipients were enrolled in managed care plans.

Verification Requirements and Application Methods

While some states require verification of important applicant information, such as income and state residency, others do not require applicants to verify such information. Information that does not require verification is typically checked for accuracy against a number of computerized data sources that contain information on wages, income reported on tax returns, availability of insurance from an employer, and other relevant information.

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

According to a 2003 Kaiser Commission report on preserving health care coverage for children and families, only 12 states, including Wisconsin, allow self-declaration of income for their family Medical Assistance and SCHIP programs. That is, they allow applicants to indicate what their income is without supporting documentation. In contrast, the Kaiser Commission report indicated that 45 states allow for self-declaration of state residency and 47 allow for self-declaration of a child's age, which may also affect program eligibility. Among the midwestern states we reviewed, only Wisconsin and Michigan allow self-declaration of income, but all allow for self-declaration of state residency and child's age, as shown in Table 8.

Table 8

Allowable Self-Declared Information in Midwestern States

State	Income	State Residency	Child's Age
Illinois		■	■
Indiana		■	■
Iowa		■	■
Michigan	■	■	■
Minnesota		■	■
Ohio		■	■
Wisconsin	■	■	■

DHFS's decision to implement a self-declaration policy in July 2001 was, in part, a response to concerns raised by the federal Department of Health and Human Services in 1998 regarding application and enrollment procedures that may pose barriers to families applying for Medical Assistance benefits. Based on concerns about these potential barriers, states were encouraged to enhance outreach efforts and streamline their eligibility determination processes. In addition, implementation of a self-declaration policy for income allowed Wisconsin to begin use of mail-in applications for Medical Assistance and BadgerCare. Applicants may mail the two-page application, apply over the telephone, or apply in person. However, those who seek food stamps, W-2, or child care assistance must initially apply in person, because those programs require in-person interviews and documentation of income. Individuals in 37.7 percent of the approximately 300,000 Medical Assistance and BadgerCare cases active in June 2004 also received other benefits for which they would have had to apply in person. Specifically:

- 34.1 percent received food stamps;
- 12.5 percent received child care subsidies; and
- 5.3 percent received W-2 services.

DHFS policy limits the circumstances under which workers may request income verification.

DHFS has developed policies regarding the circumstances under which county workers may request verification of self-declared income. These circumstances are limited to cases in which:

- inconsistencies are identified between oral and written statements;
- inconsistencies are identified between an applicant's assertions and information obtained through a review of records or other contacts the worker may make;
- the applicant is unsure of the accuracy of his or her own statements; or
- the applicant has been convicted of Medical Assistance recipient fraud or has legally acknowledged being guilty of recipient fraud.

In May 2004, DHFS implemented a new employer verification policy for BadgerCare applicants, as directed in the 2003-05 biennial budget. The new policy requires employers of applicants to verify earnings and the availability of health care coverage. Between May and

July 2004, enrollment in BadgerCare declined by 7,636 individuals, or 6.8 percent. Based on data collected by DHFS, much of the decline can be attributed to not receiving required verification and to increases in recipients' income.

Although DHFS officials note that the employer verification process may be lengthening the amount of time it takes to determine eligibility, they indicate that eligibility determinations are still being completed within the 30-day requirement specified in state law. They believe three factors have contributed to the decrease in the number of individuals enrolled in the program:

- failure to return the required verification form;
- verification of income that makes individuals ineligible for services; and
- verification of insurance coverage or access to insurance coverage that makes individuals ineligible for services.

Automated Data Exchange Systems

Automated data exchanges are used to verify income reported by applicants.

Allowing applicants to self-declare income and other information is possible only if the information reported can be checked against verifiable sources. CARES performs cross-checks, known as data exchanges, against a number of databases as part of the eligibility determination process. These exchanges occur periodically, from weekly to quarterly, depending on the data source. The timeliness and accuracy of these data are critical to the overall integrity of the eligibility determination process, and the extent to which these databases automate certain functions affects the workload of county staff.

Many components of the data exchange system are required by federal laws established in the mid-1980s, which require cross-checks with the following data sources:

- quarterly wage information provided by employers;
- unemployment compensation benefit information maintained by the State;
- self-employment, wage, and retirement income from the Social Security Administration;

- Social Security and SSI benefits information from the Social Security Administration; and

- unearned income information, including non-wage income sources such as interest and dividends, from the Internal Revenue Service (IRS).

When a data exchange occurs, CARES compares its current information with that in the data exchange. When no county worker judgment or action is needed, CARES is automatically updated to reflect the new information if appropriate. In other cases, CARES notifies the worker that new information should be reviewed to determine whether updates to the data or other actions are needed. In recent years, DHFS has expanded its use of data exchanges to include sources beyond those previously described. Appendix 4 provides information on the most significant data exchanges affecting program eligibility.

While federal law requires states to use IRS data, DHFS allowed Wisconsin's agreement with the IRS to lapse in June 2002 in order to complete an analysis of costs and benefits associated with the use of IRS data. The lapse affected access to both unearned income data from the IRS and self-employment, retirement, and wage data from the Social Security Administration. DHFS negotiated a new agreement with the IRS in mid-2003 and is now determining how these data matches can be reintroduced into the eligibility determination process. Officials indicate DHFS's 2005-07 biennial budget request will include a funding request that will allow DHFS to assume responsibility for IRS matches to better target those cases most likely to have unearned income and assets.

County staff indicated that the data exchanges are generally a useful source of information, although some indicated that time constraints caused by significant caseload increases and a lack of resources to hire additional staff made it difficult to process all data exchange updates in a timely fashion, particularly because processing new applications and conducting case reviews are higher priorities.

We reviewed a random sample of 101 data exchange cross-checks conducted in July 2003, including cross-checks on wages for the first quarter of 2003, notifications of new hires, unemployment compensation benefits, and Social Security benefits. The federal government requires states to investigate and complete action on 80 percent of all federally required data exchange matches within 45 days of the match, and on all matches within 90 days of the match.

Workers failed to properly address information in 13.9 percent of the data exchanges we reviewed.

We found that workers do not always meet federal requirements. Overall, we found:

- In 50 cases (49.5 percent), the worker pursued the data exchange appropriately and documented his or her actions. Case information was updated in 16 of these cases, and in the other 34 cases no updates or further action were required.

- In 37 cases (36.6 percent), the worker did not document having reviewed the data exchange, but the information contained in the exchange did not affect current or prior benefits, and therefore no action was required.

- In the remaining 14 cases (13.9 percent), the worker either did not pursue the data exchange or did not take appropriate action.

For instances in which workers fail to pursue or do not take appropriate action to address information in data exchanges, the potential exists for recipients who should not qualify for Medical Assistance benefits to continue to receive them. As noted, county officials attribute much of the problem to greater workloads associated with an increasing number of recipients, and lack of resources to hire additional staff.

The insurance disclosure database has a number of deficiencies.

Although most data exchanges provide accurate and useful information, county staff reported serious problems related to the insurance disclosure system that is used to determine whether applicants currently have private insurance coverage. According to county staff:

- The information is often inaccurate or several years old.

- Although workers can correct insurance information in CARES, this information is deleted each time a new data exchange occurs.

- Insurance information does not always indicate which individuals in a family are receiving coverage. This can lead to inappropriate terminations of BadgerCare coverage when, for example, “family coverage” is listed but the family includes stepchildren who may not be covered by the adult’s insurance policy.

DHFS officials acknowledge that the insurance disclosure system does not consistently provide accurate or current information and is limited by the quality of the data reported by insurance carriers. We were unable to estimate the number of Medical Assistance cases that may be affected as a result of these problems.

■ ■ ■ ■

Approvals of Eligibility ■

Although county workers generally make correct eligibility determinations from available information at the time an application is received, worker errors that are made can significantly affect program costs and applicants' eligibility. Using data from income tax returns and the state wage database that were not available to county workers at the time eligibility determinations were made, we identified a number of discrepancies between recipients' estimated and actual income. Expanding the ability of county workers to verify income, clarifying DHFS policies, and improving the mail-in application form could improve the accuracy of future eligibility determinations.

Sampling Methodology

To determine the accuracy of eligibility determinations made by county workers, we randomly selected 200 Medical Assistance cases that were active between October and December 2002. These included:

- 90 initial eligibility determinations for individuals who had not received Medical Assistance benefits during the previous month; and

- 110 determinations for continued program eligibility, which occur when a case has been open for 12 months or when a change in case circumstances warrants a review to confirm ongoing eligibility.

Our sample of 200 cases included 137 that qualified under family Medical Assistance, 43 that qualified under BadgerCare, and 47 that qualified because they included individuals who were elderly, blind, or disabled. We examined both paper files and information available in CARES. However, for ten of the cases we reviewed, county staff were unable to locate paper files. Therefore, for these cases, our analysis was based solely on information available from CARES.

As shown in Table 9, county workers conducted in-person interviews with applicants in 140, or 70.0 percent, of the 200 cases we reviewed. Mail-in applications and telephone interviews were used less frequently. In-person Medical Assistance applicants may also have been applying for programs that do not allow mail-in or telephone applications, such as the Food Stamp program.

Table 9

Contact Methods for Medical Assistance Cases in Our Sample

Method	Number	Percentage
In-person interview	140	70.0%
Mail-in application	43	21.5
Telephone interview	12	6.0
Unknown	5	2.5
Total	**200**	**100.0%**

We found no instances of non-citizens or non-Wisconsin residents who were inappropriately granted benefits.

Some legislators and others have raised concerns about whether non-citizens or individuals who are not Wisconsin residents, and therefore are not eligible, may be receiving Medical Assistance benefits. We did not find any instances in our sample of questionable citizenship or residency in which an inappropriate eligibility determination resulted. Three individuals in our sample who were not United States citizens were eligible for the program because they had qualifying alien status, which was appropriately verified and documented.

In analyzing the cases in our sample, we identified two main issues:

- worker errors in which county workers failed to accurately use information available to them at the time of the review; and

- discrepancies of at least $100 between estimated and actual monthly income, for which information was not available to county workers at the time of review.

Worker Errors

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

To evaluate whether county workers made errors in determining eligibility, we examined the information available to them at the time of application and determined if workers used that information appropriately. We found that county workers made errors in 24 cases, or 12.0 percent of the cases we reviewed. However, worker errors affected eligibility in only 13 cases, or 6.5 percent of those reviewed. As shown in Table 10, recipients benefited from the errors in seven cases and were harmed by the errors in four cases. In the other two cases, the errors had no direct effect on recipients, but the State was financially harmed because it was responsible for a greater share of total costs when individuals who were eligible for BadgerCare instead received benefits under Medical Assistance.

Table 10

Effects of Worker Errors on Eligibility Determinations[1]

Effect of Worker Errors	Number of Cases	Number of Recipients
Recipients benefited—approved when they should have been denied	7	12
Recipients harmed—denied benefits when they should have been approved	4	7
No effect on recipients—State financially harmed because more expenditures were paid with GPR	2	2

[1] Based on a review of 200 active Medical Assistance cases.

All seven cases in which worker errors benefited recipients involved approvals of benefits for ineligible individuals. For example:

- A worker incorrectly calculated income from pay stubs submitted by the recipient, resulting in two children incorrectly being found eligible.

- A worker granted benefits to a non-working recipient for whom employment was required as a condition of receiving Medical Assistance benefits.

- A worker failed to question a recipient's employment history when the worker should have known that the recipient had been consistently employed, resulting in three individuals incorrectly being determined eligible.

- A worker failed to question a discrepancy between the child support payment amount reported by a recipient and what was present in the State's child support database. The recipient reported receiving $50 per month in child support when the actual amount was $700 per month. As a result, one adult and two children were incorrectly found to be eligible.

- A worker did not verify the cash value of a recipient's life insurance policy, which would have put the recipient above the asset limit used to determine eligibility.

In total, 12 individuals were incorrectly approved for Medical Assistance benefits in these seven cases in which worker errors benefited ineligible recipients.

In the four cases in which worker errors harmed recipients, seven individuals who should have been eligible for the program were denied, including six children. These include cases in which:

- A worker overestimated an applicant's income, leading to a denial of eligibility for one child.

- A worker improperly requested verification of employment income, and when the recipient failed to provide the requested documentation, benefits ended for two individuals in the household.

- A worker incorrectly recorded a recipient as being self-employed, resulting in the loss of benefits for three individuals in the household.

In the two cases in which recipients were not directly affected by worker errors, two individuals were enrolled in family Medical Assistance coverage when they should have been placed in BadgerCare. Because the federal government covers approximately 71 percent of benefit costs for BadgerCare, but only 59 percent of benefit costs for other types of Medical Assistance, the State was financially harmed in these two cases.

Incorrect placement in either BadgerCare or family Medical Assistance also affects recipients. For example, recipients placed in BadgerCare could be harmed by having to pay premiums if they should have been in family Medical Assistance, which requires no premiums to be paid by recipients. However, we did not find any instances in our sample in which recipients' premiums were affected by incorrect placement.

Errors in determining eligibility resulted in an estimated $7,848 in unnecessary costs.

We analyzed expenditures associated with the 13 cases that involved worker error and estimated the cost of benefits provided to recipients as the result of these errors. First, for the seven cases in which recipients were inappropriately found eligible, we estimate that approximately $7,848 in state and federal funds was spent from October 2002 through December 2002. We also estimate that an additional $54 was spent by the State to cover Medical Assistance benefits that should have been paid with federal funds for the two individuals who should have been enrolled in BadgerCare. Although it is possible that benefits continued to be provided to ineligible recipients for a longer period of time, with additional unnecessary costs, our analysis could not project effects beyond this three-month period. Finally, we estimate the State would have incurred, over a three-month period, an additional $2,150 in state and federal costs associated with providing benefits to individuals in the four cases in which worker errors resulted in denials of benefits.

For Medical Assistance, there is no state or federal standard to define an unacceptable level of benefit determination errors. In the Food Stamp program, the federal government can impose monetary sanctions on states whose benefit determination error rates exceed the national average. Over the past several years, Wisconsin's food stamp benefit determination error rate has consistently been higher than the national error rate of 8.0 to 9.0 percent. It should be noted, however, that the food stamp benefit determination error rates do not include improper denial of benefits, only inaccurate payments to those already enrolled.

The eligibility determination errors we found in our sample cannot be projected with accuracy onto the entire population of recipients. However, the continually rising cost of health care increases the

importance of minimizing errors. One strategy likely to be effective is modifying CARES programming to detect and prevent common types of errors. For example, safeguards could be implemented to prevent workers from entering incorrect household relationships or erroneously assigning the employment income of an adult in the household to an infant or child who is too young to be legally employed.

☑ Recommendation

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by January 17, 2005, on CARES programming changes that could be implemented to reduce future eligibility determination errors, including estimates of the cost of each of the proposed updates.

Income Discrepancies

As noted, financial eligibility for Medical Assistance is based on an estimate of future monthly income. To develop that estimate, county workers use wages and other income sources reported by applicants, as well as information from databases. Not surprisingly, discrepancies between a recipient's estimated income and actual income are common, particularly for individuals who change jobs frequently or have varying work hours.

We used information currently available, such as 2002 state and federal income tax returns and actual wage data for the fourth quarter of 2002, to assess the accuracy of income estimates made from October through December 2002. Although actual income data were available to us in many instances, these data often had limitations. For example, wage data is reported by employers on a quarterly basis, while tax return information is available only for a one-year period, with no detail on the months in which the income was earned. In addition, in some instances we could not verify a recipient's income. For example:

- Annual tax return information was not available for 73 of the 200 cases, which were generally those with incomes below $13,850 who were not required to file a 2002 federal tax return, and those with incomes below $18,000 who were not required to file a 2002 state tax return.

- Wage information was not available for five cases, although recipients in these cases reported earnings and had Social Security numbers.

- Recipients were self-employed, paid in cash, worked out-of-state, or their Social Security numbers were not available in 22 cases.

For 57 of the 200 cases we reviewed (28.5 percent), we found variances of more than $100 between the estimated monthly income used for eligibility determination and the income an applicant actually received. Discrepancies affected program eligibility in 10 of these 57 cases.

Based on actual income amounts reported on recipients' income tax records and the state wage database, which were not available to county workers when eligibility determinations were made, we found that recipients benefited from income discrepancies in six cases—either because they were found eligible when they would not have been or because they did not pay a premium which would have been required. A recipient was harmed in one case, by being required to pay a premium when none would have been required. In the remaining three cases, there was no direct effect on recipients; however, the State was financially harmed in two of these cases because a larger share of costs would have been funded with federal revenue rather than GPR.

Income discrepancies affected program eligibility in 10 cases.

A summary of our findings is shown in Table 11. It should be noted that in some instances, discrepancies may not have been the result of county workers' miscalculations of income or of applicants' misstatements when they provided information. For example, applicants' expected incomes may differ from amounts reported because of increased work hours that were not anticipated at the time of application.

Table 11

Effects of Income Discrepancies on Eligibility Determinations[1]

Effect of Income Discrepancies	Number of Cases	Number of Recipients
Recipients Benefited		
Recipients received benefits when they would not have qualified	5	7
Recipients did not pay a premium but would have been required to pay a premium	1	2
Recipients Harmed		
Recipients were required to pay a premium when they would not have had to pay a premium	1	2
No Effect On Recipients		
State financially harmed because more expenditures were paid with GPR[2]	2	3
State financially benefited because more expenditures were paid with federal funds[3]	1	1

[1] Based on a review of 200 active Medical Assistance cases.
[2] These recipients would have been placed in BadgerCare rather than family Medical Assistance.
[3] These recipients would have been placed in family Medical Assistance rather than BadgerCare.

County staff have indicated that changes in eligibility determination policies and practices make it more difficult to accurately estimate income in some instances. For example, we were told that the mail-in application process implemented in July 2001 may not be as effective as in-person interviews. County staff noted that interviews allow workers to:

- ask clarifying questions, such as whether the applicant is reporting gross or net income;
- explore the possibility of additional unreported income sources;
- allow individuals to voluntarily supply additional supporting documents, such as pay stubs; and
- provide notice to applicants that all changes in income, residence, and other relevant information must be reported within ten days.

It may be more difficult to accurately estimate income using mail-in applications.

In addition, some county staff believe that applicants may be more likely to provide complete and truthful information during an in-person interview, in part because they can be informed that their statements can and will be verified through comparisons with statewide computerized databases.

We found that application methods appear to affect the accuracy of income estimates. Of the 140 eligibility determinations made through in-person interviews, 27.1 percent had income discrepancies of $100 or more, 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. It is not clear why discrepancies were the highest with telephone interviews, but the rate we found may be more a function of the fairly small sample size rather than a true reflection of the overall rate of discrepancies with telephone interviews. Given the extent of the discrepancies we identified with mail-in and telephone interviews in our sample, additional analysis by DHFS of the merits of requiring routine, in-person interviews may be beneficial.

The two-page application form is reportedly unclear to many applicants.

In January 2001, DHFS introduced a new two-page application form, which replaced the former eight-page form. This change was intended to streamline and simplify the application process. While the length of the application form itself has been reduced, DHFS still issues a ten-page set of instructions that are needed to accurately complete the form. Many county staff indicated that having a two-page application form is not helpful if applicants do not read the instructions and make mistakes because the two-page form provides inadequate guidance or asks for information in a manner that is unclear.

A number of changes to the mail-in application form could improve its ability to collect complete and accurate information. Although the newly created employer verification policy, which requires employers to verify earnings and the availability of health care coverage, should improve the accuracy of earnings information collected for BadgerCare applicants, it is still important that the mail-in application collect accurate information in order to determine which applicants are likely to be placed in BadgerCare.

We found that other midwestern states use a variety of methods, which are not used in Wisconsin, to ensure that complete and accurate data are collected on mail-in applications. For example:

- Iowa's application clearly states that changes in household composition or income must be reported by the recipient within ten days.

- Minnesota’s application requests specific information on seasonal employment and the number of hours an applicant works, and also provides applicants the option to state their gross wages as either monthly or hourly amounts to avoid confusion.

- Michigan’s application asks applicants who report no income to provide a brief explanation of how they are supporting themselves and their families.

- Ohio’s application incorporates instructions for completing the form into the document itself, thus encouraging applicants to read the instructions as they fill out the form.

DHFS policies regarding income verification may hamper the ability of staff to accurately estimate income.

Finally, we found that DHFS’s policies regarding the circumstances under which workers may request verification of income are unclear. This has led some county workers to believe that their ability to request verification of an applicant’s income was extremely limited. In fact, some believed that they were only permitted to request verification of an applicant’s income when the applicant requested retroactive health care coverage and data on the applicant’s actual income provided through state databases was inconsistent with the applicant's statements.

In addition, even those who were not confused by the policy believe that providing greater discretion to workers in requesting documentation of income, such as recent pay stubs, would facilitate their ability to accurately estimate an applicant’s future income. As noted, Michigan is the only other midwestern state to allow applicants to self-declare income. However, staff in Michigan also audit a random sample of cases each month for which applicants are asked to provide written documentation, such as pay stubs or tax records, to verify their income.

☑ Recommendation

We recommend that the Department of Health and Family Services:

- *notify applicants on the application form that changes in income, residence, and other relevant factors must be reported within ten days;*
- *provide space on the application form to collect detailed and accurate income information, including the number of hours worked, as well as hourly, weekly, or monthly gross income;*
- *clarify its eligibility determination policies regarding circumstances under which county workers may request additional verification of income; and*
- *allow county workers greater discretion in requesting documentation when they have legitimate reasons to seek verification, but require the reason for the request to be documented in the case file.*

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Denials of Eligibility ▪

In addition to reviewing whether recipients were correctly found to be eligible for program benefits, we reviewed a sample of cases to determine whether decisions made to deny eligibility were correct. Although the majority of denials we reviewed were correctly determined, we found that some individuals were denied Medical Assistance benefits in error. A pattern of inappropriate denials resulting from a programming deficiency in CARES was corrected during the course of our audit.

Sampling Methodology and Findings

We reviewed a random sample of 101 cases in which at least one individual in a household was denied Medical Assistance eligibility in October 2002. The sample included 54 cases in which everyone in the household was denied, and 47 cases in which at least one individual in the household was determined to be eligible. A total of 23 cases (22.8 percent) were denied benefits at initial application, while 78 (77.2 percent) were denied at recertification. Our sample included 74 cases with individuals who were denied under family Medical Assistance; 44 cases with individuals who were denied under BadgerCare; and 14 cases with individuals who were denied under the elderly, blind, or disabled Medical Assistance program.

We examined eligibility determinations only for those individuals in a case who were denied benefits. (In some cases, those individuals denied may not have actually intended to apply for assistance, but were tested for Medical Assistance eligibility when another individual in the household applied for benefits.) Our primary

sources of information were CARES and paper case files, except in seven cases for which county staff could not locate the paper files. When an individual was denied eligibility because he or she did not provide requested information or complete a required review, we examined whether the verification request was in accordance with DHFS policies and whether the individual was given the required notice.

Denials may be made for a variety of reasons, and some cases are denied for more than one reason. As shown in Table 12, for the 101 cases we reviewed, a total of 132 reasons for denial were applicable. The most common reason for denial of benefits was failure to meet basic demographic requirements. The second most common reason for denial is related to income: of the 132 reasons for denial, 28.7 percent were the result of an applicant's income exceeding the eligibility limit.

Table 12

Reasons for Eligibility Denial

Reason	Number	Percent
Did not meet demographic characteristics for eligibility[1]	34	33.7%
Income exceeded limits	29	28.7
Has or had other insurance coverage	21	20.8
Did not submit requested verification	8	7.9
Not a citizen or qualifying alien	8	7.9
Individual is no longer in the household	5	5.0
Review was not completed as required	4	4.0
BadgerCare premium was not paid	3	3.0
Death of the recipient	3	3.0
Applicant was not a Wisconsin resident	3	3.0
Other miscellaneous reasons[2]	14	13.9
Total	**132**	

[1] Includes individuals who did not have dependent children or were not elderly, blind, or disabled. In addition, some of these individuals may not have intended to apply for Medical Assistance. For example, their eligibility may have been tested because they applied for food stamps or because other household members applied for Medical Assistance, and they did not explicitly request to be excluded.

[2] Reasons include failure to provide a Social Security number and failure to cooperate with child support enforcement efforts.

Improper denials were made in 13 of the cases we reviewed and affected 26 individuals.

Of the 101 cases we reviewed, we found 13 cases in which inappropriate denials were made. In these 13 cases, benefits were denied to 26 individuals, including 19 children. As shown in Table 13, improper denials had two primary causes: worker error and problems with CARES.

Table 13

Inappropriate Denials of Medical Assistance Eligibility[1]

Primary Reason for Inappropriate Denial	Number of Cases	Number of Recipients
Worker Error	4	7
CARES Programming Problem	9	19
Total	**13**	**26**

[1] Based on a review of 101 Medical Assistance cases in which at least one individual was denied benefits.

In four cases affecting seven individuals, the improper denial was primarily attributable to worker error. Specifically:

- In two cases, workers entered incorrect or outdated insurance information, causing the applicants to be denied benefits.
- In one case, a worker incorrectly processed an application for coverage in a prior month, leading to a denial of eligibility.
- In one case, a worker incorrectly coded household relationships in CARES, resulting in the denial of an eligible child because the child's mother was not listed as the primary applicant.

In 9 cases affecting 19 individuals, we found that the primary cause of improper denial was a problem or limitation with CARES. Specifically:

- In five cases, CARES counted income from some household members inaccurately against members of the household for whom they were not financially responsible. Before July 2004, the system did not process these types of cases accurately.

- In two cases, CARES could not properly calculate eligibility during routine processing, but did not alert workers that additional manual steps would be needed to accurately determine eligibility.

- In one case, the estimate of monthly income the worker calculated using an income multiplier in CARES was higher than the applicant's actual monthly income on pay stubs submitted to the worker. In June 2003, CARES was modified to prevent these types of errors in the future.

- In one case, a recipient's BadgerCare eligibility was discontinued because the recipient failed to pay the required premium. However, we found that the premium had been charged in error. Because CARES did not process the premium calculation correctly, the worker should have performed a manual calculation instead.

While human error cannot be completely eliminated, the design of CARES has a significant effect on the number and types of errors that occur. The most significant problem we identified with CARES relates to testing financial responsibility for individuals within a case.

Family Fiscal Unit Testing

Under federal law, an individual's financial eligibility for Medical Assistance can only be affected by his or her own income and the income of those who are financially responsible for him or her (generally parents or a spouse). CARES tests for situations in which income from a non-financially responsible person may be incorrectly counted against someone else. These situations, which occur in approximately half of all Medical Assistance cases, include cases with:

- a child with income, such as child support;

- a pregnant woman;

- a couple who have a child in common but are not married;

- a stepparent; or

- a child cared for by a non-legally responsible relative.

CARES has only recently been updated to prevent a significant eligibility determination error.

Until recently, CARES did not consistently make accurate determinations in these cases, which are known as family fiscal unit (FFU) cases. A 1999 federal court settlement in Wisconsin in *Addis, et. al.* v. *Whitburn, et. al.* held that the FFU test did not use the correct income limits and thus resulted in improper denials. In response, the Department of Workforce Development (DWD)—which was responsible for CARES programming and maintenance at that time—issued an operations memorandum in November 1999 explaining the settlement and instructing workers to manually calculate financial eligibility for anyone found ineligible by CARES under the incorrect FFU calculation. However, it was not until July 2004, after we had raised the issue with DHFS staff during the course of our audit, that system changes were made to correct the problem. DHFS officials indicate that reprogramming CARES to properly calculate FFU cases had been planned for several years; however, a number of other projects, including the implementation of BadgerCare and SeniorCare, took priority.

Before CARES system changes were implemented, county staff were required to perform manual calculations for eligibility determination for FFU cases, but not all staff were aware of the FFU issue or how to perform manual calculations to determine eligibility accurately when required to do so. In our interviews with county staff, we found that the level of familiarity with the issue varied considerably. While some had a thorough understanding and indicated the issue was a serious problem affecting a significant number of cases, others did not seem well-informed. Several county staff noted that performing a correct manual calculation in FFU cases was complex, required an experienced worker, and was labor-intensive, with one county estimating it took an hour to perform the necessary calculations.

Approximately 1,100 individuals were inappropriately denied benefits in January 2004.

Advocates with whom we spoke indicated that they believed the FFU problem was significant, and one noted that his organization had requested, but had not received, information from DHFS regarding the possible prevalence of the problem. Based on our analysis, we estimate that the error resulted in the inappropriate denial of approximately 1,100 individuals in January 2004, the only month we reviewed. Nearly all of those denied were children. We estimate the added costs to serve these individuals to be approximately $198,000 per month in FY 2003-04.

In addition, we found that problems with FFU calculations and other eligibility determination errors resulted in approximately 4,800 individuals per month being placed in BadgerCare rather than

in family Medical Assistance. Had these individuals been correctly placed, the State would have been required to assume a greater share of total benefit costs. Additional costs to the State associated with these individuals would have totaled approximately $125,000 per month in FY 2003-04.

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Ensuring Program Integrity ▪

Although we found limited evidence of recipient fraud in our review, maintaining state and local efforts to prevent fraud and abuse remain important components of public assistance programs. Local program integrity efforts are intended to address problems caused by potential or actual fraudulent activity in public assistance benefits cases by reviewing situations in which errors have occurred or are likely to occur. Despite the size of Wisconsin's Medical Assistance caseload and the magnitude of expenditures for program benefits, the overall level of program integrity activities has been fairly low in recent years. In addition, the level of activity varies considerably across counties. A number of factors, including reduced funding levels, have contributed to the lack of activity. DHFS has recently begun efforts to clarify policies and improve its administration of the program; however, limited funding may reduce the effectiveness of these efforts. In addition, a recent legal challenge has hindered the State's efforts to use tax intercepts as a means of recovering benefits.

Components of Program Integrity

At the state level, program integrity efforts focus largely on identification and prevention of provider fraud.

At the state level, Medical Assistance program integrity efforts focus largely on identification and prevention of provider fraud. DHFS staff review the billing patterns of health care providers and conduct regular audits in an attempt to identify potential fraud. If fraud is suspected, the case is referred to the Medicaid Fraud Control Unit within the Department of Justice for investigation and possible prosecution.

Program integrity efforts are intended to prevent and detect fraud in public assistance programs.

At the local level, program administration focuses on ensuring that recipient eligibility determinations are made correctly. These activities include general eligibility determination and case management functions for Medical Assistance, food stamps, and child care. In addition, a more specific set of program integrity activities is intended to prevent fraud and error:

- Fraud prevention, which involves a close examination of individual cases that show characteristics of potential fraud. It is intended to ensure accurate benefit issuance at initial application, when changes are reported by recipients, or when periodic case reviews occur. Counties develop their own profiles for selecting cases for fraud prevention efforts; for example, cases in which applicants report no income may be scrutinized for the existence of unreported income sources. Generally, a fraud prevention effort is initiated by a county worker with the approval of his or her supervisor.

- Fraud control investigations, which are initiated when a worker suspects that intentional fraud may have occurred with individuals already receiving public assistance benefits. The process is generally similar to that for a fraud prevention investigation. Depending on the circumstances, cases may be referred to the district attorney for prosecution.

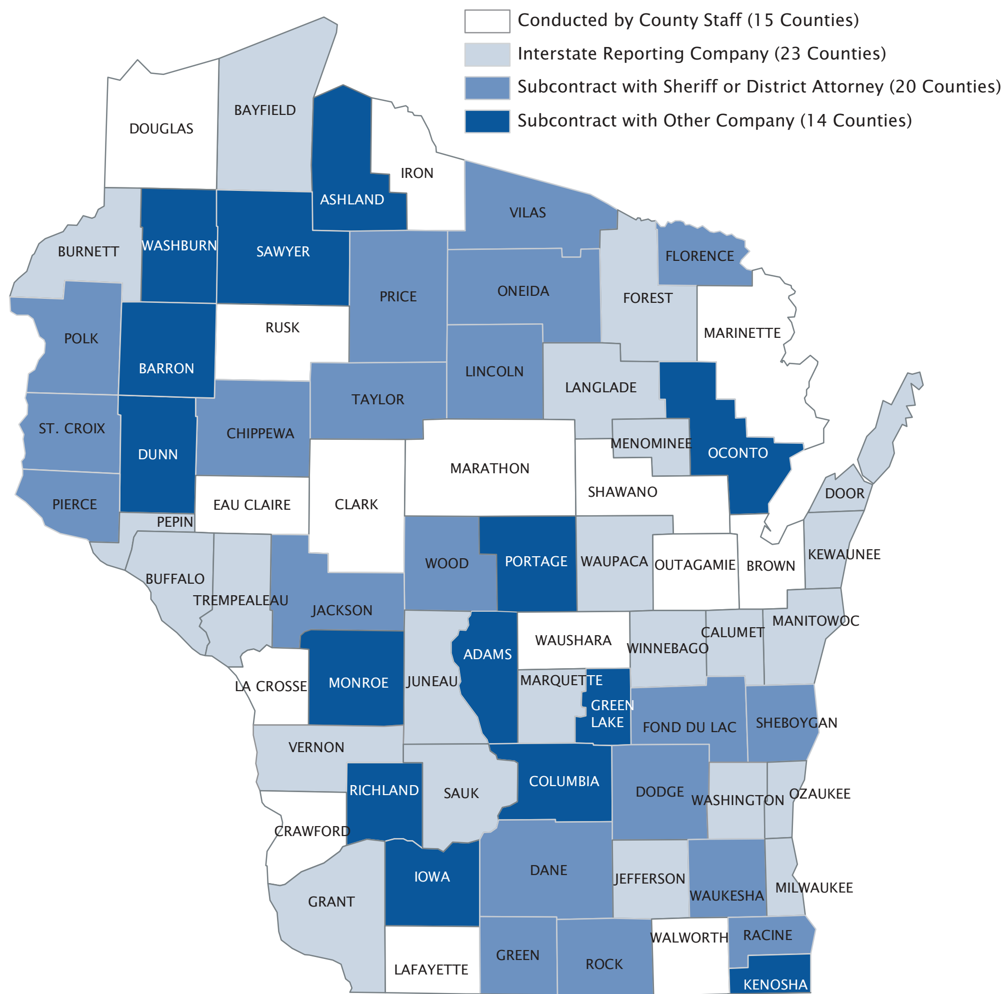
- Benefit recovery, which can occur as a result of a fraud investigation or when a worker discovers a recipient error that results in overpayment but does not warrant an investigation. Collection efforts have included intercepts of state and federal tax refunds. Most overpayments are handled without prosecution.

Counties may either conduct fraud investigations using their own staff, subcontract all or a portion of their fraud investigation responsibilities to local law enforcement or other private investigation agencies, or contract through the State, which in turn has a contract with Interstate Reporting Company, a private investigation agency. The State's contract for conducting fraud investigations began in January 2002 with a two-year contract period and two one-year renewal options. The current contract, worth $75,000 annually, was issued in January 2002 and has been renewed through December 2004.

In 2003, 57 counties subcontracted all or part of their fraud investigation responsibilities, including 23 that contracted with Interstate Reporting Company. The remaining 15 counties performed all fraud investigation functions using their own staff. Figure 2 shows who conducts fraud investigations in each of the counties.

Figure 2

Fraud Investigation Providers



All counties receive funds for fraud prevention through contracts with DHFS. Under the terms of the contracts, counties are reimbursed for their expenses up to the maximum contract amount.

In addition, any county fraud prevention or investigation cost associated with food stamps and Medical Assistance above the amount provided through the contract can be federally reimbursed at a 50 percent matching rate. Counties that choose to handle fraud investigation responsibilities themselves are reimbursed for up to $500 per investigation. The State contracts with Interstate Reporting Company at a maximum rate of $500 per investigation for those counties that do not conduct their own investigations. State law permits counties to retain 15 percent of funds recovered from Medical Assistance and food stamp overpayments, but they cannot retain any funds from W-2 or child care overpayments.

Level of Program Integrity Efforts

Program integrity activities have been limited for the Medical Assistance program.

We found that program integrity activities have been limited for the Medical Assistance program, with wide variations across counties. Counties reported that Medical Assistance cases, particularly those in which Medical Assistance was the only benefit being received, were less likely to be subject to fraud prevention or fraud control investigations than food stamp, child care, or W-2 cases. Although Medical Assistance caseloads are more than twice as large as food stamp caseloads, and considerably larger than child care or W-2 caseloads, for the 280 fraud prevention and fraud control investigations completed by counties in July 2003, only 100 (35.7 percent) involved Medical Assistance. Benefit recoveries for food stamps and Medical Assistance show the same pattern: while a total of $1.8 million was recovered in 2003 for food stamp overpayments, only $413,200 was recovered for Medical Assistance overpayments.

Total recoveries of inappropriate Medical Assistance expenditures have fluctuated over the past several years. As shown in Table 14, statewide recoveries over this period reached a high of $529,331 in 2002, but declined by more than $116,000 (21.9 percent) in 2003. The reason for the substantial decline in recoveries is not clear. However, the decline appears, in part, to be the result of a decreasing amount of program integrity activity.

Table 14

Statewide Medical Assistance Benefit Recoveries

Year	Amount Recovered	Percentage Change
1999	$383,374	
2000	332,479	(13.3%)
2001	508,005	52.8
2002	529,331	4.2
2003	413,159	(21.9)

Milwaukee County pursued only six benefit recovery claims from 1998 through 2002, but established 74 claims in 2003.

Counties vary considerably in the extent to which they pursue benefit recovery, even after adjusting for caseload size. Approximately one-third of counties did not pursue any benefit recovery claims in any given year between 1998 and 2003, and 12 did not pursue any claims during that entire period. In addition, Milwaukee County pursued only six benefit recovery claims from 1998 through 2002, despite having Wisconsin's largest public assistance caseload. However, in total, the number of claims statewide increased from 638 in 2002 to 880 in 2003, or by 37.9 percent, while the average monthly Medical Assistance caseload increased by 14.5 percent. This statewide growth is largely attributable to significant increases in the efforts of a few counties. Most notably, Milwaukee County established 74 Medical Assistance benefit recovery claims in 2003.

For most counties, the level of fraud control funds is insufficient to fund a full-time investigator.

One reason for the overall lack of activity and the great variation among counties is that there is no centralized system for hiring and assigning investigators, and for most counties the level of program integrity and state fraud investigation funding is insufficient to fund a full-time investigator. Furthermore, county staff frequently reported that eligibility workers are too busy processing applications and reviews to devote time to fraud prevention and investigation. Many smaller counties that handle their own investigations do not have the funding to support staff to work exclusively on program integrity activities, and individual workers do not have time to pursue investigations.

In counties that contract for investigations, staff reported that preparing a referral to the investigator and completing the necessary follow-up also takes a considerable amount of staff time. Our analyses indicate that when adjusted for caseload size, counties that perform fraud investigations in-house had the highest number of established claims, followed by those that subcontract with the local sheriff or district attorney. Counties that subcontract with private investigative firms or that are covered by the State's contract with Interstate Reporting Company had lower levels of claims.

Improving Program Integrity Efforts

The low level of program integrity activity in recent years has been caused by several factors, including reduced funding and inconsistencies in statutes and departmental policies that have made it difficult to successfully pursue benefit recoveries in some cases.

Administration and Funding

DHFS and DWD share responsibility for the State's program integrity efforts.

At the state level, DHFS provides oversight for fraud prevention and fraud investigations, while DWD is responsible for benefit recovery. However, most program integrity efforts take place at the local level as part of counties' overall case management responsibilities.

Overall, contracted funding amounts for local program integrity and fraud investigation decreased from $9.4 million in 1995 to $2.3 million in 2004, or by 75.5 percent. In addition, funding sources for these efforts have changed considerably over time:

- Before 1985, the federal government provided 75 percent of local fraud control funding, while counties were required to provide a 25 percent match.

- From 1985 to 1995, the federal government funded 75 percent of local and state fraud control funding; the remainder was funded with a mix of program revenue, GPR, and local funds.

- In 1995, federal funding levels decreased to 50 percent, and increased GPR funding was provided by the State to help compensate for the decline in federal funding.

- In 1998, the local match requirement ended, and all of the GPR fraud control funding was transferred to the W-2 program. As a result, the share of local program integrity costs for Medical Assistance and food stamps that are funded with program revenue increased significantly, from 8 to 50 percent.

Currently, to fund local program integrity efforts, DHFS relies entirely on program revenue from the State's share of benefit recovery collections for food stamps and Medical Assistance, and an equal amount of federal matching funds. In contrast, DWD is able to use a portion of its federal block grant funds, in addition to benefit recovery collections from W-2 and child care cases.

In 2002, no GPR was spent on local program integrity efforts.

As shown in Table 15, program integrity functions were funded in 2002 with a combination of federal funds, local funds, and program revenue from benefit recoveries; no GPR was spent. Federal funds accounted for 52.1 percent of total program integrity funding.

Table 15

Program Integrity and Fraud Investigation Contract Funding
2002

Source	Program Integrity	Fraud Investigation	Total	Percentage of Total
Federal Funds	$ 850,410	$ 606,408	$1,456,818	52.1%
County Funds	531,190	240,953	772,143	27.6
Program Revenue[1]	245,955	321,798	567,753	20.3
Total	**$1,627,555**	**$1,169,159**	**$2,796,714**	**100.0%**

[1] Generated by Food Stamp and Medical Assistance benefit recoveries.

County officials believe the current funding strategies are inadequate to support an effective program.

County officials with whom we spoke believe that current funding levels are inadequate to support an effective fraud prevention program. In particular, they believe that relying on benefit recovery collections to fund fraud prevention is unlikely to be effective over the long term because the intent of fraud prevention is to correct errors before an overpayment occurs. Therefore, if a program is successful in preventing fraud and abuse, its funding will decrease

over time and make the effectiveness of the program difficult to sustain.

Funding amounts may be further reduced by a recent legal challenge to the State's authority to use tax intercepts to recover overpayments of Medical Assistance benefits without a court order. Legal Action of Wisconsin notified DHFS in February 2004 that federal law prohibited the State from using tax intercepts to recover Medical Assistance benefit overpayments. After reviewing the complaint, DHFS subsequently ended the use of tax intercepts. At this time, DHFS officials are unsure how the resulting loss of funding will be addressed, but they estimate that tax intercepts accounted for over 70 percent of Medical Assistance benefit recoveries. The loss of this benefit recovery strategy will likely have a significant effect on funding levels. A DHFS workgroup has been convened to determine how to re-institute the Medical Assistance tax intercept process while also complying with federal law.

Wisconsin appears to be unusual in funding local program integrity efforts solely with revenue from benefit recovery collections.

We reviewed the methods other midwestern states use to fund program integrity activities and found that they do not base funding on the level of benefit recovery. Staff in Minnesota, Illinois, and Iowa indicated that program integrity budgets are not directly dependent on the level of benefit recovery, and information provided by the Wisconsin Association of Public Assistance Fraud Investigators indicates that program integrity funding in Ohio, Michigan, Pennsylvania, Connecticut, and Washington also is not directly related to the amount of revenue generated from benefit recovery collections. Although program revenue from benefit recoveries is typically used as one of several funding sources in these states, it is not used as the basis for determining funding levels for program integrity efforts.

As shown in Table 16, Wisconsin provides less funding for its program integrity efforts than most of the surrounding midwestern states for which we were able to obtain information. It should be noted that making comparisons among states is complicated by variations in how program integrity efforts are funded. For example, most programs are administered at the state level, rather than by counties, and Illinois and Michigan operate fraud prevention programs only in selected geographic areas, while their fraud investigation efforts are conducted statewide. While Minnesota is most comparable to Wisconsin in terms of its population and program structure, it funds program integrity efforts at twice the level Wisconsin does.

Table 16

Estimated Annual Funding for Program Integrity Activities
(Federal and State Funding, in Millions)

	Amount[1]
Illinois	$ 5.3
Iowa	1.8
Michigan	10.3
Minnesota	5.8
Wisconsin	2.3

[1] Represents funding for the most recent year, which in most instances was FY 2003-04.

However, DHFS officials contend that the potential need for increased program integrity funding must be weighed against other programmatic needs, including demands by counties for additional general income maintenance administration funding to support program staff. DHFS officials believe that providing more funding to address workload issues will reduce errors and limit the need for fraud prevention, while others believe that additional program integrity funding is more urgently needed. It is difficult to assess trends in county income maintenance contracts because of changes in funding levels associated with the transfer of food stamp and Medical Assistance eligibility for W-2 clients from DWD to DHFS. However, while Medical Assistance and BadgerCare caseloads increased by 8.1 percent from June 2003 to June 2004, funding provided by county and tribal income maintenance contracts decreased by 4.9 percent, or from $57.4 million in 2003 to $54.6 million in 2004.

Statutes and Department Policies

Inconsistencies in statutes have hindered local efforts to pursue benefit overpayments.

County officials reported that a number of inconsistencies in state statutes and DHFS policies and procedures hinder their efforts to recover Medical Assistance benefits. First, there are inconsistencies between the statutory definition of Medical Assistance fraud and the statutory authorization for Medical Assistance benefit recovery. Specifically, s. 49.49(1)(a), Wis. Stats., defines fraud as failure to disclose any event affecting initial or continued right to benefits. However, s. 49.497(1), Wis. Stats., limits benefit recovery to two specific circumstances: failure to disclose income or asset changes, or

misstatements or omissions of fact at application or review. Failure to disclose other events affecting eligibility between application and review, such as changes in residence or household composition, is not grounds for pursuing Medical Assistance benefit recovery. Several counties reported having benefit recovery cases overturned at hearing as a result of this inconsistency.

Second, we found a number of inconsistencies between statutes and DHFS policies, as well as differences in county interpretations of program integrity policies established by DHFS. For example:

- The definition of fraud contained in DHFS's Medical Assistance Handbook, a policy document provided to county staff, is inconsistent with state statutes. The handbook defines fraud as misstatements or omissions at application or review. As noted, statutes define fraud as failure to disclose any event affecting initial or continued right to benefits, without specifying when that failure must occur.

- When conducting routine eligibility verification, DHFS policies limit counties to requiring additional documentation only in those instances in which information supplied by the recipient is deemed "questionable," a term narrowly defined to include instances in which actual contradictory evidence is present. In contrast, the profiles counties use for fraud prevention often rely on a wide range of indicators and provide for greater worker discretion. As a result, county workers often do not have the latitude to perform additional verification checks unless they refer the case for a fraud prevention review. As noted, these reviews are conducted by separate staff in many counties, increasing the number of staff who must be involved in completing verification activities and possibly discouraging county workers from referring cases.

- Some county officials reported that counties have interpreted recent program simplification changes, such as the introduction of a mail-in application option, as a sign that DHFS encourages counties to focus on outreach and benefit issuance rather than program integrity activities.

Some county officials also believe that program simplification initiatives, including mail-in applications, have increased the need for investigation and collections efforts because fewer errors can be prevented before eligibility determination. If an error is discovered after a Medical Assistance expenditure has been made, the recipient may be required to reimburse the State for the costs of the health care that was provided in error. County officials note that initiating collections efforts creates additional work for their staff that could be avoided through adequate program integrity efforts.

☑ Recommendation

Unless the Legislature intended to limit the circumstances under which counties may recover the value of Medical Assistance benefits, we recommend it revise statutes to allow for recovery of Medical Assistance benefit costs when a recipient does not comply with program policies by failing to disclose information that affects eligibility between the time of application and review.

☑ Recommendation

We recommend the Department of Health and Family Services revise its Medical Assistance program integrity policies to be consistent with statutes.

Future Considerations

Over the past year, county and state staff have taken steps to improve the program integrity function. First, in June 2003, the Income Maintenance Advisory Committee, a group composed of state and county representatives, created a program integrity subcommittee to examine funding sources, performance standards, policies and procedures, staffing, and statutory improvements for program integrity efforts.

DHFS recently reorganized its program integrity function to improve performance.

Second, in December 2003, DHFS eliminated a public assistance fraud section and shifted responsibility for those functions to other staff in an attempt to reduce administrative costs and better integrate these efforts with other programs. In addition, the new management team has begun providing counties with data on their past collection amounts and encouraging them to increase program integrity efforts, in part to increase the revenue they will have available for additional future efforts.

County investigators believe that additional funding for program integrity, particularly fraud prevention, would result in savings, because the State's costs would be reduced by preventing expenditures for inappropriate benefits and by recovering

expenditures made for ineligible recipients. In addition, they have noted that any additional state funds put into the program would be matched at the rate of 50 percent by the federal government.

Other states report that fraud prevention efforts can reduce overall costs.

A number of other states have reported that their fraud prevention efforts have successfully reduced overall costs. For example, Minnesota has an extensive fraud prevention and investigation program in 56 of its 87 counties, covering 92 percent of that state's public assistance caseload. Minnesota's Department of Human Services has set a performance standard for savings based on the collection of overpayments and the avoidance of future costs totaling $3.00 for every $1.00 spent on the program; in FY 2002-03, Minnesota's program reported a total of $4.31 in savings for every $1.00 spent. Minnesota officials attribute their success to strong state oversight, the assignment of investigative staff to work exclusively on program integrity, and financial incentives that allow counties to retain 20 to 35 percent of benefit recovery collections.

Illinois' fraud prevention investigation program operates solely in Cook County and investigates only new applications for assistance. In FY 2000-01, Illinois officials estimated savings totaling $10.63 for each $1.00 spent, for an estimated total net savings of approximately $8.6 million in that year.

In addition, information provided by the Wisconsin Association of Public Assistance Fraud Investigators indicates that Washington and Pennsylvania saved more than $6.00 for every $1.00 spent on their fraud prevention programs. These estimates are not directly comparable across states, but they suggest that fraud prevention programs may be an effective way to reduce total costs. However, in all instances we were unable to independently confirm these savings.

☑ Recommendation

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by January 17, 2005, on the results of its plans to address program integrity needs.

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Appendix 1

2004 Income Maintenance Contracts

Agency	2004 Allocation	Agency	2004 Allocation
Adams	$ 264,710	Marinette	$ 477,023
Ashland	344,552	Marquette	172,100
Bad River	97,600	Menominee	160,644
Barron	606,214	Milwaukee	17,043,820
Bayfield	193,740	Monroe	429,724
Brown	1,595,690	Oconto	301,682
Buffalo	169,700	Oneida	427,075
Burnett	220,143	Oneida Tribe	167,714
Calumet	214,781	Outagamie	778,375
Chippewa	591,343	Ozaukee	284,292
Clark	331,389	Pepin	160,644
Columbia	387,087	Pierce	228,885
Crawford	213,190	Polk	407,240
Dane	2,591,566	Portage	600,209
Dodge	592,008	Potawatomi	97,600
Door	230,774	Price	277,029
Douglas	604,702	Racine	1,820,851
Dunn	388,120	Red Cliff	160,644
Eau Claire	907,697	Richland	232,099
Florence	160,644	Rock	1,659,380
Fond du Lac	851,385	Rusk	251,126
Forest	170,372	Sauk	476,287
Grant	446,548	Sawyer	290,372
Green	292,212	Shawano	377,943
Green Lake	180,155	Sheboygan	775,019
Iowa	182,494	Sokaogon	97,600
Iron	168,450	St. Croix	380,424
Jackson	243,706	Stockbridge-Munsee	97,600
Jefferson	542,389	Taylor	257,201
Juneau	277,804	Trempealeau	327,349
Kenosha	1,597,847	Vernon	293,077
Kewaunee	171,084	Vilas	185,872
La Crosse	1,079,829	Walworth	634,483
Lac Courte Oreilles	0	Washburn	239,540
Lac du Flambeau	160,644	Washington	580,056
Lafayette	170,268	Waukesha	1,308,628
Langlade	302,647	Waupaca	570,618
Lincoln	296,667	Waushara	249,093
Manitowoc	642,818	Winnebago	1,098,173
Marathon	1,005,217	Wood	763,840
Statewide Total			**$54,629,517**

Appendix 2

Medical Assistance Eligibility Requirements by Program

As of December 2003

Program	Asset Limit	Income Limit	Children and Custodial Parents	Pregnant Women	Blind or Disabled	Elderly	Disease-Specific
Elderly, Blind and Disabled							
SSI Recipients	■	■			■	■	
Medicare Beneficiaries	■	■				■	
Qualified Disabled Working Individuals	■	■			■		
Individuals Receiving Institutional or Other Long-term Care	■	■			■	■	
Medically Needy	■	■			■	■	
MA Purchase Plan	■	■			■		
Family Medical Assistance							
AFDC and AFDC-Related		■	■	■			
Healthy Start		■	■	■			
Family Planning Services for Certain Women		■					
BadgerCare		■	■				
Miscellaneous Groups							
Tuberculosis program	■	■					■
Well Woman program		■					■

Appendix 3

Asset and Income Limits by Program

Program	Asset Limit	Income Limit
Elderly, Blind and Disabled		
SSI Recipients	Family size of 1 = $2,000; Family size of 2 = $3,000	Family size of 1 = 85% of the federal poverty level; Family size of 2 = 95% of the federal poverty level[1]
Medicare Beneficiaries	Family size of 1 = $4,000; Family size of 2 = $6,000	135% of the federal poverty level
Qualified Disabled Working Individuals	Family size of 1 = $4,000; Family size of 2 = $6,000	200% of the federal poverty level
Individuals Receiving Institutional or Other Long-term Care	Institutionalized Spouse = $2,000; Community Spouse = $50,000 if total assets less than $100,000; half of assets if between $100,000 and $178,560; and $89,280 if assets more than $178,560	300% of the monthly federal SSI payment
Medically Needy	Family size of 1 = $2,000; Family size of 2 = $3,000	Family size of 1 = 79% of the federal poverty level; Family size of 2 = 59% of the federal poverty level
MA Purchase Plan	Family size of 1 = $15,000; Family size of 2 = $15,000	250% of the federal poverty level
Family Medical Assistance		
AFDC and AFDC-Related	None	1996 AFDC Payment Levels and Assistance Standard
Healthy Start	None	185% of the federal poverty level
Family Planning Services for Certain Women	None	185% of the federal poverty level
BadgerCare	None	185% of the federal poverty level for applicants; 200% of the federal poverty level for recipients
Miscellaneous Groups		
People with Tuberculosis	Family size of 1 = $2,000; Family size of 2 = $3,000	Family size of 1 = 85% of the federal poverty level; Family size of 2 = 95% of the federal poverty level[1]
Women Diagnosed with Breast or Cervical Cancer	None	250% of the federal poverty level

[1] Limit includes state SSI payment and assumes that a single person has shelter costs of $190 and a couple has shelter costs of $275.

Appendix 4

Selected Automated Data Exchanges

Data Exchange Type and Source	Information Included	Timeliness and Scheduling	Processing
Social Security Administration (SSA)	SSN verification; Social Security and SSI benefits; Medicare eligibility and premiums	Data updated continuously by SSA. Occurs at application or case changes and monthly for all recipients	Some information automatically updated in CARES; mismatches generate alerts to workers
Public assistance conflict match, from SSA	Receipt of public assistance in another state (does not include dates or amount)	Monthly	Workers receive report and must then request information on amounts and dates from the other state
Unemployment Compensation from DWD	Dates and amounts of unemployment insurance benefits	Data are up to five weeks old. Occurs at intake and review, and monthly on all recipients	Alert generated if amount on exchange varies by $100 or more from the amount currently in CARES
Internet (Interstate) Unemployment Compensation, from a national database	State name and claim weeks; does not include benefit amount	Monthly	Workers receive a report indicating possible receipt in another state; must then request information from the other state
State wage database from DWD with information reported by all Wisconsin employers	Employer information and quarterly wages	Data are up to 5-6 months old. Occurs at intake and review, and quarterly on all recipients	An alert is generated if the individual received benefits during the quarter reported and there is a discrepancy of more than $300 for the quarter
New hire database from DWD with information reported by all Wisconsin employers	Identifying information for employer and employee; hire date. Does not include wages	Employers are to report new hires within one week. Occurs at intake and review, and weekly on all recipients	CARES sends a notice requiring the recipient to submit verification. If it is not received on time, the worker is alerted
Insurance disclosure database maintained by EDS; information reported by Wisconsin insurers	Data on persons covered by private health insurance policies	Insurance companies report monthly or quarterly	For BadgerCare cases, CARES automatically terminates individuals found to have other insurance
Kids' Information Data System (KIDS)	Limited information on absent parents		Workers must manually query KIDS to get additional information

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

September 20, 2004

Janice Mueller, State Auditor
Legislative Audit Bureau
22 West Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

Thank you for the opportunity to comment on the Legislative Audit Bureau's (LAB) report regarding Medicaid eligibility determinations. The Department of Health and Family Services (DHFS), Bureau of Health Care Eligibility (BHCE), is the state agency responsible for the eligibility policies and processes established by county and tribal social/human services agencies for conducting eligibility determinations for Medicaid, BadgerCare, Food Stamps and SSI Caretaker Supplement.

The Department is committed to ensuring the health, safety and welfare of all Wisconsin residents, and preserving the health care safety net including Medicaid, BadgerCare and SeniorCare serving low-income children and families, people with disabilities and seniors. It oversees the delivery of eligibility-related services through the enforcement of state and federal standards in local Income Maintenance (IM) agencies.

The Department agrees with a number of the LAB recommendations contained in the report. We will work with local IM agencies to ensure a more clear and consistent understanding and application of DHFS policies regarding verification of questionable information. We will also consider whether additional changes to the CARES system will help to address worker errors as we continue the conversion of CARES mainframe screens to the more user friendly, web-based screens for IM workers. The first phase of the web-based system will be implemented beginning in early 2005.

We also agree with the recommendation to develop plans and pursue statutory language changes to address the inconsistencies in statutes related to Medicaid fraud and benefit recoveries. Our DHFS biennial budget request submitted to the Department of Administration on September 15th contains a package of initiatives that address program integrity issues. Specifically, the budget requests:

- Policy modifications that allow IM workers to request verification of income when no third-party data is available.
- Statutory changes that give the Department the authority to require third parties (i.e., employers, banks) to provide information at the request of IM workers.
- Statutory changes to restore the Department's ability to make Medicaid recoveries through the use of tax intercept.

- Statutory changes that allow the Department to recover overpayments that result from a failure to report changes in non-financial eligibility criteria (i.e., household composition, insurance coverage) outside of the application and review period.
- Resources to implement state quality control reviews for Medicaid.
- Resources for local agencies to conduct second-party reviews to identify worker errors on new applications and reviews.
- Resources to conduct Internal Revenue Service database matches at the state level to target data exchanges for certain Medicaid and Food Stamp cases to identify unreported unearned income and assets.
- Additional funding for IM administration to prevent deterioration of the eligibility determination system in light of the increasing caseload.

In 1996, federal TANF legislation delinked AFDC and Medicaid eligibility. By 1998, it had become clear that this legislation was having a significant negative impact on access to health care for low-income families, and federal officials began to encourage states to enhance outreach efforts and streamline the application process. In response to these concerns, Wisconsin implemented numerous program simplification initiatives, including self-declaration of income. These initiatives were expanded as the federal government required further program simplification as a condition of the SCHIP waiver for Wisconsin's BadgerCare program, a program strongly supported and enacted by the Legislature and Governor.

Wisconsin's SCHIP waiver allowed Wisconsin to secure SCHIP enhanced match for parents. Wisconsin is one of only four states that receive this enhanced federal match, which saved Wisconsin $8.9 million GPR in SFY04 alone. In addition, this waiver has allowed Wisconsin to receive over $143 million in SCHIP reallocations from other states in the last four years.

In its most recent analysis in May 2004, the Legislative Fiscal Bureau projected that the Wisconsin Medicaid program is currently facing a $224 million deficit. While it is suggested in the LAB report that program simplification initiatives, along with the downturn in the economy, are the primary causes of this deficit, the deficit is in fact the result of another significant factor. While $64 million of the current shortfall is attributable to caseload growth and utilization of health care services in excess of budget assumptions, the remaining shortfall is due to decreased federal revenues due to the federal government's refusal to approve certain federal revenue maximization initiatives.

The LAB case reviews found that eligibility worker errors affected eligibility in 6.5 percent of the 200 cases reviewed. There is no information available from the period prior to program simplification, however, to determine whether these policies have changed the results. Further, the analysis regarding the impact of the various methods of application (in-person, mail-in and telephone) is based on a very small sample of cases and, thus, cannot be determined significant. Although we can agree to review our application forms and consider how to best address the issues raised in the LAB report, it will be important for us to maintain forms and processes that are simple for customers to ensure access to our programs.

The state's experience with the Food Stamp program provides important perspective with regard to the impact more extensive verification and complicated policies and processes in public assistance programs can have on eligibility determinations. Federal Food Stamp program rules and regulations require verification of income and resources, as well as in-person interviews at application. Nonetheless, Wisconsin has experienced double-digit error rates in that program

each year, until 2003 when the error rate dropped to 9.3 percent. The error rate has since declined another two percentage points in 2004. This trend is directly related to increased program simplification resulting from implementation of options provided to states under recent federal legislation, enhanced automation and more state training for eligibility workers.

The findings with regard to the family fiscal unit calculation also point to the importance of clear and concise instructions in preventing eligibility worker error. Although it is true that the Department did not implement systems changes to automate this calculation due to other competing demands to implement legislative priorities, including BadgerCare, Family Care, MAPP, Family Planning Waiver program, SeniorCare and Food Stamp error reduction, county IM workers were provided specific instructions as to how to manually complete this calculation. As noted in the report, the family fiscal unit calculation is now automated.

The Department is committed to improving and maintaining program integrity for public assistance programs. Payment accuracy, timely case processing, customer service, front-end verification, fraud investigations and benefit recovery are all important components of program integrity. We have been working closely with county officials through the Income Maintenance Advisory Committee (IMAC) in addressing all aspects of program integrity. In addition, the Department is in the process of establishing a Payment Error Rate Measurement (PERM) process in preparation for new federal requirements for states to measure and report Medicaid payment accuracy rates beginning in 2006. Wisconsin has applied for a federal grant to pilot the PERM program this year. Also, as described earlier, the Department's budget request includes a package of program integrity initiatives designed to improve the quality of eligibility determinations.

We were pleased to note that the LAB case reviews did not indicate any specific instances of client fraud. Rather, the findings from case reviews emphasize the importance of preventing worker error in achieving accurate eligibility determinations. The report includes numerous comments from county staff regarding how increasing caseloads have affected their ability to accurately determine eligibility. For example, some county officials indicate that time constraints caused by caseload increases and lack of resources to hire additional staff prevent them from processing alerts timely.

The LAB reports that Medicaid enrollment increased by nearly 48 percent between June 2000 and June 2004, and that expenditures for Medicaid administration increased by 2.1 percent from SFY 1998-99 to SFY 2002-03. While this is an important comparison, the report does not provide data specifically on the amount of funding provided to local IM agencies for the administration of IM programs, including Medicaid, BadgerCare, Food Stamps and SSI Caretaker Supplement. This expenditure data is more directly pertinent to analyzing the impact increasing caseloads have had on the potential for worker error.

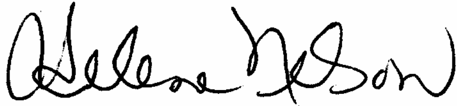
Income Maintenance administration funding allocated to county and tribal IM agencies has not increased (other than some additional amounts allocated with the start-up of BadgerCare and Family Care) since 1985. As Medicaid and Food Stamp caseloads continue to rise, local agencies face increasing pressure to maintain quality. The lack of funding increases, coupled with the increase in the number of cases an IM worker must manage, increases the likelihood of eligibility determination errors.

To begin addressing this issue, the Department initiated a project with the IMAC Committee to examine the issues of overall funding and how it is distributed to local agencies. A new methodology for distributing funds based on individual county caseload mix and related workload

was developed as a result of these efforts. Although the Department's budget request incorporates use of the new formula and modest increases in IM administration funding to help prevent deterioration of the quality of eligibility determinations, virtually all counties will receive allocations less than their full-funding amount under the formula.

We appreciate the time and effort expended by LAB staff in performing this audit. Thank you for your consideration of our comments.

Sincerely,



Helene Nelson
Secretary