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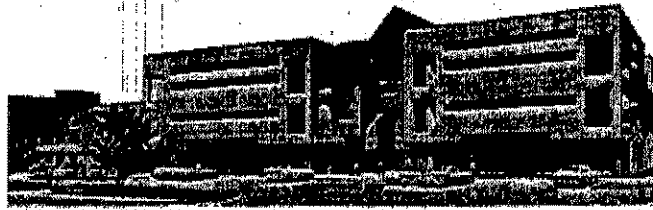
OFFICE OF THE SHERIFF



DANIEL J. TRAWICKI, *Sheriff*

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THE WAUKESHA COUNTY SHERIFF DEPARTMENT
DETECTIVE BUREAU

TO: State Rep. Suzanne Jeskewitz

PHONE #

FAX # 608-282-3624

NO. OF PAGES, INCLUDING COVER: 3

DATE: 12-9-04

FROM: Detective Debby Vandervoom
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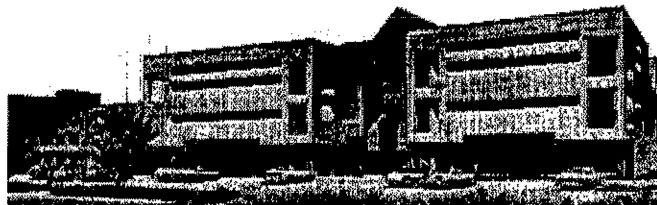
THANK YOU.

COMMENTS: See attached

OFFICE OF THE SHERIFF



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DANIEL J. TRAWICKI, ***Sheriff***

December 9, 2004

Dear Representative Jeskewitz,

I am a detective with the Waukesha County Sheriff's Department and have been assigned to conduct public assistance fraud investigations, on a full time basis, since January 1997. I am also a member of the Wisconsin Association of Public Assistance Fraud and have been a board member for the past three years.

My purpose for writing this letter is my concern for the lack of funding by the State of Wisconsin to combat this fraud.

Based on the statistics we keep in the sheriff's department, our previous detective investigated 90 to 100 cases per year prior to 1997. Between 1991 and 1999 our county experienced over one million dollars in public assistance fraud, with over 65% of these dollars recouped. Since 1997 my caseload rose dramatically, averaging 150 cases I investigate per year. (This is only my portion of the cases/investigations conducted by our fraud unit as a whole. The total number is actually much higher.) Approximately 10 per cent of my cases are criminally prosecuted. Between January 1, 2004 and September 1, 2004 the cases I sent to the District Attorney totals over $171,000.00 of fraud perpetrated. The remaining 85 percent of my investigated fraud cases have a finding of fraud perpetrated, and collection is handled on an administrative basis. Our fraud unit, consisting of myself and two fraud investigators from Waukesha County DHSS, find over $250,000 in fraud perpetrated yearly by clients in our county alone. This year we have had several cases amounting $15,000 to $20,000 each, so I have no doubt we will be above this amount for 2004. This is the fraud perpetrated by one of the wealthiest counties in the state, with a smaller client base than that of other counties.

Public assistance fraud continues to be a problem. It is my understanding there is 40 million dollars in debt to be collected from past public assistance overpayments. If only the taxpayer knew what was occurring. As far as they know "welfare" doesn't exist anymore. It has been hidden and sugar-coated with words like "public assistance" and "food share". When I speak with others about my job they are appalled to hear what is going on, especially when I tell them about the woman who faked pancreatic cancer for over two years so she wouldn't have to work, collected food stamps, and collected over $16,000 in W-2 payments. Yes, these cases do exist and she is presently in prison.

I am also a taxpayer in this state and find our taxes are absolutely outrageous. The rest of my family moved out of Wisconsin over the past 15 years because of our tax situation. If the fraud perpetrated in Waukesha County alone is over a quarter million dollars, can you imagine what is occurring in the other counties? Public assistance clients need to be held accountable for intentionally stealing from the taxpayer. Does a store such as Walmart invite their customers to steal? By failing to fund fraud you are inviting people to steal, and we are to turn our head and ignore it? Walmart doesn't do it and neither should we. Shouldn't the taxpayer expect integrity from their state government?

It is important for you to continue the allocation of funding for the fraud program. It is the only way to ensure program integrity. You are responsible with making sure the low income residents of this state who deserve those benefits receive them. You are not responsible for just handing out the tax dollars to anyone who asks for them.

Please continue our effort to combat the fraud occurring within the "system". If we don't do it, no one will.

If you have any questions or wish to respond to this letter, feel free to contact me at (262) 896-8140 or by e-mail at dvanderboom@waukeshacounty.gov.

Respectfully,

Deborah W. Vanderboom
Detective
Waukesha County Sheriff's Department

Medical Assistance
Eligibility Determinations

Legislative Audit Bureau
December 2004

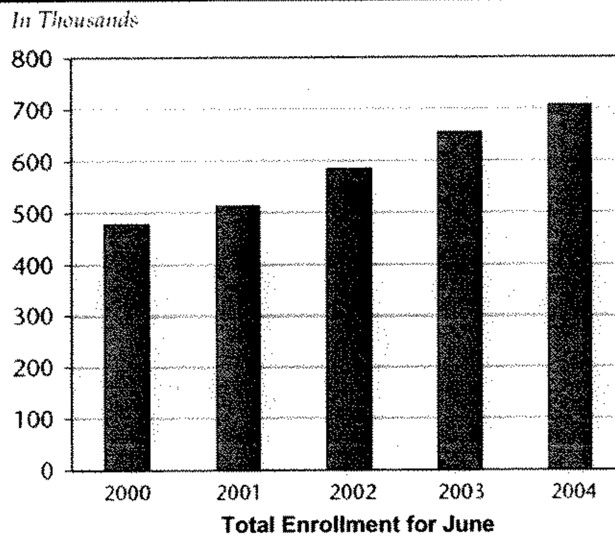
1

Overview

- DHFS administers Wisconsin's Medical Assistance program
- The FY 2004-05 budget is $4.3 billion
- Families with assets but limited incomes became eligible for benefits in July 2000
- In 2001, documentation of wages and other information used to determine eligibility was no longer required

2

Increases in Enrollment



3

Program Expenditures

- Expenditures for program benefits increased by 48.6 percent
  - Benefit expenditures increased from $2.9 billion in FY 1999-2000 to $4.3 billion in FY 2003-04
- Administrative expenditures increased by 2.1 percent
  - Administrative expenditures totaled $169.6 million in FY 2002-03

4

Comparisons with Other States

- States have flexibility in designing coverage under Medical Assistance
- At 185 percent of the federal poverty level, Wisconsin covers parents with higher incomes than any midwestern state except Minnesota
- Wisconsin is one of only 12 states that do not require documentation of income

5

Worker Errors

- Worker errors affected eligibility for 13 of 200 cases we reviewed
- We found no instances of non-citizens or non-Wisconsin residents receiving benefits inappropriately

6

Income Discrepancies

- We found 10 of 200 cases with income discrepancies that would have affected eligibility
- In-person applications resulted in more accurate income estimates

7

Denied Applications

- In 13 of 101 cases, applicants were inappropriately denied benefits
- In January 2004, an estimated 1,100 individuals were inappropriately denied benefits as a result of the CARES problem
- DHFS fixed the problem in July 2004 after we brought it to the Department's attention

8

Program Integrity Efforts

- Efforts to prevent fraud and abuse have been limited in recent years
- Since 1998, approximately one-third of counties did not attempt to recover inappropriately granted benefits in any given year
- Since 1995, funding for program integrity efforts declined 76 percent to $2.3 million in 2004

9

Obstacles to Benefit Recovery

- Inconsistencies in statutes and policies have hampered benefit recovery efforts
- Several counties reported having benefit recovery cases overturned at hearing because of these inconsistencies
- We recommend inconsistencies in statutes and DHFS policies be corrected

10

Other Recommendations

- We recommend DHFS:
  - report to the Audit Committee on additional CARES programming changes that could help to catch errors
  - make changes to the mail-in application form to improve clarity and reduce errors
  - clarify policies regarding when county workers can request documentation of income

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Joint Legislative Audit Committee
Testimony of Mark Moody on "An Evaluation:
Medical Assistance Eligibility Determinations"
State Capitol, Room 411 South
December 1, 2004

Good Morning. My name is Mark Moody. I am the Administrator for the Division of Health Care Financing in the Department of Health and Family Services. Thank you for the opportunity to talk with you about the Legislative Audit Bureau's (LAB) report regarding Medicaid eligibility determinations.

Joining me today are Cheryl McIlquham, Director of the Bureau of Eligibility Management (BEM) and Jim Jones, Deputy Director of the Bureau. This Bureau has primary responsibility for establishing eligibility policies and overseeing processes established by county and tribal social/human services agencies for conducting eligibility determinations for Medicaid, including BadgerCare and SeniorCare, and FoodShare (Wisconsin's food stamp program).

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. We are also committed to program integrity and continuous improvement in the accuracy, timeliness and efficiency of program administration. The BEM oversees the delivery of eligibility-related services for local Income Maintenance (IM) agencies to meet state and federal standards.

We appreciate the Joint Audit Committee's interest in the integrity and effectiveness of the eligibility process for Medicaid, BadgerCare, FoodShare and SeniorCare. We would also like to take this opportunity to acknowledge the courtesy and professionalism of the LAB staff who conducted this audit. It was a highly complex undertaking that they approached with diligence and professionalism.

The Department agrees with a number of the LAB recommendations contained in the report. Accordingly, we will work with local IM agencies to ensure a better and more 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 in pilot counties 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:

- Resources to implement state quality control reviews for Medicaid, to meet new federal requirements that will be effective beginning October 2005.

- Resources for local agencies to conduct second-party reviews to identify and correct 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 FoodShare cases, and to identify unreported unearned income and assets.
- Policy modifications that allow IM workers to request verification of income by applicants 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.
- Additional funding for IM administration to prevent deterioration of the eligibility determination system in light of the increasing caseloads.

The LAB Report describes the many program requirements for Medicaid and BadgerCare, including program simplification policies. In discussing these requirements and policies, historical context is important. In 1996, federal TANF legislation de-linked 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 adopted numerous program simplification policies, 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 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. This 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, allowing Wisconsin to qualify for the higher SCHIP federal matching rate for all of BadgerCare.

In its most recent analysis in May 2004, the Legislative Fiscal Bureau projected that the Wisconsin Medicaid program is currently facing a $220 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 other significant factors. 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 the federal government's refusal to approve certain federal revenue maximization initiatives incorporated in the budget. Furthermore, even the portion of the current deficit attributable to caseload arguably reflects prevailing economic and market circumstances, not lax eligibility policy.

The LAB case reviews found that eligibility worker errors affected eligibility in 6.5% 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 considered statistically significant. Although we do 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.

We believe it is important to strike a balance between making sure that people who we find eligible truly are without making the process so complex that eligible people are denied access.

The state's experience with the FoodShare 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 unacceptable error rates. The recent downward trend is directly related to increased program simplification resulting from implementation of options provided to states under recent federal legislation, enhanced automation, more state training for eligibility workers and the special case review project in Milwaukee County.

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 FoodShare 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. In addition, the Department has taken steps to correct current and prior eligibility for all the cases found to be in error.

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 applied for and was awarded 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% between June 2000 and June 2004, and that expenditures for Medicaid administration increased by 2.1% 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 FoodShare 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.

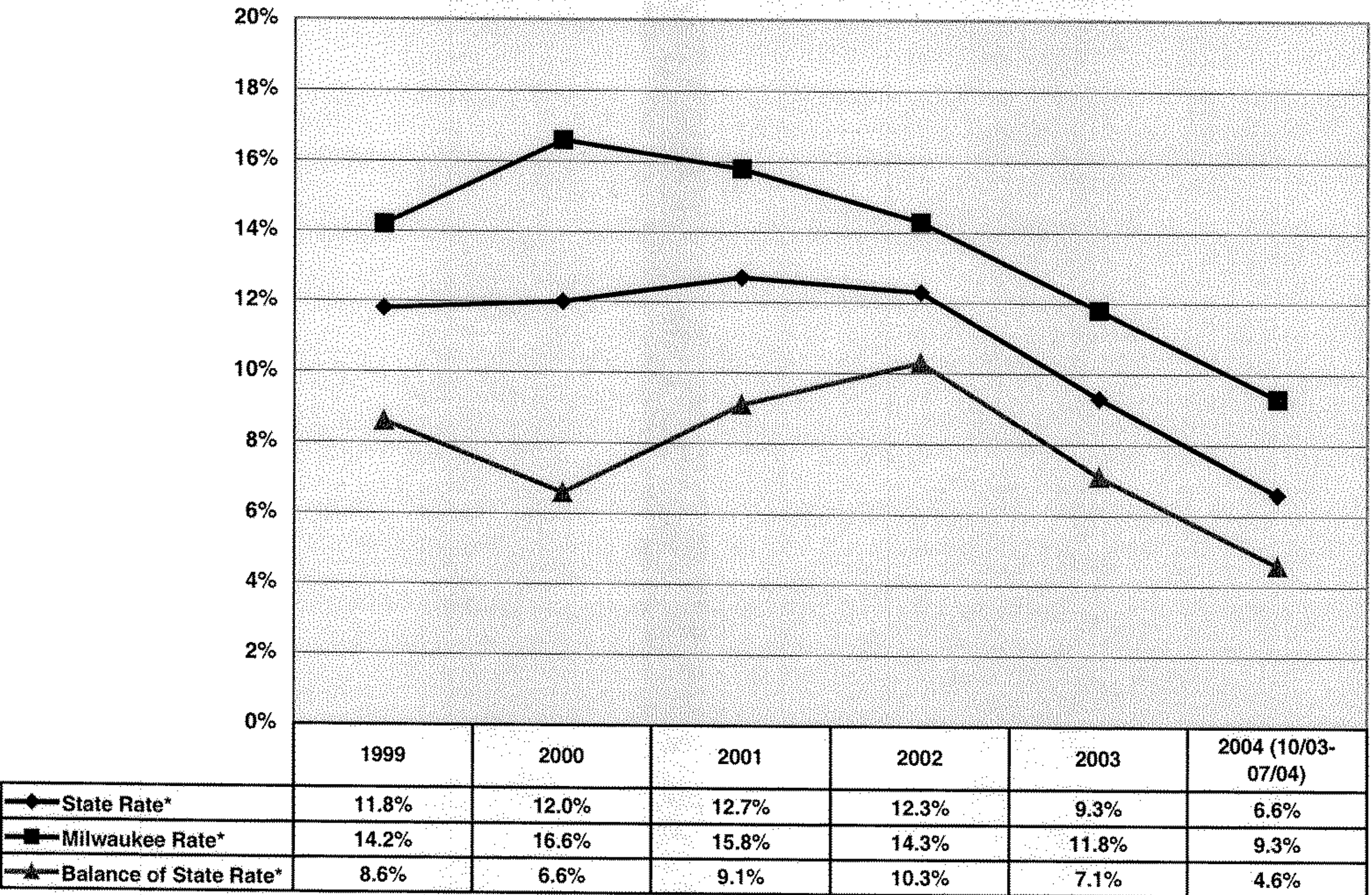
To address this issue, the Department initiated a project with the IMAC Committee to examine the issues of overall funding and how it is distributed to local agencies. A new methodology for distributing funds based on individual county caseload mix and related workload was developed as a result of these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

Lastly, the Committee asked specifically that we provide an updated report on the FoodShare error rate. As you are aware, Wisconsin experienced double-digit error rates in this program every year prior to 2003 and was liable for millions of dollars in federal sanctions for exceeding the federal tolerance level for error. In 2003, the first year after the FoodShare program was transferred to DHFS, the error rate dropped to 9.3%. For the first time, the error rate was under 10%. We are very pleased to report today, that we have been successful in lowering the statewide error rate by another 2.7%. For the period October 2003 through July 2004, the statewide error rate is 6.6%. We expect that the rate will be even closer to our 6% goal for FFY 2004 as data for August and September are finalized.

The attached Charts 1 and 2 show the trend of FoodShare error rates for the last six years and the error rates for each month of FFY 2004, respectively. You will note that in the most recent months, Milwaukee County's error rate has dropped dramatically and was actually lower than the rate for the balance of the state in several of those months. This is the first time in history that this has happened and is the direct result of a joint state and county effort to review and correct 13,500 FoodShare cases.

We appreciate the time and effort expended by LAB staff in performing this audit. Thank you for the opportunity to testify before your Committee. We would be happy to respond to any questions you may have.

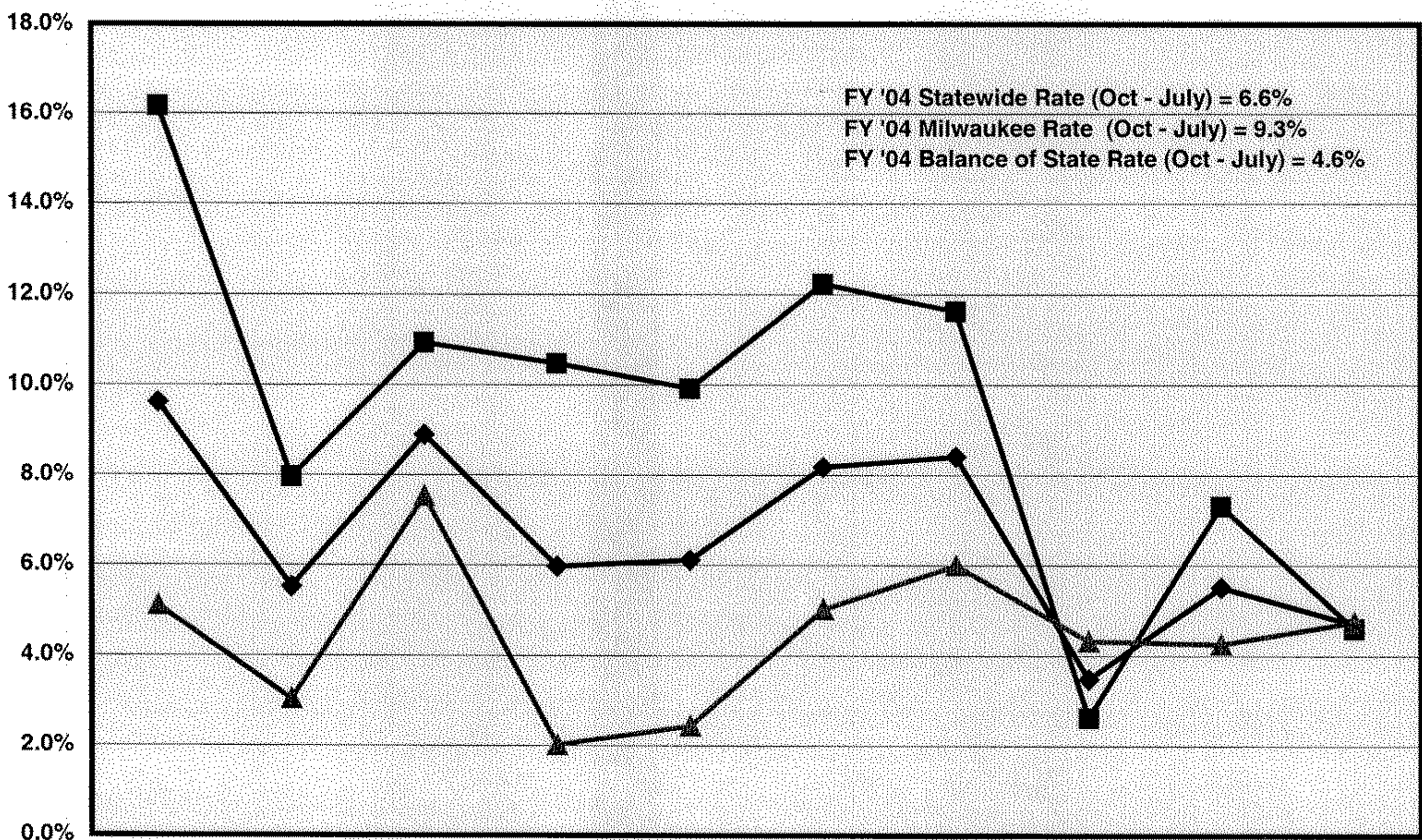
Chart 1: FoodShare - Annual Error Rates, FFY 1999-2004



	1999	2000	2001	2002	2003	2004 (10/03-07/04)
State Rate*	11.8%	12.0%	12.7%	12.3%	9.3%	6.6%
Milwaukee Rate*	14.2%	16.6%	15.8%	14.3%	11.8%	9.3%
Balance of State Rate*	8.6%	6.6%	9.1%	10.3%	7.1%	4.6%

*All rates are unregressed

Chart 2: FoodShare Rolling Error Rate FFY 2004 (Oct - July)



	Oct-03	Nov-03	Dec-03	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04
State Rate	9.6%	5.5%	8.9%	6.0%	6.1%	8.2%	8.4%	3.5%	5.5%	4.7%
Milw. Rate	16.2%	8.0%	10.9%	10.5%	9.9%	12.2%	11.6%	2.6%	7.3%	4.6%
BOS Rate	5.1%	3.0%	7.5%	2.0%	2.4%	5.0%	6.0%	4.3%	4.3%	4.7%

Senator Roessler, Representative Jeskewitz, members of the Joint Audit Committee: As President of the Wisconsin Association on Public Assistance Fraud, I would like to thank you for the opportunity to provide you with oral and written testimony regarding the Medical Assistance Eligibility audit –specifically the chapter on program integrity.

My name is Richard Basiliere, and for the last 7 ½ years, my job responsibilities have been exclusively dedicated to maintaining public assistance program integrity. I have detected and investigated benefit issuance violations and errors in public assistance cases involving Food Stamps, Medical Assistance, Child Care, and Wisconsin Works.

As the audit report alludes to, there have been major obstacles or barriers to achieving a program integrity program that is effective and efficient.

- First, the current structure of the Public Assistance Fraud Program, has been in place for almost seven years, and attempts to separate one process with two different funding methods. The funding methods together with the fact that there are various confusing ways in which a local agency can administer the investigations program, has led to over-whelming confusion that has ultimately resulted in a decline of participation in the program. As the audit report indicates, there has been limited participation in program integrity efforts.

- The second barrier is the integration of prevention funds with Income Maintenance funding. Rising caseloads and the total reduction of IM funds has resulted in low administrative priority that has been given to identifying and recovering overissued benefits.

- Thirdly, another major ~~factor~~ obstacle is due to a conflict between what is mostly perceived as the main purpose, the main goal, ~~the main ideology~~ of human services vs. the job duties associated with program integrity. We see this conflict in the audit report itself and I quote "DHFS officials contend that the potential need for program integrity funding must be weighed against other programmatic needs". What DHFS officials intend to say is that although there is currently very little funds to operate a program, the program integrity program should be left to disintegrate due to the fact that other programmatic needs, not related to program integrity efforts, are more important and much more consistent with the main purpose and priority of not only DHFS but the concept of human services in general. DHFS officials additionally say that quote "they believe that providing more funding to address workload issues will reduce errors and limit the need for fraud prevention." This comment demonstrates a fundamental misunderstanding as to what fraud prevention is, which very much concerns me as they are the department that is to be administering the program integrity program. They seem not to realize that if a client fails to report relevant information at application or at review, the reduction of the IM worker's workload would not resolve that! I concede that the more time a worker has to determine eligibility, the less likely that they themselves would make errors, but their workload, or lack of it, has very little impact on a client's propensity to misrepresent their circumstances.

Regardless of the serious issues that this program faces, as the audit report points out, this program has been and is financially beneficial to the tax payers.

The first component of program integrity is "fraud control investigations". This process involves the examination of public assistance cases in which there is probable cause that relevant information was not reported, and that benefits were determined and issued using the false information that was provided by the client. The time frame of the error, the reason for the error, who was involved, and the level of the financial loss are all determined during the course of an investigation, and may lead to a benefit recovery effort. If there is evidence that the financial loss is due to an intentional act, administrative and/or legal action may be required for fairness and justice.

In regards to fraud control in the Child Care program – the United Council on Welfare Fraud testified before the United States congress to the fact 24 States reported that fraud and abuse was detected in almost 70 % of cases that were investigated. Although Wisconsin has policy and statutes in place to enforce the regulations regarding child care, the potential for the more detection of fraud and abuse is astronomical. However, in Wisconsin, there appears to be no unity between the department responsible for administering child care and the department responsible for administering program integrity in the child care program. In addition, there has been no financial incentive for Counties to participate in detecting program violations.

In regards to Medical Assistance, the program has been vulnerable to the barriers that I previously spoke of – namely low priority given to detection and recovery. Additionally, because Medical Assistance policy can be very complicated, there is a huge training issue.

The second component of program integrity is fraud prevention which is "a close examination of individual cases that show characteristics of potential fraud". The requests or the referrals to perform fraud prevention investigations are mainly based on case characteristics that are indicative of a potential violation.

In an effort to address prevention needs there has been an attempt to link fraud prevention with an IM administrative process called a second party review, which is designed to detect administrative error. However, besides both processes being designed to detect errors, they are not at all similar. A 2nd party review evaluates the quality of how benefits are processed while a fraud prevention investigation evaluates the information provided by the client. If the two processes were combined, the time and effort would be invested into the 2nd party review process, and the State would not adequately be able to comprehensively detect fraud and abuse.

As corrosive as the programmatic structure has been on program integrity efforts, data gathered from CARES, indicates that for SFY 2003, $2.6 million dollars in public assistance is saved each month as a result of fraud prevention efforts, and with 6 months between reviews of eligibility, it is estimated that $15.6 million dollars is saved every 6 months from fraud prevention efforts.

Savings are also generated from "fraud control investigations". Not only are claims generated from this type of investigations, but savings are also generated when a case closes as a result of an investigation or when a recipient is disqualified from benefits for violating program rules. CARES data shows that $575,000 in public assistance is saved each month as a result of fraud investigations with a 12 month projection of $6.9 million.

Therefore, because of program integrity efforts, it is estimated that $38.1 million dollars worth of public assistance benefits is prevented from being issued erroneously each year, and that an additional $6.9 million is claimed in over-issued benefits, due largely to investigation efforts.

However, despite our data, as well as statistics gathered from other States that tell the same story, in terms of benefit recovery claims and savings, DHFS has informed us that there is very little money to operate a program integrity program in 2005, and has expressed serious concern about being able to comply with the statutory requirement of maintaining a program that is functional state-wide.

All other States that have been interviewed, find value in program integrity efforts, through claims and savings, and invest in their program with state tax dollars. However, I believe DHFS has declined to request state tax dollars to invest into our program and will continue to fund the program with diminishing revenue from collections even though savings data is very strong. This decision will result in the further disintegration of the funding which will result in even less involvement, and eventually will contribute to the total and complete disintegration of the program.

I hope my testimony results in the recognition that program integrity has a separate purpose and goal that is different from the general administration of public assistance programs. Therefore, it is absolutely necessary, for the survival of the program, that we legitimize a program integrity program that is sovereign with specialized administration and staff and that there be a separate budget as well as defined roles, job duties, responsibilities and expectations.

In my estimation, the program would not need a lot of investment to be effective and efficient, but the administration and the staff need to be dedicated, determined and unified towards the goal of maximizing the detection of fraud and abuse.

In conclusion, I believe that the government, owes it to the taxpayers, as well as to the truly needy, to make sure that assistance is available and issued correctly.

Gene Kucharski – December 1, 2004
Vice President, Wisconsin Association on Public Assistance Fraud (WAPAF)
Wisconsin Licensed Investigator
Investigative Concepts Unlimited Inc.
2931 Gilbert Dr.
Green Bay, WI 54311

I have been involved in the investigative area of Wisconsin's various public assistance programs since 1988. Since that time I have been involved on countless investigations involving both Front End Verification, pre-certification investigation, and investigation of suspected fraud. I have also been witness to numerous changes in all of the programs throughout the years including the implementation of new programs and the phasing out of others.

For the past several years I have been witness to a change in the core philosophy of Program Integrity within the Public Assistance Programs. Over the years vast sums of money have been spent on "error reduction" while the funds spent to investigate suspected fraud and to prevent fraud within the public assistance programs has dwindled due to the fact that funding for the investigative program is derived from program revenue, funds generated through the investigative process.

Prior to 1998, when there was a strong investigative program and because the funding sources were structured differently there was a surplus generated by the investigative program, which at that time involved all aspects of the investigative process. At about this time the funding structure changed and a two level investigative process was begun. This process involved two general types of investigations FEV (Front End Investigation) that is defined as "An intense investigation of questionable information at the time of application, review or change..." (Prevention activities), and Fraud Investigation which is defined as the establishing of intent where an overpayment has occurred and the follow through with the prosecution of an "Intentional Program Violation" or "Fraud Prosecution".

Funding for the FEV process was included in the IM Contract with Counties and was provided with no requirement to demonstrate that prevention activities were actually undertaken. (It should be noted here that this process was often delegated to the economic support worker who had an over burdensome work load with the eligibility determination process. The cost of Fraud Investigation was reimbursement through a "pay for performance" system where a maximum of $500.00 would be reimbursed toward the cost of the investigation. Much of this information is contained in the Legislative Audit Bureau report.

I do not want to duplicate information that is already covered in the report or has been testified to at this hearing. I want to be a voice shouting from the watch tower that if some kind of action is not taken soon there will be no process to investigate and prevent suspected fraud in Public Assistance Programs.

The first obstacle to overcome in building a better system of program integrity begins with the most basic premise. Wisconsin State Law requires that "the department shall have a program to investigate suspected fraud…" This system must be legitimized by having specific funding, designated personnel, strong administration and program monitoring to ensure the effectiveness and cost savings of the program.

An unstated and unaddressed problem in the system now is the fact that that there is not a strong investigation process to investigate Program Violations. I think that this is where there has been a lack of focus in the past several years. The current mindset appears to totally disregard the program violations that occur within the program. All too often these program violations are referred to as "errors" and the real cause of the problem is not addressed. When any of the Public assistance programs are approved there are certain eligibility requirements that are imposed by the body that established the program. All too often when these requirements are disregarded exaggerated or outright falsified by someone requesting the assistance program they are called errors. Errors do occur in all of the programs and actions need to be taken to reduce these types errors, which as the audit report indicate, include computer programming problems mistakes by economic support workers, out dated matches etc. These problems can and should be addressed but most times they do not require extensive investigation as there are what they are called "ERRORS" and there is no attempt to conceal the true facts and usually with minimal effort these problems can be corrected.

The more difficult to locate and establish "errors" are what I will call PROGRAM VIOLATIONS. This is where for one reason or another, the eligibility requirements for the program were usurped by the person requesting the assistance. These may or may not be intentional acts but they are certainly program violations. My experience and I think logic, dictates that not all people are honest and that some people will attempt to receive benefits that they may not be eligible for. The Audit Bureau Report indicates that for a period of about five (5) years about one-third of the counties did not attempt to recover any benefits that were granted inappropriately. I believe that this points out a lack of any effort to "investigate suspected fraud" in public assistance programs. Funding is certainly a factor in this problem but the fact that there were apparently no designated individuals who were responsible, no State Administration monitoring the activity and apparently no desire by the Health and Human Services department to remedy the problems appears to be at the root of the problem.

Two of the largest assistance programs have been the most neglected. While there has been an ongoing effort in the food stamp program toward program integrity the Medicaid program including Badger Care and the Child Care program have not had any serious emphasis placed on them. While Medicaid does have an incentive program built into it for the recovery of erroneously issued benefits the Child Care program had no such incentives built in. The Audit Bureau Report indicates that in a four-year period, the largest County in the state had only six (6) Medicaid recoveries. This occurred between 1998 and 2002 and again the Department apparently did not take any action to correct this blatant lack of action relating to program integrity. WAPAF has gathered statistics for Wisconsin and for fiscal year 2003 there was a total of $1.9 million in overpayments established. (It should be noted that under current policy errors that do not involve

Program Violations can not be collected. The fact is that all of these claims involved potential fraud.)

Even with the limited resources that have been provided recently those counties that are able to maintain a strong investigative program have had success. I am including a chart of collections and savings, which has been compiled, in part by others associated with the Wisconsin Association on Public Assistance Fraud, WAPAF and myself, including Wisconsin and other surrounding states. It should be noted that though the other state's program differ in structure they are similar in that they are funded thorough GPR thus giving them the designated staff needed to accomplish the investigative, recovery process. Wisconsin is the only state that operates solely on program revenue. (Funding a Public Assistance investigative program with program revenue is the equivalent of trying to fund a law enforcement agency through the tickets that they write.)

I would call to the Committees attention the fact that even though, per the audit report, one third of Wisconsin Counties had no activity the state had a cost benefit savings of $8.26 for every $1.00 that was spent on the program. (Keep in mind that this is not GPR but funded through the revenue generated by investigation and thus had "no cost". This will disappear if the investigative program does not survive.)

We have heard from the Department that "We were pleased to note that the LAB case reviews did not indicate any specific instances of client fraud." This statement is tantamount to saying that there are no speeders on our highways after reviewing drivers licensing applications and having no one monitoring the speed of traffic. (I again point out that for the last fiscal year $1.9 million in Medical Claims were established all of which involved violations of the program rules.)

I would ask that the Committee look for, (given the fact that current State Law requires that the Department shall have a program to investigate suspected fraud) an answer to the question,, if there are no funds designated, if there are no people responsible, if there is no administration or training and if there is no monitoring of the effectiveness, is there really a "Program to investigate suspected fraud? Certainly the counties complete a fraud plan and the state identifies in title administration but how does that address the fact that one third of the counties in the state had no investigation activity for a 5 year period. The reality that the administration feels that "no fraud occurs" dictates that the answer to that question, I think, is NO!

The solution is to legitimize a program to investigate suspected fraud in the public assistance program, have designated personnel responsible to carry out the function, have a strong administration to ensure the effectiveness of the program and monitoring to ensure that the program remains cost effective. The statistics from surrounding states and current statistics justify such a program and the taxpayers of Wisconsin deserve no less. I think that a fundamental responsibility of government is to ensure that public funds are used for the programs, for which they were indented and that the eligibility / rules established are followed,

State statistics for Fraud and Program Integrity
Related to public assistance benefits

State	OHIO	ILLINOIS	MINNESOTA
Overpayments Established	SFY 2004 All types (fraud, client, agency error) FS $7.6 million TANF $3.8 million Medicaid $446,000 (July-Sept new Medicaid local agency incentive program) **Total $11.8 million**	SF 2003 – OIG Statewide FS, Medicaid, TANF $2.38 million Child Care $408,000 **Total $3.2 million**	CY 2004 MFIP (TANF), FS, MA Overpayment Claims **Total $3.28 million**
Collections	SYF 2004 FS $11.9 million TANF $ 5.5 million Medicaid $ 187,600 (July-Sept – new Medicaid local agency incentive program) **Total $17.5 million**	SFY 2003 **FS $8.1 million** Other programs not available	CY 2003 Cash Collections (not including recoupment) AFDC/MFIP Cash $4.4 million FS/MFIP Food $2.7 million Tax Intercept $1.7 million **Total $8.8 million**
Prevention Investigations (Front-End Verification) & Fraud Investigations	CY 2003 Prevention Investigations (Voluntary for Counties- 41 of 88 participate) Gross Savings 1 Month Cost Avoidance- $815,900 Admin Costs $576,500 Net Savings $239,400 **Net Savings $4.66 million** (6 mo. benefits minus administrative costs)	SFY 2002 – Cook Co. Fraud Prevention Investigations Project Gross Savings Medicaid $ 4.8 million Financial/FS $ 5.6 million Total $10.5 million Admin./Contract Costs $ 700,000 **Net Savings $9.8 million** SFY 2003 – OIG Statewide Fraud Investigations Gross Savings Medicaid $2.74 million Food Stamps $1.74 million TANF $4.33 million Total $8.82 million Admin. Costs $ 720,000 **Net Savings $8.1 million**	CY 2004 Fraud Prevention Investigations Gross Savings $9.5 million Admin Cost (GPR/FED) $2.7 million **Net savings $ 6.8 million** CY 2003 Local Agency Fraud Programs (no state funding – all local funds with federal FS/MA match) Investigation - Overpayments $4.06 million Administrative Disqualifications $822,000 Civil Recoveries $1.35 million District Attorney - Deferred Prosecution $545,000 Convictions $1.34 million **Total $8.11 million**
Cost Benefit Savings per $1 Spent	**$8.07**	**Cook Co. Project $15.05** **OIG 7 ½ Year Average $12.41**	**$4.83**

State statistics for Fraud and Program Integrity Related to public assistance benefits

State	PENNSYLVANIA	IOWA	WISCONSIN
Overpayments Established	Data not available	Data not available	SFY 2003 All (fraud, client, agency error) FS $2.72 million MA $1.90 million CC $1.89 million W2 $395,000 AFDC $ 24,300 **Total $6.9 million**
Collections	FY 2003-2004 FS (cash only), Medicaid, TANF, Child Care **Total $40 million**	SFY 2003 Family Investment Program (TANF), Food Assistance Program, Medicaid, Child Care **Total $2.1 million**	SFY 2003 FS $1.68 million MA $408,000 CC $342,000 W2 $189,000 AFDC $1.52 million **Total $4.15 million**
Prevention Investigations (Front-End Verification) & Fraud Investigations	FY 2003-2004 Fraud Prevention Investigations Gross Savings $98 million (FS, MA, TANF, Child Care, using 1 mo. Benefit x 6 mo. Cert. Period) GPR $12 million FED $ 9 million Total Cost $21 million **Net Savings $77 million**	SFY 2003 Front-End Verification Cost Avoidance (Cost Avoidance is computed by taking benefits applied for / received x 6 months) Family Investment Program $ 642,474 Food Assistance Program $1,013,282 Medicaid Program $1,065,611 Child Care Assistance $ 19,200 (CC statistics were not kept until the end of the fiscal year) **Total Gross Savings $2.74 million** Public Assistance Fraud (Actual – no 6 mo. calculation) Family Investment Program $291,924 Food Assistance Program $371,981 Medicaid $717,600 Child Care $192,332 **Total $1.57 million** **Total FEV, Fraud, Collections Savings $6.4 million** Costs Fraud Control Bureau $1,372,627 Overpayment and Recovery Unit $335,716 **Total Costs $1.7 million** **Net Savings $4.7 million**	SFY 2003 Gross Savings – Program Integrity (FEV) FS, MA, W-2, Child Care 1 Mo. $2.6 million **6 Mo. Est. $15.6 million** Gross Savings – Fraud 1 Mo. $575,000 **6 Mo. Est. $3.4 million** **Total Gross Savings (6 mo. formula) $19 million** Program Integrity/Fraud Costs State Admin $526,000 Local Admin $1.8 million **Total Costs $2.3 million** **Net Savings** 1 Mo. $ 3.1 million **6 Mo. $15.9 million**
Cost Benefit Savings per $1 Spent	**$6.64**	**$3.76**	**$8.26**

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A MEMBER OF THE NATIONAL ASSOCIATION OF CHILD ADVOCATES

Testimony on LAB audit of Medical Assistance eligibility determinations

December 1, 2004

Thank you for this opportunity to testify on the audit of the Medicaid and BadgerCare eligibility determination process.

Overall, I think the most significant thing to note about the audit is that it did not turn up any instances of client fraud. The audit report does show that there is room to improve the accuracy of the eligibility determination process, but the error rates were relatively modest. The Wisconsin Council on Children and Families (WCCF) generally supports the recommendations that were endorsed by Secretary Nelson in her response to the audit. However, we will want to review and comment on the specific language of any changes in the statutes or rules as they are developed.

A CARES System error denied benefits to 1,100 in January alone

As you know, the audit found a number of cases where errors were made in eligibility determinations. A careful reading of the LAB report reveals that the most significant of those was an error in the CARES system software, which was incorrectly applying the federal law relating to the "family fiscal unit". The Audit Bureau estimated that the software problem "resulted in the inappropriate denial of approximately 1,100 individuals in January 2004."

Keep in mind that the 1,100 figure is for a single month. Because this was a longstanding problem, far more people were affected. Several advocacy groups had long been urging DHFS to correct the software error. We are very pleased that the Audit Bureau's work prompted DHFS to fix the problem back in July.

We support the Audit Bureau's recommendation (on p.32) that DHFS should report to the Joint Audit Committee on CARES program changes that could be implemented to reduce further eligibility determination errors. We also recommend that the department should contact families who were denied benefits because of that software problem and let them know that they might be eligible for Medicaid or BadgerCare.

Wisconsin spends a smaller portion of MA funds for administration than any other state

As you consider the LAB report, please keep in mind that in Medicaid Administration, as almost everywhere else, you get what you pay for. Wisconsin has not been paying a lot to administer the Medicaid program. The bar graph attached to my testimony illustrates that the percentage of total Medicaid spending used for administration is lower in Wisconsin than in any other state. In fiscal year 2003, Wisconsin used just 1.9 percent of MA funding for administration, compared to a national average of 4.9 percent. To put it a little differently:

- Wisconsin would have to increase spending for Medicaid administration by more than two and a half times (more than 150%) to get to the national average.

- We would have to boost spending for MA administration by 45 percent merely to catch up with Kentucky, which ranks 49th.

As a child advocacy organization, we would prefer to see MA funds spent for services rather than administration – if it comes down to that choice. But caseworkers are only human, and by under-funding MA administration Wisconsin undercuts efforts to reduce eligibility determination errors. That is not to say that we shouldn't continue to strive to improve the eligibility determination process, but policymakers should remember that there are tradeoffs when the state chooses to skimp on spending for the system's administration.

At some point – hopefully in the not-too-distant future – Wisconsin should carefully examine those tradeoffs and decide whether the state is investing enough on Medicaid administration to be able to make eligibility determinations efficiently and accurately. In the meantime, please take care not to exacerbate current problems by making procedural changes that increase the workload in the income maintenance system.

Unintended Consequences: BadgerCare Verification

Another major point I would to make is that efforts to improve the accuracy of eligibility decisions can have unintended consequences by creating significant barriers to enrollment.

The last biennial budget contained two measures to slow the growing cost of BadgerCare. First, it raised premiums from 3 percent to 5 percent of family income. Second, the biennial budget imposed new requirements for BadgerCare applicants and participants to provide verification of their income and insurance status, prior to approval of a new application and for continuation of coverage after an annual review.

The two BadgerCare changes were not expected to cause a net decrease in the program's enrollment, but were intended to substantially slow its growth. However, their actual effect will be far greater than anticipated. The second chart attached to my testimony compares the projected and actual changes in BadgerCare enrollment. The top line in the chart shows the Fiscal Bureau's estimate of the baseline growth that had been anticipated in BadgerCare if no changes had been made in the program. The middle line shows the much more modest growth that was anticipated based on the changes made in the 2003-05 budget. The third line shows how enrollment leveled out after the premium increase took effect in January of this year and then began to fall precipitously after the new verification requirements took effect in mid-May.

Over the first ten months of 2004, BadgerCare enrollment plunged by more than 18,000 people, or almost 16 percent. The primary reason for the decline is that the new income and insurance verification requirements are having a dramatic effect on the program. As the graph vividly illustrates, this is **not** what was intended or anticipated when the changes were approved.

I met with a number of DHFS staff in early October to talk about this trend, and at that point the exact reasons for the declining BadgerCare participation were still unclear. A small part of the decline appeared to be from a modest increase in the number of people found to be over income, but most of the increase seemed to stem from the fact that many people simply aren't completing the verification process. Exactly why that has been the case remains to be determined.

The audit report did not find any evidence that a significant numberof people who were over income were being enrolled in BadgerCare. Thus, it appears that the new verification requirements are causing the unintended consequence of impeding the enrollment of low-income families who are eligible for BadgerCare.

I was pleased to learn that the department is taking this issue very seriously and has begun an evaluation to find out why people aren't completing the new paperwork. Once their analysis has been completed, procedural changes may be necessary. There may be administrative changes that can be made to minimize the unintended effects of the verification requirements. However, if the problem cannot be resolved administratively, my organization and others will be urging you to consider a statutory change.

Impeding Medicaid and BadgerCare enrollment imposes costs elsewhere

Low-income, uninsured families who are deterred from enrolling in Medicaid or BadgerCare do not simply disappear. Many of them use the local emergency room as their primary source of health care, and they often add to the growing amount of uncompensated care for our health care system. That adds costs to the system in two ways. First, it is a much less cost-effective way of delivering health care. Second, the cost of uncompensated care is spread over other health care consumers in Wisconsin. And for that care, unlike Medicaid or BadgerCare coverage, our state does not get any federal matching funds to help defer the costs.

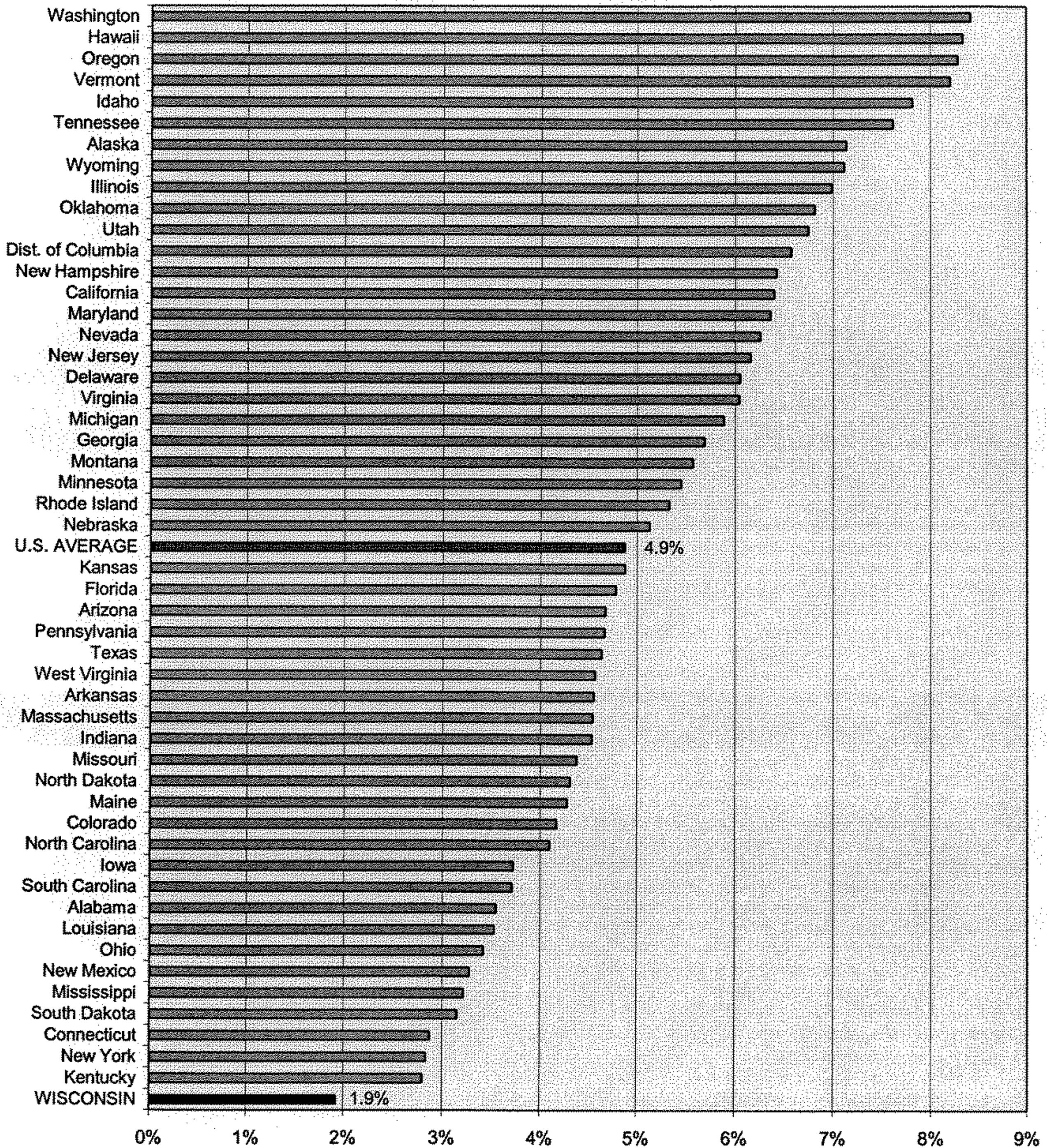
Conclusion

Wisconsin should continue to strive to improve the accuracy of Medicaid eligibility determinations. One of the reasons for doing that is to be good stewards of the public purse and to ensure that Medicaid benefits go to the people they are intended for. That means not only limiting the number of people who are improperly awarded benefits, but also minimizing the number who are improperly denied benefits. Similarly, it means not creating procedural hurdles that will deter eligible families, who are already under considerable stress, from completing the application process.

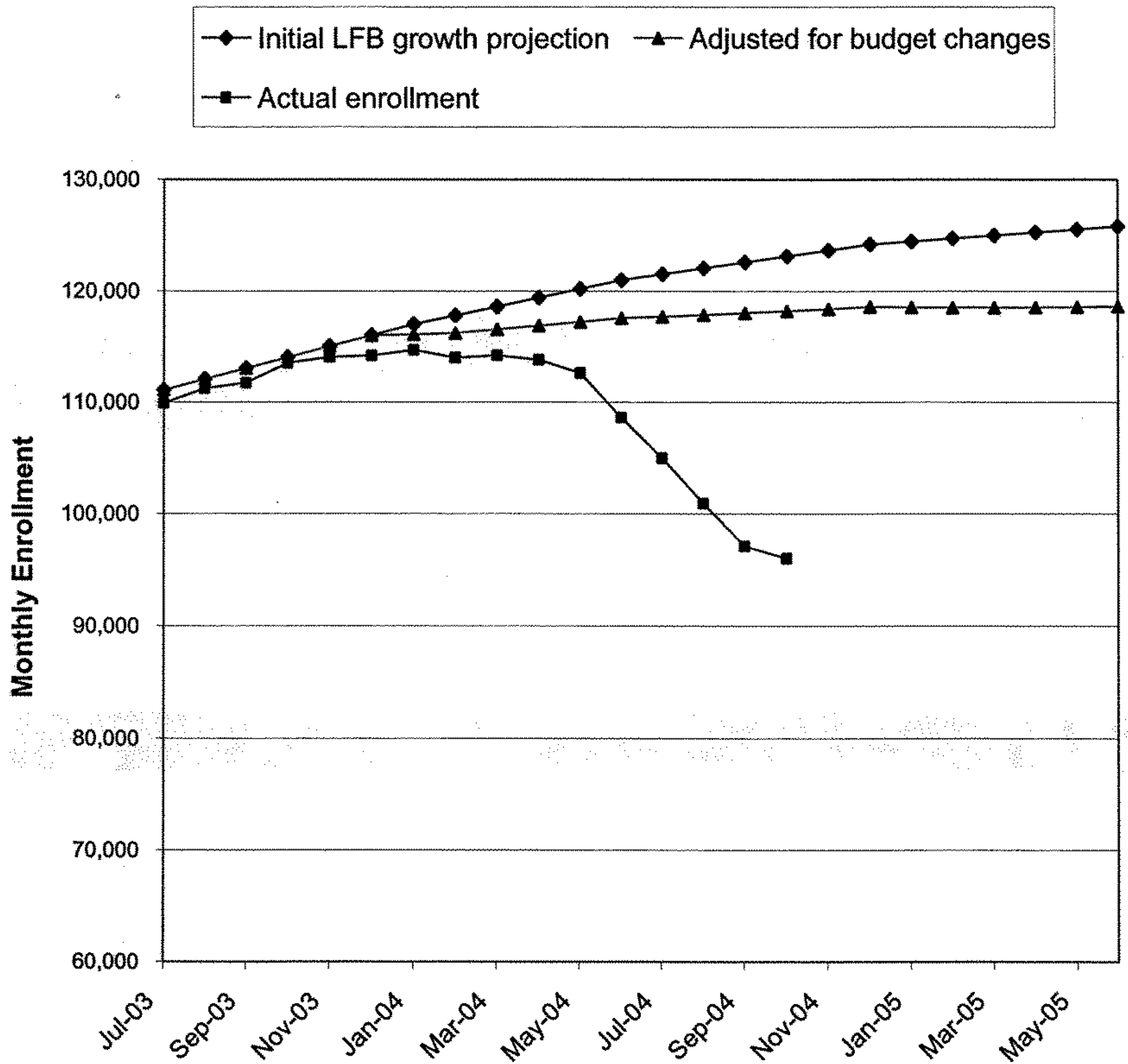
We think the BadgerCare verification process has created just that type of hurdle, and we commend DHFS for investigating the problem and for its ongoing efforts to find ways to ensure that eligible families are not thwarted by the new red tape.

Over the last five years Wisconsin implemented a number of measures to streamline the Medicaid and BadgerCare application process. The audit did not find any abuse of the system since those measures were implemented. We strongly believe that Wisconsin should continue the policies that reduce impediments to enrollment. To do otherwise would increase the number of people who are uninsured and who add to the uncompensated care at their nearest hospital's emergency room.

Finally, please keep in mind that the proportion of Medicaid funds spent for administration in Wisconsin is more than 60 percent below the national average. Optimally, at some future date Wisconsin should consider spending more to administer Medicaid and BadgerCare. Until that happens, be careful about potential changes that increase the workload of the already-overburdened caseworkers.



Prepared by the Wisconsin Budget Project of WCCF, using data gathered by the Center on Budget and Policy Priorities.



[Prepared by the Wisconsin Budget Project of WCCF. The top line is the LFB's "base budget" projection from spring 2003. The middle line uses a combination of LFB projections (for the effect of increasing premiums) and DHFS projections (for the effect of verification requirements). A few of the data points at the beginning of 2004 are interpolated from the projections for other months. The bottom line uses actual DHFS enrollment data through Oct. 2004.]

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By Bobby Peterson, Public Interest Lawyer

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December 1, 2004

ABC for Health, Inc. is a Wisconsin-based nonprofit, public-interest law firm dedicated to linking children and families to health care benefits and services. ABC for Health's mission is to provide the information, advocacy, legal services, and expert support needed to obtain, maintain, and finance health care coverage and services.

The Family Fiscal Unit (FFU) is an arcane procedure within the Medicaid program that permits income testing for each individual in certain households when the income of the group exceeds the Medicaid group income test limits. ABC for Health has been concerned about the FFU since its inception a decade ago, since this feature enhances eligibility for nearly every Wisconsin pregnant woman, child, parent, or individual with a disability when those individuals live in a household that includes a pregnant woman, a child with income, unmarried parents, a stepparent, or a child cared for by a non-legally responsible relative. Our concern initially was for outreach to these families, since many of them would assume that they were not eligible for Medicaid based on the income charts typically available.

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The need for enhanced outreach to these families increased when the court-ordered FFU system changes from the *Addis* case were published in November of 1999 along with a tag instructing Medicaid ES workers around the state to manually calculate all cases involving the groups listed above, since it would take "several months" to automate the needed changes within CARES. While this change was equally arcane, its effect was to dramatically enhance the likelihood of Medicaid eligibility for what we believed were thousands of Wisconsin individuals.

By September of 2000 – less than a year after the publication of the new FFU rules, our casework in several Wisconsin counties led us to the conclusion that not only was the CARES system not yet automated for the FFU, but many county ES workers had not been properly trained on how to calculate the FFU manually, and the available "workaround" was unpublished. In September of 2000 we addressed this concern to the Bureau of Health Program Eligibility, citing specific cases as well as the testimony from local economic support supervisors indicating that they felt CARES still did not reliably cascade to the FFU and that "their workers do not exactly understand the FFU".

Included in our message of September 2000 was our concern about what we believed would already be thousands of pregnant women and children incorrectly denied by this CARES fault. We asked then if there was any means of identifying individuals wrongly denied during this time in order to make retroactive corrections for them. From that time until this past summer we either received no response or we were told that CARES could not be changed because there were other priorities or because it was too expensive or because it only affected a small number of families.

Over the intervening years we have continued to include the FFU in our Outreach trainings and in our training of business office personnel at Wisconsin hospitals and clinics. We also included the CARES/FFU fault as a priority issue in Medicaid Simplification within the Covering Kids-Wisconsin Initiative, and we regularly requested the state to make the necessary changes, since – by our estimates – this problem negatively affected thousands of individuals and families.

The report by the LAB has confirmed our worst fears: that thousands of Wisconsin families have been incorrectly denied eligibility by a computer fault operating behind the scene in a manner that few applicants would suspect of error. According to the LAB Report 1,100 individuals – mostly children – were wrongly denied Medicaid in one month alone (January 2004) due to the CARES/FFU fault alone. From our conversations with auditors involved in this report, we understand that it is not possible to extrapolate the 1,100 incorrect denials back over the 54 months that passed between November of 1999 and July of 2004 – when CARES was reportedly fixed. It should be clear, however, that this system fault was maintaining a determination process of prohibited income deeming that had been found illegal in "*Addis*" and that this fault was affecting thousands of Wisconsin families.

Today we continue to express our concern for these families by asking Wisconsin to seek some means of identifying families wrongly denied and developing a plan of correction.

Unfortunately we must also ask another question. Both the LAB Report and the letter it includes from the Secretary of Wisconsin DHFS assert that the CARES/FFU fault has been corrected. Based on recent casework, we have some reason to question whether the system has been fixed at all or whether there might now exist even more grave faults. In November we

pursued two cases in separate counties in which CARES did not cascade to the FFU at all despite the presence of stepchildren and pregnant women. One household included both a pregnant woman and a stepchild, yet CARES could not produce a correct FFU budget until the worker tricked the system by assigning the pregnant stepmother as the primary caretaker of the husband's natural child.

It is our understanding that a new web-based eligibility system scheduled for January of 2005 may render moot much more effort to correct CARES. We ask in advance that the new system be carefully reviewed with regard to this complex but all-too-common issue, and we request that Wisconsin – at a minimum – develop and publish a plan of correction that at least permits families to seek recovery of provable losses attributable to knowing state error.

We have three recommendations to make regarding the failure of the State CARES computer system related to The FFU

First, we recommend that the training unit at DHFS promptly initiate a worker review and training orientation on the family fiscal unit so that ES workers across the state are aware of changes in the computer system and of the circumstances in which a family may qualify for services under the FFU.

Next, we recommend that outreach materials are developed to help families understand situations where they may qualify for Medicaid coverage with the FFU. These simple fact sheets would outline basic information and situations for people to understand the opportunities to qualify for Medicaid, where previously the computer system reported that they had excess

income. These situations that trigger the FFU calculation include pregnancy, children in a blended family, and children with their own source of income.

Finally, we recommend that the State support direct outreach at the provider community and other service providers. This outreach should include education and advocacy strategies organized around the state designed to help connect family to health care coverage.

We are very concerned about the families that the State of Wisconsin turned away. In addition to giving an apology to these families, the critical steps we proposed are reasonable and targeted. In summary, the activities would address issues of worker competencies related to FFU eligibility. Targeted outreach materials must be directed to denied families and providers who incurred bad debt or allocated charity care dollars needlessly. Finally, trainings that target service providers, including local health departments, head start agencies, and other members of our HealthWatch and Covering Kids and Families coalitions, would help to get the word out to families wrongly denied Medicaid

These steps must be taken with all due haste. We can help needy families and move Wisconsin to the upper tier of states where the majority of children have health care coverage.

Please Sign

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Sue Jablonowski [illegible]		
Carol Roessler		

Cheryl (1)

1/2 m $ -

Gene Wunkesher[?]

Paul ~~[illegible]~~ Auditor

FRAUD INVESTIGATION

Process needs to be legitimized

Funding this Process

Easier to gain on

DWD Audit

Child Care = next big area.

Belongs at co level - State adm.
Preven

Daily Economic support.

Random Sampling to correct errors

Only Program Rev + [illegible] collections + FEDERAL Match two fwy of public assist Pay FS/Medicaid

No designated funding for investigating Child Care two 2 fund team. Other states not so dependent

Care - auto postage. Co's can choose who do

investigations for Rom.

Short fall Every. 811 adm expense

Savings $4 - $15 in other states

Missing opp. recoup Federal $ Have

paid pay.

FIIP Way to ~~Support~~ fraud Control

Child Care Provider Recipient Fraud - problem

rel[illegible] Aeduby

Both Co's put in Co $ Gene Fraud
Winston O'Conto – Supplements [illegible] + Funds
& keep 15% of collection recoveries

Legitimization of the program.

Not ERROR
IS IN FACT SUSPECTED

Start establishing interest.

Level to Fund Fraud activities

Co's solve 2/3/4 ways. [illegible] organize [illegible]
DOA level funding. Supplemental actions
last yr. 600,00 – [illegible]
to do [illegible] this year.
$ 650,00 – 7,00 – Incremental approach
$ w/in that appropriation
Unrealized $ Stream [illegible]
Who came [illegible]

If don't put 600,00 we will cut
activity in 1/2
Gene on Ad hoc Comm. 2006-2007
keep 600,000 – to bridge to 06-07
cash
FS = 100% FED
TANF – Dept. Ccare 100% Fed
medicaid.
2004 Collections – [illegible] majority [illegible] Vol Repayments
[illegible] – MA $47,000

700,000 172,000 40% State Exp
60%
Collect only still amts still taxpayer
$ be to Fed or State,

Milw - 24 yr. Collected with

Badger Care.

Verification Wages - forms FNS, Income or
not include Forms. Sometimes employer.

Enforcement and education !!
Keep alive 2005 - current yr: 600,000 in 04
Same for calendar yr 05.
GPR FED Match Designated.
Tanf 2.3.04 to 1.8 500,000 less
CCare 1.8 = < 2.3 min
Calendar 2004 = 1/2 or 1/4 reduction

EOS C190
C191

Medical Assistance Collections CY 2004

County	Payment Type	Payment Amounts	Payment Count
Waukesha	DTI	$7,374.58	28
Waukesha	VOL	$175,472.90	205
Total		**$182,847.48**	**233**
Brown	DTI	$13,620.35	48
Brown	VOL	$46,717.19	660
Total		**$60,337.54**	**708**
Shawano	DTI	$2,339.10	9
Shawano	VOL	$49,577.29	23
Total		**$51,916.39**	**32**
Sheboygan	DTI	$4,283.31	15
Sheboygan	VOL	$45,440.68	119
Total		**$49,723.99**	**134**
Dane	DTI	$7,779.70	31
Dane	VOL	$37,588.17	66
Total		**$45,367.87**	**97**
Washington	DTI	$3,907.49	11
Washington	VOL	$22,500.55	43
Total		**$26,408.04**	**54**
Rusk	DTI	$1,510.93	5
Rusk	VOL	$22,190.70	2
Total		**$23,701.63**	**7**
Waupaca	DTI	$1,458.96	5
Waupaca	VOL	$22,094.70	109
Total		**$23,553.66**	**114**
Clark	DTI	$4,300.45	12
Clark	VOL	$19,066.51	145
Total		**$23,366.96**	**157**
St. Croix	DTI	$3,280.63	8
St. Croix	VOL	$14,971.69	152
Total		**$18,252.32**	**160**
Portage	DTI	$2,302.67	5
Portage	VOL	$15,817.80	42
Total		**$18,120.47**	**47**
Crawford	DTI	$2,992.16	13
Crawford	VOL	$14,396.71	139
Total		**$17,388.87**	**152**
Ashland	DTI	$1,117.45	3
Ashland	VOL	$14,367.77	12
Total		**$15,485.22**	**15**
Fond du Lac	DTI	$8,372.54	26
Fond du Lac	VOL	$6,302.72	171
Total		**$14,675.26**	**197**
Marinette	DTI	$1,771.52	3
Marinette	VOL	$12,359.07	103
Total		**$14,130.59**	**106**
Oconto	DTI	$0.00	0
Oconto	VOL	$12,326.94	74
Total		**$12,326.94**	**74**
Marathon	DTI	$15.71	1
Marathon	VOL	$12,295.33	30
Total		**$12,311.04**	**31**
Juneau	DTI	$0.00	0
Juneau	VOL	$11,247.74	10
Total		**$11,247.74**	**10**

Medical Assistance Collections CY 2004

Eau Claire	DTI	$3,901.50	17
Eau Claire	VOL	$5,848.00	203
Total		**$9,749.50**	**220**
La Crosse	DTI	$4,028.95	10
La Crosse	VOL	$5,252.96	43
Total		**$9,281.91**	**53**
Outagamie	DTI	$2,428.08	10
Outagamie	VOL	$5,854.63	140
Total		**$8,282.71**	**150**
Milwaukee	DTI	$4,081.60	11
Milwaukee	VOL	$2,936.39	35
Total		**$7,017.99**	**46**
Walworth	DTI	$217.75	2
Walworth	VOL	$6,100.83	14
Total		**$6,318.58**	**16**
Chippewa	DTI	$1,984.14	7
Chippewa	VOL	$3,806.21	53
Total		**$5,790.35**	**60**
Kenosha	DTI	$1,687.21	6
Kenosha	VOL	$3,357.97	78
Total		**$5,045.18**	**84**
Wood	DTI	$603.94	2
Wood	VOL	$3,632.63	19
Total		**$4,236.57**	**21**
Rock	DTI	$933.09	5
Rock	VOL	$3,019.37	98
Total		**$3,952.46**	**103**
Monroe	DTI	$274.39	2
Monroe	VOL	$3,130.50	17
Total		**$3,404.89**	**19**
Polk	DTI	$2,255.64	4
Polk	VOL	$975.00	36
Total		**$3,230.64**	**40**
Taylor	DTI	$1,379.62	5
Taylor	VOL	$1,531.76	28
Total		**$2,911.38**	**33**
Waushara	DTI	$1,423.05	3
Waushara	VOL	$1,224.24	26
Total		**$2,647.29**	**29**
Iron	DTI	$0.00	0
Iron	VOL	$2,555.97	4
Total		**$2,555.97**	**4**
Green Lake	DTI	$2,139.92	12
Green Lake	VOL	$236.00	1
Total		**$2,375.92**	**13**
Lincoln	DTI	$2,275.97	5
Lincoln	VOL	$0.00	0
Total		**$2,275.97**	**5**
Oneida	DTI	$1,818.37	4
Oneida	VOL	$275.00	10
Total		**$2,093.37**	**14**
Racine	DTI	$975.36	4
Racine	VOL	$1,112.05	26
Total		**$2,087.41**	**30**
Douglas	DTI	$238.94	1

Medical Assistance Collections CY 2004

Douglas	VOL	$1,770.00	21
Total		**$2,008.94**	**22**
Dunn	DTI	$1,788.04	6
Dunn	VOL	$145.00	3
Total		**$1,933.04**	**9**
Florence	DTI	$1,438.00	4
Florence	DPA	$355.00	32
Total		**$1,793.00**	**36**
Richland	DTI	$0.00	0
Richland	VOL	$1,442.77	11
Total		**$1,442.77**	**11**
Barron	DTI	$666.75	1
Barron	VOL	$519.66	35
Total		**$1,186.41**	**36**
Dodge	DTI	$0.00	0
Dodge	VOL	$902.50	11
Total		**$902.50**	**11**
Door	DTI	$0.00	0
Door	VOL	$850.00	9
Total		**$850.00**	**9**
Grant	DTI	$0.00	0
Grant	VOL	$770.00	15
Total		**$770.00**	**15**
Vernon	DTI	$719.91	5
Vernon	VOL	$0.00	0
Total		**$719.91**	**5**
Washburn	DTI	$528.86	2
Washburn	VOL	$0.00	0
Total		**$528.86**	**2**
Winnebago	DTI	$0.00	0
Winnebago	VOL	$509.74	11
Total		**$509.74**	**11**
Sauk	DTI	$423.12	1
Sauk	VOL	$0.00	0
Total		**$423.12**	**1**
Vilas	DTI	$300.00	1
Vilas	VOL	$115.00	9
Total		**$415.00**	**10**
Jefferson	DTI	$0.00	0
Jefferson	VOL	$340.00	1
Total		**$340.00**	**1**
Jackson	DTI	$260.33	2
Jackson	VOL	$0.00	0
Total		**$260.33**	**2**
Columbia	DTI	$14.00	1
Columbia	VOL	$150.00	6
Total		**$164.00**	**7**
Sawyer	DTI	$113.00	1
Sawyer	VOL	$0.00	0
Total		**$113.00**	**1**
Adams	DTI	$0.00	0
Adams	VOL	$0.00	0
Total		**$0.00**	**0**
Bayfield	DTI	$0.00	0
Bayfield	VOL	$0.00	0

Medical Assistance Collections CY 2004

Total		**$0.00**	**0**
Buffalo	DTI	$0.00	0
Buffalo	VOL	$0.00	0
Total		**$0.00**	**0**
Burnett	DTI	$0.00	0
Burnett	VOL	$0.00	0
Total		**$0.00**	**0**
Calumet	DTI	$0.00	0
Calumet	VOL	$0.00	0
Total		**$0.00**	**0**
Forest	DTI	$0.00	0
Forest	VOL	$0.00	0
Total		**$0.00**	**0**
Green	DTI	$0.00	0
Green	VOL	$0.00	0
Total		**$0.00**	**0**
Iowa	DTI	$0.00	0
Iowa	VOL	$748.00	1
Total		**$748.00**	**1**
Kewaunee	DTI	$0.00	0
Kewaunee	VOL	$0.00	0
Total		**$0.00**	**0**
Lafeyette	DTI	$0.00	0
Lafeyette	VOL	$0.00	0
Total		**$0.00**	**0**
Langlade	DTI	$0.00	0
Langlade	VOL	$0.00	0
Total		**$0.00**	**0**
Manitowoc	DTI	$0.00	0
Manitowoc	VOL	$0.00	0
Total		**$0.00**	**0**
Marquette	DTI	$0.00	0
Marquette	VOL	$0.00	0
Total		**$0.00**	**0**
Ozaukee	DTI	$0.00	0
Ozaukee	VOL	$0.00	0
Total		**$0.00**	**0**
Pepin	DTI	$0.00	0
Pepin	VOL	$0.00	0
Total		**$0.00**	**0**
Pierce	DTI	$0.00	0
Pierce	VOL	$0.00	0
Total		**$0.00**	**0**
Price	DTI	$0.00	0
Price	VOL	$0.00	0
Total		**$0.00**	**0**
Trempealeau	DTI	$0.00	0
Trempealeau	VOL	$0.00	0
Total		**$0.00**	**0**
Menomonie	DTI	$0.00	0
Menomonie	VOL	$0.00	0
Total		**$0.00**	**0**

Medical Assistance Collections CY 2004

Red Cliff	DTI	$0.00	0
Red Cliff	VOL	$0.00	0
Total		**$0.00**	**0**
Stockbridge-Munsee	DTI	$0.00	0
Stockbridge-Munsee	VOL	$0.00	0
Total		**$0.00**	**0**
Lac du Flambeau	DTI	$0.00	0
Lac du Flambeau	VOL	$0.00	0
Total		**$0.00**	**0**
Bad River	DTI	$0.00	0
Bad River	VOL	$0.00	0
Total		**$0.00**	**0**
Sakaogon	DTI	$0.00	0
Sakaogon	VOL	$0.00	0
Total		**$0.00**	**0**
Oneida Tribe	DTI	$0.00	0
Oneida Tribe	VOL	$0.00	0
Total		**$0.00**	**0**
Total DTI		**$105,327.08**	**357**
Total VOL		**$614,201.64**	**3,101**
Total		**$719,528.72**	**3,458**
Percentage DTI	**14.64%**		
Percentage VOL	**85.36%**		

MA
- Mark Moody
- Cheryl McIlquhan
- Jim Jones

- majority denied were children
- efforts to correct errors limited
- 98-03 1/3 of cos did not attempt to recover benefits inapprop provided
- 1/2 of prog. integrity funds
  State used to have dedicated funding
  1/2 federal
  co
  dedicated GPR - other states
  WI unusual b/c other states had dedicated staff funding

- improve clarity & reduce errors

Lassa:
- 1100 inapp. denied benefits
- issue raised in 1999 guideline
  DWD was resp at the time

Jeskewitz:
legislative process
- does not always match in d.b.

Kerkman:

Jeskewitz
- asset change 2000
- no doc. sought 2001
  for self income
- what assets can retain
  → no asset test for families
  → asset test elderly blind & disabled
- no limit on MA
- healthy adult
  31 year old CPA
  wd have to have a child

Mark Moody –

1st phase begin in pilot co's
early 2007
Stat lang – Medicaid recovery
pkg of init in budget
→ see testimony

$220 million deficit as reported by
LFB still accurate

65 current error rate no pretest to see
what wd. have been under
other policies
WI experienced

Food share = Food Stamps

incr. steadily participation

2003 · when transferred to DHFS
successful
7/03 – 7/04
6.6 Statewide error
as of Aug Sept finalized hope
to reach 6% goal

in order to not be sanctioned – must be below 6%
3.3% – 5th most improved
missed bonus

bonuses
CARES
largest change – next up when
user interface web based off the
mainframe

- co workers not in W-2 agencies
  Problem w/ rents

Kerkman pg. 21

going from medicare to badgercare has declined

Richard - program integrity
  public
    MA, food stamps

if 2 processes combined
  not comprehensively be able to fraud

$15.6 mil saved every 6 mos
savings generated
  $75,000 in public assist saved
$38.1 mill in public assist
  add $6.9 mill

error?

if no monitoring
  ∘ taxpayers deserve it to know
  ∘ taxpayers
Gene 1988 - pub. ast. fraud
  $9 mill prevention prior to change

his perception - when W-2 started b/c work
  program → no fraud in it
  $6 return for every $1 spent
  in collection

Richard - investigator 1/2 ...? w/ public fraud
  - co obtains funds from state to hire invest
  - some co's no fraud investigation
  - 36 co's pg 47
- fraud invest pay for self:
  reimb up to $500 per fraud invest.

- many co's budget 2,000/yr for fraud investigation

MA

LAB – Jan Mueller mad.
Paul Stuiber mad.

DHFS – Mark Moody pam mad.
Cheryl McIlquham mad.
Jim Jones mad.

WI Assoc of Public Assistance Fraud
– Richard Basiliere,
– Gene Kucharski, Vice President
Green Bay –

ABC for Health
– Bobby Peterson

WI Council on Children and Families
– Charity Eleson – John Peacock testified in her place.

Michael Jacob → Covering Kids and Families

~~[illegible]~~

AARP / CWAG

more complicated application

if verify eligibility - send in

if audit soup everything

- scarce audit resources

an evaluation of a program

shouldn't be afraid of an audit

30 yrs. working w/older people

best experiences - legis. & Dept

hard time getting efficiencies

best gov. programs

any gov't programs w/older people

?- Dept getting an award for that

senior form

audit would complicate process

AARP-

offer resources

Jefferson / Sauk Benefit specialists

- still getting people coming in

= we didn't think this going to last

too good to be true

- able to spend

→ is it seniorcare? only?

— medical assist. — talked to Rhodes/Lazich re com-
DHFS proposal - gov only on
medicaid cost to continue
given waiver IGT ~~$~~ - let's assume
at least get med. cost to continue

~~dept~~
Tom talked to ~~[illegible]~~ Kevin - draft today
option 4
$ 370 mill. - allow adopt a bal. budget
buy a little more time

State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

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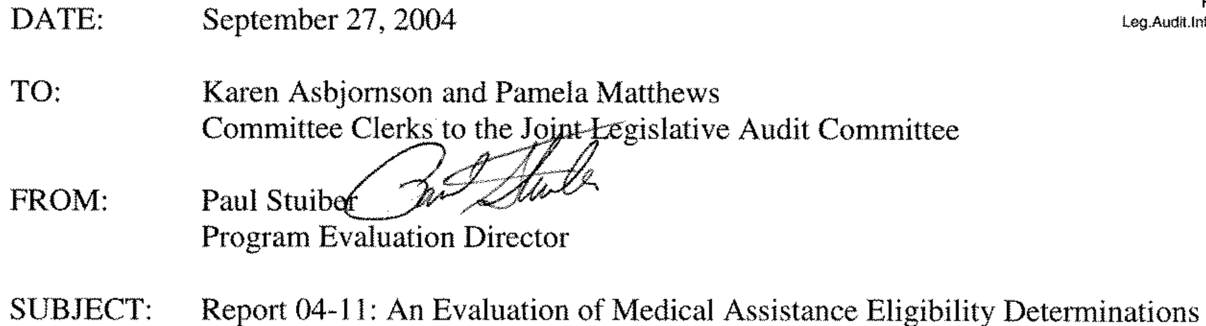


DATE: September 27, 2004

TO: Karen Asbjornson and Pamela Matthews
Committee Clerks to the Joint Legislative Audit Committee

FROM: Paul Stuiber
Program Evaluation Director

SUBJECT: Report 04-11: An Evaluation of Medical Assistance Eligibility Determinations

Enclosed is our evaluation of Medical Assistance Eligibility Determinations. The Medical Assistance program is administered by the Department of Health and Family Services (DHFS), but individual determinations of eligibility are made by county staff. A total of $4.3 billion in state and federal funds is budgeted for Medical Assistance benefits in fiscal year 2004-05.

The audit was requested by Senator Lazich, who was concerned that individuals who do not qualify for the program may be receiving services. Based on testimony given during the Joint Legislative Audit Committee hearing at which the request was approved, the Committee directed that the audit's scope be broadened to include a review of potentially inappropriate denials of eligibility.

Overall, we found that eligibility determinations are generally made accurately. However, in 6.5 percent of 200 cases we reviewed in which individuals were receiving benefits, worker errors affected eligibility. In addition, in another 12.9 percent of 101 cases we reviewed, applicants had been inappropriately denied benefits.

We found that the main problem with inappropriate denials was a longstanding computer problem that was not resolved by DHFS staff until we brought it to their attention during the course of our audit. We estimated that in January 2004, the only month we reviewed, 1,100 individuals, mostly children, were inappropriately denied benefits as a result of this error.

We also found that Wisconsin provides less funding for efforts to prevent recipient fraud and abuse than many other states and that Wisconsin is unusual in relying on benefit recoveries to fund these efforts.

We recommend that the Joint Legislative Audit Committee hold a public hearing on the report and its findings. The report will be released at 9:00 a.m. on Tuesday, September 28th. Please contact us if you have any questions.

PS/bm

Enclosure

04-11

An Evaluation:

Medical Assistance Eligibility Determinations

Department of Health and Family Services

September 2004

Highlights

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.

Key Facts and Findings

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

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

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

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

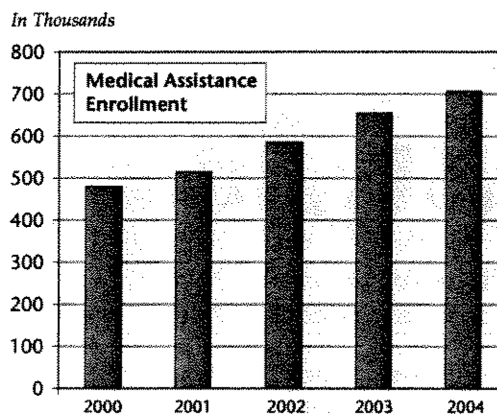
In January 2004, an estimated 1,100 individuals were inappropriately denied benefits.

Wisconsin provides less funding for program integrity than many surrounding states.

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

Enrollment and Costs

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



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

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.

:rrors and Discrepancies

:ounty workers generally make orrect eligibility determinations. Iowever, both worker errors and liscrepancies between estimated nd actual income can result in naccurate eligibility determinaions. These errors can have signifiant effects on applicants and on rogram costs.

Vorker errors affected the outcome f eligibility determinations for 13 f the 200 cases we reviewed in vhich someone in the household vas receiving Medical Assistance enefits. 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.

/e did not find any instances in ur sample of non-citizens or non-/isconsin residents receiving enefits inappropriately.

iscrepancies between estimates f future income, which are used 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

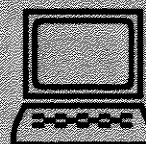
☑ report to the Legislature regarding its plans to address program integrity needs *(p. 56).*

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).*

Additional Information

For a copy of report 04-11, which includes a response from the Department of Health and Family Services, call **(608) 266-2818** or visit our Web site:



www.legis.state.wi.us/lab

Address questions regarding this report to:

Paul Stuiber
(608) 266-2818

Legislative Audit Bureau

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Janice Mueller
State Auditor

The Legislative Audit Bureau is a nonpartisan legislative service agency that assists the Wisconsin Legislature in maintaining effective oversight of state operations. We audit the accounts and records of state agencies to ensure that financial transactions and management decisions are made effectively, efficiently, and in compliance with state law, and we review and evaluate the performance of state and local agencies and programs. The results of our audits, evaluations, and reviews are submitted to the Joint Legislative Audit Committee.