☞ **03hr_JC-Au_Misc_pt08g**

☞ Details: Medical Assistance Eligibility Determination

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2003-04
(session year)

Joint
(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (November 2012)

Record of Committee Proceedings

Joint Legislative Audit Committee

Proposed Audit of Eligibility Determination for Medical Assistance and Related Health Care Programs

Requested by Senator Lazich

May 05, 2003 Referred to Joint committee on Audit.

May 29, 2003 **PUBLIC HEARING HELD**

Present: (9) Representative Jeskewitz; Senators Roessler, Cowles, Darling, George and Plale; Representatives Kaufert, Kerkman and Cullen.

Absent: (1) Representative Pocan.

Appearances For

- Mary Lazich, State Senator - 28th Senate District, New Berlin
- Tom Van Ess, Senator Lazich Office, Madison

Appearances Against

- None.

Appearances for Information Only

- Janice Mueller, State Auditor, Legislative Audit Bureau, Madison
- Paul Stuiber, Legislative Audit Bureau, Madison
- Mark Moody, Department of Health and Family Services, Division of Health Care Financing-Administrator, Madison
- James Jones, Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Care Eligibility-Deputy Director, Madison
- Gail Sumi, AARP, Madison

Registrations For

- None.

Registrations Against

- None.

May 29, 2003 **EXECUTIVE SESSION HELD**

Present:	(9)	Representative Jeskewitz; Senators Roessler, Cowles, Darling, George and Plale; Representatives Kaufert, Kerkman and Cullen.
Absent:	(1)	Representative Pocan.

Moved by Senator Cowles, seconded by Senator Darling that **Proposed Audit of Eligibility Determination for Medical Assistance and Related Health Care Programs** be approved according to the scope statement prepared by the Legislative Audit Bureau.

Ayes:	(9)	Senators Roessler, Cowles, Darling, George and Plale; Representatives Jeskewitz, Kaufert, Kerkman and Cullen.
Noes:	(0)	None.

ADOPTION RECOMMENDED, Ayes 9, Noes 0

Karen Asbjornson
Committee Clerk


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State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
STATE AUDITOR

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May 20, 2003

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:

At your request, we have reviewed the issue paper prepared by the Wisconsin Medical Society related to undertaking a review of medical coding and billing procedures under the Medical Assistance program.

We believe that the establishment of a task forces, as proposed by the Society, would be the most effective means of addressing many of the issue they identified. These issues involve the procedures currently in use to submit claims for reimbursement by health care providers. Many of the concerns raised would involve technical changes that may affect overall program costs. Consequently, rather than conducting an audit of coding and billing practices, it may be more appropriate for a task force—composed of public and private members—to assess the efficiency of the current procedures and the policy implications of potential changes to these procedures, then make recommendations for modifications to the Legislature for its consideration.

There is one area in which we believe we could provide information useful to the Legislature and the task force. We propose collecting and analyzing information on trends in emergency room services funded under the Medical Assistance program. To the extent adequate data are available, this would include reviewing information related to the total number of emergency room visits, the number of participants served, the cost of services provided under the program, and the regional variations in costs.

I hope you find this information helpful. Please contact me if you have any questions.

Sincerely,

Janice Mueller
State Auditor

JM/PS/bm


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Mary Lazich

Wisconsin State Senator
Senate District 28

May 29, 2003

Representative Suzanne Jeskewitz, Chair
Joint Legislative Audit Committee
314 North, State Capitol
Madison, WI 53707

Dear Suzanne:

Thank you for your prompt response to my request for an audit hearing on the Medical Assistance, BadgerCare and SeniorCare programs. I also appreciate your support in voting to approve the audit.

Medical Assistance, BadgerCare, and SeniorCare are very important to working people and elderly Wisconsin residents. These programs have improved the ability of many state citizens to meet their medical needs. Particularly in these difficult budgetary times, it is important to ensure that only persons who are eligible receive benefits.

The audit of these programs will provide important information and best practices for Wisconsin's self-declaration eligibility process. Again, thank you for your support. If you have any questions for me, please contact me.

Sincerely,

Mary Lazich

Mary Lazich
State Senator
Senate District 28

MAL/tve

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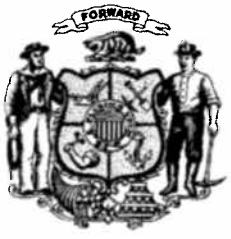
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Joint Legislative Audit Committee
May 29, 2003

Public Hearing on Proposed Audit of Eligibility Determination for Medical Assistance and Related Health Care Programs

Good Morning. My name is Mark Moody and I am the Administrator of the Division of Health Care Financing within the Department of Health and Family Services. Thank you for the invitation to appear before you this morning to speak with you about the proposed audit of eligibility determination for Medical Assistance and related health care programs.

We are aware that concerns have been raised about individuals participating in Medicaid, BadgerCare and SeniorCare being determined eligible inappropriately based on incorrect information provided to eligibility workers with regard to income, age, residency, and access to private health insurance.

We agree that it is important to make sure that only those who are truly eligible for these programs receive benefits. At the same time, of course, we want to make sure that every Wisconsin resident who is eligible can know about these programs and apply for the assistance they need without unnecessary barriers.

DHFS is committed to program integrity and effective administration of all benefit programs, including Medicaid, BadgerCare, SeniorCare and the Food Stamp Program. Our goals for eligibility administration are to:

- Assure accurate and timely eligibility and benefit determination;
- Provide excellent customer service;
- Remove unnecessary barriers to access;
- Improve the health status of the people of Wisconsin;
- Maximize federal revenue to benefit the State's economy;
- Operate programs in an efficient and cost-effective manner; and
- Detect and prevent fraud.

DHFS is committed to working in partnership with local income maintenance (IM) agencies to operate these programs in a fiscally responsible way, balancing funding and workload, to achieve the stated goals.

Specifically, concerns have been raised about self-declaration of income. That term may lead to the perception that we do not verify income. That is not correct. DHFS does verify income that is self-declared. Over recent years, the Department has dramatically increased the efficiency and effectiveness of IM administration by using automated methods to verify income and other relevant information. These new business processes assure that eligibility is determined accurately and promptly and that benefits to those who are eligible are both timely and accurate.

Our policy is to require, once initial income is verified and eligibility determined, that all conditions related to eligibility be re-determined at least every 12 months. In addition, all

eligible people are required to report any changes in household composition, residency and income within 10 days. → Senior Care - every year

Consistent with our program goals, DHFS has pursued opportunities to simplify program administration and reduce work for local IM agencies in a way that does not compromise program integrity. Counties, federal funding agencies, the State Legislature, advocacy groups, health care providers, local social service agencies, and our customers have requested and encouraged program simplification.

Program simplification included the development of a mail-in application for Family Medicaid and has two basic components:

- Client choice of application method for Family-Related Medicaid; and
- Reduced in-person verification requirements for all Medicaid.

This initiative was made possible by the availability of automated data exchanges with databases from other trusted sources that provide the information needed to verify income. By relying on sources such as the State's wage database, the State's New Hire database, Social Security Administration (for social security numbers and benefit amounts) Medicare and Unemployment Compensation, we are able to reduce the amount of paperwork required by the applicant and agency worker during the application process. These sources are accessed with every initial eligibility determination and are continuously updated and utilized for reviewing ongoing eligibility. We also believe that these forms of independent verification are more accurate and reliable as well.

Instead of relying only on self-declaration, local agency workers are now alerted to new information from these sources and others through the automated eligibility management system known as CARES. We have streamlined this automated alert system and have found it to be very effective in helping local workers keep case information on work and wages up to date. In fact, based on March 2003 data, local workers took action on 98% of the nearly 797,000 alerts sent in that month.

Changes that have already occurred to streamline program administration and create cost efficiencies have come at the request of counties. Over the next biennium, counties will continue to count on us to implement many additional changes. We hope that the workload associated with this audit will not deter us from making the necessary and requested improvements to an already stressed county system.

This program simplification has also provided the opportunity to bring increased federal revenue to Wisconsin, and reduce state costs for health care services. One of the conditions of the demonstration program waiver of Title XXI law and regulation that allowed Wisconsin to receive SCHIP funding for parents in BadgerCare required that the state eliminate the asset test for Family Medicaid and to implement a simplified application process. As you know, BadgerCare currently claims over $125 million in federal funds (SFY 2003).

The Division of Health Care Financing is in the process of conducting a quality assurance review of a sample of Medicaid cases to determine the extent to which income errors have caused eligibility to be certified incorrectly. Preliminary results indicate that only 3.4% of the cases reviewed had eligibility income errors that allowed the case to receive benefits incorrectly. This is a very positive result. This result shows that our new methods of confirming information with trusted sources has lowered the cost of IM administration without any material effect on our error rate.

We are very pleased to report that by virtue of reducing barriers that would otherwise deter participation in our health care programs, we have not compromised program integrity.

As you are aware, the Joint Committee on Finance approved a modified version of the Governor's budget proposal related to the administration of the Income Maintenance (IM) programs (Medicaid, BadgerCare and Food Stamps). The goal of this provision is to find the right balance between funding and workload given the state's current fiscal environment. As passed by the JFC, this proposal is aimed at reducing local IM agency workload through policy changes and CARES system enhancements. We look forward to this opportunity to focus on systems improvements and other efforts to further streamline program administration and continue to improve program integrity.

As part of its action in considering the Governor's recommendation, JFC included a component of this proposal that would add $1.2 million GPR annually to provide an additional increase in the IM contracts within counties. These funds come from the current DHFS state administration appropriations that support our contracts for Medicaid and Food Stamp operations. We have not yet determined how we would absorb this cut and what impact it will have on our CARES development budget.

The Governor's budget proposal relies heavily on our current fiscal and staff resources to plan and implement the policy and systems enhancements necessary to effect the workload changes. Therefore, we are concerned that any further diversion of our resources would hinder our ability to accomplish these tasks according to the schedule committed to in this proposal. Delays could result in local agencies not experiencing the workload reductions associated with the proposal funding reductions.

We would envision this audit, as proposed, to be a broad endeavor would require significant resources from our Department. Regardless of when it is scheduled, we will cooperate fully with the audit if approved by the Joint Audit Committee. We welcome the opportunity to improve program integrity balanced with our goals of cost-effectiveness of IM administration and convenient and easy access to benefits. This may provide us with helpful information to make decisions about what how we might further improve our program administration.

Thank you for the opportunity to be here today. We will be happy to answer any questions you may have.


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Make the programs consistent

Mary Lazich

Wisconsin State Senator
Senate District 28

Testimony
Joint Legislative Audit Committee
May 29, 2003

Good morning, Committee Chairs Roessler and Jeskewitz and committee members. Thank you for promptly addressing my request that the Legislative Audit Bureau audit eligibility determination processes used by the Department of Health and Family Services in the Medicaid, BadgerCare and SeniorCare programs.

My request stems from concern that these programs, that are so important to working people and elderly Wisconsin residents be efficiently administered during difficult budgetary times. It is important to ensure that only people who are eligible receive benefits.

It has come to my attention that the State of Wisconsin allows Medicaid, BadgerCare and SeniorCare applicants to declare their income level, age, ability to obtain private health insurance and residence. This is referred to as self-declaration. The Department also has a twelve-month eligibility certification period for Medicaid. During the twelve months, eligibility is only reviewed if the recipient reports changes.

The Department's position appears to be that the use of income database matches is sufficient to verify self-declared income. However, a more detailed look reveals that it takes time for the matches to be completed. It would be useful to learn the amount of time it takes to complete a match between each database and application in each program. In addition, it is important to understand the process applied when the database indicates a discrepancy in the applicant's information. The worker assigned to the case is sent an alert, and must take action to investigate the discrepancy and correct the case. It would be very useful to learn the process and amount of time it

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takes caseworkers to process alerts on residency and income, correct the case and make a new determination. Furthermore, it is difficult for individuals, especially seniors who make an error on the application to be informed three or four months later, after an alert has been issued and the worker has taken action, that they are no longer eligible for Medicaid or SeniorCare. Finally, it would be useful to learn the percentage of applications that trigger an alert from one of the databases. An audit could answer many of these questions.

Two states, Arizona and Washington recently audited their Medicaid and S-CHIP programs. Arizona audited a sample of Medicaid cases in which applications were made through outreach offices rather than through county public assistance offices. Forty-three percent of the 2, 570 applications reviewed contained incorrect information. Immediate denials were issued to 33 percent of the applications, based on information obtained as a result of the audit. The most common misrepresentation was related to residency: 29 percent of the applicants provided a false address. Arizona now requires residency and other information to be verified, and the state estimates it saves approximately $1.15 million per month in Medicaid expenditures.

The state of Washington audited a sample of its Medicaid cases. It discovered that 13 percent of the clients in the 1,140 cases reviewed did not accurately declare their income on their application. Almost 50 percent of the clients, who were declared ineligible as a result of the review, had unreported income. In more than one-third of the cases reviewed, reviewers were unable to verify income, because the initial information and documentation provided were inadequate. I have provided a copy of the Executive Summary of the Washington audit to Committee members.

Wisconsin may or may not experience the type of savings estimated by Arizona. However, I note that in the Governor's budget the Department has proposed increasing verification of income, and availability and cost of insurance in the BadgerCare program. The Department expects total savings of $9,721,400 as a result of their changes to this single program. The Joint Finance Committee has approved the Department's changes.

The Center for Medicaid and Medicare Services (CMS) is the federal agency that manages the Medicaid and Medicare programs. CMS has encouraged states in recent years to streamline the application and eligibility determination process for all Medicaid funded programs.

However, Janet Reichert from CMS informed my office that CMS has never taken the position that states should not verify information; it is their position that states should make it easier for people to initially apply. In addition it is my understanding that CMS has asked the federal Office of Management and Budget to review six options that may require states to complete in-depth eligibility review samples that include verifying information provided by the applicant.

I am confident of the ability of the State Auditor and Legislative Audit Bureau staff to conduct a thorough audit and analysis. I think it is crucial that LAB staff investigate and verify residency of applicants, and that they go beyond relying on database matches and applicant reports and instead, determine independently whether the residency and income being reported by recipients is accurate and complete.

In addition, an audit interview of county workers who routinely handle Medicaid, BadgerCare and SeniorCare applications maybe helpful. Although SeniorCare is designed to be processed directly by DHFS, I have been told that Waukesha County handles seven to fifteen requests a day for assistance in filling out SeniorCare applications. I have also been told that in other areas of the state, county workers have indicated that face-to-face interviews with applicants for any of these programs often result in more complete or different information, particularly in the area of income, than appears on the application form. The additional information obtained sometimes resulted in a finding of ineligibility and in other instances resulted in a finding of eligibility after an initial denial.

I am pleased that Secretary Nelson has indicated to me that the Department of Health and Family Services will cooperate fully with the audit. As noted in the Secretary's letter of May 2, 2003, such an audit may provide the Department with helpful information to make decisions about added verification measures and savings. I agree wholeheartedly that the audit I have requested will provide all of us with helpful information.

In addition AARP in its recent letter to members of the Joint Audit Committee noted that while SeniorCare applicants were very scrupulous about reporting their income they still made errors. AARP noted that "a number of dairy farmers used last year's income when filling out the application (which requires projection of next year's income): even though they had sold cows and knew that their income would decrease." That type of error could have disqualified them from the program at a time they were actually financially eligible. Clearly, if the audit is able to confirm AARP's concerns that citizens are being disqualified because they are incorrectly reporting their income that would be very valuable information for the Legislature and the Department.

Thank you for your time and consideration. If you have any questions, I am happy to address them.

Washington State audit

EXECUTIVE SUMMARY
Self-Declaration of Income
Medicaid Eligibility Quality Control (MEQC) Project #27
December 2002

Project Goals: Determine: 1) Whether Medicaid clients are accurately declaring income at application; 2) The effect of inaccurately declared income on eligibility.

Project Request: Requested by Judy Maginnis, lead program manager in the eligibility policy section of the Division of Client Support (DCS) at MAA.

Background: MAA established a policy of self-declared income for children and pregnant women Medicaid programs in December, 1998. This project was requested to review the effects of this policy on Medicaid eligibility.

Sample: Children and pregnant women who were opened on one of four Medicaid programs in July, August, or September, 2001, and applied in one of three sites: CSOs (Community Services Offices), MEDS (Medicaid Eligibility Determination Section) and the Call Center in Region 6. Programs included both CN (Categorically Needy) programs for citizens and state-funded only programs for non-citizens, including undocumented aliens.

Completions: Completed 1140 reviews.

Findings: 150/13% of all clients reviewed did not accurately declare their income at application. We found 84 ineligible clients; nearly half, 39/46%, had unreported income. We were unable to verify income for over one-third of all cases reviewed because of inadequate documentation in ACES. The number of ineligible clients would have been even higher had we been able to verify income for these cases.

Issues/Recommendations:
1) Revise verification policy and procedures to require increased verification of income. Require eligibility workers to at least: a) Use available databases; b) Enter information on clients' SSNs and jobs in ACES; c) Ask clients about potential contributions from other household members and document; d) Ask clients who report questionable circumstances to explain and verify, and document.
2) Remind eligibility workers to: a) Ask clients about income from tips; b) Consider seasonal differences in income; and c) Review all ACES eligibility decisions for accuracy.
3) Emphasize the perjury clause on the application to remind clients that MAA may verify income.
4) Verify all income if a client has previously had unreported income.
5) Establish a monitoring system that tracks performance improvement in this area.


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AARP Wisconsin

Testimony for Joint Legislative Audit Committee Hearing

Gail Sumi, Government Affairs Representative (286-6307)

Thursday May 29, 2003

AARP Wisconsin thanks the Joint Legislative Audit Committee for the opportunity to comment on a proposed audit of SeniorCare eligibility determination. AARP Wisconsin is committed to a fair and just operation of the SeniorCare program. AARP Wisconsin does *not* want to see resources spent inefficiently or on those who are not eligible to receive benefits. However, AARP Wisconsin believes an audit of the SeniorCare program is unnecessary at this time for the following reasons:

- The SeniorCare program has been in operation for less than one year. The Department of Health and Family Services (DHFS), county benefit specialists, advocates and participants are still adapting to the program and its eligibility process. The program has not yet been through one full annual re-enrollment cycle. SeniorCare has not operated long enough for an audit to provide useful information.

- An audit of SeniorCare is being requested to determine if self-declaration of income, residency, and family composition may open the door to ineligible people receiving benefits. The implication is that an audit would investigate whether or not self-declaration is a viable policy. The alternative to self-declaration is to require applicants to provide documents verifying information the applicant supplies. In the case of SeniorCare, the determination of benefits relies on a *prospective estimate* of the next twelve month's household income. The instructions for the SeniorCare application state that applicants should supply a good faith estimate, and that errors made in good faith would not be actionable. Given that applicants are reporting a prospective estimate, it is difficult to see how requiring additional income verification would be feasible.

SeniorCare participants' incomes are much more likely to decrease over time than to increase as people leave the workforce and use their retirement savings. Sixty-five percent of SeniorCare participants are age 75 or over[1]. Using a self-declared *prospective* estimate of income makes sense for this population because participants' income from the previous year is likely to be higher than their income in the benefit year. Basing the benefit level on the previous year's income would be a hardship for many SeniorCare participants. Since DHFS and the legislature recognized that a prospective estimate was the fairest way to determine income, and given that it is unclear how a participant would provide verifying evidence of a prospective estimate, the concern about self-declaration of income does not seem relevant for the SeniorCare program.

- Research done by the Kaiser Commission on the Uninsured and the Center on Budget and Policy Priorities, among others, shows that requiring verification of information provided on applications for health care assistance results in decreased enrollment, *even of those eligible to participate in the program.* The Kaiser Commission report states:

> "Low-income families have reported in surveys and focus groups that a complex and difficult enrollment process is a significant barrier to enrollment...States should continue to revise their application forms to make them easier to understand and fill out...Easing verification requirements or accepting a family's self-declaration of information would increase the likelihood that a family will be able to complete the application process"[2].

Many SeniorCare participants are frail, do not have easy access to transportation, and rely on others to handle their finances. The average SeniorCare participant is female, single or widowed, and over the age of 75. Any change in the enrollment process for SeniorCare that makes it more difficult to apply for the program threatens to prevent the most frail and vulnerable from receiving the benefits they desperately need.

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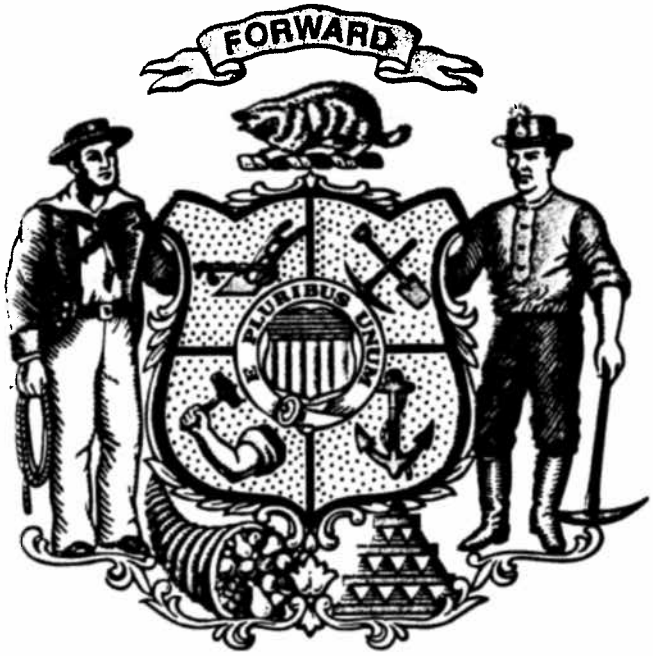
[1] All data on SeniorCare participant characteristics and participation levels are from DHFS and are current as of 3/9/03.

[2] "Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures," Prepared by Donna Cohen Ross and Laura Cox, The Kaiser Commission on Medicaid and the Uninsured, October 2000, p.iii-iv.

- Another concern raised is that eligibility and benefits for MA, BadgerCare and SeniorCare are determined on a 12-month continuous eligibility calendar. The alternative is to have eligibility and benefits determined more frequently than once a year. This is not practicable for SeniorCare because a year-long benefit cycle is built into the design of the program's deductibles and spend-downs.

  Forty-seven percent of SeniorCare participants have a deductible or a spend-down that they need to meet before they receive benefits each year. For SeniorCare participants with incomes over 160 percent of the poverty level, SeniorCare does not start cost-sharing for prescription medications until *after* the spend-down or deductible is met. The average spend-down is $4,200 and only 25 percent of people in the spend-down group met their spend-down in the first six months of participating in the program. In other words, many SeniorCare participants do not start receiving benefits until after six or seven months have passed. It does not make sense for the state to re-determine benefit levels more than once a year when the program requires a full year for all participants to see their benefit. Requiring re-enrollment more than once a year would double the paperwork for each participant, resulting in much higher administrative costs for the state. Requiring re-enrollment more than once a year would also constitute a barrier to enrollment for vulnerable and frail participants.

AARP Wisconsin has helped over 9,500 people enroll in the SeniorCare program though events starting in the summer of 2002 and continuing efforts by our volunteers. In our experience, the vast majority of people applying for SeniorCare are scrupulously honest and very intent on filling out the application correctly. When they have to estimate income, the majority of people we talked to preferred to knowingly overestimate (potentially reducing their benefit level) rather than underestimate. For instance, many people estimated that they would receive the same amount of interest earnings on savings as they had the previous year, even though interest rates had fallen steadily over the previous months. In this time of tight budgets and economic uncertainty, AARP Wisconsin does not believe that there is sufficient justification to spend the resources required for an audit of the SeniorCare program.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Record of Committee Proceedings

Joint Legislative Audit Committee

Audit Report 04-11,
An Evaluation: Medical Assistance Eligibility Determinations Department of Health and Family Services.

December 1, 2004 **PUBLIC HEARING HELD**

Present: (9) Senators Roessler, Cowles, Darling, Plale and Lassa; Representatives Jeskewitz, Kaufert, Kerkman and Cullen.

Absent: (1) Representative Pocan.

Appearances For
- None.

Appearances Against
- None.

Appearances for Information Only
- Janice Mueller, Madison - State Auditor, Legislative Audit Bureau
- Paul Stuiber, Madison - Legislative Audit Bureau
- Mark Moody, Madison – Administrator, Division of Health Care Financing, Department of Health and Family Services (DHFS)
- Cheryl McIlquham, Madison – Director, Bureau of Eligibility Management, DHFS
- Jim Jones, Madison – Deputy Director, Bureau of Eligibility Management, DHFS
- Richard Basiliere, Appleton - Wisconsin Association on Public Assistance Fraud
- Gene Kucharski, Green Bay - Wisconsin Association on Public Assistance Fraud
- Bobby Peterson, Madison - ABC for Health
- Jon Peacock, Madison - Wisconsin Council on Children and Families
- Michael Jacob, Madison - Covering Kids and Families

Registrations For
- None.

Registrations Against
- None.

Karen Asbjornson, Committee Clerk


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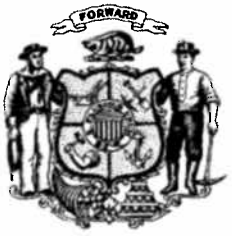
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WISCONSIN DEPARTMENT OF
ADMINISTRATION

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October 15, 2004

The Honorable Jim Doyle
The Honorable Members of the Legislature

This report presents statements of fund condition and operations (budgetary basis) of the State of Wisconsin for the fiscal year ended June 30, 2004. This satisfies the requirements of sec. 16.40(3), Wisconsin Statutes. Displayed are major sources of revenues and major categories of expenditures for the General Fund and other funds compared to the prior year.

The General Fund has an undesignated balance of $105.2 million as of the end of the fiscal year. This is $28.2 million lower than the balance of 133.4 million projected in the final Chapter 20 appropriation schedule, and a $387.4 million improvement in the $282.2 million deficit at the start of the fiscal year. The slightly lower ending balance was due to higher tax collections and higher payments for income tax credits combined with shifts in expenditures within the biennium.

General-purpose revenue taxes were $10.7 billion compared to $10.2 billion in the prior year, an increase of $539.6 million or 5.3 percent. This increase was $69.3 million above the Legislative Fiscal Bureau February 2004 estimate of $10.670 billion. General-purpose revenue expenditures, excluding fund transfers, were $10.661 billion compared to $11.033 billion in the prior year, a decrease of $372 million or 3.4 percent.

In fiscal year 2004, the State of Wisconsin continued to devote the major share of state tax collections to assistance to local school districts, municipalities and counties. Local assistance accounted for 61.0 percent of total general purpose revenue spending. Aid payments to individuals and organizations represented 15.1 percent of total general purpose revenue expenditures. The University of Wisconsin accounted for 8.8 percent of total general purpose revenue spending and state operations spending for all other state agencies accounted for 15.1 percent of the total. Wisconsin, along with many other states, continues to struggle with Medicaid costs and insufficient federal revenues. Indicative of that problem it should be noted that the Medical Assistance Trust Fund had a $195.6 million deficit that may eventually need to be financed by the General Fund.

The State of Wisconsin expects to publish its comprehensive annual financial report in December of 2004. The report will be prepared under generally accepted accounting principles.

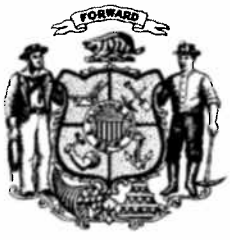
Respectfully submitted,

Marc J. Marotta
Secretary

William J. Raftery, CPA
State Controller

$195 million – deficit MA

WISCONSIN STATE LEGISLATURE



WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

November 19, 2004

Ms. Helene Nelson, Secretary
Department of Health and Family Services
1 West Wilson Street, Room 650
Madison, Wisconsin 53703

Dear Ms. Nelson:

The Joint Legislative Audit Committee will hold a public hearing on Legislative Audit Bureau report 04-11, *An Evaluation: Medical Assistance Eligibility Determinations* on Wednesday, December 1, 2004, at approximately 11:00 a.m. in Room 411 South of the State Capitol.

As this report relates to the activities of the Department of Health and Family Services, we ask that you, or appropriate members of your staff, be present at the hearing to offer testimony in response to the evaluation findings and to address questions from committee members. Before you begin testifying at the hearing, please plan to provide each committee member with a written copy of your testimony.

In addition to testifying on the findings of report 04-11, we would also appreciate receiving another brief update on the status of the error rates in the Food Stamp program from you or your staff. Please plan to incorporate this update into both your written and oral testimony at the hearing.

Please contact Ms. Karen Asbjornson in the office of Senator Carol Roessler at 266-5300 to confirm your participation in the hearing. Thank you for your cooperation and we look forward to seeing you on December 1, 2004.

Sincerely,

Carol Roessler

Senator Carol A. Roessler, Co-chair
Joint Legislative Audit Committee

Suzanne Jeskewitz

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

Enclosure

cc: Janice Mueller
State Auditor

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