Department of Health and Human Services

Centers for Medicare & Medicaid Services

Wisconsin Focused Program Integrity Review

Final Report

May 2022

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Wisconsin Focused Program Integrity Review Draft Report
May 2022

Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Wisconsin Medicaid managed care program. The primary objective of the review was to assess the level of program integrity oversight of efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In July 2021, CMS conducted a focused review of Wisconsin's single state Medicaid agency, the Department of Health Services (DHS), which is responsible for program integrity oversight of Wisconsin's Medicaid program. This focused review helped CMS to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs' Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MCOs' program integrity practices. CMS also evaluated the status of Wisconsin's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2015.

During this review, CMS identified a total of eight recommendations based upon the completed

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. HMO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Wisconsin Medicaid

The DHS is the single state agency charged with overseeing the medical assistance plans in Wisconsin. Wisconsin contracts with 14 health maintenance organizations (HMOs) to operate the state's BadgerCare Plus and Supplemental Security Income (SSI)-Related Medicaid programs. Wisconsin also contracts with five prepaid inpatient health plans (PIHPs) to operate the state's Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE) programs. The PIHPs provide long-term care services and supports for Medicaid and Medicare dual eligible beneficiaries.

In FY 2019, Wisconsin's Medicaid expenditures were approximately $9.2 billion, with approximately 1.43 million beneficiaries enrolled. The Federal Medical Assistance Percentage (FMAP) matching rate was 59.37 percent. Approximately 76 percent of the Medicaid population was enrolled in a HMO or PIHP; however, the overwhelming majority of managed care beneficiaries are enrolled in a HMO. Wisconsin managed care expenditures were approximately $2.3 billion, which included both Medicaid and the Children's Health Insurance Program (CHIP), representing approximately 25 percent of Wisconsin's total Medicaid expenditures.

Three of Wisconsin's 14 operating HMOs were selected to be interviewed during the virtual program integrity review, based on size and expenditures: Molina, Managed Health Services (MHS), and the Children's Community Health Plan (CCHP). Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each HMO that CMS interviewed.

Table 1. Summary Data for Wisconsin HMOs

	Molina	MHS	CCHP
Beneficiary enrollment total	65,200	77,810	124,242
Provider enrollment total	21,663	33,624	19,764
Year originally contracted	2010	1986	2006
Size and composition of SIU (FTEs)	Multiple*	2 FTEs	8 FTEs
National/local plan	National	Local	Local

*Molina does not have a dedicated SIU to the Wisconsin Medicaid program. Approximately 72 FTEs from Molina share oversight duties for multiple Commercial, Medicare, and Medicaid markets throughout the United States.

Table 2. Medicaid Expenditure Data for Wisconsin HMOs

HMO	FY 2017	FY 2018	FY 2019
Molina	$104.8 Million	$119.9 Million	$120.8 Million
MHS	$109.7 Million	$125.1 Million	$151.6 Million
CCHP	$235.8 Million	$233.1 Million	$214.3 Million

Results of Review

CMS evaluated the following six areas of Wisconsin's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. HMO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified seven areas of concern with Wisconsin's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

The Wisconsin Office of Inspector General (OIG) and the Division of Medicaid Services (DMS) are the organizational units responsible for the overall program integrity operations and oversight of the managed care program in Wisconsin.

The DMS has two divisions that share programmatic oversight over the managed care program. The Bureau of Programs and Policy is responsible for managed care programs and adult long-term care programs, including: program policy and operations, management of program waivers and contracts, review and analysis of new federal and state legislation, policy interpretation, and quality strategy and policy. The Bureau of Quality & Oversight provides quality and compliance oversight for managed care programs and adult long-term care programs, including initial and on-going certification reviews, network adequacy reviews, provider appeals, External Quality Review Organization (EQRO) compliance and remediation, issuance and monitoring of corrective action plans, Home and Community Based Services (HCBS) waiver monitoring requirements, member critical incidents, complaints, and appeals.

The Program Integrity and Compliance Section (PICS) within the Wisconsin OIG is responsible for program integrity oversight of the HMOs in Wisconsin's Medicaid program. The Wisconsin OIG's main function is to identify and review providers who may be practicing abusive or fraudulent billing. The Wisconsin OIG ensures DHS' compliance with federal regulations and reviews fee-for-service; Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and

CHIP claims; medical documentation; medical reports; and prior authorizations (if applicable) to identify potentially fraudulent, abusive, or incorrect billing practices.

2. Provider Screening and Enrollment

To comply with 42 CFR 438.602(b)(1)-(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, Wisconsin requires that all providers furnishing services to Wisconsin Medicaid members, including providers participating in a HMO provider network, are required to be screened and enrolled with the State Medicaid Agency (SMA). The HMOs must ensure that all providers are registered in Wisconsin's provider enrollment system prior to contracting and credentialing with the provider. This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

The DHS screens and enrolls providers in accordance with § 455.436. All providers are required to obtain a DHS Medicaid provider number to enroll with an HMO or MCO. The DHS has assigned risk levels to providers in accordance with § 455.450, which requires the SMA to screen all initial applications, including applications for a new practice location, and any applications received in response to re-enrollment or revalidation of enrollment request, based on a categorical risk of "limited," moderate," or "high." States in compliance with these requirements subject high risk and moderate risk providers to enhanced screening that may include onsite visits, Federal Bureau of Investigation (FBI) background checks, and FBI fingerprinting.

While discussing subcontractor relationships with the HMOs, the HMOs advised CMS that they do not require federally required disclosures of ownership, controlling interests, managing employees and business affiliation(s), as listed in § 438.602 (c) and § 438.608 (c) in their contract(s) with subcontractors. A CMS review of the contract language confirmed the HMO's assertion.

Recommendation #1: The SMA should develop a process to ensure HMOs require their subcontractors to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in §§ 455.104 and 438.602(c).

3. HMO Investigations of Fraud, Waste, and Abuse

State Oversight of HMOs

As required by § 438.608(a)(1)(vii) Wisconsin has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. Wisconsin requires HMOs to have in place policies and procedures for ensuring protections against actual or potential fraud, waste, and abuse. The HMO must have a formal comprehensive Wisconsin Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct, and prevent fraud, waste, and abuse, and to support correction and prevention efforts.

The PICS conducts quarterly Program Integrity collaborative sessions with the HMOs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. The attendees include representatives from the HMOs' program integrity divisions, and the Medicaid Fraud Control Elderly Abuse Unit (MFCEAU). During these meetings, Wisconsin OIG staff have provided educational guidance to all the HMOs on MFCEAU referral standards to ensure only quality cases are being referred.

Additionally, on a quarterly basis, the HMOs submit a report electronically to the Wisconsin OIG detailing all activities conducted on behalf of program integrity by the HMOs and include findings related to these activities. The report includes allegations received and results of the preliminary review, investigations conducted and outcome, payment suspension notices received and suspended payments summary, claims edits/automated review summary, and other activities.

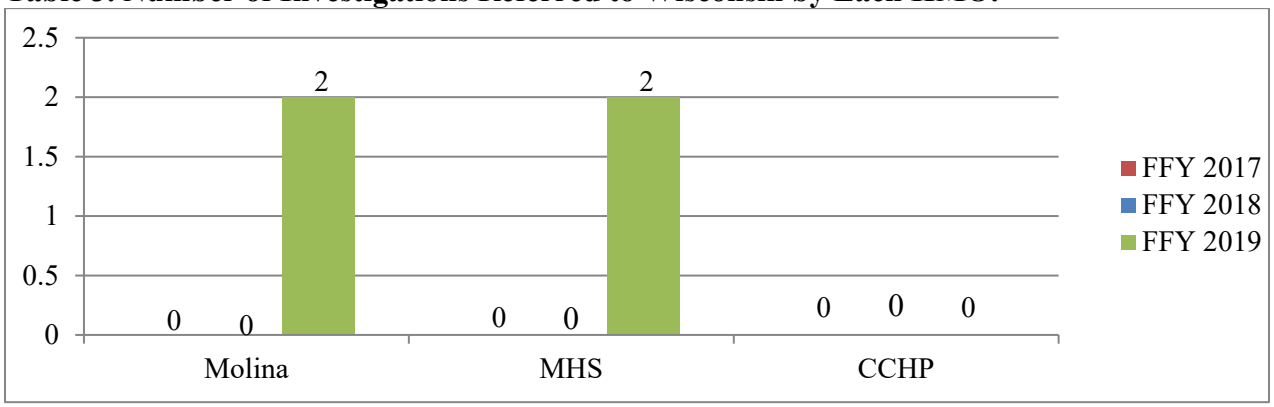
Upon submission, the Wisconsin OIG reviews the Quarterly Fraud/Waste/Abuse Overpayment Report. This evaluation examines ongoing reporting, as well as the contents of the report to ensure that all contractual requirements are being met. According to the HMO contract, HMOs must have methods for identification, investigation, and referral of suspected fraud cases (§§ 455.13 and 455.14). When the HMO identifies suspected fraud (as defined in § 455.2) by one of its providers or subcontractors, it shall be reported to the Wisconsin OIG within five days of discovery on the Referral of Suspected Provider Fraud form.

The Wisconsin OIG advised CMS that it regularly initiates and hosts program integrity meetings with the HMOs to provide general information on trends that may cause risks to the Medicaid program. **However, the Wisconsin OIG indicated it does not share specific information about provider identities linked to potential credible allegations of fraud. The Wisconsin Medicaid managed care program consists of many HMOs, and we believe that a lack of information sharing about specific provider concerns makes it more difficult to identify suspected provider fraud across health plans.** Allowing and encouraging the sharing of more specific information could help create a more robust picture of provider risk than the current fragmented, aggregate approach. Additionally, more cohesive information sharing in the early stages of suspected fraud investigation would allow for more effective use of HMO program integrity resources, likely resulting in more complete referrals to the MFCEAU and ultimately a more robust risk mitigation program.

HMO Oversight of Network Providers

Table 3 describes the number of investigations referred to Wisconsin by each HMO. As illustrated below, the HMOs collectively referred a limited number of credible allegations of fraud during the review period in relation to the Medicaid expenditures and beneficiary/provider enrollment. From FYs 2017-2019, the Wisconsin OIG received a total of nine credible allegation of fraud referrals from the fourteen contracted HMOs.

Table 3. Number of Investigations Referred to Wisconsin by Each HMO.



A review of the quarterly FWA PI logs indicate there may be areas of opportunity to identify more referrals that may rise to a credible allegation of fraud. The HMOs recouped a significant amount of overpayments in several instances, yet the investigations did not result in a referral to the OIG for further investigation or review of credible allegation of fraud. More proactive measures by HMOs to actively refer suspected fraud to the OIG, in addition to the state facilitating information sharing amongst the HMOs should help improve the number of credible allegations of fraud.

Overpayments

The Wisconsin OIG reported to CMS that it is in the process of developing and implementing HMO provider audits into its oversight strategies. However, the Wisconsin OIG does not have the ability to initiate and recoup overpayments due to a lack of contract language granting the agency the appropriate authority. The Wisconsin OIG relies on the HMOs to conduct adequate preliminary investigations if the Wisconsin OIG identifies aberrant billing patterns of HMO providers. The Wisconsin OIG is in the process of amending the contract for the FY 2022 cycle to include Wisconsin OIG authority to initiate HMO provider audits. The Wisconsin OIG plans to begin a series of provider audits when that authority is granted. Developing the process for initiating provider audits should drive more case referrals and preliminary investigations to further identify suspected fraud.

During the review, the Wisconsin OIG stated that its recoupment authority had been challenged by the Private Duty Nurses' Association, but the case was recently resolved by the Wisconsin Supreme Court after four years of litigation. As a result of the Supreme Court decision, the Wisconsin OIG stated its recoupment authority has been limited. As such, any finding resulting in recoupment of overpayments must be clearly based on the administrative

code in the promulgated rule. Therefore, overpayments identified and recovered were generally less prevalent during the review period. As mentioned above, the BadgerCare Plus model contract lacks adequate language on granting OIG recoupment authority over services rendered by HMO providers, shifting the majority of responsibility for identification and recoupment of overpayments to the HMOs. Pursuant to § 438.608(c), states must require that MCOs report excess capitation or other contract overpayments to the state within 60 calendar days. **During the review period, contract language did not require HMOs to report excess capitation or other contract overpayments to the state within 60 calendar days.** Since CMS' review was conducted, the DHS has implemented contract language for this provision for the FY 2022-2023 contract cycle.

Pursuant to § 438.608(d)(3)-(4), MCOs are required to report recovered overpayments annually to the state. The Wisconsin OIG informed CMS that the HMOs report overpayments quarterly. After further review of the quarterly reports, the overpayments consisted of all claims adjustments without distinction if they were related to fraud, waste, or abuse. As a result, reported overpayments were generally within the tens of millions of dollars. The Wisconsin OIG acknowledged the overpayment reporting should be refined and improved to reflect genuine overpayments, and not claims adjustments**. Further, the Wisconsin OIG acknowledged overpayment reporting should be more consistent with CMS requirements.** Since CMS' review was conducted, the DHS has taken steps to come into compliance with CMS requirements.

Overall, the amount of overpayments identified and recovered by the HMOs appears to be exceedingly low. Although the MCOs are not normally required to return overpayments from their network providers to the state, the state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. (§ 438.608(d)(4)) Without these adjustments, MCOs could be receiving inflated rates per member per month. Tables 4-A, 4-B, and 4-C describe each MCO's recoveries from program integrity activities.

Table 4-A Molina's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	0	0	$0	$0
2018	4	2	$0	$0
2019	38	32	$420,844.85	$84,012.22

Table 4-B. MHS' Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	26	3	$288.02	$0
2018	27	8	$47,668.64	$1,048.60
2019	15	8	$0	$17,498.98

Table 4-C. CCHP's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	0	10	$369,756.00	$31,998.00
2018	17	19	$0	$156,000*
2019	14	15	$208,337.00	$165,815.00

***All of the monies collected in 2018 were from overpayments identified in 2017**

Recommendation #2: The Wisconsin OIG should develop strategies for sharing information about suspected fraud with other HMOs, and collaborate with the HMOs to enhance and develop more comprehensive suspected fraud case referrals.

Recommendation #3: The Wisconsin OIG should consider developing tools to measure SIU and program integrity effectiveness. Further, the Wisconsin OIG should continue to implement processes to incorporate comprehensive HMO provider audits and oversight procedures, and to refine program integrity strategies and efforts to ensure adequate oversight of managed care expenditures.

Recommendation #4: The Wisconsin OIG should ensure that its HMOs are being proactive in identifying and collecting overpayments and accurately reporting all overpayments to the state. The state should ensure that the HMOs develop and maintain appropriate overpayment identification/collection/reporting policies and procedures consistent with § 438.608(d).

Recommendation #5: The SMA should amend the HMO contract to ensure compliance with § 438.608(d)(2), which requires managed care plans have a mechanism for a network provider to report and return an overpayment to the plan within 60 days of identification.

Recommendation #6: The SMA should amend the HMO contracts to ensure that the HMOs are accurately reporting overpayments, annually, in accordance with § 438.608(d)(3)-(4).

4. Encounter Data

Encounters are submitted directly from the HMOs, in accordance with the BadgerCare Plus contract, once per month. Encounter data is certified by the plan CFO in accordance with § 438.606. The HMOs have listed guidance and expectations for submitting specific, identified

data fields each month. The HMOs are responsible for validating each data field, and certifying encounters in accordance with § 438.606. The Wisconsin OIG did not have access to the encounter data universe until 2017, and nuances in proprietary data and encounter recording continue to be a barrier to efficiently analyzing encounters from HMOs. Strategies to incorporate encounter data in all investigations are being developed so that auditors can consider risk to both fee-for-service (FFS) and HMOs when determining how to proceed with a complaint. Myers and Stauffer is contracted to perform audits of the financial statements and encounter data every three years, in accordance with § 438.602(e). These audits are performed on a rolling basis with one-third of total HMOs audited each year.

All three HMOs were found to be properly gathering and submitting encounter data in accordance with the terms of their contract and § 438.606. As such, CMS did not identify any recommendations regarding Wisconsin's encounter data program.

5. Payment Suspensions Based on Credible Allegations of Fraud

Consistent with § 438.608(a)(8), Wisconsin's HMO model contract includes a provision regarding the suspension of payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23. Specifically, Wisconsin's HMOs are contractually required to suspend payments to network providers at the state's request if the state determined a credible allegation of fraud exists in accordance with § 455.23. Suspension of payments must be implemented immediately and applied to all Medicaid claims (FFS and encounter/managed care) submitted by the network provider.

The DHS contract states that the HMO must suspend payments to providers or subcontractors against whom the SMA has determined there to be a credible allegation of fraud. Upon notification from the SMA that such a determination has been made, and provided the SMA has not determined good cause exists to not suspend payments or to suspend payment only in part, the HMO must suspend payment as soon as possible and no later than the date indicated in the notice from the SMA.

All three HMOs have a suspension policy and comply with the terms of their contract. As such, CMS did not identify any recommendations regarding Wisconsin's payment suspension policies and processes

6. Terminated Providers and Adverse Action Reporting.

Consistent with §§ 438.608(b) and 455, subparts B and E, CMS requires Medicaid MCOs to meet CMS' provider enrollment and screening requirements, including the requirement at § 455.416 to terminate network providers in certain circumstance, including for cause, which may include, but is not limited to, fraud, integrity, or quality. The DHS informed CMS that provider terminations based on violations of fraud, integrity, and quality are considered for cause terminations. CMS acknowledges that this may be DHS' expectation of the HMOs, but the Wisconsin model contract does not support this assertion and does not specify that terminations due to fraud, integrity, or quality are considered for-cause. The BadgerCare Plus HMO contract only requires notification of provider termination if the action negatively impacts patient access. The Medicaid Provider Enrollment Compendium (MPEC) states that for cause adverse

terminations may include, but are not limited to, termination for reasons based upon fraud, integrity, or quality. The MPEC provides guidance on identifying and mandatory reporting of for-cause terminations. **The HMOs do not appear to have a clear understanding of what constitutes a for cause action and how it should be effectively reported.** Each HMO interviewed provided varying responses regarding what constitutes a for cause provider terminations and how those provider terminations are reported to DHS. When reported to DHS, the provider terminations did not clearly identify that the providers were terminated for fraud, integrity, or quality related reasons. It is necessary for the HMOs to clearly identify and report for-cause terminations so that DHS can take the appropriate actions to safeguard the Medicaid program.

Table 5 depicts the number of provider terminations by each HMO. Overall, the number of providers terminated for cause by the plans appear to be low, compared to the number of providers enrolled with the HMOs and the number of providers disenrolled or terminated for any reason. The DHS has not adopted clear contract language, policies, and procedures for identifying and reporting adverse provider terminations.

Table 5: Provider Terminations in Managed Care

HMOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs		Total # of Providers Terminated for Cause in Last 3 Completed FYs	
Molina	2017	3,935	2017	0
	2018	4,099	2018	10
	2019	8,035	2019	3
MHS	2017	3,011	2017	3
	2018	3,271	2018	3
	2019	4,190	2019	1
CCHP	2017	19	2017	0
	2018	37	2018	1
	2019	59	2019	0

Recommendation #7: The SMA should consider taking the following actions: 1) adopt for cause provider termination criteria consistent with guidance listed in the MPEC, and amend the HMO contract to include such provisions; 2) implement policies and/or contract language to address clear reporting of for cause terminations; and 3) require prompt reporting requirements regarding for cause terminations that should be adopted by all HMO plans. Accordingly, additional education is warranted to ensure provider for cause terminations are identified, reported, and handled appropriately

Status of Wisconsin's 2016 Corrective Action Plan

Wisconsin's previous focused program integrity review was in July 2015, and the final report was issued in July 2016. The report contained nine recommendations. CMS completed a desk review of the corrective action plan in July 2018, which indicated that the findings from the 2015 review have all been satisfied by the state.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Wisconsin to consider utilizing:

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf.
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx.
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx.
- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCU.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address Overpayment and Recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Conclusion

CMS supports Wisconsin's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified five areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

CMS looks forward to working with Wisconsin to continue building an effective and strengthened program integrity function.