Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Wisconsin Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's last program integrity review in 2011. An assessment of the state Medicaid agency's corrective action plan (CAP) is included in the report.

Background: State Medicaid Program Overview

The review focused on the activities of the Department of Health Services (DHS) which administers Wisconsin's Medicaid program and serves 72 counties. Wisconsin's Medicaid program provides health care for approximately 1,189,409 Wisconsinites with approximately 65 percent of those enrolled in managed care and operates with an annual budget of approximately $8.1 billion. For federal fiscal year (FFY) 2014, the state reported $1.8 billion of the total computable Medicaid expenditures went to the managed care programs in place during this time period. The Federal Medical Assistance Percentage (FMAP) for Wisconsin for FFY 2015 was 58.27 percent. Wisconsin chose not to expand the Medicaid program under the Affordable Care Act.

Methodology of the Review

In advance of the onsite visit, CMS requested that Wisconsin complete a managed care review guide that provided the review team detailed insight to the operational activities of the areas that were subject to the focused review. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of July 13, 2015, the CMS review team visited DHS and other agencies, as well as the program integrity staff of four MCOs, to discuss their program integrity activities at length. The four MCOs reviewed were UnitedHealthcare (UHC); Children's Community Health Plan (CCHP); Physicians Plus Insurance Corporation (PPlus); and Molina Healthcare of Wisconsin Inc. (MHWI). In addition, the CMS review team conducted sampling of Medicaid provider investigations and other primary data to substantiate DHS's implementation of their managed care program integrity policies and procedures.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity activities and managed care oversight, thereby creating risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS will work closely with the state to ensure that the identified issues are satisfactorily resolved as soon as possible.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 85 percent of the Wisconsin Medicaid population was enrolled in a managed care plan at the time of the CMS review. The state spent approximately $1.8 billion on managed care contracts in FFY 2014.

Summary Information on the Plans Reviewed

The CMS review team met with program integrity staff of the four MCOs to discuss their program integrity activities at length. There were 372,628 beneficiaries enrolled in the four MCO health plans reviewed: 8 percent of beneficiaries were members of UHC; 37 percent of beneficiaries were members of CCHP; 22 percent of beneficiaries were members of MHWI; and 3 percent of beneficiaries were members of PPlus.

The UHC health plan has been a long-standing contractor since 1984 and pays their network providers on a fee-for-service (FFS) basis. The UHC program integrity activities are supported nationally by various UHC functions responsible for the detection, prevention, and investigation of health care fraud, waste, and abuse perpetrated by their beneficiaries and/or providers. The UHC Wisconsin health plan is primarily responsible for overseeing and ensuring that all Wisconsin requirements and expectations are fulfilled. OptumInsight, which is a wholly owned subsidiary of UHC, conducts data mining. OptumInsight processes cases specific to Wisconsin related fraud, waste, or abuse originating from various sources including data mining, hotline, etc. The special investigations unit (SIU) only handles cases referred to the unit for the investigation of fraud. Cases that are referred to the state go through the local UHC compliance office.

The MHWI health plan contracted with the state in 2010 and pays its network provider on a FFS basis. The MHWI does not have an SIU, but does have a compliance department that is responsible for program integrity activities supported at a local level. The MHWI compliance department addresses suspected provider fraud and abuse. All complaints and provider oversight are administered by the MCO's provider relations department.

The CCHP health plan contracted with the state in 2006 and pays its network providers on a FFS basis, with the exception of dental and routine vision providers who are paid at a capitated rate. The CCHP is an affiliate of Children's Hospital and Health System, Inc. (CHHS). The CHHS has a corporate compliance department that performs special investigations for all affiliates of CHHS, including CCHP. The investigations include monitoring and audits for compliance with laws and regulations as well as for policies and procedures. Program integrity is in the scope of monitoring audits performed by the corporate compliance department located in Milwaukee.

PPlus health plan contracted with the state in 2006 and pays its network providers through a combination of FFS and capitation rate basis. PPlus does not have an SIU or compliance department; instead, program integrity activities span the organization.

Enrollment information for each MCO as of May 2015 is summarized below:

Table 1.

MCO	Medicaid Enrollees	Medicaid Contracted Providers
UHC	143,090	17,281
CCHP	138,174	11,921
PPlus	11,203	2,136
MHWI	80,161	13,370

State Oversight of MCO Program Integrity Activities

The Office of the Inspector General (OIG) is housed within DHS and is responsible for all program integrity activities. The OIG and the Bureau of Benefits Management (BBM), within the DHS Division of Health Care Access Accountability (DHCAA), have oversight responsibility for the Wisconsin Medicaid program. The BBM oversees MCO contracts, quality, and monitoring activities. The OIG conducts an average of 1,850 provider audits annually, including providers in MCO networks. The OIG has 50 full-time employees (FTEs) assigned to program integrity functions with five vacancies which include the surveillance and utilization review unit and provider enrollment. The OIG oversees audits, suspensions, provider enrollment, and reviews fraud and abuse reports from MCOs.

The state Medicaid agency does not conduct onsite reviews of MCOs. However, the external quality review organization (EQRO) shares its compliance reports with the managed care division. The EQRO contract does not specifically include review activities or reporting requirements for managed care fraud and abuse. According to the state, as the EQRO performs comprehensive reviews for MCOs, elements of the MCO contract's requirements may be covered by other standards. Examples include a determination if the MCO is in compliance with all applicable federal and state statutes and rules and regulations in effect when the contract is signed or coming into effect during the term of the contract. The review conducted by the EQRO covers when the MCO or any provider is found noncompliant/in violation of any federal or state law related to enrollee rights, and MCO processes related to debarment checks including federal exclusions from participation due to fraud and abuse.

If there are items that are deemed as "partially met" or "not met" in the EQRO's comprehensive or Information Systems and Capability Assessment review findings, the department and/or the EQRO will follow-up with the MCO to ensure items are addressed or submitted. The EQRO protocols do not specifically include fraud and abuse questions or review activities. The EQRO does not specifically request MCO fraud and abuse policies and procedures; however, if the documents were submitted by the MCO, the EQRO describes the documents as having a tendency to be comprehensive, lengthy, and contain sound processes for addressing fraud and abuse.

Prior to contracting with the MCO, the department reviews the MCO's policies and procedures to ensure readiness with key contract requirements. This certification process uses a standard certification application for each entity to complete and submit supporting documentation for DHS review. A DHS documentation checklist is used along with the certification application. The process is completed at initial enrollment and repeated every two years.

MCO Investigations of Fraud, Waste, and Abuse

The state contract requires MCOs to report suspected fraud, waste, or abuse by providers, members, employees, or subcontractors within 15 days. The four MCOs stated that they were compliant in referring cases to the state. However, two plans (MHWI and PPlus) reported no referrals in four years and one plan (CCHP) had no referrals for three years. The MCOs' assertions regarding compliance in reporting suspected fraud, waste, and abuse are not supported by their lack of referrals.

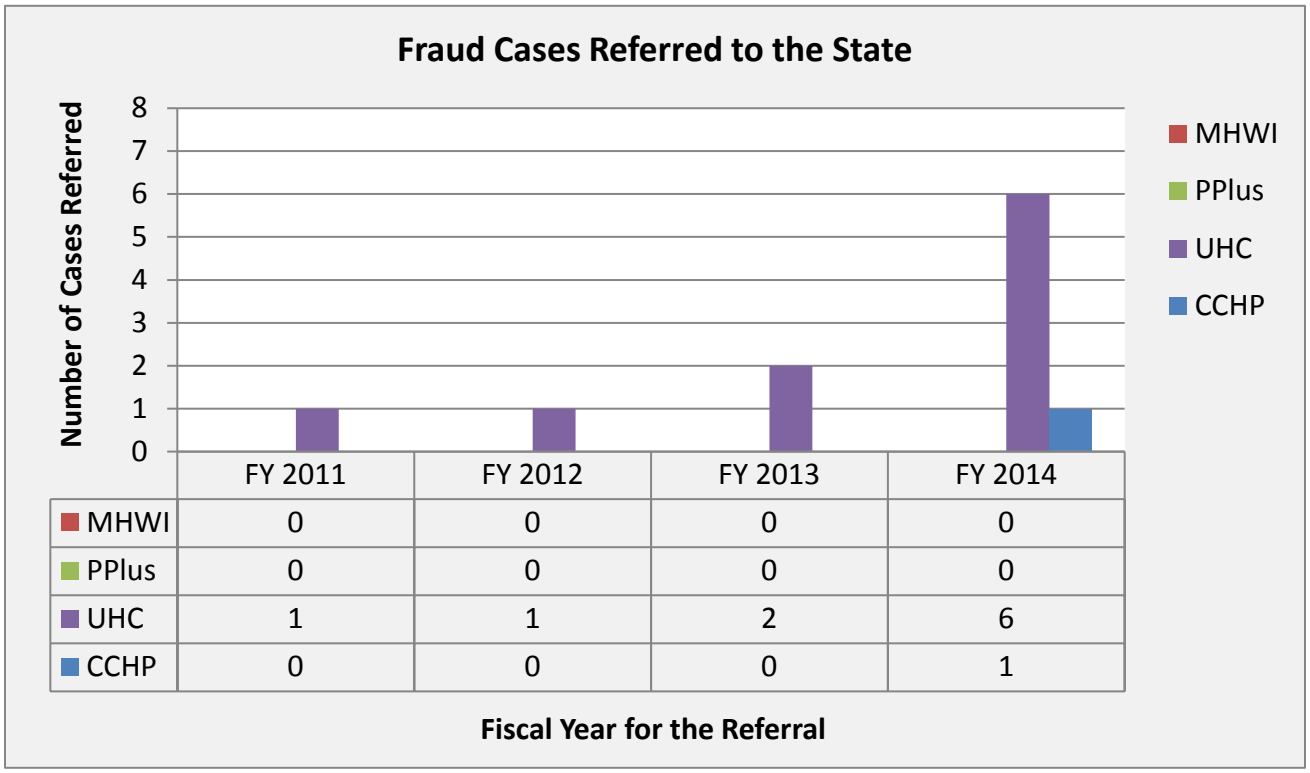
The MCOs submit fraud and abuse reports on an ad hoc basis. The state Medicaid agency has a fraud and abuse reporting portal for the plans to access either directly or through the DHS's external website. The MCO referrals sent to the state are forwarded to the OIG complaint coordinator, where they are triaged and tracked. Currently, documents cannot be uploaded through the portal; when supporting documentation is indicated, the OIG complaint coordinator contacts the plan via email or by phone to obtain the documents. The OIG refers all credible allegations of fraud to the Medicaid Fraud Control Unit (MFCU) for investigation.

The UHC referred ten cases of suspected fraud to the state in the last four fiscal years. The MHWI listed three referrals to the state in their tracking system, but reported no referrals when asked to confirm the numbers. The CCHP reported one case of suspected fraud in the last four fiscal years. PPlus did not refer any suspected fraud and abuse cases to the state in past four fiscal years.

During the last four fiscal years, the state reported 15 cases referred to the MFCU; the MCOs report a total of 11 cases referred.

The chart below shows the number of fraud cases referred by each plan to the state in the past four fiscal years.

Table 2.



	FY 2011	FY 2012	FY 2013	FY 2014
MHWI	0	0	0	0
PPlus	0	0	0	0
UHC	1	1	2	6
CCHP	0	0	0	1

Case Tracking

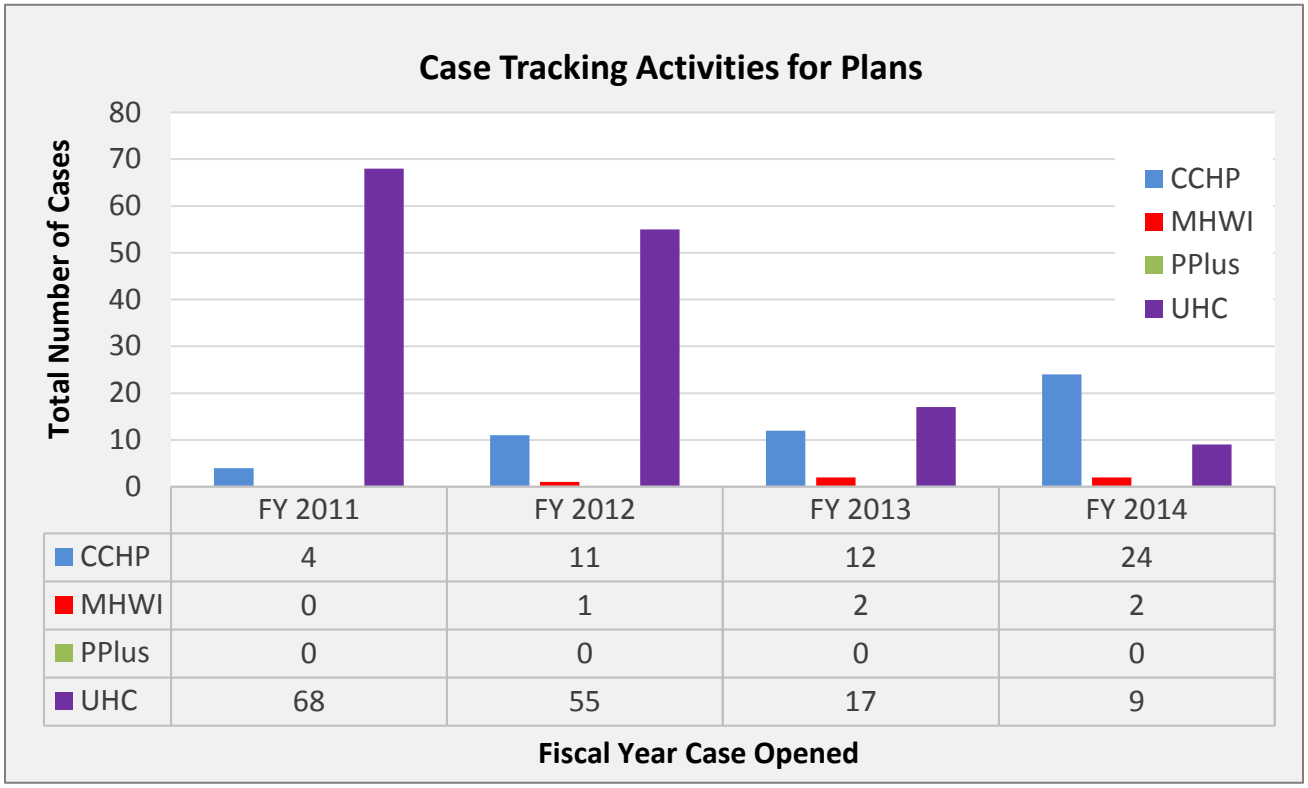
Case tracking systems utilized by the health plans were evaluated. The UHC case tracking system's capabilities include: association of current cases with past cases similar in nature; documenting notes; and attaching appropriate case-related documents and files. The UHC did refer cases of suspected fraud to the state appropriately and in a timely manner, as required by the contract.

The MHWI case tracking system's capabilities include: documenting detailed notes in chronological order; identifying the case investigator; case location (such as with the investigator, state, or other entity); case status; and the results of the investigation. Concern regarding appropriately referring potential fraud to the state was noted during sampling of the case tracking system. One of the six cases sampled identified a provider billing for services not rendered. In this instance of suspected fraud, the MHWI did not refer the case to the state. Instead, MHWI educated the provider and issued a letter for recoupment.

The CCHP tracked cases utilizing an excel spreadsheet; this limits the ability to run queries and detailed reports. The CCHP is, however, able to track the dates cases are opened and closed, and note if the case was reported to the state. During case tracking sampling, it was noted that the case file did not contain the dollar amounts involved or the claims history to determine potential losses for future recoupment. Out of the ten files reviewed, none of the case files were referred to the state and none of the case files contained a reasonable amount of supporting information or other details necessary to determine the existence of fraud, waste, or abuse, and the appropriate actions taken.

PPlus did not have a formal case tracking system. Instead, PPlus utilized an excel spreadsheet which limited the capability to perform many case tracking functions. There were no case files currently being tracked. PPlus refers to providers tracked regarding suspected fraud under review for audits; preliminary or full investigation; and cases opened and closed in error. PPlus reports no errors have ever been reported externally outside of its organization. Providers with errors were described as either "pay and educate" or "recoup money paid incorrectly". PPlus currently has several third party entities under consideration to perform case tracking functions, after issuing a request for proposal to review the usability and capabilities of the entities case tracking systems for implementation by September of 2015.

Table 3.



	FY 2011	FY 2012	FY 2013	FY 2014
CCHP	4	11	12	24
MHWI	0	1	2	2
PPlus	0	0	0	0
UHC	68	55	17	9

Sampling and interviews determined that all MCOs utilize education and recoupment as the solution to all potential suspected fraud.

MCO Compliance Plans

The team reviewed the state's MCO model contract with regard to specific program integrity requirements. Besides the selected provider, enrollment, and screening requirements discussed earlier, the CMS review team considered the contractual requirements for program integrity compliance programs and staffing of such activities. The CMS review team found that the state

requires its MCOs to have a compliance program consistent with the regulation at 42 CFR 438.608.

The state Medicaid agency reported that it will work with the MCOs to ensure all required documents are complete and included in the submission including: written procedures; a description and designation of a compliance officer and compliance committee; training requirements for the compliance officer and employees; enforcement standards; disciplinary guidelines; internal monitoring; auditing procedures; and description of prompt responses to detected problems are not submitted prior to the contract procurement.

Meetings and Trainings

The DHCAA and OIG conduct meetings, webinars, and conference calls on a regular basis to discuss quality issues. The agenda for the meetings does not include fraud topics. However, if fraud trends are identified, DHCAA and OIG discuss these trends and concerns during the meetings. Annually, the OIG the OIG provides fraud training covering compliance with state and federal requirements.

The UHC investigative staff is required to maintain at least nine hours of anti-fraud training annually. The SIU staff maintains this educational requirement by attending the annual National Health Care Anti-Fraud Association (NHCAA) conference.

The MHWI compliance staff participates in MFCU trainings, as required. Additionally, MHWI staff attends the MHWI-sponsored compliance summit, compliance forums, and compliance round tables. The compliance department provides ad-hoc trainings to enforce reporting responsibilities and processes. All employees complete mandatory annual anti-fraud training.

The CCHP reported attending conferences provided by two of their vendors that focused on fraud, waste and, abuse, including webinars. In addition, there is mandatory in-house general compliance training for all staff. PPlus reported attending trainings provided by the DHS-OIG on payment suspensions, webinars on the Supreme Court and whistleblowing, and two fraud-training conferences.

Encounter Data

The state Medicaid agency does receive encounter data from the MCOs. The data is entered into the Medicaid Management Information System and analyzed with the FFS data. This encounter data from the MCOs must be adequate or it is returned to the health plans for correction. If the MCO does not supply new data, the state will issue a CAP.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state's MCO contract did not specifically address the return of overpayments collected by the MCOs. According to both the MCOs and the state, recoupments have been returned to the state. The team requested the recoupment amounts received by the state from the MCOs.

However, the state was unable to provide specific amounts because the report would capture all negative payment adjustments.

Table 4.

MCO	Overpayments Recovered SFY 2011	Overpayments Recovered SFY 2012	Overpayments Recovered SFY 2013	Overpayments Recovered SFY 2014
CCHP	$0	$0	$0	$54,293
MHWI	$0	$347,463	$2,019,738	$1,757,065
PPlus	$227,790	$355,862	$20,073	$0
UHC	$0	$0	$0	$227,850*

**UHC behavioral health services recoveries.*

Payment Suspensions

Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The plans reported suspending payments for providers, upon notification from the state. Although UHC, MHWI, PPlus, and CCHP have policies to suspend payments when a credible allegation of fraud has been identified, none of the four MCOs reported initiating payment suspensions which was confirmed during sampling of MCO payment suspension case files.

Terminated Providers and Adverse Action Reporting

All MCOs are required to report changes in the provider network, including voluntary and involuntary terminations, to DHS. In turn, the state notifies the MCOs of terminated providers from other plans. This allows the MCOs to ensure that terminated providers are not operating in another plan.

The table below depicts the number of terminated providers reported by each of the plans.

Table 5.

MCOs	Total Number of Providers in FFY as of May 2015	Total Number of Providers Enrolled by FFYs		Total Number of Providers Disenrolled or Terminated	Total Number of Providers Terminated for Cause
CCHP	11,921	2012	7,951	4	4
		2013	8,133	5	5
		2014	10,319	3	3
MHWI	13,370	2012	2,176	0	0
		2013	5,698	0	0
		2014	3,837	2	2
PPlus	4,584	2012	3,910	0	0
		2013	4,371	0	0
		2014	4,664	0	0
UHC	30,830	2012	25,069	11	8
		2013	25,069	22	11
		2014	29,059	16	3

The number of providers terminated for cause by the plans appears to be low, compared to the total number of providers in each of the MCO networks. Few, if any, providers were disenrolled or terminated by PPlus and MHWI. Overall, there is a declining trend in the number of adverse actions taken against providers over the past three FFYs. In the chart, all terminated provider actions listed were initiated by the state.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and the Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The Wisconsin DHS is responsible for enrolling all Medicaid providers including all MCO network providers. The DHS is responsible for checking all federal databases, this was found to be in accordance with requirements in 42 CFR 455.436.

The state's model contract with the MCOs at Article XVI section A requires the health plans to check its directors, partners, employees, and others to ensure it does not have a relationship with such parties who have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations in accordance with 42 CFR 438.610.

The four health plans were not in full compliance with checking all the federal databases required at 42 CFR 455.436 for all required persons identified at the organizational level and those the health plan subcontracts with in accordance with 42 CFR 438.610. This was confirmed during MCO interviews and by reviewing the MCO responses to the review guide module.

The CCHP reports that it conducts a semiannual database check of its organization against the HHS-OIG's LEIE. There are no checks of all LEIE, SAM monthly or of the SSA-DMF at hiring or contracting.

The MHWI conducts checks of the LEIE and SAM at hiring and contracting and monthly for directors, partners, employees, subcontractors, and board members in accordance with 42 CFR 438.610. However, there is no check of the SSA-DMF upon hiring or contracting for the same individuals.

PPlus does not conduct any checks of the required databases at hiring and contracting or monthly thereafter.

The UHC conducts an LEIE and SAM database check for all employees, owners, vendors, and affiliates upon hiring or contracting and on a monthly basis thereafter. There is no check of the SSA-DMF upon hiring or contracting for the same individuals.

Section 2: Status of Corrective Action Plan

Wisconsin's last CMS program integrity review was in 2011, and the report for this review was issued in 2012. During the on-site review in July 2015, the CMS team conducted a thorough review of the corrective actions taken by Wisconsin to address all issues reported in 2011. The findings of this review are described below.

Findings -

1. ***The state does not capture all required ownership, control, and relationship information from FFS providers, fiscal agents, and MCOs.***

   Status at time of the review: Not corrected

   - The state has changed the enrollment forms, MCO contracts, and the online portal to request all ownership and controlling interest disclosures required by 42 CFR § 455.104.
   - The state must use consistent language regarding disclosure information in its MCO contract, provider agreement, enrollment form, and certification application. The language needs to capture the name, address, date of birth, and social security number of any managing employee of the disclosing entity, fiscal agent, or managed care entity.

2. ***The state does not require submission of business transaction information, upon request, from MCOs and PACE contractors.***

Status at time of the review: Not corrected

- The state now requires submission of business transaction information for the MCO and PACE contracts.
- The state should include specific language from 42 CFR § 455.105 to fully address the regulatory requirements in the contracts.

3. The state does not collect all criminal conviction disclosures in the FFS, managed care, and home and community-based services programs.

Status at time of the review: Not corrected

- The enrollment process now captures health care-related criminal convictions for all providers and programs.
- The language from 42 CFR § 455.106 (a)(1) is present, but needs to be updated in the certification application to include the word "agent".

4. The state has not complied with the state plan requirement to review providers' policies and employee handbooks pertaining to the False Claims Act.

Status at time of the review: Not corrected

- The state supplied documentation demonstrating that the Wisconsin Medicaid provider agreement requires providers and contractors to include policies and procedures regarding fraud, waste, and abuse detection and prevention in employee handbooks.
- The Medicaid Standard Agreement should be corrected to include all language from 42 CFR § 455.106.

5. The state does not have written program integrity policies and procedures specific to managed care.

Status at time of the review: Not corrected

- The state provided documentation for fraud and abuse policies and procedures related to MCO oversight in the new model contract.
- The disclosure section should use the language contained in 42 CFR § 455.104, 105, and 106.

6. The state does not require MCOs to verify services billed by providers with beneficiaries.

Status at time of the review: Not corrected

- The current DHS contract with the MCOs does not require verification of services with beneficiaries. The MCO contract should be modified to make verification of services by MCO mandatory.

- The fiscal agent distributes recipient explanation of medical benefits (REOMBs) on a monthly basis to a sample of 1,001 FFS beneficiaries who received services during the prior month. This sample may possibly include beneficiaries participating in the managed care program.

7. The state does not capture managing employee information on long term care and support (LTCS) enrollment forms.

Status at time of the review: Not corrected

- The LTCS enrollment applications have been changed to now require ownership, disclosure, and sanction information in MCO contracts.
- The state must update its new contract to included language requesting managing employees to identify excluded individuals working for providers or health care entities.
- This information should be maintained in a database used to search for exclusions.

8. The state does not report adverse actions taken on managed care network provider applications for participation in the program.

Status at time of the review: Corrected

- The state provided the new MCO contract which now requires the reporting of all network provider denials or terminations.

9. The states do not conduct complete searches for individuals and entities excluded from participating in Medicaid.

Status at time of the review: Not corrected

- The state now requests disclosure and ownership information in the new MCO contracts.
- The state should capture managing employee information to conduct the required database checks. Without the managing employee information, the state is unable to meet the full requirements for database checks in accordance with 42 CFR 455.436.

10. The state does not have policies and procedures on initiating provider exclusions.

Status at time of the review: Corrected

- The DHS has policies and procedures in place for excluding providers.
- The DHS's fiscal agent runs a monthly match with the OIG exclusions database and terminates any providers who are excluded.
- The fiscal agent checks all applicants to ensure that they are not excluded.

Summary Recommendations

- The state should schedule frequent meetings with the MCOs to review program integrity activities and contract performance.

- The state should develop benchmarks to increase SIU activity for plans with a low volume of audits, investigations, and referrals in proportion to the number of their enrolled beneficiaries.
- The state should provide Medicaid program integrity training as a routine part of their meetings with the MCOs.
- The state should require that contracting MCOs form SIUs or functional equivalents with sufficient resources commensurate with the plan size to conduct the full range of program integrity functions including the review, investigation, and auditing of provider types where Medicaid dollars are at the greatest risk.
- The state should collect information on all types of MCO improper payments, recoveries, and cost avoidance activities, not only those relating to cases defined as fraud.
- The state should ensure that appropriate recovery and cost avoidance data is reported for future MCO rate setting.
- The state should consider requiring MCOs to report cases opened and resolved by education and recoupment.
- The state should provide training to MCOs on payment suspensions pursuant to 42 CFR 455.23 and require the reporting of plan-initiated payment suspensions based upon credible allegations of fraud in its MCO model contracts.
- The state should provide training to MCOs on required database checks for the organization (42 CFR 455.436) and for all others required (42 CFR 438.610).
- The state should modify its model contract to ensure all federal regulations are included and properly stated in accordance with the regulation.
- The state should monitor the effectiveness of the MCOs' infrastructures; program integrity resources; evaluations and referrals of potential fraud; and systems to detect and deter fraud.
- The state should develop a mechanism to track overpayments returned by the MCOs.
- The state should address and resolve all recommendations from the previous CAP.

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:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Wisconsin based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.

- 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdfwand.

Conclusion

CMS supports DHS's efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction 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 CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well. CMS looks forward to working with Wisconsin to build an effective and strengthened program integrity function.

Scott Walker
Governor

Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

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August 24, 2016

Mark Majestic
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Director Majestic:

Attached you will find the responses to the findings and recommendations from your letter and Focused Review report, dated July 22, 2016. We hope that these responses satisfy any areas of concern following the Investigations and Audits Group on-site review during the week of July13, 2015.

We appreciate your assistance throughout this review and look forward in continuing to working with you in order to achieve compliance.

Sincerely,

Kevin E. Moore
Medicaid Director

Anthony J. Baize
Inspector General

cc: Lori Thornton, Deputy Inspector General, Office of the Inspector General, DHS
Curtis Cunningham, Interim Administrator, Division of Long Term Care, DHS
Laurie Battaglia, CMS
Ruth Hughes, CMS