Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WISCONSIN INAPPROPRIATELY WITHDREW FEDERAL MEDICAID FUNDS FOR FISCAL YEARS 2010 THROUGH 2012

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

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A-05-13-00045

Office of Inspector General

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EXECUTIVE SUMMARY

For Federal fiscal years 2010 through 2012, Wisconsin inappropriately withdrew $89.6 million in Federal Medicaid funds for services provided under Home and Community-Based Service waiver programs, which should have been paid for solely with State funds.

WHY WE DID THIS REVIEW

To fund their Medicaid programs, States receive Federal grant awards that pay for the Federal share of their Medicaid medical and administrative expenditures. An external audit of the Federal fiscal year (FY) 2012 financial statements for the Centers for Medicare & Medicaid Services (CMS) determined that State Medicaid programs owed $950 million to the Federal Government. This review is part of a series of U.S. Department of Health and Human Services, Office of Inspector General (OIG), reviews related to States' Federal Medicaid withdrawals.

Our objective was to determine whether the Wisconsin Department of Health Services' (State agency) Federal Medicaid withdrawals during FYs 2010 through 2012 complied with Federal and State regulations.

BACKGROUND

Before each quarter, States estimate their Medicaid expenditures. CMS uses the estimates to determine the initial grant awards, which are the Federal fund amounts that will be available to States during the quarter. If a State underestimates the amount of funds it will need during a quarter, it may request additional funds through a supplemental grant award.

The Payment Management System (PMS) is used to account for Medicaid financial activity. Throughout a quarter, States withdraw Federal funds from PMS accounts to pay the Federal share of Medicaid expenditures. After the end of each quarter, States report to CMS the expenditures and the associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). CMS calculates a finalized grant award amount for each State by comparing the initial and supplemental grant awards for the FY to both the expenditures reported on the CMS-64 report and adjustments to those expenditures that were not included on the CMS-64 report.

After each year, the State agency performs a reconciliation to compare the total Federal funds withdrawn with the Federal share of net expenditures. If total Federal funds withdrawn are less than expenditures, the State agency increases a future withdrawal. Conversely, if total Federal funds withdrawn exceed expenditures, the State agency will decrease a future withdrawal to offset the difference.

The State agency requests approval for Home and Community-Based Service (HCBS) waiver programs under the authority of section 1915(c) of the Social Security Act. The design of a waiver program varies depending on the specific needs of the population, State goals and objectives, and other factors. The services provided under the HCBS waiver programs are

coordinated with State-funded services and with Medicaid services covered by the Medicaid fee-for-service system.

The State agency uses the Community Aids Reporting System (CARS) to process service contracts and reimburse local agencies for Medicaid HCBS. The State agency enters into contractual agreements with local agencies to provide support services related to the HCBS waiver programs. Some CMS-approved waivers in Wisconsin specifically direct the State agency to pay, in advance, the first 3 months of each calendar year for each CARS provider. The amount of the advance payment is a portion of the aggregate annual projected costs for all CARS services. The waivers require this payment to be made with 100-percent State funds.

WHAT WE FOUND

The State agency's Federal Medicaid withdrawals during FYs 2010 through 2012 did not fully comply with Federal and State regulations. The State agency properly withdrew $13,691,557,996 of the $13,781,182,197 obtained in Federal Medicaid funds. However, the State agency inappropriately withdrew the difference of $89,624,201 to pay for aggregate annual projected costs. According to the approved State waivers, these costs should have been paid for solely with State funds for the first 3 months of each calendar year during FYs 2010 through 2012.

Additionally, the State agency lacked formal policies and procedures for withdrawing Federal Medicaid funds from the PMS account.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $89,624,201 to the Federal Government,
- establish formal policies and procedures for withdrawing Federal funds from PMS for Medicaid in accordance with Federal and State requirements, and
- ensure all Federal withdrawals from PMS that occurred after our audit period comply with Federal and State requirements.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not concur with our three recommendations. The State agency disagreed with the finding that the $89,624,201 of withdrawals in question should have been paid for solely with State funds. However, the State agency noted a corrective action planned for calendar year 2016 and subsequent contracts to eliminate payments before receipt of actual expenditure reports.

After reviewing the State agency's comments, we maintain that our findings and recommendations remain valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

To fund their Medicaid programs, States receive Federal grant awards that pay for the Federal share of their Medicaid medical and administrative expenditures. Before Federal fiscal year (FY) 2010, States had grant award accounts that combined the Medicaid funds from every year. Consequently, yearly balances were not distinguished. Beginning in FY 2010, the Centers for Medicare & Medicaid Services (CMS) implemented annualized accounts for grant awards that had beginning and ending balances to improve the transparency of Medicaid funding. As a part of the CMS financial report for FY 2012, an external audit of CMS's financial statements determined that State Medicaid programs owed $950 million to the Federal Government.[1] This review is part of a series related to States' Federal Medicaid withdrawals.

OBJECTIVE

Our objective was to determine whether the Wisconsin Department of Health Services' (State agency) Federal Medicaid withdrawals during FYs 2010 through 2012 complied with Federal and State regulations.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In Wisconsin, the State agency administers the Medicaid program. Although the State agency has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Funding Process

Before each quarter, States estimate their Medicaid expenditures and report the estimates to CMS on the quarterly Medicaid Program Budget Report (CMS-37 report). CMS uses the estimates to determine the initial grant awards, which are the Federal fund amounts that will be available to States during the quarter. If a State underestimates the amount of funds it will need during a quarter, it may request additional funds by submitting a revised CMS-37 report. The resulting increase in Federal funds is known as a supplemental grant award.

CMS provides the grant award amounts to the Division of Payment Management (DPM), a division within the U.S. Department of Health and Human Services, which operates as CMS's fiscal intermediary. DPM uses the Payment Management System (PMS) to account for Medicaid financial activity, such as recording grant award amounts and processing the States'

[1] CMS, *CMS Financial Report Fiscal Year 2012, "*Financial Section, Audit Reports," page 123.

withdrawals. Beginning in FY 2010, CMS implemented annualized PMS accounts for the grant awards. As a result, each State has PMS accounts for each FY rather than PMS accounts that combined the funds for multiple FYs.

Throughout a quarter, States withdraw Federal funds from the PMS accounts to pay the Federal share of Medicaid expenditures. Within 30 days after the end of each quarter, States report to CMS the expenditures and the associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The amounts that States report must represent actual expenditures.

CMS calculates a finalized grant award amount for each State by comparing the initial and supplemental grant awards for the FY with expenditures reported on the States' CMS-64 report. CMS also includes in its calculation adjustments to expenditures that were not included on the CMS-64 report, such as interest due to CMS and expenditures that CMS disallowed. If a State's initial and supplemental grant awards are less than its expenditures, CMS increases the State's grant award. Conversely, if a State's initial and supplemental grant awards exceed its expenditures, CMS decreases the State's grant award by the difference.

Wisconsin Is Taking Part in an Annual Grant Award Pilot Program

Wisconsin is one of six States that is taking part in a pilot program that CMS established to determine the viability of giving States their annual FY funding in a grant award during the first quarter of the FY. At the end of the FY, the six States in the pilot program reconcile expenditures for all four quarters to the annual grant award.

After each FY, CMS notifies the State agency of any differences between total Federal funds withdrawn according to the PMS and the Federal share of expenditures reported on the CMS-64 report. The State agency provides CMS with an explanation of the difference. If total Federal funds withdrawn are less than expenditures, the State agency increases a future withdrawal to obtain the difference. Conversely, if total Federal funds withdrawn exceed expenditures, the State agency will decrease a future withdrawal to offset the difference.

The State Agency Uses the Community Aids Reporting System To Process Payments for Home and Community-Based Service Waiver Program Services

The State agency's Community Aids Reporting System (CARS) processes service contracts and reimburses expenses for local agencies. Among other things, CARS processes payments for services provided under Wisconsin's Medicaid Home and Community-Based Service (HCBS) waiver programs. The State agency enters into contractual agreements with local agencies to provide support services related to the HCBS waiver programs. In this report, we refer to these local agencies as CARS providers.

The State Agency Receives Funds for Medicaid Home and Community-Based Services Waiver Programs

The State agency requests approval for HCBS waiver programs under the authority of section 1915(c) of the Social Security Act. The design of a waiver program varies depending on the specific needs of the population, State goals and objectives, and other factors. The services provided under the waiver programs are coordinated with State-funded services and with Medicaid services covered by the Medicaid fee-for-service system.

The State agency manages several waivers, including three HCBS waiver programs:

- **Community Integration Program Waiver**—provides services to individuals with developmental disabilities.

- **Community Options Program Waiver**—provides services to elderly individuals who are physically disabled, encouraging coordinated planning and cost-effective support by using informal and community resources, such as community care as opposed to institutional care, for identified needs.

- **Brain Injury Waiver Program**—provides services to individuals who meet the Wisconsin statutory definition of brain injury, are financially and functionally eligible according to waiver program standards, and who meet a nursing facility or hospital level of care.

In describing the State's financial accountability, the HCBS waivers state that the State agency pays in advance for the first 3 months for each CARS provider. The amount of advance payment is a portion of the aggregate annual projected costs for all services. This payment should be paid for solely with State funds.

HOW WE CONDUCTED THIS REVIEW

The State agency received $13,781,182,197 in Federal Medicaid funds for FYs 2010 through 2012 (October 1, 2009, through September 30, 2012). While we reviewed the State agency's annual reconciliations and compared the amounts that it withdrew to the final amounts that CMS awarded for expenditures, we identified several transactions related to CARS transfers from one FY to the next. We then determined whether the transfers were done in compliance with State and Federal regulations, specifically the HCBS waiver agreement between CMS and the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency's Federal Medicaid withdrawals during FYs 2010 through 2012 did not fully comply with Federal and State regulations. The State agency properly withdrew $13,691,557,996 of the $13,781,182,197 obtained in Federal Medicaid funds. However, the State agency inappropriately withdrew the difference of $89,624,201 to pay for aggregate annual projected costs. According to the approved State waivers, these costs should have been paid for solely with State funds for the first 3 months of each calendar year during FYs 2010 through 2012.

Additionally, the State agency lacked formal policies and procedures for withdrawing Federal Medicaid funds from the PMS account.

FEDERAL REQUIREMENTS

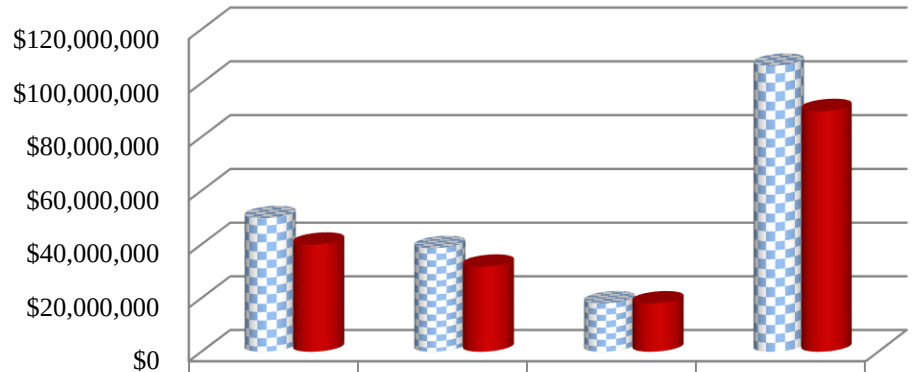
Federal financial participation is available only for the total amount expended as medical assistance and for the proper and efficient administration of a CMS-approved State plan (sections 1903(a)(1) and (a)(7) of the Social Security Act). Also, States can withdraw Federal funds as needed to pay the Federal share of Medicaid disbursements (42 CFR § 430.30(d)(3)).

Additionally, the CMS-approved waivers WI.0229.R04.00 (Community Integration Program), WI.0154.R05.00 (Community Options), and WI.0275.R03.00 (Brain Injury Waiver) specifically direct the State agency to pay, in advance, the first 3 months of each calendar year for each CARS provider. The amount of the advance payment is a portion of the aggregate annual projected costs for all CARS services. The waivers require this payment to be made with 100-percent State funds.

THE STATE AGENCY INAPPROPRIATELY WITHDREW FEDERAL FUNDS FOR PROGRAMS THAT SHOULD HAVE BEEN PAID FOR SOLELY WITH STATE FUNDS

The State agency withdrew $106,476,102 in Federal Medicaid funds from the PMS account for CARS-related costs. Of this amount, the State agency inappropriately withdrew $89,624,201 in Federal Medicaid funds for aggregate annual projected costs that should have been paid for solely with State funds. These inappropriate withdrawals occurred because the State agency lacked formal policies and procedures to govern the withdrawal of Federal Medicaid funds from the PMS account. According to the approved State waivers, aggregate annual projected costs should have been paid for solely with State funds for the first 3 months of each calendar year for each CARS provider during FYs 2010 through 2012. The figure shows the inappropriate Federal funds withdrawn by year.

Figure: Community Aids Reporting System Advance Payments Inappropriately Withdrawn



	FY 10	FY 11	FY 12	Total
Total Reported Advances Withdrawn	$49,816,836	38,631,228	18,028,038	$106,476,102
Inappropriate Advances With Federal Funds Withdrawn	$39,913,023	31,691,390	18,019,788	$89,624,201

The State agency told us that the CARS advanced withdrawals were subsequently claimed as allowable expenditures on the CMS-64. The time between withdrawing funds and reporting expenditures could take several months. While the State agency was not required to pay interest on the funds it held for extended periods of time, the Federal Government still has a loss of use of the funds during the time. In this instance, we estimated that the Federal Government could have lost as much as $94,935 in interest.[2]

THE STATE AGENCY HAS NOT ESTABLISHED FORMAL POLICIES AND PROCEDURES FOR WITHDRAWING FEDERAL FUNDS

Federal financial participation is available only for the total amount expended as medical assistance and for the proper and efficient administration of a CMS-approved State plan (§§ 1903(a)(1) and (a)(7) of the Social Security Act). Appendix I, Financial Accountability, of the CMS-approved waivers WI.0229.R04.00, WI.0154.R05.00, and WI.0275.R03.00 specifically note that the funding flow in the State agency's Medicaid waivers complies with all Federal Medicaid regulations, including the payment to local agencies for the aggregate annual projected costs for all services. Additionally, as stated in each waiver agreement, for the first 3 months of each calendar year, this advanced payment should have been paid for solely with State funds.

[2] We calculated this estimate using annualized interest rates published by the Department of the Treasury (available online at www.fms.treas.gov/cmia/interest-13.html; accessed on January 12, 2015). Those rates ranged from 0.05 to 0.12 percent. The interest amount reflects only the possible interest lost due to the State agency's payment for the aggregate annual projected costs for HCBS waivers, which should have been paid for solely with State funds.

We requested to review a copy of the State agency's policies and procedures for making Federal withdrawals. The State agency did not have formal procedures established for withdrawing Federal funds nor did it have any policies and procedures established to ensure that it withdrew only funds in accordance with Federal and State regulations.

RECOMMENDATIONS

We recommend that the State agency:

- refund $89,624,201 to the Federal Government,
- establish formal policies and procedures for withdrawing Federal funds from PMS for Medicaid in accordance with Federal and State requirements, and
- ensure all Federal withdrawals from PMS that occurred after our audit period comply with Federal and State requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not concur with our three recommendations. The State agency did not concur with our finding that the $89,624,201 of withdrawals in question should have been paid for solely with State funds. The State agency commented that the amounts transferred from the State agency to the County Waiver Agencies (CARS providers) are used to pay for provider claims for that month and are reconciled and returned to the Federal program (reduce Federal withdrawal of funds) within 2 months after the end of the month of service. The amount transferred includes both the Federal and non-Federal share.

The State agency did not comment directly on the remaining findings; however, it noted a corrective action plan for calendar year 2016 and subsequent contracts that includes changes to its contract language with county agencies to eliminate payments before receipt of actual expenditure reports.

Regarding our first recommendation to refund $89,624,201 to the Federal Government, the State agency commented that both Federal and State (non-Federal) funds were used to pay for the first 3 months of each calendar year for each provider. This use of Federal funds is contrary to the approved waiver agreements, which state that advance payments made to CARS providers for the first 3 months of the calendar year are to be solely State funded. Furthermore, nothing in the State agency's response contradicts our findings; therefore we maintain that our findings and recommendations remain valid.

The State agency's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

The State agency obtained $13,781,182,197 in Federal Medicaid funds for FYs 2010 through 2012 (October 1, 2009, through September 30, 2012).

We limited our review of supporting documentation to records supporting the State agency's withdrawals of Federal funds; we did not evaluate the accuracy of the expenditures that the State agency reported on its CMS-64 report. Our objective did not require a review of the overall internal control structure of the State agency. Therefore, we limited our internal control review to the State agency's procedures for withdrawing Federal Medicaid funds.

We conducted fieldwork from August 2013 through September 2014 at the State agency's offices in Madison, Wisconsin.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and waiver agreements between CMS and the State agency;
- interviewed State agency officials to obtain an understanding of the State agency's policies and procedures for withdrawing Federal Medicaid funds;
- analyzed the State agency's procedures for conducting annual reconciliations and reviewed those reconciliations;
- obtained and analyzed the PMS account details, including grant award amounts and actual withdrawals that the State agency made;
- compared the grant award amounts in the PMS for each FY with Medicaid grant award documents to ensure the accuracy of the PMS data;
- traced the amounts that CMS used to calculate the final grant award amounts for each quarter to the CMS-64 report;
- compared the State agency's documentation supporting its Federal Medicaid fund withdrawals with the withdrawals in the PMS;
- identified all HCBS waiver program expenditures recorded in CARS and determined their allowability;
- calculated the possible interest lost by the Federal Government; and
- discussed our results with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATE AGENCY COMMENTS

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

June 19, 2015

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Re: Report No: A-05-13-00045

Dear Ms. Fulcher:

This letter sets forth the comments of the Wisconsin Department of Health Services (WIDHS) regarding the U.S. Department of Health and Human Services, Office of Inspector General's (OIG) draft report entitled *Wisconsin Inappropriately Withdrew Federal Medicaid Funds for Fiscal Years 2010 Through 2012*, Report No: A-05-13-00045, dated May 20, 2015 (hereinafter, "Draft").

The Draft makes three recommendations:

- Refund $89,624,201 to the Federal Government,
- Establish formal policies and procedures for withdrawing Federal funds from PMS for Medicaid in accordance with Federal and State requirements, and
- Ensure all Federal withdrawals from PMS that occurred after our audit period comply with Federal and State requirements.

WIDHS does not concur with these recommendations, for the reasons set forth below.

Background

Before each quarter, States estimate their Medicaid expenditures. CMS uses the estimates to determine the initial grant awards, which are the Federal fund amounts that will be available to States during the quarter. If a State underestimates the amount of funds it will need during a quarter, it may request additional funds through a supplemental grant award.

The Payment Management System (PMS) is used to account for Medicaid financial activity. Throughout a quarter, States withdraw Federal funds from PMS accounts to pay the Federal share of Medicaid expenditures. After the end of each quarter, States report to CMS the expenditures and the

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associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). CMS calculates a finalized grant award amount for each State by comparing the initial and supplemental grant awards for the FY to both the expenditures reported on the CMS-64 report and adjustments to those expenditures that were not included on the CMS-64 report.

After each year, the State agency performs a reconciliation to compare the total Federal funds withdrawn with the Federal share of net expenditures. If total Federal funds withdrawn are less than expenditures, the State agency increases a future withdrawal. Conversely, if total Federal funds withdrawn exceed expenditures, the State agency will decrease a future withdrawal to offset the difference.

The State agency requests approval for Home and Community-Based Services (HCBS) waiver programs under the authority of section 1915(c) of the Social Security Act. The design of a waiver program varies depending on the specific needs of the population, State goals and objectives, and other factors. The services provided under the HCBS waiver programs are coordinated with State-funded services and with Medicaid services covered by the Medicaid fee-for-service system.

The State agency uses the Community Aids Reporting System (CARS) to processes service contracts and reimburses local agencies for Medicaid HCBS. The State agency enters into contractual agreements with local agencies to provide support services related to the HCBS waiver programs. Some CMS-approved waivers in Wisconsin specifically direct the State agency to pay, in advance, the first 3 months of each calendar year for each CARS provider. The amount of the advance payment is a portion of the aggregate annual projected costs for all CARS services. The waivers require this payment to be made with 100-percent State funds.

DHHS OIG finding:

> The State agency's Federal Medicaid withdrawals during FYs 2010 through 2012 did not fully comply with Federal and State regulations. The State agency properly withdrew $13,691,557,996 of the $13,781,182,197 obtained in Federal Medicaid funds. However, the State agency inappropriately withdrew the difference of $89,624,201 to pay for aggregate annual projected costs. According to the approved State waivers, these costs should have been paid for solely with State funds for the first 3 months of each calendar year during FYs 2010 through 2012.
>
> Additionally, the State agency lacked formal policies and procedures for withdrawing Federal Medicaid funds from the PMS account.

WI DHS Response:

WI DHS does not concur with this recommended finding.

Reasons for nonconcurrence:

> WI did not withdraw $89,624,201 to pay for aggregate annual projected costs.

Under the approved 1915(c) HCB waivers in question [Community Integration Program (CIP), Community Options Program (COP), and Brain Injury Waiver(BI)], county agencies act in part as local waiver administrative agencies. (The BI waiver ended on 5/1/2014 and its participants were enrolled in CIP.)

Wisconsin county waiver agencies perform some of the functions of the State Medicaid Agency on behalf of, and under the guidance and supervision of, the State Medicaid agency. The Wisconsin Constitution defines a county as serving as an arm or political subdivision of the state, primarily performing state functions at the local level. The functions of Wisconsin county waiver agencies in assisting the State in the operation of Medicaid waiver programs is specified in Wisconsin statutes and administrative rules which are consistent with the approved waivers. The State enters into a contract with each county waiver agency to administer these waivers. These contracts reference the State's Medicaid Waivers Manual, which lays out the required policies and procedures and standards to which county waiver agencies must adhere.

County waiver agencies carry out all of the following functions of the State Medicaid Agency, among others, in administration of the waivers:

- Enter into provider agreements for the provision of the supports and services each participant needs through the waiver
- Verify provider qualifications
- Maintain a provider registry
- Determine participant eligibility
- Develop Self Directed Supports (SDS) implementation plan approved by DHS.
- Enroll providers and participants
- Help develop the Individual Service Plan (ISP), an agreement between the county waiver agency and the participant as to how the program will meet the needs of the participant
- Assure that a Provider Agreement is completed
- Monitor participant self-direction of services
- Maintain participant grievance system
- Receive reports of and investigate critical incidents and events
- Review requests for use of restraints and Restrictive Interventions

In addition to the above waiver administrative functions, Wisconsin county waiver agencies receive billings from and pay waiver service providers for covered waiver services provided to eligible participants. Before paying providers, the county waiver agency audits billings to verify that the claim is reimbursable under the Medicaid Waiver by determining that the participant is eligible, the provider is qualified to provide the service for which the claim is made, the service is covered by the waiver and was authorized via the approved ISP, and the service was actually provided to the participant. Payment is made at rates that comply with applicable federal allowable cost principles.

Near the beginning of each month, the State Medicaid Agency transfers to each county waiver agency an amount, for the county waiver agency to use to pay waiver provider claims during the month. The amount of the transfer is determined based upon one-twelfth of the county's annual waiver contract amount for the most recent month for which the county has reported waiver expenditures. This transfer includes both the federal and non-federal share. The county

waiver agency reports its payments to providers for waiver services to the State Medicaid Agency via an automated cost-reporting system within 60 days of the service being delivered. The State Medicaid Agency reconciles reported expenditures to the amount of funds transferred to the county waiver agency at the beginning of the month in question, and adjusts transfers for subsequent months accordingly. The State Medicaid Agency also conducts an annual contract reconciliation and closeout, and makes any necessary adjustment to the federal claim to account for discrepancies in eligibility or allowable services discovered through that process.

With respect to their provider payment responsibilities, Wisconsin county waiver agencies essentially function as fiscal intermediaries for the State Medicaid Agency. They make Medicaid payments to providers on behalf of the State Medicaid Agency, based on provider claims, using federal and non-federal Medicaid funds transferred to them at the beginning of each month by the State Medicaid Agency. These monthly transfers of funds to county waiver agencies do not represent Medicaid payments and accordingly are not claimed on the quarterly CMS-64; rather, they are transfers of funds to a fiscal intermediary for purposes of subsequently making Medicaid payments when eligible claims are received from providers. None of these payments to county waiver agencies are made prior to the month to which they pertain, and all such payments are reconciled and adjusted to actual Medicaid expenditures within 65 days of the end of the month to which they pertain.

For the reasons set forth above, WI DHS does not concur with OIG's recommended finding that the costs in question should have been paid for solely with State funds. Amounts claimed on the CMS -64 are solely the actual incurred costs of eligible services provided to Medicaid waiver eligible clients by Medicaid waiver certified providers via an approved ISP. Amounts transferred to the County Waiver Agencies at the start of each service month to allow timely payment by the county to providers, and are reconciled and returned to the federal program (reduces withdrawal of funds) within 2 months after the end of the month of service.

Statement of alternative corrective action taken or planned:

DHS has changed its contract language with county agencies to eliminate payments prior to receipt of actual expenditure reports for calendar year 2016 and subsequent contracts.

Thank you for the opportunity to comment.

Sincerely,

Kitty Rhoades
Secretary
Wisconsin Department of Health Services