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Wisconsin May Have Improperly Claimed \$455 Million in Medicaid Reimbursement for Its School- Based Program

REPORT HIGHLIGHTS



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Why OIG Did This Audit

- HHS-OIG is conducting a series of audits of States that claim Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal reimbursement because contractors improperly conducted random moment time studies (RMTSs). An RMTS is a statistical method used to identify the percentage of time personnel spend on a particular activity.
- Wisconsin has an agreement with a contractor to conduct its RMTSs.
- This audit examined whether Wisconsin properly claimed Medicaid reimbursement of \$505.5 million in school-based program services during a 4-year period.

What OIG Found

Wisconsin may have improperly claimed an estimated \$454.9 million in Federal Medicaid reimbursement for its school-based program.

- We estimate that Wisconsin improperly claimed at least \$67 million based on unsupported RMTS coding and services provided by unlicensed providers.
- Wisconsin may have improperly claimed an additional \$387.9 million because it could not provide documentation to support ratios used to allocate costs to Medicaid.
- Wisconsin may have claimed additional unallowable costs because the RMTSs did not sample moments during the beginning of the school year.

What OIG Recommends

We made six recommendations to Wisconsin, including that it refund \$67 million in estimated improper reimbursement to the Federal Government and refund \$387.9 million or provide documentation that can reasonably support its allocation ratios. We also made procedural recommendations to assist Wisconsin in preparing accurate and supportable claims. The full recommendations are in the report.

The State agency generally disagreed with our findings, disagreed with some recommendations, and described actions it has taken to improve compliance with Federal requirements. The State agency agreed in part with our first finding, disagreed with our second finding, and did not indicate whether it agreed or disagreed with our third finding.

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INTRODUCTION

WHY WE DID THIS AUDIT

As part of its oversight activities, the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) is conducting a series of audits of States that claim Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal reimbursement because contractors improperly conducted random moment time studies (RMTSS).¹ Wisconsin has an agreement with a contractor to conduct its RMTSSs.

OBJECTIVE

The objective of our audit was to determine whether the Wisconsin Department of Health Services (State agency) properly claimed Federal reimbursement through its Medicaid school-based program.

BACKGROUND

The 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, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Wisconsin, the State agency administers the Medicaid program.

The Individuals With Disabilities Education Act

States may claim Federal Medicaid reimbursement for health services provided by schools under the Individuals with Disabilities Education Act, which requires schools to provide special education and related services² for children with disabilities.

Among other requirements for Medicaid payment, health services must be necessary, as determined by a child's individualized education program (IEP). The IEP is a document describing a child's needs for special education and related services, and the educational and

¹ See Appendix B for related OIG reports.

² Related services are services required to help a child with a disability to benefit from special education and may include health care services covered by Medicaid and non-health care services.

health services to be provided to the child. Health services must be provided by qualified practitioners who meet Federal and State license requirements.

The Wisconsin Medicaid Administrative Claiming and School-Based Services Program

The Wisconsin Medicaid Administrative Claiming (MAC) and School-Based Services (SBS) program is administered by the State agency. The SBS program allows school districts to receive reimbursement for health-related services provided to Medicaid-enrolled children when services are documented in their IEPs. Before submitting claims, school districts must obtain parental consent to release protected information, including the child's IEP.³ Under this program, the State agency also claims Federal reimbursement for school-based Medicaid administrative activities, known as Medicaid administrative claiming.

Random Moment Time Studies

During our audit period, the State agency contracted with Public Consulting Group (PCG) to conduct quarterly statewide RMTSs to estimate the time spent on Medicaid-eligible health services and Medicaid-eligible administrative activities. At a randomly selected moment, a participant was required to identify the activity they were performing by answering five

Exhibit: Random Moment Time Study

An RMTS is a statistical method used to identify the percentage of time personnel spend on a particular activity, including a measurement known as the RMTS percentage. All activities performed—whether or not allowable under Medicaid—by school district staff participating in the Medicaid program should be included, and the entire time period involved must be covered by the sample.

standard questions.⁴ Based on the participant's answers, PCG assigned a Medicaid-eligible or non-Medicaid-eligible activity code to the moment. PCG may also have asked additional questions to determine how to code the moment. The coded results were aggregated and used to allocate personnel costs to the Medicaid program. Results of random moment sampling must be sufficiently detailed to determine whether the claimed services and activities are Medicaid-eligible. Appendix C contains details of selected Federal school-based documentation requirements.

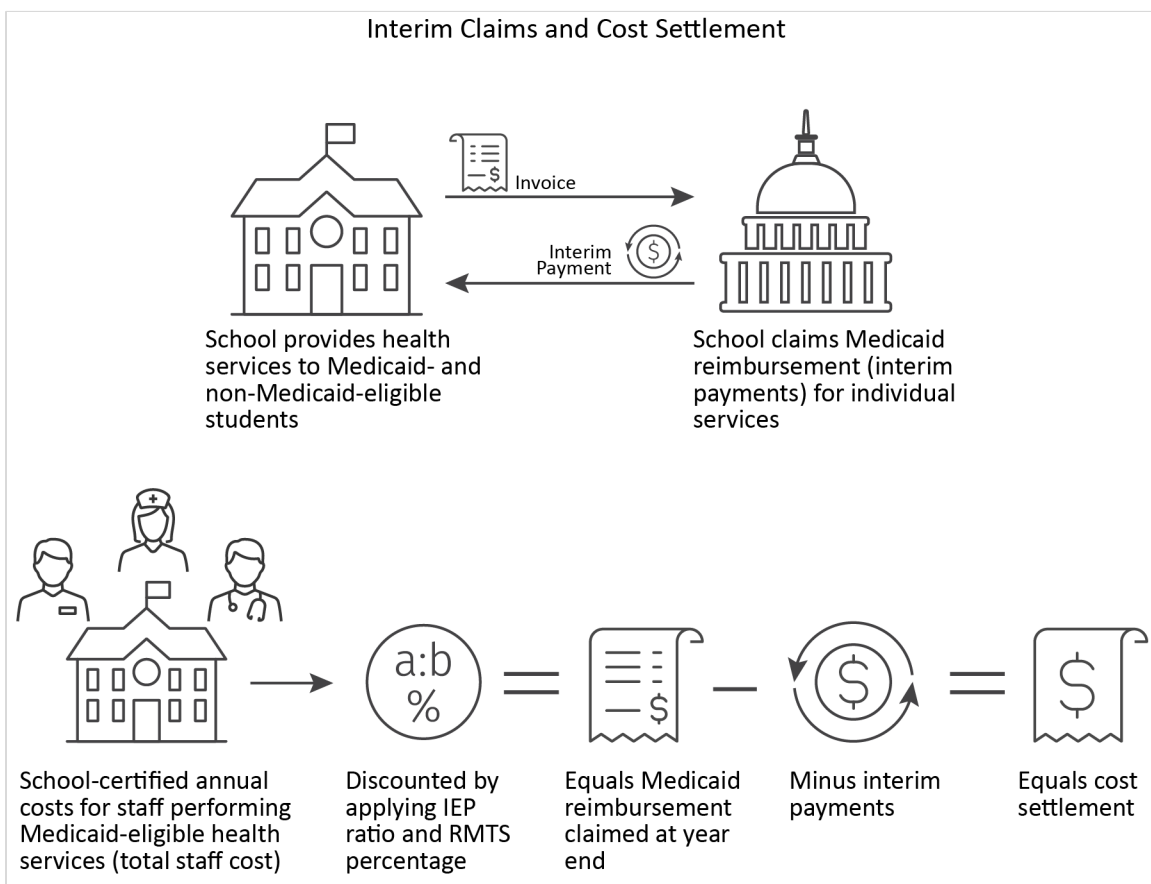
³ See [Joint Guidance on the Application of the Family Educational Rights and Privacy Act \(FERPA\) and the Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) to Student Health Records](#), issued by HHS and the U.S. Department of Education, and Federal regulations cited therein. Accessed on Jan. 12, 2026.

⁴ A participant was a school staff member randomly selected to participate in an RMTS.

Wisconsin's Medicaid Health Services Claims

The State agency obtains Federal reimbursement for school districts' actual costs.⁵ For health services costs, the State agency uses a multistep process that includes interim payments, end-of-year cost totals, and a cost settlement. Throughout each school year, the State agency makes interim payments to school districts for Medicaid-eligible health services provided to Medicaid-eligible students. End-of-year costs are calculated through a complex process discussed below. The process includes conducting quarterly statewide RMTSs and applying a percentage known as the IEP ratio. These final Medicaid-eligible costs are then compared to the interim payments to determine each school district's cost settlement. The figure that follows illustrates how the State agency determines each school district's cost settlement.

Figure: How the State Agency Calculates Cost Settlement



To calculate end-of-year costs, the Medicaid-eligible RMTS percentage is applied to total staff costs (i.e., Medicaid- and non-Medicaid-eligible costs) for school staff providing health services to determine the estimated total health services costs. To identify Medicaid-eligible costs, the IEP ratio is applied to the estimated total health services costs. This ratio is calculated by

⁵ Wisconsin uses funds certified as actual expenditures by the school districts as the State share to receive matching Federal Medicaid reimbursement.

dividing the number of students enrolled in Medicaid who have IEPs containing health services by the total number of students (Medicaid- and non-Medicaid-eligible) who have IEPs containing health services. The cost settlement is then calculated as the difference between Medicaid-eligible costs and interim payments for each school district for each school year.⁶

During our audit period, in every school year school districts' total Medicaid-eligible costs exceeded their total interim payments, resulting in the State agency claiming additional Federal Medicaid reimbursement. The State agency pays the school districts 60 percent of the final cost settlement amount. The State retains the remaining 40 percent.

Medicaid School-Based Administrative Activities

A State agency may claim Federal Medicaid reimbursement for activities necessary for the “proper and efficient administration” of its State plan (Social Security Act § 1903(a)(7)). These administrative activities are functions other than providing direct health services to Medicaid beneficiaries and may include Medicaid school-based activities provided by school districts (e.g., Medicaid outreach, assistance with processing Medicaid applications, and assisting beneficiaries with receiving access to Medicaid services).

Wisconsin’s Medicaid Administrative Claims

PCG also assists with quarterly MAC cost calculations. Each calculation is based on the same RMTSs used to calculate direct health service costs. However, the percentage used to allocate MAC costs is based on moments coded as administrative activities. The State agency pays the school districts 90 percent of Federal reimbursement. The State agency retains the remaining 10 percent. PCG receives an annual fixed contractual amount that is paid out of the State’s administrative budget.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$505,513,513 in Federal Medicaid payments for school-based services claimed for reimbursement in Wisconsin from July 1, 2018, through June 30, 2022 (school years 2019 through 2022). This included \$415,887,146 for Medicaid-eligible health services and \$89,626,367 for Medicaid administrative activities. We reviewed a stratified random sample of 300 random moments,⁷ each coded as a Medicaid-eligible “health service” or an

⁶ In Wisconsin, the school year runs from July 1 through June 30.

⁷ The sample unit is defined as a combination of an RMTS activity moment and a school district (moment-district combination).

“administrative activity.”⁸ We also reviewed the methods used to allocate health services costs to Medicaid.

We did not review the overall internal control structure of the State agency or PCG. Rather, we limited our review to those controls related to the State agency’s Medicaid health services claiming methodology and the MAC claiming methodology.

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, Appendix D contains our sample design and methodology, and Appendix E contains our sample results and estimates.

FINDINGS

The State agency improperly claimed Federal reimbursement through its Medicaid school-based services program. Specifically, the State agency claimed estimated unallowable Federal reimbursement totaling at least \$67 million for moments in its RMTSs that were not supported as Medicaid-eligible health services or Medicaid administrative activities, and for services by providers whom the State agency did not document as appropriately licensed before providing health services to students. In addition, the State agency may have improperly claimed \$387.9 million because it could not provide documentation to support ratios used to allocate costs to Medicaid. Finally, the State agency’s RMTSs did not include all days school staff members worked because the RMTSs did not include the beginning of the school year. As a result, the State agency may have improperly claimed \$454.9 million in Federal reimbursement.

These deficiencies occurred because the State agency’s contractor did not obtain students’ identifying information or IEPs and sufficient information from program participants to support that all moments coded as Medicaid-eligible were for Medicaid-eligible health services or Medicaid administrative activities. In addition, the State agency’s school districts did not document that they followed the State Medicaid plan and State agency guidance that require services to be provided by licensed providers. Further, the State agency’s contractor used complex cost allocation methods that were difficult or impractical to support with documentation or did not follow CMS guidance.

⁸ Specifically, we reviewed 195 activity moments coded as a Medicaid-eligible “health service” and 105 activity moments coded as a Medicaid “administrative activity.” See Appendix D for our sample design and methodology.

THE STATE AGENCY DID NOT SUPPORT THAT ALL MOMENTS CODED AS MEDICAID-ELIGIBLE WERE FOR MEDICAID-ELIGIBLE HEALTH SERVICES OR MEDICAID ADMINISTRATIVE ACTIVITIES

Federal regulations require documentation be maintained to assure that claims for Federal funds are in accordance with applicable Federal requirements and that documentation be made available for audits and examinations (42 CFR § 433.32, 45 CFR § 75.364). Federal regulations (42 CFR part 440) and the State Medicaid plan (Supplement 1 to Attachment 3.1-A) also require that certain services be provided by or under the direction of a licensed provider.

Of the 300 items in our sample, 218 moments were coded correctly, but 82 were not. The State agency's documentation did not support 82 of the moments. For these moments, we could not determine whether the moment covered Medicaid-eligible health services listed in the associated student's IEP or Medicaid administrative activities. Also, for two moments the State agency did not support that school districts followed licensure requirements stated in the State plan and State agency guidance.⁹

- For 82 moments with codes that were not supported:
 - The State agency's contractor did not collect students' names or other identifying information. Therefore, neither the contractor nor the State agency could identify students to obtain health records or IEPs to allow us to determine whether the associated services were Medicaid-eligible health services, Medicaid administrative activities, or educational services.
 - The State agency's contractor did not obtain sufficient information from the associated participant to ascertain whether the participant performed a Medicaid-eligible health service or a Medicaid administrative activity. For example, for one moment, a special education aide was sitting next to a student during math instruction. For these moments, the contractor did not ask the participant to describe the nature of the activity so that the contractor could determine whether it was part of a health care therapy. The contractor also did not ask whether these activities were included as health care therapies in the IEPs. The activities could have had an educational goal of developing academic ability or maintaining school order and, accordingly, would not be eligible for Medicaid payment.
- For two moments, the State agency documentation did not support that school districts followed the State Medicaid plan and State agency guidance that requires services to be provided by or under the direction of a licensed provider.¹⁰ For example, for one

⁹ The number of errors exceeds 82 because 2 moments described in the list below had more than 1 deficiency.

¹⁰ Wisconsin State Plan, Supplement 1 to Attachment 3.1-A, page 1.d-1.e; [ForwardHealth Online Handbook](#). Accessed on Jan. 12, 2026.

moment the individual reported that they were helping a student with his hearing device; however, the State agency did not provide documentation that the individual was providing services under the direction of a registered nurse. If a service provider is not supervised by an appropriately licensed provider, the quality of care the student receives could be diminished.

On the basis of our sample results, we estimated that the State agency claimed at least \$67,042,719¹¹ in unallowable Federal Medicaid reimbursement based on unsupported RMTS coding and services provided by unlicensed providers.

THE STATE AGENCY DID NOT PROVIDE DOCUMENTATION TO SUPPORT RATIOS USED TO ALLOCATE COSTS

States must provide adequate support to show that their Medicaid funds have been used according to Federal requirements and must maintain adequate source documentation to support their expenditures (45 CFR § 75.302). To be allowable, costs must be allocable to Medicaid (i.e., chargeable or assignable to Medicaid in accordance with relative benefits received) (45 CFR §§ 75.403(a), 75.405). Also, State Medicaid agencies must assure appropriate audits of records if payment is based on costs of services (42 CFR § 447.202).

The State agency could not validate or provide supporting documentation that the school districts' IEP ratios used to allocate Medicaid health services costs were correctly calculated. The State was unable to provide documentation to support the denominator used in the calculation of the IEP ratio because of Federal privacy requirements.¹² Specifically, Federal privacy requirements¹³ do not allow the State agency to review IEPs of students not enrolled in Medicaid,¹⁴ which would be required to audit the school districts' IEP ratios. The State agency did not provide an alternate verification method.¹⁵ Therefore, we could not audit the ratio.

¹¹ Specifically, we estimated the State agency claimed at least \$28,016,753 in unallowable health services and at least \$39,025,966 in unallowable Medicaid administrative activities. To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

¹² The denominator of the IEP ratio represents the total number of students (Medicaid- and non-Medicaid-eligible) who have IEPs containing health services.

¹³ See [Joint Guidance on the Application of the Family Educational Rights and Privacy Act \(FERPA\) and the Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) to Student Health Records](#), issued by HHS and the U.S. Department of Education, and the regulations cited therein. Accessed on Jan. 12, 2026.

¹⁴ School districts obtain consent to disclose information to the State agency from a Medicaid-enrolled student's parent before they submit associated interim claims for Medicaid payment. However, some parents of Medicaid-enrolled students do not consent to disclose information to the State agency. Additionally, school districts do not request consent from parents of students not enrolled in Medicaid.

¹⁵ CMS informed us that it believes that IEPs with redacted personally identifiable information may be produced to comply with Federal privacy protections.

The State agency's cost allocation method applied the IEP ratio to all health services costs claimed; therefore, \$387,870,393¹⁶ for health services costs is unsupported and may have been improperly claimed.

THE STATE AGENCY DID NOT SAMPLE MOMENTS DURING THE BEGINNING OF THE SCHOOL YEAR

Federal regulations state that RMTS results must be applied to the sample period, and the entire time period involved must be covered by the sample (45 CFR § 75.430(i)(5)(i)).

RMTSs performed by PCG, however, did not include days during the beginning of the school year when schools were in session. The Wisconsin Medicaid Administrative Claim (MAC)/School Based Services (SBS) Implementation Guide incorrectly states that CMS guidance does not require sampling during the July through September period.¹⁷ The State agency used time studies conducted in the prior three quarters (October through June) to allocate costs for the first quarter (July through September). As a result, the State agency may have claimed additional unallowable Medicaid school-based costs.¹⁸

CONCLUSION

The State agency may have improperly claimed an estimated \$454.9 million in Federal reimbursement through its Medicaid school-based program. The unallowable reimbursement was claimed for moments used in the State agency's RMTSs that were not supported as Medicaid-eligible health services or Medicaid administrative activities, and for services by providers who the State agency did not document were appropriately licensed before providing health services to students. In addition, the State did not provide documentation to support the ratios used to allocate costs to Medicaid. Finally, the State agency's RMTSs did not include all days worked by school staff members because the RMTSs did not include the beginning of the school year.

These deficiencies occurred because the State agency's contractor did not obtain students' identifying information or IEPs and sufficient information from program participants to support that all moments used in RMTSs and coded as Medicaid-eligible were for Medicaid-eligible health services or Medicaid administrative activities. In addition, the State agency's school districts did not document that they followed the State Medicaid plan and State agency guidance that require services to be provided by licensed providers. Further, the State agency's

¹⁶ This amount is the total Medicaid-eligible health services of \$415,887,146 less the estimated \$28,016,753 in unallowable health services.

¹⁷ CMS officials confirmed to us that they would expect an RMTS to include all days worked in a school year.

¹⁸ We are unable to quantify the effect of not including the first quarter in the RMTS.

contractor used complex cost allocation methods that were difficult or impractical to support with documentation or did not follow CMS guidance for claiming Medicaid school-based costs.

RECOMMENDATIONS

- We recommend that the Wisconsin Department of Health Services refund the estimated \$67,042,719 to the Federal Government related to moments that could not be supported as Medicaid-eligible health services or Medicaid administrative activities.
- We recommend that the Wisconsin Department of Health Services provide documentation that can reasonably support its allocation of health services costs to Medicaid or refund \$387,870,393 to the Federal Government.
- We recommend that the Wisconsin Department of Health Services ensure that its contractor obtains sufficient information so that the Wisconsin Department of Health Services can validate the contractor's coding of RMTS moments.
- We recommend that the Wisconsin Department of Health Services ensure that school districts verify and document that providers are appropriately licensed or under the direction of licensed providers before they provide health services to students.
- We recommend that the Wisconsin Department of Health Services develop an accurate, supportable method to identify Medicaid costs that can be verified with source documents.
- We recommend that the Wisconsin Department of Health Services revise its RMTSs to include the beginning of the school year.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally disagreed with our findings, disagreed with some recommendations, and described actions it has taken to improve compliance with Federal requirements. The State agency agreed in part with our first finding, disagreed with our second finding, and did not indicate whether it agreed or disagreed with our third finding. Specifically, for our first finding, the State agency believes that the contractor's coding was largely accurate, but it agrees that some moments should not have been coded as a Medicaid reimbursable activity without obtaining sufficient information through followup questions. The State agency did not agree with our second finding because it believes agreements it had with CMS allowed the use of self-reported IEP ratios for the purpose of calculating annual school-based costs. Also, the State agency says that CMS does not require the review of individual IEPs and that the collection of all student IEP data would raise significant privacy and security concerns. For our third finding, the State agency indicated it has

submitted a State plan amendment (SPA) to CMS that will replace the existing random moment sampling methodology.

Based on our review of the State agency's comments, we revised our determination for one sample moment, the related statistical estimate, and the financial recommendations. We maintain that our findings and recommendations as revised are valid.

A summary of the State agency's comments and our responses follows. The State agency's comments are included as Appendix F.

THE STATE AGENCY DID NOT SUPPORT THAT ALL MOMENTS CODED AS MEDICAID-ELIGIBLE WERE FOR MEDICAID-ELIGIBLE HEALTH SERVICES OR MEDICAID ADMINISTRATIVE ACTIVITIES

State Agency Comments

The State agency said it believes that the coding for our audit period was mostly accurate. It is also confident the contractor's improvements related to RMTS coding are sufficient for achieving accuracy in the coding process.

The State agency's review of unsupported moments identified by OIG indicated the following:

- Of the 22 moments coded as Medicaid-eligible health services, the State disagreed with 19.
- Of the 60 moments coded as Medicaid administrative activities, the State disagreed with 53.

Additionally, the State agency disagreed that services associated with three moments were provided by unlicensed providers. Specifically, for two moments, the State agency stated that unlicensed people may provide delegated nursing services as long as a registered nurse has delegated the nursing care. For one other moment, the State agency stated that the person providing speech therapy had changed her name and was licensed under her prior name.

The State agency agreed that the contractor should have conducted followup with the sampled participants for the remaining 10 moments. The State agency indicated that the contractor's expanded followup procedures will ensure that all coded moments fully comply with the CMS-approved RMTS Implementation Guide.

Finally, the State agency disagreed with our recommendation that its contractor obtain sufficient information for the State agency to validate the contractor's coding of moments, as that would require the State agency to collect student names and related IEP information in violation of Federal privacy requirements.

Office of Inspector General Response

We disagree with the State agency's assertion that 19 moments coded as Medicaid-eligible health services and 53 moments coded as Medicaid administrative activities are supported. The State agency did not provide any additional information to support that these moments were coded appropriately. Instead of addressing specific moments, the State agency included in its comments a description of the codes and examples of activities listed in the Implementation Guide.

The State agency asserted that two of the three moments with services performed by unlicensed providers were allowable. We agree that, according to the Wisconsin Department of Public Instruction, services designated as delegated nursing services can be provided by an unlicensed individual. However, for a service to be reimbursable for Medicaid, it must be a medical service classified as a delegated nursing act by a registered nurse and documented as such.¹⁹ The State agency did not provide documentation to show these moments met this requirement.

We agree with the State agency that one moment that was originally determined to be a license error is allowable. The State agency explained that the provider had changed her name. We were able to verify that the provider was licensed and qualified to provide speech therapy services during our audit period per the Wisconsin Department of Public Instruction website.

Based on the State agency's comments, we revised our determination for one moment, the related statistical estimate, and the financial recommendations.²⁰

We do not agree that our recommendation to require the State agency's contractor to obtain sufficient information to permit the State agency to validate the contractor's coding would require the State agency to violate Federal privacy requirements. CMS has informed us that IEPs with redacted personally identifiable information may be produced to comply with Federal privacy protections. The State agency can therefore design a process that uses redaction to maintain privacy and allow it to validate the contractor's coding.

THE STATE AGENCY DID NOT PROVIDE DOCUMENTATION TO SUPPORT RATIOS USED TO ALLOCATE COSTS

State Agency Comments

The State agency stated that collecting the names and IEP information for all students in Wisconsin would be an intrusion into the private details of students with special education

¹⁹ Wisconsin Admin. Code §§ N 6.03(3), DHS 108.02(4); [ForwardHealth Online Handbook](#).

²⁰ As a result, we also revised our finding and recommendation related to the State agency's use of unsupported ratios. See the calculation described in footnote 16.

needs. The State agency would have access to sensitive information that would go beyond the Medicaid program. Furthermore, the State agency indicated that CMS never required that IEPs be collected by the school districts and reviewed by the time study contractor at the moment of coding.

The State agency contended that the use of the IEP ratio to calculate annual SBS cost settlements is consistent with its agreement with CMS. CMS approved the State agency's SPA in 2011. The SPA describes the various steps in the calculation of total allowable costs, including the use of the IEP ratio in the calculation process. In addition, the State agency indicated that CMS did not require the State agency to review IEPs for the purpose of determining the numerators and denominators of the IEP ratios. According to the State agency, since it is required to administer the Medicaid program consistent with these binding agreements with CMS, it cannot be held to a retroactive standard regarding the verification of IEPs. The State agency stated that collecting all student IEP data would raise significant privacy and security concerns and that it would "run afoul" of the constraints of FERPA and HIPAA.

The State agency stated that, in the interest of alleviating OIG's concerns, it submitted a SPA to CMS that would change the way the State agency determines the IEP ratios. It will partner with the Department of Public Instruction to calculate IEP ratios instead of having school districts self-report the information. According to the State agency, this new CMS-approved methodology will add a layer of veracity to the IEP ratio that will address OIG's concerns.

Office of Inspector General Response

While the State agency followed the methodology in the approved 2011 SPA to calculate total allowable costs and the IEP ratio, Federal requirements state that States must provide adequate support to show that their Medicaid funds have been used according to Federal requirements and must maintain adequate source documentation to support their expenditures. Also, State Medicaid agencies must assure appropriate audits of records if payment is based on costs of services. We maintain that our findings and recommendations are valid because the State agency could not validate or provide documentation to support that the IEP ratios used to allocate Medicaid health services costs were calculated correctly.

While OIG understands the sensitive nature of IEP data, States must maintain and make available documentation to ensure claims for Federal funds are in accordance with applicable Federal requirements. Despite the limitations the State agency faces, it is obligated to provide documentation to support the accuracy of the IEP ratio. Otherwise, the proper percentage of total costs allocated to Medicaid cannot be determined. CMS has informed us that IEPs with redacted personally identifiable information may be produced to comply with Federal privacy protections. In its May 2023 guidance, CMS reinforced the importance of having

documentation available to support the IEP ratio and stated that use of de-identified or masked data is an option to meet these documentation requirements.²¹

We acknowledge the State agency's efforts to address and rectify the issues surrounding the use of the IEP ratio. CMS approved a SPA submitted by the State agency on August 18, 2025. The SPA states that the denominator will now be the "total number of students with an IEP identifying a covered service." However, we note that the current CMS-approved Implementation Guide states that the denominator will be the "audited total number of Special Education students with an IEP for each district." These two methodologies do not match and may still lead to future issues when using the IEP ratio to allocate costs.

THE STATE AGENCY DID NOT SAMPLE MOMENTS DURING THE BEGINNING OF THE SCHOOL YEAR

State Agency Comments

The State agency indicated that CMS approved the Wisconsin RMTS methodology first in 2011 and again in May 2020. Both versions outlined that a time study would not be conducted during the July-September period. The State agency is pursuing CMS approval to conduct a year-round time study. If approved, the new SPA would include all regular school days, including those during the July-September period. The State agency believes that this new SPA would resolve the OIG finding.

Office of Inspector General Response

While the State agency did previously submit its RMTS methodology to CMS in its Implementation Guide (not a SPA), CMS guidance in effect during the audit period stated that all days when school is in session must be included in the time study.²²

We commend the State agency's efforts to address this issue in order to become compliant with Federal requirements in future periods.

²¹ CMS, [Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming](#). Accessed on Aug. 13, 2026.

²² CMS, [Medicaid School-Based Administrative Claiming Guide](#), May 2003, p.42. Accessed on Aug. 13, 2026.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed \$505,513,513 in Federal Medicaid payments for school-based services Wisconsin claimed for reimbursement from July 1, 2018, through June 30, 2022 (school years 2019 through 2022). This included \$415,887,146 for Medicaid-eligible health services and \$89,626,367 for Medicaid administrative activities. We reviewed a stratified random sample of 300 random moments, each coded as a Medicaid-eligible “health service” or an “administrative activity.”²³ We also reviewed the methods used to allocate health services costs to Medicaid.

We assessed the reliability of the State agency’s claim data by reconciling them to the school-based services that the State agency claimed for Federal Medicaid reimbursement on its CMS-64 forms (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) and to cost reports school districts submitted to PCG. We determined the data to be sufficiently reliable for the purposes of this report.

During our audit, we did not review the overall internal control structure of the State agency, its contractor, or the Medicaid program. Rather, we limited our review to those controls related to the State agency’s Medicaid health services claiming methodology and the MAC claiming methodology.

We conducted our audit from October 2024 through March 2026. We performed audit work by reviewing the documentation the State agency provided to us electronically.

METHODOLOGY

To accomplish our objective, we:

- Reviewed applicable Federal and State requirements
- Held discussions with State agency officials to gain an understanding of the SBS program and school district cost reports
- Reviewed the Wisconsin MAC/SBS Implementation Guide
- Obtained and reviewed documents from the State agency that were used to calculate SBS program costs, including RMTS results and summarized school district cost reports

²³ Specifically, we reviewed 195 activity moments coded as a Medicaid-eligible “health service” and 105 activity moments coded as a Medicaid “administrative activity.”

- Reviewed final net settlements from the State agency that were used to claim costs for services provided from July 1, 2018, through June 30, 2022
- Reconciled interim claims reported on CMS-64 forms to interim claims from the State agency
- Reconciled the final net settlement reported on the State agency's cost settlement report to the amount reported as school-based health services on CMS-64 forms
- Reviewed Medicaid administrative activity costs claimed for services provided from July 1, 2018, through June 30, 2022
- Reconciled Medicaid administrative activity costs claimed to the CMS-64 forms
- Assessed the completeness and reliability of the random moment data provided by the State agency
- Joined the Medicaid-eligible coded activity moments to corresponding school districts so that each moment was listed once for each school district, resulting in a sampling frame of 18,487,427 unique moment-district combinations
- Selected a stratified random sample of 300 moment-district combinations from the sampling frame²⁴
- Reviewed the stratified random sample and, for each sample item:
 - Determined whether coding was supported by documentation provided
 - Determined whether the provider was adequately licensed to provide services
 - Determined the cost effect of any unsupported code on its corresponding school district for the sample item
 - Calculated the related unallowable claim amount for Federal reimbursement
- Estimated the total amount of overpayment for Medicaid school-based health services and administrative activities related to RMTS activity moment coding²⁵

²⁴ Each item in our sampling frame corresponded to a unique combination of an RMTS activity moment and a school district. See Appendix D for details on our sample design.

²⁵ See Appendix E for our sample results and estimates.

- 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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Pennsylvania Improperly Claimed \$551 Million in Medicaid Funds for Its School-Based Program</i>	<u>A-02-21-01011</u>	3/11/2024
<i>New Jersey's Medicaid School-Based Cost Settlement Process Could Result in Claims That Do Not Meet Federal Requirements</i>	<u>A-02-20-01012</u>	3/8/2022
<i>New York Improperly Claimed \$439 Million in Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures</i>	<u>A-02-18-01019</u>	7/20/2021
<i>Florida Received Unallowable Medicaid Reimbursement for School-Based Services</i>	<u>A-04-18-07075</u>	11/24/2020
<i>Nebraska Claimed Unallowable School-Based Administrative Costs Because of Improper Coding of Random Moment Timestudy Responses</i>	<u>A-07-19-03234</u>	8/14/2020
<i>New Jersey Improperly Claimed Tens of Millions for Medicaid School-Based Administrative Costs Based on Random Moment Sampling That Did Not Meet Federal Requirements</i>	<u>A-02-17-01006</u>	11/8/2019
<i>Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling To Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures</i>	<u>A-07-18-04107</u>	12/6/2018

APPENDIX C: SELECTED SCHOOL-BASED DOCUMENTATION REQUIREMENTS

To claim Federal reimbursement, the allocation of costs for Medicaid-eligible and non-Medicaid-eligible activities requires careful documentation of all work performed by certain school staff over a set period of time. This documentation is used to identify, measure, and allocate the school staff time that is devoted to services and activities reimbursable by Medicaid.²⁶

Federal reimbursement may be available for Medicaid-eligible health services included in a child's IEP. CMS's *Medicaid and School Health: A Technical Assistance Guide* states that a school must keep records that detail student-specific information regarding all services provided. Relevant documentation includes who provided the service and any required medical documentation related to the student's diagnosis or medical condition. This information is necessary in the event of an audit.²⁷

CMS's *Medicaid School-Based Administrative Claiming Guide* states that documentation of results must be sufficiently detailed to determine whether the claimed activities are necessary for the proper and efficient administration of the State plan. The burden of proof and validation of sample results remain the responsibility of the State agency. To meet this requirement, the time study documentation can include a narrative description of the Medicaid activity being performed, including student names or case information where applicable. Regardless of how the State validates sample results, it must maintain appropriate documentation for audit purposes.²⁸

²⁶ Wisconsin State Plan, Supplement 1 to Att. 3.1-A and Att. 4.19-B; the *Medicaid School-Based Administrative Claiming Guide*, May 2003; and the Wisconsin MAC/SBS Implementation Guide contain details of these requirements.

²⁷ CMS, *Medicaid and School Health: A Technical Assistance Guide*, August 1997.

²⁸ CMS, [Medicaid School-Based Administrative Claiming Guide](#), May 2003. Accessed on Aug. 13, 2026.

APPENDIX D: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 18,487,427 unique combinations of RMTS activity moments joined to the school districts to which PCG's RMTS results were applied to allocate costs for the period July 1, 2018, through June 30, 2022. Each RMTS activity moment coded as Medicaid-eligible was joined to every school district participating in the corresponding quarter to create a unique RMTS activity moment to school district combination (moment-district combination).²⁹

SAMPLE UNIT

The sample unit was defined as a moment-district combination.

SAMPLE DESIGN AND SAMPLE SIZE

We randomly selected 300 sample items according to the following stratified design:

Stratum	Range of Potential Financial Impact Amounts for Moment-District Combinations ³⁰	Frame Count	Sample Size
1	Combinations with potential direct health service impact amounts $\leq \$38.03$	11,466,750	65
2	Combinations with potential direct health service impact amounts $> \$38.03$ and $\leq \$179.33$	1,937,446	65
3	Combinations with potential direct health service impact amounts $> \$179.33$	320,913	65
4	Combinations with potential administrative activity impact amounts $\leq \$38.40$	4,434,510	35
5	Combinations with potential administrative activity impact amounts $> \$38.40$ and $\leq \$419.23$	306,413	35
6	Combinations with potential administrative activity impact amounts $> \$419.23$	21,395	35
Total		18,487,427	300

²⁹ The RMTS activity moments were coded as Medicaid allowable for either direct health services or administrative activities. The 18,487,427 moment-district combinations in the sampling frame included 13,725,109 direct health service moment-district combinations and 4,762,318 administrative activity moment-district combinations.

³⁰ Potential impact amounts were calculated by using the RMTS results and other applicable ratios to determine the potential impact each Medicaid allowable moment had on the total calculated Medicaid costs.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OIG/OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

Within each stratum, we sorted the units by moment date, school district to which the moment was assigned, last name of participant, first name of participant, key,³¹ and school district to which the moment was joined, and then consecutively numbered the sample units in each of the strata. After generating the random numbers for each stratum, we selected the corresponding frame units for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicaid cost overpayments for the direct health services portion of the sampling frame (strata 1 through 3). We also used OIG/OAS statistical software to estimate the total amount of Medicaid cost overpayments for the administrative activity portion of the sampling frame (strata 4 through 6). To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

³¹ The key is the quarter-year-moment number assigned to every moment.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Table 1: Medicaid Health Services Moment-District Combinations

Stratum	Frame Count	Sample Size	Unsupported Moment-District Combinations
1	11,466,750	65	4
2	1,937,446	65	10
3	320,913	65	8
Total	13,725,109	195	22

Table 2: Medicaid Administrative Activity Moment-District Combinations

Stratum	Frame Count	Sample Size	Unsupported Moment-District Combinations
4	4,434,510	35	18
5	306,413	35	20
6	21,395	35	22
Total	4,762,318	105	60

Estimated Unallowable Federal Medicaid Costs Claimed in the Sampling Frame³² (Limits Calculated at the 90-Percent Confidence Level)

Table 3: Medicaid Health Services Estimates

Point estimate	\$45,474,834
Lower limit	28,016,753
Upper limit	62,932,915

Table 4: Medicaid Administrative Activities Estimates

Point estimate	\$53,003,567
Lower limit	39,025,966
Upper limit	66,981,169

³² We estimated that the State agency claimed unallowable Federal reimbursement of at least \$67,042,719 (\$28,016,753 for unallowable health services and \$39,025,966 for unallowable Medicaid administrative activities).

APPENDIX F: STATE AGENCY COMMENTS



State of Wisconsin
Department of Health Services

Tony Evers, Governor
Kirsten L. Johnson, Secretary

Ms. Jennifer Webb
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Dear Ms. Webb:

This letter is in response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report (dated May 14, 2026) titled *Wisconsin May Have Improperly Claimed \$455 Million in Medicaid Reimbursement for Its School-Based Program* (Report Number: A-02-24-01020).

The draft report reflects the six years (May 2020 – May 2026) the OIG spent auditing the Wisconsin Department of Health Services' (DHS or Department) School-Based Services (SBS) and Medicaid Administrative Claiming (MAC) programs. The audit period reflected the school years 2017-18 through 2021-22.

The OIG made three findings in the report related to three areas:

- The Individualized Education Program (IEP) ratios used in the calculation of the annual SBS cost settlements,
- The coding of certain sampled moments pertaining to the annual statewide Random Moment Time Study (RMTS) for SBS and MAC, and
- The months covered as part of the statewide time study.

After careful review of the OIG report, DHS welcomes the opportunity to respond to the findings made in the report and outline inaccurate findings by OIG as well as describe the steps DHS has already taken to address some of the findings in the OIG report. You will find the department's response to each of the findings below:

OIG FINDING: THE STATE AGENCY DID NOT PROVIDE DOCUMENTATION TO SUPPORT RATIOS USED TO ALLOCATE COSTS

States must provide adequate support to show that their Medicaid funds have been used according to Federal requirements and must maintain adequate source documentation to support their expenditures (45 CFR § 75.302). To be allowable, costs must be allocable to Medicaid (i.e.,

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chargeable or assignable to Medicaid in accordance with relative benefits received) (45 CFR §§ 75.403(a), 75.405). Also, State Medicaid agencies must assure appropriate audits of records if payment is based on costs of services (42 CFR § 447.202).

The State agency could not validate or provide supporting documentation that the school districts' IEP ratios used to allocate Medicaid health services costs were correctly calculated. The State was unable to provide documentation to support the denominator used in the calculation of the IEP ratio because of Federal privacy requirements. Specifically, Federal privacy requirements do not allow the State agency to review IEPs of students not enrolled in Medicaid, which would be required to audit the school districts' IEP ratios. The State agency did not provide an alternate verification method. Therefore, we could not audit the ratio. The State agency's cost allocation method applied the IEP ratio to all health services costs claimed; therefore, \$385,987,251 for health services costs is unsupported and may have been improperly claimed.

DHS RESPONSE: The Department does not concur with this finding.

DHS contends that our use of self-reported IEP ratios for the purpose of calculating annual SBS cost settlements is consistent with, and a necessary part of, our binding agreements with the Centers for Medicare and Medicaid (CMS).

CMS approved DHS's SBS State Plan Amendment (SPA) on 10/31/11. The approved SPA identifies the various steps DHS must use in calculating total allowable costs. Step 4 in the process describes the use of the IEP ratios in the process:

4. Medicaid's portion of total direct services cost will be calculated.

The results of the previous step are multiplied by the ratio of the total number of IEP students receiving medical services and eligible for Medicaid to the total number of IEP students receiving medical services. One IEP ratio is applied to cost for all practitioner types.

[Number of Medicaid Students enrolled in Special Education with a prescribed medical service in their IEP] / [Total Number of Students enrolled in Special Education with a prescribed medical service in their IEP]

Wisconsin's CMS-approved RMTS Implementation Guide for SBS did not and does not impose any requirement on DHS to review each individual IEP when employing the IEP ratios for settlement calculation purposes:

[The district . . . will . . . determine the numerator in the equation above by identifying those students . . . that are Medicaid Eligible, Enrolled in Special Education and have a prescribed medical service documented in their IEP. They will provide this number, along with the total population of Special Education students with a medical service prescribed in their IEP to the contractor through

the submission of the Medicaid cost report. Districts will maintain documentation to support the data provided to the contractor.

As CMS did not require DHS to review IEPs for the purpose of determining the numerators and denominators in the IEP ratios and DHS is required to administer its program consistent with these binding agreements with CMS, DHS does not believe that the OIG can hold DHS to a retroactive standard regarding the verification of the individual IEPs.

Furthermore, the collection of *all* Wisconsin students' IEP data (regardless of whether the student is enrolled in Medicaid) would raise significant privacy and security concerns. Any DHS attempt to secure statewide access to IEPs would almost certainly run afoul of privacy constraints embedded in the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA). The OIG admits as much in its own finding:

The State was unable to provide documentation to support the denominator used in the calculation of the IEP ratio because of Federal privacy requirements. Specifically, Federal privacy requirements do not allow the State agency to review IEPs of students not enrolled in Medicaid, which would be required to audit the school districts' IEP ratios.

The OIG recognizes that privacy restrictions prevent DHS from obtaining IEPs related to non-Medicaid students (who represent the denominator in the IEP ratio). Meanwhile, our CMS-approved SPA and RMTS Implementation Guide for SBS require DHS to use that IEP methodology to calculate the denominator. As a result, DHS finds itself caught between two different standards – the CMS-approved one and the retroactive OIG one – with no obtainable path for resolving the contradiction.

However, in the interest of alleviating OIG's concerns, DHS submitted SPA changes to CMS on 5/28/25. One of the approved changes (approval date 8/18/25; effective back to 7/1/25) would alter the way DHS determines the IEP ratios. Rather than having school districts and charter schools self-report this information, DHS will now partner with the Wisconsin State Department of Public Instruction (DPI) to calculate these ratios. From Section 4.19B p. 16.e-2 of the CMS-approved SPA:

Medicaid IEP Ratio: The Medicaid IEP Ratio will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to an IEP. *The names and birthdates of students with an IEP identifying a covered service will be identified from the Fall Count Report and matched against the Medicaid enrollment file to determine the percentage of those that are enrolled for Medicaid.* The numerator of the rate will be the number of Medicaid enrolled students with an IEP identifying a covered service and the denominator will be the total number of students with an IEP identifying a covered service. The IEP ratio will be calculated for each LEA participating in the SBS program on an annual basis.

From p.20 of the CMS-approved Time Study Implementation Guide:

DHS will provide DPI the eligibility file that corresponds to the annual student data collection date utilized by DPI. DPI will match the eligibility file to the student file containing all Special Education students with an IEP for each school district. DPI will provide DHS with the number of Special Education students with an IEP that are eligible for Medicaid as a result of the match (numerator) and DPI will provide the contractor the audited total number of Special Education students with an IEP for each district (denominator).

Since school districts and charters schools must report this IEP data to DPI and since DPI vets the reported information, DHS believes that this change – as approved by CMS in 2025 – will confer an added layer of veracity to the IEP ratio process which would, in turn, meet the OIG’s concern that self-reported IEP ratios leave open the possibility for district and school error.

History of CMS approvals for Wisconsin’s SPA and RMTS Implementation Guide:

- Approval letter for State Plan Amendment signed by Verlon Johnson, Associate Regional Administrator, 10/31/11 (effective to 7/1/09)
- Approval letter for RMTS Implementation Guide signed by Verlon Johnson, Acting Regional Administrator, 12/21/11
- Approval letter for RMTS Implementation Guide signed by Todd McMillion, Director, Division of Reimbursement Review, 5/18/20
- Approval letter for RMTS Implementation Guide signed by Nicole McKnight, Acting Director, Division of Program Operations, 8/19/25
- SPA change materials submitted to CMS on 3/27/26. DHS is awaiting final approval from CMS.

OIG FINDING: THE STATE AGENCY DID NOT SUPPORT THAT ALL MOMENTS CODED AS MEDICAID-ELIGIBLE WERE FOR MEDICAID-ELIGIBLE HEALTH SERVICES OR MEDICAID ADMINISTRATIVE ACTIVITIES.

Federal regulations require documentation be maintained to assure that claims for Federal funds are in accordance with applicable Federal requirements and that documentation be made available for audits and examinations (42 CFR § 433.32, 45 CFR § 75.364). Federal regulations (42 CFR part 440) and the State Medicaid plan (Supplement 1 to Attachment 3.1-A) also require that certain services be provided by or under the direction of a licensed provider.

Of the 300 items in our sample, 217 moments were coded correctly, but 83 were not. The State agency’s documentation did not support 82 of the moments. For these moments, we could not determine whether the moment covered Medicaid-eligible health services listed in the associated student’s IEP or Medicaid administrative activities. Also, for three moments the State agency did

not support that school districts followed licensure requirements stated in the State plan and State agency guidance. [Note: The number of errors exceeds 83 because 2 moments described in the list below had more than 1 deficiency.]

- For 82 moments with codes that were not supported:
 - o The State agency's contractor did not collect students' names or other identifying information. Therefore, neither the contractor nor the State agency could identify students to obtain health records or IEPs to allow us to determine whether the associated services were Medicaid-eligible health services, Medicaid administrative activities, or educational services.
 - o The State agency's contractor did not obtain sufficient information from the associated participant to ascertain whether the participant performed a Medicaid-eligible health service or a Medicaid administrative activity. For example, for one moment, a special education aide was sitting next to a student during math instruction. For these moments, the contractor did not ask the participant to describe the nature of the activity so that the contractor could determine whether it was part of a health care therapy. The contractor also did not ask whether these activities were included as health care therapies in the IEPs. The activities could have had an educational goal of developing academic ability or maintaining school order and, accordingly, would not be eligible for Medicaid payment.
- For three moments, the State agency documentation did not support that school districts followed the State Medicaid plan and State agency guidance that requires services to be provided by or under the direction of a licensed provider. For example, for one moment the individual reported that they were providing speech therapy to a student; however, the State agency did not provide documentation that the individual was a licensed speech language therapist or under the direction of a licensed speech language pathologist. If a service provider is not adequately qualified to provide services, the quality of care the student receives could be diminished.

On the basis of our sample results, we estimated that the State agency claimed at least \$68,925,861 in unallowable Federal Medicaid reimbursement based on unsupported RMTS coding and services provided by unlicensed providers.

DHS RESPONSE: The Department concurs in part with these findings and has taken proactive measures to address these findings.

Unsupported Moments Claim

The OIG's proposed remedy for resolving what it refers to as 'unsupported moments' in the RMTS coding process would involve the same solution it proposed for the IEP ratio issue: the collection of student names (or other identifying information) and related IEP details (if applicable).

As explained earlier in the department's IEP Ratio response, collecting the names and IEP information for all students in the State of Wisconsin (regardless of whether they are Medicaid-eligible or not) would represent a dramatic intrusion of the State into the private details and affairs of students with Special Education needs. If put into effect, DHS would now have access to sensitive medical documentation that would sprawl far beyond the borders of Wisconsin's Medicaid program. Furthermore, CMS has never imposed a requirement on DHS to collect IEPs from school districts and then have the time study contractor review these IEPs at the moment of coding.

DHS believes that the contractor's coding for the 2017-2022 audit period was largely accurate. In addition, DHS is confident that the contractor's implemented improvements in relation to how RMTS moments are coded are sufficient for achieving accuracy in the coding process.

Improperly Coded Moments The OIG provided DHS with an Excel file indicating which coded moments were in dispute. (83 moments were related to coding and 3 moments were related to licensure). In two instances, a moment was disputed for both coding and licensure reasons.

FY	Total Number of Moments Sampled	Total Number of Moments Coded as Reimbursable	Total Number of Moments Coded as Reimbursable Reviewed by OIG	Percentage of Reimbursable Moments Reviewed by OIG	Moments Flagged by OIG as Errors	Percentage of Reimbursable Moments Flagged by OIG as errors	Moments DHS Agrees Should Not Have been Coded Reimbursable	Percentage of Reimbursable Moments Flagged by OIG as Errors in Agreement
FY18	27,600	9,970	not provided		7	0.070%	1	0.010%
FY19	27,600	9,824	not provided		18	0.183%	3	0.031%
FY20	18,600	6,562	not provided		17	0.259%	2	0.030%
FY21	28,200	9,784	not provided		18	0.184%	3	0.031%
FY22	28,400	10,792	not provided		23	0.213%	1	0.009%
Total	130,400	46,932	300	0.639%	83	0.177%	10	0.021%

Upon further review of the 83 disputed coding moments, DHS believes that 73 moments were coded correctly and were coded in alignment with CMS-approved RMTS Implementation Guide. These coded moments clearly show an activity that is reimbursable either as (a) Direct Medical Service or (b) Medicaid Administrative Claiming and fall into several categories:

- **19 Flagged Moments Related to RMTS Code G1**

The OIG flagged 19 moments coded to RMTS Code G1 as 'unsupported'. DHS disagrees with this characterization. The definition of Code G1 (CMS-approved RMTS Implementation Guide, pp. 35-37) is as follows:

Code G1 - TIME SPENT PERFORMING MEDICAL SERVICES LISTED IN A CHILD'S IEP AND SUPPORTING SERVICES DIRECTLY RELATED TO PERFORMING MEDICAL SERVICES LISTED IN A CHILD'S IEP (INCLUDES FACE-TO-FACE AND CLINICAL NON-FACE-TO-FACE)

Summary:

Time spent on all IEP Medical school-based services and direct supporting services that meet the following criteria:

- Medical services listed below
- Performed by a person who meets the requirements under the SPA 05-015.
- In the child's IEP

Example Activities Listed:

- IEP Medical Services Time When the Child is Present (Direct Face-to-Face Time) (See CMS-approved RMTS Implementation Guide, pp. 36-37)
 - IEP Medical Services Time that is an Integral Part of or Extension of a Medical Service Listed in the Child's IEP (Clinical Non-Face to Face time) (See CMS-approved RMTS Implementation Guide, pp. 36-37)
 - Attendant Care Services (See CMS-approved SPA, Attachment 3.1-A pp.1.d.)

While the OIG identified these moments as 'coded inappropriately', DHS believes the moments were coded correctly under the following CMS-approved guidelines.

- **53 Flagged Moments Related to RMTS Code B and 1 Flagged Moment Related to RMTS Code C1**

The OIG flagged 53 moments coded to RMTS Code B and 1 moment coded to RMTS Code C1 as 'unsupported'. DHS disagrees with this characterization. For instance, here is the definition of Code B (CMS-approved RMTS Implementation Guide, pp. 25-26):

B. MEDICAL COORDINATION OF CARE: COORDINATION AND MONITORING OF HEALTH CARE SERVICES

Summary

- Referrals for health care services.
- Coordination and monitoring of health care services.
- Early identification and referral of students with special health care needs to HealthCheck services.

(Note: Use this category to record activities related to the coordination and monitoring of **all health care services for all students**, regardless of their Medicaid eligibility status.)

Example Activities Listed:

- Referrals for Health Care Services (See CMS-approved RMTS Implementation Guide, p. 25)
 - Coordination of Health Care Services (See CMS-approved RMTS Implementation Guide, p. 25)
 - Monitoring and Follow-up of Health Care Services (See CMS-approved RMTS Implementation Guide, pp.25-26)

While the OIG identified these moments as ‘coded inappropriately’, DHS believes the moments were coded correctly under CMS-approved guidelines.

- **Remaining 10 Moments Flagged as Improperly Coded**

DHS acknowledges that the department’s contractor should have conducted additional follow-up with the sampled participant for the remaining 10 moments to clarify further. Those moments should not have been coded to a reimbursable activity absent information more clearly supporting a reimbursable moment.

Since the point in time in which these moments were coded, the contractor has expanded its follow-up procedures relative to submitted moments. Under the expanded follow-up procedures, coders will ask for additional information in instances where the proper coding of the moment would benefit from further questioning on the part of the coder. By modifying the process in this way, the department is ensuring that all coded moments are in full compliance with the CMS-approved RMTS Implementation Guide.

- **Flagged 3 Moments Related to Unlicensed Providers**

DHS disagrees with the three findings related to providers not having the correct licensure for the rendered service the provider described.

- The first contested moment related to a licensed Speech Language Pathologist in Pecatonica Area School District. In response to the moment dated 1/29/21, respondent * [REDACTED] indicated that her Job Title was ‘Therapist’, and her Job Category was ‘Speech-Language Therapist (DS)’.

DHS believes the confusion regarding the respondent’s licensure relates to the respondent changing her last name. The Wisconsin State Department of Public Instruction’s (DPI) Licensing Team believes [REDACTED] and [REDACTED] are one and the same. [REDACTED] was reported in Pecatonica Area School District that school year (2020-2021) and her Tier III lifetime license for school Speech-Language Practice remains valid.

- The second and third contested moments pertained to staff members providing Delegated Nursing Services (DNS):
 - One DNS provider’s response to the sampled moment reflected delivery of student medication (per an IEP).
 - The other DNS provider’s response to the sampled moment involved assistance to a Special Education student with their hearing aid device (per an IEP).

According to DPI, Delegated Nursing Services do not have specific licensure requirements. As long as a registered nurse has delegated the nursing care or medical procedure per the Nurse Practice Act, the care or procedure can be done by an unlicensed individual.

* **OIG Note:** The deleted text has been redacted because it is personally identifiable information.

OIG FINDING: THE STATE AGENCY DID NOT SAMPLE MOMENTS DURING THE BEGINNING OF THE SCHOOL YEAR

Federal regulations state that RMTS results must be applied to the sample period, and the entire time period involved must be covered by the sample (45 CFR § 75.430(i)(5)(i)).

RMTSs performed by PCG, however, did not include days during the beginning of the school year when schools were in session. The Wisconsin Medicaid Administrative Claim (MAC)/School Based Services (SBS) Implementation Guide incorrectly states that CMS guidance does not require sampling during the July through September period. The State agency used time studies conducted in the prior three quarters (October through June) to allocate costs for the first quarter (July through September). As a result, the State agency may have claimed additional unallowable Medicaid school-based costs.

DHS RESPONSE: The Department has submitted a SPA to CMS which reflects existing practice and will address this funding.

Wisconsin is pursuing CMS approval to conduct a year-round time study with the submission of WI-26-0009. CMS is reviewing the SPA and the department hopes that the year-round time study change will be effective 7/1/26. As described below, the recent changes to our SPA will bring the department into compliance with CMS guidance on the matter, which will also resolve this OIG finding.

Furthermore, DHS disputes the OIG's characterization of the history surrounding a July – September time study. CMS approved the Wisconsin MAC/SBS RMTS methodology submitted (pursuant to approved SPA #09-013) in December 2011. CMS approved the time study methodology a second time in May 2020 when DHS requested permission from DHS to suspend the time study during the 2020 COVID State of Emergency.

Both of these CMS-approved versions addressed the July – September period. The CMS-approved time study clearly outlines on page 7 that a time study will not be conducted during the July – September period:

“Wisconsin will use an average of the three (3) previous quarter’s time study results to calculate a claim for the July-September period. This is in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, page 42.”

When DHS requested a COVID-related change to its RMTS Implementation Guide in 2020, CMS did not voice any objections to existing practice related to a July – September time study. In 2025, DHS filed a SPA request with CMS to expand the SBS program to cover Free Care Services. CMS approved this SPA change with an effective date of 7/1/25. As part of that approval process, CMS allowed the continuation of existing RMTS practice in which a time study would not be required during the July – September period.

In 2026, DHS submitted an additional SPA to CMS (with a requested effective date of 7/1/26), which will bring Wisconsin SBS into full compliance with the mandated requirements outlined

in 2023 CMS guidance. The approved SPA request would include the inclusion of all regular school days in the time study, including those during the July – September period.

History of CMS approvals for Wisconsin's RMTS Implementation Guide:

- Approval letter signed by Verlon Johnson, Acting Regional Administrator, 12/21/11
- Approval letter signed by Todd McMillion, Director, Division of Reimbursement Review, 5/18/20
- Approval letter signed by Nicole McKnight, Acting Director, Division of Program Operations, 8/19/25
- SPA change materials submitted to CMS on 3/27/26. DHS is awaiting final approval from CMS.

Thank you for the opportunity to respond to the OIG's three findings regarding our SBS program and outline in detail why some of the OIG report findings are factually inaccurate as well as describe the proactive steps DHS has already taken to address the findings which we concur with in the OIG report. If the OIG should have any additional questions, those questions should be directed to Krista Willing, Assistant Administrator, System/Fiscal/Operations Area, Division of Medicaid Services, at (608) 266-2469 or KristaE.Willing@dhs.wisconsin.gov.

Sincerely,



Kirsten Johnson
Secretary

cc: Calvin Jones
Latoya Pettway

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U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov