



State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

Joint Legislative Audit Committee

**Testimony of Secretary Dennis G. Smith on
An Evaluation of Medical Assistance Program
Report 11-15**

February 1, 2012

Senator Cowles, Representative Kerkman, and members of the Joint Audit Committee, I am pleased to appear before you today to discuss the Audit Bureau's evaluation of the Medicaid program, issued in December 2011.

Let me begin by thanking the LAB staff for the conscientious and thorough approach on the audit and for their thoughtful recommendations. I appreciate the courtesy and professionalism that they exhibited during the course of their review.

As the audit illustrates, Medicaid is a large and complex program that funds health coverage for low-income families, seniors, and people with disabilities. It encompasses a number of separate eligibility categories, benefit packages, and service delivery systems, including BadgerCare Plus, Family Care, nursing home services, prescription drugs, and other services.

These programs now cover one out of every five Wisconsin residents and one of every three children, with expenditures totaling \$7 billion per year. As the audit report indicates, expenditures rose by 42% from FY 2007 through FY 2010, driven by state decisions to expand eligibility, recession-fueled enrollment growth, and rate increases supported by provider taxes. On top of all of this, the state, as occurred in all states, was hit on July 1, 2010 with a significant decline in federal matching funds. The Governor and Legislature responded by injecting \$1.2 billion GPR into Medicaid in this biennial budget to cover the majority of this growth and the loss of federal funding.

If this rate of growth were to continue, it would consume all new available state government resources, crowding out priorities for education, transportation, public safety and other programs for years on end. This mirrors the challenge we face nationwide regarding rapid growth in overall health expenditures, which harms business competitiveness and limits our ability to invest for the future.

To provide some context to the size and complexity of the program, consider that:

- Medicaid will spend about \$14 billion (All Funds) this biennium, which is about \$2,500 per year for every taxpayer in the state.
- The program spends about \$19 million in state and federal funding per day. That means that over a million dollars will have been spent during my time with you today.

Growth in Medicaid Enrollment and Expenditures

Medicaid, of course, does not exist in a vacuum. The overall economy and the cost of health care have an impact on enrollment and the per service costs. Chart 1 (attached) shows the growth of Medicaid enrollment since January 2000. Imposed upon the enrollment is the rate of unemployment and periods of economic recession. The relationship between unemployment and enrollment is readily apparent, but enrollment also continued to grow in periods in which unemployment declined.

But increased enrollment does not provide the full explanation for the growth in Medicaid expenditures.

Health care spending as a percentage of our gross domestic product (GDP) continues to increase. According to the annual report on National Health Expenditures (NHE) recently released by the Centers for Medicare and Medicaid Services (CMS), over the 15-year period 2006-2020 per capita health care expenditures grew and are projected to grow faster than the economy as a whole in all but three years.¹ Medicaid costs therefore would be expected to increase simply because all health care costs continue to rise. However, the decisions states make in their Medicaid programs certainly affect total costs throughout the health care system.

According to a recent study by the Office of the Actuary, CMS estimates that in 2009, the per capita personal health care spending for the nation as a whole was \$6,815.² Spending on health care is affected by a number of factors including age, health status, income, and insurance status. Per capita spending was lowest in Arizona and Georgia, both at 80 percent of the national figure. Among states, Massachusetts had the highest per capita spending at \$9,278 or 136 percent of the national amount.

Wisconsin per capita spending was at \$7,233 or 6 percent higher than the national figure. The average annual growth rate for Wisconsin over the period 2004-2009 was 4.7 percent, which matched the national average.³

But what does all of this mean for how we should be looking at Medicaid? As shown in Table 1 (attached), Wisconsin spending per Medicaid enrollee in 2004 was \$5,924 compared to the national spending per Medicaid enrollee of \$6,089 or 97 percent of the national amount.⁴

¹ See table 1, <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>

² Exhibit 2, https://www.cms.gov/MMRR/Downloads/MMRR2011_001_04_A03.pdf. E6.

³ Exhibit 2., Ibid. E7.

⁴ Exhibit 4. Ibid. E12.

Between 2004 and 2009, Medicaid spending per enrollee grew at an average annual rate of 5.1 percent compared to the national Medicaid growth rate of 2.3 percent. In 2009, Wisconsin spending Medicaid per enrollee had reached \$7,584 or 111 percent of the nation's amount.

Regional Medicaid Per Enrollee Spending

Because there are so many differences in Medicaid programs across the states, the usefulness of national data has its limits. Table 1 displays what has occurred regionally, comparing Wisconsin to Illinois, Indiana, Iowa, Michigan, Minnesota, and Ohio. Minnesota spends the greatest amount, \$9,851, on a Medicaid per enrollee basis followed by Wisconsin at \$7,584.

Michigan Medicaid spends nearly \$1,900 per enrollee less than Wisconsin. This difference of 33 percent is not readily apparent. The two states are similar enough in such factors such as percentage of population over age 65, median household income, and percentage of population below the federal poverty level, we should look for other explanations as to why the difference in Medicaid expenditures is so significant.

We can see the differences over a period of time as well. In 1998, Wisconsin spent \$6,451 per enrollee, the highest amount in the region. But between 1998 and 2004, the state actually reduced its spending per enrollee (even though the total budget continued to grow due to increased enrollment). More recently, however, Medicaid spending per enrollee in Wisconsin grew at an average annual rate of 5.1 percent in the period 2004-2009. The average annual rate changes for this period by state are:

- Illinois: 2.1 percent
- Indiana: -0.7 percent
- Iowa: -1.6 percent
- Michigan 1.5 percent
- Minnesota 1.7 percent
- Ohio: 0.3 percent
- Wisconsin: 5.1 percent

In sum, between 2004 and 2009, Wisconsin Medicaid per capita spending grew at a faster rate than total health care spending in the state; faster than the national Medicaid per capita spending; and faster than each of our neighboring states in the region. The one exception among various comparisons is the increase in per enrollee cost in the Medicare program. On a per enrollee average annual rate basis, Medicare spending in Wisconsin has increased faster than Medicaid over this period.

To lower the rate of growth in per capita costs, which would be more in line with our neighbors, the Department is pursuing a range of efficiency measures. These include aligning Medicaid coverage more closely with coverage working families receive in the private sector, implementing "medical home" care models to improve care for people with complex needs, and reforming payment methods to providers, not just reducing their rates.

DHS Initiatives

The key to lowering the rate of growth in health care over the long term is to find ways to reform Medicaid's service delivery and reimbursement structure from a volume-based model to one based on value and health outcomes.

Many of our initiatives are pending federal approval or are still in the design phase, but we have already implemented several: brand name prescription drug reimbursement reform, enhancing third party liability identification, and changing policy for reimbursing the patient's share of Medicare Part A claims for patients who are also Medicaid eligible. As you know, we also have contracted with a provider to manage and coordinate non-emergency transportation services for Medicaid enrollees across the state, which has already generated savings and efficiencies. We project that as a result of the initiatives that have been implemented just thus far will save approximately \$36 million GPR over the biennium.

The Department is pursuing several "medical home" initiatives for individuals with special care needs, including foster children, pregnant women, individuals diagnosed with HIV/AIDS, individuals with mental illness, individuals exiting the criminal justice system, and individuals with chronic conditions. Medical homes focus on coordinating care to improve the patient's health outcomes and avoid unnecessary hospitalizations and other costly medical interventions. A "medical home" is not a physical place, it is a method of delivering services in a coordinated manner. More than half of all Medicaid expenditures are made on behalf of enrollees with complex care needs comprising 5% of total enrollment.

We are also aggressively pursuing the "Virtual PACE" initiative to coordinate the care of seniors and people with disabilities who receive long term care services funded through Medicaid and their primary and acute care services funded from Medicare. The idea is to combine the two funding streams and care systems to support the person holistically and to eliminate cost shifting from Medicare to Medicaid. One of the keys to creating an integrated model that will be better for beneficiaries and save money for both the state and the federal government is the Medicare data. We are pressing CMS for the data we need to assess risk and develop sound rates.

Administrative Costs

In terms of Medicaid administrative expenditures, the LAB raised important concerns about the rapid increase in expenditures, the heavy reliance on contract staff, and seriously insufficient internal fiscal controls that occurred before 2011. Again, let us look for some explanations for this growth.

It should be noted that significant growth in administrative costs have tracked the significant growth in benefit expenditures. Table 6 on page 22 of the audit indicates that administrative costs increased by the same percentage as benefit costs since FY 2007.

Much of the growth in the administrative budget stems from eligibility expansions implemented in the last several years. As enrollment grows, it must be expected that the administrative structure will as well. Chart 2 (attached) illustrates the relationship between enrollment and administrative costs.

The gap between enrollment and administrative expenditures in FY 2010 had to be covered by increased appropriations in the budget enacted last year. As noted in the report, the Department entered into administrative contracts without always considering available spending authority and relied heavily on contracted staff. The number of contract staff at our largest vendor, HP Enterprises, grew to over 1,123 positions in 2011. Despite the increase, administrative costs represent only 4% of the total Medicaid budget.

Improving Financial Management

Since last January, we have taken several steps to better manage and control our administrative costs:

- Consistent with the LAB recommendations, the Department has implemented a new process by which the Division of Enterprise Services will independently review all administrative contract amendments for funding availability and to verify that we have purchasing authority to procure the services. DHS is formalizing this process in its Accounting Policies and Procedures Manual.

This process change is vital to ensuring that we fully understand the financial implications of procuring additional services before we sign a contract amendment. This information will help us better manage the Medicaid administrative budget by setting service priorities.

- Over the last year, we have been conducting a thorough review of all existing Medicaid administrative contracts in the Division of Health Care Access and Accountability to assess their ongoing value and priority.
- As provided by Act 32, we have been working with counties to implement a regionalized, more efficient, income maintenance program for determining Medicaid and FoodShare eligibility, which was implemented January 1st. As part of that process, DHS is phasing down the Enrollment Services Center, eventually eliminating 335 contract staff. Implementation of the new regional model has gone very smoothly, with counties forming 10 consortia to pool resources to deliver customer service to applicants in a more efficient way.
- The Department plans to rebid existing contracts as they come up for renewal over the next few years. The competitive bid process will help us get the best price and best quality for our dollars.
- We will continue to seek opportunities to reduce contract staff with state staff where cost effective. For example, in September, the Joint Committee on Finance approved the conversion of 10.5 contract staff to state positions. We expect to submit another request to the committee in March.

We need to continue to rely on the expertise of private partner vendors, as every state does, to deliver cost effective services, comply with the federal requirements, strengthen program integrity and customer service. Our goal is to procure such assistance at the best price. Table 3

(attached) is a listing of our administrative services contracts that includes their procurement cycles.

In the past year, the Department created the Office of Inspector General, reporting directly to me. The office is injecting renewed focus and vigor to the Department's fraud prevention and detection efforts, especially for Medicaid. The 2011-13 biennial budget gave DHS funding for 15 additional Medicaid provider auditors as well as 19 FTE to expand recipient fraud detection and prevention efforts for both Medicaid and FoodShare.

Thus far, the OIG has identified weaknesses in third party liability procedures, increased involvement with the U. S. Attorney's Health Care Task Force, established a DHS complaint hotline, improved alliances with state and federal law enforcement agencies, and increased the number of Medicaid provider audits and recoveries. Overall, the OIG has increased the number of audits from 1,493 in CY 2010 to 1,750 in CY 2011, with audit recoveries increasing by more than \$4 million. Since December, we have received 183 complaints to the audit hotline.

The Department has also expanded efforts to educate providers on their responsibility to properly bill third party insurance for patient care before submitting claims to Medicaid. Federal law generally requires that Medicaid should be the payer of last resort. The Department plans to contract for recovery audit services later this year to further expand our program integrity capacity.

In addition, we understand that Representative Nygren has circulated a bill that would allow the Department to electronically verify assets of individuals applying for Medicaid. Currently, applicants are permitted to self-report assets, which may not be up-to-date. This legislation will allow the Department to work with over 400 financial institutions across Wisconsin to ensure eligibility determinations are accurate.

Medicaid has voluminous policies documenting what services for which providers may bill the program. The Medicaid payment system has various electronic controls to detect and deny claims that are contrary to our billing practices. With the implementation of the new Medicaid Management Information System (MMIS) in October of 2008, up to 100 edits to monitor provider billing were "turned off" for various reasons. We are systematically reviewing them to decide which should be "turned back on" to properly enforce current policy. Examples of such edits include:

- Starting in FY12, claims balancing edits were turned back on to ensure the payment accuracy of crossover claims.
- In January 2012, the Department turned back on edits related to National Provider Identification to ensure proper payment by more accurately identifying providers.
- Currently, the Department is in the process of turning back on referring provider edits to ensure that individuals have a physician referral to receive services.
- In December 2009, a policy was implemented to restrict providers from billing Medicaid twice for an emergency room visit that lasts from 11:00 p.m. to 1:00 a.m., technically

over two days. However, this was never implemented in the system. The Department is currently implementing a systematic way to enforce this policy.

- Finally, the Department is taking steps to ensure that providers stop submitting fee-for-service claims to Medicaid for services provided after the date a patient enrolls in an HMO.

In addition to the claims edits and audits that the system employs, on a daily basis the Bureau of Fiscal Management approves the release of all Medicaid payments and provides oversight of the fiscal payment system. Over the past year, the Department has increased efforts to ensure the fiscal integrity of the payment process. Efforts include hiring additional staff to monitor the payment process, reviewing the internal controls used to monitor the fiscal agents' financial processing, ensuring that expenditures are funded by the appropriate fund sources, and ensuring that payments are properly reported for federal claiming.

We will continue to pursue systems changes to enable BadgerCare Plus recipients who have been determined eligible to choose and enroll in an HMO quickly. On the opposite end, we are also pursuing system changes to stop payments to HMOs on the day a person exits the program, rather than at the end of the month.

Recommendations on Reporting

The audit includes a number of recommendations regarding the Department's budget and fiscal practices, including creating appropriations for each Medicaid subprogram, which I am pleased to address.

The Department has a very robust MMIS, which we rely on a daily basis for forecasting, rate setting, program integrity, and other analytical tasks. As an example, I brought a copy of our most recent quarterly report to CMS. Replicating that detailed data in the state's separate accounting system is challenging, because the program is so multi-faceted.

Over the years, I have served in both the legislative and executive branches of government. I fully appreciate your need for accurate, timely, and comprehensive information in order to discharge your responsibilities. We believe it is important that you have access to the Medicaid budget in greater detail.

I would recommend against creating separate Chapter 20 appropriations for each Medicaid subprogram or service category because of the many interdependencies between enrollees and service expenditures. For example, expenditures for nursing homes are affected by Family Care and home and community-based waiver enrollment. DHS directly manages prescription drug reimbursement for both managed care and fee for service enrollees. An increase in pharmacy costs or physician services can be a positive indication that enrollees are seeking services in more appropriate and more cost effective ways.

However, it would be feasible and beneficial to identify expenditures at the "sub-appropriation" level within the state budget and accounting systems, in a way that would be more readily accessible for LAB and LFB to review. Accordingly, in this biennium, we will resume the presentation of expenditures by service category that had been previously discontinued.

Conclusion

The Medical Assistance audit was an important contribution to improving the management of the \$7 billion Medicaid program. I hope that my remarks appropriately convey our mutual recognition that improvement is needed and our determination to safeguard the resources entrusted to us.

I would like to again thank the LAB for the time and effort they devoted to the audit, and I look forward to continuing to work with the Legislature to improve the efficiency, transparency, and quality of the Medicaid program.

Chart 1

Wisconsin Medicaid Enrollment and Unemployment Rate: 2000 to 2010

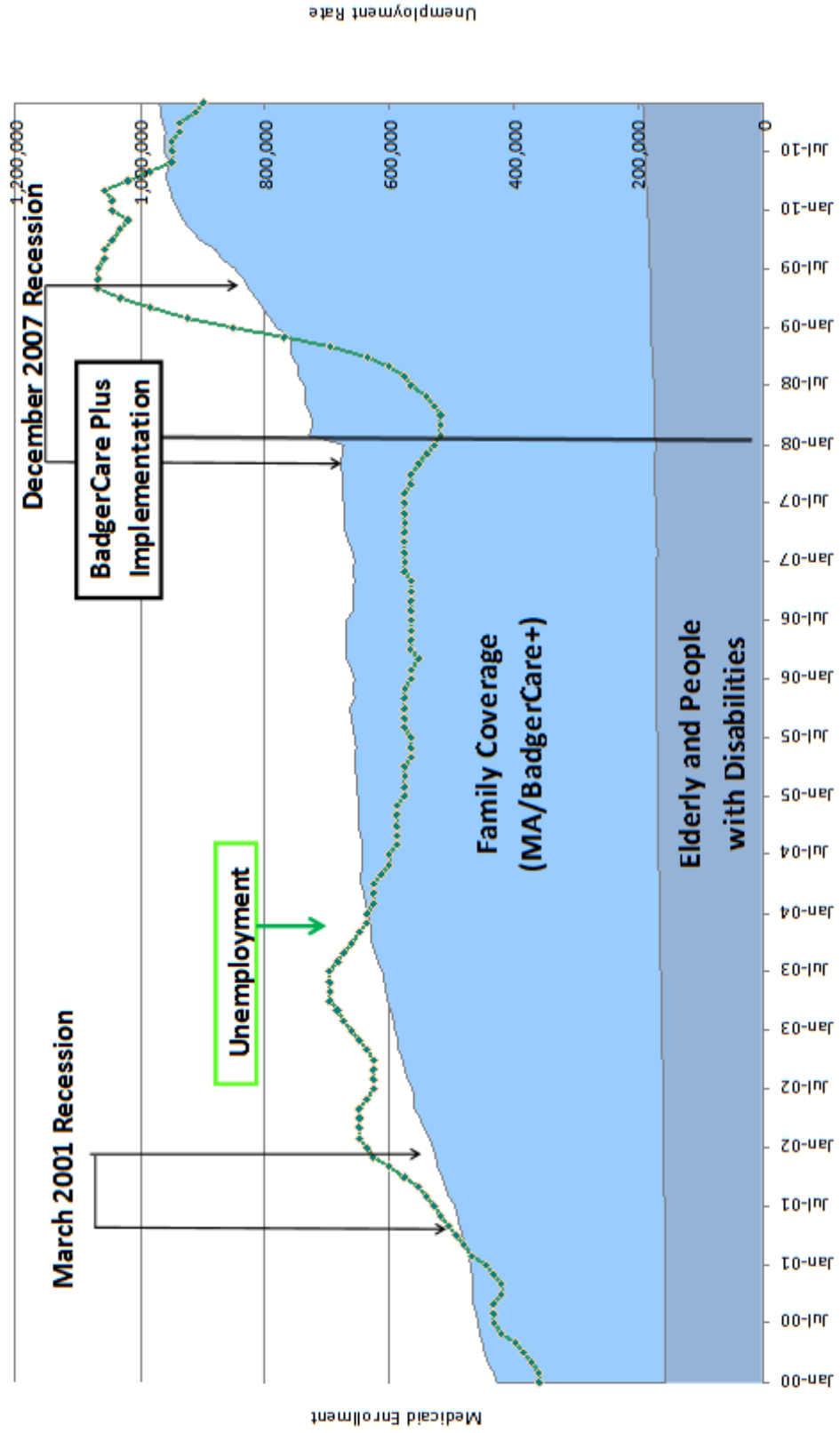
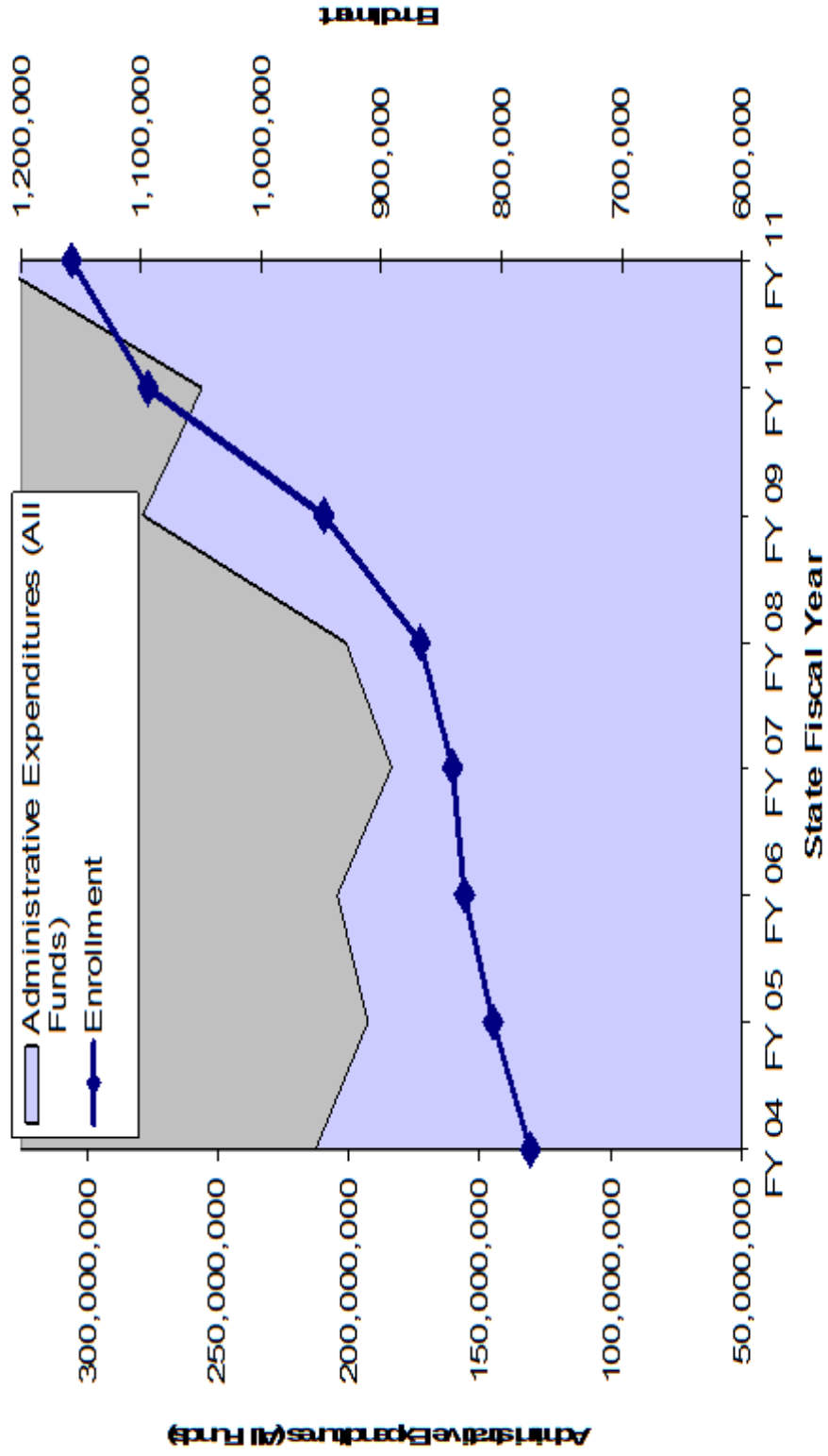


Table 1
Medicaid Personal Health Care Spending Per Enrollee

	Spending per Enrollee			Average Annual % Growth per Enrollee	
	1998	2004	2009	1998-2004	2004-2009
United States	\$5,023	\$6,089	\$6,826	3.3	2.3
Illinois	\$4,368	\$5,208	\$5,773	3.0	2.1
Indiana	\$5,676	\$6,456	\$6,229	2.2	(.07)
Iowa	\$5,415	\$7,460	\$6,887	5.5	(1.6)
Michigan	\$4,472	\$5,282	\$5,703	2.8	1.5
Minnesota	\$6,269	\$9,044	\$9,851	6.3	1.7
Ohio	\$5,861	\$7,365	\$7,469	3.9	0.3
Wisconsin	\$6,451	\$5,924	\$7,584	(1.4)	5.1

Source: Medicare and Medicaid Research Review 2011: Volume 1, Number 4 (CMS)

Chart 2
Medicaid Administrative Expenditures and Enrollment



Source: CMS-64 reporting forms. Includes county matching funds

**Table2
Vendor Payments for Medical Assistance Administrative Services**

Procuring Division	Contractor	Service	Date most recently procured	Current Renewal Options	SOONEST Re-procurement Opportunity	LATEST Re-procurement Opportunity
DHCAA	HP Enterprise Services	MMIS and Fiscal Agent Contractor	23-Aug-2004	(5) One Year Renewals	1-Jan-2013	1-Jan-2018
DHCAA	HP Enterprise Services	Healthy Birth Outcomes Registry	23-Aug-2004	(5) One Year Renewals	1-Jan-2013	1-Jan-2018
DHCAA	HP Enterprise Services	Enrollment Services Center	23-Aug-2004	(5) One Year Renewals	1-Jan-2013	1-Jan-2018
DHCAA	HP Enterprise Services	Planning and analysis for the X12 5010 Project only.	23-Aug-2004	(5) One Year Renewals	1-Jan-2013	1-Jan-2018
DHCAA	HP Enterprise Services	Food Share Quality Control Resources.	23-Aug-2004	(5) One Year Renewals	1-Jan-2013	1-Jan-2018
DHCAA	HP Enterprise Services	Data Processing Unit (DPU MIIES)	23-Aug-2004	(5) One Year Renewals	1-Jan-2013	1-Jan-2018
DHCAA	HP Enterprise Services	Family Care Allocation of Base Contract for MMIS and Fiscal Agent	23-Aug-2004	(5) One Year Renewals	1-Jan-2013	1-Jan-2018
The Department amended the HP MMIS Fiscal Agent Contract to include the Enrollment Service Center functions (Case Processing) effective 01-July-2010.						
DHCAA	Deloitte Consulting LLP	CARES Maintenance, Operation and Enhancements	1-Jul-2010	(2) Three Year Renewals	1-Jan-2015	1-Jan-2018
DHCAA	Deloitte Consulting LLP	Project Manager for IM Regionalization.	1-Jul-2010	(2) Three Year Renewals	1-Jan-2015	1-Jan-2018
DHCAA	Deloitte Consulting LLP	Health Information Technology (HIT)	1-Jul-2010	(2) Three Year Renewals	1-Jan-2015	1-Jan-2018
DLTC	The Management Group	IRIS Consulting Agency	1-Jun-2008	None	New RFP is in development	N/A
DLTC	The Management Group	Quality Assurance / Quality Improvement Long Term Care Programs	22-Mar-2010	(4) One Year Renewals	1-Jan-2013	1-Jan-2015

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Vendor Payments for Medical Assistance Administrative Services**

Procuring Division	Contractor	Service	Date most recently procured	Current Renewal Options	SOONEST Re-procurement Opportunity	LATEST Re-procurement Opportunity
The Management Group was contracted for Quality Assurance and Quality Improvements (QA/AQI) of Long Term Care Programs. On 01-June-2008, TMG was also awarded the IRIS Consulting Agent Contract via competitive procurement thereby expanding the size of the contract and its cost going forward						
DHCAA	Automated Health Services	HMO MA Enrollment Broker Services	1-Jul-2008	(1) Two Year Renewals & (5) One Year Renewals	1-Apr-2013	1-Apr-2018
Automated Health Systems was awarded the Enrollment Service Center (Case Processing/Enrollment Broker) contract on 01-Dec-2008. DHS amended this contract on 01-Nov-2010 to eliminate Case Processing functions when this work was transferred to HP via a contract amendment whose authority was grounded in the original IHP procurement. Automated Health Systems continues to act as the Department's MA Enrollment Broker Contractor.						
DLTC	MetaStar Inc.	External Quality Review Organization (Long Term Managed Care Program Review)	8-Jan-2008	(3) One Year Renewals	New RFP is in development	N/A
DHCAA	Department of Administration	Appeal Hearings for MA Benefits	State agency: no procurement required	Recurring	N/A	N/A
DHCAA	UW Oshkosh (CCDET Contract)	QA Review FoodShare eligibility determinations	State agency: no procurement required	Recurring	N/A	N/A
No competitive solicitation is required to contract for services with another State agency. DHS contracted with UW-O in FY09 to help train employees working at the Enrollment Services Center.						
DHCAA	UW Madison	Evaluation of programs, analyses of pharmacological services, assessment of enrollment and claims data.	State agency: no procurement required	Recurring	N/A	N/A
DES	Public Consulting Group	Revenue Maximization: Analysis of programs to increase federal funding and reduce program costs	31-Dec-2009	(4) One Year Renewals	1-Jul-2012	1-Jul-2015
The variance in the cost from year to year on this contract is a function of the percentage of dollars recovered by the contractor for each individual revenue maximization project. These projects vary in complexity and dollar value from one fiscal year to another.						

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Vendor Payments for Medical Assistance Administrative Services**

Procuring Division	Contractor	Service	Date most recently procured	Current Renewal Options	SOONEST Re-procurement Opportunity	LATEST Re-procurement Opportunity
DHCAA	PricewaterhouseCoopers, LLP	Actuarial Services	3-Feb-2010	(2) One Year Renewals	1-Jan-2013	1-Jan-2015
DLTC	PricewaterhouseCoopers, LLP	Actuarial Services	3-Feb-2010	(2) One Year Renewals	1-Jan-2013	1-Jan-2015
DLTC	Sally Mather Associates	Assessment of children with severe disabilities to determine eligibility for care provided in a home setting	1-Jul-2011	(4) One Year Renewals	1-Jan-2013	1-Jan-2015
DLTC	Board on Aging and Long Term Care	Ombudsmen serving those who participate in long term care programs including Family Care	Required in s. 16.009; contract must be with a state agency	Annually renewed	N/A	N/A
DLTC	Milwaukee Center for Independence	IRIS Fiscal Agent	1-Jun-2008	None	New RFP is in development	N/A
Milwaukee Center for Independence was awarded the IRIS Fiscal Agent contract on 1-June-2008 via competitive RFB. Client participation began thereafter to increase markedly resulting in larger contract outlays.						
DLTC	Disability Rights Wisconsin	Ombudsman Contractor	1-Jul-2008	(4) One Year Renewals	1-Jan-2013	1-Jan-2013
DHCAA	Disability Rights Wisconsin	SSI External Advocate Services	10-Nov-2009	(2) One Year Renewals	1-Jan-2013	1-Jan-2013
Disability Rights Wisconsin was awarded the Ombudsmen contract on 1-July-2008. The SSI External Advocate program was added to DRW's contract on 1-April-2010 accounting for the increase in outlay between FY10 and FY11.						
DES	Maximus	Revenue Maximization: Analysis of programs to increase federal funding participation (FFP) and reduce program costs	This contract has expired. A new RFP is set to be released in FY2013	N/A	N/A	N/A
DLTC	Marci Katz & Associates	Strategic Planning: Division of Long Term Care	1-Jul-2011	None	1-Mar-2012	1-Mar-2012

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Procuring Division	Contractor	Service	Date most recently procured	Current Renewal Options	SOONEST Re-procurement Opportunity	LATEST Re-procurement Opportunity
DHCAA	Wisconsin Health Information Organization	Data repository for MA insurance claims accessed by DHS to analyze varying costs and quality of care among diverse health insurance programs	Exempted from Ch. 16 Procurement Requirements by DOA approval dated 28-Mar-2007	N/A	N/A	N/A
DHCAA	CMS	Identifies Medical Assistance recipients who are also eligible for Medicare in order to reduce health care claims costs in Medical Assistance subprograms.	Ongoing contract with CMS does not require procurement authority.	Annual	Annual	Annual
DHCAA	Fox Systems	Assisted DHS in completing a federally required information technology assessment and plan.	1-Jul-2009	None	N/A: this was a one-time project	N/A: this was a one-time project
DHCAA	Coleman & Williams	Performs federally required annual audits of hospitals receiving disproportionate share hospital payments.	Mandatory State Contract used	None	Mandatory State Contract will again be used when this audit is required.	Mandatory State Contract will again be used when this audit is required.
DLTC	Developmental Disabilities Network	Provides health benefit counselors to assist individuals during the Medical Assistance application process.	1-Jul-2011	(3) One Year Renewals	1-Mar-2012	1-Jan-2015
DLTC	Employment Resources	Provides a health and employment counseling program for high-functioning developmentally disabled individuals.	1-Jan-2008	(4) One Year Renewals	1-Jul-2012	1-Jul-2012

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Vendor Payments for Medical Assistance Administrative Services**

Procuring Division	Contractor	Service	Date most recently procured	Current Renewal Options	SOONEST Re-procurement Opportunity	LATEST Re-procurement Opportunity
DHCAA	Oregon Health & Science University	Provides information on prescription drug usage which assists DHS in establishing provider rates. This contract had been annually renewed for a number of years but has recently been discontinued.	Classified as a subscription. Competitive procurement not required.	Classified as a subscription. Competitive procurement not required.	Classified as a subscription. Competitive procurement not required.	Classified as a subscription. Competitive procurement not required.
	Wisconsin State Health Information Network	DHS is one of several entities funding an effort to develop an interoperable network of statewide health information. DHS used federal grant funds to make payments of approximately \$2.3 million since FY 2006-07, and in FY 2010-11 it began using Medical Assistance administrative funds to support the network.	Exempted from Ch. 16 Procurement Requirements by DOA approval dated 28-Mar-2007	N/A	N/A	N/A
	While this schedule incorporates the major vendor contracts supported by MA administrative funding, it does not reflect all contracts funded in whole or in part by MA allocations. Specifically not included: contracts with local units of government to support MA administration at those levels; and agreements with entities providing healthcare and related benefits to MA recipients.					

