Section 3.6 Wisconsin Medicaid Cost Reporting (WIMCR) – 2014 *(Significant changes throughout)*

This section is applicable to audits of counties and 51 boards.

Funding: Medical Assistance, CFDA number 93.778. The federal government has identified Medical Assistance as a program of higher risk. Auditors will need to ensure that they meet the federal requirements for testing a major federal program within the context of also ensuring they meet the requirements from the Department of Health Services.

Under Wisconsin Medicaid Cost Reporting (WIMCR), the Department of Health Services (DHS) calculates each county health agency or public health department's total deficit for Medicaid services rendered (after interim claims and interim settlement payments are subtracted) and issues payments in December of each year. DHS makes checks payable to the Medicaid billing provider but mails them to the county designee. With the implementation of a new WIMCR cost settlement process and corresponding Web tool, counties can find their payment information within the tool.

Once DHS processes and issues payments, it performs the State Maintenance of Effort (MOE) calculation. The (MOE) calculation is a two-tiered calculation which apportions $19.25 million to counties as follows:

- The first-tier calculation is the Community Services Deficit Reduction Benefit (CSDRB) look-back which distributes a portion of the $19.25 million based on county participation in CSDRB in 2002.
- The second-tier calculation allocates all remaining MOE funding proportionally among all counties based on their share of the total statewide deficit.

Once the MOE calculation is set, DHS adjusts each county's Basic County Allocation (BCA) to reflect the following:

December Payments – MOE Calculation = BCA Adjustment

The BCA adjustment is the amount DHS takes back from the counties.

[Note: In the following section, "program" means an administratively distinct service or set of services that has received certification for reimbursement under a given Medicaid billing number.]

Auditors can confirm an agency's participation in WIMCR, and the programs covered by the benefit, the amounts claimed, and the amounts (or estimated amounts) paid by contacting PCG WIMCR Coordinator at WIMCR@pcgus.com or (866) 803-8698.

This document is part of the 2014 Revision to the *Department of Health Services Audit Guide*, which is an appendix to the *State Single Audit Guidelines* for programs from the Department of Health Services. It is to be used in conjunction with Sections 1 and 2 of the *DHS Audit Guide* and with the *Main Document to the State Single Audit Guidelines*. All of these documents are available at www.ssag.state.wi.us.

Many counties and other local governments provide health care services for which they bill Medicaid on a fee-for-service service basis. Medicaid reimbursement rates typically do not cover the entire cost of providing services. This results in deficits that the agencies make up using community aids or local tax levy.

The objective of WIMCR is to make payment adjustments to local governments that have expended local government funds in excess of Medical Assistance reimbursement for certain community services delivered to Medicaid recipients.

Each eligible agency prepares an annual cost report that includes data the Department uses to calculate average costs per unit of service. This cost per unit of service includes the cost of direct service staff, direct support staff, and agency overhead. The Department calculates the amount of the payment to eligible providers using this cost per unit of service data, the Medicaid allowed amount for each service, and the units of service provided to Medicaid clients.

Risk assessment

The Department of Health Services has designated WIMCR to be a Type A program when the auditee receives funding for this program directly from the department. DHS has declared WIMCR to be a Type A program. Since agencies annually file cost reports seeking additional federal Medicaid reimbursement, the Department recommends performing the audit work in the year following the calendar year in which services were actually provided. For example, cost reports for services provided in CY2013 were due in 2014 and would be included as part of the CY 2014audit.

General risk factors include:

- The program has not been audited in at least one of the last two audits.
- The auditor identified significant findings in the most recent audit.
- The auditee has had significant changes in personnel or systems affecting the program.
- The program is new for this auditee or the program requirements have recently changed substantially.
- The program has complex administrative requirements.
- The auditor identified significant problems in performing the general compliance testing for requirements that are relevant to this program (Section 2 of the DHS Audit Guide).

Compliance requirements and suggested audit procedures

WIMCR A. Types of Services Allowed

Compliance requirement(s)

Wisconsin state statute defines WIMCR services and the Department details these services in the annual instruction packet sent to agencies.

The eligible programs include: home health, adult mental health day treatment, outpatient mental health and substance abuse services, outpatient mental health and substance abuse services in the

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home and community, personal care, AODA day treatment, child/adolescent day treatment, crisis intervention including stabilization per diem, prenatal care coordination, community support program, and case management.

For the CY2014 cost settlements, DHS changed its practice regarding the number of cost settlement reports a county agency must submit. Counties no longer have to submit a report for each WIMCR service area. Instead, counties submit one report which captures all service area costs in the report.

Suggested audit procedure(s)

- Verify that the services covered by the cost reports are limited to those that are eligible for the Benefit.
- Verify that the cost report documents costs incurred only by the WIMCR program with no overlap or double counting with other health benefits (i.e. Comprehensive Community Services, Community Recovery Services.)

WIMCR B. Accuracy of Program Costs

Compliance requirement(s)

Cost reports must reflect the actual costs incurred by the program for the period covered by the report. The agency must allocate direct support staff time and overhead to programs in a manner that is consistent with the *Allowable Cost Policy Manual* and established Medicaid policies. For example, if a staff person in an outpatient or day treatment program is providing case management services that are billed under case management, the portion of the staff person's time spent on case management cannot also be allocated to an outpatient or day treatment program.

Suggested audit procedure(s)

- Review the completed annual cost report and instructions.
- Verify that the cost report reflect the costs of services provided through the applicable programs to all clients for the whole of the fiscal year.
- Verify that agency financial records support the cost report.
- Verify that the plan for allocating direct support service staff time and overhead is consistent with the Allowable Cost Policy Manual and with established Medicaid policy.
- Verify that the counties have included, in an equitable manner, all costs supporting the programs from all levels of county government. A review of the county's organization charts with administration should be an integral part of this review, identifying those costs at the county, department, division, and service levels that should be included.
- Verify that administration, supervisory, and clerical staff costs are included. Even programs that are operated by a contracted agency may need county staff for contract administration, supervision, and clerical for billing services.

WIMCR C. Consistency of Total Billable Units of Service

Compliance requirement(s)

Cost reports must report total billable units of service in a manner that is consistent with how Medicaid units of service are identified in the WIMCR instructions and Medicaid Provider

Manual. Total billable hours include Medicare, Medicaid, and all other payers. Other payers include the county when services are paid through the tax levy.

Suggested audit procedure(s).

- Review the county's system of internal control for reporting weekly time to assure that they require all billable time to be reported.
- Review the time record classifications and descriptions to assure that there is adequate identification and labeling to report direct billable time.
- Identify total time in each payer category and compare with the number of recipients in each payer category for reasonableness.
- Review direct employee job descriptions for duties that are not in support of the services covered in the cost reports whose costs should be eliminated.
- Test medical records to assure that billable units of service are included.
- Review time records with supervisor for that area to discuss problems with adequacy of time records.
- Review contracts or documentation from contracted agencies to assure that the cost report units of service that are provided by these agencies are consistent with units billed to Medicaid and other payers of service.

WIMCR D. Eligibility

The eligibility of an agency's programs for WIMCR is tested as part of the audit procedures identified above. The auditor is not expected to test client eligibility for Medicaid as part of the testing for the Benefit.

Presentation of findings

See Section 4.11 of the *Main Document to the State Single Audit Guidelines* for guidance on development of an audit finding. When presenting findings, identify the program and the specific compliance requirement, for example "WIMCR A. Types of Services Allowed."

Questions

Please send questions by email to DHSAuditors@Wisconsin.gov and include the identifier for the audit procedure (example "WIMCR A. Types of Services Allowed") and the name of the auditee in the message.