State of Wisconsin
Department of Health Services

OFFICE OF THE INSPECTOR GENERAL
INTERNAL AUDIT SECTION

Department of Health Services
Audit Guide

An Appendix to Wisconsin's State Single Audit Guidelines

December 2016 Revision
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The Internal Audit Section within the Office of the Inspector General for the Department of Health Services (DHS) performs independent, objective assurance, and consulting activities designed to add value and improve DHS operations. It helps DHS accomplish its objectives by bringing a systematic, disciplined approach to evaluate the effectiveness of risk management, internal control and governance processes.

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State of Wisconsin
Department of Health Services

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To Auditors, Auditees, and other Stakeholders:

The *Department of Health Services Audit Guide* (the *DHS Audit Guide*) provides a comprehensive overview of federal, state, and DHS audit requirements to assist providers receiving DHS funding and the auditors performing audits of these provider agencies. This version of the *DHS Audit Guide* has been completely rewritten to streamline information and incorporate the compliance requirements of Title 2 Code of Federal Regulations Part 200 Subpart F, "Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards" (the Uniform Guidance). In accordance with the Uniform Guidance, the *DHS Audit Guide* emphasizes the auditors' use of a risk-based approach in determining programs for audit inclusion.

The various other changes to this guide are too many to list here. Some new sections were added, while others have been eliminated. As such, auditors and auditees must treat this version of the *DHS Audit Guide* as a new document. To improve readability and navigation throughout this document, all sections have been combined into one searchable document.

We want to thank Baker Tilly for their input in our revision process. The firm's staff provided suggestions for improving this guide, which has helped clarify audit compliance requirements and developed more risk-focused instructions.

This guide will continue to evolve as needed, and we welcome any additional suggestions and feedback. Please contact us at DHSAuditors@dhs.wisconsin.gov.

Internal Audit Section
Office of the Inspector General
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INTERNAL AUDIT SECTION

Department of Health Services
Audit Guide

An Appendix to Wisconsin's State Single Audit Guidelines

December, 2016 Revision

The 2016 revision of the *Department of Health Services Audit Guide* serves as an appendix to the *State Single Audit Guidelines Main Document* and supersedes the 2014 revision. Electronic versions of all documents are accessible at www.ssag.state.wi.us.

Auditors of agencies required to provide audits to the Department should use this 2016 revision until additional updates or revisions are released. The 2016 revision of the *Department of Health Services Audit Guide* is effective for audit periods ending on or after December 31, 2016.

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Acronyms

ABAWD – Able-Bodied Adult Without Dependents

ACPM – Allowable Cost Policy Manual

ADRC – Aging and Disability Resource Center

AMSO – Agency Management and Support Overhead

AICPA – American Institute of Certified Public Accountants

BCA – Basic County Allocation

CAP – Corrective Action Plan

CARS – Community Aids Reporting System

CBRF – Community-Based Residential Facility

CESA – Cooperative Educational Service Agency

CFDA – Catalog of Federal Domestic Assistance

CIP – Community Integration Program

CLTS – Children's Long-Term Support

CMS – Centers for Medicare and Medicaid Services

COP – Community Options Program

CSDRB – Community Services Deficit Reduction Benefit

CWA – County Waiver Agency

CY – Calendar Year

DBS – Disability Benefit Specialist

DCF – Department of Children and Families

DHS – Department of Health Services

DLTC – Division of Long Term Care, now DMS

DMS – Division of Medicaid Services

DOA – Department of Administration

DOR – Department of Revenue

DPI – Department of Public Instruction

EBT – Electronic Benefits Transfer

FAC – Federal Audit Clearinghouse

FFP – Federal Financial Participation

FFS – Fee-for-Service

FSET – FoodShare Employment and Training

FMAP – Federal Medicaid Assistance Participation

GAQC – Government Audit Quality Center

GAS – Government Auditing Standards

GWAAR – Greater Wisconsin Agency on Aging Resources

HCBS – Home and Community-Based Services

HIPAA – Health Insurance Portability and Accountability Act

HSRS – Human Services Reporting System

I & A – Information and Assistance

IDD – Intellectual or Developmental Disability

IEP – Individualized Education Program

IM – Income Maintenance

IP – Internet Protocol

ISP – Individual Service Plan

LEA – Local Education Agency

LTCFS – Long-Term Care Functional Screen

MCO – Managed Care Organization

MMIS – Medicaid Management Information System

MOE – Maintenance of Effort

OIG – Office of the Inspector General

PERS – Personal Emergency Response Services

PHI – Protected Health Information

POS – Purchase of Service

PPL – Parental Payment Liability

RCAC – Residential Care Apartment Complex

SBS – School-Based Services

SEFSA – Schedule of Federal and State Finanical Awards

SNAP – Supplemental Nutrition Assistance Program

SSAG – State Single Audit Guidelines

SSC – Support and Service Coordinator

TPA – Third-Party Administrator

UGCS – Uniform Guidance Compliance Supplement

W2 – Wisconsin Works

WIMCR – Wisconsin Medicaid Cost Reporting

Department of Health Services Audit Guide

Section 1: General Information

1.0 General Audit Requirements

The Department of Health Services (DHS or the Department) exercises multiple roles in the protection and promotion of the health and safety of the people of Wisconsin. To carry out its mission, DHS relies on a network of provider agencies across numerous programs to fulfill this goal. Provider agencies that receive funding from DHS may be subject to audit requirements as mandated by contract, grant agreement, or state and federal laws. The *Department of Health Services Audit Guide* (the *DHS Audit Guide*) provides a comprehensive overview to assist providers and auditors in meeting federal, state, and DHS audit requirements.

This *DHS Audit Guide* serves two purposes: First, it is an appendix of the State Single Audit Guidelines (SSAG). The SSAG is comprised of the Main Document of the State Single Audit Guidelines (the Main Document) and appendices of other Wisconsin agencies. The SSAG incorporates the federal audit requirements of Title 2 Code of Federal Regulations Part 200 Subpart F, "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards" (the Uniform Guidance). The DHS Audit Guide incorporates additional auditing and program-specific compliance requirements for those agency providers that receive funding from DHS and are subject to Uniform Guidance requirements. Second, it establishes audit guidelines for provider agencies that expend $25,000 or more in DHS-related funding for an audit period but do not meet the single audit threshold of $750,000 or more.

1.0.1 Audit Authority

Agency providers that expend $750,000 or more in total federal awards are subject to the audit requirements of the Uniform Guidance. This audit requirement cannot be waived. In addition, these agencies are required to have an audit in accordance with the SSAG, including the *DHS Audit Guide*, if expending $25,000 or more of direct or pass-through funding from DHS.

Per Wisconsin Stat. § 46.036 (4)(c), all agency providers that receive DHS funding are required to annually provide a certified financial and compliance audit report to the purchaser if care and services purchased are $25,000 or more. This audit requirement applies to both direct and pass-through DHS funding and must comply with the requirements of the *American Institute of Certified Public Accountants (AICPA)*, *Government Auditing Standards (GAS)* and the *DHS Audit Guide*. Audit reports are due to DHS for agencies that receive direct funding or to the agency that purchased the services for pass-through DHS funding (a county, for example). This audit requirement can be waived by DHS, Area Administration or a county mandate relief waiver.

1.0.2 What Type of Audit is Required?

For agencies that expend or pass-through DHS funding, several factors determine the type of audit required:

- The funding source(s)
- The amount of funding
- The substance of the agreement between agencies that expend or pass-through DHS funding
- The type of care and services purchased with DHS funding

To assist agencies in determining whether expending or passing-through DHS funding is a subrecipient or contractor relationship, reference the Uniform Guidance, § 200.330 – Subrecipient and Contractor Determinations for guidance.

In determining whether an agency is required to have an audit in accordance with the DHS Audit Guide, it is necessary to differentiate between "purchase of care and services" and "purchase of goods or administrative, technical or professional services" within the flowchart below, Figure 1. Care and service purchases refer to direct personal care and support services provided to a recipient on behalf of a DHS program. Goods or administrative, technical or professional services refer to ancillary items that are necessary for the program to carry out its objectives. Some examples of the different types of purchases used with DHS funding:

- Care and services include medical, dental or behavioral care and private-duty, custodial or non-medical services. Care and services can be provided by licensed medical personnel or individuals not required to have a license or certification. Purchase of care and services would include the agency's indirect costs for the program, such as administration and overhead.
- Goods include office supplies, materials and merchandise.
- Administrative services include payroll processing, telephone routing, mail distribution and report compilation services.
- Technical services include translation, multi-media or maintenance repair services.
- Professional services include engineering, auditing and architectural services. Medical services, although requiring professional licensure, would be included in the care and services category.

The following flowchart provides guidance to determine if an agency needs an audit and the type of compliance requirements that the audit must follow.

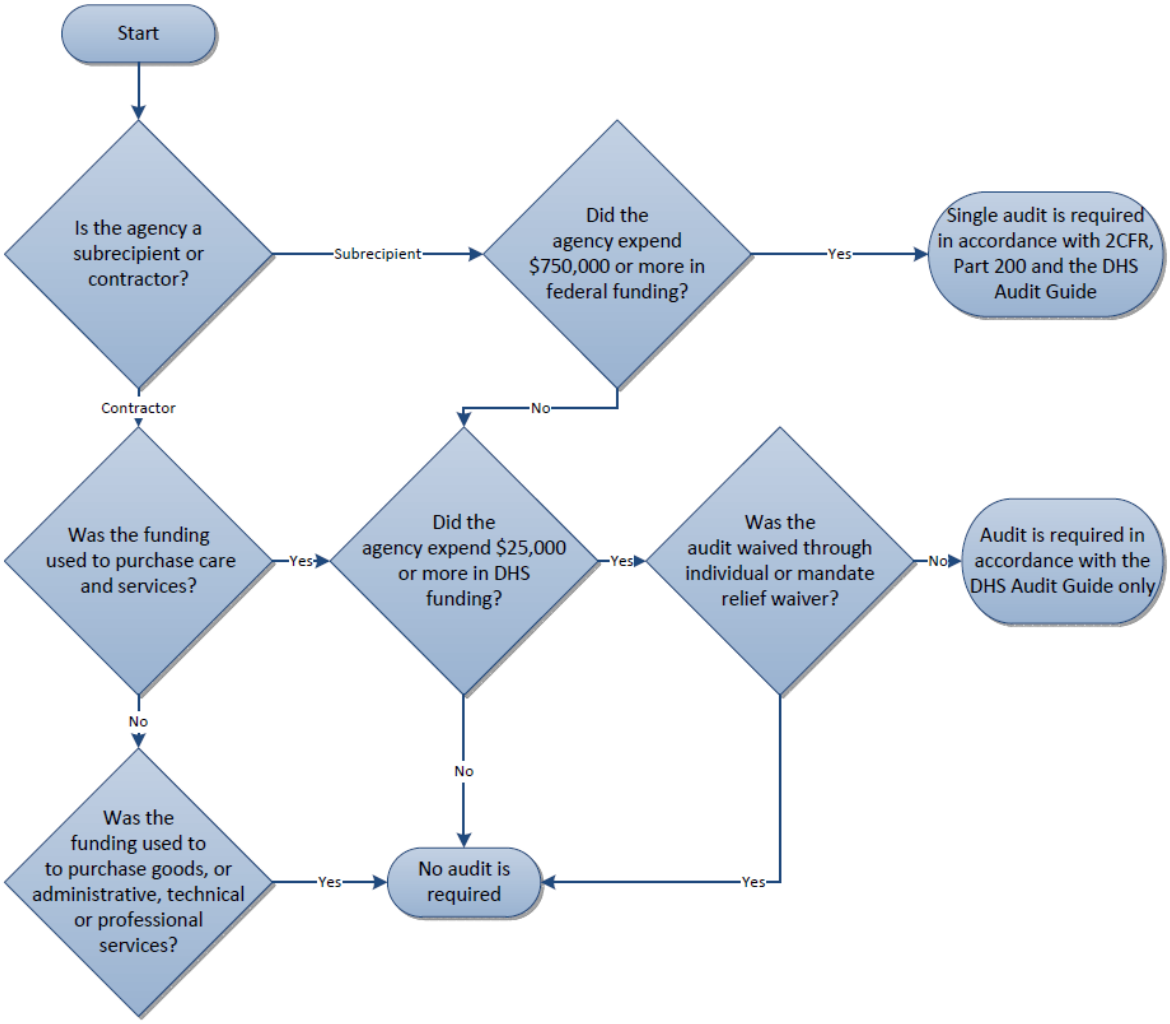


Figure 1: Audit Requirements Determination

The funding agency (DHS or a county) reserves the right to include contractual language requiring an audit for any appropriate business reason, such as if the provider agency is relatively new or deemed high-risk based on prior history with the funding agency. Funding agencies should explicitly specify audit requirements in all grant agreements and contracts for purchase of care and services that involve DHS funding. Funding from DHS can be direct, passed-through or a combination of both. All of the following entity types are required to submit audits to DHS (or a county agency that passes through DHS funding) if the DHS funding level was $25,000 or more and no audit waiver exists:

- Local government agencies – counties, cities, towns, villages, and Chapter 51 boards
- School districts
- For-profit and nonprofit agencies
- Tribal entities

1.0.3 Audit Waivers

DHS may waive the audit requirement for agencies that receive DHS funding on a case-by-case basis or by county mandate relief waiver of the audit threshold. Although Wisconsin Statute 46.036 (4)(c) requires

agency providers that receive more than $25,000 in direct or pass-through DHS funding to provide an audit report, an audit waiver may be granted based on a number of factors, including:

- The contract or grant amount is relatively small.
- The audit cost is burdensome to the agency.
- An alternative form of monitoring is available.
- The agency is deemed low risk.

All case-by-case waiver requests require an approval from DHS. Generally, DHS will not grant an agency's audit waiver request if the request occurs after the start of the contract period except in extenuating circumstances.

Counties can request audit waivers on behalf of their subrecipients and contractors by completing the Purchase of Service Audit Waiver Request/Risk Identification and Assessment Worksheet. This form shall be submitted to the county's Area Administration regional office for approval. For all other requests of agency audit waivers, the provider agency can directly contact DHS program personnel. DHS Internal Audit will make the final determination on behalf of the Department.

Wisconsin Stat. § 66.0143 authorizes local governmental agencies to request relief from certain statutory mandates that are financially burdensome. Numerous Wisconsin counties utilize this provision to request an increase in the audit threshold from $25,000 to either $75,000 or $100,000. This audit waiver is in effect for four years and the Department may renew the waiver for an additional four-year period. The Wisconsin Department of Revenue (DOR) administers mandate relief waivers, and the DHS Office of the Inspector General (OIG) approves them. Forms and instructions for requesting this waiver are available on the DOR website. A complete listing of counties with mandate relief waivers, their respective waiver threshold amounts, and expiration dates is available online.

Some providers have miscalculated the effect of individual audit waivers and mandate relief waivers when determining the appropriate audit threshold. If the provider agency receives DHS funding from multiple sources, then the amount of DHS funding by county shall determine if an audit is required. If a provider receives funding from multiple counties with mandate relief waivers, the audit threshold that applies is the threshold from the individual counties, not the cumulative total for all waiver thresholds granted to the counties.

> For example, Packerland Mental Health Services contracts with five counties to provide counseling services and expends a total of $324,000 in DHS funding. Mandate relief waivers have been granted to three of the counties, which have increased their audit thresholds to either $75,000 or $100,000. Two counties do not have mandate relief waivers and require audits of agencies that expend more than $25,000 in funding. One of those counties requested an individual waiver for Packerland Mental Health Services, which DHS approved.
>
> Although the sum of the thresholds at which an audit is required at all five counties ($325,000) exceeds the total amount of funding expended by the agency ($324,000), they are not exempt from audit requirements. Figure 2 summarizes the funding, waiver thresholds and audit requirements by county.

Figure 2: Audit Requirement Example for Packerland Mental Health Services

County	Amount of Funding Expended	County Audit Threshold	Individual Waiver?	Audit Required by County?
County A	$ 40,000	$ 25,000	Yes	No
County B	105,000	100,000		Yes
County C	73,000	100,000		No
County D	98,000	75,000		Yes
County E	8,000	25,000		No
Totals	$324,000	$325,000		

In this example, Packerland Mental Health Services is required to have an audit by counties B and D, but is not required to provide one to counties A, C, and E. In addition, the cost of the audit can be charged only to the counties that required the audit, not allocated to all of them.

DHS recognizes that current auditing and waiver statutes could permit agencies that receive substantial amounts of funding to be exempt from audit requirements due to a combination of mandate relief and individual waivers. DHS is working to identify these agencies and to amend current statutes to rectify this anomaly.

Audit waivers are not allowed for agencies that expend $750,000 or more in federal grant funding for an audit year since they are required to have a single audit in compliance with the Uniform Guidance.

Auditor requests for waivers of testing specific programs are no longer necessary, as DHS has eliminated the automatic designation of major programs from the 2016 *DHS Audit Guide*. This change in guidance will now enable the auditor to fully implement a risk-based approach for major program determination and allow the auditor to identify those programs that present the highest level of risk and merit compliance testing.

1.1 Main Document of the State Single Audit Guidelines

Many sections throughout this *DHS Audit Guide* refer to the *Main Document of the State Single Audit Guidelines* for examples and guidance that commonly apply to any DHS funding environment, not only single audits. Figure 3 on the following pages provides a crosswalk of the applicability of the various sections of the *Main Document* to the *DHS Audit Guide*.

Figure 3: Applicability of the *Main Document of State Single Audit Guidelines* for Audits in Accordance with the *DHS Audit Guide*

Section in *Main Document of the State Single Audit Guidelines*	Audit Requirements for DHS Audits (*DHS Audit Guide*, Section 1.2.1)	Additional Requirements for Single Audits (*DHS Audit Guide*, Section 1.2.2)
1 Introduction		
1.1 Definitions	Yes, however, the term "funding agency" is used instead of "granting agency" because the state law that requires audits applies to purchases and grants	Yes, however, the term "funding agency" is used instead of "granting agency" because the state law that requires audits applies to purchases and grants
1.2 Overview of guidelines	Yes, the *DHS Audit Guide* is an appendix to SSAG	Yes, the *DHS Audit Guide* is an appendix to SSAG
1.3 When are guidelines applicable and what type of audit is needed?	Yes, the *DHS Audit Guide* points to the Main Document for many auditing concepts that also apply to audits that are not single audits	Yes, the threshold for single audits is now at $750,000 in expenditures of federal awards
1.4 Single audit cost	Yes, except cost for single audits does not apply to audits that are not single audits	Yes
1.5 Additional review	Yes	Yes
1.6 Audit due date	No, see *DHS Audit Guide*, Sections 1.7 and 1.7.2	No, see *DHS Audit Guide*, Sections 1.7 and 1.7.1
1.7 Sanctions	Yes	Yes
1.8 Effective date	No, see *DHS Audit Guide*, Section 1.8	No, see *DHS Audit Guide,* Section 1.8
1.9 For additional information	Yes, also see *DHS Audit Guide*, Section 1.9, for contact information	Yes, also see *DHS Audit Guide,* Section 1.9, for contact information
2 Roles and responsibilities		
2.1 The auditee 2.1.1 Identify state and federal pass-through awards in accounts 2.1.2 Maintain internal controls over state and federal pass-through awards 2.1.3 Comply with laws and regulations 2.1.4 Prevent and detect fraud 2.1.5 Procure audit services 2.1.6 Prepare financial statements and other report elements 2.1.7 Take corrective action for audit findings 2.1.8 Submitting the audit reporting package 2.1.9 Follow audit report retention requirements	Yes, see *DHS Audit Guide*, Section 1.6, for elements of the audit reporting package	Yes, see *DHS Audit Guide*, Section 1.6, for elements of the audit reporting package

Figure 3: Applicability of the *Main Document of State Single Audit Guidelines* for Audits in Accordance with the *DHS Audit Guide* (continued)

Section in *Main Document of the State Single Audit Guidelines*	**Audit Requirements for DHS Audits (*DHS Audit Guide,* Section 1.2.1)**	**Additional Requirements for Single Audits (*DHS Audit Guide,* Section 1.2.2)**
2.2 The auditor 2.2.1 Be qualified to perform an audit according to the applicable standards 2.2.2 Perform the audit in accordance with applicable standards 2.2.3 Prepare elements of the audit reporting package 2.2.4 Retention of working papers 2.2.5 Access to workpapers	Yes, see *DHS Audit Guide*, Sections 1.5 through 1.7	Yes, see *DHS Audit Guide*, Sections 1.5 through 1.7
2.3 The granting agency 2.3.1 Advise auditees on federal and state law 2.3.2 Require auditee to provide access to records 2.3.3 Prepare information for granting agency's programs 2.3.4 Provide technical assistance to auditees and auditor 2.3.5 Identify agencies that need audits and collect those audits 2.3.6 Access the Federal Audit Clearinghouse and Obtain Reporting Package 2.3.7 Review the audit report and resolve audit findings 2.3.8 Consider additional steps to promote audit quality 2.3.9 Notify other granting agencies of irregularities	Yes, *DHS Audit Guide* generically refers to the "funding agency"	Yes, *DHS Audit Guide* generically refers to the "funding agency"
2.4 The Department of Administration 2.4.1 Maintain the *State Single Audit Guidelines* 2.4.2 Provide assistance 2.4.3 Track auditor quality issues	The Department of Administration (DOA) maintains the *State Single Audit Guidelines*, of which the *DHS Audit Guide* is an appendix. DOA is only involved with single audits.	Yes
2.5 The Legislative Audit Bureau	No	Yes

Figure 3: Applicability of the *Main Document of State Single Audit Guidelines* for Audits in Accordance with the *DHS Audit Guide* (continued)

Section in *Main Document of the State Single Audit Guidelines*	**Audit Requirements for DHS Audits (*DHS Audit Guide*, Section 1.2.1)**	**Additional Requirements for Single Audits (*DHS Audit Guide*, Section 1.2.2)**
3 Performing an audit		
3.1 Applicable audit standards	Yes, except those audit requirements for auditees not subject to the Uniform Guidance	Yes
3.2 Financial statements	Yes	Yes
3.3 Internal control	Yes, as needed for *Government Auditing Standards* (the Yellow Book)	Yes
3.4 Compliance	Yes, as needed for *Government Auditing Standards* (the Yellow Book)	Yes, see *DHS Audit Guide*, Section 1.2.3 for state major program determination guidelines
3.5 Audit follow-up	Yes	Yes
3.6 Consideration of fraud in a financial assistance environment 3.6.1 Auditor's responsibility 3.6.2 Reporting fraud to management 3.6.3 Reporting fraud to the granting agency	Yes	Yes
4 Preparing an audit reporting package		
4.1 Financial Statements of the Overall Agency 4.2 Schedule of Expenditures of Federal and State Awards 4.3 Additional Supplemental Schedule Required by a Granting Agency 4.4 Summary Schedule of Prior Audit Findings 4.5 Corrective Action Plan 4.6 Independent Auditor's Report on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards 4.7 Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With Government Auditing Standards	Yes, see *DHS Audit Guide*, Section 1.6	Yes, see *DHS Audit Guide*, Section 1.6

Figure 3: Applicability of the *Main Document of State Single Audit Guidelines* for Audits in Accordance with the *DHS Audit Guide* (continued)

Section in *Main Document of the State Single Audit Guidelines*	Audit Requirements for DHS Audits (*DHS Audit Guide,* Section 1.2.1)	Additional Requirements for Single Audits (*DHS Audit Guide,* Section 1.2.2)
4.8 Report on Compliance for Each Major Program and on Internal Control Over Compliance in Accordance with the *Uniform Guidance* and the *State Single Audit Guidelines*	Yes, see *DHS Audit Guide*, Section 1.6	Yes, see *DHS Audit Guide*, Section 1.6
4.9 Opinion on the Financial Statement of a Federal and State Program in Accordance with the Program-Specific Audit Option under the *Uniform Guidance* and the *State Single Audit Guidelines*	No, DHS does not allow program-specific audits	No, DHS does not allow program-specific audits
4.10 Report on Compliance for the Federal and State Program and on Internal Control Over Compliance in Accordance with the Program-Specific Audit Option under *Uniform Guidance* and the *State Single Audit Guidelines*	No, DHS does not allow program-specific audits	No, DHS does not allow program-specific audits
4.11 The Schedule of Findings and Questioned Costs	Yes, see *DHS Audit Guide,* Section 1.6	Yes, see *DHS Audit Guide,* Section 1.6
4.12 Management letter	Yes, see *DHS Audit Guide,* Section 1.7.2	Yes, see *DHS Audit Guide,* Section 1.7.2
5 Submitting the audit report		
5.1 Management Letter Submission	Yes, also see *DHS Audit Guide*, Section 1.7.2	Yes, also see *DHS Audit Guide,* Section 1.7.2

1.2 Audits Involving DHS Funding

1.2.1 Audit Requirements

This section applies to all audits involving funding from DHS.

All provider agency audits that involve $25,000 or more in DHS funding from grants or purchases of care and service contracts must be an agency-wide audit since DHS no longer allows program-specific audits. A certified public accountant must perform the agency-wide audit in accordance with generally accepted auditing standards established by the *American Institute of Certified Public Accountants (AICPA)*, *Government Auditing Standards* and *the DHS Audit Guide*. The agency-wide audit may also need to be in accordance with the *Uniform Guidance* and Wisconsin's *Main Document of the State Single Audit Guidelines* if the agency expended $750,000 or more in federal funding during the audit period.

In an agency-wide audit, the auditor:

- Provides an opinion as to whether the auditee's financial statements are presented fairly in all material respects in accordance with generally accepted accounting principles (*Main Document,* Section 3.2*).*
- Determines whether the supplemental schedules are presented fairly, in all material respects, in relation to the financial statements. The supplemental schedules include the following:
  - "Schedule of Expenditures of Federal and State Awards" for all auditees (*Main Document,* Section 4.2).
  - "DHS Cost Reimbursement Award Schedule" (*DHS Audit Guide,* Section 2.9.1) is required when the agency:
    - Is a nonprofit, for-profit, or local unit of government other than a county, tribe, Chapter 51 board, or school district, and
    - Expends a total amount of $100,000 or more of direct DHS awards for the audit period. Each award within the audit period must be separately identifiable within this schedule.
  - "Allowable Reserves Schedule" for nonprofits paid on a prospectively set rate basis (*DHS Audit Guide,* Section 2.9.2).
  - "Allowable Profit Schedule" if a for-profit agency (*DHS Audit Guide,* Section 2.9.3).
- Reviews prior year findings, performs procedures to assess the reasonability of the auditee's "Summary Schedule of Prior Audit Findings" (Main Document, Section 4.4, for required elements), and reports a current year finding if the "Summary Schedule of Prior Audit Findings" materially misrepresents the status of the prior year's audit findings.
- Tests compliance and internal controls over compliance for 25 percent or more of total expenditures related to DHS-funded programs for single audits. For agencies that do not meet the single audit threshold but expend DHS funding, the auditor only tests compliance for 25 percent or more of total expenditures related to DHS-funded programs.

1.2.2 Additional Requirements for Single Audits

This section applies to agencies required to comply with the Uniform Guidance.

The previous section addresses the core requirements that apply to all audits of grants and purchases of care and services involving DHS funding. This section provides additional guidelines if the agency's audit needs to also comply with the single audit requirements of the Uniform Guidance if the agency is a local government or nonprofit organization that expended $750,000 or more in federal awards for the audit period. The *Main Document of the State Single Audit Guidelines* provides guidance on performing single audits involving federal funding passed through state agencies, and it extends the federal single

audit concepts to state-funded programs. The *DHS Audit Guide* provides guidance on applying the federal single audit concepts to the DHS funding environment.

In performing a single audit, the auditor is required to use the percentage-of-coverage guidance in the Uniform Guidance, § 200.518 (major program determination) for federal programs. Additionally, the auditor needs to apply guidelines from the Uniform Guidance's Appendix XI to Part 200 – Compliance Supplement and the *DHS Audit Guide* for applicable compliance testing requirements.

Part 2 (Matrix of Compliance Requirements) of the Uniform Guidance's Appendix XI – Compliance Supplement provides a matrix overview of 12 potential compliance requirements that auditors must consider for each federal funding grant with each Catalog of Federal Domestic Assistance (CFDA) program number listed. The Compliance Supplement's Part 3.2 (Compliance Requirements), Part 4 (Agency Program Requirements), and Part 6 (Internal Control) provide general guidance on auditing these 12 requirements, and Part 4 (Agency Program Requirements) provides additional guidance on selected requirements for specific programs. The following chart, Figure 4, crosswalks the Uniform Guidance's Appendix XI, Part 3.2 (compliance requirements most applicable to DHS programs), and the *DHS Audit Guide,* Sections 2 and 3.

Figure 4: Crosswalk of Compliance Requirements of the UG to the *DHS Audit Guide*

Compliance Requirements of the Uniform Guidance's Appendix XI, Part 3.2	**Guidance in the *DHS Audit Guide, Sections 2 and 3***
A. Activities Allowed or Unallowed	Section 2.1 "Activities Allowed or Unallowed" and DHS program-specific requirements in Section 3
B. Allowable Costs/Cost Principles	Section 2.2 "Allowable Costs" and DHS program-specific requirements in Section 3
C. Cash Management	No additional guidance provided by DHS
E. Eligibility	Section 2.3 "Eligibility" and DHS program-specific requirements in Section 3
G. Matching, Level of Effort, Earmarking	Section 2.4 "Matching, Level of Effort, and Earmarking" and DHS program-specific requirements in Section 3
H. Period of Performance	No additional guidance provided by DHS.
I. Procurement and Suspension and Debarment	Section 2.6 "Procurement and Suspension and Debarment"
L. Reporting	Section 2.5 "Reporting" and DHS program-specific requirements in Section 3
M. Subrecipient Monitoring	Section 2.7 "Subrecipient Monitoring"
N. Special Tests and Provisions	DHS program-specific special tests in Section 3

1.2.3 State Major Program Determination

To incorporate the risk-based approach of the Uniform Guidance, DHS no longer designates certain state programs as major programs that automatically require compliance testing. Auditors can employ the risk-based criteria detailed in the Uniform Guidance to identify state programs that are further determined to be major programs by applying the following expenditure thresholds for audit periods ending December 31, 2016, or later:

The threshold for Type A state programs is the greater of:

- $250,000, or 3 percent (0.03) of total expenditures for state programs that DHS either directly funds or passes through when total expenditures for these programs do not exceed $100 million.

- $3,000,000, or three-tenths of one percent (0.003) of total expenditures for state programs that DHS either directly funds or passes through when total expenditures for state programs from DHS exceed $100 million.

The threshold for Type B state programs is the greater of $62,500, or 25 percent of the auditee's applicable Type A state program threshold.

Reference the *Main Document*, Section 3.4 – Compliance for complete testing requirements of DHS state programs within the single audit environment. Sections 2 and 3 of this *DHS Audit Guide* list general compliance and specific DHS program requirements potentially identified as state major programs by the auditor.

Auditors can identify state major programs by incorporating the aforementioned state Type A threshold of $250,000 (or more, dependent on total expenditures for state programs from DHS) and applying the risk criteria detailed in the Uniform Guidance's § 200.518 – 200.520. All single audits must incorporate the percentage-of-coverage threshold levels of 20 or 40 percent for federal programs as determined by the auditor's assessment of the agency's level of risk. Per this DHS audit guide, at least 25 percent of DHS-funded program expenditures must have compliance testing for both single and non-single audits with single audits also required to test internal controls over compliance.

1.2.4 Managed Care Organizations for Family Care, Family Care Partnership and PACE

This section applies to managed care organizations contracting with the Department of Health Services to administer Family Care, Family Care Partnership, and PACE programs.

Contact the Division of Medicaid Services for audit guidance related to contracts with managed care organizations that provide Family Care, Family Care Partnership, and PACE:

Bureau of Managed Care
608-267-7286
DHSFCWebmail@wisconsin.gov

Refer questions about audit requirements for contracts between a managed care organization and a service provider to the managed care organization.

1.3 Payment Information and Confirmation Requests

1.3.1 Programs Paid through DHS Community Aids Reporting System

DHS uses the Community Aids Reporting System (CARS) to make payments to many provider agencies that have audit requirements. Information on payments and the federal and state funding sources for programs paid through CARS is available on the Department's website:

- The CARS 603 and 620 reports have the CARS profile number, profile name, contract amount, reported expenses, and payments. These reports are available at http://apps.health.wisconsin.gov/cars/GetIndexServlet. For specific queries, obtain the agency number and agency type from the contract, and select the first voucher for each month. (Only the first voucher of each month includes information for agencies paid through CARS.)
- The CARS website has a crosswalk of the CARS profiles and their federal and state funding sources.

1.3.2 Audit Confirmations for DHS Programs

To confirm amounts of DHS funding paid to an agency by funding source(s), auditors can do the following:

- Complete the Audit Confirmation Request form (F-80479).
- Email the Audit Confirmation Coordinator at dhsdldesbfscars@dhs.wi.gov. Please allow a minimum of 15 business days for processing this request.

1.4 Protecting Confidential Member Information

This section applies to all audits involving DHS-funded programs.

While performing audits of programs for DHS, auditors are likely to access confidential member information protected by state and federal confidentiality laws. An example of such information is protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Confidential client information includes client name, address, telephone number, date of birth, dates of services of care, and Social Security number/unique identifier numbers (see the discussion of de-identification and re-identification at the end of this section and 45 CFR 164.514 for an extensive list).

1.4.1 Auditor Safeguards

Any confidential information should have appropriate safeguards applied to ensure that inappropriate or improper disclosure does not occur. The Department's Privacy Officer recommends that auditors:

- Collect only the minimum amount of data necessary for sufficient audit documentation.
- Ensure administrative, physical, and technical safeguards are in place to protect individually identifiable information. Do not email this type of information without encryption.
- Contact the breached entity's Privacy Officer as soon as possible, if confidential and individually identifiable health information is lost, stolen, or inappropriately disclosed.

The Department recommends auditors request that their clients redact or de-identify confidential client information from information provided to the auditor. If protected health information is required for inclusion within the audit's documentation, then only obtain the minimum amount of information needed to perform auditing procedures.

If the auditor does receive confidential client information, it is the auditor's responsibility to retain the confidentiality of that information. Options include the auditor redacting or de-identifying confidential information. If confidential client information is required for supporting documentation, the Department recommends creating a separate document that maps confidential client information to a unique identifier that is stored in an encrypted file. Best practices to ensure the protection of confidential client information are to secure files, laptops and other portable media devices and encrypt electronically stored information.

1.4.2 De-Identification

If information is considered de-identified (and there is no basis to identify the individual) under the HIPAA Privacy Rule, it is no longer subject to the protections of this regulation. Health information is considered individually identifiable health information unless the following identifiers of the individual, or of relatives, employers, or household members of the individual, are removed and there is no reasonable basis to believe that an individual can be identified:

- Names
- All geographic subdivisions that are smaller than a state, including street address, city, county, and precinct zip code and their equivalent geo-codes, except for the initial three digits of a zip code
- All elements of dates (except year) that are directly related to the individual, including birth date, admission date, discharge date, and date of death; and all such ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
- Telephone numbers
- Fax numbers
- Electronic email addresses
- Social Security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web universal resource locators (URLs)
- Internet protocol (IP) address numbers
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code, except as permitted in re-identification

1.4.3 Re-Identification

A code or another means of record identification assignment to allow information to be re-identified, providing that:

- The code or other means of record identification is not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual and
- The covered entity does not use or disclose the code or other means of record identification for any other purpose and does not disclose the mechanism for re-identification.

1.5 Auditor Qualifications and Peer Review

This section applies to all auditors performing audits of DHS-funded programs.

1.5.1 Auditor Qualifications

An auditor contracted to perform an audit that includes DHS-funded programs must possess the required qualifications to perform the engagement. The auditor's qualifications are to comply with the standards established by the *American Institute of Certified Public Accountants' (AICPA) Generally Accepted Auditing Standards – AU Section 150*, *Government Auditing Standards*, and the *Main Document of the State Single Audit Guidelines*, Section 2.2.1. For an auditor to perform audits of provider agencies that receive direct or pass-through funding from DHS, the auditor must do the following:

- Meet the appropriate state licensing requirements per Wis. Stat. § 442.04.

- Maintain independence from personal, organizational, or external impairment.
- Have adequate educational qualifications, technical training, and proficiency to perform an audit.
- Have audit experience with the type of entity and possess a responsible work record.
- Obtain appropriate audit evidence by performing audit procedures to afford a reasonable basis for an opinion regarding the financial statements under audit.
- Have not been suspended or debarred from performing government audits.
- Have not received disciplinary action during the previous three years.
- Have completed their continuing professional education requirements.
- Have passed their peer review within the last three years.

If an auditor passed their peer review with deficiencies, the implementation of corrective measures is expected to prevent recurrence of similar deficiencies in the future. The auditor that passed their peer review with deficiencies should contact the Wisconsin Institute of Certified Public Accountants' peer review committee, by letter, to address the deficiencies identified in the peer review report. The peer review committee will oversee the auditor's corrective action plan and may impose additional actions or monitoring.

1.5.2 Auditor Requirement – Peer Review

Per Wis. Stat. § 442.087, an audit firm must have a peer review at least once every three years. Additional requirements of the peer review are:

- Only a person approved by an examining board can perform a peer review and that person is to have no affiliation with the firm or members of the firm under review.
- The auditor must provide the peer review report to the auditee and to each funding agency upon request.
- An auditor that does not provide the peer review report to the funding agency upon request can no longer perform audits of agencies that receive DHS funding.
- If an auditor fails a peer review and continues to perform audits involving DHS funding, the auditor must:
  - Provide the auditee and all funding agencies with written notification of the results of the peer review prior to beginning an audit involving DHS funding.
  - Provide the auditor's corrective plan to ensure that the audit meets applicable professional, federal, and state requirements.
  - At the audit's completion, provide each funding agency with an audit report and its supporting documentation.

DHS strongly encourages provider agencies to engage an audit firm that passes its peer review and is a member of the AICPA's Government Audit Quality Center (GAQC). Engaging an audit firm that fails to pass its peer review imposes additional responsibilities and liabilities on the funding agency. The auditor should use its peer review as a tool to comply with professional requirements and improve the overall quality of the firm's audit methodology.

1.6 Audit Reporting Package Elements

This section details the required elements to include in the audit reporting package submitted to the Federal Audit Clearinghouse (FAC) or DHS. The following elements are required to be included in the audit reporting package for all audit and entity types, unless otherwise noted (*):

- Financial Statements of the provider agency
- Schedule of Expenditures of Federal and State Awards (SEFSA)
- Independent Auditor's Report on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards
- Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards and the DHS Audit Guide
- Report on Compliance for Each Major Program and on Internal Control over Compliance in Accordance with the Uniform Guidance and the State Single Audit Guidelines* (only required for single audits)
- Schedule of Findings and Questioned Costs
- Summary Schedule of Prior Audit Findings – DHS requires for all audit types
- Corrective Action Plan (CAP) – § 200.511(c) of the Uniform Guidance requires the auditee to prepare, in a separate document, a CAP that addresses each finding. This CAP must detail the corrective action planned, the responsible party, and the anticipated completion date. If the auditee does not agree with the findings, the CAP should include an explanation and rationale.
- Management Letter – The management letter, if issued by the auditor, is not required for submission to the FAC; however, State Single Audit Guidelines mandate that the provider submit the management letter to each Wisconsin funding agency if issued by the audit firm.
- *DHS Cost Reimbursement Award Schedule (only required if an agency is a nonprofit, for-profit, or a city/municipality expending a total of $100,000 or more in direct funding from DHS)
- *Reserves Schedule (only required for nonprofit agencies paid on a prospectively set rate basis)
- *Allowable Profit Schedule (only required if agency is for-profit)

Regarding the SEFSA, some programs commingle funding from federal and state sources. In the rare situation where it is not practical to identify the individual funding sources, then the total amount should be included in the federal section of the SEFSA with a footnote description of the commingled nature of the program's funding.

1.7 Audit Reporting Package – Submission and Due Date

Unless the agency received an audit waiver from DHS or through a county's mandate relief waiver, the following information applies to all audits involving DHS funding:

- All audit reporting package documents are to be unencrypted, unlocked, and in a text-searchable PDF format.
- DHS does not grant extensions for submitting the audit reporting package. If your audit is late, then DHS may consider sanctions.
- Please comply with the submission requirements of the audit reporting package for all funding agencies. If applicable, please see the provider's contract or contact the funding agency for specific submission requirements.

1.7.1 Single Audit Reporting Package – Submission and Due Date

For single audits that comply with the Uniform Guidance, reference § 200.512(b) of the Uniform Guidance for submission requirements regarding the audit reporting package. The auditee is responsible for ensuring that the Federal Audit Clearinghouse (FAC) receives a complete, electronically submitted audit reporting package by the audit's due date. This due date is the earlier of 30 days after receipt of the auditor's report or nine months after the end of the audit period.

Please ensure that the FAC's website is fully functional and enables complete viewing access to the audit reporting package. If the audit reporting package is not viewable on the FAC's website, then it is the auditee's responsibility to submit the audit reporting package to DHSAuditors@wisconsin.gov.

If the auditee is a tribal entity that opts out of allowing the audit reporting package to be publicly available on the FAC's website, then the complete audit reporting package must be submitted to DHSAuditors@wisconsin.gov by the due date. This package *must* also include the management letter if issued by the auditor.

1.7.2 DHS Audit Reporting Package – Submission and Due Date

For auditees that receive $25,000 or more in DHS funding but are not required to have a single audit based on federal funding expenditures, the audit reporting package must be submitted to the funding agency by the earlier of the date specified in the contract/grant agreement or six months from the end of the audit period.

The audit reporting package must be electronically submitted to DHSAuditors@wisconsin.gov if the agency received $25,000 or more in direct funding from DHS. This package must also include the management letter if issued by the auditor. If your agency received DHS funding passed through a Wisconsin county or another funding agency, then please contact the county or funding agency for their requirements for submitting the audit reporting package.

DHS continues to receive audit reports via the United States Postal Service. Please save valuable financial and natural resources, and only electronically submit the audit reporting package. It is not necessary to submit an audit report both electronically and by mail.

1.8 Effective Date for the *DHS Audit Guide*, 2016 Revision

The 2016 update to the *DHS Audit Guide* is effective for audit periods ending on or after December 31, 2016.

1.9 Contact Information

For any technical assistance questions regarding audits and their requirements, email DHSAuditors@wisconsin.gov and identify the provider agency as applicable.

Department of Health Services Audit Guide

Section 2: General Compliance Requirements

2.0 General Compliance Requirements

To provide assurance that Wisconsin DHS programs are properly administered and efficient, departmental oversight and independent audits are required. As these programs have funding from federal agencies and DHS, auditors need to ensure that the agencies administering these programs meet general compliance requirements of federal and state audit guidelines. This *DHS Audit Guide* segregates compliance requirements into separate sections. Section 2 discusses general compliance requirements that auditors test for major state programs as well as general testing procedures of provider agencies that receive DHS funding, while Section 3 details the compliance testing requirements for specific DHS programs.

In prior years, several DHS programs were designated as Type A programs with some automatically deemed as state major. DHS no longer makes this distinction. To better align its requirements with that of the risk-based testing approach of the Uniform Guidance, DHS now requires compliance testing of those DHS programs identified by the auditor as state major programs for single and non-single auditees. For single audits, the auditor must also test internal controls over compliance.

Non-federal entities that expend $750,000 or more in federal awards must comply with the single audit requirements of the Uniform Guidance. The Uniform Guidance's Appendix XI – Compliance Supplement (UGCS) provides information on individual program objectives, procedures, and compliance requirements and assists the auditor in determining appropriate audit objectives and procedures for testing compliance of federal programs. Part 2 of the UGCS provides a matrix that identifies the categories of compliance requirements for each federal grant number. As an example, for Category of Federal Domestic Assistance (CFDA) #93.778 (Medical Assistance Program or Medicaid, Title XIX), a common federal program for DHS providers, the auditor must consider the following 10 categories for testing compliance requirements:

- Activities Allowed or Unallowed
- Allowable Costs/Cost Principles
- Cash Management
- Eligibility
- Matching, Level of Effort, Earmarking
- Period of Performance
- Procurement Suspension and Debarment
- Reporting
- Subrecipient Monitoring
- Special Tests and Provisions

The auditor is responsible for determining which of these 10 compliance requirements are direct and material for testing the Medical Assistance Program for single audits. For other federal programs, these 10 compliance requirements, in addition to program income and equipment and real property management, are considered for single audits. The guidance within this section will focus on the compliance categories of activities allowed, allowable costs, eligibility, matching/level of effort/earmarking, reporting, procurement/suspension/debarment, and subrecipient monitoring. These seven compliance categories are most applicable to DHS providers that receive federal and state funding.

Single audits must comply with Section 3.2 of the UGCS for testing of compliance and internal controls over compliance requirements *and* the compliance requirements listed in Sections 2 and 3 of this DHS audit guide. Section 2 discusses general compliance requirements for all agencies with DHS funding and Section 3 discusses particular compliance requirements for specific DHS programs.

Audits of provider agencies that expend $25,000 or more in DHS funding but do not meet the federal funding expenditure threshold level of $750,000 or more must comply with the auditing standards of the *American Institute of Certified Public Accountants (AICPA)*, *Government Auditing Standards*, and the *DHS Audit Guide*. Non-single audits with DHS funding are required to follow the compliance requirements of Sections 2 and 3. The main difference between single and non-single audits that both expend DHS funding is that the non-single audit does not need to include testing of internal controls over compliance. Although it is the auditor's discretion to determine compliance testing audit procedures based on the assessed level of risk for the auditee, DHS recommends that auditors utilize the general compliance requirements detailed within UGCS to complement their existing general compliance testing methodology for non-single audits.

2.1 Activities Allowed or Unallowed

Activities allowed or unallowed are unique to each program and determined in laws, regulations, contracts, and grant agreements that pertain to each program.

2.1.1 Compliance Requirements

Prior to performing suggested audit procedures, auditors should review the sources and consider the specific requirements listed below:

- Any contracts between DHS, the provider and any subcontractors.
- The UGCS – Part 3.2, Topic A., "Activities Allowed and Unallowed."
- DHS awards may be expended only for allowable activities specific to the program's requirements.
- Agency management and staff should have sufficient understanding of procedures and program requirements to identify unallowable activities.

2.1.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Apply the guidance from the UGCS – Part 3.2, Topic A., "Activities Allowed and Unallowed."
- Obtain an understanding of the entity's internal control over compliance for activities allowed or unallowed and assess risk. Additionally for single audits, test internal controls over compliance.
- Identify activities either specifically allowed or prohibited by the laws, regulations, and the terms and conditions pertaining to the program's award(s).

- Perform sampling procedures to verify that activities were allowable and that those individual transactions had proper classification.
- Ensure that the provider complied with all contractual requirements of the funding agency regarding their use of subrecipients and contractors.

2.2 Allowable Costs

Grant agreements and contracts involving DHS funding require agencies to comply with the *Allowable Cost Policy Manual (ACPM)*. The *ACPM* incorporates federal cost principles by reference and includes links to the federal policies. These federal allowable cost principles are detailed in subpart E (Cost Principles) and Appendices III-IX of the Uniform Guidance.

2.2.1 Compliance Requirements

Prior to performing suggested audit procedures, auditors should review the sources and consider the specific requirements listed below:

- The UGCS – Part 3.2, Topic B., "Allowable Costs/Cost Principles."
- Any contracts between DHS, the provider and any subcontractors.
- Costs must be documented to be allowable.
- All costs charged to the Department's programs must be allowable.
- Costs must be necessary and reasonable for proper and efficient program administration.
- Costs are only reimbursable if directly attributed to program-specific activities or to program administration.
- Program costs should reconcile to the agency's financial records.
- DHS does not approve an agency's cost allocation or indirect cost plan. The Department relies on the independent auditor to confirm that cost allocation and indirect cost plans are in accordance with the *ACPM* and applicable federal cost principles.
- Allocable costs may not be included as a cost of any other federal, state, or other agency-funded program in either the current or a prior period.

2.2.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Apply the guidance from the UGCS – Part 3.2, Topic B., "Allowable Costs/Cost Principles."
- Obtain an understanding of the entity's internal control over compliance for allowable costs/cost principles and assess risk. Additionally for single audits, test internal controls over compliance.
- Test expenditures charged to DHS programs and determine if allowable and supporting documentation exists.
- Trace total costs charged to a program to the provider's general ledger. If the provider filed monthly cost reports throughout the audit year, then the general ledger's year-end balances should match or exceed the total amount charged to the program per the summarized cost reports.
- For cost allocation or indirect cost plans, determine if the plans were in accordance with the *Allowable Cost Policy Manual* and any applicable federal allowable cost principles.

2.3 Eligibility

The requirements for eligibility are unique to each Department program and are found in the laws, regulations, and provisions of contract or grant agreements pertaining to the program.

2.3.1 Compliance Requirements

Prior to performing suggested audit procedures, auditors should review the sources and consider the specific requirements listed below:

- The UGCS – Part 3.2, Topic E., "Eligibility."
- Any contracts between DHS, the provider and any subcontractors.
- Only eligible individuals may participate in the program. Amounts or services provided to or on behalf of clients must be in accordance with each program's requirements.

2.3.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Apply the guidance from the UGCS – Part 3.2, Topic E., "Eligibility."
- Obtain an understanding of the entity's internal control over compliance for eligibility and assess risk. Additionally for single audit, test internal controls over compliance.
- Select a sample of individuals receiving benefits, and verify that the agency appropriately determined eligibility and that the individuals were eligible in accordance with the program's compliance requirements.

2.4 Matching, Level of Effort, and Earmarking

The auditor is required to test matching, level of effort, and earmarking if these requirements are a condition of the agency's funding. The requirements for matching, level of effort, and earmarking are unique to each program and are found in the laws, regulations, and provisions of the contract or grant agreement pertaining to the program.

Matching or cost sharing may require contributions of a specified amount or percentage to match program awards. Matching may be in the form of allowable costs incurred or in-kind contributions.

Level of effort requirements may specify a level of service to be provided from period to period, a level of expenditures from other sources for specified activities to be maintained from period to period, or additional program funds to supplement non-program funding of services.

Earmarking requirements designate a percentage or minimum/maximum amount of program funding for specified activities, including funds provided to subrecipients. Earmarking may also specify the types of participants covered.

2.4.1 Compliance Requirements

Prior to performing suggested audit procedures, auditors should review the sources and consider the specific requirements listed below:

- The UGCS – Part 3.2, Topic G., "Matching, Level of Effort, Earmarking."

- Any contracts between DHS, the provider and any subcontractors
- Matching funds must be allowable under applicable cost principles and be verifiable from the agency's records.
- Specified service(s) and/or expenditure levels must comply with the contractual agreement(s).
- The agency must meet the minimum or maximum limits for specified purposes and/or types of participants.

2.4.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Apply the guidance from the UGCS – Part 3.2, Topic G., "Matching, Level of Effort, Earmarking."
- Obtain an understanding of the entity's internal control over matching, level of effort and earmarking and assess risk. Additionally for single audits, test internal controls over compliance.
- Matching: Identify the matching requirements, and perform tests to verify that the agency met any applicable requirements for matching contributions and followed allowable cost principles.
- Level of Effort: Identify the required level of effort, and perform tests to verify that the agency met the level of effort requirement. Ensure that expenditures agree to the accounting records from which the audited financial statements were prepared.
- Earmarking: Identify the applicable percentage or dollar requirements for earmarking. Perform procedures to verify that the amounts recorded in the financial records met the minimum percentage or amount requirements.

2.5 Reporting

Section 2.5.1 applies to all audits. Sections 2.5.2 and 2.5.3 apply to counties and the nonprofits administering Children's Long Term Support Waiver (CLTS, *DHS Audit Guide,* Section 3.3).

2.5.1 Reporting – General

Reporting requirements are unique to each program as described in the laws, regulations, contract provisions, and/or grant agreements specific to the program.

2.5.1.1 Compliance Requirements

Prior to performing suggested audit procedures, auditors should review the sources and consider the specific requirements listed below:

- The UGCS – Part 3.2, Topic L., "Reporting."
- Any contracts between DHS, the provider and any subcontractors.
- The funding agency may require reporting of costs or activities as the basis for making payments to providers. Financial reporting requirements for subrecipients, as specified by the pass-through entity, are in the contract or grant agreement of the program.
- The funding agency may require performance, program, or other special reporting on an annual, quarterly, or monthly basis. The contract contains special reporting requirements of the program if applicable. Compliance testing of performance and special reporting are only required for the data that are quantifiable and meet the following criteria:
  - Have a direct and material effect on the program.
  - Can be evaluated against objective criteria stated in the statutes, regulations, contracts, or grant agreements pertaining to the program.
- Financial, performance, or other reports should be:

- Supported by the accounting records or other reliable data.
- Net of all applicable credits.
- Complete and mathematically accurate.

2.5.1.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Apply the guidance from the UGCS – Part 3.2, Topic L., "Reporting."
- Obtain an understanding of the entity's internal control over reporting and assess risk. Additionally for single audits, test internal controls over compliance.
- Trace and verify the submitted cost report amounts to the accounting records that support the audited financial statements and the Schedule of Expenditures of Federal and State Awards.
- For financial reports, review accounting records to ascertain if all applicable accounts were included in the sampled reports, including program income, expenditure credits, loans, interest earned, and reserve funds.
- For performance and special reports, review the supporting records to ascertain if all applicable data elements were included in the sampled reports.
- Ensure mathematical accuracy of submitted reports and supporting documentation.

2.5.2 Reporting – Invoices and Community Aids Reporting System (CARS)

2.5.2.1 Compliance Requirements

The following requirements related to allowable costs apply to reports submitted to DHS:

- Net expenses reported to the Department through CARS or invoices must be complete, accurate, and supported by the agency's documentation.
- All expenses must meet the criteria for allowable costs in the *Allowable Cost Policy Manual*.
- Payments received from Medicaid fee-for-service, third-party insurers, and co-payments must offset reported costs of the respective programs.

2.5.2.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Determine whether the agency is reporting allowable costs and netting third-party revenues on CARS and invoices.
- Determine whether the agency is performing control activities to ensure accurate reporting, such as timely and accurate reconciliations between accounting records and CARS reports/invoices submitted to the Department.
- Confirm that the agency has reconciled final costs reported to DHS to those amounts in the audited financial statements.
- Determine if any CARS payments made to and retained by the provider agency are in excess of net allowable costs. If so, then report as a finding with questioned costs if $1,000 or more.

2.5.3 Reporting – Human Services Reporting System (HSRS)

This section applies to counties and Chapter 51 boards that report long-term care costs to the Department through HSRS. HSRS records Medicaid payment and detailed client information for waiver programs. Since HSRS does not generate payments, agencies must report expenditures to CARS. The Department reconciles the reported expenditures to CARS with waiver service costs that the county or Chapter 51 board reported to HSRS.

2.5.3.1 Compliance Requirements

Net expenses reported to the Department through HSRS must be complete, accurate, and supported by the agency's records. All expenses must meet the criteria in the *Allowable Cost Policy Manual*. Costs must meet the following criteria to be an allowable service for the specific service category:

- All services provided to a recipient are documented in an approved Individual Service Plan.
- The cost of the service does not include non-service components, such as personal allowances.
- Program expenses must be net of third-party insurance, client co-payment, or Medicaid fee-for-service payments.

2.5.3.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Determine whether the agency is reporting allowable costs and netting third-party revenues against expenses.
- Determine whether the agency's internal controls ensure accurate reporting and timely and accurate reconciliations between the agency's accounting records and reports submitted to the Department through HSRS.

2.5.4 Relationship between CARS and HSRS

This section and Figure 5 pertain to agencies that report costs for Medical Assistance waiver programs to the Department through CARS and HSRS.

The Medical Assistance waiver programs were established with federal approval in accordance with Sections 1115 or 1915 of Title XIX of the Social Security Act. These programs include Community Integration Program I and Community Integration Program II/Community Options Program Waiver. These programs enable Wisconsin's counties to provide community-based care to citizens who otherwise may require nursing home or institutional care.

Throughout the year, the county waiver agency reports detailed Medicaid waiver program information to HSRS that includes clients served, services provided and expenditures. Since HSRS is not a payment issuance system, the county agency also reports their Medicaid waiver program costs to the appropriate CARS waiver profile. CARS issues monthly payments based on these costs submitted to the appropriate CARS waiver profile(s). All costs reported to CARS and HSRS must be complete, accurate, netted and supported by the county waiver agency's records. All expenses must meet the allowable cost criteria as set in the *Allowable Cost Policy Manual* and be for an allowable service as defined within the recipient's Individual Service Plan. These costs exclude non-service components, such as room, board, and personal allowances.

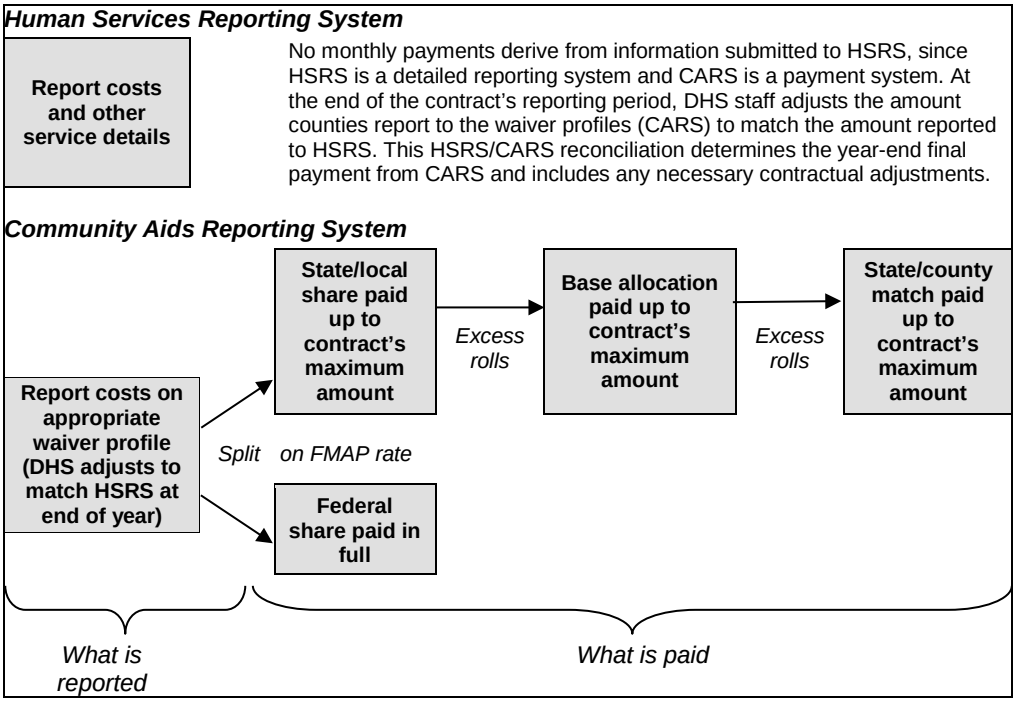
Costs reported by the agency to the Home and Community-Based Services waiver profiles are allocated between the state and federal share amounts based on the yearly Federal Medical Assistance Participation (FMAP) rate. CARS remit monthly payments for the state's share of the contract's maximum and rolls excess costs to the Base County Allocation (BCA). CARS pay the BCA up to the agency's contractual maximum amount and rolls excess costs to the state/county match profile. County agencies typically have costs roll to the state/county match profiles.

Costs allocated to the federal share profiles are fully reimbursed to the reporting agency. The Department draws federal funds to cover reimbursement of waiver costs. The Department's program managers reconcile costs recorded and paid by the CARS waiver profile to match the detailed cost information on

HSRS to finalize the contract year. Final payments include this year-end reconciliation and any contract amendments as needed.

Figure 5 depicts the flow of information in HSRS and CARS.

Figure 5: Payment Determination Based on HSRS/CARS Relationship



2.6 Procurement and Suspension and Debarment

Section 2.6.1 applies to all agencies and all DHS contracts. Section 2.6.2 applies to purchase of care and service contracts only.

Section 2.6.1 discusses general procurement requirements that expend DHS funding for both subrecipients and contractors. Section 2.6.2 applies to those agencies that expend funding for the purchase of care and services and are typically contractors.

2.6.1 General Procurement Requirements and Suspension and Debarment

Procurement requirements of this section apply to all agencies when:

- Payments are made on or limited to an allowable cost basis, including limits on reserves and profit;
- The auditee has a match requirement that is met through other allowable expenditures for the program; or
- Only allowable costs are charged to DHS programs as reported in the audit report.

Grant agreements and contracts involving Department funds require that agencies comply with the *Allowable Cost Policy Manual (ACPM)*. The *ACPM* discusses several aspects of acceptable procurement practices, including written standards of conduct, open and free competition, and minimum procedural requirements.

Many grant agreements and contracts that involve DHS funding prohibit contracts or grant arrangements to agencies or their principals that were suspended or debarred.

2.6.1.1 Compliance Requirements

Prior to performing suggested audit procedures, auditors should review the sources and consider the specific requirements listed below:

- The UGCS – Part 3.2, Topic I., "Procurement and Suspension and Debarment."
- The agency must follow procurement practices that are acceptable under the ACPM.

2.6.1.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Apply the guidance from the UGCS – Part 3.2, Topic I., "Procurement and Suspension and Debarment."
- Obtain an understanding of the entity's internal control over procurement and suspension and debarment and assess risk. Additionally for single audits, test internal controls over compliance.
- Ensure that the agency has written procurement policies and procedures.
- Determine if the agency contracted with eligible Wisconsin contractors/subrecipients. Review the State of Wisconsin's suspended and debarred list online at VendorNet within the "Wisconsin Office of Contract Compliance Vendor Directory" worksheet.

2.6.2 Purchase of Care and Services

This DHS compliance requirement relates to agencies that do meet the Uniform Guidance's definition of a contractor and receive DHS funding for the purchase of care and services.

2.6.2.1 Compliance Requirements

The following compliance requirements apply to purchase of care and services:

- Agencies must follow acceptable procurement standards when purchasing care and services with funds from DHS.
- All care and services purchased shall meet standards established by the Department and other requirements specified by the purchaser within the contract.

2.6.2.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Determine if the agency procured care and services in compliance with applicable procurement policies and procedures.
- Ensure that the agency has a conflict of interest policy regarding the selection, award, or administration of the contract.
- Ensure purchase of care and services contracts are on file at the agency.
- Ensure that payment for care and services does not exceed the contract's specified amount.

2.7 Subrecipient Monitoring

This section applies to agencies that have single audits and sub-award funding: tribes, counties, 51 boards and nonprofit agencies.

A subrecipient is a non-federal entity that receives a sub-award from a pass-through entity to carry out an aspect of a federal program, excluding individuals that benefit from such programs. To assist provider agencies in determining if an award is a subrecipient or contractor relationship, Section 200.330, "Subrecipient and Contractor Determinations," of the Uniform Guidance provides guidance for pass-through entities to make case-by-case determinations regarding the type of relationship an award represents. Depending on the entity and terms of its agreements, an agency can be a pass-through entity, a subrecipient, and a contractor per a contract's language.

Characteristics that support the classification of the non-federal entity as a subrecipient include when the non-federal entity:

- Determines who is eligible to receive federal assistance.
- Has its performance measured in relation to whether objectives of a federal program are met.
- Has responsibility for programmatic decision-making.
- Is responsible for adherence to applicable federal program requirements specified in the federal award.
- Uses federal funds to carry out a program for a public purpose specified in authorizing statute as opposed to providing goods or services for the benefit of the pass-through entity, in accordance with its agreement.

Characteristics indicative of a procurement relationship between the non-federal entity and a contractor are when the contractor:

- Provides the goods and services within normal business operations.
- Provides similar goods or services to many different purchasers.
- Normally operates in a competitive environment.
- Provides goods or services that are ancillary to the operation of the federal program.
- Is not subject to compliance requirements of the federal program per the contract even though similar responsibilities may apply for other reasons.

In determining if an entity that receives funding is a subrecipient or contractor, also consider the following factors:

- Competition – Awards are not required to be issued on a competitive basis, while procurement contracts are typically based on free and open competition.
- Multiple Awards – Federal awards are usually issued to multiple recipients, whereas purchase contracts usually select one contractor to provide the required goods or services.
- Elements of Cost – Subrecipients normally are reimbursed only for incurred allowable cost, while contractors are paid some amount above cost.
- Risk – Contractors assume most of the risk for performance on a contract.
- Cost Participation – Subrecipients are many times required to provide matching funds or share in the cost of a federal program, whereas cost sharing is highly unlikely in contractor's agreements.
- Selection Criteria – For sub-awards, generally a demonstrated need for the funds is most important, whereas the ability to deliver a product or service takes precedence for contractors.

- Purpose – In a sub-award, the direct recipient provides assistance to the subrecipient for the subrecipient program, whereas in a contractor relationship the direct recipient hires help for its own program.
- Scope of Services – For contractor procurements, the goods or services purchased are detailed in the contract. In a sub-award transaction, only the program details are identified in the award document.
- Terms/Conditions – Subrecipients may have special terms and conditions unilaterally imposed by direct recipients per terms of the contract. For procurement contracts, special terms and conditions are typically not included unless agreed upon by the contractor at the time of the award.
- Termination – In general, an award or sub-award can be unilaterally terminated by the awarding agency only for cause. A procurement contract can be terminated for the convenience of the awarding agency.

2.7.1 Requirements for Pass-Through Entities

This section is applicable to all agencies that pass-through federal or state funds. The Uniform Guidance, § 200.331, contains the requirements for entities that pass through federal awards. Wisconsin awards should also follow these requirements, substituting State of Wisconsin program identification information if applicable.

Audit requirements can present challenges for pass-through entities since the requirements differ depending on the awarding agency's level of federal expenditures, program requirements, and the contractual language of the award. Therefore, it is imperative that the pass-through entity understands the nuances of audit requirements before imposing them on a subrecipient. For its subrecipients, the pass-through entity must identify the award and its applicable requirements, evaluate the risk, monitor, and ensure accountability of for-profit subrecipients. Since the Uniform Guidance's audit requirements do not apply to for-profit subrecipients, the pass-through entity is responsible for establishing requirements to ensure for-profit subrecipient compliance for sub-awards.

2.7.1.1 Compliance Requirements:

The following information should be helpful for understanding subrecipient monitoring and its compliance requirements:

- Review the requirements detailed in the UGCS, Appendix XI, Part 3.2, Topic M. "Subrecipient Monitoring."
- Provider audit reports are typically due to the funding agency six months from the end of the provider's fiscal period. The funding agency should review and resolve each provider's audit report within six months of receiving the audit report.
- Wisconsin Stat. § 46.036(4)(c) requires providers, both subrecipients and contractors that receive $25,000 or more in direct funding from DHS or pass-through funding from a county, to have an audit, unless waived by the Department. See Section 1.0.3, DHS – Audit Waivers, within this guide for audit waiver information.
- An effective system for proper subrecipient monitoring by a funding agency must include the following characteristics as required by the Uniform Guidance, § 200.331, Requirements for Pass-Through Entities:
  - Ensure that every sub-award is clearly identified to the subrecipient as a sub-award, and include the following information at the time of the sub-award:
    - Federal Award Identification: Subrecipient's name and unique entity identifier, the Federal Award Identification Number, federal award date, sub-award period of performance start and end date, amount of funds, description, CFDA number and name, and identification of whether the award is research and development.

- All requirements imposed by the pass-through entity on the subrecipient so that the federal award is used in accordance with federal statutes, regulations, and the terms and conditions of the federal award.
- Any additional requirements that the pass-through entity imposes on the subrecipient in order for the pass-through entity to meet its own responsibility to the federal awarding agency, including identification of any required financial and performance reports.
- An approved federally recognized indirect cost rate negotiated between the subrecipient and the federal government or, if no such rate exists, either a rate negotiated between the pass-through entity and the subrecipient (in compliance with this part) or a de minimis indirect cost rate as defined in the Uniform Guidance, § 200.414 (f).
- A requirement that the subrecipient permit the pass-through entity and auditors to have access to the subrecipient's records and financial statements as necessary for the pass-through entity to meet the requirements of this part.
- Appropriate terms and conditions concerning closeout of the sub-award.

- Evaluate each subrecipient's risk of noncompliance with federal statutes, regulations, and the terms and conditions of the sub-award for purposes of determining the appropriate subrecipient monitoring.
- Consider imposing specific sub-award conditions upon a subrecipient if deemed appropriate per the Uniform Guidance, § 200.207 – Specific Conditions.
- Monitor the activities of the subrecipient as necessary to ensure that the sub-award is used for authorized purposes in compliance with federal statutes, regulations, and the terms and conditions of the sub-award and that sub-award performance goals are achieved. Pass-through entity monitoring of the subrecipient must include:
  - Reviewing financial and performance reports required by the pass-through entity.
  - Following up and ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the federal award provided to the subrecipient from the pass-through entity detected through audits, on-site reviews, and other means.
  - Issuing a management decision for audit findings pertaining to the federal award provided to the subrecipient from the pass-through entity as required by the Uniform Guidance, § 200.521 – Management Decision.
- Depending upon the pass-through entity's assessment of risk posed by the subrecipient, monitoring tools, such as providing the subrecipient with training or technical assistance and performing on-site reviews of the subrecipient' s program operations, may be useful for the pass-through entity to ensure proper accountability and compliance with the program's requirements and achievement of performance goals.

2.7.1.2 Suggested Audit Procedures

Auditors should consider the following procedures:

- Obtain an understanding of the entity's internal control over subrecipient monitoring and assess risk. Additionally for single audits, test internal controls over compliance.
- Review documentation to determine if the pass-through entity properly identified the sub-award and applicable requirements for the subrecipient at the time of the sub-award in the terms and conditions of the sub-award and other award documents sufficient for the pass-through entity to comply with federal or state statutes, regulations, and the terms and conditions of the federal award.
- Determine if the funding agency has an effective tracking system in place to monitor audit reports due from its contractors and subrecipients. Ensure that the methodology employed by the funding agency accurately determined contractual relationships as either contractor or subrecipient.

- Determine if the funding agency collected and reviewed provider audit reports in a timely manner, and ensure that the subrecipient takes timely and appropriate action on deficiencies detected through audits.

Due to timing, auditors may encounter situations in which due dates for audit report submissions to the funding agency and/or oversight review by the county have yet to occur during the auditor's fieldwork. In these instances, there is no audit finding of noncompliance, and the auditor must follow up on the status of the agency's monitoring of provider audits in the subsequent audit period. Auditors should report an audit finding if the funding agency did not implement an effective tracking system for those audit reports due or if the funding agency failed to collect or review an audit report in a timely manner.

2.8 Patient Rights and Funds

This section applies to audits of counties and 51 boards for major programs as assessed by the auditor.

Wisconsin Stat. § 51.61 and Wis. Admin. Code ch. DHS 94, Patient Rights, define the legal requirements for patients' rights and funds for patients with a mental illness, a developmental disability, alcohol abuse or dependency, or other drug abuse or dependency. The purpose of this section is to ensure that county agencies and boards comply with the requirements for patients' rights and funds while county staff provides services to these patients.

2.8.1 Compliance Requirements

Review Wis. Stat. § 51.61 and Wis. Admin. Code ch. DHS 94 for regulations and rules that pertain to patient rights and funds.

2.8.2 Suggested Audit Procedures

For a representative sample of case files, determine whether the county has complied with the laws and administrative rules governing patient rights and patient funds. Counties typically document compliance with these requirements in the patient's case file. Auditors should:

- Check for an annual invitation to or meeting with the patient/guardian to participate in the planning of his/her treatment and care.
- Check for annual written informed consent, signed by the patient/guardian, for treatment and medications.
- Check for documentation of annual re-notification of rights, including the right to file a grievance.
- Verify that consent is documented if the provider acts as a representative payee for the patient. If a provider agency (including facilities such as community-based residential facilities, adult family homes, residential care apartment complexes, nursing homes, or facilities for the developmentally disabled) manages a patient's funds, review transaction records on the use of the patient's funds and cash disbursements, confirm that the patient's funds were segregated and individually identifiable from the provider's funds, that the patient has access to his/her personal allowance/petty cash, and that a written monthly account of any financial transactions using the patient's funds was provided to the patient or guardian if such information was requested in writing
- Check for documentation of patient rights' training for staff members that work with patients.

Report any absence of appropriate case files or training documentation as an audit finding if the agency cannot produce the required documentation.

2.9 Additional Supplemental Schedules Required by DHS

The *Main Document of the State Single Audit Guidelines*, Section 4.3, allows a funding agency, through approval from Wisconsin's Department of Administration, to require additional supplemental schedules for inclusion in the audit reporting package. DHS uses audited information from supplemental schedules to review allowable costs, excess reserves and profit as applicable. DHS requires the following three supplemental schedules, contingent on specified conditions:

- DHS Cost Reimbursement Award Schedule
- Reserves Schedule
- Allowable Profit Schedule

2.9.1 DHS Cost Reimbursement Award Schedule

The DHS Cost Reimbursement Award Schedule is required for each award (i.e., contract or grant) when all of the following conditions are met:

- The auditee is a nonprofit, for-profit, or a local unit of government other than a county, tribe, Chapter 51 board, or school district.
- The auditee received payments totaling $100,000 or more directly from DHS.
- The payments were limited to an allowable cost basis or based on reported allowable costs.

Figures 6 and 7 illustrate the schedule's format and provide instructions for its completion. The DHS Cost Reimbursement Award Schedule must be covered by the auditor's Opinion on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards (*Main Document*, Section 4.6). This states the auditor's opinion on whether the information in the schedule is "fairly stated, in all material respects, in relation to the basic financial statements taken as a whole."

Figure 6: DHS Cost Reimbursement Award Schedule

<Name or Organization>
<Name of Grant>
DHS Cost Reimbursement Award Schedule
For the Audit Period Ended <date>

DHS identification number	**CARS profile XXXXX**	**CARS profile XXXXX**
Award amount	**$XXX,XXX**	**$XXX,XXX**
Award period	**m/d/y – m/d/y**	**m/d/y – m/d/y**
Period of award within audit period	**m/d/y – m/d/y**	**m/d/y – m/d/y**
A. Expenditures reported to DHS for payment	$ xxx,xxx	$ xxx,xxx
B. Total costs of award		
1. Employee Salaries and Wages	$ xx,xxx	$ xx,xxx
2. Employee Fringe Benefits	xx,xxx	xx,xxx
3. Payroll Taxes	xx,xxx	xx,xxx
4. Rent or Occupancy	xx,xxx	xx,xxx
5. Professional Services	xx,xxx	xx,xxx
6. Employee Travel	xx,xxx	xx,xxx
7. Conferences, Meetings or Education	xx,xxx	xx,xxx
8. Employee Licenses and Dues	xx,xxx	xx,xxx
9. Supplies	xx,xxx	xx,xxx
10. Telephone	xx,xxx	xx,xxx
11. Equipment	xx,xxx	xx,xxx
12. Depreciation	xx,xxx	xx,xxx
13. Utilities	xx,xxx	xx,xxx
14. Bad Debts	xx,xxx	xx,xxx
15. Postage and Shipping	xx,xxx	xx,xxx
16. Insurance	xx,xxx	xx,xxx
17. Interest	xx,xxx	xx,xxx
18. Bank Fees and Charges	xx,xxx	xx,xxx
19. Advertising and Marketing	xx,xxx	xx,xxx
20. Other	xx,xxx	xx,xxx
Total Operating Costs of Award	xxx,xxx	xxx,xxx
C. Less disallowed costs	xx,xxx	xx,xxx
D. Less program revenue and other offsets to costs	xx,xxx	xx,xxx
E. Net allowable operating costs before profit (to Figure 10, Line 1a of Allowable Profit Schedule if for-profit agency)	xx,xxx	xx,xxx
F. Add allowable profit (from Figure 10, Line 3 of Allowable Profit Schedule if for-profit agency)	xx,xxx	xx,xxx
G. Total Allowable Costs	$ xxx,xxx	$ xxx,xxx

Figure 7: Instructions for Preparing the DHS Cost Reimbursement Award Schedule

Instructions for Preparing the DHS Cost Reimbursement Award Schedule

Prepare a DHS Cost Reimbursement Award Schedule for each award if all of the following conditions are met:

- The auditee is a nonprofit, for-profit or a local unit of government *other than* a county, tribe, Chapter 51 board, or school district,
- The auditee expended a total amount of $100,000 or more of direct funding from DHS, and
- The basis for DHS funding payments were reported allowable costs or limited to allowable costs.

If the award period differs from the audit period, present separate columns for each award period that overlaps the audit period. Add additional expense account categories to Figure 6 as needed. A nonprofit agency may substitute a Schedule of Functional Revenue and Expenses for the DHS Cost Reimbursement Award Schedule if the funding source columns identify each DHS award by CARS profile number within the audit period.

***A* – Expenditures reported to DHS for payment –** Report total expenditures the agency reported to DHS for payment. This amount must tie out to the summarized invoices or CARS expenditure reports that the agency filed for the audit period.

B – Total costs of the award – For presenting the actual allowable cost of the award, all costs must meet the requirements of the *Allowable Cost Policy Manual*.

C – Less disallowed costs – Deduct disallowed costs such as bad debts, marketing or disallowed advertising.

D – Less program revenue and other offsets to costs – Deduct program revenue and other offsets to costs and include a note explaining these amounts.

E – Total allowable costs before profit and ***F – Allowable profit*** – Sections E and F apply to for-profit organizations. Use the amount for Line E -Total allowable costs before profit" in the "DHS Cost Reimbursement Award Schedule" (Figure 6) for "Line 1a – Net allowable operating cost" in the "Allowable Profit Schedule" (Figure 10). Use the amount of "Line 3 - Allowable profit" from the "Allowable Profit Schedule" for "Line F – Allowable profit" in the "DHS Cost Reimbursement Award Schedule."

G – Total allowable costs – Total allowable costs for the award are the program costs, less program revenue and other offsets to costs, plus profit if applicable. If total allowable costs are less than the payment(s) based on reported allowable costs, the auditor must report a finding with questioned costs if $1,000 or more.

2.9.2 Reserves Schedule

This part applies only to nonprofits paid on a prospectively set rate basis and settled to an allowable cost basis.

Wisconsin Stat. § 46.036(5m) allows certain provider agencies to retain reserves funded by Department programs when the agency is a nonprofit, non-stock corporation *and* the funding agency purchased care and services for members on the basis of a unit rate per unit of client service. The statute defines rate-based service as "a service or a group of services, as determined by the Department, that is reimbursed through a prospectively set rate and that is distinguishable from other services or groups of services by the purpose for which funds are provided for that service or group of services and by the source of funding for that service or group of services." Examples to distinguish services include different rate per unit of service at different locations, different funding sources, and purchased by different purchasers.

The statute limits the retention amount based on two tests. The first test limits the retention amount in the current year to 5 percent of the contract amount. The second test limits accumulated total reserves for all years to 10 percent of the amount paid under the current contract.

Auditors should be aware that some providers that receive funding from DHS also receive funding from the Department of Children and Families (DCF). Both have similar statutes allowing providers to retain reserves. Wisconsin Stat. § 49.34 details the rules for DCF funding reserves and exempts certain child welfare providers from limitations on use of surplus revenue. These changes **do not apply** to funding from DHS. Auditors should be alert that providers have errantly applied the reserves' policies of DCF to the DHS' funding reserves.

2.9.2.1 Reserves Schedule Requirement

If the agency provider maintains a reserves fund from the Department's program(s), the audit report must include a "Reserves Schedule" for each rate-based service. The schedule must be covered by the auditor's "Opinion on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards," which states the auditor's opinion on whether the information in the schedule is "fairly stated, in all material respects, in relation to the basic financial statements taken as a whole."

For purposes of this schedule, materiality is in relation to the service as discussed for additional considerations in the Main Document of the State Single Audit Guidelines, Section 4.11. General agency costs cannot be included in the schedules for the program unless the overall cost pool/distribution basis is included in the scope of the audit.

2.9.2.2 Excess Reserves

Reserves in excess of either test belong to the funding agency, including situations in which the funding agency no longer contracts with the agency provider. The Department recommends that the agency provider contact the purchaser to remedy the excess reserves in accordance with the allowable uses of this funding per Wis. Stat. § 46.036(5m)(b)2. The auditor should report a finding if an agency diverts or uses excess reserves not in accordance with the contract or statute.

Figures 8 and 9 illustrate the format and instructions for completing the Reserves Schedule.

Figure 8: Reserves Schedule

Reserves Schedule
<Name of Facility>
For the Audit Period Ended <date>

1. Total units of service _____
2. Allowable expenses for rate-based service _____
3. Total revenue for rate-based service _____
4. Excess (deficiency) revenue over expenses (line 3 minus line 2) _____
5. Total reserves from all prior periods, excluding this period _____
6. Calculation of reserve and amounts due to purchasers:

6a Purchaser	6b Revenue from purchaser	6c Purchaser's share of total revenue	First Test				Second Test					6m Total amount due to purchaser
			6d Purchaser's share of excess revenue (deficiency)	6e Cap on reserves for first test	6f Amount to add to reserves for this period	6g Amount due to purchaser from first test	6h Purchaser's share of reserves from prior periods	6i Purchaser's share of reserves from all periods	6j Cap on reserves for second test	6k Amount of reserves	6l Amount due to purchaser from second test	

Figure 9: Instructions for the Reserves Schedule

Name of Facility – Enter the name of the facility and all other information on the Reserves Schedule, Figure 8. DHS requires separate schedules for each type of rate-based service operated by the provider.

For the Audit Period Ended – Enter the ending date of the audit period.

1. Total Units of Service – Enter the total units of rate-based service provided during the audit period.

2. Allowable Expenses for Rate-Based Service – Enter the total allowable expenses for rate-based service.

3. Total Revenue for Rate-Based Service – Enter the total amount of rate-based revenue received from all sources (total of column 6b; see instructions below).

4. Excess (Deficiency) Revenue Over Expenses = Line 3 minus Line 2 (Total Revenue for Rate-Based Service – Allowable Expenses for Rate-Based Service).

5. Total Reserves From All Prior Periods – Enter the amount of reserves carried forward from all prior periods. Exclude reserves for the current audit period.

6. Calculation of Reserves and Amounts Due to Purchasers:

6a. Purchaser – List the name of each purchaser that provided rate-based revenue to the facility.

6b. Revenue from Purchaser – List the amount of rate-based revenue from each purchaser. Enter the total amount on Line 3.

6c. Purchaser's Share of Total Revenue – Calculate each purchaser's percent share of the total revenue for each rate-based service. Divide each purchaser's revenue in column 6b by the total revenue amount of column 6b. Column 6c should total 1.00, or 100 percent.

Columns 6d through 6g are used to calculate the first reserves test. The first test limits the current audit period's amount of excess revenue available for reserves' retention to 5 percent of the current contract's total revenue amount or the limit determined by contract, whichever amount is lower.

6d. Purchaser's Share of Excess Revenue (Deficiency) – Calculate each purchaser's share of the excess revenue by multiplying the amount from Line 4 by the share of total revenue in column 6c. The total amount of column 6d must equal Line 4.

6e. Cap on Reserves for First Test – Enter the lower amount of column 6b multiplied by 5 percent (0.05) or the cap amount on the reserves specified by contract in column 6e. Calculate this amount for each purchaser's row.

6f. Amount to Add to Reserves for This Period, and 6g. Amount Due to Purchaser as a Result of the First Test – If the purchaser's share of excess revenue (column 6d) exceeds the cap

on reserve for the first test (column 6e), then enter the amount of the cap (6e) in column 6f, and enter the amount in excess of the cap (columns 6d-6e) in column 6g. If 6d is less than 6e, then enter 6d in column 6f and $0 in column 6g.

Columns 6h-6l are used to calculate the second test that limits the amount or reserves for all audit periods to 10 percent of current contract revenue or the limit imposed by contract, whichever is lower.

6h. Purchaser's Share of Reserves from All Prior Periods – Enter the purchaser's share of reserves from all prior periods. Providers may use a method agreed to by the purchasing agency for determining the share. Two possible ways to determine shares are to use the purchaser's share as determined by prior audit or to use a pro-rata share obtained by multiplying the amount of reserve for all prior periods (Line 5) by the purchaser's share of total revenue (column 6c).

The total for column 6h must agree with Line 5.

6i. Purchaser's Share of Reserve from All Periods – Add the amount to add to reserves for this period (column 6f) to the share of the reserves from prior periods (column 6h).

6j. Cap on Reserves for Second Test – Enter the cap on the reserves specified by the contract or 10 percent of the amount of revenue from the purchaser (column 6b), whichever is lower.

6k. Amount of Reserves and 6l. Amount due to Purchaser from Second Test – If the purchaser's share of the reserves from all periods (column 6i) exceeds the cap on reserves for the second test (column 6j), enter the amount of the cap in column 6k and enter the amount in excess of the cap (column 6i-6j) in column 6l. Otherwise, enter the amount of the purchaser's share of reserve from all periods (column 6i) in column 6k and $0 in column 6l.

6m. Total Amount Due to Purchaser – For each purchaser's row, add the amounts due to the purchaser from the first test (column 6g) and the second test (column 6l) to determine the total amount due to the purchaser.

2.9.3 Allowable Profit Schedule

This section applies to for profit entities paid on a prospectively set rate basis settled to an allowable cost basis.

Wisconsin Stat. § 46.036(3)(c) states that contracts with proprietary agencies may include a percentage add-on for profit according to rules promulgated by the Department. Allowable profit is calculated by applying a percentage equal to 7.5 percent of net allowable operating costs plus 15 percent of net equity, the sum of which may not exceed 10 percent of net allowable operating costs. Net equity is the cost of equipment, buildings, land, fixed equipment, less accumulated depreciation, and long-term liabilities. The average net equity for the year is used. If the net equity is less than zero, then disregard the net equity calculation in determining allowable profit.

Funding agencies may establish lower limits on allowable profit or disallow profit per their contracts.

2.9.3.1 Allowable Profit Schedule Requirement

If the auditee is a for profit entity, the audit report must include an Allowable Profit Schedule. The schedule must be covered by the auditor's "Opinion on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards," which states the auditor's opinion on whether the information in the schedule is "fairly stated, in all material respects, in relation to the basic financial statements taken as a whole." Figure 10 illustrates the format to use for this schedule.

Separate profit calculations are required at the function or program level if an agency operates multiple functions or programs.

For purposes of this schedule, materiality is in relation to the program and takes into account additional considerations in discussion in *Main Document of the State Single Audit Guidelines*, Section 4.11.

General agency costs cannot be included in the schedules for the program unless the overall cost pool/distribution basis is included in the scope of the audit.

2.9.3.2 Excess Profit

Profit in excess of the allowable limit must be returned to the funding agency. The funding agency determines the recovery method for excess profit, typically through a future rate adjustment or by the provider agency remitting the excess profit amount to the funding agency. The provider agency should contact the funding agency for treatment of excess profit.

Figure 10: Allowable Profit Schedule

Allowable Profit Schedule
<Name of Facility>
<Name of Parent Company>
For the Audit Period Ended <date>

1	Base calculation			
1a	Net allowable operating costs	$ -		
	From Figure 6, Line E			
	x 0.075	$ -		
	Note – deduct unallowable costs (such as costs above cost of ownership for related party rent) and cost offsets (such as commodities)			
1b	Adder for average net equity (disregard this step if equity is less than zero)	Beginning of Period	End of Period	
	Cost of equipment	$ -	$ -	
	Cost of building	$ -	$ -	
	Cost of land	$ -	$ -	
	Cost of fixed equipment	$ -	$ -	
	Less accumulated depreciation	$ -	$ -	
	Less long term liabilities	$ -	$ -	
	Net equity	$ -	$ -	
	Average net equity	$ -		
	x 15%	$ -		
1c	Total base calculation	$ -		
	(Sum of amounts calculated in steps 1a and 1b)			
2	Cap on allowable profit:			
	Net allowable operating cost	$ -		
	x 10%	$ -		
3	Allowable profit	$ -	To Figure 6, Line F	
	(Lesser of amounts calculated in steps 1c and 2)			

Department of Health Services Audit Guide

Section 3: Compliance Requirements for DHS Programs

3.1 Aging and Disability Resource Centers

This section is applicable to audits of agencies that have employees working on Aging and Disability Resource Center activities, whether the funding for these activities is directly received from the Department of Health Services or through a lead agency. Funding: General Purpose Revenue and Medical Assistance, CFDA number 93.778. The former Division of Long Term Care (DLTC) is now the Division of Medicaid Services (DMS).

3.1.1 Background

Aging and Disability Resource Centers (ADRC) provide elderly adults and people with physical or developmental/intellectual disabilities the resources needed to live with dignity and security and to achieve maximum independence and quality of life. The goal of the ADRC is to empower individuals to make informed choices and to streamline access to the right and appropriate services and supports. The ADRC provides information on a broad range of programs and services, helps people understand the various long-term care options available, helps people apply for programs and benefits, and serves as the access point for publicly funded long-term care that includes Family Care and IRIS (Include, Respect, I Self-Direct).

The ADRC provides numerous services, including:

- Information about local services and available resources.
- Assistance in finding adaptive equipment, assisted living/nursing home options, employment programs, financial aid, health and wellness programs, housing options, in-home personal care, nutrition, prescription drug coverage, respite, support groups, and transportation.
- Counseling for long-term care options.
- Information about Medicaid long-term care programs benefits counseling related to Medicare, Medicaid, Social Security, FoodShare and private health insurance.
- Health and wellness programs.
- Functional and financial eligibility determination for Family Care.

Unless noted, the DHS compliance requirements are from the DHS and ADRC contract for the current calendar year. The auditor should reference the contract and supplementary materials to assess the requirements for each ADRC.

3.1.2 Risk Assessment

The ADRC program is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform a risk assessment to determine if this program is a major state program.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the ADRC program:

- The ADRC's time reporting is inaccurate or undocumented.
- The salary and benefit costs of the ADRC program include costs of employees not involved in ADRC activities.
- The program is new or the program requirements have substantially changed in the current audit period.
- The program has complex administrative requirements.

3.1.3 Compliance Requirements and Suggested Audit Procedures

3.1.3.1 Allowable Activities – Medicaid Cost Center for Information and Assistance (I & A) Activities

3.1.3.1.1 Compliance Requirements

In order to claim Medicaid funds, each Resource Center must establish a separate cost center or department for ADRC expenses. There can be one cost center for the entire program in the accounting records, or there may be one for I & A staff, one for DBS (Disability Benefits Specialist) I & A staff, and one for EBS (Elder Benefits Specialist) I & A staff. These cost centers will include all costs related to performing approved ADRC activities.

Costs charged to these cost centers are based on 100 percent time reporting or, in the case of indirect expenses, an acceptable methodology.

Regardless of the number of cost centers, the costs eligible for Medicaid reimbursement are determined by applying the results from the 100 percent time reporting summary sheets to the cost centers and are reported to the state via the Community Aids Reporting System (CARS) on profile numbers 560086 for I & A, 560080 for DBS I & A staff, and 560070 and 560074 for EBS I & A staff. EBS I & A staff can also be claimed through Greater Wisconsin Agency on Aging Resources (GWAAR) using profile numbers 560020 and/or 560028. Fifty percent is the total of the Medicaid-eligible portion of the costs, which is then allocated to profiles 560087, 560081, 560072, 560021, and 560029, respectively, for reimbursement to the Resource Center. The remaining amounts are then allocated to profiles 560088, 560092, 560072, 560022, and 560030, respectively, for reimbursement up to the Resource Center's contract maximum. Those costs not eligible for Medicaid reimbursement, which are identified by the 100 percent time reporting results being applied to the cost centers, and are reported on profiles 560095, 560085, 560075, 560023, and 560031, respectively.

3.1.3.1.2 Suggested Audit Procedures

Auditors should apply the following audit procedures:

- Ensure that expenditures reported on CARS profiles 560086, 560080, 560074, and 560070 were not also reported on CARS profiles 560095, 560085, and 560075.
- Ensure that expenditures reported on CARS profiles 560070, 560074, and 560075 were not also reported on CARS profiles 560020, 560023, 560028, and 560031.
- Review monthly hours and expenditures for reasonableness and consistency. If a material fluctuation exists, perform a more extensive analysis to determine its source.

3.1.3.2 Allowable Costs – Functional Screen Federal Financial Participation (FFP)

3.1.3.2.1 Compliance Requirements

The following allowable cost requirements apply to ADRCs:

- Resource Centers are eligible to receive federal payments to offset 50 percent of the costs of administering functional screens if those screens are used to determine an individual's eligibility for the Medicaid program.
- Costs of functional screens are reported on CARS profile number 560090. The calculated Medicaid portion is allocated to CARS profile 560091 for reimbursement to the Resource Center. The remaining amount is allocated to CARS profile 560092 for reimbursement up to the Resource Center's contract maximum.

3.1.3.2.2 Suggested Audit Procedure

Auditors should ensure that expenditures reported on CARS profile 560090 were not also reported on CARS profile 560095.

3.1.3.3 Eligibility

DHS has no additional compliance requirements or suggested audit procedures for eligibility.

3.1.3.4 Matching, Level of Effort, and Earmarking

DHS has no additional compliance requirements or suggested audit procedures for matching, level of effort, and earmarking.

3.1.3.5 Reporting Requirements

3.1.3.5.1 Compliance Requirements

The contract between the WI DHS Division of Medicaid Services (DMS) and ADRC details the requirements and procedures for operating an ADRC. The following reporting requirements are detailed in the ADRC contract:

- Daily activity logs (100 percent time reporting) are required of all ADRC staff members and subcontractors using the Department's spreadsheet format for claiming the Medicaid administration match for eligible ADRC services. Monthly time reports are due by the 20th of the month following the time report month.
- The ADRC shall electronically submit monthly expenditure reports to the Department at DHS600RCARS@dhs.wi.gov with the CARS Expenditure Report, F-00642.
- The ADRC shall submit an annual expenditure report using the standard report form provided by the Department. The ADRC shall submit the annual expenditure report to the Department no later than June 1 of the year following the year for which the report is prepared. Annual expenditure reports shall be submitted to the Office for Resource Center Development's Fiscal Analyst at DHSRCTeam@wisconsin.gov.

3.1.3.5.2 Suggested Audit Procedures

Auditors should apply the following procedures:

- Sample monthly time reports, and trace the submitted information to the agency's timesheets to ensure accuracy and proper documentation.

- Review the monthly and annual expenditure reports to determine accuracy and consistency between the submitted reports and the agency's general ledger.

3.2 Basic County Allocation

This section is applicable to audits of counties and 51 boards. Funding: The Basic County Allocation (BCA) is funded by DHS, the Social Service Block Grant (93.667), and the Temporary Assistance to Needy Families (93.558) program and is reported through the Community Aids Reporting System (CARS profile #561). The BCA funding composition annually varies and includes federal funding with the majority of funding provided by the state of Wisconsin.

3.2.1 Background

The Basic County Allocation is a block grant to Wisconsin counties for assistance in funding social and community service programs. The BCA (CARS profile #561) is a Wisconsin DHS budget fund category that tracks expenditures for administrative costs of social and community service programs and captures excess amounts of contracted amounts for several other CARS profile numbers. If the reported expenditures for the BCA exceed the agency's budget, those expenditures in excess of the contracted amount roll to the State/County Match CARS profile #681. Social service unit costs for the applicable BCA programs submit to CARS profile #561 by reporting costs for all staff members whose assigned functions are social services. Social service unit costs include:

- Salaries and fringe benefits of supervisors, workers, aides, specialists, and direct clerical support staff
- Travel costs associated for the employees listed above
- Supplies, services, and equipment directly identifiable to the social services unit

BCA funding pays for social services and services for mentally disabled persons, including payments remitted to DHS for Family Care contributions.

3.2.2 Risk Assessment

The BCA program is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform this risk assessment to determine if this program is a major state program.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the BCA program:

- Costs submitted to CARS are unallowable, unverifiable, undocumented, or not traceable to the county's general ledger.
- The auditor identified significant internal control or compliance issues regarding the county's payroll function.
- The program is new or the program's requirements have substantially changed for this auditee.

3.2.3 Compliance Requirements and Suggested Audit Procedures

3.2.3.1 Activities Allowed or Unallowed

DHS has no additional compliance requirements or suggested audit procedures for activities allowed or unallowed.

3.2.3.2 Allowable costs

3.2.3.2.1 Compliance Requirement

All costs charged to the Basic County Allocation must be allowable and conform to the cost policies detailed in the *CARS Accounting Reports Manual* and the *Allowable Cost Policy Manual*.

3.2.3.2.2 Suggested Audit Procedure

Select a sample of detailed expenditures from the agency's submitted BCA cost reports to determine if costs are in accordance with the CARS Accounting Reports Manual, the ACPM, and are documented and traceable to the agency's general ledger.

3.2.3.3 Eligibility

DHS has no additional compliance requirements or suggested audit procedures for eligibility.

3.2.3.4 Matching, Level of Effort, and Earmarking

DHS has no additional compliance requirements or suggested audit procedures for matching, level of effort, and earmarking.

3.2.3.5 Reporting Requirements

DHS has no additional compliance requirements or suggested audit procedures for reporting.

3.3 Children's Long-Term Support (CLTS) Waivers

This section applies to counties, Lutheran Social Services, and the St. Francis Children's Center. Funding: Medical Assistance, CFDA #93.778. The former Division of Long Term Care (DLTC) is now the Division of Medicaid Services (DMS).

3.3.1 Background

The CLTS Waiver Program is comprised of three Medicaid Home and Community-Based Service (HCBS) Waivers established under Section 1915(c) of the Social Security Act as part of the Wisconsin Medicaid Program. The three CLTS waivers serve children who have a developmental disability (DD), a physical disability (PD), or a severe emotional disturbance (SED).

The objective of these waivers is to provide eligible children and their families with individualized supports and services that allow the child to live in the community with their families or guardians instead of residing in an institution or an alternate care setting.

Since 2012, all provider claims of CLTS waiver services are processed and paid by DHS' contracted third-party administrator (TPA). This change enabled the Department to meet federal requirements for a standardized, statewide Medicaid Management Information System (MMIS) for authorizing, adjudicating, and processing claims and encounter data collection.

County waiver agencies (CWAs) issue prior authorizations to their providers and the TPA. The prior authorizations include details for the approved provider, the participant, units, and rates for each covered waiver service. Following delivery of the service, the provider submits its claims to the TPA for payment. The TPA processes and adjudicates the claims (including Medicaid card and health insurance coordination of benefits) and, if approved for payment, issues a claim notification to DHS each business

day. The Department reviews and approves the payment, and the funds for the claim expenditures are drawn from a CARS profile, which is tied to the county's CLTS waiver grant allocation. The funds are then submitted to the TPA and the TPA issues a payment to the provider.

Since CLTS waiver funds are issued as grant funding to the CWAs, the expenditures must be presented as a federal award in the Schedule of Expenditures of Federal and State Awards. If the county includes a column in the SEFSA for revenue, then the CLTS waiver revenue should be listed.

3.3.2 Risk Assessment

The CLTS Waivers program is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform a risk assessment to determine if this program is a major state program.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the CLTS program::

- Providers are not properly credentialed, trained or authorized to deliver CLTS waiver services.
- CLTS cost sharing is incorrectly calculated and collected by the CLTS county waiver agency.
- The program has complex administrative requirements.

3.3.3 Compliance Requirements and Suggested Audit Procedures

The compliance requirements in this section are applicable for individual CLTS waiver participants and should be tested through review of the participants' case files.

3.3.3.1 Allowable Services – Qualified Providers

3.3.3.1.1 Compliance Requirements

The Department is aware of the time and effort required by the auditor to ensure compliance within this CLTS Waiver Program compliance category. This monitoring activity is expected to become the Department's responsibility as a state-administered provider management database and is currently in development with a targeted implementation date of CY 2018.

Providers must meet the applicable standards for allowable services of the CLTS waiver to claim reimbursement. These standards are contained in Chapter IV of the *Medicaid Home and Community-Based Services Waivers Manual*. The sections for each service are headed by two subtitles: "Service Requirements/Limitations/Exclusions" and "Standards." Both sections contain compliance requirements that providers must meet, including the following:

- County waiver agencies have contractually agreed to assure the Department that all providers comply with these requirements. Each provider must be registered on the Medicaid Waiver Provider Registry and have a signed Medicaid Waiver Provider Agreement.
- The CWA must ensure that each provider is properly trained, licensed, or credentialed to deliver authorized services according to the required standards. The CWA is required to maintain documentation that specifies the minimum credentialing qualifications and/or minimum training requirements needed to provide appropriate services to an individual child.
- A caregiver background check must be completed for each provider that has regular or direct access to the participant and/or his or her funds to ensure no barring offense exists that would prohibit Medicaid payment for employment as a caregiver.

3.3.3.1.2 Suggested Audit Procedures

Auditors should sample service provider files to determine if the CWA has assessed provider compliance with the provisions listed under "Service Requirements/Limitations/Exclusions" and "Standards" for the following services:

- Respite Care (SPC 103)
- Supportive Home Care (SPC 104)
- Daily Living Skills Training (SPC 110)
- Housing Modifications (SPC 112.56)
- Consumer Education and Training (SPC 113)
- Mentoring (SPC 503)
- Counseling and Therapeutic Services (SPC 507.03)
- Intensive In-Home Treatment Services (SPC 512)
- Financial Management (SPC 619)

3.3.3.2 Allowable Services – Service Claims Paid by Third-Party Administrator (TPA)

3.3.3.2.1 Compliance Requirement

County waiver agencies must issue service prior authorization files via the TPA's secure web portal. Following delivery of the service, the provider submits its claims to the TPA for payment within 120 days. County Support and Service Coordinators' case management services are also paid through the TPA claims' process. The TPA processes and adjudicates the claims (including coordination of Medicaid card and health insurance benefits), issues payment to the provider and submits encounter data to the Department.

3.3.3.2.2 Suggested Audit Procedure

Auditors should sample the CLTS clients' files and review the county waiver agency's methodology and system for issuing service authorizations based on the child's need in a timely manner to the TPA.

3.3.3.3 Allowable Costs – Established Provider Rates and Contracts

3.3.3.3.1 Compliance Requirement

To establish allowable provider service rates, county waiver agencies are required to adhere to the Allowable Cost Policy Manual. Wisconsin Stat. § 46.036 requires providers receiving more than $10,000 in funds from a county agency for care and services to have a Purchase of Services (POS) contract that meets the Department's standards.

3.3.3.3.2 Suggested Audit Procedures

Auditors should sample the CLTS waiver providers and review:

- The county waiver agency's rate-setting methodology.
- If a POS contract was required and executed.
- The county waiver agency's procedures and processes for ensuring that required audit reports were collected and reviewed. Audit requirements are only waived by the Department or through county mandate relief.

3.3.3.4 Matching – Cost Sharing

3.3.3.4.1 Compliance Requirements

Cost sharing only affects CLTS waiver participants who are eligible under Medicaid Group B Plus (See Division Long Term Care (DLTC) Number Memo 2015-03). If a cost share is applicable, the child's eligibility for waiver services can only be maintained if the economic support worker has determined the proper amount of her or his cost share liability and the family paid this cost share liability in a timely manner.

The county waiver agency is required to establish cost sharing agreements with the participant's family as appropriate. The county must maintain a recording system that tracks and documents that the family paid the appropriate cost share amount and that this cost share amount has been correctly applied toward waiver-covered services. If the participant pays the provider directly, then the waiver agency must have an accurate method to ensure cost share obligation payments. The cost share requirement does not apply for months that the waiver participant did not receive any waiver-funded services. The amount of the cost share cannot be higher than the cost of services for any month. For additional information, see Section 3.04 of the *Medicaid Home and Community-Based Services Waivers Manual*.

3.3.3.4.2 Suggested Audit Procedures

For each participant's file in the sample, the auditor should obtain the current copy of the MA Waiver Eligibility and Cost Sharing Worksheet (F-20919) and/or CARES screen for review. Line 11 on F-20919 will indicate whether the participant has a cost sharing obligation. For waiver participants required to cost share, auditors should:

- Review the Individual Service Plan (F-20445) to establish whether the entire cost share obligation has been correctly applied to the allowable CLTS waiver-covered service(s).
- Determine whether the CWA has a methodology to ensure that the service to which the cost share obligation is applied is delivered and that the payment to the provider includes the cost share amount. The CWA can either report the cost share to the Department or apply the cost share to a specific service.
- Verify that the agency did not collect a cost share for any month without waiver-covered service delivery or that the amount of the cost share applied did not exceed the total cost of services for that month.

3.3.3.5 Matching – Parental Payment Liability (PPL)

3.3.3.5.1 Compliance Requirement

For a child participating in the CLTS Waivers Program, the family may be liable for a portion of the cost of their child's waiver services. After the family and the service coordinator have finalized the development of the child's Individual Service Plan (ISP), the service coordinator will apply a formula to determine if the family has any parental payment liability.

3.3.3.5.2 Suggested Audit Procedure

For each participant's file in the sample, the auditor should review if a parental payment liability (PPL) was determined. The waiver agency must obtain required information and complete PPL calculations related to the PPL for all children under the age of 18 participating in the CLTS Waiver Program.

3.4 Community Integration Program 1

This section is applicable to audits of counties and 51 boards that receive funding for the Community Integration Program 1 directly from the Department of Health Services. Funding: Medical Assistance, CFDA #93.778. The former Division of Long Term Care (DLTC) is now the Division of Medicaid Services (DMS).

3.4.1 Background

The Community Integration Program 1 (CIP 1) is a Medicaid Home and Community-Based Services (HCBS) Waiver for persons over the age of 18 who have an intellectual and/or developmental disability (IDD). The CIP 1 Waiver assists eligible individuals to remain in the community or to relocate from nursing homes or other institutions back to their communities. CIP 1 receives partial funding through the federal Medicaid Program and is a Medicaid waiver program because the federal government has waived certain regulations to permit Wisconsin to use this funding to allow individuals to remain in their communities. The state issues the funding to the waiver agencies to administer the program.

To meet the eligibility criteria for CIP 1, the person must meet the following criteria for the federal definition of a severe and chronic disability:

- Is attributable to a mental or physical impairment, or a combination of mental and physical impairments.
- Is manifested before the person attains the age of 22.
- Is likely to continue indefinitely.
- Results in a substantial functional limitation in three or more of the following seven areas:
  - Self-care.
  - Receptive or expressive language.
  - Learning.
  - Mobility.
  - Self-direction.
  - Capacity for independent living.
  - Economic self-sufficiency.
- Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

To qualify for the CIP 1 Waiver, the applicant must meet all of the following criteria:

- Meets the definition of an appropriate target group.
- Meets a waiver-eligible level of care.
- Resides in an eligible setting.
- Meets the non-financial and financial eligibility criteria for Medicaid.
- Meets any applicable requirements for Wisconsin residency.
- Is determined to need Medicaid waiver services.

CIP 1 includes two state-level programs called CIP 1A and CIP 1B authorized by Wis. Stat. § 46.275 and § 46.278. The CIP 1 programs are established under Section 1915 (c) of the Social Security Act and are funded through the Wisconsin Medicaid Program. Each Medicaid HCBS waiver program must submit an individual program application to the Centers for Medicare and Medicaid Services (CMS) for approval.

CIP 1A and CIP 1B waiver funds may be used for services provided in a five- to eight-bed community-based residential facility (CBRF), a certified adult family home (one- to two-bed or three- to four-bed), a

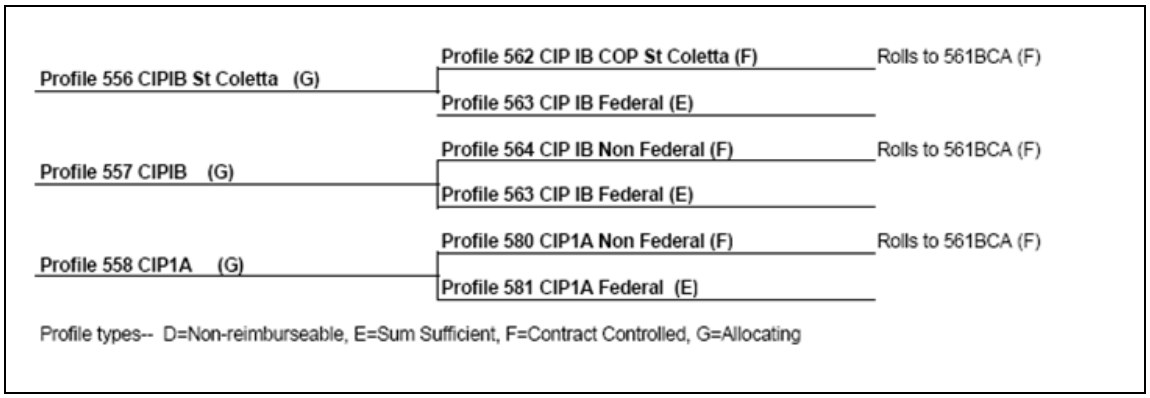
rooming/boarding house, or a house, apartment, condominium, or other private residence. CIP 1A and CIP 1B funds may not be used for services provided in a CBRF larger than eight beds or in a facility that is located within or structurally connected to an intermediate care facility for individuals with IDD, a nursing home, other institution, or a residential care apartment complex (RCAC). The use of CIP 1 funds is subject to approval as part of the person's Individual Service Plan (ISP). A complete listing of allowable services for the CIP 1 Waiver is online at the Medicaid Home and Community-Based Services Waivers Manual, Chapter IV, page IV-15 on the Department's website.

DMS contracts with county and tribal agencies to administer CIP 1 services using the "State and County Contract Covering Social Services and Community Programs." Each agency implements and operates the program in accordance with a set of prescribed guidelines developed by the Department. These guidelines are contained in the following publications:

- State and County Contract
- Contract Appendix for each specific program
- Wisconsin Medicaid Handbook
- Medicaid Home and Community-Based Services Waivers Manual

Waiver agencies report expenditures for the CIP 1 program on both HSRS and CARS. At the end of the period, the Department reconciles CARS to match HSRS. These programs use the CARS profiles shown in Figure 11.

Figure 11: CIP 1 CARS Profiles



3.4.2 Risk Assessment

The CIP 1 program is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform a risk assessment to determine if this program is a major state program.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the CIP 1 program:

- Waiver funds may be used for disallowed services, ineligible participants, non-qualified providers performing services, and services performed not authorized within an individual service plan.
- The program is new for this auditee or the program's requirements recently changed.
- The program has complex administrative requirements.

3.4.3 Compliance Requirements and Suggested Audit Procedures

3.4.3.1 Eligibility – Program

3.4.3.1.1 Compliance Requirement

An eligible participant must have a **current** adult Long-Term Care Functional Screen (LTCFS), completed by a qualified screener. For new applicants, to be current, the Screen Completion Date may not be more than 90 calendar days prior to the waiver start date. Participants on the waiver must have a new screen completed no more than 365 days after the date of the prior screen. To receive CIP 1A or CIP 1B services, the applicant must qualify for a developmental disability level of care in an ICF-IID.

3.4.3.1.2 Suggested Audit Procedure

Auditors should review a sample of CIP 1 enrollees to determine that a current LTCFS exists for each sampled participant of the waiver program.

3.4.3.2 Eligibility – Financial

3.4.3.2.1 Compliance Requirements

The following compliance requirements apply to CIP 1:

- Review the program's requirements per the Medicaid Home and Community-Based Services Waivers Manual.
- Waiver participants must be eligible for Wisconsin Medicaid as determined by initial review and annual recertification by the Economic Support Agency.
- Eligible waiver recipients may be required to pay a cost share for waiver expenses, as determined by the Economic Support Agency. The participant may pay the cost share directly to the waiver agency or to the provider. The waiver agency must document this payment.
- A waiver agency is not to bill CIP 1 for services provided to a participant who is not financially eligible for CIP 1 service funding.

3.4.3.2.2 Suggested Audit Procedures

Auditors should perform the following audit procedures:

- Sample case files to determine if the waiver agency has documentation to verify Wisconsin Medicaid eligibility on the dates of waiver expenditures.
- Determine from the sampled case files that annual recertification for Medicaid eligibility occurred.
- Determine from the sampled case files that, if applicable, the participant made any required cost share payments.
- Any service costs charged to CIP 1 for recipients who did not meet Wisconsin Medicaid eligibility, or did not fulfill her/his cost share requirements, are to be reported as questioned costs if in excess of $1,000.

3.4.3.3 Eligibility – Assessments and Plans

3.4.3.3.1 Compliance Requirements

The following compliance requirements apply to CIP 1, Eligibility – Assessments and Plans:

- Auditors should review the Medicaid Home and Community-Based Services Waivers Manual for the required contents of a CIP 1 assessment and case plan.

- To qualify for CIP 1 services, a CIP 1 applicant's county of established residency is responsible for providing an assessment of that person's service needs.
- Each CIP 1 participant who received CIP 1-funded services must have a care plan signed by the participant (or guardian).
- Per contract, counties are reimbursed for CIP 1 assessments and case plans by actual hours.

3.4.3.3.2 Suggested Audit Procedures

Auditors should perform the following audit procedures:

- Sample CIP 1 participant files to determine if the waiver agency prepared a written assessment document that specifies the necessary requirements for the applicant to live in the community arrangement of his or her choice. The assessment should also detail the support and service arrangements necessary for the applicant to achieve her or his normalization goals.
- Sample CIP 1 participant files to determine if the participant (or guardian) signed a current care plan. The care plan must be reviewed with the participant every six months.
- Verify through sampling participants' files that assessments and case plans reported to HSRS occurred. Any undocumented assessment or case plan's hours billed are questioned costs if in excess of $1,000.

3.4.3.4 Allowable CIP 1 Services

3.4.3.4.1 Compliance Requirements

The following compliance requirements apply to CIP 1 allowable services:

- Review the program's requirements per the Medicaid Home and Community-Based Services Waivers Manual online.
- For CIP 1 services to be allowable, the rendered services must be included in the participant's individual care plan.
- CIP 1 services reported on the CIP 1 HSRS 016 report must match the services listed and provided in the participant's case file.

In certain circumstances, CIP 1 funding cannot provide CIP 1 services even though specified in the participant's care plan. A CIP 1 agency may not:

- Purchase services provided to a community resident in an institutional setting without a variance (i.e., adult day care provided in a nursing home).
- Purchase community services for an individual who is residing in an institution without a variance. No variance is required for a recipient institutionalized for 30 days or less.
- Purchase Residential Care Apartment Complex (RCAC) services for an individual residing in an RCAC, including room and board.
- CIP 1 service funds cannot be used to purchase land or construct buildings.

3.4.3.4.2 Suggested Audit Procedures

Auditors should perform the following audit procedures:

- Sample case files of CIP 1 participants to ensure that CIP 1 services provided were authorized per the participants' individual care plans.
- Review the sampled CIP 1 participants' case files to ensure that billed CIP 1 services were listed within the case files and that the claims' costs matched.

3.4.3.5 Allowable Services – Qualified Providers Deliver Allowable Services

3.4.3.5.1 Compliance Requirements

Providers receiving Medicaid Waiver funding must have a Medicaid Waiver Provider Agreement form on file with DHS. Services paid for by the program must be specified in the participant's individual service plan (ISP), allowed by the specific Medicaid Waiver, and delivered by a qualified provider. Provider screening requirements and a list of allowed services and detailed descriptions of those services are in Chapter IV of the Medicaid Home and Community-Based Services Waivers Manual.

Waiver agencies report all expenditures for services for each waiver participant monthly on the Human Services Reporting System (HSRS). Services are generally authorized by agencies through some type of contract, provider agreement, or the participant's ISP. To qualify for reimbursement, a service must be allowed by the Medicaid Waiver, delivered to an eligible Medicaid Waiver participant by a qualified provider, and specified in the person's approved ISP during the audit period.

Counties must be able to verify the delivery of the service as reported on HSRS and document the number of units of service delivered in accordance with HSRS.

3.4.3.5.2 Suggested Audit Procedures

Auditors should obtain the agency's "L-300" that lists participants, the services in which the participants were enrolled, the number of service units provided, and the amount of waiver funding claimed for the services provided. Sample participant files to determine that:

- The waiver services listed in the ISP are allowed by the Medicaid Waiver.
- The waiver-funded services reported on HSRS were specified in the approved ISP.
- Payments made to certified providers are for allowable waiver services with one payment per claim.

3.4.3.6 Special Testing – County Administrative Costs

3.4.3.6.1 Compliance Requirements

County administrative costs are defined by the county agency and allowed up to 7 percent of total waiver service costs in CIP 1A and CIP 1B. For CIP 1A and CIP 1B, counties may request written approval from the Department to claim administrative costs up to a maximum of 10 percent of the total waiver service costs.

Administrative costs are not typically attributable to a specific service but represent general management of the service system. Examples of costs that are generally included are for HSRS, electronic health recording, contract management, and administrative and managerial staffing. These costs shall be reported using the method prescribed by the Department.

3.4.3.6.2 Suggested Audit Procedures

Auditors should determine whether:

- The county has a written description of its methodology to ensure that it does not report more than the maximum limit for administrative costs.
- The reported county service coordination costs are not also reported as administrative costs.

3.5 Community Integration Program II/Community Options Program – Waiver

This section is applicable to audits of counties and 51 boards that receive funding for the Community Integration Program II/Community Options Program – Waiver directly from the Department of Health Services. Funding: Medical Assistance, CFDA #93.778. The former Division of Long Term Care is now the Division of Medicaid Services.

3.5.1 Background

The Community Integration Program II and Community Options Program – Waiver (CIP II/COP-W) are Medicaid Home and Community-Based Waiver programs that enable frail elders or persons with physical disabilities to either relocate from or prevent admission to a nursing home. CIP II/COP-W receives partial funding through the federal Medicaid program and is a Medicaid waiver because the federal government waived certain regulations to allow Wisconsin to use this funding to allow individuals to remain in their communities. These programs originated in 1986.

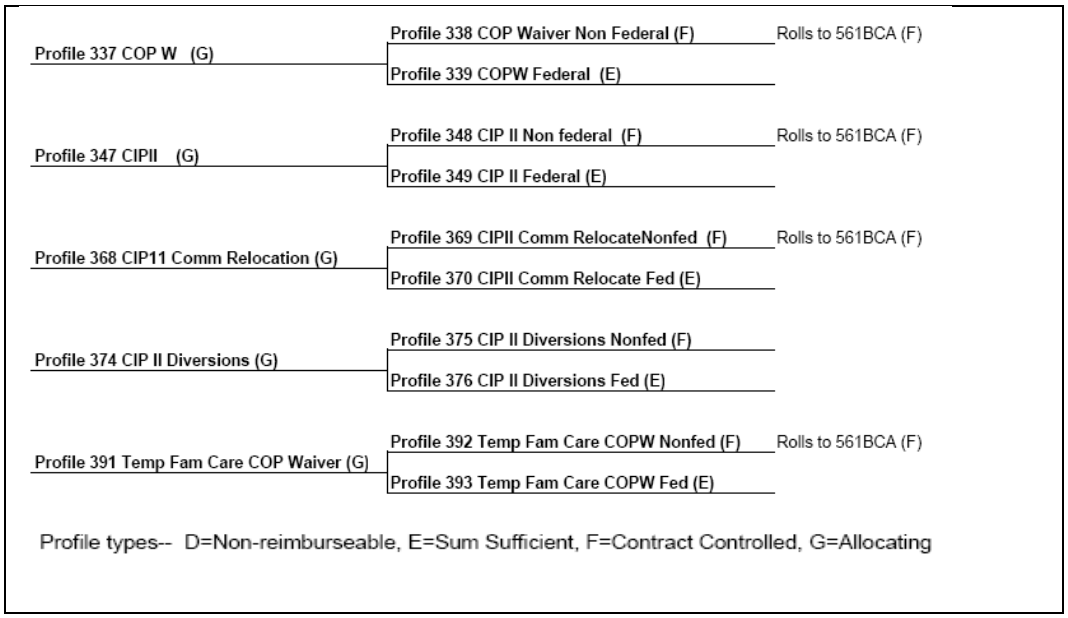
The CIP II/COP-W program cluster provides Medicaid funds to agencies to pay for home and community-based services to Medicaid-eligible persons relocated or diverted from a nursing home. Programming and services are available to eligible elderly and disabled adults.

DMS contracts with county and tribal agencies to administer CIP II/COP-W services using the "State and County Contract Covering Social Services and Community Programs." Each agency implements and operates the program in accordance with a set of prescribed guidelines developed by the Department. These guidelines are contained in the following publications:

- State and County Contract
- Contract Appendix for each specific program
- Wisconsin Medicaid Handbook
- Medicaid Home and Community-Based Services Waivers Manual

Waiver agencies report expenditures for the CIP II/COP-W programs on both the Human Services Reporting System (HSRS) and Community Aids Reporting System (CARS). At the end of the audit year, the Department reconciles CARS to match HSRS. These programs utilize the CARS profiles shown in Figure 12.

Figure 12: CARS Profiles Used by CIP II/COP-W



3.5.2 Risk Assessment

The CIP II/COP-W is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform a risk assessment to determine if this program is a major state program.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the CIP II/COP-W program:

- The program pays for non-covered services or ineligible participants.
- The program is new or the program's requirements have recently changed.
- The program has complex administrative requirements.

3.5.3 Compliance Requirements and Suggested Audit Procedures

3.5.3.1 CIP II/COP-W - Allowable Services Billed

3.5.3.1.1 Compliance Requirements

Only approved waiver services are allowable. A list of allowed services and detailed descriptions of those services are in the Medicaid Home And Community-Based Services Waivers Manual, Chapter IV. The following restrictions apply to reimbursement for these services:

- Room and board costs are not covered except for institutional and residential respite (adult family homes, community-based residential facilities, and residential care apartment complexes) services.
- No reimbursement allowed for services provided on any day the program participant was an inpatient at a Medicaid facility (hospital, skilled nursing facility, or intermediate care facility) with two exceptions. Institutional discharge-related care management services up to 30 days prior to discharge may be covered (this does not include discharge-planning services prior to the initial period of eligibility except for services described in number 3 below). The second exception is Personal Emergency Response Services (PERS), which may continue during institutional residency.

- The services of care management and home modifications are billable prior to relocation from a nursing home. Additionally, relocation-related housing startup and energy assistance services are allowable if an individual relocated from a nursing home. Costs for these services incurred prior to the individual's relocation date are billable to CIP II/COP-W after the start date.

Reimbursement is made for allowable services only. County agencies must report monthly expenditures online to HSRS via the Long-Term Support Module for each recipient. Monthly expenditures are reported on the Report of Expenditures, Form 600.

Administrative costs, up to 7 percent of the total allowable service charges, are separately reported at the end of the year. Adequate documentation is required to substantiate the billing of administrative costs incurred. The Department may approve a variance to exceed the seven percent limit on administrative costs.

3.5.3.1.2 Suggested Audit Procedures

Auditors should determine through sampling whether:

- Payments billed on HSRS were only for allowable services (see Waivers Manual, Chapter IV).
- Billings are specific to each eligible recipient and correspond to the date of provided service (not the date of the agency billing).
- Reimbursements for contracted services were in accordance with provider agreements or contracts.
- Payments made to a recipient's spouse/guardian are not allowed.

3.5.3.2 Special Testing – County Administrative Costs

3.5.3.2.1 Compliance Requirements

- County administrative costs are defined by the county agency and allowable for up to 7 percent of total waiver service costs in CIP II/COP-W. Waiver agencies may request written approval from the Department to claim administrative costs up to a maximum of 10 percent of the total waiver service costs.
- Administrative costs are not typically attributable to a specific service but represent general management of the service system. Examples of administrative costs include HSRS, electronic health recording, contract management, and administrative and managerial staffing. These costs are reported using the method prescribed by the Department.

3.5.3.2.2 Suggested Audit Procedures:

Auditors should determine whether:

- The agency reported administrative costs under the contract's maximum limit.
- The reported county service coordination costs are not also reported as administrative costs.

3.6 Community Options Program (COP)

This section is applicable to audits of counties and 51 boards that receive funding for the Community Options Program directly from the Department of Health Services. Funding: Medical Assistance, CFDA #93.778. The former Division of Long Term Care (DLTC) is now the Division of Medicaid Services (DMS).

3.6.1 Background

The Community Options Program (COP), enacted in 1981, is available in a limited number of Wisconsin counties to assist people with long-term care needs to remain in their homes and communities. COP funding is available to frail elders and adults who have an intellectual or physical disability that requires a level of care similar to that in a nursing home. COP provides funding to participating counties to conduct functional assessments and develop an individual's case plan to provide community-based services based on an individual's needs. COP is 100 percent state-funded and may be used for participants who are eligible for, but not enrolled in, a federal home and community-based services (HCBS) waiver or as matching funds for waiver expenditures. COP may fund services/items that are not allowable by an HCBS waiver. Examples of COP services include:

- Home modification and adaptive equipment
- Respite care and care management
- Communication aids
- Home health care and residential services
- Personal care and housekeeping

There is no income limit for a COP assessment or care plan, but income guidelines determine if COP will pay all or a portion of services deemed necessary. All funding sources or voluntary assistance must be expended before COP funding is used to pay for services outlined in the individual's care plan.

DMS contracts with participating COP counties to operate the program under the direction of a designated lead agency and a local planning committee. Each county develops a county plan for the operation of the program in accordance with guidelines that the Department ultimately approves. The lead agency is typically a county human services department, a social services department, a community board created under Wis. Stat. §§ 51.42 or 51.437, a county aging department, or a joint lead agency.

Auditors should be aware that after a county agency transitions to Family Care and IRIS, COP funding is no longer be available.

Eligible COP counties report all COP costs to CARS profile #367. The lead county receives payments throughout the year with the final year-end Community Options expenditures based on the information submitted to HSRS and the Community Options supplemental reconciliation form.

Counties report all COP assessment, planning activity, and service costs by individual recipient on the HSRS Long-Term Support Module. For final cost reconciliation, if the amount due based on HSRS reporting differs from the amount reported on CARS profile #367, the HSRS amount remains on CARS profile #367, and the difference rolls to the BCA CARS profile #561.

Counties receive their COP allocation in two sub-allocations as identified in the state-county contract. Sub-allocation A pays for assessments and case plans based on a state-approved hourly rate per unit of activity. During the year-end HSRS budget reconciliation, dollars not earned in sub-allocation A automatically become available to cover service costs in sub-allocation B. Eligible service costs paid by sub-allocation B include:

- Services based on actual service cost to the program for eligible program participants that had an assessment and case plan.
- Administrative costs set by the Department, up to the BCA contract's maximum amount.
- Allowable service expenses in a Medicaid waiver program that were not reimbursed by that waiver program due to insufficient funding.

Sub-allocation B funding may be used as matching funds to capture federal funds for allowable waiver services. Sub-allocation B funding may not be used to cover costs from assessments or case plans in sub-allocation A.

3.6.2 Risk Assessment

The COP program is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform this risk assessment to determine if this program is a major state program.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the COP program::

- The program's participants were not eligible.
- The program's services provided were not supported by an individual's care plan.
- The program is new for this auditee or the program requirements have significant changes.
- The program has complex administrative requirements.

3.6.3 Compliance Requirements and Suggested Audit Procedures

3.6.3.1 Eligibility – Program

3.6.3.1.1 Compliance Requirements

Auditors should be aware of the following compliance requirements:

- An agency cannot bill COP for services unless the individual meets a level of care as determined by completing the Long-Term Care Functional Screen (LTCFS) by a certified screener.
- Only certified screeners are able to perform and calculate the LTCFS.

3.6.3.1.2 Suggested Audit Procedure

Auditors should select a sample of COP participants enrolled during the audit period to determine if the agency has documented that the individual was functionally eligible by completing the LTCFS by a certified screener.

3.6.3.2 Eligibility – Financial

3.6.3.2.1 Compliance Requirements

An agency cannot bill COP for services provided to a participant who is financially ineligible for COP service funding as determined by completion of the appropriate eligibility and cost sharing worksheets (COP Eligibility: F-29136 or F-29317 and COP Uniform Cost Sharing Plan: F-29319 or F-29321 or F-29322). Based on income and asset thresholds, eligible COP recipients may be required to share the cost of services received.

3.6.3.2.2 Suggested Audit Procedures

Auditors should apply the following audit procedures:

- Sample case files to determine if the county agency completed the appropriate worksheets for participants that received services and were financially eligible.
- Determine from the sampled case files if an annual update of the Community Options Eligibility and Cost
- Sharing Worksheets occurred.
- Any service costs charged to COP for recipients determined to be ineligible or that have an unpaid cost share are reported as questioned costs if the amount is $1,000 or more.

3.6.3.3 Eligibility – Assessments and Plans

3.6.3.3.1 Compliance Requirements

Auditors should be aware of the following compliance requirements:

- Review the COP Guidelines for assessment and case plan requirements.
- To qualify for COP services, a COP applicant's county of established residency is responsible for providing an assessment of that person's service needs.
- Each COP participant who received COP-funded services must have a care plan signed by the participant (or guardian).
- Per contract, counties are reimbursed for COP assessments and case plans based on actual service hours.

3.6.3.3.2 Suggested Audit Procedures

Auditors should apply the following audit procedures:

- Sample COP participant files to determine if the county agency prepared a written assessment document that specifies the necessary requirements for the applicant to live in the community arrangement of his/her choice. The assessment should also detail the support and service arrangements necessary for the applicant to achieve her or his normalization goals.
- Sample COP participant files to determine if the participant (or guardian) signed a current care plan. The care plan must be reviewed with the participant every six months.
- Verify through a sample of recipients' files that assessments and case plans reported to HSRS occurred. Any undocumented assessment or case plans hours billed should be identified as a finding with questioned costs if the amount is $1,000 or more.

3.6.3.4 Allowable COP Services

3.6.3.4.1 Compliance Requirements

Auditors should be aware of the following compliance requirements:

- For COP services to be allowable, the rendered services must be within the participant's individual care plan.
- COP services reported on the COP HSRS 016 report must match the services listed and provided in the participant's case file.
- In certain circumstances, COP funding cannot provide COP services even though specified in the participant's care plan. A COP agency may not:

- Purchase services provided to a community resident in an institutional setting without a variance (i.e., adult day care provided in a nursing home).
- Purchase community services for an individual who is residing in an institution without a variance. No variance is required for a recipient institutionalized for 30 days or less.
- Purchase residential care apartment complex (RCAC) services for an individual residing in a RCAC, including room and board.
- COP service funds cannot be used to purchase land or construct buildings.

3.6.3.4.2 Suggested Audit Procedures

Auditors should apply the following audit procedures:

- Sample COP participants' case files to ensure authorization of the COP services provided within the participant's individual care plan.
- Review the sampled COP participants' case files to ensure that billed COP services were listed within the case files and that the claims' costs matched.

3.6.3.5 Special Testing – COP Administrative Claim

3.6.3.5.1 Compliance Requirement

Auditors should be aware that COP agencies may claim reimbursement for administration expenses up to 7 percent of the calendar year's COP service allocation (unless the Department approves a larger percentage). With written permission from DMS, the COP agency may expend carryover funds or high-cost funds for administrative expenses in addition to the 7 percent allowance on base funds. (High-cost funds are special funds allocated and approved by DMS for specific, one-time expenses. Carryover funds are unspent funds from the prior calendar year that the Department contracted into the ensuing calendar year.) During the COP expenditure reconciliation process, DMS ensures that the county's administrative reimbursement amount does not exceed the maximum allowable administrative amount.

3.6.3.5.2 Suggested Audit Procedure

Auditors should determine whether the county has proper documentation to support that the amount reimbursed was expended for administrative expenses related to the COP and/or COP-Waiver/CIP II programs. No other DHS program can claim administrative expenses reimbursed by the COP program.

3.6.3.6 Special Testing – Elements of a Case File

3.6.3.6.1 Compliance Requirements

Auditors should be aware of the following compliance requirements:

- The lead agency shall maintain individual case records for participants who receive assessments, care plans, and/or services. The agency is required to retain the participant's case file for a minimum of three years after the case's closure date.
- The Community Options participant's case file shall include:
  - Documentation of the Community Options assessment.
  - Documentation of a care plan, including information used in projecting the monthly cost of the participant's ongoing community services.
  - Financial eligibility documentation.
  - Functional eligibility documentation per the LTCFS.
  - Entries in case records, including a review of the care plan.

3.6.3.6.2 Suggested Audit Procedure

Auditors should review a sample of participant case files to ensure inclusion of the proper elements.

3.7 FoodShare Employment and Training

This section is applicable to audits of FoodShare Employment and Training providers. Funding: State Administrative Matching Grants for the Supplemental Nutrition Assistance Program, CFDA # 10.561.

3.7.1 Background

Wisconsin's FoodShare Employment and Training (FSET) program is an employment and training program operated as part of the federal Supplemental Nutrition Assistance Program (SNAP), also known as FoodShare (FS) in Wisconsin. DHS administers FS and FSET and is responsible for annually submitting Wisconsin's FSET Plan for service provision and funding approval to the federal Food and Nutrition Service.

The Food and Nutrition Act of 2008 and federal regulations provide Wisconsin with flexibility in designing its employment and training program. The Wisconsin FSET program's design focuses on identifying the strengths, needs, and preferences of job seekers and offers individualized services to improve job-seeking skills and increase employment opportunities to promote economic self-sufficiency.

Effective April 1, 2015, Wisconsin implemented statewide FoodShare time-limited benefits for Able-Bodied Adults without Dependents (ABAWDs). An ABAWD who needs to meet the work requirement in order to maintain ongoing eligibility for FS receives a referral and may choose to participate in FSET in order to comply with the work requirement. ABAWDs not meeting the work requirement may lose their FS eligibility after exhausting three months of time-limited benefits within a 36-month period. Any FS recipient can choose FSET participation.

A FoodShare member is a non-ABAWD if he or she meets any of the following criteria, as determined by the Income Maintenance agency:

- Under age 18 or age 50 and older
- Unable to work or pregnant
- Resides in a FoodShare household with a child under age 18

The FSET program consists of six components, and participants must agree to engage in at least one approved activity to retain enrollment in FSET. The six components of the FSET program are:

- Job Search
- Education and Vocational Training
- Workfare
- Work Experience
- Self-Employment
- Job Retention is only for FSET participants who have obtained employment.

3.7.2 Risk Assessment

The FSET program is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the

audit period. The auditor will perform this risk assessment to determine if this program is a major state program.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified FSET program::

- The monthly invoices submitted to DHS include unallowable, inaccurate or undocumented expenses.
- The reported salary and benefit costs submitted to DHS are for workers not performing allowable FSET-related activities.
- The allocated costs of FSET submitted for FSET program reimbursement may also be allocated to other DHS programs or the Wisconsin Works (W-2) program.
- The acquisition and distribution of gas cards or bus passes for FSET participants' travel expenses lack documentation or an inventory system.
- The program has complex administrative requirements.

3.7.3 Compliance Requirements and Suggested Audit Procedures

The documents that detail the FSET program's requirements include, but are not limited to:

- *Employment and Training Toolkit*, United States Department of Agriculture, Food and Nutrition Service, Supplemental Nutrition Assistance Program.
- Current *FSET Handbook*, Wisconsin DHS, Division of Health Care Access and Accountability.
- FSET Contract between DHS and the FSET Agency.
- Contracts between the FSET Agency and its subcontractors.

3.7.3.1 Allowable Activities

The FSET program allows each FSET agency to tailor an employment and/or training plan to meet the individual needs of the FSET participant. For proper participation in the FSET program, all participants must have an assessed plan for placement and accept training or services that are within an FSET component category.

3.7.3.1.1 Compliance Requirements

Allowable activities of an FSET program must be within one or more of the program's six components:

- Job Search – Allowable activities include resume development, interviewing skills, job leads/referrals/placement, labor market information, and motivational workshops.
- Education and Vocational Training – Allowable educational activities include English as a second language, high school equivalency, workplace literacy, and short-term training certification. Allowable vocational activities improve employability through training in a skill or trade that allows the FSET participant to move directly and promptly into employment. Acceptable vocational training should expect to lead to employment that is in demand.
- Workfare – Allows FSET participants the opportunity to learn new job skills and establish work references. Workfare positions typically require minimal training, and work crews easily expand or contract as based upon the need for positions. Parks, housing authorities, and sanitation departments are examples of workfare placements.
- Work Experience – Offers the opportunity for job shadowing or a short-term placement in an actual work setting or training setting.
- Self-Employment – The focus is to provide technical assistance to FSET participants that have a sound business plan but lack the skills to create and implement a successful plan for self-employment. Technical assistance includes creating a small business plan, conducting feasibility studies to

determine the viability of the service or produce, developing marketing strategies, resolving credit issues, and navigating state/federal regulations.
- Job Retention – Only individuals who have received employment and employment/training services through the FSET program are eligible for job retention services. This component typically includes participant reimbursement for reasonable and necessary expenses to assist the individual in retaining employment, such as clothing, transportation, tools, relocation, case management, childcare, and equipment.

The FSET program allows a variety of activities to improve a participant's job-seeking skills and employability. Therefore, reasonable and necessary activities that ultimately lead to expedited employment opportunities may be allowable.

3.7.3.1.2 Suggested Audit Procedures

Auditors should perform the following procedures when auditing allowable activities:

- Select a sample of FSET participants and determine if the participant had a comprehensive, individualized assessment to identify strengths, needs, and preferences of the participant. Without an individualized FSET assessment plan, no FSET activities are allowable.
- Review the activities of the sampled FSET participants to determine if the activities not only qualify within one of the FSET's six component categories, but also are reasonable and necessary.

3.7.3.2 Allowable Costs and Reporting

Monthly invoices submitted to DHS must reflect qualifying FSET program expenses incurred for the month of the invoice. Costs are allowable if they are reasonable and necessary to carry out essential functions of FSET and must be appropriately allocated.

3.7.3.2.1 Compliance Requirements

Auditors should be aware of the following compliance requirements regarding allowable costs:

- FSET costs must comply with the *Allowable Cost Policy Manual* and allowable participant reimbursements per Food and Nutrition Services guidance from the *Employment and Training Toolkit*.
- FSET costs submitted to DHS by monthly invoices are classified within the four categories of program administrative (personnel and operating), participant reimbursement, dependent care, and job retention. Reported salary and wages of FSET personnel require 100 percent time reporting with supporting timecard documentation.
- Participation reimbursements include transportation, childcare, clothing suitable for job interviews, uniforms, textbooks, licensing, and test fees. Childcare expenses should be pursued through the Wisconsin Shares childcare subsidy program prior to expending FSET resources for childcare.

3.7.3.2.2 Suggested Audit Procedures

Auditors should perform the following audit procedures to test for allowable costs:

- Sample the monthly invoices submitted to DHS and determine if the costs are allowable per federal and state cost guidelines and FSET compliance rules (*Employment and Training Toolkit*).
- Verify that salary and benefit costs for FSET personnel were not charged to the Wisconsin Works (W-2) program or other Wisconsin Medicaid programs. Employees' wages and benefits are high-risk cost categories that may result in duplicative charges to multiple Medicaid programs. Also, verify that charged salary and benefit costs have supporting timecard documentation.

- Verify that the agency's financial records support the sampled monthly invoice(s) by ensuring the submitted invoice amount ties to the agency's general ledger.
- Verify that the plan for allocating direct support service staff time and overhead is consistent with the *Allowable Cost Policy Manual* and with Medicaid policies.

3.7.3.3 Subcontractor Monitoring

Per terms of the contract between DHS and the Wisconsin FSET service regions, the contractor may subcontract part of this contract with approval from DHS.

3.7.3.3.1 Compliance Requirements

The following compliance requirements apply to subcontractor monitoring of the FSET program:

- The FSET agency (the contractor) can subcontract part of this contract with written approval from DHS. When the contractor enters into a subcontracting relationship, DHS reserves the right of approval over the process used to solicit proposals, criteria used by the contractor in choosing a subcontractor, terms and conditions of the subcontract(s), and the subcontractor(s) selected.
- The contractor retains responsibility for fulfillment of all terms and conditions of this contract when it enters subcontracting relationships.

3.7.3.3.2 Suggested Audit Procedures

Auditors should perform the following audit procedures related to subcontractor monitoring:

- Review the FSET agency's subcontracts to verify that DHS granted written approval for the subcontract arrangement if applicable.
- Determine whether the FSET agency has a viable monitoring program in place to examine its subcontractors' activities and provide reasonable assurance that the subcontractors administered the program in compliance with the terms and conditions of the contract.

3.7.3.4 Special Tests – For Cash Equivalent Participant Reimbursements

FSET vendors may provide gas cards or bus passes for transportation expenses to assist those FSET participants seeking employment or job training. The vendors should have a tracking system in place to record the acquisition and distribution of gas or gift cards.

3.7.3.4.1 Compliance Requirements

To understand compliance requirements, auditors should do the following:

- Review the FSET agency contract with DHS to determine the total budgeted transportation costs within the participant reimbursement category.
- Discuss with the FSET agency's personnel if any of the budgeted transportation costs within the participant reimbursement category were related to purchases of gas cards or bus passes.

3.7.3.4.2 Suggested Audit Procedures

Auditors should perform the following audit procedures:

- Ascertain if the FSET agency purchased gas cards or bus passes for FSET participant transportation expenses.
- Determine if the FSET agency has a tracking mechanism that inventories the purchases and issuances of the gas cards or bus passes.
- Verify that the gas card or bus token inventory is correct with supporting documentation.

3.7.3.5 Special Tests – ABAWDs Work Requirement

In order to maintain eligibility for FoodShare benefits, ABAWDs must participate in FSET to meet the work requirement or may meet the work requirement through fulfilling other allowable requirements.

3.7.3.5.1 Compliance Requirements

Auditors should be aware of the following compliance requirements regarding ABAWDs work requirements:

- For complete FSET participation requirements, review the *FSET Handbook*.
- ABAWDs not meeting the work requirement may lose eligibility for FoodShare benefits after exhausting three months of time-limited benefits within a 36-month period.
- For ABAWDs, the term working is defined as work in exchange for money, goods, or services; unpaid work, such as community service or volunteer work; self-employment; or any combination of this definition.
- An ABAWD is considered to be meeting the work requirement if one of the following applies:
  - Working a minimum of 80 hours per month. Use converted work hours if paid weekly or bi-weekly;
  - Participating in and complying with the requirements of an allowable work program at least 80 hours per month; or
  - Working and participating in an allowable work program for a combined total of at least 80 hours per month.
  - Participating in and complying with the requirements of a workfare program.
- FSET agency staff must collect and record attendance information for assigned activities. All participation documentation must be obtained from the FSET participant, work site, or other education and training providers on a weekly, biweekly, or monthly basis. The documentation must be maintained in the participant's electronic case file.
- FSET agencies are responsible for collecting group activities when multiple participants are engaged in the same activity at one location. The FSET participant is responsible to provide paperwork to the FSET agency to verify participation in activities that involve an activity log. The FSET agency should arrange with the service provider to receive paperwork directly whenever possible.
- By the fifth of the current month, the FSET agency is responsible for recording whether the prior month's work requirement was met. This action is required for nonexempt ABAWD participants required to meet the work requirement.
- By the second Saturday of the month, the FSET agency is responsible for recording whether a participant is expected to fulfill the ABAWD work requirement by the end of the current month. This action is only required for those nonexempt ABAWDs who are enrolled and fully participating in FSET, expected to meet the ABAWD work requirement through FSET participation by the end of the current month, and are in their third time-limited benefit month.

3.7.3.5.2 Suggested Audit Procedures

Auditors should perform the following audit procedures:

- Sample the files of nonexempt ABAWDs to determine if the FSET agency recorded the prior month's work requirement by the fifth of the current month. Also, determine if the FSET agency recorded the anticipation of the nonexempt ABAWDs work requirement for the current month by the second Saturday of the month.
- Sample the files of nonexempt ABAWDs to ensure that the FSET agency retains proper documentation to support the work requirement of the ABAWDs.

3.8 Income Maintenance

This section is applicable to audits of IM Consortia lead and non-lead (member) counties.

Funding: Income Maintenance funding is comprised of Medical Assistance Program – CFDA # 93.778, the State Administrative Matching Grants for Supplemental Nutrition Assistance Program (SNAP) – CFDA # 10.561, Children's Health Insurance Programs – CFDA #93.767 and numerous state profiles.

3.8.1 Background

In 2011, Act 32 required the organization of income maintenance (IM) consortia to administer county IM programs while providing administrative and statewide cost efficiencies across a variety of assistance programs (Wis. Stat. § 49.78). As of 2016, there were 10 multicounty IM consortia throughout Wisconsin.

The lead county agency for each IM consortium is responsible to DHS for its consortium's compliance with the terms of the IM contract between DHS and the consortium and provides representation for all members of the consortium. The lead county is also responsible for submitting monthly cost reports for the consortium to the Department on form F-00642 no later than the 30th day of the following month. Each lead county agency separately contracts with the other members of the consortium.

The IM consortium administers the following programs:

- FoodShare and FoodShare Employment and Training (FSET) referrals
- Wisconsin Medicaid and BadgerCare Plus Standard Benchmark Plans
- Family Care
- SSI Caretaker Supplement
- The Wisconsin Funeral and Cemetery Aids Program

The Department contracts with the consortium's lead county to perform a variety of services, including:

- Conducting application processing.
- Providing in-person services.
- Performing FoodShare program eligibility processing services.
- Coordinating with state staff and consortium partners to ensure that the provisions of estate recovery, subrogation, benefit recovery, fair hearings, fraud prevention, and investigative programs are properly administered.

A multicounty consortium is a group of county agencies approved by the Department to administer IM programs. Each IM consortium contract designates a lead county agency to provide representation for all member counties of the consortium.

Income maintenance consortia lead counties report consortia expenses on CARS Profile #76. CARS allocate these expenses to two other profiles for payment: to Profile #283 IMAA State Share, which is funded with state and local funds, and to Profile #284, IMAA Federal Share, which is funded by a mix of state and federal funds. These federal funds are from the Medical Assistance Program - CFDA # 93.778, the State Administrative Matching Grants for Supplemental Nutrition Assistance Program – CFDA # 10.561 and Children's Health Insurance Programs - CFDA #93.767. The respective share of each funding source is available in the 2016 Listing of CARS Program Funding Sources.

3.8.2 Risk Assessment

Income Maintenance is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform the risk assessment to determine if this program is a state major program. Risks identified by the auditor may require additional compliance testing of the IM consortium's lead or non-lead county agencies.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the Income Maintenance program:

- Submitted cost report expenses are unallowable, inaccurate, undocumented, or untraceable to the agency's general ledger. This includes cost report submissions by either the lead county agency to DHS or the non-lead county to the lead county agency.
- Submitted cost reports by each IM consortium member agency are not identifiable within the agency's general ledger.
- Reported salary and benefit costs are for workers not performing allowable IM-related activities.
- Allocated costs submitted for IM program reimbursement may be submitted to multiple DHS programs.

3.8.3 Compliance Requirements and Suggested Audit Procedures

3.8.3.1 Allowable Activities

3.8.3.1.1 Compliance Requirements

Auditors should review the *DHS Audit Guide*, Section 2.1, "Activities Allowed or Unallowed," and the IM contract for further information regarding allowable activities. All IM functions must be performed in accordance with state statutes and administrative rules, federal statutes, rules and regulations, court orders, and the division numbered memo series, as set forth in or established by the Department under the authority granted to it by state and federal statutes, rules, regulations, and court orders.

All IM agencies perform the following activities, per their respective IM contracts:

- Enter member data into the designated automated system for IM programs.
- Accurately explain IM programs and policies to members and others as needed.
- Confirm eligibility in the designated automated system for IM programs.
- Request and process required verifications.
- Establish a claim if overpayment occurs.
- Explain estate recovery and subrogation, and fill out appropriate forms.
- Perform all administrative responsibilities related to electronic benefit transfers (EBT) for the FoodShare program that are eligibility functions (SNAP, CFDA #10.561).
- Perform additional IM consortium responsibilities as defined in Wis. Stat. § 49.78(2)(b).

In addition, the lead agency is responsible for the following activities:

- Perform activities outlined in the relevant sections of the DHS CARS Manual.
- Maintain a contractual relationship with member counties.
- Monitor compliance of member counties.
- Collect and compile information, and submit required program performance reports.

3.8.3.1.2 Suggested Audit Procedures for Lead and Non-Lead Counties

Auditors should perform the following audit procedures to test for allowable activities:

- Identify the IM activities performed by the agency and determine if allowable.
- Review transactions submitted for IM reimbursement to determine if the services provided were for allowable IM activities.

3.8.3.1.3 Suggested Audit Procedures for Lead Counties

Auditors should perform the following audit procedures for lead counties only:

- Verify that a valid contract exists between lead and member agencies.
- Examine procedures for monitoring compliance of member counties.
- Verify that required program reports are accurate and submitted in a timely manner.

3.8.3.2 Allowable Costs

3.8.3.2.1 Compliance Requirements

The *DHS Audit Guide* and the IM contract contain additional information regarding the compliance requirements for allowable costs. Requirements of the IM contract between DHS and the IM consortium's lead county agency include, but are not limited to, the following:

- Functions are performed in accordance with state statutes, administrative rules, federal statutes, rules and regulations, court orders, division numbered memo series, the *Allowable Cost Policy Manual*, and the *Financial Management Manual*, as set forth in or established by the Department under the authority granted to it by state and federal statutes, rules, regulations, and court orders.
- Claims for reimbursement are for costs incurred in providing services under the contract during the month covered by the cost report and follow generally accepted accounting principles and the Department's *Allowable Cost Policy Manual*.
- Distribution and reporting of agency management support and overhead (AMSO) costs are in accordance with the federally approved cost allocation plan for local organizational units.
- Consortiums maintain and report employee roster information to the Department in compliance with instructions from the Department for the IM/Wisconsin Works (W-2) random moment sampling (RMS).

3.8.3.2.2 Suggested Audit Procedures for Lead and Non-Lead Agencies

Auditors should perform the following procedures to test for allowable costs:

- Request an organizational chart of the agency's personnel to verify that salaries and benefits charged or allocated to the IM program are for employees identified as IM workers.
- Review expense reports for accurate reporting of expenses and revenues. Test expenditure records and supporting documentation to determine if expenses submitted for reimbursement are allowable.
- Verify that the employee counts reported to the lead agency or to the state are complete and that those employees identified are within the correct functional area per the organizational chart.
- Verify that the AMSO and share costs reported to the state are reconciled to the agency's accounting records, documented, and have not been direct charged.

3.8.3.2.3 Suggested Audit Procedures for Lead Agencies

In addition, for lead agencies, auditors should review CARS expense reports for accurate reporting of expenses and determine that they are in accordance with the appropriate sections of the CARS manual.

3.8.3.3 Reporting – Expenditures

3.8.3.3.1 Compliance Requirements

Auditors should review the *DHS Audit Guide* and the IM contract for further information regarding the compliance requirements for reporting of expenditures.

The lead county of the IM consortium files the monthly CARS cost report for all consortium counties and for all activities of the IM consortium. Each non-lead county agency submits a monthly cost report to the lead county agency.

3.8.3.3.2 Suggested Audit Procedures – Lead County Agency

Auditors should perform the following procedures to test for proper reporting of expenditures:

- Select a sample of the IM consortium's monthly cost reports submitted to DHS by the IM consortium's lead county. Review for mathematical accuracy and determine if supporting documentation exists to support the filed cost reports.
- Trace and verify the submitted cost report amounts to the accounting records of the lead county agency.

3.8.3.3.3 Suggested Audit Procedures – Non-Lead County Agency

Auditors should perform the following audit procedures for non-lead counties:

- Select a sample of the IM consortium's monthly cost reports submitted to the lead county agency by the non-lead county agency. Review for mathematical accuracy and determine if supporting documentation exists to support the submitted cost reports.
- Trace and verify the submitted cost report amounts to the accounting records of the non-lead county agency.

3.8.3.4 Monitoring

3.8.3.4.1 Compliance Requirements

The consortium is responsible for performance of all subcontracted services under the IM contract. The following provisions apply:

- Eligibility determination may not be subcontracted. It is the responsibility of the IM consortium certified by the Department.
- Contracts must adhere to Wis. Stat. § 46.036 and the Department's policies and procedures.
- DHS must approve all subcontracting relationships.
- IM consortia shall establish instructions and monitoring procedures to ensure that each subcontractor complies with this contract, applicable state and federal laws, rules and regulations, and the Department's policies and procedures.
- The contract between the Department and the consortium's lead county may contain additional compliance requirements.

3.8.3.4.2 Suggested Audit Procedures for Lead and Non-Lead Agencies

Auditors should perform the following audit procedures to test compliance with monitoring requirements:

Determine if the county agency contracted with eligible Wisconsin contractors/subrecipients for the IM program. Review the State of Wisconsin's suspended and debarred list online at VendorNet within the "Wisconsin Office of Contract Compliance Vendor Directory" worksheet.

3.8.3.4.3 Suggested Audit Procedures for Lead Agencies

Auditors should perform the following audit procedures at lead counties to test compliance with monitoring requirements:

- Determine whether the Department approved the IM contract between the lead county and its member county agencies and if all counties signed the contract. The IM consortium approved by the Department only performs eligibility determination for the IM program.
- Determine whether the lead county agency monitored the activities of the member county agencies throughout the contract period, ensured the timely correction of any identified noncompliance issues, and reviewed the reasonableness of the submitted cost reports of the IM consortium's member county agencies.

3.9 School-Based Services (SBS)

This section is applicable to all audits of agencies that receive funding for the School-Based Services directly from the Department of Health Services. Funding: Medical Assistance, CFDA number 93.778.

3.9.1 Background

School-Based Services (SBS) is designed to provide federal Medicaid funding to Wisconsin schools for medically related special education services for children who are eligible for Medicaid. Participants in this program include many Wisconsin school districts, Brown and Walworth County Children with Disabilities Education Boards, and 2nd charter schools.

Wisconsin Medicaid issues fee-for-service (FFS) payments and final cost reconciliation adjustments to Medicaid-certified SBS providers. FFS payments are based on the specific rate set for each type of SBS provided and each SBS provider completes an annual cost report for a final cost settlement. SBS providers have up to 365 days to bill for services following the date of service and settlements within two years after the end of the school year. Therefore, during any given audit period's settlement process, a school district could receive payments for the current audit period and the previous two audit periods.

All SBS providers that bill Medicaid for eligible students must file a Medicaid cost report via an Internet-based SBS cost reporting tool. This website contains all pertinent guides, training presentations, and information regarding the cost reporting settlement process. For additional questions, contact the state's SBS vendor, Public Consulting Group, at WiCostReport@pcgus.com or 877-395-5015, option 3.

3.9.2 Risk Assessment

SBS is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform a risk assessment to determine if this program is a major state program.

The Department will provide an annual list of SBS payments made to all SBS providers for each audit period on the *State Single Audit Guidelines* website to confirm SBS funding levels once the data is available. This information is typically posted in late July, a few weeks after the June 30 close to the fiscal period.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the School-Based Services:

- An Individualized Education Program (IEP) for each student is not obtained.
- Wisconsin Department of Public Instruction's (DPI) Form M-5, "Consent to Bill Wisconsin Medicaid for Medically Related Special Education and Related Services" is not obtained.
- Transportation, salaries/benefits, and contractor costs may not be sufficiently documented or disallowed.
- The SBS program is new for this auditee.

3.9.3 Compliance Requirements and Suggested Audit Procedures

This entire compliance requirement section is applicable for all audits and supplements guidance for the Uniform Guidance's Appendix XI to Part 200 – Compliance Supplement, Part 3.2.

3.9.3.1 Activities Allowed or Disallowed

For an agency to bill Wisconsin Medicaid for SBS, an IEP and "Consent to Bill Wisconsin Medicaid for Medically Related Special Education and Related Services," (WI DPI Form M-5) must be current and signed. Covered SBS services that must be identified within the child's IEP are:

- Nursing
- Occupational and Physical Therapy
- Psychological Services, Counseling, and Social Work
- Speech-Language Pathology, Audiology, and Hearing
- Transportation
- Attendant Care

3.9.3.1.1 Compliance Requirements

Auditors should be aware of the following compliance requirements regarding allowable activities:

- For Medicaid reimbursement, all SBS must be identified in the IEP. The IEP must be updated annually and approved by the recipient's parent or guardian. Cost reimbursement is disallowed for Medicaid-coverable services not specified in the student's IEP. See the *SBS Handbook* and the *State Medicaid Updates* for IEP information.
- Per DPI Form M-5 (revised 2/13), all local education agencies (LEAs) that are Medicaid-certified SBS providers are required to have a signed and dated "Consent to Bill Wisconsin Medicaid for Medically Related Special Education and Related Services" from the parent or guardian of a student with an IEP before claims can be submitted to BadgerCare Plus. DPI Form M-5 is required for each IEP and must be made available to the auditor within the agency's documentation. It is recommended that forms be kept in a student's file, but it is not mandatory if the agency is able to produce the documents upon the auditor's request.
- School districts should take timely action to correct IEP errors and claims on cost reports for ineligible recipients.

3.9.3.1.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their audit programs for SBS:

- Through sampling, determine if billed SBS were included in the recipient's IEP and that the IEP was updated for the current audit period.
- Through sampling, determine if the school district's DPI Form M-5 is signed, dated, and current.

If the auditor finds a noncompliant IEP or Form M-5, the total amount of questioned costs should be identified within the applicable audit finding. Any identified SBS that were paid must be approved by the parent/guardian and included in the current IEP.

3.9.3.2 Allowable Costs/Costs Principles

DHS has no additional compliance requirements or suggested audit procedures regarding allowable costs for SBS.

3.9.3.3 Eligibility

DHS has no additional compliance requirements or suggested audit procedures regarding eligibility for SBS.

3.9.3.4 Matching, Level of Effort, and Earmarking

DHS has no additional compliance requirements or suggested audit procedures regarding matching, level of effort, or earmarking for SBS.

3.9.3.5 Reporting Requirements – SBS Medical Salaries and Benefit Costs

3.9.3.5.1 Compliance Requirements

The following compliance requirements relate to the reporting of medical salaries and benefit costs related to SBS:

- Each school district's salary and benefit information of direct medical service providers are reported through *Quarterly Financial Submissions.* These submissions automatically aggregate into the annual cost report.
- School districts should take timely action to correct errors identified in *Quarterly Financial Submissions*.

3.9.3.5.2 Suggested Audit Procedures

Auditors should include the following audit procedures when auditing SBS:

- Trace salaries and fringe benefits on the *Quarterly Financial Submissions* back to payroll records and financial ledgers.
- Trace the amounts on the *Quarterly Financial Submissions* to ensure federal funds are appropriately identified.
- Trace the amounts included on the *Quarterly Financial Submissions* to allocation worksheets provided by a Cooperative Educational Service Agency (CESA) if applicable. The salaries and benefits of employees of CESAs and other school districts should be included. The CESAs and school districts should provide documentation to support the reported salary and benefit amounts.
- If applicable, trace the salary and benefit amounts reported for contracted staff listed on the *Quarterly Financial Submissions* to appropriate invoices.

3.9.3.6 Reporting Requirements – Final Cost Report

The auditor must consider reporting errors for the final cost report to be a significant finding that precludes the program from being low risk in the subsequent audit. The auditor must identify questioned costs when it is feasible to determine the impact of reporting errors.

3.9.3.7 Special Tests and Provisions – MA Eligibility Rate for Medical Services IEP Ratio

3.9.3.7.1 Compliance Requirement

The IEP ratio is reported within the General and Statistical Information section of the online annual cost report. The auditee should have a system to identify the total number of students enrolled in IEPs with medical services. This system must annually identify the total number of IEP students within each medical service category: speech, language, and hearing services; social work; counseling services; health (nursing); psychological services; occupational therapy; attendant care; and physical therapy. This IEP ratio is the total number of Medicaid-eligible students identified over the total number of IEP students that receive a medical service.

3.9.3.7.2 Suggested Audit Procedures

The auditor should include the following audit procedures to test compliance in this area:

- Review the provider's system for identifying the total number of IEP students receiving medical services by service area is functional and accurate.
- Trace the provider's records to identify the total number of IEP students receiving a medical service across service areas to the cost report.

3.9.3.8 Special Tests and Provisions – Purchased Medical Services and Medical Supplies

3.9.3.8.1 Compliance Requirements

The following compliance requirements pertain to this area:

- Purchased Medical Services and Medical Supplies are reported under the Direct Medical Services Other Costs Summary and the Direct Medical Services Equipment Depreciation section of the online annual cost report.
- The Direct Medical Services Other Costs Summary section of the SBS cost report details IEP purchased medical services, professional dues/fees, depreciation of direct medical equipment, employee travel, and medical supplies obtained from annual report data and the school district's invoices.
- Providers may only report costs of purchased services for IEP medical services and the cost of employee travel and medical supplies used for IEP medical services. All materials and supplies reported on the annual cost report must be allowed per the *CMS List of Allowable Materials and Supplies*.

3.9.3.8.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their audit programs:

- Test the invoices to verify that districts only include costs for IEP medical services, medical supplies used in IEP medical services, and employee travel related to IEP medical services on the cost report.
- Review materials and supplies listed on invoices to ensure costs are allowed per the *CMS List of Allowable Materials and Supplies*.

3.9.3.9 Special Tests and Provisions – SBS Transportation Costs

3.9.3.9.1 Compliance Requirement

All allowable specialized transportation costs are reported on the following sections of the online annual cost report: Transportation Payroll Information, Transportation Other Costs, and Transportation

Equipment Depreciation. Transportation costs charged to SBS must be supported with payroll information, asset ledgers, and any other documentation related to special education transportation.

3.9.3.9.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their programs:

- Trace the transportation amounts on the cost report to relevant financial data.
- Review all costs to ensure that they tie to special education transportation and that those costs are not exclusively reported as general education transportation.
- Ensure that transportation logs exist for SBS transportation costs.

3.9.3.10 Special Tests and Provisions – Medicaid Eligibility Rate for Transportation One-Way Trips and Vehicle Ratios

3.9.3.10.1 Compliance Requirements

The following compliance requirements apply in this area:

- The one-way trips ratio is reported under the General and Statistical section of the online annual cost report. Providers should have an ongoing program with sufficient internal controls to identify total one-way student trips for reporting specialized transportation. The number of one-way trips on IEP transportation should be reported on the cost report. The numerator of this ratio is the total number of one-way trips by Medicaid-eligible students with specialized transportation needs documented in their IEP that receive a direct medical service (also relating to their IEP) on that day. The denominator is the total number of one-way trips by all students with specialized transportation needs in their IEP (regardless of whether they received a service that day). The maximum number of trips reported on a single day is two per student.
- If a district cannot discreetly identify costs as special education costs from all transportation costs, then they may report costs as "not only specialized transportation." If this occurs, the district will then be required to report a vehicle ratio under the General and Statistical Information section. The numerator of this ratio is vehicles used to transport students with specialized transportation needs in their IEP, and the denominator is total amount of busses used for all transportation.

3.9.3.10.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their programs:

- Review the provider's system for identifying the total number of one-way bus trips for IEP transportation, including any bus costs included on the cost report.
- Trace the provider's records that identify the total number of one-way bus trips for IEP transportation to the cost report.
- Ensure the district has bus logs and attendance sheets to provide support that the Medicaid-eligible child rode the bus and received a direct medical service that day (pursuant to an IEP) for the numerator of the one-way trips ratio.
- If applicable, review vehicle counts to determine the validity of the vehicle ratio.

3.9.4 Submitting the Audit Report to DHS

School districts that need to comply with the single audit guidelines of the Uniform Guidance will submit their audit reports through the Federal Audit Clearinghouse. School districts that do not meet the single audit threshold are only required to submit an audit reporting package to DHS if the SBS program was tested as a major program for the current audit period or the school district expended DHS funding

outside of SBS that was tested as a federal or state major program. See section 1.7 of this guide for complete details for submitting the audit reporting package.

3.10 Wisconsin Medicaid Cost Reporting (WIMCR)

This section is applicable to audits of counties, 51 boards, and regions. Funding: Medical Assistance, CFDA #93.778.

3.10.1 Background

Wisconsin counties and other local governmental agencies provide certain WIMCR services to Medicaid recipients that Wisconsin Medicaid reimburses on a fee-for-service (FFS) basis. The Medicaid FFS reimbursement rates usually do not cover the total cost of providing these services. This results in a deficit that the agency supplements through community aids or local tax levies. The objective of the WIMCR program is to enhance the FFS payment rates to alleviate the financial burden on the agency providing these services. Please reference the "Type of Services Allowed" section below for eligible WIMCR services.

Agencies eligible for WIMCR reimbursement prepare an annual cost report that summarizes data the Department uses to calculate the average cost of providing each unit of service by category. This cost per unit of service includes the cost of direct service, 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 recipients.

DHS calculates each eligible county health agency's or public health department's total deficit for WIMCR Medicaid services rendered (less interim claims and settlement payments) and then issues payments in December of each year. DHS issues checks payable to the county designee. With the recent implementation of an internet-based WIMCR cost settlement tool, eligible WIMCR agencies can now find their payment information and submit their cost report online.

Once DHS processes and issues payments, it performs the state maintenance of effort (MOE) calculation. This (MOE) calculation is a two-tiered calculation that apportions $19.25 million to counties as follows:

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

Once the MOE calculation is set, then DHS adjusts each county's basic county allocation (BCA) to reflect the following:

December Payments – MOE Calculation = BCA Adjustment

This BCA adjustment is the amount DHS recovers from the counties through an adjustment to the BCA contract amount. This information is for background purposes and the provider does not need to adjust the SEFSA for either the WIMCR or BCA program.

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

3.10.2 Risk Assessment

WIMCR is a Type A program that requires a risk-based assessment when expenditures reported for reimbursement are the greater of $250,000 or 3 percent of total DHS expenditures for the audit period. The auditor will perform the risk assessment to determine if this program is a state major program. Since agencies can annually file cost reports for additional federal Medicaid reimbursement, the Department recommends that the auditor perform WIMCR testing one calendar year after the audit period in which the Medicaid services were provided. For example, cost reports for services provided in calendar year (CY) 2015 that are due in CY2016 would be included as part of the auditor's CY2016 audit.

Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, the following potential risks have been identified for the WIMCR program::

- Cost classifications are improper, disallowable, or unverifiable.
- The program is new for this agency, or the program's requirements have significant changes.
- The program has complex administrative requirements.

3.10.3 Compliance Requirements and Suggested Audit Procedures

3.10.3.1 Types of Services Allowed

3.10.3.1.1 Compliance Requirements

Wisconsin State Statutes define WIMCR services, and DHS details these services in the annual instruction packet sent to agencies.

Eligible WIMCR 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 home and community; personal care; substance abuse day treatment; child/adolescent day treatment; crisis intervention, including stabilization per diem; prenatal care coordination; community support program; and targeted case management.

Comprehensive Community Services is another mental health program settled in the WIMCR tool. However, it is *not* a WIMCR service.

For the CY2016 cost settlement, eligible WIMCR agencies now submit only one cost report that captures all service area costs.

3.10.3.1.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their audit programs related to WIMCR:

- Verify that the cost report identifies costs only incurred by eligible WIMCR programs.
- Costs reported on the cost report should tie to the agency's general ledger.

3.10.3.2 Accuracy of Program Costs

3.10.3.2.1 Compliance Requirement

The following compliance requirements apply in this area:

- 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.

3.10.3.2.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their audit programs related to WIMCR:

- Review the completed annual cost report and instructions.
- Verify that the cost report reflects the costs of services provided through the applicable programs to eligible recipients for the audited period.
- Verify that WIMCR costs were not charged to other Wisconsin Medicaid programs (i.e., Comprehensive Community Services, Community Recovery Services). Employees' wages and benefits are high-risk cost categories that may result in duplicative charges to multiple Medicaid programs.
- Verify that agency financial records support the cost report by ensuring the cost report requested amount ties to the agency's general ledger.
- Verify that the plan for allocating direct support service staff time and that overhead is consistent with the *Allowable Cost Policy Manual* and established Medicaid policies.

3.10.3.3 Eligibility

DHS has no additional compliance requirements or suggested audit procedures related to Medicaid recipient eligibility for the WIMCR program.

3.10.3.4 Matching, Level of Effort, and Earmarking Requirements

DHS has no additional compliance requirements or suggested audit procedures related to matching, level of effort, and earmarking requirements for WIMCR.

3.10.3.5 Reporting

3.10.3.5.1 Compliance Requirement

WIMCR providers submit the cost report through Public Consulting Group's Wisconsin Medicaid Cost Reporting online tool. Per WIMCR program requirements, adjustments to the final cost report settlement may include activity from the prior audit period.

3.10.3.5.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their audit programs related to WIMCR:

- Select a cost report submitted to the WIMCR online cost reporting tool. Review its mathematical accuracy and determine if supporting documentation exists to support the filed cost report.
- Trace and verify the submitted cost report amounts to the accounting records of the agency

3.10.3.6 Special Tests and Provisions: Consistency of Total Billable Units of Service

3.10.3.6.1 Compliance Requirements

The following compliance requirements apply in this area:

- Cost reports must report total billable units of service in a manner that is consistent with the identification of Medicaid units of service per WIMCR instructions and the Medicaid Provider Manual.
- Total billable hours include Medicare, Medicaid, and all other payers. Other payers may include the county if payments for services are through the tax levy.

3.10.3.6.2 Suggested Audit Procedures

Auditors should include the following audit procedures into their audit programs related to WIMCR:

- Review the agency's system of internal control for reporting weekly time to ensure that reported billable time is accurate.
- Review the time record classifications and descriptions to ensure that there is adequate documentation to report direct, billable time.
- Identify total time by payer category and compare that with the number of recipients in each payer category for reasonableness.
- Verify whether contractors' reported costs match those reported by the county agency.

3.11 Guidance for Auditing a Program that does not have a Compliance Supplement

This section is applicable to all audits.

Auditors may encounter Type A and Type B programs that do not have compliance supplements in the Uniform Guidance's Compliance Supplement or in the *DHS Audit Guide*. Auditors will need to identify the applicable compliance requirements and audit procedures for these programs.

3.11.1 Risk Assessment

Auditors should review the provider contract with the Department and program guidance to identify program specific risks. Auditors should follow the Uniform Guidance for conducting risk assessments of individual state programs. In addition, auditors should consider the following:

- 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.

3.11.2 Compliance Requirements and Suggested Audit Procedures

Auditors will need to identify the applicable compliance requirements and audit procedures for the program. Auditors should consider applying the following considerations:

- The contract between the Department and the provider explains the nature and purpose of the program and may identify compliance requirements where noncompliance could have a direct and material effect on the program.

- The Uniform Guidance, Appendix XI, Compliance Supplement, Part 7 – "Guidance for Auditing Programs Not Included in This Compliance Supplement," provides guidance for identifying the compliance requirements to test if no program compliance supplement exists. This guidance is for federal programs; however, it can also be applicable to state programs.
- The general compliance requirements described in Section 2 of this *DHS Audit Guide* apply to most of the Department's programs. Auditors should consider testing results of these general compliance requirements while assessing risk and formulating an audit plan.