

Section 3.6 Wisconsin Medicaid Cost Reporting (WIMCR) – 2010

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

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

(Note: The Wisconsin State Plan Amendment 03-005 for Medicaid replaced the Community Services Deficit Reduction Benefit (CSDRB) with the Wisconsin Medicaid Cost Reporting (WIMCR) program.)

The main objective of WIMCR is to bring additional funding to the State of Wisconsin. Under this program, the Department of Health Services (DHS) will make Medicaid payment adjustments to counties based on actual costs incurred, as reported by counties on cost reports, for specified Medicaid services. Medicaid payment adjustments will be funded by General Purpose Revenue (GPR) and federal Medicaid matching funds.

Each county's Community Aids Basic County Allocation (BCA) will be:

- Offset to reflect any increase in Medicaid payments the county will receive.
- Increased to reflect the lesser of the amount the county received through CSDRB for Medicaid services provided in 2002 or the county's actual deficit for the calendar year and the specified service.
- Increased to reflect the amount that would have been received under the Community Based Medicaid Administrative Claiming (CBMAC) initiative. The final increase related to CBMAC was applied in December 2005, against the calendar year 2005 BCA.

Each year, Medicaid will issue interim payments and final cost reconciliation adjustments to Medicaid-certified county providers.

The WIMCR payment checks will be made payable to the Medicaid billing provider, but they will be mailed to the county treasurer or designee who also receives the BCA payments. DHS will send reports to the county providing details on changes in these payments.

DHS has declared WIMCR to be a Type A program. Since agencies annually file cost reports seeking additional federal Medicaid reimbursement, the Department recommends performing the audit work in the year following the calendar year in which services were actually provided. For example, cost reports for services provided in CY 2004 were due in 2005 and would be included as part of the CY 2005 audit. Risk factors relating to the services provided in CY 2005,

when they become available, will be posted on the WIMCR web site at www.wimcr.org. See the contact person at the end of this document for further information.

In the following section, “program” means an administratively distinct service or set of services that are certified for reimbursement under a given Medicaid billing number.

Auditors can confirm an agency’s participation in WIMCR, and the programs covered by the Benefit, the amounts claimed, and the amounts (or estimated amounts) paid by contacting Kandice Marquardt at kmarquardt@pcgus.com or telephone (866) 913-4232, extension 4668.

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

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

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

Risk assessment

The Department of Health Services has designated WIMCR to be a Type A program when the auditee receives funding for this program directly from the department.

A. General risk factors

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

B. Program specific risk factors

A county program should be audited if any of its services meets any of the four WIMCR risk factors for prior period cost reports. **Contact the department for data to be used in risk assessment.**

- *Reported Costs Outside Usual Range* - Costs reported by WIMCR participating agencies are evaluated for reasonableness and accuracy. The allowable cost per service unit for each agency should be close to the average cost for all agencies. Program and provider-specific unit costs in the highest 5% of all reported costs are risk factors for audit.

Reported costs that are outside the usual range may be considered a risk factor. Information on counties that have reported costs in the highest 5% of reported costs within each eligible program is available from the department.

- *Overhead to Direct Staff Costs Ratio in Excess of 100% or no overhead costs and a negative deficit* - When completing a WIMCR cost report, participating agencies report the program overhead costs for each eligible WIMCR program. These overhead costs are then compared to the direct costs for staff for that program.

A ratio of Overhead to Direct Costs for Staff exceeding 100% or a cost report with no overhead costs with a corresponding Provider Summary Report (PSR) having a negative deficit is considered a risk factor. Information on counties that have a ratio exceeding 100% or reports with no overhead costs and a negative deficit are available from the Department.

- *Non-Direct Staff Costs to Direct Cost Ratio in Excess of 100% or no non-direct staff costs and a negative deficit* - When completing a WIMCR cost report, participating agencies report administrative, supervisory, clerical and other overhead staff costs for each eligible WIMCR program. These Non-Direct Staff costs are then compared to the Direct Costs for that program.

A ratio of Non-Direct Staff Cost to Direct Cost exceeding 100% or a cost report with no non-direct staff cost with a corresponding PSR having a negative deficit is considered a risk factor. Information on counties that have a ratio exceeding 100% or reports with no non-direct staff costs and a negative deficit are available from the Department.

- *Reported Units of Service Not Within Reasonable Limits* – Reported units of service are over reasonable limits if they are greater than 90% of the units worked as calculated using weekly hours and full time equivalents (FTEs) reported on the cost reports. For example, if units of service are reported in hour intervals, units worked would equal Weekly Hours X FTEs X 52 weeks. We estimate conservatively that approximately 10% of an employee’s time is spent in non-productive activities, such as vacation, holidays, sick leave, and breaks. Units of service should be less than 90% of the units worked, because not all productive time is spent providing billable services. Time spent in training, administration, and record keeping typically is not billable.

Cost report units of service are under reasonable limits if they are less than Medicaid units of service obtained from claims. Cost report units include not only Medicaid, but also all other payers of service. Therefore, cost report units have to be greater than Medicaid units.

Information on counties whose units of service in total are greater than 90% of units worked with corresponding PSR having a negative deficit is available from the department. Note that counties with calculated units of zero may have contracted staff services. For this reason providers with contracted services will not be designated for audit under this risk factor.

Compliance requirements and suggested audit procedures

A. Types of Services Allowed

Compliance requirement(s)

The programs included in WIMCR are defined by statute and are detailed in the annual instruction packet that the Department provides to the agency.

The eligible programs include: home health, adult mental health day treatment, outpatient mental health and substance abuse services, outpatient mental health and substance abuse services in the home and community, personal care, AODA day treatment, child/adolescent day treatment, crisis intervention including stabilization per diem, prenatal care coordination, community support program, and case management.

A separate cost report is completed for each program that is eligible for the Benefit. Programs are considered to be separate if they have different Medicaid billing provider numbers (as opposed to Medicaid performing provider numbers).

Suggested audit procedure(s)

- Verify that the services covered by the cost reports are limited to those that are eligible for the Benefit.
- Verify that each cost report documents costs incurred only by that program with no overlap or double counting.

B. Accuracy of Program Costs

Compliance requirement(s)

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

Suggested audit procedure(s)

- Review the completed annual cost reports and instructions.

- Verify that the cost reports reflect the costs of services provided through the applicable programs to all clients for the whole of the fiscal year.
- Verify that the cost reports are supported by agency financial records.
- Verify that the cost reports identify county cost for services, not contractor cost when the county contracts to other agencies to provide services.
- Verify that the plan for allocating non-direct service staff time and overhead is consistent with the *Allowable Cost Policy Manual* and with established Medicaid policy.
- Verify that the counties have included, in an equitable manner, all costs supporting the programs from all levels of county government. A review of the county's organization charts with administration should be an integral part of this review, identifying those costs at the county, department, division, and service levels that should be included.
- Verify that administration, supervisory, and clerical staff costs are included. Even programs that are operated by a contracted agency may need county staff for contract administration, supervision, and clerical for billing services.

C. Consistency of Total Billable Units of Service

Compliance requirement(s)

Cost reports must report total billable units of service in a manner that is consistent with how Medicaid units of service are identified in the WIMCR instructions and Medicaid Provider Manual. Total billable units of service should be obtained from the county's time reporting system used for billing, not their payroll system. Units billed to the county for services provided by a contractor might not necessarily be the same units that are billed by the county for payment from Medicaid and other payers. In such situations, units billed to the county from contractors cannot be used as total billable services.

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

Suggested audit procedure(s)

- Review the county's system of internal control for reporting weekly time to assure that they require all billable time to be reported.
- Review the time record classifications and descriptions to assure that there is adequate identification and labeling to report direct billable time.
- Identify total time in each payer category and compare with the number of recipients in each payer category for reasonableness.
- Review direct employee job descriptions for duties that are not in support of the services covered in the cost reports whose costs should be eliminated.

- Test medical records to assure that billable units of service are included.
- Review time records with supervisor for that area to discuss problems with adequacy of time records.
- Review contracts or documentation from contracted agencies to assure that the cost report units of service that are provided by these agencies are consistent with units billed to Medicaid and other payers of service.

D. Eligibility

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

Contact person: Steve Milioto
Telephone: 608 266-3802
Email: Steve.Milioto@Wisconsin.gov