



Audit requirements for providers of government-paid health care prompt suggestions for change

by Paul Denis (shareholder)

Our federal and state governments pay tens of millions of dollars in health care each year. Pending legislation is likely to result in expending still larger sums. The government's need to manage these amounts properly has never been more important.

This article looks at how the government monitors public funds used primarily for health care of the elderly and disabled. Because our firm does substantial work helping health care providers and local governments comply with reporting requirements, our focus here will be on how the government monitors compliance accuracy.

The federal government has provided health care for the elderly and disabled for as long as most of us can remember. It pays for these services through Medicare and Medicaid. Federal regulations monitor the quality of care and financial practices of service providers. State participation varies. In Wisconsin, state statutes supplement the federal regulations.

Wisconsin should seize this opportunity to lead

We believe that Wisconsin has the opportunity to lead the way and establish fiscal reporting practices that will provide confidence to taxpayers. For the long term, we would like to suggest that the state and its managed care organizations adopt our recommendations outlined in the display on this page.

Making government funds available for health care has a long and complex history. Let's look at the development of various agencies and providers, and the requirements for reporting, managing, and monitoring use of these funds.

Collaboration helped eliminate duplication of efforts

Prior to the 1980s, nursing facilities and institutional settings normally provided care for individuals. Multiple federal and state departments audited their financial practices, which often resulted in duplication of effort.

By the end of the decade, Wisconsin had made an important service delivery decision. That decision was to provide care in the least restrictive setting for each individual. This led to a significant expansion of care facilities, such as adult family homes, community-based

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We recommend that Wisconsin and its managed care organizations consider these suggestions

Adopt one of these alternative long-term methods

- Require each managed care organization (MCO) to have an audit committee with the authority to act on financial practices and contracting decisions, or
- Require each MCO to have uniform third-party billing procedures to enable central billing and receipt of third-party collections.

Adopt cost considerations vital to good contract decisions by developing state-wide cost data and analysis, with emphasis in these areas

- Distribution of operating and capital cost components,
- Identification of compensation to key personnel,
- Identification of expenses
- not related to patient care,
- Separation of reported costs involving related party organizations, and
- Allocation of shared and indirect expenses along with methodology used.

Adopt necessary uniform accounting methods such as these to facilitate the accumulation of data

- Use generally accepted accounting principles,
 - Provide a uniform chart of accounts for the MCO and the provider network,
 - If costs to providers are material, extend the cost considerations important to the MCO to its provider agency network, and
 - Require audits of all MCOs and material members of the provider network, as determined by risk analysis at the state level (since some providers are integral to multiple MCO provider networks).
- Such audits should require an opinion on the basic financial statements and significant cost areas. The state should develop and approve audit firm qualifications.



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residential facilities, residential care apartment complexes, and hybrid assisted-living arrangements.

To pay for these services, federal and state governments worked collaboratively to develop “Medicaid waiver” programs, carving out the portions of Medicaid funding that had previously paid for care in institutional settings. Wisconsin still uses these programs extensively. They include the Community Options Program, Community Integration Program, and Brain Injury Waiver Program, as well as numerous alcohol and drug abuse programs.

CPA-certified audits eliminated duplication of efforts

Of course it was necessary to monitor how the funds were used. To largely eliminate early duplication of effort, the federal government consolidated its many separate audit requirements with a Single Audit Act, which assigned the attestation role to the public accounting profession. Wisconsin passed a similar Single Audit Guideline, with a mirror impact at the state level.

However, this made the federal Medicare and Medicaid programs technically no longer considered federal assistance, so none of the new federal and state single audit legislation applied to them. Even now, both federal and state Department of Health Services auditors continue to audit Medicare and Medicaid. Interestingly enough, the instructions for completing the 45-page annual cost report for the Medicaid program is 33 pages in length.

Wisconsin counties administer significant state programs

In contrast, the Wisconsin medical assistance waiver programs were subject to the single audit changes, and Wisconsin counties administered them. They quickly became the most significant county programs because of their use and cost. Although counties determine eligibility in most cases, provider agencies normally determine service delivery and corresponding program costs.

Wisconsin statute 46.036 requires virtually all provider agencies to furnish a CPA-certified annual financial and compliance audit report to the county, verifying that the report follows applicable federal and state cost principles.

In recent years, Wisconsin made another important service delivery decision. To better coordinate long-term care services by creating a single flexible benefit, the state now contracts with managed care organizations (MCOs) to

provide care under the Medicaid waiver programs. Although these programs continue to have the characteristics of Medicare and Medicaid federal programs, payments to MCOs are not considered federal financial assistance.

Each county chooses an MCO, which, as a practical matter, “stands in the shoes” of the county. In addition, MCOs need a comprehensive network of long-term care and the support of existing provider agencies. Initially, MCOs will probably pay the majority of their costs to current county employees and provider networks. Material program expenditures must meet federal 42 CFR 438.600, which basically requires the MCO to determine that reported costs are accurate, complete, and truthful.

State and federal requirements provide two options

To satisfy state statute 46.284(4)(L) and federal requirements, there are two options. The first is to contract with a single-county MCO for which the existing 46.036(4) statute continues to apply, requiring the use of the Provider Agency Audit Guide (PAAG). The second option is to operate as a private entity or a long-term care district organized by more than one county and is subject to statute 46.284(3), which does not mandate independent audits of service providers. However, the MCO should have alternative methods to support rate negotiations with the state and to ensure that it provided the contracted services. State guidelines consider this a critical function of the MCO, and suggest that the course of action is to follow the Provider Agency Audit Guide.

Because Wisconsin decided to consider waiver programs for federal and state financial assistance approximately 20 years ago, there are not enough federal and state auditors available who are trained to ascertain federal and state cost compliance. The technical experience now exists with the CPA profession – in particular, with CPAs engaged in the audit of Wisconsin counties administering Medicaid waiver programs.

In the short term, we believe the only logical audit approach for a multiple-county MCO is to continue adhering to the Provider Agency Audit Guide. We do not believe that jeopardizing federal financial participation by adopting alternative methods is practical until qualified sources develop those methods.

For the long term, please see our recommendations in the display on the reverse.