AGENCY 2023 Audit Programs

June 30, 2023 **MENTAL HEALTH INSTITUTIONS AND RESOURCE CENTERS**

PROCEDURE	DONE BY	W/P REF	N/A	REMARKS
Audit Objective:				
To document and test the institution's/resource center's procedures for billing the Medicaid program for client care and to determine the accuracy of those billings. Also, to review all relevant information regarding the Medicaid program as well as eligibility, matching and reporting requirements at the institution/resource center.				
Audit Procedures:				
A. Billings:				
1. Internal control:				
a. Document procedures used to bill for client care. Determine the adequacy of these procedures.				
b. Document the Institution's/Resource Center's procedures in determining possible third party liability and evaluate for adequacy.				
2. Select a sample of individual clients from receivables billed for the period under audit.				
3. Verification of patient days:				
a. Determine proper dates of leave and correct coding for type of leave was reported (home visits, limited leave and temporary medical treatment).				
b. Trace leave taken to billing movement ledger.				
4. Other client services:				
a. Determine types of client services billed (medication, medical treatment and/or lab work).				
b. Determine client services are adequately supported and billed correctly.				
5. Third party revenues:				
a. Identify any applicable third party payees.				
b. Determine if reported revenues from third party payee on client accounts are supported and accurately applied against patient charges.				
B. Medicaid:				
1. Review the following:				
a. Medical Assistance Compliance Supplement.				

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b. Title XIX allowable services/cost report requirement per the State Plan. Available from DHS audit staff.				
c. Prior year workpapers, comments, pending matters and items for next year.				
d. Permanent file, Title XIX section and Title XIX notebooks.				
e. Department of Human Services Employees' manual (Title 8) available from DHS staff.				
f. 42 CFR 431.107 and 440.10.				
2. Review internal control fieldwork performed and determine if audit program should be modified.				
3. Contact AOS DHS audit staff to determine if any DHS audit findings exist relating to the following areas:				
a. Status of prior pending disallowances known to the Center for Medicare and Medicaid Services (CMS).				
b. Outstanding fiscal sanctions or disallowances pending or under appeal.				
c. Pending litigation involving the State and Medicaid compliance issues.				
d. Allowability of claims submitted to DHS by the Institution.				
e. Utilization of services for long-term institutional care.				
f. Identification of third party liabilities.				
4. Eligibility – The State (DHS) is required to operate a Quality Control (QC) system which reviews the determination of recipient eligibility made by Agencies by using statistical sampling methods to select and review claims. The state's QC system is reviewed at the DHS state level.				
a. Supplemental Security Income Recipients. Post-eligibility treatment of income/resources of institutional individuals. 42 CFR 435.725 and Public Law 101.508.				
1) Document procedures and evaluate for adequacy.				
2) Randomly select a sample of SSI recipients.				
3) Document method of sample selection.				

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4) For the recipients selected, determine if the file contains the Resident Care agreement form 470-0374. Note: This is NOT applicable for MHI's.				
5) For the recipients selected, determine if the financial participation by the resident is in accordance with these guidelines:				
a) Thirty dollars of unearned income was retained for personal needs. In the case of veterans whose pension is subject to a $90 limitation, the personal needs allowance is $90 instead of $30. [After November 1, 1990, earnings of up to $65 were disregarded and, therefore, available to be used for personal needs, thus making personal needs allowances as low as $30 (for someone with no earned income) or as high as $95.]				
b) The balance of the income was applied toward the cost of care.				
b. Eligibility of the Institution/Resource Center (IAC Section 481 Chapter 64 and 42 CFR 442)				
1) Review for the following to ensure the Institution/Resource Center meets health and safety standards.				
a) MHI's are certified by the Center for Medicare and Medicaid Services (CMS).				
b) Glenwood and Woodward are certified by the Department of Inspections and Appeals (DIA) for CMS.				
c) Cherokee and Independence receive their accreditation for impatient psyche services from the Joint Commission of Accreditation of Health Care Organizations (JCAHO).				
d) All institutions are inspected by the Fire Marshall.				
5. Matching Requirements (42 CFR 433.10 and 433.15) Note: Medicaid expenditures are tested at the DHS state level via the CMS-64 quarterly report.				

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6. Reporting Requirements (IAC Section 441 Chapter 82.5) Note: Institutions/Resource Centers are using a software package developed by CMS for the preparation of its cost report. Therefore, only the input of this report needs to be supported. (Because the software was developed by CMS, it does not need to be tested.)				
a. Review the following:				
1) For the MHIs (Cherokee, Clarinda, Independence and Mt. Pleasant), review the Medicare Cost Report (CMS 2552-96) filed with Medicare Fiscal Intermediary, Wisconsin Physicians Service Insurance Corporation.				
2) For the MHIs, review the Medicaid Cost Report (CMS 2552-96) and additional worksheets required for Medicaid filed with the Iowa Medicaid Enterprise.				
3) For the Resource Centers and for Clarinda, review the Financial & Statistical Report for ICF/MR (AA-4036-0) filed with the Iowa Medicaid Enterprise.				
4) For the Psychiatric Medical Institute for Children (PMIC-Independence is the only one), review the Financial and Statistical Report for Purchase of Service Contracts filed with the Iowa Medicaid Enterprise.				
b. Determine if report(s) has (have) been reviewed by the appropriate entity as identified above.				
c. Determine if the reports were used by the Iowa Medicaid Enterprise for cost settlement purposes relating to MHIs to compute the subsequent 6-month per diem rate. Documentation for cost settlement results and per diem rates established is maintained by the Institution/Resource Center.				
d. Determine if the reports were signed by the appropriate authorized officer providing certification.				
e. Determine if the reports comply with the State Plan instructions. (Medicaid Cost Reports follow Medicare Institution.)				

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f. Review the Institution/Resource Center's controls over reporting of statistical data – patient days. Test the following for reliability:				
1) Days of period.				
2) Total beds available.				
3) Change reports supporting admissions and discharges.				
4) Reserved bed days:				
a) For Resource Centers: Test for inclusion of reserved days.				
b) For MHIs: Per attachment 4.19C of the State Plan, MHIs (which are considered "hospitals") are not to receive payment for reserved bed days. Test to determine these are not included.				
5) Billing test – Test records for accurate calculation of patient days.				
a) Select a sample time period (i.e. month).				
b) Trace change period from supervisor's change report daily to change notice.				
c) Assure proper dates of leave and correct coding for type of leave were reported (home visits, limited leave and temporary medical treatment).				
d) Trace leave taken to billing movement ledger.				
e) Assure no leave exceeded the regulated period (30 days annually for home visit or 10 days/month for TMT).				
6) Trace changes for the period from change notice to DHS billing document. Note: Leaves are billed at 80% rate.				
7) Determine client participation (CP) per billing and compare to CP printout for period to ensure proper amount was posted.				

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g. Determine if reported revenues:				
1) From residents are supported and sufficiently recorded and include only charges for daily care.				
2) For guest meals and lodging are reported accurately and reflect a reduction of the related expense.				
3) From "other revenue" is supported and recorded accurately.				
4) From "other federal aid" reduces reported costs.				
h. While institutional indirect Medicaid expenditures are tested for allowability at the DHS level, direct Medicaid expenditures are not. For reported expenditures:				
1) Determine if reported expenditures are allowable per OMB Circular A-87 and have adequate supporting documentation.				
2) Determine if reported expenditures are in compliance with Title XIX Medical Assistance scope and limitations. (State Plan/42 CFR 482.12/Code of Iowa Chapter 135.61)				
a) Depreciation should be based on base cost using the straight-line method.				
b) Capital expenditures and/or a permanent change in the bed capacity must receive approval from the Health Facilities Council. Check for a "Certificate of Need" from the Department of Health. Note: See Code of Iowa Chapters 135.61(18) and 135.63 for limitations.				
3) Determine if reported expenditures on the compilation by Institution/Resource Center are appropriate and supported.				
4) Determine if reported expenditures are capitalized appropriately.				
7. Identification of Third Party Liabilities (TPL) 42 CFR 433.135-154:				
a. Document the Institution/Resource Center's procedures in determining possible TPL. Determine if procedures were implemented and evaluate for adequacy.				

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b. Review recipient files for completed and signed form number UB-92 CMS-1450. If this specific form is not used, review alternate process for identifying third parties.				
c. Review the Institution/Resource Center's procedures for review of files and submission of claims to appropriate liable parties.				
d. Document who receives the payments from third parties.				
8. Receivables:				
a. Obtain a list of receivables at year-end.				
1) Test mathematical accuracy, if obtained.				
2) Service billings:				
a) Review controls over billing procedures and receivable balances.				
b) Obtain reconciliation of receivables performed by institution and DHS.				
c) Review reconciliation for accuracy.				
d) Determine if reconciling items have been recorded/resolved.				
b. Test collectability of the balances. (The Institution/Resource Center needs to develop a system to properly age accounts receivables so the balance carried reflects what an institution actually expects to receive. The Institution/Resource Center will need to know which billings are in dispute or haven't been collected due to some other reason.)				
c. Test deposits made in the next year to determine if amounts should have been recorded as receivable in the current year.				
d. Determine whether receivables are properly classified and disclosures are adequate.				
C. Determine if the risk of material misstatement due to fraud or error has changed based on results of substantive tests performed. If so, perform appropriate procedures.				

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ALTERNATE/ADDITIONAL PROCEDURES:				
CONCLUSION:				
We have performed procedures sufficient to achieve the audit objective for service billings and Medicaid programs at the Institutions/Resource Centers and the results of these procedures are adequately documented in the accompanying work papers.				