

RISK IDENTIFICATION AND ASSESSMENT WORKSHEET INSTRUCTIONS

Risk Identification and Assessment Worksheet ([F-00945](#))

IDENTIFYING AND ASSESSING RISKS

All providers that receive Department of Health Services (Department) - related funding in excess of the statutory threshold of \$100,000 may be required to provide the grantor or purchaser of qualifying care and services an agency-wide audit unless this audit requirement is waived by the Department or county. Prior to offering an agency a grant agreement or contract, the Department or county agency should perform a risk assessment of the entity under consideration. This Risk Identification and Assessment Worksheet will enable the Department and counties to determine the level of risk an entity poses and whether an audit waiver request by the entity is justified.

The Risk Identification and Assessment Worksheet is a simplified and systematic approach to performing and documenting an entity's level of risk. The Department or county may also opt to include additional risk factors or assign more importance to certain risk factors when performing the risk assessment. This approach to assessing risk segregates risk factors into the following categories:

1. [Risks associated with a particular program](#)
2. [Risks associated with a particular provider](#)
3. [Risks associated with the county](#)

By assessing risk across these categories, the county or Department can determine the level of risk within each category's risk factors and evaluate the agency's overall level of risk as low, moderate or high. Since this risk assessment instrument may require the evaluator to subjectively assess certain risk factors, the evaluator should consider all available information in formulating her or his responses that ultimately determine an agency's overall level of risk.

RISKS ASSOCIATED WITH A PARTICULAR PROGRAM

Programs differ in their inherent risks, which include:

- 1.1 [Life stage of the program](#)
- 1.2 [Complexity of the program](#)
- 1.3 ["Sensitivity" of the program](#)
- 1.4 [Who decides eligibility for the program](#)
- 1.5 [Who decides amount or type of service from the program](#)
- 1.6 [Payment method](#)
- 1.7 [Competition](#)

In addition to the factors listed in this section, the Department may periodically identify specific risks of certain programs. Dependent on the circumstances, the Department may notify counties of alerts or other program bulletins describing potential issues of concern. The Department's contract administration and program staff can provide additional information about specific risks for particular programs.

1.1 Life Stage of the Program

Established programs generally have less risk than new programs, although recent changes to an established program may increase risk.

1.2 Complexity of the Program

Programs that have simple requirements (eligibility, calculations, reporting) generally have less risk than programs that have more complex requirements.

1.3 Sensitivity of the Program

The “sensitivity” of the program is made up of two factors: the vulnerability of clients and the visibility of the program. Programs that serve vulnerable clients inherently have higher risk. High visibility programs typically have more scrutiny and monitoring. This level of monitoring can lower the level of risk as issues are more readily identified, but yet the additional scrutiny can increase the risk level to an organization as its reputation may be harmed if numerous issues and problems are identified.

1.4 Who Decides Eligibility for the Program

Risk is typically lower when the county determines eligibility and it is typically higher when the provider determines eligibility.

1.5 Who Decides Amount or Type of Service from the Program

Risk is typically lower when the county determines the level and type of services provided to a client and it is typically higher when the provider makes this determination.

1.6 Payment Method

All payment methods have risks, although some are inherently more risky than others depending on the circumstances. Most payment methods are a variant of one of four basic provider payment methods:

1. **Cost-based contract** – in a cost-based contract, the provider reports costs to the county who reimburses the costs. Cost-based contracts include those where:

- The provider is reimbursed for its costs.
- The provider is responsible for the cost of providing care and services up to a certain amount, after which the county shares in the cost or assumes full risk of the cost overruns.
- The provider’s reimbursement is limited by allowable costs, such as the provider maintaining a reserve.

A cost-based contract can have high risk if the county does not have means of ensuring that the provider is claiming only allowable costs for reimbursement.

Some of the risks of inappropriate payments for a cost-based contract include unallowable costs resulting from:

- Inaccurate cost reports.
- Misallocation of costs or cost shifting.
- Lack of approval for costs.
- Inappropriate or unnecessary items.
- Lack of documentation for costs

2. **Units-times-unit-price contract** – Under a unit-times-unit-price system, the provider and the county decide on a per unit price for the service. The provider reports the number of units of service to the county and the county pays the provider for the number of units times the price per unit. A unit-times-unit-price method can have high risk if the county does not have means of ensuring that the unit price is reasonable and that the number of units the provider claims to have supplied is accurate.

Some of the risks of inappropriate payments for a unit-times-unit price contract include:

- Inaccurate count of units.
- Price is too high or too low.
- Unnecessary units.
- Undocumented units.

3. **Performance-based contract** – Under a performance-based contract, payments are tied to achieving performance goals. Developing performance metrics that promote the intent of the program without introducing additional risks to the program can be very difficult, and successful use of this contracting method requires careful planning. Risks of inappropriate payments for a performance based contract may include a shift of focus from overall program purpose to measured activities or inaccurate performance reports.

4. **Capitated contract**¹ – In a capitated contract, the basis for payment is reported eligible enrollees. The provider is paid a certain amount to deliver services to a target group and it is held accountable for providing the services despite the final cost.

There are two types of capitated contracts:

- Full risk – the provider is responsible for all costs of providing care or services.
- Shared risk – the provider is responsible for costs of providing care and services up to a certain amount, after which the county shares in the costs.

Some risks of inappropriate payments in capitated contracts include:

- Rates set too low or too high.
- Inaccurate reporting of the number of eligible enrollees or services provided to enrollees.
- Reduction in costs through reduction in level of services or types of services provided to enrollees.
- For shared risk capitated contracts, also see the risk factors associated with cost-based contracts (See cost-based contracts above).

Counties can influence the relative amount of risk by selecting a payment method that suits the particular circumstances. For example, if the county has a program that it does not have much experience with, a unit-times-unit-price contract can be very risky unless there is a means of ensuring that the unit price is reasonable. One way to mitigate this risk is to use a cost-based contract for the first few years to establish a base line metric for costs.

1.7 Competition

Contracts that are awarded on a competitive basis are generally lower risk because the competitive process helps reduce the likelihood that the county will be overcharged for the service provided. Some characteristics of awards made on a competitive basis include:

- The county has a written conflict of interest policy, which it follows in making the award.
- The award is made as a result of a written bid.
- More than two providers bid on the award.
- The county has credible, independent knowledge that the price is reasonable, and is sufficient to support an acceptable level of service.
- As part of the bid process, the county identifies and evaluates the level of services to be provided.

RISKS ASSOCIATED WITH A PARTICULAR PROVIDER

Certain provider types may have characteristics that influence risks, including:

- 2.1 [Provider's total funding from the Department](#)
- 2.2 [Provider's length of time in business](#)
- 2.3 [Provider's experience and past performance](#)
- 2.4 [Provider's financial health and practices](#)
- 2.5 [Provider's compliance and internal controls](#)
- 2.6 [Provider's fiduciary responsibilities](#)
- 2.7 [Provider's subcontracting](#)

¹ Wisconsin Statutes allow capitated contracts only for certain services funded by the Medical Assistance program. Contact the Department if you have questions about the allowability of a contract method.

2.1 Provider's Total Funding from the Department

A key factor in considering a provider's level of risk is the total amount of Departmental related-funding that the provider receives from all sources, including other counties or agencies. The amount of Department-related funding is a measure of the amount of the Department's financial exposure if the provider encounters problems in program administration. Smaller amounts of Department-related funding correspond to lower exposure and risk, while larger amounts of funding correspond to higher exposure and risk. However, the level of funding is just one of many factors that feed into risk. Therefore, a provider paid \$150,000 is not automatically deemed low risk and a provider paid \$250,000 is not automatically classified as high risk.

Since risk exposure is measured from the Department level, all sources of Department-related funding must be considered. This funding can be direct from the Department or passed through one or more counties.

Wisconsin Statute 46.036 (4)(c) establishes the \$100,000 threshold for the audit requirement unless the audit is waived by the Department. In addition to the statutory threshold, the Department has established the following guidelines in determining risk based on the level of funding:

TABLE 1: RISK ASSOCIATED WITH TOTAL DEPARTMENT FUNDING

Amount of Department -related Funding from all Sources	Risk
Less than the statutory threshold of \$100,000	Audit not required
More than the statutory threshold of \$100,000 and less than \$200,000	Lower
More than \$200,000	Higher

2.2 Provider's Length of Time in Business

A provider that has been in business for several years is generally lower risk than a start-up provider. A county can mitigate these risks by performing additional monitoring of new providers.

2.3 Provider's experience and past performance

The provider's experience and past performance are key factors in risk. Extensive experience and a history of solid performance generally equates to lower risk, while an agency with little to no experience or a poor performance history generally indicates higher risk.

2.4 Provider's financial health and practices

Providers that have strong financial health and sound financial practices generally are of lower risk. Providers have higher risk if cash flow or operational financing issues are prevalent.

2.5 Provider's compliance and internal controls

A provider with a history of compliance and sound internal controls is generally lower risk than a provider with a history of compliance or internal control issues. Some questions to answer in assessing the provider's compliance and internal controls include:

- Does the provider's latest audit report show weaknesses in internal controls?
- Does the provider's audit report show findings of non-compliance with requirements that relate to Departmental programs?
- Do audits findings annually recur? If so, this indicates that management is not committed to improving operations or ensuring compliance with the contract's terms.
- Does the provider have adequate segregation of duties? If not, does the provider have effective compensating controls?

2.6 Provider's fiduciary responsibilities

Providers that have fiduciary responsibilities for resident funds have higher risk than providers that do not have such responsibilities.

2.7 Provider's subcontracting

Subcontracting affects risk because the subcontractor performs program functions, but the provider remains responsible for compliance with the terms and conditions of the contract with the county. Risk is higher if the provider subcontracts material activities to other providers. Risk is also higher if the provider does not have an effective monitoring function for contract oversight.

RISKS ASSOCIATED WITH THE COUNTY

The third area of risk is a county's own inherent risk. Counties differ in their level of experience in contracting with particular programs or providers and in the availability and effectiveness of their monitoring efforts:

- 3.1 [County's experience with the provider](#)
- 3.2 [County's experience with the program](#)
- 3.3 [County's monitoring methods](#)

3.1 County's experience with the provider

Contracting with a provider that the county has an existing business relationship is generally lower risk than contracting with a provider with no prior working relationship.

3.2 County's experience with the program

The county having extensive experience with the program generally means lower risk than does the county having little or no experience with the program.

3.3 County's monitoring methods

Risk is lower overall if the county's monitoring methods effectively mitigate the other risks identified in this section. The county must weigh the consequences of potential issues with the costs to prevent or detect the issues. In doing so, the county may choose to increase its own monitoring efforts to ensure that a provider complies with the program's requirements and that the appropriate level of risk was assessed.

Some of the possible monitoring efforts include:

- Providing technical assistance to the provider on understanding and meeting the county's expectations.
- Reviewing financial reports and claims for reimbursement for reasonability and mathematical accuracy before authorizing payment.
- Requiring supporting documentation for claims for reimbursement.
- Reviewing performance reports and correlating them to financial reports and claims for reimbursement.
- Making site visits to observe services being delivered and to review program records.
- Surveying clients (or their families or caseworkers) on service satisfaction and responding to complaints about inadequate services.
- Following up on complaints from whistle-blowers.
- Paying attention to media stories regarding the provider.
- Performing background checks on key staff of the provider. State law requires mandatory background and criminal history checks of key personnel responsible for the care, safety and security of children and adults. See the Department of Health Services home page for more information on the statutory requirements for background and criminal history checks.
- Obtaining references or performing other checks to confirm that key provider staff has sufficient experience to administer the contract.
- Requiring a provider to engage in on-going quality improvement or assurance efforts. Results of these operational improvement initiatives should be accessible reviewed by the county of Department.

The Department and county should perform a thorough internal review of its monitoring efforts to confirm that the scope and monitoring methods sufficient oversight of an agency as based on the assessed level of risk.

OVERALL RISK ASSESSMENT

Upon completion of the worksheet, the evaluator shall make a final determination by assessing the agency's overall level of risk as low, moderate or high. If the prevalence of risk factors identified is high or low, then that would merit the agency's overall level of risk classification as a high or low. If the risk factors are split between high and low, then the overall risk level would be moderate. The assessor should utilize her or his best judgment in making this overall risk determination since there is no pre-defined metrics that automatically classify an agency within one of the risk categories. Additionally, some counties may determine that certain risk factors are more significant in the final determination of an agency's overall level of risk.