

Section 3.2 Community Integration Program I (CIP I) & Brain Injury Waiver - a program cluster – 2010

This section is applicable to audits of counties and 51 boards that receive funding for the Community Integration Program I and Brain Injury Waiver directly from the Department of Health Services.

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.

The Community Integration Program I and the Brain Injury Waiver program cluster uses both HSRs and CARS for reporting. See *DHS Audit Guide* Section 2.6 “Reporting” for additional explanation for the detail shown below.

Counties report expenditures for the Community Integration Program I (CIP I) and Brain Injury Waiver on both HSRs and CARS. At the end of the period, the department reconciles CARS to match HSRs. These programs use the following CARS profiles:

Profile 501 Brain Injury Waiver (G)	Profile 506 BIW Non Federal (F)	Rolls to 561BCA (F)
	Profile 507 BIW Federal (E)	
Profile 556 CIPB St Coletta (G)	Profile 562 CIP IB COP St Coletta (F)	Rolls to 561BCA (F)
	Profile 563 CIP IB Federal (E)	
Profile 557 CIPB (G)	Profile 564 CIP IB Non Federal (F)	Rolls to 561BCA (F)
	Profile 563 CIP IB Federal (E)	
Profile 558 CIP1A (G)	Profile 580 CIP1A Non Federal (F)	Rolls to 561BCA (F)
	Profile 581 CIP1A Federal (E)	

Profile types-- D=Non-reimbursable, E=Sum Sufficient, F=Contract Controlled, G=Allocating

(Source: <http://dhs.wisconsin.gov/bfs/CARS/CARSManual2009/WaiverFlowchart.pdf>)

The Community Integration Program I (CIP I) includes two state-level programs called CIP IA and CIP IB authorized by statute: s. 46.275 and s. 46.278 respectively. The Brain Injury Waiver is also authorized by S. 46.278. The two CIP 1 programs and the Brain Injury Waiver (BIW) are Medicaid home and community-based services waivers programs established under Section 1915 (c) of the Social Security Act and are part of the Wisconsin Medicaid Program. All Medicaid home and community-based services waiver programs are described in individual program applications submitted to and approved by the Center for Medicare and Medicaid Services (CMS).

The objective of all Medicaid Waivers is to provide program participants with adaptive, individualized services and supports to give them choices about where and how they live and work in the community. Services permit people to reside in a community setting or, in some cases, with their families instead of some type of institution or alternate care setting. CIP IA funds persons who previously received long-term care services and resided at one of the three State Centers for people with Developmental Disabilities; or persons who are eligible for and at risk of admission to the Centers; or people who replace the individuals who were originally relocated from a Center but who terminated from the Medicaid Waiver program for some reason. CIP IB funds persons who resided at other Intermediate Care Facilities for persons who are Mentally Retarded (ICF/MR) and relocated to the community; or persons who are eligible for this setting but were diverted from those facilities. This includes people who are relocated under the department's ICF/MR restructuring initiative (which is coded separately on HSRS). Some people served may have been inappropriately placed in general nursing homes. The Brain Injury Waiver serves people who are either relocated or diverted from specialized brain injury rehabilitation facilities.

The Division of Long Term Care contracts with a County agency to finance the services funded by all of these programs. County agencies have separate appendices to the State and County contract for Social and Mental Hygiene Services for CIP 1A, CIP 1B and BIW. This appendix or contract prescribes the requirements necessary for proper implementation and operation of this program by county agencies and reference certain other documents which also prescribe proper operation of these programs. The key document referenced in the contract is the Medicaid Waiver Manual. (See link/site information: <http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>).

The program manager notes that audit results are a valuable tool for monitoring program adherence to policies and rules and that Quality Assurance staff follow-up with counties on the findings to ensure correction. The audit guide is now an integral part of the state's agreement with the federal government allowing Medicaid funds to be used for supporting people in community settings.

Risk assessment

The Department of Health Services has designated the Community Integration Program 1 (CIP 1) and the Brain Injury Waiver (BIW) to be a state major program when the auditee receives funding for any/all of these programs directly from the department.

Compliance requirements and suggested audit procedures

I. Participant file testing

All of the following compliance requirements in this section apply to individual Medicaid Waiver participants and should be tested through review of the participant's agency files.

Even limited or seemingly inconsequential noncompliance with certain program requirements can reflect or result in a profound impact on the quality of services, the health and safety and the quality of life of program participants. Therefore, all findings of noncompliance need to be reported in the Schedule of Findings and Questioned Costs. If it is unclear whether a particular

situation constitutes noncompliance, call or send an email to the contact person listed at the end of this section for guidance. See Section 4.11 “The Schedule of Findings and Questioned Costs” of the *Main Document to the State Single Audit Guidelines* (www.ssag.state.wi.us) for elements of a finding.

Do not include confidential client information in an audit report. See Section 1.5 of the *DHS Audit Guide* for more information on handling confidential client information.

The auditor does not usually need to determine questioned costs, but will need to provide the department with identifying information for specific cases involved in the finding if the department requests this information. The department will typically calculate potential disallowances based on the nature of the noncompliance. For example, the potential disallowance for a county’s failure to re-certify a client would be the amount of waiver funds spent on the client’s behalf during the time since the end of the period covered by the previous certification or re-certification. Whether the department will require full or partial repayment for that amount will depend on the nature and circumstances of the noncompliance and the county’s previous record of compliance.

A. Eligibility

Compliance requirement(s) - Financially eligible

Participants must be eligible for Medicaid or Waiver funding under CIP 1A/B or BIW. Eligibility must be redetermined annually.

For Group A participants, eligibility is documented through the Form F-20919 (previously DDE-0919) “Medicaid Waiver Eligibility and Cost Sharing Worksheet,” which is completed by county staff. (In some situations, the participant file for a Group A client will also need to contain a CARES screen. However, the requirement for a CARES screen for Group A participants is beyond the scope of this supplement.)

For Group B and Group C participants, eligibility is documented on the Form F-20919 (previously DDE-0919) or through the CARES screen. The F-20919 is completed by the Support and Service Coordinator. The CARES screen is completed by the County Economic Support Specialist.

Counties may use an equivalent to the F-20919 form.

Suggested audit procedure(s)

For the cases selected in the sample,

- For Group A participants, verify that the participant’s files include at least a Form F-20919.
- For Group B and Group C participants, verify that the participant’s files includes a Form F-20919 or a CARES screen.
- For all participants, verify that the F-20919 form and the CARES screen are updated at least annually.

- For all participants, verify that the eligibility documents were completed by the appropriate person.

2. Compliance requirement(s) - Functionally eligible

Every Medicaid Waiver participant must meet a level of care requirement established by the department to establish their functional eligibility for Medicaid Waiver services.

For CIP 1A/B, this level of care must be DD1a, DD1b, DD2 or DD3 level and remain at one of those levels through subsequent years. Level of care is determined by the automated Long Term Care Functional Screen. The screen must be completed annually by a qualified screener. Evidence that the screen has been completed by a qualified screener in a timely manner must be maintained in the participant's file.

For BIW, the level of care must be a BI level of care. The level of care must be documented on the Forms OQA-2256 "Request for Title XIX Level of Care Determination" and OQA-2256a "Request for Title XIX Level of Care Determination Addendum for Developmentally Disabled Client/Resident." These forms are also required for annual recertifications.

Suggested audit procedure(s)

For each participant file selected for the sample,

- Determine whether documentation shows that the results of a timely functional screen done for/on the participant contain a rating for an appropriate level of care
- Determine whether the county has recertified the level of care within the last twelve months (or 15 months for the first recertification for CIP IA/B only).

3. Compliance requirement(s) - Recertification up-to-date, complete and current

Counties are required to conduct a recertification of eligibility not less than once per year. The content of the recertification for each waiver is covered in Chapter VII of the waiver Manual. Counties are required to report to the department they have performed a complete recertification in a timely manner by completing a "County Monthly Recertification Assurance Report" for each person funded by CIP 1A/B /BIW. The department does not receive the actual recertification documents but requires them to be on file at the county. The reports for all of these Medicaid Waivers are required to be sent to the respective department's DD Section overseeing these specific Medicaid Waivers where dates and updated information are reviewed and documented in related client databases. The audit is intended to determine if recertifications were completed as required, are current, complete and accurate as was reflected in the most recently required "County Monthly Recertification Report.

For additional detailed information, see Chapter VII of the *Medicaid Waivers Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>), supplemented by CIP 1 Update #2005-01 "Simplifying the Annual Recertification Process and Reducing County Reporting Burden." Recertifications must meet the requirements of Chapter VII of the Waiver Manual.

Suggested audit procedure(s)

For each participant file in the sample, determine whether the county accurately reported the recertification to the department on time and with all required documents and accurately communicated this on the “County Monthly Recertification Assurance Report” for the CIP/BIW client.

B. Assessment and Individualized Service Planning

Compliance requirement(s) – Up to date Assessments

Each Medicaid Waiver participant must have a current assessment that covers the required elements listed in Chapter VI the Medicaid Waiver Manual in their file. The only requirement defining a time period within which an assessment is considered current is that there needs to be a reassessment done not less than once per year, generally as part of the recertification. The client record must show evidence of the assessment having been reviewed at least annually and its findings reconfirmed. Assessments are the basis of the services listed in the individualized service plan. If the assessment in the file uses the Long Term Care Functional Screen, it must be supplemented by additional information. An assessment supplement form, the F- 20980 has been developed to include all of the information needed for an assessment that is not included on the Functional Screen. The content of the assessment and its relationship to the Individualized Service Plan will be reviewed outside of the audit process.

Suggested audit procedure(s)

Verify that there is a written assessment in each participant file sampled. If the functional screen is used, a current version of the F- 20980 must also be on file. There must also be some evidence of a review of the assessment in whatever form it takes in the file. The review must be not less than annual and can be evidenced by a file note or some other means. The manner of documentation is at the county’s discretion.

Compliance requirement(s) – Current, Accurate and Approved Individualized Service Plan(ISP)

Each waiver participant must have an ISP that is up to date, includes individual outcomes which accurately reflect the Medicaid Waiver services the individual is to receive, and is signed and approved by the person or the person’s guardian. Initial ISPs require approval by the department as evidenced by a letter from DD Section Staff, generally the county’s assigned Community Integration Specialist (CIS). Approval generally is granted for the individual’s entire individualized service plan. The ISP must be reviewed by the county not less than once every six months and updated not less than annually. The plan must be done using Form F-20445 and F-20445a (previously DDE-445 and 445a), although local versions are permitted if they have been submitted to and approved by the Bureau of Long-Term Support. The County Agency must receive written approval from the department in order for them to use a unique county-developed form.

Individualized Service Plans are required to be up-to-date, based on the assessment contained in the file and conform to the requirements in the Waiver Manual (See Chapter VI of the Manual). The ISP must specify each service the participant is authorized to receive, the provider of the services and a reasonable estimate of the number of units of service and cost of the service based on a rate derived by the county for the specific service which the individual receives. While the service and provider must be accurately listed, the units and

cost are considered an estimate. The ISP must be reviewed every six months and updated not less than annually or when needs, services, providers, or units of service change.

Suggested audit procedure(s)

For each participant file in the sample, determine if there is a current (i.e. a year old or less) ISP in the participant's file, that it was reviewed by the support and service coordinator, the participant and his/her guardian, if any, at least every six months, that the plan is signed by the participant or his/her guardian, if any, and that the state has approved the initial ISP. State approval is evidenced by an approval letter in the file. For additional information, see Chapter VI of the *Waiver Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>).

Compliance requirement(s) – Qualified providers deliver allowable services

No provider qualifies for receiving Medicaid Waiver funding unless that provider has an agreement with the State Medicaid Agency (SMA) or has had that requirement waived. Providers must sign and submit the appropriate SMA Provider Agreement form to county waiver agencies. There are three separate forms for agencies, individual providers and self directed providers.

No reimbursement can be made for a service specified in the participant's Individualized Service Plan unless the service is one that is allowed by the specific Medicaid Waiver and is delivered by a provider determined to be qualified. The list of allowed services and provider requirements is defined in Chapter IV of the *Waiver Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>). Reimbursement may also be restricted by special "Service Requirements/Limitations/Exclusions" specified under the specific service discussed in Section 4.10 in Chapter IV of the Manual. All services identified in the ISP should be delivered to the participant, and all services that the participant receives should be specified in the ISP. It is also important that any service listed in the ISP be provided. If it is not, this should be identified in the audit. Note however that some services may be delivered intermittently (e.g. respite care), seasonally (e.g. a summer day services program for young people when school is out) or during a defined period involving the purchase of equipment or items.

County agencies report all expenditures for services for each waiver participant monthly on the Human Services Reporting System (HSRS). Services are generally authorized by county agencies through some type of contract, provider agreement or via the person'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 time period when all these factors were in place. The only exception to this is start up costs which include any cost that is covered by the Medicaid Waiver incurred within the 180 days prior to the Medicaid Waiver participant's start date.

All units of any services reported on HSRS must be documented in the participant's file by some indication that the activity occurred. This can take the form of a file note, an annual review report, an attendance record or an invoice that includes sufficient information to verify the delivery of the service (such as what service was provided, when the service was provided, who provided the service, who received the service, how many units of service were provided, and where the service was provided). County agencies also must document

the number of units of service delivered using the units prescribed for the particular service per the instructions contained in the HSRS Handbook (<http://dhs.wisconsin.gov/HSRS/docs/lts2009.pdf>).

Since all services paid for with Medicaid Waiver funds must be reported on HSRS, the services identified in the ISP and on HSRS should be in general agreement. Precise, one to one matching is not required: a person may receive more or less than the services authorized in the ISP. Large discrepancies should be noted in the audit report. For additional information, see Chapter VI of the *Waiver Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

Review the Section 2.6 “Reporting” and apply the audit procedures in that section. In addition, obtain an L-300 report for the agency. This report lists each participant, the services in which they were enrolled, the number of service units provided and the amount of waiver funding claimed for the services provided. For each participant file in the sample, determine whether:

1. the waiver services listed in the ISP are allowed by the Medicaid Waiver,
2. the waiver services listed in the ISP were actually provided to the participant as evidenced by the L300,
3. the waiver funded services reported on HSRS were specified in the approved ISP,
4. the number of units of service, cost per unit of service and the total cost for the time period considered are reasonably consistent between the ISP and HSRS,
5. that there is documentation in the participant file that supports the reported units of service, and
6. that waiver funds were used to finance the entire cost of the allowed service and that no participant funds or family contributions were used for allowed services.

C. Living Arrangement

Compliance requirement(s) – Living in a place permitted under the waiver

To receive reimbursement for any/all covered service(s), a Medicaid Waiver participant must reside in either a natural community setting (e.g. home or apartment) or in an eligible regulated setting. A person’s living arrangement in this context means their place of permanent residence and not a place where they might be temporarily staying or visiting for any reason including respite care.

If the participant resides in a regulated setting, the setting must be either a certified (1-2 bed) or licensed (3-4 bed) adult family home or a community-based residential facility licensed for eight or fewer beds. Other eligible settings are natural homes or apartments in the community where the adult has a lease with the landlord who is not also the service provider or where the person or his/her family owns the house or condominium.

No reimbursement can be made for any service on any day the program participant was an inpatient in a Title XIX facility such as a hospital, SNF, ICF, or ICF-MR unless the person was approved to receive institutional respite care.

Suggested audit procedure(s)

For the case files selected in a sample, verify that the place that the person regularly resides is one that is allowed by these waivers.

D. Monitoring Contacts

Compliance requirement(s) – Direct and collateral contacts and home visits

County agencies shall ensure that direct and collateral contacts or home visits required in the Waiver Manual (See Chapter IV, Section 4.08, Support and Service Coordination) are accomplished and are done in a timely manner. Direct contact with the participant includes written or e-mail exchange, telephone conversation, or face-to-face contact. A collateral contact includes written or e-mail exchange, telephone conversation, or face-to-face contact with a participant's family member, medical or social service provider, or other person with knowledge of the participant's long-term care needs. A home visit is a visit where the county staff sees the exterior and interior of residence of the Medicaid Waiver participant.

The minimum requirements regarding these visits are specified in the section of the Medicaid Waiver Manual that covers the service Support/Service Coordination are:

1. A collateral contact must be completed at least once each calendar month.
2. Face-to-face participant contact not less than every three months.
3. At least one of the face-to-face contacts under 2. shall be at the participant's place of residence during each calendar year.

An exception or waiver to provide less than the minimum ongoing monitoring contacts may be made by the DHS. Such exceptions must be applied for and must be approved by the department's Community Integration Specialist (CIS) who is assigned to the county. Documentation of the application and the approval of exceptions granted must be in the participant's file. Please consult Chapter IV of the Manual (Support and Service Coordination) for the procedure that must be followed in requesting and gaining approval for this variance. For additional information, see Support and Service Coordination, Section 4.08 of the *Waivers Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

For each participant file in the sample, select a one year period and determine whether the file shows documentation that the support and service coordinator had collateral contacts at least once each calendar month, at least one face-to-face contact every three months and one visit to the participant's residence during the year.

E. Fiscal Compliance

Compliance requirement(s) – Room and board is not an allowable Medicaid Waiver cost
Participant room and board costs are not allowed by Medicaid Waiver dollars except when the participant is receiving institutional or residential respite care. Participant room and board includes the participant's share of the household costs (rent, maintenance not covered by the landlord, supplies, etc.) and food. Shares must be fairly and equitably divided based on any method that would be permitted by the IRS for apportioning costs in shared rental property.

Room and board does not include approved housing start up funding. Such funding must be paid for by the waiver and documented in the participant's approved ISP. Room and board also does not include funding for an approved home modification authorized in the approved ISP.

The use of participant funds for room and board must be based on a reasonable estimate of these costs according to the *Allowable Cost Policy Manual*. Room and board shall not include charges for items or services not needed or requested by the participant unless these came with the place leased. For example, a participant who has no interest in watching TV should not be charged for cable TV but may have to share the cost of central air conditioning if that cost is included in a rental agreement.

Providers occasionally include additional charges for items such as cable TV or DSL into the room and board rate. The client or guardian must specifically approve any charges for room and board items that go beyond the basic requirements for health and safety as identified in the ISP. If not approved, then these charges are an overcharge to the participant and should be noted in the audit report.

For all requirements in this section, respite care is defined in Chapter IV of the Waiver Manual. Room and board costs for many waiver participants are typically covered by a share of a participant's SSI grant. These may be supplemented by COP or other non-federal state or county funding sources.

Suggested audit procedure(s)

For each participant file in the sample, determine whether room and board costs were excluded from claims for Medicaid Waiver funds and were appropriately allocated to the individual. Review the forms used to calculate and document the cost of room and board and determine if it complies with the *Allowable Cost Policy Manual*. Determine if the cost of additional items, if any, included in the room and board were requested or approved by the participant or their guardian.

Compliance requirement(s) – Federal Waiver Match claiming and appropriate non-federal funding sources

Medicaid funding for waivers consist of a federal share and non-federal share in the cost of each unit of service. The non-federal share is used to generate the federal match. The non-federal share can be composed of a number of different funding sources some of which originate with the state such as GPR funding, and other funds such as base community aids or

COP funds which are used in the waiver at the discretion of the counties. The most common sources used to make up what is called the state share here are: state Medicaid appropriations allocated to the county with the slot that funds the person (often a relocation from an institution), local COP or Community aids funds that the county chooses to apply to a waiver participant's Medicaid Waiver services thereby generating federal matching funds and local funding that originates in local sales or property taxes. There are a few small state funding sources that also can be used for state matching purposes to generate the federal funding. For example, Foster Care Transition (Act 405) funds, Family Support funds or funds generated by local certification fees can be/are often used as matching funds for waiver participants who qualify for those funds. Under no circumstances can federal funds of any kind or funds donated by family members, providers, from any other private, non-governmental source or others be used as a source of matching funds to cover the cost of any Medicaid Waiver-covered service. However, funds such as these can supplement room and board since this is not a Medicaid Waiver allowable service.

Suggested audit procedure(s)

For each participant file in the sample, review funding sources to determine whether the county used any type of funds other than funds originating from the appropriate state or local governmental sources discussed in the previous section.

Compliance requirement(s) – Cost-sharing

Cost-sharing only affects participants who are eligible under Groups B or C. When a cost-share applies, the person's eligibility for Medicaid Waiver services can only be maintained if the person pays the proper amount of their cost-share liability in a timely manner. The county must maintain a record and system that is able to track and document that the participant has paid the appropriate amount of the cost-share and that it has been correctly applied toward Medicaid Waiver-covered services. The county agency is required to establish Cost-Sharing Agreements with individual participants where appropriate. If the participant pays the provider directly, then the waiver agency must have a method to assure the correct amount of the cost-share obligation has been correctly paid. The cost-share requirement does not apply in any month in which the Medicaid Waiver participant does 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 Waivers Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

For each participant file in the sample, the auditor should obtain the current copy of the Form F-20919 (previously DDE-919) (Medicaid Waiver Eligibility and Cost Sharing Worksheet) and/or CARES screen for review. Line 11 on the 919 form will indicate whether the participant has a cost-sharing obligation.

For those Medicaid Waiver participants where cost-sharing is required:

- Review the Form F-20445 "Individual Service Plan," to establish whether the entire cost share obligation has been correctly applied to one or more Medicaid Waiver-allowable service(s).

- Determine whether the county has a methodology to assure the service to which the cost- share obligation is applied is being delivered and that the payment to the provider includes the cost-share.
- Verify that the agency did not collect a cost-share for any month where no Medicaid Waiver allowable service was delivered or that the amount of the cost- share applied did not exceed the total cost of services for that month.

Compliance requirement(s) – Other participant payment for Medicaid Waiver allowable services

Participant payments for the cost of services are limited to the amount of the cost-share calculated on the F-20919 (see Chapter III of the Waivers Manual). Contributions by participant or members of their families or other private interests, even if these are voluntary, are never permitted to be used by counties or providers for any Medicaid Waiver-allowable service. All instances of such practices should be reported as an audit finding.

For additional information, see Section 3.05 of the *Medicaid Waivers Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>)

Suggested Audit Procedure(s)

For each participant file in the sample, determine the source of funds for all Medicaid Waiver allowable services and verify that no participant contributions or contributions made on his/her behalf by his/her family or other private interests are financing the cost of any Medicaid Waiver allowable services.

Compliance requirement(s) – Personal care services

Personal care services that are authorized by the Medicaid Claims Contractor (currently EDS) and reimbursed by the Wisconsin Medicaid State Plan (card) claims cannot be paid or supplemented by the Medicaid Waiver for the same unit of service as supportive home care for costs that exceed the reimbursement rate paid by Medicaid State Plan. Such a payment would be considered supplementation and could constitute Medicaid fraud. These services may be delivered by the same provider but the units of service must be strictly separated by the billing process.

Suggested Audit Procedure(s)

Determine if the time spent delivering Medicaid Personal Care is distinct from the time spend delivering supportive home care in situations where the provider of both is the same individual. To accomplish this, the audit should compare payment detail for personal care on the Medicaid Card to supportive home care reimbursed under the Medicaid Waiver. The department will provide payment detail for personal care. Send a list showing program, participant name, Medicaid identification number (preferred) marked confidential by US mail to:

Rebecca Hotynski
Office of Family Care Expansion
Division of Long Term Care
1 West Wilson Street, Room 418
Madison, WI 53703

For questions, call (608) 264-9870 or send an email to Rebecca.Hotynski@Wisconsin.gov. (Do not send confidential participant information by email. See Section 1.5 of the *DHS Audit Guide* for more information on handling confidential client information.)

II. Agency-level testing

The following procedures are applicable at the general waiver agency level.

A. Provider qualifications

Compliance requirement(s): Qualified providers

Providers must meet the standards that apply to the Medicaid Waiver allowable services for which they claim reimbursement. These standards are contained in the Waiver Manual in Chapter IV. The sections for each service are headed by two subtitles: “Service Requirements/ Limitations/ Exclusions” and “Standards.” Both sections contain requirements for providers to which providers must comply. Counties/Waiver agencies have contractually agreed, and must be able to assure the department that all providers comply with these requirements. This expectation does not apply in the same way to facilities licensed by the State (CBRFs, and 3-4 Bed Adult Family Homes). The possession of a current license is considered evidence of compliance for most of the expectations. The county waiver agency though must make sure the provider agency is properly licensed.

Suggested audit procedure(s)

Typically/frequently records for this are held by contract monitoring staff in the county waiver agency. Determine if the County or contract agency has assessed provider compliance with the provisions listed under “Service Requirements/ Limitations/ Exclusions” and “Standards” for the service covered. Counties must have some form of documentation showing that they have assessed provider compliance with each of the standards. For licensed providers, the county waiver agency should have documentation that the provider is licensed.

B. Caregiver background checks

Compliance requirement(s)

Caregiver background checks are required for Medicaid Waiver service providers, including relatives, whose services are funded by the Medicaid Waiver programs. Caregivers include “...those persons who will have regular, direct contact with clients.” Examples of such persons are:

- Supportive home care workers providing home care;
- Daily living skill training providers;
- Respite care providers;
- Bus drivers for private transit agencies (not municipal bus systems);
- People who perform home chores inside the home under supportive home care;

- Adult family home providers; and
- Vocational and prevocational service providers.

Examples of persons who are not considered to be caregivers include:

- People who provide outside chores including lawn mowing or snow removal;
- Volunteers or other persons that provide some type of support or supervision or who accompany people on trips outside the home whose services may not be funded by a Medicaid Waiver program but whose services are in the person's ISP.

A caregiver background check must be performed at least once every four years and consists of three steps:

- A criminal history search from the records of the Wisconsin Department of Justice, and
- A search of the Caregiver Registry maintained by the Department of Health Services, and
- A search for the status of credentials and licensing from the records of the Wisconsin Department of Regulation and Licensing, if applicable.

Counties must also perform background checks for persons employed by the county waiver agency who meet the definition of caregiver in the manual. County waiver agencies must also ensure that provider agencies perform background checks for people who are employed as caregivers. Medicaid Waiver program funds cannot be used to employ any person who meets the following description unless that person has been reviewed and found to be acceptable under the process described in Section 4.05 G of the Waiver Manual:

- Has a criminal conviction substantially related to the care and safety of agency clients. (Note: there are cases where a person may be employed but be barred from certain responsibilities (e.g. a person with misappropriation of funds on their record may provide support but be barred from any access to a person's funds.)
- Is listed on the Caregiver Registry due to a finding of misconduct.
- Has been denied license, certification or registration or denied renewal of license, certification or registration due to a finding of misconduct.

For additional information, see Section 4.05 of the *Medicaid Waivers Manual* (<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

Determine if there is either documentation that all people who meet the definition of caregiver have had a background check performed prior to their employment and that the

check was done within the past four years or that the county has a process in place that covers all providers that ensures that all provider employees covered by the definition have been checked.

C. County administrative costs

Compliance Requirements

County administrative costs are defined by the county agency and are permitted in an amount up to seven percent (7%) of total waiver service costs in CIP 1A and CIP 1B. For CIP 1A and CIP 1B, counties may request and receive written approval from the department allowing them to claim up to ten percent (10%) of the total waiver service costs. For BIW, the amount which may be claimed for service coordination costs is ten (10%) per cent of allowable service costs. No written approval is required for a claim of up to 10% in BIW.

County administrative costs must be defined in writing by the county agency. The definition is subject to but does not require State approval. Generally, these are costs that cannot be easily attributable to a specific service but that represent the overall management of the service system. Examples of costs that are generally included are the local cost of operating HSRS, equipment costs for electronic information systems for claims processing or participant records, the cost of staff who operate HSRS, staff involved in a local quality management program, staff involved in contract management, the agency director and associated administrative support staff..

These costs shall be reported using the method prescribed by DDSS. There must be written evidence that supports the claims for all service coordination costs. Where portions of staff time are being included, a time study or other method should be used to apportion such costs.

Suggested audit procedure(s)

Determine whether:

- The county has a written description of its method for ensuring it reports no more than the allowed limit for service coordination costs.
- The county reported service coordination costs were within the allowed limitation.

Resources:

- Waiver Manual - <http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>
- DLTC Memo Series - http://dhs.wisconsin.gov/dsl_info/Index.htm
- Forms –<http://dhs.wisconsin.gov/forms/index.htm> - search by number; also available through the Waiver Manual Appendices
<http://dhs.wisconsin.gov/bdds/waivermanual/appendix.htm>
- HSRS Handbook - <http://dhs.wisconsin.gov/HSRS/docs/lts2009.pdf>
- MA Community-based Services Updates: Copies are available from DDSS on request by calling (608) 266-0547.

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LISTING OF COVERED SERVICES BY CIP 1A, CIP 1B, and BI WAIVERS

SERVICE CODE (SPC)	SERVICE NAME	CIP 1A/B & BIW
112.57	Adaptive Aids-Vehicle Related	Yes
112.99	Adaptive Aids- Other	Yes
102	Adult Day Care	Yes
202.01	Adult Family Home- 1-2 bed	Yes
202.02	Adult Family Home 3-4 bed	Yes
203	Children's Foster Care/ Treatment Foster Care	No
112.47	Communication Aids	Yes
506.61	Community Based Residential Facility	Yes
609.20	Consumer and Family Directed Supports	No
609.10	Consumer- Directed Supports	Yes
113	Consumer Education and Training	Yes
507.03	Counseling and Therapeutic Services	Yes
110	Daily Living Skills Training	Yes
706.10	Day Services-Adults	Yes
706.20	Day Services-Children	No
619	Financial Management Services	Yes
112.56	Home Modifications	Yes
402	Home-delivered meals	Yes
610	Housing counseling	Yes
106.03	Housing Start-up	Yes
512	Intensive In-home Autism Services	No
710	Nursing Services	Yes
112.46	Personal Emergency Response System (PERS)	Yes
108	Pre-vocational Services	Yes

LISTING OF COVERED SERVICES BY CIP 1A, CIP 1B, and BI WAIVERS

SERVICE CODE (SPC)	SERVICE NAME	CIP 1A/B & BIW
103.22	Respite Care: Residential	Yes
103.24		(All)
103.26		
103.99		
112.55	Special Medical and Therapeutic Supplies	Yes
107.30	Specialized Transportation - 1 way trips- Miles	Yes
107.40		Yes
604	Support and Service Coordination	Yes
615	Supported Employment	Yes
104.10	Supportive Home Care - Days	Yes
104.20		Hours