

Section 3.5 Community Integration Program II/Community Options Program Waiver (CIP II/COP-W) – a program cluster– 2010 Revision

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.

Counties report expenditures for the Community Integration Program II/Community Options Program Waiver program cluster on both HSRS and CARS. At the end of the period, the department reconciles CARS to match HSRS (see *DHS Audit Guide* Section 2.6 “Reporting” for additional explanation of the requirements for reporting). These programs use the following CARS profiles:

Profile 337 COP W (G)	Profile 338 COP Waiver Non Federal (F)	Rolls to 561BCA (F)
	Profile 339 COPW Federal (E)	
Profile 347 CIP II (G)	Profile 348 CIP II Non federal (F)	Rolls to 561BCA (F)
	Profile 349 CIP II Federal (E)	
Profile 368 CIP11 Comm Relocation (G)	Profile 369 CIP II Comm Relocate Nonfed (F)	Rolls to 561BCA (F)
	Profile 370 CIP II Comm Relocate Fed (E)	
Profile 374 CIP II Diversions (G)	Profile 375 CIP II Diversions Nonfed (F)	
	Profile 376 CIP II Diversions Fed (E)	
Profile 391 Temp Fam Care COP Waiver (G)	Profile 392 Temp Fam Care COPW Nonfed (F)	Rolls to 561BCA (F)
	Profile 393 Temp Fam Care COPW Fed (E)	

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

(Source: <http://dhfs.wisconsin.gov/bfs/CARS/CARSManual2007/WaiverFlowchart.pdf>)

The Community Integration Program II (CIP II) and Community Options Program Waiver (COP-W) program cluster provide Medicaid (MA) funds to counties to pay for home and community-based services to MA eligible persons who have been relocated or diverted from a nursing home. Programming and services are available to eligible elderly and disabled adults ages 18 to 64.

The Division of Long Term Care contracts with a county via an appendix to the “State and County Contract Covering Social and Mental Hygiene Services” (state/county contract) to operate the program. Each county agency implements and operates the program in accordance with a set of prescribed guidelines developed by the department. These guidelines are contained in the following publications:

1. MA Handbook
2. Medicaid (MA) Community Waivers Manual
(http://dhs.wisconsin.gov/ltc_cop/waivermanual)
3. DLTC (DDES) (DSL) Numbered Memo Series (waiver related)

Risk assessment

The Department of Health Services has designated the Community Integration Program II/Community Options Program Waiver 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 appendix).

B. Program specific risk factors

- The County has received program disallowances from T.M.G. in excess of \$1,000.00 during fiscal year 2009. Counties receiving disallowances are identified in the following list:

County	Disallowance
Brown County	\$268.00
Grant County	\$937.00
Milwaukee County	\$164,094.00
Oneida Tribe	\$1,965.00
Shawano County	\$1,159.00
Total	\$168,414.00

- For COP-W only, the County has spent less than 90% of their annual allocation for the prior year and they had a waiting list.
- One of the waiver requirements is that the client meets the non-financial and financial criteria for Medical Assistance. Funding for any client not meeting this requirement is a risk.

Compliance requirements and suggested audit procedures

The Department of Health Services relies in on the single audit and on biennial reviews by The Management Group (TMG) for monitoring the CIP II/COP-W program. The department uses the

A. Types of services allowed and disallowed/billing

Compliance requirement(s)

Only approved waiver services can be provided. See attached list of allowable services. The following restrictions apply to reimbursement for these services:

1. Room and board costs are not covered (AFH, CBRF, RCAC) except for institutional respite services. No reimbursements can be made for services any day the program participant was an inpatient in a Title XIX facility such as a hospital, SNF, ICF, or ICF-MR, except for institutional related care management services up to 30 days prior to discharge or Personal Emergency Response Services (PERS), or approved institutional respite. (Does not include discharge planning services prior to the initial period of eligibility except for services described in # 3 below).
2. The services of care management and home modifications may be billed prior to relocation from a nursing home. In addition, Housing Start-up and Energy Assistance services are also allowable ONLY when an individual is relocating from a nursing home. Costs for these serviced incurred prior to the individual’s relocation date, must be billed to CIP II/COP-W after the start date.

Reimbursement can be made for allowable services only. The allowable payment provision is included in the state/county contract appendix and may be used in the auditing process. A written variance may be granted which allows a county to exceed contract allowable payments.

County agencies must report expenditures on the Human Services Reporting System (HSRS) on-line using the Long Term Support Module for each recipient monthly. Expenditures must also be reported monthly on the Report of Expenditures, Form 600.

A county must document the units of services delivered using on-line HSRS.

Administrative costs up to seven percent of the total allowable service charges must be reported separately at the end of the year. There must be written evidence of administrative costs incurred to substantiate billing for them. The department may approve a variance to exceed the seven percent limit.

Suggested audit procedure(s)

Review the Section 2.6 “Reporting” and apply the audit procedures in that section. In addition, determine whether:

1. Payments billed on HSRS were only for allowable services (see attachment of allowable services).
2. Units of service have been recorded for each reported expenditure.
3. Billings are specific to each eligible recipient and correspond to the date the service was delivered (not the date of the agency billing).
4. Waiver payments for supportive home care were not made for costs/services concurrently paid by the Medicaid card for personal care. This is considered duplicate reimbursement to Medicaid. The department will provide payment detail for personal care to compare to the reimbursements for supportive home care. Send a list showing program, client name, Medicaid identification number (preferred) or social security number by US mail to the contract person listed at the end of this section.
5. Agency has a method which prevents payments being made for room and board costs except where allowed under respite.
6. Reimbursement amounts for contracted service are in accordance with provider agreements or contracts.
7. Back-up documentation exists to support expenditures and units of service reports (case notes, service logs, billings from providers).
8. Documentation exists as to county administrative costs.
9. Agency has a method to insure that payments are made only to qualified providers. That is, methodology should exist to assure, up-front, that a provider used is qualified based

on standards outlined in the Medicaid Community Waivers Manual. Examples include the following:

- a. Payments made for adult day care services are made only to a certified adult day care center.
- b. Payments made for supportive home care services are made only to certified providers.
- c. No payment may be made to a recipient's spouse or parent of a minor child.

B. Cost sharing agreements

Compliance requirement(s)

The county agency is required to establish Cost Sharing Agreement with individual clients where appropriate.

Suggested audit procedure(s)

See a sample of participant records for a Medicaid Waiver Eligibility & Cost Sharing Worksheet (DLTC 919) or Community Waivers Budget screen print for groups B and C. The last line on this form will indicate whether the participant has a cost sharing obligation or is required to meet a spend down amount. For those cases where cost sharing is required, determine the following:

1. Review the ISP, DLTC (DDE) (DSL) Form 445, to establish that a cost-shared service is indicated and determine that it is an allowable service.
2. Then determine that the agency has a methodology to assure that service is being delivered and payment is being made to the provider of service (either by the agency as collected from the participant, or if participant pays provider directly, how the agency insures payment is being made).

C. Eligibility

Compliance requirement(s)

1. Every CIP II/COP-W participant must meet a level of care requirement established by the department and determined by county review to be found functionally eligible through the Automated Long Term Care Functional Screen.
2. Any individuals determined to be at an appropriate level of care, MA eligible, and eligible to participate in the waiver program must be informed of: 1) feasible alternatives under the waiver; and 2) their choice of institutional/inpatient services or the alternative noninstitutional services.

Suggested audit procedure(s)

1. Determine whether participants have been determined to meet an eligible level of care and that level of care is reevaluated on an annual basis. Each participant must have an Automated Long Term Care Functional Screen. Level of care must be redetermined every 12 months following the date of the initial functional screen.
2. Review the back of DLTC (DDE) (DSL) Form 445, the Individual Services Plan Form,

for applicant's (or guardian) signature, which documents evidence of choice was made to participate in the waiver program. (Federal requirement.)

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(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.)

**4.09 Service Definitions for CIP II/COP-W
Summary of Services by Program**

http://dhs.wisconsin.gov/ltc_cop/waivermanual/waiverch04_09.pdf#page=20

SPC Code	Sub-Program	Service	CIP II	COP-W	Page
112	99	Adaptive Aids	Yes	Yes	21
112	57	Adaptive Aids (Vehicle Related)	Yes	Yes	21
102		Adult Day Care	Yes	Yes	24
202		Adult Family Home – 1-2 bed	Yes	Yes	27
202		Adult Family Home – 3-4 bed	Yes	Yes	29
604		Care Management	Yes	Yes	34
112	47	Communication Aids	Yes	Yes	53
506		Community Based Residential Facility	Yes	Yes	56
507		Counseling and Therapeutic Resources	Yes	Yes	71
110		Daily Living Skills Training	Yes	Yes	74
706		Day Services - Adults	Yes	Yes	77
619		Financial Management Services	Yes	Yes	92
203		Foster Home (Children)	No	No	NA
402		Home Delivered Meals	Yes	Yes	95
112	56	Home Modifications	Yes	Yes	97
106	01	Housing Start-Up (relocations only)	Yes	Yes	129
106	02	Utilities (relocations only)	Yes	Yes	129
710		Nursing Services	Yes	Yes	116
112	46	Personal Emergency Response System (PERS)	Yes	Yes	122
406		Protective Payment/ Guardianship Services	No	No	NA
711		Residential Care Apartment Complex (RCAC)	Yes	Yes	132
103		Respite Care	Yes	Yes	136
103	24	Respite Care (Institutional)	Yes	Yes	136
112	55	Specialized Medical Supplies	Yes	Yes	146
104		Supportive Home Care	Yes	Yes	160
	10	SHC-days	Yes	Yes	160
	20	SHC-hours	Yes	Yes	160
107		Transportation – Specialized	Yes	Yes	149
114		Vocational Futures Planning	Yes	Yes	164
509		Community Support	No	No	NA

