

Section 3.18 Children’s Long-Term Support (CLTS) Waivers – 2012

The section applies to counties, Lutheran Social Services, and St. Francis Children’s Center.

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 federal program within the context of also ensuring they meet the requirements from the Department of Health Services.

The CLTS Waivers are home and community-based programs established under Section 1915(c) of the Social Security Act and are part of the Wisconsin Medicaid Program. The CLTS Waivers are three separate waivers that serve children who have a developmental disability (DD), a severe emotional disturbance (SED), or a physical disability (PD).

The objective of these waivers is to provide program participants and their families with choices about where and how the child lives in the community by providing that child with individualized services and supports. Services permit children to reside with their families instead of some type of institution or alternate care setting.

2012 was the first year following implementation of the Third Party Administration (TPA) system for payment of CLTS waiver service claims. This change enabled the Department to meet federal requirements for a standardized, state-wide Medicaid Management Information System for authorizing, adjudicating, and processing claims and encounter data collection.

Risk assessment

The Department of Health Services has designated the CLTS program to be a Type A program when expenditures reported for reimbursement are \$100,000 or more (see [DHS Audit Guide](#), Section 1.2.2 “Additional requirements for single audits”). Risk factors include:

- The program has not been audited in at least one of the last two audits.
- The auditor identified significant findings for this program 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 ([DHS Audit Guide](#), Section 2).

Compliance requirements and suggested audit procedures

All of the following compliance requirements in this section apply to individual waiver participants and should be tested through review of the participant case files.

CLTS A. Qualified Providers

Compliance requirement(s)

Providers must meet the standards that apply to the Medicaid Waiver allowable services for which they claim reimbursement. These standards are contained in Chapter IV of the [Medicaid Home and Community-Based Services Waivers Manual](#). The sections for each service are headed by two subtitles: “Service Requirements/ Limitations/ Exclusions” and “Standards.” Both sections contain compliance requirements for providers which must be met. County 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 trained and credentialed to deliver the authorized services according to the required standards.

Suggested audit procedure(s)

Determine if the CWA has assessed provider compliance with the provisions listed under “Service Requirements/ Limitations/ Exclusions” and “Standards” for the following services:

- Counseling and Therapeutic Services (SPC 507.03)
- Daily Living Skills Training (SPC 110)
- Intensive In-Home Treatment Services (SPC 512)
- Respite Care (SPC 103)
- Supportive Home Care (SPC 104)

For each of these services, the *Medicaid Home and Community-Based Services Waivers Manual* will include a list of minimum qualifications and/or training requirements. This list will also indicate that the provider must meet specific unique training needs identified by the family and the CWA, as required in order to provide appropriate services to the individual child.

For each of the five services, the CWA is required to maintain within the child’s record documentation that specifies the minimum qualifications and/or training requirements, including the unique training needs identified by the family and the county waiver agency as required in order to provide appropriate services to the individual child, as well as documentation that demonstrates that the provider met the minimum training requirements prior to being determined to be qualified to provide the service identified.

CLTS B. Service Plan Development

Compliance requirement(s)

The Individual Service Plan represents an agreement between the CWA and the participant as to how the assessed needs of the child will be met, and how the services will help the participant reach his/her individual outcomes. The ISP must be reviewed every six months in a face-to-face meeting with the participant and his/her guardian, if applicable. During the 6-month review, participants must be informed that they may:

1. Request a change in type, amount or frequency of service;
2. Request new or additional service(s) not currently provided, or

3. Choose to change providers of current services by selecting another provider from the Medicaid Waivers Provider Registry or by asking that the waiver agency assist in qualifying a provider not currently listed on the Registry.

Suggested audit procedure(s)

For the waiver services listed above, determine whether the CWA met the CLTS program requirements for the participant's Individual Service Plan (ISP) development.

CLTS C. Cost Sharing

Compliance requirement(s)

The audit is intended to determine if cost-share requirements have been met. Cost sharing only affects CLTS Waiver participants who are eligible under Medicaid Groups B or C. When a cost share applies, the child's eligibility for waiver services can only be maintained if the proper amount of their cost-share liability is paid in a timely manner.

The county waiver agency is required to establish Cost Sharing Agreements with the participant's family where appropriate. The county must maintain a record system that is able to track and document that the family has paid the appropriate cost share amount and that the cost share has been correctly applied toward waiver-covered services. If the participant pays the provider directly, the waiver agency must have a method to ensure the correct amount of the cost-share obligation has been correctly paid. The cost-share requirement does not apply for those months in which the 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 Home and Community-Based Services Waivers Manual](#).

Suggested audit procedure(s)

For each participant file in the sample, the auditor should obtain the current copy of the MA Waiver Eligibility and Cost Sharing Worksheet (Form F-20919) and/or CARES screen for review. Line 11 on the F-20919 form will indicate whether the participant has a cost sharing obligation. For those waiver participants where cost sharing is required:

1. Review the Individual Service Plan (Form F-20445) to establish whether the entire cost share obligation has been correctly applied to one or more Waiver-covered allowable service(s).
2. The CWA can either report the cost share in HSRs under SPC 095.01 or apply the cost share to a specific service. Determine whether the CWA is reporting cost share under SPC 095.01 or 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.
3. Verify that the agency did not collect a cost share for any month where no waiver covered service was delivered or that the amount of the cost share applied did not exceed the total cost of services for that month.

CLTS D. County administrative costs

Compliance Requirements

County administrative costs are defined by the county waiver agency and are permitted in an amount up to seven percent (7%) of total waiver service costs in the CLTS Waivers. 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 cost of performing background checks on potential waiver service providers, the local cost of operating HSRS, equipment costs for electronic information systems for claims authorization or participant records, the cost of staff who perform data entry or other office support tasks, staff involved in a local quality management program, staff involved in contract management, the agency director and associated administrative support staff, etc. These costs shall be reported using the method prescribed by DHS. There must be written evidence that supports the claims.

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 and that it prevents the duplicate reporting of administrative costs.

Presentation of findings

See [Main Document to the State Single Audit Guidelines](#), Section 4.11 for guidance on development of a finding. Even limited or seemingly inconsequential noncompliance with certain program requirements can profoundly impact the quality of life of program participants. Therefore, all findings of noncompliance need to be reported in the Schedule of Findings and Questioned Costs. Request guidance from the department if it is unclear whether a particular situation constitutes noncompliance (see “Questions” at the end of this section).

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 participant would be the amount of waiver funds spent on the participant’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.

When presenting findings, identify the program and the specific compliance requirement, for example “CLTS A. Qualified Providers”

Resources

- *Medicaid Home and Community-Based Services Waivers Manual* - <http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>
- DLTC Memo Series - <http://www.dhs.wisconsin.gov/partners/memos.htm>
- Forms – <http://dhs.wisconsin.gov/forms/index.htm> - search by number
- HSRS Handbook - <http://www.dhs.wisconsin.gov/HSRS/index.htm>
- CLTS Service Codes Crosswalk
- Long-Term Care Encounter Reporting (Data Warehouse) - <http://www.dhs.wisconsin.gov/LTCare/encounter/index.htm>
- Medical Assistance Community-Based Services Updates. Copies are available from DLTC on request by calling (608) 261-6836.

Questions

Please send questions by email to DHSAuditors@Wisconsin.gov and include the identifier for the audit procedure (example - “CLTS A. Qualified Providers”) and the name of the auditee in the message.