

Section 3.2 Community Integration Program I & Brain Injury Waiver – a program cluster – 2012

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 federal 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 (CIP) I and the Brain Injury Waiver (BIW) 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 [Community Aids Reporting System \(CARS\)](#) profiles:

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

CIP I includes two state-level programs called CIP IA and CIP IB authorized by [Wisconsin Statute: s. 46.275 and s. 46.278](#) respectively. BIW is also authorized by [s. 46.278](#). The two CIP I programs and the 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, 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. BIW serves people who are either relocated or diverted from specialized brain injury rehabilitation facilities.

Program managers note 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 CIP I and the Brain Injury Waiver (BIW) to be a Type A program when expenditures reported for reimbursement are \$300,000 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

CIP I/BIW A. Qualified providers deliver allowable services

Compliance requirement(s)

Providers receiving Medicaid Waiver funding must have a State Medicaid Agency (SMA) Provider Agreement form on file with the Department of Health Services. Services paid for by the program must be specified in the participant's Individualized Service Plan, allowed by the specific Medicaid Waiver, and delivered by a qualified provider. Provider screening requirements and a list of allowed services and detailed descriptions of those services are in Chapter IV of the [Medicaid Home and Community-Based Services Waivers Manual](#).

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.

Counties must be able to verify the delivery of the service as reported on HSRS and document the number of units of service delivered using the units prescribed for the particular service per the instructions contained in the [HSRS Handbook](#).

Suggested audit procedure(s)

Review the [DHS Audit Guide](#), 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 funded services reported on HSRS were specified in the approved ISP,
3. payments are made to claims from providers for allowable waiver services and no more than one payment per claim.

CIP I/BIW B. County administrative costs

Compliance Requirement(s)

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 DHS.

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 administration.
- The county reported service coordination costs are not duplicative of administrative costs.

Presentation of findings

See Section 4.11 of the [Main Document to the State Single Audit Guidelines](#) for guidance on development of an audit finding. When presenting findings for CIP I/BIW, identify the program and the specific compliance requirement, for example “CIP I/BIW A. Qualified providers deliver allowable services.”

Questions

Please send questions by email to DHSAuditors@Wisconsin.gov and include the identifier for the audit procedure (example - “CIP I/BIW A. Qualified providers deliver allowable services”) and the name of the auditee in the message.