

Section 3.16 Comprehensive Community Services (CCS) - 2010

This section is applicable to audits of counties. Counties participating in CCS are reported on the CCS website (http://www.dhs.wisconsin.gov/mh_bcmh/ccs/index.htm).

Funding: Medical Assistance, CFDA number 93.778. The federal government has identified Medical Assistance (CFDA number 93.778) 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.

Wisconsin Statutes authorize the Wisconsin Medicaid program to make federal financial participation (FFP) funds available to counties for non-institutional psychosocial rehabilitation services. Per HFS 107.13 (7), the services must be authorized by a licensed mental health professional under HFS 36.15 for recipients determined to have a need for the service under HFS 36.14 (Wisconsin Statutes also currently require a physician prescription).

These non-institutional services must fall within the definition of rehabilitative services under 42CFR 440.130 (d). Covered services include assessment, recovery/service planning, service facilitation and individual psychosocial rehabilitation services. This service is known Comprehensive Community Services (CCS).

Medicaid reimbursement for CCS is administered by the Department of Health Services (DHS), Division of Health Care Access & Accountability (DHCAA), the division responsible for administering Wisconsin's Medicaid program. Under CCS, counties provide the non-federal share of CCS payments with local match. Medicaid reimburses counties only the federal share of CCS payments.

Payment is received based upon a total individual daily rate that varies depending upon the services provided and the cost of those services. The services may vary by county, by consumer and by day. Each county determines their own array of rehabilitative services. Each consumer picks from this array their services, in cafeteria style, based upon their service plan. Services provided each day depend upon the schedule established in the service plan.

The payment cycle for CCS services follows this sequence:

- Interim rates for the various CCS services are either (1) calculated by the counties using budget data for the upcoming year on interim rate worksheets or (2) based on county-specific cost data from the most recently approved cost reconciliation worksheet.
- The Department performs a desk audit on these rate worksheets and approves the rates for each county before they may bill for services.
- These rates are used by the county to sum the daily amounts for services provided to a consumer in a day. The total daily amount for each consumer is billed to Medicaid.
- Records of these interim amounts by service are maintained by the counties.

- At the end of the calendar year, the counties reconcile these interim amounts for each service activity to their cost on cost reconciliation worksheets.
- The Department performs a desk audit on the cost reconciliation worksheets and approves the reconciliation before final payment.
- The difference between interim payments and actual cost is either paid to or received from the county.

The Interim Rate Worksheet and the Cost Reconciliation Worksheet and instructions are posted on the CCS website (http://www.dhs.wisconsin.gov/mh_bcmh/ccs/index.htm).

Risk assessment

DHS has declared CCS to be a Type A Program when a county claims \$100,000 or more in its cost report.

Since the counties annually file cost reports, the department recommends performing audit work in the year following the calendar year in which the services were actually provided. For example, cost reports for services provided in CY 2008 due in CY 2009 would be included as part of the CY 2009 audit.

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. Financial risk factors

The department performs desk audits of the cost reports that the county files with the department, and it notifies the county of the results of those desk audits. The notification includes a component for risk factors. A county program should be audited if any of its services meets any of the following risk factors:

- *Overhead to Direct Staff Costs Ratio in Excess of 100%* - When completing a CCS cost report, participating agencies report the program overhead costs for each service. These overhead costs are then compared to the direct costs for staff for that program. Overhead includes both indirect service staff and other indirect costs. A ratio of Overhead to Direct Costs for Staff exceeding 100% is considered a risk factor.
- *Calculated Medicaid Costs in Excess of Total Reported Costs.* When completing a CCS cost report, counties report the total cost of providing services for each CCS services. The total cost includes a service's direct service staff costs (clinical staff), non-direct service staff costs (administrators, clerical staff), overhead costs and contracted staff costs. This cost information is then combined and compared with calculated costs for the service on cost report. A calculated Medicaid cost that exceeds the reported total cost would be considered a risk factor.
- *Reported Units of Service Not Within Reasonable Limits* – Reported units of service are not within reasonable limits if they are less than 40% of the paid hours. We estimate very conservatively that approximately 60% of an employee's time is spent in non-productive and supportive activities. Reported units of service are also unreasonable if they are less than Medicaid units of service. Cost report units include not only Medicaid, but also all other payers of service. Therefore, cost report units have to be greater or equal to Medicaid units. Note that counties contracted services may not report paid hours. For this reason, contracted service activities will not be designated for audit under this risk factor.

Compliance requirements and suggested audit procedures

A. Consistency Across Programs

Compliance requirement(s)

Since many county services draw many of their costs from the same cost pools, the cost principles and methods used for CCS must be consistent across programs. For example, a staff member cannot claim the same costs for same time for both CCS service facilitation and case management done in another program.

Suggested audit procedure(s)

- Review to confirm that time records, allocations schedules and other supporting schedules include all components when these costs are provided to both by an activity.
- Review documentation and inquire to personnel for both programs to confirm that cost principles are being consistently applied.

B. Accuracy of Program Costs

Compliance requirement(s)

Cost reports must reflect the actual costs incurred by the program for the period covered by the report. The agency must allocate non-direct service staff time and overhead to programs in a

manner that is consistent with the *Allowable Cost Policy Manual* and established Medicaid policies.

Suggested audit procedure(s)

- Review the completed annual cost reports and instructions.
- Verify that the cost reports reflect the costs of services provided through the applicable CCS services to all clients for the whole of the fiscal year.
- Verify that the cost reports are supported by agency financial records.
- Verify that the cost reports identify county cost for services, not contractor cost when the county contracts to other agencies to provide services.
- Verify that the plan for allocating non-direct service staff time and overhead is consistent with the *Allowable Cost Policy Manual* and with established Medicaid policy.
- Verify that the counties have included, in an equitable manner, all costs supporting the programs from all levels of county government. A review of the county's organization charts with administration should be an integral part of this review, identifying those costs at the county, department, division, and service levels that should be included.
- Verify that administration, supervisory, and clerical staff costs are included. Even programs that are operated by a contracted agency may need county staff for contract administration, supervision, and clerical for billing services.

C. Consistency between Financial Records and Medical Records

Compliance requirement(s)

The CCS financial charge logs need to be consistent with the consumer's medical record documentation. In other words, for each unit charged on the financial charge log, there must be a progress note entry in the consumer's medical record.

Suggested Audit Procedure(s)

- Determine whether the agency is performing control activities for ensuring accurate reporting between what it records in its financial charge logs and what is reported in a progress note in the consumer's medical record.
- All units of any CCS reported on the CCS financial charge log must be documented in the consumer's medical record by some indication of activity such as a progress note, annual service plan review, attendance record, or invoice that includes sufficient information (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).

D. Consistency of Total Billable Units of Service

Compliance requirement(s)

Cost reports must report total units of service in a manner that is consistent with how Medicaid units of service are identified for CCS services. The Department has allowed some flexibility in how the counties define their units-of-service measures for CCS. Total units of service must be identified in the county's billing system. That is the only way to assure that Total units and Medicaid units are consistent. Adjustment of paid hours by excluding vacation sick leave and other non-productive time is not allowed for determining total units of service.

Total billable hours include Medicare, Medicaid, and all other payers. Other payers include the county when services are paid through the tax levy.

Suggested audit procedure(s)

- Review instructions for the time records to assure that they require all billable time to be reported for all consumers in the program.
- Review the time record classifications and descriptions to assure that there is adequate identification and labeling to report billable time.
- Identify total time in each payer category and compare with the number of recipients in each payer category for reasonableness.
- Test financial charge logs to assure that billable units of service are included properly.
- Review time records with supervisor for that area to discuss problems with adequacy of time records.

D. Eligibility

The eligibility of an agency's programs for CCS is tested as part of the audit procedures identified above. The auditor is not expected to test client eligibility for Medicaid as part of the testing for the Benefit.

E. Assessments and Individualized Service Plans

Compliance requirement(s)

Every CCS consumer who received CCS services must have an assessment and Individualized Service Plan (ISP). The ISP must have been updated within the last six months, show the consumer's or guardian's participation through his or her signature on the plan, and be authorized through a prescription dated and signed by a physician (MD or DO is acceptable) prior to the first day that services are provided and billed for.

Suggested audit procedure(s)

For each consumer file in the sample, determine whether the Individualized Service Plan

- was updated within the last six months,
- shows the consumer's or guardian's participation through his or her signature on the plan, and
- is authorized through a prescription dated and signed by a physician (MD or DO) prior

to the first day that services are provided and billed for.

F. Covered services

Compliance requirement(s)

No reimbursement can be made for a service not specified in the consumer's Individualized Service Plan. All services identified in the Individualized Service Plan should be delivered to the consumer, and all services that the consumer received must be authorized through the plan.

Suggested audit procedure(s)

- For a sample starting with the Individualized Service Plans, determine whether the services authorized in the plans were actually delivered as evidenced in the medical records and whether the services were recorded in the financial charge logs. If the services were not delivered, the reason(s) for not delivering the services should be noted in the case file.
- For a sample starting with the financial charge logs, determine whether the services had actually been delivered as evidenced in the medical records and whether the services were authorized as evidenced in the Individualized Service Plans.

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