

Section 3.18 Children’s Long-Term Support Waivers – 2010

Part 1 is applicable to audits of vendor agencies that receive funding for the Children’s Long-Term Support (CLTS) Waivers through purchase of care and services. Part 2 of this section is applicable to audits of agencies that receive grant funding for these waivers directly from the Department of Health Services.

Part 1 – Vendors, i.e. agencies that receive CLTS funding from counties for purchases of care and services

Counties typically purchase CLTS services from providers, specifying in their contracts that costs charged to the county contract are to be in accordance with the *Allowable Cost Policy Manual* and that the provider audits are to be in accordance with the *DHS Audit Guide* (or the *Provider Agency Audit Guide*, which has now been replaced by the *DHS Audit Guide*). Owner’s compensation and profit are particular concerns for the CLTS program, and audit is necessary to ensure that charges to department programs meet allowable cost requirements.

Compliance requirements:

As with any cost, compensation must be necessary and reasonable and meet all other applicable criteria for an allowable cost. Profit is treated like an allowable cost, in that a limited profit can be included in the cost of services.

Audit procedures:

1. Apply the procedures for Core Audit Requirements in the *DHS Audit Guide*, Section 1.1, with particular attention to owner’s compensation and profit.
2. Ensure that the audit report includes an “Additional Supplemental Schedule Required by Granting Agency” for each service, and that the schedule include a breakout of allowable owner’s compensation and allowable profit (Section 1.3 of the *DHS Audit Guide* and Section 4.3 of the *Main Document of the State Single Audit Guidelines*, www.ssag.state.wi.us).
3. Ensure that the audit report includes a Profit Schedule (*DHS Audit Guide*, Section 2.3.4) for each service.

Contacts:

- See contract for contact information for purchasing agency.
- See end of next section for department contact person.

Part 2 – Grantees, i.e. agencies that receive grant funding 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 CLTS Waivers use 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 CLTS Waivers only on HSRS, and the department transfers these costs to CARS. The following profiles are used:

Profile 420 CLTS DD AUTISM (LTS Code F)	Profile 427 CLTS DD Autism Federal (E)	
	Profile 450 CLTS Non Federal (F)	Rolls to 561 BCA (F)
Profile 421 CLTS DD BCA MATCHED (LTS Code I)	Profile 428 CLTS DD Federal (E)	
	Profile 561 BCA (F)	
Profile 422 CLTS DD OTHER (LTS Code H)	Profile 429 CLTS DD Federal Other (E)	
	Profile 460 CLTS Non Federal Other (F)	Rolls to 561 BCA (F)
Profile 430 CLTS MH AUTISM (LTS Code G)	Profile 437 CLTS MH Autism Federal (E)	
	Profile 451 CLTS MH Non Federal (F)	Rolls to 561 BCA (F)
Profile 431 CLTS MH BCA MATCHED (LTS Code K)	Profile 438 CLTS MH Federal (E)	
	Profile 561 BCA (F)	
Profile 432 CLTS MH OTHER (LTS Code J)	Profile 439 CLTS MH Federal Other(E)	
	Profile 461 CLTS MH Non Federal Other (F)	Rolls to 561 BCA (F)
Profile 440 CLTS PD AUTISM (LTS Code P)	Profile 447 CLTS PD Autism Federal (E)	
	Profile 452 CLTS PD Non Federal (F)	Rolls to 561 BCA (F)
Profile 441 CLTS PD BCA MATCHED (LTS Code M)	Profile 448 CLTS PD Federal (E)	
	Profile 561 BCA (F)	
Profile 442 CLTS PD OTHER (LTS Code L)	Profile 449 CLTS PD Federal Other (E)	
	Profile 462 CLTS PD Non Federal Other (F)	Rolls to 561 BCA (F)

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

(Source: <http://dhs.wisconsin.gov/bfs/CARS/CARSManual2007/07CLTSFlowchart.pdf>)

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' families with choices about where and how their 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.

The Division of Long Term Care (DLTC) contracts with either county agencies or private agencies that act as county agencies to coordinate and provide the services funded by all of the children's waivers. County agencies have an addendum to the County Contract for all the CLTS

Waivers. In areas where a private agency is used in lieu of a county, the private agency has a standard contract with similar terms. This contract addendum or contract prescribes the requirements necessary for proper implementation and operation of this program by agencies and references other documents which also prescribe proper operation of these programs. The key document referenced in the contract is the *Medicaid Waivers Manual*. (See link/site information: <http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>).

Risk assessment

The Department of Health Services has designated the CLTS program to be a state major program when the auditee receives funding for any/all of the CLTS Waivers directly from the Department.

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's agency files.

Findings of noncompliance – Even limited or seemingly inconsequential noncompliance with certain program requirements can reflect or result in a profound impact on the quality of services and 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.

For each finding of noncompliance, the auditor does not usually need to determine questioned costs but does need to provide the identifying number for each participant involved in the finding (not the participant's name), the compliance requirement (what should be), and the condition found (what is). Recommendations for corrective action are especially valuable if the findings indicate a systematic and/or problem with the county's procedures for these waivers.

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

A.1. Functionally eligible

Compliance requirement(s)

The audit is intended to determine if participants meet financial eligibility requirements.

Participants of the Medicaid waivers must be found to be financially eligible for Medicaid. If Medicaid financial eligibility is not present, the individual is not eligible for the waiver program. Fiscal eligibility must be redetermined annually.

There are three Medicaid Waiver Income groups. These groups are labeled Group A, Group B and Group C. For Group A participants, eligibility is documented through the Form F20919 “MA 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 F20919 or through the CARES screen. The F20919 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 F20919 form.

Suggested audit procedure(s)

For the cases selected in the sample:

1. For all participants, verify that the financial eligibility documents were completed by the appropriate person.
2. For Group A participants, verify that the participant’s files include at least a Form F20919 updated at least annually.
3. For Group B and Group C participants, verify that the participants’ files include a Form F20919 or a CARES screen updated at least annually.

A.2. Functionally eligible

Compliance requirement(s)

The audit is intended to determine if participants meet functional eligibility requirements. Every waiver participant must meet a level of care requirement established by the Department to establish their functional eligibility for waiver services. Functional eligibility must be redetermined annually.

For Children’s Waivers, level of care is determined by completion of the Children’s Long Term Care Functional Screen (CLTS-FS). This screen must be completed by a screener who is certified by completing the required on-line training course and who has maintained their certification. The children’s screen must be administered annually. Evidence that the screen has been completed by a qualified screener in a timely manner must be maintained in the participant’s file. (Note: evidence of screener qualifications may be in a provider or county personnel file and is not required to be in the participant file.)

Suggested audit procedure(s)

For each participant file selected for the sample,

1. Verify a CLTS functional screen was completed for the participant and the screen results contain eligibility results for a rating for an appropriate level of care within the recertification month.
2. Determine whether the person performing the screen had the necessary qualifications for performing this work.

A.3. Current and Complete Recertification

Compliance requirement(s)

The audit is intended to determine if recertifications are current and complete. The CLTS Waivers require the “Children’s Long Term Support (CLTS) Waivers Recertification Checklist” be completed upon recertification for each child. This document and applicable reports are required to be sent to the respective Department Section overseeing the CLTS Waivers. The Department reviews the documentation and approves the recertification.

Recertifications must meet the requirements of the *Medicaid Waivers Manual*.

For these requirements and additional information, see Chapter VII 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 whether the county accurately submitted the recertification to the Department on the “Children’s Long Term Support (CLTS) Waivers Recertification Checklist” and received written approval from the Department.

B. Assessment and Individualized Service Planning

B.1. Covered services by Qualified Providers; SPC 507.04

Compliance requirement(s)

The audit is intended to verify all services reimbursed as SPC 507.04, Counseling and Therapeutic Services, were rendered by a qualified provider; the service was an allowable service; and 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 individualized service plan and HSRS.

Counseling and therapeutic services (SPC 507.04) includes the provision of professional evaluation, consultation and treatment-oriented services to participants’ identified needs for physical, medical, personal, social, behavioral, cognitive developmental, emotional or substance abuse treatment. The goal of counseling and therapeutic services is to maintain or improve participant health, welfare or functioning in the community. No reimbursement should be made for a service specified in the participant’s Individualized Service Plan unless the service is one that is delivered by a provider determined to be qualified. Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice. If services are provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certifications, the services must be authorized by a medical professional or approved by Department of Health Services (DHS) or its designee. For CLTS, DHS approval means documentation has been received from the BLTS Children’s Services Specialist (CSS) or the DHS central office approving the use of funds under SPC 507.4. For CIP 1A/1B, DHS approval means documentation has been received from the BLTS Area Quality Specialist or the DHS central office approving the use of funds under SPC 507.04.

All services identified in the plan should be delivered to the client, and all services that the client receives should be specified in the plan. If this is not the case, it should be identified in the audit. However, some services may be delivered intermittently, 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. The list of covered services and provider requirements may be found in Chapter IV of the *Medicaid Waivers Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>). Reimbursement may also be restricted by special “Service Requirements/Limitations/Exclusions” specified under the particular service discussed in Section 4.10 in Chapter IV of the *Medicaid Waivers Manual*.

County agencies report all expenditures for services for each waiver participant monthly on the Human Services Reporting System (HSRS). 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 must also 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/index.htm>).

Since all services paid for with waiver funds must be reported on HSRS, the waiver-funded services identified in the plan and on HSRS should be in general agreement. Precise, one-to-one matching is not required (i.e., a person may receive more or less than the services authorized in the plan), however, large discrepancies should be noted. For additional information, see Chapter VI of the Waiver Manual (<http://dhfs.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. A targeted audit of SPC 507.04, Counseling and Therapeutic Services, is required. For each participant file in the sample:

1. Determine if the child received Counseling and Therapeutic Services (SPC 507.04).
2. Determine if the waiver-funded services reported on HSRS were specified in the approved plan.
3. Determine documentation in the participant file supports that the services were denied funding by the Medicaid State Plan. (It should be assumed that intensive in-home treatment typically identified by profile 420 or 430 were denied by the Medicaid State Plan.)
4. Determine 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 individualized service plan and HSRS.
5. Determine waiver funds were used to finance the entire cost of the covered service and that no participant funds or family contributions were used for covered services.

6. Determine documentation in the participant file demonstrates that the waiver funded counseling or therapeutic services were prescribed, ordered or recommended by a medical professional, or a licensed or treatment professional.
7. Determine documentation in the participant file identifies the provider of the services as a licensed physician, registered nurse, or holds state licensure or certification in their field of practice. If services are provided by trained technicians, therapy assistances or other specially trained persons who do not require state licensure or certifications, documentation supports the services were authorized by a medical professional or approved by Department of Health Services.

B.2. 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 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.2. 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,
- 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)

1. Verify that the county's methodology for performing background checks complies with the requirements for such checks.
2. For a sample of persons expected to have regular, direct contact with clients, trace or re-perform the background checks to verify the county's conclusion on whether the person passed the background check.

C. Living Arrangement

C.1. Living in a residence permitted under the waiver; SPC 203

Compliance requirement(s)

The audit is intended to determine if the applicable waiver requirements have been met for funding of a participant residing in a shift staff treatment foster home setting.

A Children's Foster Home is a family-oriented residence licensed under: §48.62 of the Wisconsin Statutes; DHS 56 of the Administrative Code as a Foster Home; or DHS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if the children in foster care are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care, personal care, supervision, behavior and social supports, daily living skills training and transportation. No reimbursement should 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.

Joint approval from Division of Safety and Permanence and Division of Long-Term Care (Previously named Division of Children and Family Services and Division of Disability and Elder Services) is required for the use of shift staff in a Treatment Foster Home prior to the placement of any waiver participant in the home. These requirements ensure the health and safety of the child.

Suggested audit procedure(s)

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,

1. Determine if the participant resides in a shift staff treatment foster home.
2. Determine if the file includes documentation of joint approval from Division of Safety and Permanence and Division of Long-Term Care (Previously named Division of Children and Family Services and Division of Disability and Elder Services) for the use of shift staff in a Treatment Foster Home prior to the placement of the participant in the home.
3. Determine if documentation clearly describes the individual room and board and care and supervision costs in the facility. (Documentation must show that no waiver funds are being used to reimburse room and board costs).
4. Determine if the participant file includes documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan or individual medical care plan that the foster care provider will implement.
5. Determine if documentation of the specific training the foster parent received related to the child's need and the psychiatric/behavioral treatment plan or individual medical care plan.

For each provider of Treatment Foster Home, the following documentation must be kept by the county:

1. Evidence of a valid license for all providers of foster care. A Foster Home is licensed under DHS 56 Family Foster Care for Children; a Treatment Foster Home is licensed under DHS 38.
2. Evidence of current criminal and caregiver background checks in the provider or licensing file.
3. Evidence that the provider executed Wisconsin Medicaid Agreement and Acknowledgement of Terms of Participation form (F-21192 or F-21192A or F-21192B) on file with the county agency.

C.2. Living in a place permitted under the waiver SPC 103.24

Compliance requirement(s)

The audit is intended to determine if the applicable waiver requirements have been met for funding respite care in an institutional setting.

Respite care services are those services provided to a waiver eligible participant on a short-term basis to relieve the participant's primary caregiver(s) from care demands. For all respite occurring in an institution, prior approval from the Department is required. Allowable locations of institutional respite are limited for each waiver target group.

Participants in the CLTS – Developmentally Disabled Waiver (Profiles 421 422) may receive institutional respite care in a Medicaid certified institutional setting including any of the following:

- (a) Hospital
- (b) Nursing Home
- (c) Intermediate Care Facility for the Mentally Retarded (ICF-MR)
- (d) Residential Care Center /Child Caring Institution
- (e) Wisconsin State Developmental Disability Center

Participants in the CLTS – Physically Disabled Waiver (Profiles 441 442) may receive institutional respite care in a Medicaid certified institutional setting including any of the following:

- (a) Hospital
- (b) Nursing Home
- (c) Intermediate Care Facility for the Mentally Retarded (ICF-MR)
- (d) Residential Care Center/Child Caring Institution

Participants in the CLTS – Social Emotional Disabled Waiver (Profiles 431 432) may receive institutional respite care in a Medicaid certified institutional setting including any of the following:

- (a) Residential Care Center/ Child Caring Institution
- (b) Wisconsin State Mental Health Institution

Institutional respite services may involve over night or partial day stays by the participant. Costs for room and board in these settings may be included in the charge to the waiver. The actual length of the respite stay must be specified in the participant record.

Suggested audit procedure(s)

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. Conduct a targeted audit of SPC 103.24, Respite Care, Institutional Respite. For each participant file in the sample:

1. Determine if the child participated in institutional respite.
2. Verify documentation of prior approval for the institutional respite is in the participant's file.
3. Verify the actual length of the respite state is specified in the participant record.
4. Verify 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 individualized service plan and HSRS.
5. Verify that waiver funds were used to finance the entire cost of the covered service and that no participant funds or family contributions were used for covered services.

D. Fiscal Compliance

D.1. Cost sharing

Compliance requirement(s)

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

The county agency is required to establish Cost Sharing Agreements with individual participants where appropriate. The county must maintain a record system that is able to track and document that the participant has paid the appropriate amount of the cost share 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 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 MA Waiver Eligibility and Cost Sharing Worksheet (Form F20919) and/or CARES screen for

review. Line 11 on the F20919 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 F20445) to establish whether the entire cost share obligation has been correctly applied to one or more Waiver-covered (allowable) service(s).
2. 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.
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.

D.2. Other participant payment for waiver-covered services

Compliance requirement(s)

Participant payments for the cost of services are limited to the amount of the cost-share calculated on the F20919 (see Chapter III of the *Medicaid 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 waiver-covered service. All instances of such practices should be reported as a finding.

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

Suggested Audit Procedures

For each participant file in the sample, determine the source of funds for all waiver-covered services and verify that no participant contributions or contributions made on their behalf by their family or other private interests are financing the cost of any waiver-covered service.

E. 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 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 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, etc.

These costs shall be reported using the method prescribed by DLTC 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.

Resources:

- *Medicaid Waivers Manual* - <http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>
- DLTC Memo Series - http://dhs.wisconsin.gov/dsl_info
- Forms – <http://dhs.wisconsin.gov/forms/index.htm> - search by number
- HSRS Handbook - <http://dhs.wisconsin.gov/hsrs/lts2009.pdf>
- Medical Assistance Community-Based Services Updates. Copies are available from DLTC on request by calling (608) 261-6836.

Contact:

Contact person: Julie Bryda
Telephone: (608) 266-7469
Email: julie.bryda@wisconsin.gov

**4.09 Service Definitions for CLTS
Summary of Services by Program**

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

SERVICE CODE (SPC)	SERVICE NAME	ALLOWABLE IN THE CLTS WAIVER?
112.57	Adaptive Aids-Vehicle Related	Yes
112.99	Adaptive Aids- Other	Yes
102	Adult Day Care	No
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	Yes
112.47	Communication Aids	Yes
506.61	Community Based Residential Facility	No
609.20	Consumer and Family Directed Supports	Yes
609.10	Consumer- Directed Supports	No
113	Consumer Education and Training	Yes
507.04	Counseling and Therapeutic Services	Yes
110	Daily Living Skills Training	Yes
706.10	Day Services-Adults	No
706.20	Day Services-Children	Yes
619	Financial Management Services	Yes
112.56	Home Modifications	Yes
402	Home-delivered meals	No
610	Housing counseling	Yes
106.03	Housing Start-up	Yes
512	Intensive In-home Autism Services	Yes
710	Nursing Services	Yes

SERVICE CODE (SPC)	SERVICE NAME	ALLOWABLE IN THE CLTS WAIVER?
112.46	Personal Emergency Response System (PERS)	Yes
108	Pre-vocational Services	No
103.22 103.24 103.26 103.99	Respite Care: Residential Institutional Home-based Other	Yes (All)
112.55	Special Medical and Therapeutic Supplies	Yes
107.30 107.40	Specialized Transportation - 1 way trips- Miles	Yes Yes
604	Support and Service Coordination	Yes
615	Supported Employment	Yes
104.10 104.20	Supportive Home Care - Days Hours	Yes Yes