

Section 3.1 Community Options Program (COP) – 2010

This section is applicable to audits of counties and 51 boards that receive funding for the Community Options Program directly from the Department of Health Services.

Funding: State funded, state identification number 435.367, CARS profile number 367

The Community Options Program (COP) provides funds to local county agencies to conduct functional assessments, develop case plans and provide community-based services based on an individualized care plan to individuals who otherwise would be at risk of institutional care. There are no eligibility requirements for assessments and case plan. People of any age or disability may be served with COP service funds if they are both programmatically eligible and financially eligible. A COP assessment and service plan is required in order to use COP service funds for a person. COP service funds are considered funding of last resort and are to be used to fill the gaps left between other available services and the needs outlined in each individual's care plan.

The Division of Long Term Care (DLTC) contracts with each county to operate the program under the direction of a designated lead agency and a local planning committee. Each county develops a county plan for the operation of the program in accordance with departmental guidelines, which is then approved by the department. Lead agencies may be a human services department, a social services department, a community board created under state statute 51.42 or 51.437, a county aging department, or a joint lead between any of the above agencies.

NOTE: After county transitions to managed care (Family Care); elderly, physically disabled and developmentally disabled adults are no longer eligible for COP service funds. Adults with a chronic mental illness or AODA disabilities and children may be eligible for COP service funds.

Counties are directed to report all COP program costs on the CARS reporting system on profile 367, which provides payment and cash flow to lead agencies during the year. However, final year-end COP reimbursement is based upon reporting on both the Human Services Reporting System (HSRS) Long Term Support Module and the Supplemental Budget Reconciliation Report format provided by the department. Counties are to report all assessment and plan activity, plus service costs to be charged to COP by individual on the HSRS Long Term Support Module. During final budget reconciliation, if the payment due based on HSRS reporting differs from the amount reported on CARS profile 367, the HSRS payment amount is placed on CARS profile 367 and the difference rolls to CARS profile 561. Therefore, unallowable COP costs reported on CARS but not on HSRS, will not be reimbursed with COP funds. This also means that COP allowable costs may roll to the base if sufficient COP funds are not available OR if reimbursement for an activity is subject to a flat rate or maximum reimbursement, which is less than actual cost. (See *DHS Audit Guide* Section 2.6 "Reporting" for additional explanation of the requirements for reporting.)

Counties receive their COP allocation in two suballocations as identified in the state-county contract. Suballocation A pays for assessments conducted and case plans developed based on a state approved hourly rate for each activity. During the year-end HSRS budget reconciliation, dollars not earned in suballocation A automatically become available to cover service costs in suballocation B. Suballocation B pays for: 1) services based on actual service cost to the program for eligible program participants who have had an assessment and case plan, 2) administrative costs up to a maximum amount per agency set by the department, 3) may cover allowable service

expenses in the Medicaid waiver programs which were not reimbursed by those programs due to insufficient funding and 4) may be used as additional match to capture federal funds for waiver allowable services. Allocated service dollars (suballocation B) may not be used to cover costs from assessments/plans in suballocation A.

Risk assessment

The Department of Health Services has designated the Community Options Program to be a state major program when the auditee receives funding for this program directly from the department.

Compliance requirements and suggested audit procedures

A. Assessments and plans

Compliance requirement(s)

Every COP participant who received COP funded services must have a care plan (similar to a Waiver “ISP” – Individual Service Plan) that is signed by the participant or the participant’s guardian. (COP Guidelines, page V-17).

Suggested audit procedure(s)

For each participant file in the sample, determine if there is a current (i.e. a year old or less) service plan that it was reviewed at least every six months and that it is signed by the participant or their guardian, if any.

Compliance requirement(s)

Pursuant to the state/county contract, counties are reimbursed for each assessment conducted and each case plan developed based on the actual hours needed to complete an assessment or case plan. The minimum contents of a COP assessment and case plan are defined in the Community Options Program (COP) Guidelines. If county actual costs exceed the annual allocation received, the additional costs may be paid from the agency’s community aids base.

Suggested audit procedure(s)

Based on the total sample, determine whether the assessments and case plans reported on HSRS were actually conducted. If a reported assessment or case plan is not documented, list the client number and the total cost/hours billed for the assessment or plan as a questioned cost.

B. Eligibility

Compliance requirement(s) – financial eligibility

A county is not to bill COP for services provided to a participant who is not eligible for COP service funding as determined by the COP Uniform Cost Sharing Plan tools. Eligible recipients may be required, according to the fiscal eligibility tools, to contribute a cost share which results in less expense to the program (s. 46.27 (6u)). A recipient of COP funded services who is also served by a Medicaid Waiver is automatically eligible for COP with no COP cost share.

Suggested audit procedure(s)

Determine whether there is:

1. Evidence in the case file that the county has completed a COP eligibility and cost sharing worksheet for each client receiving services; unless the individual's financial eligibility has been determined in a Medicaid Waiver program.
2. Evidence that the completed worksheet has been reviewed in the last year or in the last six months IF the person has a cost share and assets are involved in the cost share amount.
3. Evidence that any collections from program participants are applied directly to service costs.

Any service costs charged to COP for persons not documented as eligible are to be listed as questioned costs.

Compliance requirement(s) – program eligibility

A county is not to bill COP for services unless the individual meets ONE of the following:

1. Is certified eligible according to the COP Functional Screen or found functionally eligible through the Automated Long Term Care Functional Screen.
2. The persons is referred to the county for community placement under Interdivisional Agreement 1.67 or
3. The person is referred for COP funded services after discontinuation from a waiver program due to a level of care change, which precludes further waiver funding.

Suggested audit procedure(s)

For clients who enrolled in the COP program during the audit period, determine whether the county has documentation showing that the client was programmatically eligible prior to receipt of COP funded services by meeting one of the criteria listed above. All service costs charged to COP for persons not documented as eligible are to be listed as questioned costs.

C. COP services

Compliance requirement(s) - Proof that services were actually provided and were allowable
 COP service funds are to be used as a funding source of last resort to provide services to COP eligible persons based on an individual service plan. Cost share amounts received from program participants reduce the cost to COP for the services delivered. COP service funds may not be used to purchase land or construct buildings. (This includes COP used as match for any Medicaid waiver.)

Suggested audit procedure(s)

Review the Section 2.6 “Reporting” and apply the audit procedures in that section. In addition, verify that the total service costs claimed on the final COP HSRS 016 report for each program participant in the sample for a calendar year agree with the client service costs documentation. If an error is identified, list the client number and the amount of the difference as questioned costs and subtract the amount from the audited expenditure figure. If service cost documentation

indicates that COP service funds were used to purchase land or construct a building, the amount of the expenditures should be listed as a questioned cost.

Compliance requirement(s) - Unallowable service conditions

In certain circumstances, COP service fund may not be used to fund services even though specified in a case plan. A county MAY NOT:

1. purchase services provided to a community resident in an institutional setting without a variance, for example, adult day care provided in a nursing home.
2. purchase community services for an individual who is residing in an institution without a variance. Exception: in circumstances when a program recipient is institutionalized for 30 days or less, a variance is not required.
3. purchase RCAC services for an individual residing in a Residential Care Apartment Complex (RCAC) including room and board.

Note: Service funds can only be expended in accordance with the provisions of the department's *Allowable Cost Policy Manual*.

Suggested audit procedure(s)

If services were charged to a new COP recipient prior to their discharge from an institution, verify that the case file contains a variance approved by the county COP Planning Committee or its designated representative(s) for expenditures not to exceed 90 days prior to discharge (a good example is a deposit on an apartment).

For an ongoing COP recipient, if services were charged to COP for a period of time longer than 30 days but less than 90 days while a person was in an institution, determine whether the case file contains a variance approved by the county COP Planning Committee or its designated representative(s). (For example, a person may be in the hospital, but the county wants COP to pay for Lifeline, case management, apartment cleaning, etc. during that time.)

If services to an on-going recipient were provided in an institutional setting, verify that the file contains a variance approved by the county COP Planning Committee or its designated representative(s). (For example, an ongoing recipient is transported from their home to attend Adult Day care located in a nursing home.)

Any costs charged to COP without documentation of a required variance should be listed as questioned costs.

Any costs charged to COP for a participant residing in an RCAC should be listed as questioned costs.

D. COP administrative claim

Compliance requirement(s)

Counties may claim and be reimbursed for actual administration expenses up to 7% of the calendar year COP **service** allocation (unless the department provides a variance for a larger

percentage) to pay for administrative expenses in the COP and/or COP-Waiver/CIP II Programs. With written permission from DLTC, the county may expend carryover funds or High Cost funds for administrative expenses in addition to the 7% allowance on base funds. (High Cost funds are special funds allocated and approved by DLTC for specific one-time expenses. Carry over funds are unspent funds from the prior calendar year that the department contracted into the ensuring calendar year.) During the budget reconciliation process, DLTC assures that counties are not reimbursed more than the maximum allowable administrative amount. Once the final payment is determined in DLTC according to HSRS and a COP Supplementary Budget Reconciliation Report, excess administrative expenses reported on CARS profile 367 will roll to CARS profile 561.

Suggested audit procedure(s)

Based on the administrative amount reimbursed, determine whether the county has proper documentation to support that the amount reimbursed had actually been expended for administrative expenses related to the COP and/or COP-Waiver/CIP II programs. Any administrative expense reimbursed under the COP program may not be claimed again in any other program.

Audit elements summary

Elements of a case file:

1. Documentation of an Assessment
2. Documentation of a Care Plan
3. Financial Eligibility Documentation
4. Programmatic (Functional) Eligibility Documentation
5. Documentation indicating
 - a. whether unallowable services were funded by COP (purchase land or construct a building),
 - b. evidence of variances if unallowable service conditions existed.

Other audit elements:

1. Documentation to verify service costs charged to COP
2. Verification of administrative expenses to justify claim

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