

Section 3.7 Medicaid Personal Care Program – 2010

This section is applicable to audits of counties that receive funding for Medicaid Personal Care Program 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 Wisconsin Medicaid personal care benefit (MAPC) provides funding through the Medicaid State Plan to assist persons with the performance of their activities of daily living. Participants need a valid Wisconsin Medicaid card, and a medically necessary need for the service. All hours of care provided in a year, beyond 50 hours, are required to be prior authorized by the Wisconsin Medicaid Program.

Counties that meet the statutory requirements of 46.215, 46.22 or 46.23, Stats., or a county department established under s.51.42 or 51.437, Stats., may become certified personal care providers under Wisconsin Medicaid. Each certified agency is required to submit a plan of operations which meets the requirements of Wisconsin Administrative Code DHS 105.17 and DHS 107.112 in order to bill as a certified provider for the personal care benefit.

The supervisory registered nurse employed or sub-contracted by the county conducts a home care assessment on each participant who has a medical necessity for assistance with personal care and a valid Wisconsin Medicaid card. The nurse determines the number of hours the recipient needs, obtains physician orders, completes a plan of care which the physician signs, and then requests prior authorization for the care. The prior authorization packet is submitted to the Wisconsin Medicaid Program, and hours of care are prior authorized for up to one year.

All hours and visits billed per participant must be accounted for in appropriate personnel and participant records. Counties shall develop a clear audit trail for personal care which shows revenues for each participant for the care provided under this benefit, separate from other services and benefits being provided under long term care programs (e.g., CBRF costs, adult family home costs, supportive home care costs).

A county will not be reimbursed for services provided to a client who is not eligible for Medicaid funding. The county may choose to use another funding source or pass on the disallowed service reimbursement to the personal care provider due to non-compliance with a provider/agency contract.

Risk assessment

The Department of Health Services has designated the Medicaid Personal Care Program to be a Type A program when the auditee receives \$100,000 or more in funding for this program directly from the department.

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. Program specific risk factors

- *Medicaid Audit of Personal Care Services* - The Wisconsin Medicaid Program has conducted compliance audits of several counties billing for personal care services. If the county has been audited by Bureau of Program Integrity and the prior audit contained findings that resulted in overpayments, determine if the provider has taken appropriate follow-up action. This would include reviewing the audit findings, determining if the county has developed a corrective action plan and determining whether or not the corrective action has been taken.

If no change in policies and procedures to correct the audit findings has taken place since the last program compliance audit, this would be considered a risk factor.

- *Subcontracting of Personal Care Services* - Many counties sub-contract for personal care services through other agencies. These sub-contracted agencies are not Medicaid certified providers. As a result, these agencies do not receive the Medicaid rules, regulations and provider publications from the Wisconsin Medicaid Program. This information governs how the personal care benefit is administered. Therefore, it is expected that the county has provided this information to their sub-contracted agencies and monitors the sub-contractor's performance for compliance with these rules.

If the county has not provided the sub-contracted agencies with the Medicaid rules, regulations and publications or if it does not have a monitoring plan in place and being followed, this would be considered a risk factor.

- *Services Provided in a CBRF or Adult Family Home* - In many instances, recipients receiving personal care services through counties reside in a community based residential facilities (of 20 beds or less) or adult family homes. The county reimburses the CBRF or adult family home for some similar services that may also be provided under the

Medicaid personal care benefit. These services may include activities such as meal preparation, housekeeping, assisting with bathing, laundry, changing beds or medication reminders. Thus, there is the potential that the county is already reimbursing the CBRF or adult family home for the same services that are being billed under the Medicaid personal care benefit. The CBRF or adult family home will have either a recipient service plan or individual contract, which identifies the services to be provided. Therefore, it is expected that a review of the recipient service plan or individual contract will be conducted to ensure no duplication of services are being billed.

If the county were billing for Medicaid personal care services that are also covered under the recipient service plan or individual contract, this would be considered a risk factor.

Compliance requirements and suggested audit procedures

. A. Types of services allowed and disallowed/billing

Compliance requirement(s)

Personal Care cannot be provided outside the participant's home, in an institution, (hospital or nursing home) or in a Community Based Residential Facility (CBRF as defined in s. 50.01 (1) Stats.,) of more than twenty beds. The housekeeping component cannot exceed more than one third of the total hours provided per week in the recipient's home. A prior authorization has to be processed after the first fifty hours of care, before care can continue.

Suggested audit procedure(s)

Determine whether:

1. Contracts or provider agreements exist for all MA personal care provided.
2. Contract providers and providers funded through a fiscal agent may bill the county only for actual hours of personal care services provided. Further, billed hours should not exceed the number of hours approved by the physician and prior authorized.
3. The following documentation must be present in the participant's personal care file:
 - a. A physician's order for the service. Physician's orders are in the form of Plans of Care (POC's). POC's must meet the guidelines as outlined in the General Information Section of the Personal Care Handbook.
 - b. Hours in excess of 50 in a year's period of time must be prior authorized.
 - c. Recorded units of services by individual personal care providers correspond to hours billed to MA with individual tasks and in-and-out time delineated. Ensure the recipient has signed each personal care providers visit sheet. (For further clarification, see the Wisconsin Medicaid Updates 2000-54 and 2003-69 at <https://www.forwardhealth.wi.gov/WIPortal>.)
 - d. Recorded units of travel time billed meet the documentation requirements as

outlined in the Wisconsin Medicaid Updates 2000-53 and 2003-69 at <https://www.forwardhealth.wi.gov/WIPortal>.

The suggested format as presented is not a requirement; however, all the documentation and information contained in this format is required.

- e. Copies or originals of the Personal Care Screening Tool (PCST), as appropriate, and of all documents submitted to Wisconsin Medicaid with the PA request as outlined in the Wisconsin Medicaid Updates 2006-71 and 207-37 at <https://www.forwardhealth.wi.gov/WIPortal>. (Providers completing the Web-based PCST are required to maintain the entire PCST on file, not just the PCST Summary Sheet.)
- f. Billings are specific to each eligible recipient and correspond to the date the service was delivered. Up to four days of service can be billed on one claim provided all services each day were for the exact number of hours.
- g. Reimbursement amounts for contracted services are in accordance with provider agreements or contracts and recipient case plans.
- h. Reimbursement amounts for services documented through a fiscal agent are in accordance with individual provider agreements and recipient case plans.
- i. Time sheets for personal care must correspond with the billing dates for the personal care provided.
- j. County has a method to assure that payments are made only to qualified providers of personal care and nursing supervision. The county or the contract agency maintains records of compliance with licensing, certification and/or training.

B. Eligibility

Compliance requirement(s)

Personal care services can be provided for participants who have a valid Wisconsin Medicaid card; have a medical necessity for assistance with personal care and light housekeeping (in essential areas of the home occupied by the participant); and who live in an allowable living arrangement.

Suggested audit procedure(s)

Determine whether:

1. Services are provided in the participant's own home or in an allowable substitute care living arrangement. (Adult Family Homes or CBRFs of 20 beds or less are allowable.)

2. Counties shall maintain an accounting of personal care which includes revenues received for each participant for the care provided under this benefit. The accounting of personal care must indicate costs associated with personal care separately from other services provided under other long term care programs and funding sources.

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