

Section 3.9 Community Recovery Services – 2010

This section is applicable to audits of counties and tribes who are CRS providers.

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 (DHS).

Wisconsin Statutes authorize the Wisconsin Medicaid program to make federal financial participation funds available to counties for non-institutional psychosocial rehabilitation services under a program called Community Recovery Services (CRS). Under CRS, counties provide the non-federal share of CRS expenditures, and Medicaid reimburses counties the federal share based on the Federal Medical Assistance Percentage (FMAP) applicable at the time of the service.

The non-institutional services covered by CRS must fall within the definition of rehabilitative services under 42CFR 440.130 (d). Covered services include Community Living Supportive Services, Supported Employment, and Peer Supportive Services. Although each CRS county or tribal provider must have all three services available to eligible consumers, not all consumers will receive all three services. The consumer's state-approved individual service plan (ISP) determines the mix of CRS services that the consumer will receive.

The payment cycle for CRS services follows this sequence:

- Interim rates for the three CRS services are established by DHS and entered into the Medicaid fee schedule.
- County or tribal CRS providers submit claims to Medicaid as services are rendered. Reimbursement is based upon the fee schedule, or the claim amount, whichever is less.
- Medicaid reimburses clean claims for CRS services in the same manner as fee-for-service claims.
- County or tribal CRS providers are responsible for preparing an annual cost report for each CRS service type to document their unit cost in providing CRS services.
- The Department reconciles interim payment to actual costs based upon a review of the cost report.
- The federal share of the difference between interim payments and actual cost, as determined by the FMAP, is either paid to or recovered from the county.

The cost reconciliation worksheets and instructions are posted on the CRS website at: http://www.dhs.wisconsin.gov/MH_BCMH/crs/index.htm.

Risk assessment

DHS has declared CRS to be a Type A Program when a county claims costs for the program of \$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 benefit 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 benefit.
- The benefit is new for this auditee or the benefit requirements have recently changed substantially.
- The benefit has complex administrative requirements.
- The auditor identified significant problems in performing the general compliance testing for requirements that are relevant to this benefit (Section 2 of the DHS appendix).

B. Financial risk factors

The department performs desk audits of the cost reports that the county or tribe files with the department, and it notifies the county or tribe of the results of those desk audits. The notification includes a component for risk factors. This benefit 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 CRS 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 benefit. 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 CRS cost report, counties and tribes report the total cost of providing services for each CRS 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 the 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 than or equal to Medicaid units.

Compliance requirements and suggested audit procedures

A. Consistency Across Programs

Compliance requirement(s)

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

Suggested audit procedure(s)

- Review to confirm that time records, allocation schedules, and other supporting schedules encompass all programs when costs are distributed.
- Review documentation and inquire of personnel for all 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 CRS 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 or tribal cost for services, not contractor cost when the county or tribe contracts with other providers 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 and tribes 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/tribal staff for contract administration, supervision, and clerical for billing services.

C. Consistency between Financial Records and Provider Medical Records

Compliance requirement(s)

The county/tribal claims billing system must be consistent with the consumer's medical record documentation. For each unit of service billed to Medicaid, 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 consistency between the Medicaid billing system, and the progress note in the consumer's medical record.
- All units of service billed to Medicaid must be documented in the consumer's medical record in the form of a progress note as prescribed by the Medicaid Provider Update for CRS.

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 CRS services. Total units of service must be identified in the county's billing system.

Total billable hours include Medicare, Medicaid, and all other payers. Other payers include the county/tribe 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 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 CRS consumer who received services must have an assessment and ISP. The ISP must have been updated within the last twelve months, show the consumer's or guardian's participation through his or her signature on the plan.

Suggested audit procedure(s)

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

- was updated within the last twelve months,
- shows the consumer's or guardian's participation through his or her signature on the plan, and

F. Covered services

Compliance requirement(s)

No reimbursement may be made for a service not specified in the consumer's ISP. All services identified in the ISP 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 ISP, 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 Medicaid billing system. 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 from the Medicaid claims, determine whether the services had actually been delivered as evidenced in the medical records, and whether the services were authorized as evidenced in the ISP.

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