Section 3.4 Case Management Agency Providers – 2014 *(Minor changes)*

This section is applicable to audits of counties that receive funding for Case Management from the Department of Health Services through its fiscal agent, EDS Federal.

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 federal program within the context of also ensuring they meet the requirements from the Department of Health Services.

The Wisconsin Medical Assistance Program provides funds to counties to pay for Case Management, in accordance with Wisconsin Administrative Code DHS 105.51 and DHS 107.32, which assists individuals eligible under the plan in gaining access to and managing needed medical, social, educational, vocational, rehabilitational, and other services. Counties participating in this program are reimbursed for these services through filing a claim with the Medicaid fiscal agent, currently Hewlett Packard (HP). Remittance advices from HP accompanying the reimbursement checks will detail amounts paid for Case Management.

The department has developed guidelines and procedures for counties who choose to participate in the case management program. In order to participate as a provider of case management services, the county or tribal agency shall have state statutory authority to operate one or more community human service programs. The county or tribal government must elect to participate in the case management program and it must specify the target groups to whom it wishes to provide services.

Risk assessment

The Department of Health Services has designated Case Management Agency Providers to be a Type A program when the auditee receives $100,000 or more in funding for this program directly from the department. General risk factors include:

- 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 (*DHS Audit Guide*, Section 2).

Program risk factors include:

- *Medicaid audit of case management services* - The Wisconsin Medicaid Program conducts compliance audits of counties billing for case management services. If the

county has been audited by the DHS Office of Inspector General 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 has taken place since the last program compliance audit, this would be considered a risk factor.

- *Subcontracting of case management services* - Some counties sub-contract for case management 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 case management 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.
- *Multiple provider numbers* - More than one agency has a Wisconsin Medicaid provider number for case management.

Compliance requirements and suggested audit procedures

CM A. Reimbursement

Compliance requirement(s)

Reimbursement is based on the contract rate as set by the department for services rendered to individuals eligible for case management. Payments may be made for only the following services:

1. Assessments
2. Case Plan Development
3. Ongoing Monitoring and Service Coordination
4. Institution Discharge Planning
5. Any Recordkeeping and travel associated with the above services.

The following restrictions apply to reimbursement for the above services:

1. Case management is not allowable for those individuals who are in a medical assistance funded hospital, skilled nursing facility or intermediate care facility, except for discharge-related case management services up to 30 days prior to discharge from the institutional setting. Discharge related case management services may not duplicate discharge planning services that the institution normally is expected to provide as part of inpatient services.
2. The actual delivery of medical services, such as administration of medications and monitoring of clinical symptoms are not allowed as case management.

Case Management funds can be expended only in accordance with the provisions of Wisconsin Administrative Code DHS 105.51, DHS 107.32.

Case management services are covered to those recipients in a county in which case management services are provided and who meet the eligibility requirements in the Wisconsin Medicaid Case Management Handbook.

Suggested audit procedure(s)

Determine whether:

1. There are files for each recipient receiving case management which include the assessment document, case plan and documentation of ongoing monitoring and service coordination.
2. There is a list of the names of individuals employed by or under contract to the county who are performing case management services; and that they possess the qualifications as stated in DHS 105.51 (2).
3. The county is providing case management services only to a target population which is eligible and to which it has elected to provide case management services.
4. The county is only billing for case management services that are covered under DHS 107.32. Services can only be billed if:
   a. there was client or collateral contact during the period being billed;
   b. there are notes in the case file describing the services provided; and
   c. the assessment was completed within 30 days, if ongoing monitoring has begun.
   d. the services were not for administering medication or monitoring clinical symptoms or provision of other services, e.g. AODA counseling, or ADL (Adult Daily Living Skills) assistance.
5. The county has identified a single, primary case manager for each recipient, who performs ongoing monitoring and service coordination. Another case manager may fill in on an emergency basis, in which case, the file must include documentation of the emergency and that the primary case manager was not available.
6. Recordkeeping was billed only when there was client or collateral contact during the calendar month.
7. Case Management services for clients who are eligible for the Community Integration Program and Community Options Program-Waiver are not paid by both the CIP/COP-W programs and the Wisconsin Medical Assistance program.
8. Rounding for Ongoing Monitoring and Service Coordination:
   - May occur either daily or monthly. Ongoing monitoring and service coordination may be billed only one time per month.
   - On *individual dates of service*, providers may record their actual time (e.g. 3 minutes, 45 minutes) or accumulate the time spent on case management services on that day.
   - On a monthly basis, providers must add up the time for the individual dates of service. The actual accumulated time at the end of the month must follow the rounding guidelines in Attachment 4 of the Wisconsin Medicaid Update 2003-46.
   - For more detailed information and examples, please see the “Ongoing Monitoring & Service Coordination” Section of the Wisconsin Medicaid Case Management Handbook.
   - Providers must maintain documentation of all services billed including the time spent and a summary of the service provided.

This document is part of the 2014 Revision to the *Department of Health Services Audit Guide*, which is an appendix to the *State Single Audit Guidelines* for programs from the Department of Health Services. It is to be used in conjunction with Sections 1 and 2 of the *DHS Audit Guide* and with the *Main Document to the State Single Audit Guidelines.* All of these documents are available at www.ssag.state.wi.us.

9. Presence of Allowable Matching Funds
    - Counties are required to provide the state share of the Medicaid payments for Case Management services. The funds used for the state share must meet the following criteria:
        a. be non-federal funds
        b. not be used to match other federal funds (e.g. Community Support Program);
        c. be expended on allowable services to eligible recipients.
    - Where the County is providing Case Management services directly, there must be evidence that an adequate amount of allowable matching funds is found in the program budget for Case Management. This may be included in the salaries of staff providing the Case Management, staff supervising or administering the service or in an appropriate allocation of county operating costs.
    - Where the County is contracting for Case Management services, there must be evidence that an adequate amount of allowable matching fund is expended through contracts to the providers of Case Management services or for an appropriate allocation of County costs associated with administering those contracts.

Presentation of findings

See Section 4.11 of the *Main Document to the State Single Audit Guidelines* for guidance on development of an audit finding. When presenting findings for Case Management, identify the program and the specific compliance requirement, for example "CM A. Reimbursement."

Questions

Please send questions by email to DHSAuditors@Wisconsin.gov and include the identifier for the audit procedure, for example, for example "CM A. Reimbursement," and the name of the auditee in the message.