Section 3.18 Children's Long-Term Support (CLTS) Waivers – 2014 *(Extensive revisions throughout)*

This section applies to counties, Lutheran Social Services, and St. Francis Children's Center.

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 CLTS Waiver Program is comprised of three Medicaid Home and Community-Based Service (HCBS) Waivers established under Section 1915(c) of the Social Security Act and is part of the Wisconsin Medicaid Program. The three CLTS Waivers 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 eligible children and their families with individualized supports and services that allow the child to live in the community with their families instead of residing in an institution or alternate care setting.

Since 2012, all CLTS Waiver service provider claims are processed and paid by the Department of Health Services' contracted Third Party Administrator (TPA). This change enabled the Department to meet federal requirements for a standardized, statewide Medicaid Management Information System (MMIS) for authorizing, adjudicating, and processing claims and encounter data collection.

Under this process, county waiver agencies issue prior authorizations to both their providers and the TPA, which include details regarding the approved provider, the participant, units, and rates for each covered waiver service. Following delivery of the service, the provider submits their claims to the TPA for payment. The TPA processes and adjudicates the claims (including Medicaid card and health insurance coordination of benefits), and if approved for payment, issues a claim notification to DHS each business day. The Department reviews and approves the payment, and the funds for the claim expenditures are drawn from a CARS profile, which is tied to the county's CLTS Waiver grant allocation. The funds are then submitted to the TPA and the TPA issues a payment to the provider.

As CLTS Waiver funds are issued as grant funding to the county waiver agencies, the expenditures must be presented as a federal award in the Schedule of Expenditures of Federal and State Awards, and the program must be audited. If the county includes a column in the SEFSA for revenue, the CLTS Waiver revenue should also to be presented.

It will be left to the professional judgment of each county waiver agency and their auditor in deciding whether to include the expenditures paid through the TPA claims process on the general ledger. The audit will meet the Single State Audit requirements as long as the auditor does not need to qualify the opinion on the financial statements due to the presentation for CLTS Waiver funding.

Risk assessment

The Department of Health Services has designated the CLTS Waiver Program to be a Type A program when expenditures reported for reimbursement are $100,000 or more (see *DHS Audit Guide*, Section 1.2.2 "Additional requirements for single audits"). Risk factors include:

- The program has not been audited in at least one of the last two audits.
- The auditor identified significant findings for this program 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).

Compliance requirements and suggested audit procedures

All of the following compliance requirements in this section apply to individual CLTS Waiver participants and should be tested through review of the participant case files.

CLTS A. 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 Chapter IV of the *Medicaid Home and Community-Based Services Waivers Manual*. The sections for each service are headed by two subtitles: "Service Requirements/ Limitations/ Exclusions" and "Standards." Both sections contain compliance requirements for providers which must be met. County waiver agencies have contractually agreed, and must be able to assure the department that all providers comply with these requirements. Each provider must have registered on the Medicaid Waiver Provider Registry and have signed a Medicaid Waiver Provider Agreement. The county waiver agency must also ensure each provider is properly trained, licensed or credentialed to deliver the authorized services according to the required standards. A caregiver background check must be completed for each provider that has regular direct access to the participant and/or his or her funds to ensure no barring offense exists that would prohibit Medicaid payment for employment as a caregiver.

Suggested audit procedure(s)

Determine if the CWA has assessed provider compliance with the provisions listed under "Service Requirements/ Limitations/ Exclusions" and "Standards" for the following services:

- Respite Care (SPC 103)
- Supportive Home Care (SPC 104)
- Daily Living Skills Training (SPC 110)
- Housing Modifications (SPC 112.56)
- Consumer Education and Training (SPC 113)
- Mentoring (SPC 503)
- Counseling and Therapeutic Services (SPC 507.03)

- Intensive In-Home Treatment Services (SPC 512)
- Financial Management (SPC 619)

For each of these services, the *Medicaid Home and Community-Based Services Waivers Manual* will include a list of minimum qualifications and/or training requirements. This list also indicates the provider must meet specific unique training needs identified by the family and the CWA, as required in order to provide appropriate services to the individual child.

For each of the services, the CWA is required to maintain within the child's record documentation that specifies the minimum credentialing qualifications and/or minimum training requirements, including the unique training needs identified by the family and the county waiver agency as required to provide appropriate services to an individual child, prior to being determined to be qualified to deliver the identified service.

CLTS B. Established Provider Rates and Contracts

Compliance requirement(s)

To establish allowable provider service rates, county waiver agencies are required to adhere to the Allowable Cost Policy Manual and OMB Circular A-87. Wis. Stat. 46.036 requires providers receiving more than $25,000 in funds from a county agency for the delivery of care and services is to have a Purchase of Services (POS) contract that meets the Department's standards, unless the audit is waived by DHS. The county may also file a request with the Department of Revenue to increase the $25,000 POS contract threshold.

Suggested audit procedure(s)

For each service provider file in the sample, the auditor should review the county's rate setting methodology, and whether a POS contract was executed, as appropriate, or obtained DHS approval for a waiver.

CLTS C. Service Claims Paid by Third Party Administrator (TPA)

Compliance requirement(s)

County waiver agencies must issue service prior authorization files via the TPA's secure web portal, according to established formats (e.g., details regarding the approved provider, the participant, units, rates and method). Following delivery of the service, the provider submits their claims to the TPA for payment within 120 days. County Support and Service Coordinators (SSC) case management services are also paid through the TPA claims process, The TPA processes and adjudicates the claims (including coordination of Medicaid card and health insurance benefits), issues payment to the provider, and encounter level data is reported to the Department.

Suggested audit procedure(s)

For each service provider file in the sample, the auditor should review the county waiver agency's methodology and system for issuing service authorizations based on the child's need on a timely basis to the TPA, and the claim encounter data for the authorized services.

CLTS D. Cost Sharing

Compliance requirement(s)

The audit is intended to determine if cost-share requirements have been met. Cost sharing only affects CLTS Waiver participants who are eligible under Medicaid Groups B or C. When a cost

share applies, the child's eligibility for waiver services can only be maintained if the Economic Support worker has determined the proper amount of their cost-share liability and the family paid the cost-share liability in a timely manner.

The county waiver agency is required to establish Cost Sharing Agreements with the participant's family where appropriate. The county must maintain a record system that is able to track and document that the family has paid the appropriate cost share amount 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 Home and Community-Based Services Waivers Manual*.

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 F-20919) and/or CARES screen for review. Line 11 on the F-20919 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 F-20445) to establish whether the entire cost share obligation has been correctly applied to one or more Waiver-covered (allowable) service(s).
2. The CWA can either report the cost share to the Bureau of Children's Services or apply the cost share to a specific service. Determine whether the CWA 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.

CLTS E. Parental Payment Liability (PPL)
Compliance requirement(s)
When a child is participating in the CLTS Waivers, a family may be liable for a certain portion of the cost of their child's waiver services. After the family and the service coordinator have finalized the development of the child's Individual Service Plan (ISP), the service coordinator will apply a formula to determine whether or not the family will have any Parental Payment liability.

Suggested audit procedure(s)
For each participant file in the sample, the auditor should review if a parental payment liability has been determined or if the service coordinator determined that there was no liability. The waiver agency must obtain required information and complete PPL calculations related to the PPL for all children under the age of 18 participating in the CLTS Waiver Program.

Additional information regarding the Parental Payment Limit may be found at https://www.dhs.wisconsin.gov/clts/waiver-cost.htm.

Additional information regarding the HCBS Waiver Manual and other resources may be

found at https://www.dhs.wisconsin.gov/clts/index.htm.

Presentation of findings

See *Main Document to the State Single Audit Guidelines*, Section 4.11 for guidance on development of a finding. Even limited or seemingly inconsequential noncompliance with certain program requirements can profoundly impact the quality of life of program participants. Therefore, all findings of noncompliance need to be reported in the Schedule of Findings and Questioned Costs. Request guidance from the Department if it is unclear whether a particular situation constitutes noncompliance (see "Questions" at the end of this section).

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 properly screen a provider would be the amount of waiver funds issued for services delivered by the provider on the participant's behalf. 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.

When presenting findings, identify the program and the specific compliance requirement, for example "CLTS A. Qualified Providers."

Resources

- *Medicaid Home and Community-Based Services Waivers Manual* - http://dhs.wisconsin.gov/bdds/waivermanual/index.htm
- DLTC Memo Series - http://www.dhs.wisconsin.gov/partners/memos.htm
- Forms – http://dhs.wisconsin.gov/forms/index.htm - search by number
- CLTS Waiver Third Party Administration (TPA) Handbook
- CLTS Service Codes Crosswalk
- Long-Term Care Encounter Reporting (Data Warehouse) - http://www.dhs.wisconsin.gov/LTCare/encounter/index.htm
- Medical Assistance Community-Based Services Updates. Copies are available from DLTC on request by calling (608) 261-6836.

Questions

Please send questions by email to DHSAuditors@Wisconsin.gov and include the identifier for the audit procedure (example - "CLTS A. Qualified Providers") and the name of the auditee in the message.