

Section 3.2 Community Integration Program I (CIP I), Brain Injury Waiver, and Children’s Long Term Support Waivers - a program cluster – 2007 Revision

This section is applicable to audits of agencies that receive funding for the Community Integration Program I, Brain Injury Waiver, and Children’s Long Term Support Waivers directly from the Department of Health and Family Services. This section is part of the “Appendix to the State Single Audit Guidelines for Programs from the Department of Health and Family Services,” and it is to be used in conjunction with the “State Single Audit Guidelines Main Document,” other parts of this appendix, and appendices from other departments. All of these documents are online at www.ssag.state.wi.us.

The Community Integration Program I, Brain Injury Waiver, and Children’s Long Term Support Waivers program cluster uses both HSRS and CARS for reporting. See Section 2.1 “Reporting” for additional explanation for the detail shown below.

Counties report expenditures for the Community Integration Program I (CIP I) and Brain Injury Waiver on both HSRS and CARS. At the end of the period, the department reconciles CARS to match HSRS. These programs use the following CARS profiles:

Profile 501 Brain Injury Waiver (G)	Profile 506 BIW Non Federal (F)	Rolls to 561BCA (F)
	Profile 507 BIW Federal (E)	
Profile 556 CIP1B St Coletta (G)	Profile 562 CIP IB COP St Coletta (F)	Rolls to 561BCA (F)
	Profile 563 CIP IB Federal (E)	
Profile 557 CIP1B (G)	Profile 564 CIP IB Non Federal (F)	Rolls to 561BCA (F)
	Profile 563 CIP IB Federal (E)	
Profile 558 CIP1A (G)	Profile 580 CIP1A Non Federal (F)	Rolls to 561BCA (F)
	Profile 581 CIP1A Federal (E)	

Profile types-- D=Non-reimbursable, E=Sum Sufficient, F=Contract Controlled, G=Allocating

(Source: <http://dhfs.wisconsin.gov/bfs/CARS/CARSManual2007/WaiverFlowchart.pdf>)

Counties report expenditures for Children’s Long Term Support Waivers only on HSRS, and the department transfers these costs to CARS. CLTS uses the following profiles:

Profile 420 CLTS DD AUTISM (LTS Code F)	Profile 427 CLTS DD Autism Federal (E)	
	Profile 450 CLTS Non Federal (F)	Rolls to 561 BCA (F)
Profile 421 CLTS DD BCA MATCHED (LTS Code I)	Profile 428 CLTS DD Federal (E)	
	Profile 561 BCA (F)	
Profile 422 CLTS DD OTHER (LTS Code H)	Profile 429 CLTS DD Federal Other (E)	
	Profile 460 CLTS Non Federal Other (F)	Rolls to 561 BCA (F)
Profile 430 CLTS MH AUTISM (LTS Code G)	Profile 437 CLTS MH Autism Federal (E)	
	Profile 451 CLTS MH Non Federal (F)	Rolls to 561 BCA (F)
Profile 431 CLTS MH BCA MATCHED (LTS Code K)	Profile 438 CLTS MH Federal (E)	
	Profile 561 BCA (F)	
Profile 432 CLTS MH OTHER (LTS Code J)	Profile 439 CLTS MH Federal Other(E)	
	Profile 461 CLTS MH Non Federal Other (F)	Rolls to 561 BCA (F)
Profile 440 CLTS PD AUTISM (LTS Code P)	Profile 447 CLTS PD Autism Federal (E)	
	Profile 452 CLTS PD Non Federal (F)	Rolls to 561 BCA (F)
Profile 441 CLTS PD BCA MATCHED (LTS Code M)	Profile 448 CLTS PD Federal (E)	
	Profile 561 BCA (F)	
Profile 442 CLTS PD OTHER (LTS Code L)	Profile 449 CLTS PD Federal Other (E)	
	Profile 462 CLTS PD Non Federal Other (F)	Rolls to 561 BCA (F)

Profile types-- D=Non-reimbursable, E=Sum Sufficient, F=Contract Controlled, G=Allocating

(Source: <http://dhfs.wisconsin.gov/bfs/CARS/CARSManual2007/07CLTSFlowchart.pdf>)

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 and Family Services.

The Community Integration Program I (CIP I) includes two programs called CIP IA and CIP IB, which are each authorized by statute: s. 46.275 and s. 46.278 respectively. The two CIP 1 programs, the Brain Injury Waiver (BIW) and the three Children’s Long-Term Support Waivers (CLTS) are home and community based waivers programs under the Wisconsin Medicaid Program.

The objective of all waivers is to provide program participants with individualized services and supports permitting them to reside in a community setting or, for children, with their families

instead of some type of institution or alternate care setting. CIP IA funds persons who previously received long term care and resided at one of the three State Centers for people with Developmental Disabilities, persons who are at risk of admission or people who replace people originally relocated from a Center who terminated from the program for some reason. CIP IB funds persons who resided at other Intermediate Care Facilities for persons who are Mentally Retarded (ICF/MR) and relocated to the community or persons who are eligible for service in but were diverted from those facilities. This includes people who are relocated under the department's ICF/MR restructuring initiative (which is coded differently on HSRS). Some people served may have been in general nursing homes inappropriately. The Brain Injury Waiver serves people who are either relocated or diverted from specialized brain injury rehabilitation facilities. The CLTS Waivers serve children who have a developmental disability, a severe emotional disturbance, or a physical disability.

The Division of Disability and Elder Services contracts with a County agency or in the case of CLTS, with either county agencies or private providers who act as county agencies. County agencies have a separate appendix to the State and County contract for Social and Mental Hygiene Services for CIP 1 and BIW but one addendum for all the CLTS waivers while private agencies have a standard contract with similar terms as the appendix. All references to counties below apply to these providers in CLTS if a private provider is used in lieu of a county. This appendix or contract prescribes the requirements necessary for proper implementation and operation of this program by county agencies and reference certain other documents which also prescribe proper operation of these programs. The key document referenced in the contract is the Medicaid Waiver Manual (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>).

Risk assessment

The Department of Health and Family Services has designated the Community Integration Program 1 (CIP 1), the Brain Injury Waiver (BIW), and the three Children's Long Term Support Waivers (CLTS) program cluster to be a state major program when the auditee receives funding for these programs directly from the Department.

Compliance requirements and suggested audit procedures

I. Case file testing

All of the following compliance requirements in this section apply to individual waiver participants and should be tested through review of the participant's agency files.

Sample size - The final HSRS L300 report identifies the program participants of the CIP I and BIW waiver programs funded for services during the calendar year being audited. It should be used for sample selection, based on the criteria listed below. If the total persons receiving CIP I and BIW funded services in a calendar year is less than 300, test records for 7% of those individuals receiving CIP I and BIW funded services or 10 cases, whichever is greater. If the total persons receiving CIP I and BIW funded services in a calendar year is between 300-500, test records for 6% of the reported individuals. If the total persons receiving CIP I and BIW funded services in a calendar year is greater than 500, test records for 5% of the reported individuals. For CLTS, test 7% but not less than 10 participant records.

The auditor should use a judgmental method for selecting cases for the sample, taking into account factors such as achieving:

- Higher proportion of persons with higher costs
- Higher proportion of newer cases
- Higher proportion of persons with significant changes in services during the year
- Proportionate representation of support and service coordinators (case managers)
- Proportionate representation from both the CIP I and the BI Waivers
- A sample of cases funded by ICF/MR restructuring (these can be identified via HSRS long term support code R-field 26).
- In CLTS, the sample should include cases from each of the three CLTS populations: developmental disability, mental health, and physical disability.

Findings of noncompliance – Even limited or seemingly inconsequential noncompliance with program requirements can reflect or result in a profound impact on the quality of life of program participants. Therefore, all findings of noncompliance need to be reported in the Schedule of Findings and Questioned Costs. If it is unclear whether a particular situation constitutes noncompliance, call or send an email to the contact person listed at the end of this section for guidance.

For each finding of noncompliance, list the participant’s identifying number (not the participant’s name), the compliance requirement (what should be), and the condition found (what is). Recommendations for corrective action are especially valuable if the findings indicate a systematic and/or problem with the county’s procedures for these waivers.

The auditor does not need to determine questioned costs. The Department will calculate potential disallowances based on the nature of the noncompliance. For example, the potential disallowance for a county’s failure to re-certify a client would be the amount of waiver funds spent on the client’s behalf during the time since the end of the period covered by the previous certification or re-certification. 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.

A. Eligibility

Compliance requirement(s) - Financial eligibility

Participants must be eligible for Medicaid or Waiver funding under CIP 1A/B, BIW or CLTS. Eligibility must be redetermined annually.

For Group A clients, eligibility is documented through the Form DDE-0919 “MA Waiver Eligibility and Cost Sharing Worksheet,” which is completed by county staff. (In some situations, the case file for a Group A client will also need to contain a CARES screen. However, the requirement for a CARES screen for Group A clients is beyond the scope of this supplement.)

For Group B and Group C clients, eligibility is documented on the Form DDE-0919 or through the CARES screen. The DDE-0919 is completed by the case worker, and the CARES screen is completed by the County Economic Support Specialist.

Counties may use an equivalent to the DDE-0919 form.

Suggested audit procedure(s)

For the cases selected in the sample,

- For Group A clients, verify that the case files include at least a Form DDE-0919.
- For Group B and Group C clients, verify that the case files includes a Form DDE-0919 or a CARES screen.
- For all clients, verify that the DDE-0919 form and the CARES screen are updated at least annually.
- For all clients, verify that the eligibility documents were completed by the appropriate person.

Compliance requirement(s) - Functional eligibility

Every Waiver participant must meet a level of care requirement established by the Department.

For CIP 1A/B, this level of care must be initially be at a DD1a, DD1b, DD2 or DD3 level and remain at one of those levels through subsequent years. Certification is determined by using of automated Long Term Care Functional Screen. The screen must be completed annually. Evidence that the screen has been completed in a timely manner must be maintained in the participant's file.

For BIW, the level of care must be a BI level as documented on the Forms DDE-2256 "Request for Title XIX Level of Care Determination" and 2256a "Request for Title XIX Level of Care Determination Addendum for Developmentally Disabled Client/Resident." These forms are also required for annual recertifications.

For Children's Waivers, level of care is documented by completion of the Children's Long Term Care Functional Screen, which also must be updated annually.

Suggested audit procedure(s)

For each participant file selected for the sample,

- Determine whether documentation shows that the participant meets the an appropriate level of care
- Determine whether the county has recertified the level of care within the last year (or 15 months for the first recertification for CIP IA/B only).

Compliance requirement(s) - Recertification up-to-date and current

Starting in 2005, counties are required to report they have performed a recertification in a

timely manner by completing a “County Monthly Recertification Assurance Report” for each person funded by CIP 1A/B /BIW. The department no longer receives the actual recertification documents but requires them to be on file at the county. The CLTS Waivers require the Children’s Long Term Support (CLTS) Waivers Recertification Checklist be completed upon recertification for each child. These reports are sent to the respective Department Section where dates and updated information is reviewed and documented in related client databases. The audit should determine if recertifications are current and the report is accurate.

For additional information, see Chapter VII of the *Medicaid Waivers Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>), supplemented by CIP 1 Update #2005-01 “Simplifying the Annual Recertification Process and Reducing County Reporting Burden.” Recertifications must meet the requirements of Chapter VII of the Waiver Manual.

Suggested audit procedure(s)

For each client case file in the sample, determine whether the county accurately reported the recertification to the Department on the “County Monthly Recertification Assurance Report” for the CIP/BIW client or “Children’s Long Term Support (CLTS) Waivers Recertification Checklist.”

B. Assessment and Planning

Compliance requirement(s) - Assessments

Each Waiver participant must have an assessment of some kind in their file. The assessment is described in the Waiver Manual, Chapter VI. Assessments are the basis of the services listed in the individualized service plan. If the assessment in the file uses the Long Term Care Functional Screen, it must be supplemented by additional information.

Suggested audit procedure(s)

Verify that there is a written assessment in each participant file sampled.

Compliance requirement(s) – Individualized service plan

In order to receive reimbursement for any service, a written individualized service plan must be developed, signed by the participant or their guardian, if any. Initial plans require approval by the Department. The plan must be reviewed by the county at least every six months and updated annually. The plan is generally found on DDES Form 445, although local versions are permitted if approved by the Bureau. The County Agency must receive written approval from the Department for the initial service plan. Approval generally is granted for the individual’s entire individualized service plan.

Individualized service plans shall be current, be based on an assessment and conform to the requirements in the Waiver Manual (See Chapter VI of the Manual). The Individual Service Plan must be reviewed every six months and updated not less than annually or when needs, services, providers, or units of service change.

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 (DDES 445 or local version), that it was reviewed at least every six months, that it is signed by the participant or their guardian, if any, and that the state has approved the

initial plan evidenced by a letter in the file approving the plan. For additional information, see Chapter VI of the *Waiver Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>).

Compliance requirement(s) – Covered services

No reimbursement can be made for a service not specified in the participant’s Individualized Service Plan. Reimbursement may also be restricted by special “Service Requirements/Limitations/Exclusions” specified in Chapter IV of the Manual. All services identified in the plan should be delivered to the client, and all services that the client receives should be authorized through the plan. It is also important that any service listed in the plan be provided. If it is not, this should be identified in the audit.

County agencies report all expenditures for services for each waiver participant monthly on the Human Services Reporting System (HSRS). To qualify for reimbursement, a service must be covered by the Waiver, delivered to an eligible waiver participant by a qualified provider and authorized in the person’s individualized service plan during the time period when all these factors were in place. The only exception to this is start up costs which include any waiver-allowed cost incurred within 180 days prior to the waiver participant’s start date.

All units of any services reported on HSRS must be documented in the participant’s file by some indication that the activity occurred such as a file note, an annual review report, an attendance record or invoice that includes sufficient information (such as what service was provided, when the service was provided, who provided the service, who received the service, how many units of service were provided, and where the service was provided). County agencies also must document the number of units of service delivered using the units prescribed for the particular service per the instructions contained in the HSRS Handbook (<http://dhfs.wisconsin.gov/HSRS/index.htm>).

Since all services paid for with waiver funds must be reported on HSRS, the waiver funded services identified in the plan and on HSRS should be in general agreement. Precise, one to one matching is not required: a person may receive more or less than the services authorized in the plan. Large discrepancies should be noted. For additional information, see Chapter VI of the *Waiver Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

Obtain an L-300 report for the agency showing each participant, the services in which they were enrolled and the amount of funding claimed for the services provided. For each participant file in the sample, determine whether:

1. the waiver services listed in the plan are covered by the waiver,
2. the waiver services listed in the plan were actually provided to the client as evidenced by the L300,
3. the waiver funded services reported on HSRS were authorized in the approved plan,
4. the number of units of service and cost per unit of service are reasonably consistent between the plan and HSRS,

5. that there is documentation in the participant file that supports the reported expenditures and units of service and
6. that waiver funds were used to finance all of the cost of the covered service.

C. Living Arrangement

Compliance requirement(s) – Living in a place permitted under the waiver

To receive reimbursement for any covered service, a waiver participant must reside in either a natural community setting (e.g. home or apartment) or in an eligible regulated setting. A person's living arrangement in this context means their place of permanent residence and not a place where they might be temporarily staying or visiting.

If the adult resides in a regulated setting, the setting must be either a certified or licensed adult family home or community-based residential facility licensed for eight or fewer beds. Other eligible settings are natural homes or apartments in the community where the adult has a lease with the landlord who is not also the service provider or where the person or their family owns the house or condominium.

Children under age 18 must reside either in their family home or in a standard or treatment children's foster home. Children may not reside in a children's group home licensed for five - eight beds. The use of such a facility is limited to situations where the child is receiving Residential Respite Care and the stay is temporary. Children's group homes are permitted only if the child is temporarily placed in that setting for respite care only. Long term, permanent residence of the child in children's group homes (5-8 beds) are not permitted. Payments for any/all Waiver service(s) are not permitted if the child resides in a group home licensed for 5 to 8 residents. Payments for all Waiver services for a waiver participant are not permitted if the participant resides in a CBRFs or children's residential facilities of any kind that are larger than eight beds under any circumstances.

No reimbursement can be made for any service on any day the program participant was an inpatient in a Title XIX facility such as a hospital, SNF, ICF, or ICF-MR unless the person was approved to receive institutional respite care.

Suggested audit procedure(s)

For the case files selected in a sample, verify that the place that the person regularly resides is one that is allowed by these waivers.

D. Monitoring Contacts

Compliance requirement(s)

County agencies shall ensure that direct and collateral contacts required in the Manual (See Chapter IV, Section 4.08, Support and Service Coordination) are done in a timely manner. Direct contact with the participant includes written or e-mail exchange, telephone conversation, or face to face contact. A collateral contact includes written or e-mail exchange, telephone conversation, or face to face contact with a participant's family member, medical or social service provider, or other person with knowledge of the participants long term care needs.

The minimum requirements regarding the provision of Support/Service Coordination are:

1. Collateral contact at least once each calendar month.
2. Face to face participant contact not less than every three months.
3. At least one of the face to face contacts under 2. shall be at the participant's place of residence during each calendar year.

An exception or waiver to provide less than the minimum ongoing monitoring contacts may be made by the state. Such exceptions or waivers must be applied for and must be approved by the department's Community Integration Specialist (CIS) who is assigned to the county. Documentation of the application and the approval of exceptions or waivers granted must be in the participant's file. Please consult Chapter IV of the Manual (Support and Service Coordination) for the procedure that must be followed in requesting and gaining approval for this variance. For additional information, see Support and Service Coordination, Section 4.08 of the *BDDS Medicaid Waivers Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

For each client case file in the sample, select a one year period and determine whether the file shows documentation that the case manager had collateral contacts at least once each calendar month, at least one face to face contact every three months and one home visit during the year.

E. Fiscal Compliance

Compliance requirement(s) – Room and board

Room and board costs may not be covered by Waiver dollars except when institutional or residential respite care is provided. Room and board includes the participant's share of the household costs (rent, maintenance not covered by the landlord, supplies, etc) and food. If there is a live-in provider, a portion of the room and board cost must be allocated to that provider. The provider's room and board may be considered a form of compensation and may be covered by the waiver. Under no circumstances shall the waiver participant pay for the cost of a live-in provider's room and board. Room and board also does not include approved housing start up funding documented in the participant's approved plan or funding for an approved home modification authorized in the approved service plan.

The use of participant funds for room and board must be based on a reasonable estimate of these costs based on the *Allowable Cost Policy Manual*. Room and board shall not include charges for items or services not needed by the participant.

Providers occasionally include additional charges for items such as cable TV or DSL into the room and board rate. The client or guardian must specifically approve any charges for room and board items that go beyond the basic requirements for health and safety as identified in the Individual Service Plan. If not approved, these charges are an overcharge to the participant and should be noted in the audit report.

For all requirements in this section, respite care is defined in Chapter IV of the Waiver Manual. Room and board costs for many waiver participants are typically covered by a share

of a participant's SSI grant. They may be supplemented by COP or other state and county funding sources.

Suggested audit procedure(s)

For each case file in the sample, determine whether room and board costs were inappropriately charged to waiver. Review the forms used to calculate and document the cost of room and board and determine if it complies with the *Allowable Cost Policy Manual*. Determine if the cost of additional items included in the room and board was approved by the participant or their guardian, if any.

Compliance requirement(s) – Matching and service funding sources

Matching funds that are applied to the cost of covered services that are not otherwise covered by state matched Medicaid funds must come from state or local governmental sources that are either allocated to the county by the department such as COP, Community Aids, Rollo, Foster Care Transition (Act 405) funds, Family Support or that originate via a local tax such as local property or sales taxes. Under no circumstances can federal funds of any kind or funds donated by family members or others be used as a source of matching funds. In addition, funds obtained from the waiver participant, their family or guardian or from any other private, non-governmental source may not be used as matching funds or to cover the cost of any waiver-covered service listed in the person's approved individualized service plan. Such funds can supplement room and board.

Suggested audit procedure(s)

For each case file in the sample, review funding sources to determine whether the county used any type of funds other than funds originating from state or local governmental sources.

Compliance requirement(s) – Cost sharing

Cost sharing only affects participants who are eligible under Groups B or C. When a cost-share applies, the person's eligibility for Waiver services can only be maintained if the cost-share liability is met. The county must maintain a fiscal record and system that is able to track and document that the participant has paid the appropriate cost-share and that it has been applied toward Waiver-covered services. The county agency is required to establish Cost Sharing Agreements with individual participants where appropriate. If the participant pays the provider directly, the agency shall have a method to assure the cost share obligation has been correctly applied. The cost share requirement does not apply in any month in which the client does not receive waiver-funded services. For additional information, see Section 3.04 of the *Medicaid Waivers Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

For each client case file in the sample, review the Form DDE-919 (MA Waiver Eligibility and Cost Sharing Worksheet). Line 11 on this form will indicate whether the participant has a cost sharing obligation. For those cases where cost sharing is required:

- Review the DSL Form 445 "Individual Service Plan," to establish whether the entire cost share obligation has been applied to one or more Waiver-covered (allowable) service(s).
- Determine whether the county 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.

- Verify that the agency did not collect a cost share for any month where no waiver covered service was delivered.

Compliance requirement(s) – Other participant payment for waiver covered services

Participant payments for the cost of services are limited to the amount of the cost share calculated on the DDES 919 (see Chapter III of the Waivers Manual).

Contributions, voluntary or mandated, are never permitted to be collected by counties or providers for Waiver-covered services. Counties may not compel a participant to make contributions for such services.

For additional information, see Section 3.05 of the *Medicaid Waivers Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>)

Suggested Audit Procedures

For each case file in the sample, determine the source of funds for all waiver covered services and verify that no participant contributions are supporting the cost of any waiver covered service.

Compliance requirement(s)

Personal care services that are paid by the Medicaid card cannot also be paid under the waiver as supportive home care. Supportive home care payments under this compliance requirement includes any service for which federal Medicaid funds were received. This is considered duplicate reimbursement under Medicaid.

Suggested Audit Procedures

Compare payment detail for personal care on the Medicaid Card to supportive home care reimbursed under the waiver. The department will provide payment detail for personal care. Send a list showing program, client name, Medicaid identification number (preferred) or social security number by US mail to:

Anne Olson
Bureau of Developmental Disabilities Services
Division of Supportive Living
1 West Wilson Street, Room 418
Madison, WI 53703

For questions, call (608) 264-9870 or send an email to olsonac@dhfs.state.wi.us (do not send confidential client information by email)

Compliance requirement(s) - Conflict of interest in money management

Placeholder for future audit requirements.

II. Agency-level testing

The following procedures are applicable at the general agency level.

A. Provider qualifications

Compliance requirement(s)

Providers must meet the standards that apply to the waiver-covered services they provide. These standards are contained in the Waiver Manual in Chapter IV. The sections for each service that is headed by “Service Requirements/ Limitations/ Exclusions” and “Standards” both contain key requirements for providers. Providers must comply with these standards and counties must be able to assure the Department that they do so. This does not apply to facilities licensed by the State (CBRFs, 3-4 Bed Adult Family Homes, Children’s Foster Homes and Children’s Treatment Foster Homes).

Suggested audit procedure(s)

Determine if the County or contract agency has assessed provider compliance with the provisions listed under “Service Requirements/ Limitations/ Exclusions” and “Standards” for the service covered. Counties must have some form of documentation showing that they have assessed provider compliance with standards.

B. Caregiver background checks

Compliance requirement(s)

Caregiver background checks are required for service providers, including relatives, whose services are funded by the Medicaid Waiver programs. Caregivers include “...those persons who will have regular, direct contact with clients.” Examples of such persons are:

- Supportive home care workers providing home care,
- Respite care providers,
- People who perform home chores inside the home under supportive home care,
- Adult family home providers

Examples of persons who are not considered to be caregivers include:

- People who provide outside chores including lawn mowing or snow removal
- Volunteers or other persons whose services are not funded by a Waiver program.

A caregiver background check must be performed at least once every four years and consists of three steps:

- A criminal history search from the records of the Wisconsin Department of Justice, and
- A search of the Caregiver Registry maintained by the Department of Health and Family Services, and
- A search for the status of credentials and licensing from the records of the Wisconsin Department of Regulation and Licensing, if applicable.

Counties must perform background checks for persons employed as caregivers by the county agency. Counties must also ensure that provider agencies perform background checks for people who are employed as caregivers. Waiver program funds cannot be used to employ any person who:

- Has a criminal conviction substantially related to the care and safety of agency clients.
- Is listed on the Caregiver Registry due to a finding of misconduct.
- Has been denied license, certification or registration or denied renewal of license, certification or registration due to a finding of misconduct.

For additional information, see Section 4.05 of the *BDDS Medicaid Waivers Manual* (<http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>).

Suggested audit procedure(s)

Determine if there is documentation that all people who meet the definition of caregiver have had background checks performed prior to their employment and every four years after that.

C. County administrative costs

Compliance Requirements

County administrative costs are defined by the county agency and are permitted in an amount up to seven percent (7%) of total waiver service costs in CIP 1A, CIP 1B and the CLTS Waivers. For CIP 1A and CIP 1B, counties may request and receive written approval from the department allowing them to claim up to ten percent (10%) of the total waiver service costs. For BIW, the amount which may be claimed for service coordination costs is ten (10%) per cent of allowable service costs. No waiver is required in BIW.

County administrative costs must be defined in writing by the county agency. The definition is subject to but does not require State approval. Generally, these are costs that cannot be easily attributable to a specific service but that represent the overall management of the system. Examples of costs that are generally included are the cost of operating HSRS, equipment costs for electronic information systems for claims processing or participant records, the cost of staff who operate HSRS, staff involved in a local quality management program, the agency director, etc.

These costs shall be reported using the method prescribed by DDSS. There must be written evidence that supports the claims for all service coordination costs. Where portions of staff time are being included, a time study or other method should be used to apportion such costs.

Suggested audit procedure(s)

Determine whether the county has a written description of its method for ensuring it reports no more than the allowed limit for service coordination costs.

Resources:

- Waiver Manual - <http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm>
- DDES Memo Series - http://dhfs.wisconsin.gov/dsl_info

- Forms – <http://dhfs.wisconsin.gov/forms/index.htm> - search by number
- HSRS Handbook - <http://www.dhfs.wisconsin.gov/hsrs/handbook>
- MA Community-based Services Updates; These informational communications have been used to substitute for a current, up to date manual. Copies are available from BDDS on request by calling (608) 266-0547.

For CIP 1A/B and BI Waivers:

Contact person: Anne Olson
Telephone: (608) 264-9870
E-mail: olsonac@dhfs.state.wi.us

For CLTS Waivers:

Contact person: Beth Wroblewski
Telephone: (608) 266-8427
Email: Wroblbm@dhfs.state.wi.us

LISTING OF COVERED SERVICES BY CIP 1A, CIP 1B, BI and CLTS WAIVERS

SERVICE CODE (SPC)	SERVICE NAME	CIP 1A/B & BIW	CLTS
112.57	Adaptive Aids-Vehicle Related	Yes	Yes
112.99	Adaptive Aids- Other	Yes	Yes
102	Adult Day Care	Yes	No
202.01	Adult Family Home- 1-2 bed	Yes	No
202.02	Adult Family Home 3-4 bed	Yes	No
203	Children's Foster Care/ Treatment Foster Care	Yes	(1)Yes
112.47	Communication Aids	Yes	Yes
506.61	Community Based Residential Facility	Yes	No
609.20	Consumer and Family Directed Supports	No	Yes
609.10	Consumer- Directed Supports	Yes	No
113	Consumer Education and Training	Yes	Yes
507.03	Counseling and Therapeutic Services	Yes	Yes
110	Daily Living Skills Training	Yes	Yes
706.10	Day Services-Adults	Yes	No
706.20	Day Services-Children	Yes	Yes
619	Financial Management Services	Yes	Yes
112.56	Home Modifications	Yes	Yes
402	Home-delivered meals	Yes	No
610	Housing counseling	Yes	No
106.03	Housing Start-up	Yes	No
512	Intensive In-home Autism Services	No	Yes

¹ There are separate definitions in the three children's LTS Waivers

LISTING OF COVERED SERVICES BY CIP 1A, CIP 1B, BI and CLTS WAIVERS

SERVICE CODE (SPC)	SERVICE NAME	CIP 1A/B & BIW	CLTS
710	Nursing Services	Yes	No
112.46	Personal Emergency Response System (PERS)	Yes	Yes
108	Pre-vocational Services	Yes	No
103.22	Respite Care: Residential	Yes	Yes
103.24	Institutional	(All)	(All)
103.26	Home-based		
103.99	Other		
112.55	Special Medical and Therapeutic Supplies	Yes	Yes
107.30	Specialized Transportation - 1 way trips-	Yes	Yes
107.40	Miles	Yes	Yes
604	Support and Service Coordination	Yes	Yes
615	Supported Employment	Yes	Yes
104.10	Supportive Home Care - Days	Yes	Yes
104.20	Hours	Yes	Yes