

Chapter VII: Records and Reports

7.01 General

Department representatives, as authorized by the department Secretary, shall have access to all records and reports pertinent to Community Options.

Each lead agency shall maintain records and submit reports prescribed by the department.

7.02 Fiscal Records

The lead agency shall retain all fiscal records per county ordinance in accordance with Wisconsin Statutes §19.21(5). At a minimum, financial records shall be retained for seven (7) years from the date of reconciliation. The lead agency shall specify persons who are responsible for maintaining financial records.

7.03 Case Records

A. Maintaining Records

The lead agency shall maintain individual case records for participants who receive assessments who receive assessments, care plans and/or services. The lead agency shall specify persons who are responsible for maintaining case records.

The lead agency shall retain all case records per county ordinance in accordance with Wisconsin Statutes §19.21(5). At a minimum, case records shall be retained for three (3) years from the date of case closure.

B. Confidentiality

Case records must be confidential and shall be protected from unauthorized examination in accordance with Administrative Rule HSS 92.

C. Content

At a minimum, each Community Options participant's case record shall include the following information and documentation, when applicable:

1. A copy of the person's application, if written;
2. A statement signed by the applicant or his/her guardian attesting that all assets available for the support of the applicant have been disclosed to the lead agency.

3. A statement signed by the applicant or his/her guardian attesting that the applicant meets the residency requirements for receipt of Community Options-funded services (see Section 4.04 C);
4. Identifying information, including Medical Assistance Number, if applicable;
5. A copy of release of information forms;
6. Documentation of receipt of/review of rights, including appeal and grievance procedures;
7. A copy of the Community Options assessment;
8. A copy of the completed Community Options Functional Screen or a Patient Plan of Care (PPOC) if services were initiated prior to June 30, 1993;
9. A copy of the participant's Cost-Sharing Worksheet;
10. A copy of the participant's current care plan as well as past care plans, including any information used in projecting the monthly cost of the participant's ongoing community services;
11. A copy of each provider service agreement;
12. Entries in case records, including care plan reviews;
13. A copy of any variance approval;
14. A copy of any appeals or grievances filed;
15. A copy of an Estate Recovery Program Disclosure Form for each participant age 55 or over.
16. A copy of any exception to the 25% limit on the use of funds for residents of CBRFs.

7.04 Reporting

A. General

Counties are required to report both programmatic and fiscal information to the department. Total expenditures reported are reconciled against individual county contracts. Final year end reconciliation of Community Options expenditures will be based on the information submitted on the Human Services Reporting System (HSRS) or equivalent system as approved by the department, and the Community Options supplemental reconciliation format.

B. Case Closure

If a participant no longer receives services other than extended care management provided directly by a county agency, the participant shall be reported as terminated on the HSRS Community Options Module (or other equivalent system approved by the department) no later than thirty (30) days from the date of termination of services.

If there is a short term (less than 30 days) interruption in services the case may be kept open. If there is a long-term (30 days or more) interruption in services the recipient's Community Options service episode must be temporarily closed. Such temporarily closed service episodes are considered ongoing cases for waiting list and planning purposes if they are closed using the temporary closure code. Temporarily closed cases are reopened on the same service module whenever services resume. If it becomes apparent that services will not resume, the case must be permanently closed.

Appropriate costs which unavoidably occur after the case is closed (for example unemployment compensation claims of supportive home care providers) remain billable to Community Options during the calendar year in which the case was closed. Counties may be reimbursed for costs which infrequently and unavoidably occur after the budget reconciliation of the calendar year in which the case was closed by submitting a request to BLTS which describes the amount of the bill, services covered, closing date and name of actual recipient, and requests that the amount be billed to Community Options at year end reconciliation of the current year's budget.

7.05 Billing

A. General

The lead agency bills for assessments, care plans and services for those recipients for which, based upon residency, it has responsibility (see Section 4.01). Billing is done by reporting assessments, care plans and service dollars on HSRS or equivalent reporting system as approved by the department. Lead agencies may subcontract for these services with other agencies, including other county lead agencies. When a lead agency provides services to a resident of another county, the lead agency in the responsible county shall bill Community Options activities on HSRS. The responsible county shall reimburse the providing agency.

The lead agency may also bill for administrative expenses as outlined below. Such claims are not billed on HSRS, but on the department's Community Options Supplemental Reporting Forms.

B. Assessments and Care Plans

Within the limits of state and federal funds allocated, counties are reimbursed for assessments and care plans completed according to rates established by the department (see Section 2.04 A). Assessments and care plans which are interrupted before completion may be reimbursed provided they are at least 50% completed and the assessment of the recipient's health status has been completed, or under other circumstances with written approval of the Bureau of Long Term Support.

No more than one assessment may be billed and reimbursed for any recipient unless a significant change in the recipient's condition or life circumstances has occurred; and:

1. The initial care plan did not result in services funded under either Community Options or a Medicaid community waiver; or,
2. The individual has previously received Community Options- or waiver-funded services, but is not currently receiving services funded under either.

Any reassessment or care planning activities for current recipients of Community Options- or waiver-funded services are billed and reimbursed as ongoing care management.

In accordance with Chapter HSS 73.05, a lead agency may be reimbursed for more than one care plan per participant in a 12 month period only if:

1. The initial care plan did not result in services funded either under Community Options or a Medicaid community waiver; or
2. A significant change to the participant's condition or life circumstances has occurred and a new assessment has been completed.

A lead agency may never be reimbursed for more than two care plans per participant in a 12 month period.

C. Services

Within the limit of state and federal funds allocated, counties are reimbursed for the actual cost of services provided in accordance with a recipient's care plan.

Care management is a service provided to Community Options participants. It is billed, along with other purchased or provided services, as a Community Options activity on HSRS. Care management may not be billed unless a recipient receives at least one other service which is being "managed." When care management is provided it must include assistance in managing all of the services, whether Community Options-funded or not, an individual receives.

D. Administrative Expenses

The lead agency may bill for administrative expenses in an amount up to seven percent (7%) of its total Community Options base service allocation (see Section 2.04 C). A variance may be granted by the department which allows a county to exceed its base administrative claim (see Section 5.12 B 4). In addition, under limited circumstances and with department approval, additional administrative expenses may be charged to carryover funds (see Section 2.04 K), high cost funds (see Section 2.04 D), or specially awarded project funds.

Administrative claims are reported on the department's Community Options Supplemental Reporting Forms rather than on HSRS. These forms are auxiliary to the reporting of assessments, care plans and services on HSRS.

E. Coordination With
Medicaid-Funded
Care Management

Lead agencies are strongly encouraged to bill care management services provided to non-waiver participants who are Medicaid-eligible to EDS in order to access the Medicaid care management benefit. This will allow lead agencies to receive the federal share of the Medicaid care management benefit rate. When billing EDS for care management provided to Community Options participants, lead agencies must earmark such billings as Community Options related whenever the care management is provided to an eligible Community Options participant and the care management hours of service billed to EDS are also billed to Community Options on HSRS at the county's care management rate. This ensures that the requisite match for federal funds is available and will augment the lead agency's Community Options budget by the amount of the EDS revenue when it is received. Alternatively, counties may choose not to earmark EDS billings as Community Options-related. However, if a county elects to submit EDS billings for Community Options-related care management which are not earmarked as Community Options-related, the Community Options budget cannot be billed for those activities. Furthermore, if a county chooses this option, the burden to document the existence of sufficient match for Medicaid care management funds falls on the county.

F. Coordination With
Medicaid
Community
Waivers

Community Options is intended to be used flexibly in coordination with Medicaid community waivers as needed.

1. Assessments and Care Plans.

Current needs assessment information is required as part of a service plan packet for participants in the Medicaid community waivers. To be "current" such information must have been obtained within three months of the start date for waiver-funded services. Community Options may pay for such assessment activities as follows:

- a. For waiver applicants who have not previously received Community Options- or waiver-funded services, an assessment and care plan may be billed to Community Options and reported on HSRS as a new Community Options assessment or care plan.

- b. For Medicaid community waiver applicants who are current Community Options participants reassessment or care plan reevaluation may not be reported on HSRS as a new assessment or care plan. Such activities after the waiver start date should generally be billed to the Medicaid community waiver as ongoing care management. (Alternatively, such activities may be billed to Community Options as ongoing care management. For example a county may decide to bill Community Options rather than the Medicaid community waiver because it is uncertain what the waiver effective date will be.)
- c. For former Community Options participants reevaluation of the existing assessment or plan is usually adequate. A new Community Options assessment or care plan may only be billed to Community Options if the county determines that the existing assessment or care plan contains little valid information pertaining to the participant's current situation. If the assessment or plan does contain a significant amount of valid information, the county must reopen the service period on the HSRS Community Options module and bill reevaluation activities to Community Options as ongoing care management.

2. Ongoing Services.

Since some services are not allowable costs in the Medicaid community waivers it is often necessary for recipients to receive services through both the Medicaid community waiver and Community Options. In such cases, if the recipient receives both Community Options- and waiver-funded services, the case should be opened and reported on both the Community Options and Medicaid community waiver modules in HSRS. If the recipient is not currently receiving Community Options services, but is expected to require Community Options services infrequently to supplement Medicaid community waiver services (for example during short term hospital stays), the Community Options service period should be closed until such time as Community Options-funded services are needed. The Community Options service period may be closed and reopened as often as necessary whenever Community Options-funded services are needed.

7.06 Donations

Donated funds are treated as program revenue which must be expended within the Community Options Program.

Any efforts to compel recipients to make payments beyond their cost-sharing obligation are prohibited under the Community Options Uniform Eligibility and Cost-Sharing Plan.