

SECTION 6300

OFFICE OF MENTAL HEALTH AND MENTAL RETARDATION

SECTION 6301 - GENERAL INFORMATION

.01 The mission of the Philadelphia Office of Mental Health and Mental Retardation (OMH/MR) encompasses five sets of diverse activities intended to ensure that Philadelphia residents who experience mental retardation and/or acute and extended mental illness will receive the services, support and opportunities they need. The five sets of diverse activities include:

- Strengthening the capacity of providers of services to respond to individual needs and the needs of unique groups.
- Strengthening the capacity of consumers of services as well as their families and communities to acquire needed services and arrange for more mature networks of support.
- Restructuring the governmental and private sector relationships between the OMH/MR-sponsored service system, State service system, private system and the consumers of services who are the priority populations for Philadelphia OMH/MR.
- Creating long-term relationships with institutions of higher education which increase the potential that those who require in-service training and pre-service education will have educational opportunities that 1) encourage employment in those services affecting the OMH/MR priority consumers and 2) offer training and education consistent with the orientation and treatment outcomes sought by the OMH/MR.
- Fostering the integration and community acceptance of persons experiencing mental retardation or mental illness for the improvement of delivery systems and for the benefit of the individuals those systems serve.

SECTION 6310 - PROGRAM DESCRIPTIONS AND OPERATIONS

.01 The above noted OMH/MR operations are funded to potential providers via a contract award. The Commonwealth of Pennsylvania, Department of Public Welfare (DPW) regulations provide for the general use of two basic methods of funding, although other methods may be used with the prior written approval of the Secretary of DPW. The two basic methods are:

- Program Funding: Also referred to as deficit financing, program funding is the most common method employed by the OMH/MR to fund its Provider Agencies. This method allows the OMH/MR to fund a Provider Agency's actual eligible expenditures for a Provider Agency's service(s), offsetting these expenses by

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anticipated revenues to be received directly by the provider, and establishing the remaining deficit as its authorized level of funding (allocation).

- **Unit of Service Funding:** Also referred to as fee-for-service funding, this method is based upon establishing a set fee or rate of reimbursement for each authorized unit of service rendered by a Provider Agency to eligible clients. The fee or rate may be set through negotiation with the OMH/MR or may be established by DPW or a designated third party such as Community Behavioral Health (CBH).

.02 In addition, the Philadelphia OMH/MR currently funds mentally retarded residents in State licensed private facilities throughout the Commonwealth of Pennsylvania. Interim Care was developed for mentally retarded clients who met stringent criteria for institutional care but for whom no institutional placement was available. Clients placed in Interim Care are considered to be in need of 24-hour a day care and for the most part are expected to require this care for the rest of their lives. Today the life management plans for all Interim Care clients state that progression to the least restrictive service environment is a primary goal. Plans have been underway and will continue throughout this period to place Interim Care clients in Family Living, Teaching Family and/or other Community Living Arrangements.

SECTION 6320 - FEDERAL CFDA NUMBERS/OTHER REGULATIONS

.01 The following Federal CFDA numbers are applicable to the Mental Health and Mental Retardation Programs:

Mental Health

<u>Reference</u>	<u>CFDA Number</u>	<u>Formal Reference</u>
MH SSBG	93.667	Social Services Block Grant
MH Access	93.125	Homeless Access to Community Care/SVC/Support
MH CMHBG	93.958	Community Mental Health Block Grant
MH PATH HMLESS	93.150	Mental Health Services for the Homeless
MH CASSP	84.027	Federal Child and Adolescent Service System Program
(PHMC) Homeless Assistance	93.151	Project Grants for Health Services to the Homeless
CMHI-Federal	93.104	Child Mental Health Initiative
HIV AIDS-Federal	93.216	HIV/Aids - Mental Health Services

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Mental Retardation

MR Federal SSBG	93.667	Social Services Block Grant
Fed WVER Maint.	93.778	Medical Assistance (Title XIX)
TSM Administrative Reimburs.	93.778	Admin. Chargeable to Targeted Services Management
Early Intervention SSBG	93.667	EI-Social Services Block Grant
Early Intervention	84.181	Infants and Toddlers w/Disabilities

.02 In addition to the above the auditor should be familiar with the following documents:

- Commonwealth of Pennsylvania, Department of Public Welfare – Single Audit Bulletin (February 1998)
- Guide to County Service Provider Audit Management, issued by the Commonwealth of Pennsylvania, Department of Public Welfare. (April 1992)
- Commonwealth of Pennsylvania - Pennsylvania Code - Title 55, Public Welfare -- DPW's 4300 Regulations, "County MH/MR Fiscal Manual."
- OMH/MR Manual, issued July 1987 by the City of Philadelphia, Department of Public Health, Office of Mental Health and Mental Retardation.
- OMH/MR Annual Expenditures Reporting Instructions Supplement and Annual Allocation Notice and Budget Instructions
- Pennsylvania Code, Title 55, Chapter 5221, Mental Health Bulletin Numbers 00-89-08, 5220-89-01 and 5220-89-02

SECTION 6330 - PROGRAM COMPLIANCE PROCEDURES

.01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Schedule of Findings and Questioned Costs.

.02 The program compliance procedures for MH/MR are provided on the following pages:

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Mental Health Programs

Client Liability: (1)

.03 Based on the 4305 Client Liability Regulations, the County Program or designate shall determine the financial liability for clients receiving community mental health or mental retardation services funded in whole or in part by the County MH/MR Program that is not listed as an exempt service as described in subsection 4305.11 (Exempt Services). As indicated in subsection 4305.40 (Redeterminations), client liabilities should be done on each client at least every 12 months. In addition, Agencies should be assisting clients who are eligible in applying for Supplemental Security Income (S.S.I.), Supplemental Security Disability Income (S.S.D.I.), and Medical Assistance (M.A.).

.04 The audit procedures should include a check for evidence that client liabilities are being done every 12 months. Dated and signed copies of client liability forms should be found in the client record. In addition, check for evidence that, where eligible, clients are applying for S.S.I., S.S.D.I., and M.A. (*A sample copy of liability form is enclosed as Exhibit 1.*)

Agency Fee Schedule:

.05 Based on subsections 4305.101 through 4305.103 of the 4305 Liability Regulations, Provider Agencies must develop fee schedules based on the actual cost of delivering services.

.06 The audit procedures should include a check for evidence that the Agency's fee schedule is actually based on the cost of providing services.

Inpatient Letters of Agreement:

.07 Because of their cash flow problems and because the inpatient advance has not been clearly identified to the CMHC's, the centers have often not reimbursed inpatient providers in a timely manner. Conversely, inpatient bills have not always been submitted by providers to the centers in a timely manner. The effect has been a reluctance of the inpatient providers to accept County funded patients with a resultant back-up of clients in the Psychiatric Emergency Services.

.08 In order to solve the problem, the County (OMH/MR) has required the CMHC's to establish letters of agreement with their primary inpatient providers based on utilization. These agreements must contain the following:

- a. An estimated inpatient "budget" for the Provider for the current fiscal year. The budget may be based on a two-year history or any mutually acceptable basis;
- b. A statement that appropriate regulations and policies will be adhered to by both parties;
- c. A deadline for billing;

(1) A "DPW Community MH/MR Program Client Liability Training Manual" is available for reference, if needed, from OMH/MR.

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- d. A close out date for final bills not to occur later than 18 weeks after the close of the fiscal year;
- e. An agreement to follow an advance payment and final reconciliation process with dates for billings and payments; and
- f. An agreement on the type of accounting records to be maintained by the Inpatient Provider.

Agency Client Service Recordkeeping:

.09 As mandated in the State's 5200 Regulations, each Agency must maintain files for each client it serves. As the source of client data for the County, each Agency must maintain the minimum information necessary for identifying each client, the service the client is receiving, the length of service, referral or transfer data and discharge information. Base Service Units must also maintain information related to involuntary and voluntary inpatient commitment.

.10 The client records within a given Agency should have a consistent format, but each particular form may be individualized to suit the needs of the Agency. Each record should contain at minimum:

- Admission summaries
- History forms:
 - (1) Medical (including lab tests)
 - (2) Psychiatric
 - (3) Social
- Treatment Plan (dated and signed by a psychiatrist)
- Progress notes (dated)
- Liability determination (dated)
- Discharge summaries

.11 The audit procedures should include a check that client record contains the material described above so that a client's admission, prior treatment, treatment, financial, and disposition status can be checked against information provided to OMH/MR through the automated data system. (Please note that this is merely a check for the presence of the required material in the record and does not require a judgment as to the content of the material.)

Community Residential Rehabilitation (CRR) Program:

.12 The CRR Program provides structured, therapeutic residential services to the chronically mentally ill. This program addresses several basic goal areas: increasing independent living skills, stabilization following hospitalization, prevention of hospitalization and homelessness. A therapeutic milieu encourages peer input and control in setting and enforcing behavioral norms, expectations and privileges.

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.13 Productive daytime activity (partial hospitalization, social or vocational rehabilitation services, school, part-time employment, etc.) is an expectation for those participating in the CRR Program. Individual service plans must coordinate residential treatment with day treatment services in order to further progress toward meeting rehabilitation goals and to provide added support during time of crisis.

.14 As part of the placement process, clients are required to abide by the rules of CRRs and to sign a Service Agreement which sets forth the responsibilities of the Provider Agency and the client during the client's stay at the CRR. The agreement must be in conformance with Section 8605.4 of the Mental Health Community Residential Rehabilitation Services (CRRS) 8600 Regulations which require the following:

- a. The agreement is negotiated during the intake process;
- b. It is signed by both parties (Provider and client);
- c. It specifies the arrangements and charges for housing and food;
- d. It specifies the goals to be achieved and services to be provided;
- e. It specifies the rights and responsibilities of the client;
- f. It includes a copy of the CRR's "house rules", client rights, client Grievance Procedures, and termination policy;
- g. It specifies any liability for the cost of service other than room and board; and
- h. It is updated and signed again whenever any of the terms change.

.15 The audit procedures should include a check that a written Service Agreement exists between the client in a CRR and the CRR Provider and check that the Provider is using a standard and uniform agreement which contains the above items for all clients.

Mental Health Intensive Case Management

.16 Intensive Case Management (ICM) was established as a primary direct service to both adults with serious and persistent mental illness and children and adolescents with or at risk of serious mental illness. It is designed to ensure access to community agencies, services, and persons whose functions are to provide the support, training, and assistance required for a stable, safe, and healthy community life. Services are offered within the parameters imposed by funding and other resources. The families of children and adolescents are also eligible for ICM Services as they relate to the treatment plan of the child. ICM Services are services which will assist eligible persons in gaining access to needed resources such as medical, social, educational, and other services.

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.17 ICM Program Services requirements stipulate that:

- ICM Services are currently available to persons admitted to a healthcare facility. However, Medical Assistance (MA) cannot be billed for Case Management Services or for ICM Services provided to persons in a jail.
- Needed services to persons in ineligible environments are expected to be provided using State funds.
- ICM services are to be provided in accordance with a written client specific service plan.

.18 The auditing procedures for determining compliance with program services would require the auditor to ascertain whether procedures are in place to ensure that Providers of service have complied with these requirements and evaluate/assess the Provider's implementation of the procedures

include: adults, 18 years of age or older, who have a serious and persistent mental illness; and children and adolescents with, or at risk of, serious mental illness. Two of three specific criteria must be met for a person to be considered eligible; however, a waiver of this requirement may be granted by the County Administrator. The families of children and adolescents are also eligible for ICM services as they relate to the treatment of the child (Section 5221.12, Chapter 5221 Regulations).

.19 The auditor for determining compliance to program eligibility should:

- Review the Provider's established procedures for determining eligibility and evaluate for adequacy.
- Test selected program records and verify that eligibility was determined.
- If the sample contains persons for whom a waiver of eligibility has been granted, verify that adequate documentation of that waiver is maintained in the case file.

.20 The ICM programs require matching reporting on operations. This requires that an authorized representative must certify that State matching funds are available for Medicaid eligible costs. A State Match Verification Form which corresponds directly to the invoice (i.e. line for line) must be completed for each invoice submitted to the Department for processing through the MAMIS System and must be maintained within the Provider Agency for a minimum of four years.

.21 The auditor should determine that the above matching requirement is met by a review of procedures the Organization has in place in completing the form, and that the completed form is properly filed.

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Family Based Mental Health Service Program

.22 The Family Based Mental Health Service Program (FBMHS) was established as a primary team to deliver services to families with at least one child with mental illness who is at risk of placement outside of the home. It provides mental health treatment to families so that they may continue to care for their children with serious mental illness or emotional disturbance at home. Services are offered within the parameters imposed by funding and other resources. This Program reduces psychiatric hospitalization by enabling families to maintain their role as primary care givers for their children.

.23 Family Based Services requirements stipulate that:

- At least one child with mental health diagnosis is with an adult care giver willing to receive services within their home. The child must be at risk of psychiatric hospitalization or out-of-home placement.
- Providers of service must be licensed by the Office of Mental Health, included in the County MH/MR annual plan and enrolled with the Office of Medical Assistance.
- Treatment plans must be formulated within five days of initial service, and authorized by the County Administrator or designee within 30 days of the first date of service.
- Services which involve more than one child care system must develop a jointly written plan which documents service responsibilities of each system and be included in the treatment plan within the first 30 days of service.
- All staff must have Act 33/80 clearance before providing services. Documentation of clearance and maintenance of record keeping requirements set forth in PA Code Chapter 1101 (Medical Assistance General Provisions), must be on file at contract provider offices.

.24 The auditing procedures for determining compliance with program services would require the auditor to ascertain whether procedures are in place to ensure that Providers of service have complied with the requirements stipulated above and to evaluate/assess the Provider's implementation of the required procedures.

.25 Eligibility for Family Based Services is determined by the administering Agency. Eligibility for MA is determined by the County Assistance Office (CAO). Children and adolescents and their families are eligible for service if the child or adolescent is 18 years of age or younger and has a mental illness or emotional disturbance and is determined to be at risk for out of home placement. The determination to recommend treatment can be made by a physician, licensed psychologist or child service agency. The recommendation must occur prior to initiation of services and be documented. The specific criteria must be met for a family to be considered eligible as they relate to the treatment of the child (Section 5260.91, Chapter 5260 Regulations). A waiver of the requirement may be granted by the County Administrator.

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.26 The auditor determining compliance to the program eligibility should:

- Review the Provider's established procedures for determining eligibility and evaluate for adequacy.
- Test selected program records and determine that eligibility was performed in accordance with the regulations specified above.
- If the sample contains persons for whom a waiver of eligibility has been granted, determine that adequate documentation of that waiver is maintained in the case file.

.27 Family Based Services required matching reporting on operations. This requires that an authorized representative must certify that State matching funds are available for Medicaid eligible costs. A State Match Verification Form which corresponds directly to the invoice (i.e., line for line) must be completed for each invoice submitted to the Department for processing through the Medical Assistance Management Information System (MAMIS) System and must be maintained within the Provider Agency for a minimum of four years.

.28 The auditor should determine that the above matching requirements are met by a review of procedures the Organization has in place for completing the form, and that the completed form is properly filed.

Cost Settlement Policy and Procedures for Community Based Medicaid Initiatives

.29 As indicated in the Mental Health Bulletin No. OHM-94-06 (Exhibit 16), the following programs are subject to cost settlement:

<u>Program</u>	<u>Corresponding PAC Codes:</u>
MH Intensive Case Management	7703, 8703, 6706
MH Family Based Services	7733
MH Resource Coordination	2708, 8708
MR Targeted Services Management	2771
MH Crisis Intervention (Res)	8416

The Cost Settlement Report (CSR) as implemented in this bulletin serves as the vehicle to capture the interim reconciliation to actual costs for community based Medicaid initiatives. This calculation is based upon unaudited expenditures and accrued Medicaid revenues for each service activity. CSR's must be completed by all independent contractors for each service activity within each fiscal reporting period. The CSR is designed to compare overall expenditures eligible for DPW State/Federal participation to combined DPW State/Medicaid accrued revenues. Please be advised that Targeted Services Management reflects a total case management function and agencies should include the non-MA eligible components for cost settlement.

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.30 The City of Philadelphia OMH/MR is requiring providers of the above programs to include a CSR for each distinct program funded by OMH/MR as part of the Supplemental Financial Schedules included as part of their year end audit. **Based upon this requirement the auditor is to perform sufficient auditing procedures on the Cost Settlement Report (CSR) in order to express an opinion on the CSR as part of the overall audit.**

Mental Retardation Programs

Community Living Arrangement (CLA) Base Program:

.31 This program serves individuals with mental retardation who require supervision, training and a variety of services to enable them to live in the least restrictive setting in the community. Services include room and board, habilitation training, recreation and access to medical and specialized therapies (i.e. physical, occupational and speech therapy) on an as needed basis.

.32 The audit procedures should include a check, on a test basis, that:

1. Signed Room and Board Agreement is utilized. The State residential regulations (PA DPW Title 55 Chapter 6200) require that an agreement, outlining room and board charges, be executed, in writing, between the client and the Residential Provider. *(The items to be included in a Room and Board Agreement are included in the sample enclosed and labeled as Exhibit 2.)* The agreement must include these items; however, the Agency may develop its own form.

The charge for room and board is 72% of the maximum SSI level exclusive of liability. The maximum SSI level usually changes annually, on a calendar year basis.

2. Evidence of client insurance (i.e. Medical Assistance Card, Blue Cross Policy, HMO Policy). (The majority of CLA clients have Medical Assistance coverage and those who have excess resources which preclude Medical Assistance should have private carrier coverage.)

Waiver Community Living Arrangement Program:

.33 This program serves individuals with mental retardation who require supervision, training and a variety of services to enable them to live in the least restrictive setting in the community. Services include room and board, habilitation training, recreation and access to medical and specialized therapies (i.e. physical, occupational and speech therapy) on an as needed basis.

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.34 The audit procedures should include a check, on a test basis, that:

1. Signed Room and Board Agreement is utilized. The State residential regulations require that an agreement outlining room and board charges be executed in writing between the client and the residential provider. *(The items to be included in a Room and Board Agreement are included in the sample enclosed and labeled as Exhibit 3.)* The agreement must include these items; however, the Agency may develop its own form.) The maximum charge is seventy-two percent (72%) of the maximum SSI level.
2. Evidence of client insurance (i.e. Medical Assistance Access Card, Blue Cross Policy, HMO Policy). (The majority of CLA clients have Medical Assistance coverage and those who have excess resources which preclude Medical Assistance should have private carrier coverage.)
3. A current (dated within the last 365 days) PA 162. A PA 162 demonstrates eligibility for waiver funding and indicates if there is a client liability. *(See Exhibit 3 for sample PA 162.)* This does not apply to clients receiving S.S.I. Those clients are only required to have a PA 162 documenting initial eligibility.

Adult Day Care (ADC) Program:

.35 Day Care Services for adults provide a program of activities within a protective non-residential setting. Specific activities and services include but are not limited to: assisting in performing the basic tasks of everyday living, providing a planned program of social, recreational, and developmental activities; referring to and advocating for specialized health, therapeutic, rehabilitation of social services; providing for a nutritious meal and snack program; working with transportation arrangements.

.36 The audit procedures should include a test for:

1. Evidence of current license. Each ADC Center is licensed by the Commonwealth of Pennsylvania. A copy of the license must be maintained at the site to meet State regulations.
2. A spot check to insure that clients have current program plans (within the last 365 days). The State ADC Regulations require that each client have an individual day program plan which was completed within the last 365 days. The Plan outlines clients' goals and general activities for the client during that period. These plans must be maintained at the ADC site.
3. A check to insure that emergency procedures are prominently posted. Current State regulations require that emergency procedures (i.e. evacuation in the event of fire or medical emergency) be prominently posted at the program site.

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Vocational Day Program:

.37 This day program for adults provides activities and services that include: vocational evaluation, a systematic assessment of a client's service needs and their potential for employment and the identification of employment objectives, personal work adjustment training, training that emphasizes the development of skills in interpersonal relationships, appropriate attitude toward work, good work habits and other behavior necessary for higher vocational placement; work activity training, a service that provides that handicapped person with an opportunity to work and attain sufficient vocational, personal, social, and independent living skills to progress to a higher level vocational placement; and employment training, a service that provides training and employment to individuals who are not readily absorbed into the regular labor force due to their limitations. All these services are provided in a sheltered setting.

.38 The audit procedures should include a test for:

1. Evidence of current license. Each Adult Day Care (ADC) Center is licensed by the Commonwealth of Pennsylvania. A copy of the license must be maintained at the site to meet State regulations.
2. A spot check to insure that clients have current program plans (within the last 365 days). The State ADC Regulations require that each client have an individual day program plan which was completed within the last 365 days. The Plan outlines clients goals and general activities for the client during that period. These plans must be maintained at the ADC site.
3. A check to insure that emergency procedures are prominently posted. Current State regulations require that emergency procedures (i.e. evacuation in the event of fire or medical emergency) be prominently posted at the program site.
4. Evidence that a client handbook exists and has been distributed to clients and staff. State Regulations require that each Vocational Program develop and distribute to participants a client handbook which outlines the program and general requirements of the program. A copy of the handbook must be maintained at the site.
5. A record of client earnings "year-to-date" should be maintained at the program.

Transition to Work Program:

.39 This is a program that provides services to recent mentally retarded high school graduates to help them make the transition from school to the working world and community life. This program assists the student in developing functional skills and provides work training in real jobs.

.40 At this time, there are no specific programmatic audit requirements.

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Competitive Employment:

.41 This is service that involves the placement of an individual into real work for real pay. The individual being placed is job ready and motivated to work. Limited follow-up services are necessary to ensure job retention. The individual is employed by a company or industry rather than by the rehabilitation facility and the client is usually limited to the initial job training and short-term follow up services.

.42 At this time, there are no specific programmatic audit requirements.

Supported Employment:

.43 Supported Employment is a new approach to providing vocational services which combines placement of severely handicapped persons in competitive jobs, with training on the job and long-term support services. Characteristics of Supported Employment are: real work in a real work place, training on the job site, substantial pay (minimum wage or higher), long-term support services, job placement which is physically and socially integrated within the business/industry, services which are coordinated and specific to the client's needs and disabilities and significant consumer and/or advocate involvement in the development of the Supported Employment program.

.44 At this time, there are no specific programmatic audit requirements.

Early Intervention Program (EIP):

.45 This program makes available one or more of the sixteen authorized services as defined in MR Bulletin #00-92-09, entitled "Early Intervention Services for Infants and Toddlers", to an eligible child. An eligible child is a child who is experiencing a 25% delay in one or more developmental areas and whose age is between the date of birth through the second year. Early Intervention (EI) services are currently funded by the Department of Public Welfare (DPW) for children under three years of age through the Philadelphia Office of Mental Health and Mental Retardation (OMH/MR). Eligibility for Early Intervention Services is determined in accordance with MR Bulletin #4225-91-05, entitled Screening, Evaluation, and Eligibility for Infants and Toddlers.

.46 Services are provided in the home, a community setting or in a center. The center may be operated by a specialized Early Intervention provider or by an agency in the community such as a hospital or day care center. Services in a community center are provided by staff of an early intervention provider agency. These services are designed to meet the developmental needs of each eligible child and the needs of the family as they relate to enhancing the child's development. Service needs shall be determined by a team of individuals, including the parents and members of the discipline(s) most appropriate to the child's developmental needs; these services must be documented in a plan of care document known as an Individual Family Service Plan (IFSP).

.47 In order to determine eligibility for EIP Services, a child's file should contain a Child Health Appraisal form (or a similar type Health Appraisal Form) which must be signed by a physician. A sample form is provided as Exhibit 10. The auditor should perform sample testing to determine whether the form was completed and signed by a physician.

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.48 In addition to the general audit requirements which pertain to all services funded by OMH/MR, compliance testing for Early Intervention Services must include testing to determine that services are appropriately reported, since services are reimbursed on a fee-for-service basis. Compliance testing must also be included to determine that costs associated with specific early intervention service recipients are assigned to the appropriate funding sources. Service costs which are reimbursed by the OMH/MR must be restricted to recipients who reside in Philadelphia County and who are under three years of age. Service costs associated with recipients residing in counties other than Philadelphia must be charged to the respective county of residence. Service costs of children three or older, regardless of their county of residence, are reimbursed by the Pennsylvania Department of Education through a contract with the School District of Philadelphia.

.49 DPW implemented a unit of service funding model of reimbursement in FY '98. Published rate ceilings established on the DPW fee schedule will apply to all EIP service activities including those reimbursed by the OMH/MR. All services covered on the fee schedule will be reimbursed on a fee for service basis only. The OMH/MR will not assume liability for provider service costs in excess of the ceilings nor for costs associated with non-direct service billable activities which exceed the levels negotiated in the approved budget.

An Early Intervention Cost Reconciliation Report will be submitted with the final invoice which will disclose the financial ramifications of providing various service activities within an Early Intervention program activity (PAC) by comparing actual costs to reimbursement from anticipated fees. **The auditor must include an audited copy of this report in the financial statements. Based upon this requirement the auditor is to perform sufficient auditing procedures on the Cost Settlement Report in order to express an opinion on it as part of the overall audit.**

Compliance Testing

- Determine that the provider agency has an internal control structure system which properly:
 - a. Accumulates and documents the early intervention service data reported to OMH/MR's RIM unit each month.
 - b. Distributes costs and applicable revenues among the various funding sources which reimburse services associates with specific populations. Service costs must be distributed in direct relation to services delivered to respective populations and the system employed must take in to account that the funding source of a specific recipient may change during the course of the fiscal year as a result of aging out (turning three years of age) of OMH/MR's service population. In programs where mixed populations are served, numbers of children enrolled cannot be used in place of actual services delivered to distribute costs among funding sources since the level of services received may vary significantly among children served.

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- On a test basis, determine that documentation exists which supports the eligibility of early intervention individuals served.
- On a test basis, determine that the services reported to OMH/MR's RIM unit (as discussed in item a. above) are supported by attendance records or other appropriate supporting documentation.

ICF/MR:

.50 A community based facility that provides a variety of services to mentally retarded individuals including residential care, day services, transportation, specialized therapies and case management services.

Program is financed with State and Federal funds, with the Federal share of the cost of the program ranging from 50% to 80%. It is administered by the State within broad Federal guidelines.

.51 At this time, there are no specific programmatic audit requirements.

SECTION 6340 - FINANCIAL COMPLIANCE PROCEDURES

.01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Independent Auditor's Report(s) on Specific Compliance Applicable to Major or Non-major Federal, State and City Financial Assistance, as appropriate.

.02 The financial compliance procedures for MH/MR are provided on the following pages based upon the following types of categories:

- a. Mental Health and Mental Retardation Programs (Section 6340.03 to 6340.33).
- b. Interim Care Facilities (Section 6340.34 and 6340.35).
- c. Client Funds (Section 6340.36 to 6340.40).

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Mental Health and Mental Retardation Programs

OMH/MR Manual:

.03 The Philadelphia Office of Mental Health and Mental Retardation (OMH/MR) Manual, called the "OMH/MR Manual", issued July 1987, serves the purpose of promulgating official policies and procedures governing requirements for Providers of Services contracting with OMH/MR. The OMH/MR Manual is intended to become a comprehensive single source of directives, references, and information to be observed and maintained by all contractors.

.04 As an official OMH/MR body of directives, the Manual is generally referenced in every contract executed with OMH/MR under Administration and Program Compliance, and it is binding on all contractors, as applicable. The Manual is divided into three parts:

- Part I - General
- Part II - Mental Health
- Part III - Mental Retardation

.05 The Pennsylvania Department of Public Welfare (DPW) has adopted 55 PA. Code CH.4300 (4300 Regulations) which specify requirements for the general fiscal management of County mental health and mental retardation programs and the reimbursement of costs by DPW. These regulations are incorporated by reference in this Manual in order that OMH/MR and its contracted Providers of services will be in compliance with these regulations in administering and providing mental health and mental retardation services which are funded by DPW. The manual also includes policies and procedures which cover situations which are unique to the Philadelphia MH/MR Program, areas which are not covered by DPW Regulations, or areas where DPW regulations require administrative interpretation.

.06 First issuance of the OMH/MR Manual was distributed to Contract Agencies during the week of August 10-14, 1987. One objective during initial development of Manual sections was to incorporate those previously issued OMH/MR numbered memos which contained Policies and Procedures which were still current or needed some revision to become current. That objective has been achieved in large measure, but the Manual is not completed yet. Additional policy information needs to be developed. Therefore, fiscal year 1987-88 is considered a transition period between the former numbered memo system and the new Manual system. The Manual contains official OMH/MR Policies and Procedures as of July 1, 1987. The numbered memo system was retired effective June 30, 1987. During this transition and implementation phase, it may occur that some past policies and procedures may not have been incorporated into the Manual at a given time. If a question arises regarding a past policy or procedure which is not addressed in the Manual, Agency Directors are advised to seek clarification from the appropriate OMH/MR Senior Staff person: the MH or MR Program Administrator, the Deputy Administrator, or the Fiscal Administrator. Feedback and discussion of such apparent omissions is useful and necessary to make the Manual most effective. However, it is generally assumed that if a policy is not identified in the Manual, it does not exist.

SECTION 6340 (CONT.)

.07 The entire OMH/MR Manual is incorporated into all contracts as applicable, by reference as administration and program compliance requirements. Compliance with Manual directives will be considered in monitoring and evaluating contractors.

.08 All new Manual sections and revisions will be issued under a cover "OMH/MR MEMORANDUM" (See Section 1.07 "Forms"). These cover memos will be identified by Fiscal Year and sequential numbering, as issued. For example: OMH/MR Memorandum #87-1, 87-2, etc. In order not to miss any Manual issues, Providers should make sure that numbered cover memos received are in sequence without omissions. It is advisable to retain these cover memos for a period to insure that complete Manual updates are received.

.09 Providers are responsible to determine internal distribution needs, to take timely action to share Manual information with appropriate staff, to orient staff to policies and procedures, to implement necessary activities, and to monitor and evaluate on-going compliance.

.10 Audit procedures should include the following:

- By inquiry, has the OMH/MR Manual been read by appropriate Agency officials and placed into use.
- Have appropriate individuals at the Agency obtained copies of the Manual for use in program operations.

Recordkeeping, Accounting and Cost Requirements/Standards:

.11 OMH/MR has established certain minimum standards regarding recordkeeping, accounting and cost requirements/standards. The OMH/MR allowable cost standards to a great extent are the same as the DPW allowable cost standards promulgated under the Title 4300 Regulations, the OMH/MR standards impose additional restrictions on the use of funding and/or in a few instances, represent more restrictive modifications of DPW standards.

.12 The auditor should determine Agency compliance with the following provisions and report any deficiencies in the accountants' report on internal accounting control. (The reference at the conclusion of each requirement is a reference to the OMH/MR Manual.)

- Regardless of level and type of fiscal reporting required by the OMH/MR, agency records must be maintained in accordance with the Account Structure Manual. This account structure, as described in the State Mental Health and Mental Retardation Regulations, is a uniform classification for the recording of expenditures incurred and revenues received in the delivery of contracted program services. All Agencies are required to maintain records by this structure unless the County Administrator grants a waiver of these requirements. Additionally, Agencies must maintain records at the site level for all residential programs which serve mixed populations that are categorically funded. It is recommended that records for all MR Vocational or Adult Day Care programs also be maintained at the site level since categorically funded clients may be

SECTION 6340 (CONT.)

placed in such programs. These records must be maintained so that the information will be available upon request by the OMH/MR or for inspection by Federal, State or local authorities. (6.07.02)

- All program Providers will maintain and report fiscal data on the modified basis of accrual accounting. (4300.146)

Revenues:

.13 The costs of providing services to Philadelphia clients who are mentally ill or mentally retarded are reimbursed from a variety of sources and through several payment mechanisms. Some funds are received directly by the Organization that provides the direct service to the client. Other funds are allotted to the OMH/MR to provide services directly, to distribute among Provider Organizations, and to cover the administrative costs of the OMH/MR, the Department of Public Health, and the City in overseeing these services and Providers.

.14 The Department of Public Health utilizes two basic methods of funding program activities. The two basic methods are:

- Program Funding:

Program funding is the most common method employed by the OMH/MR to fund its Provider Agencies. This method allows the OMH/MR to fund a Provider Agency's actual eligible expenditures for a Provider Agency's service(s), offsetting these expenses by anticipated revenues to be received directly by the Provider, and establishing the remaining deficit as its authorized level of funding (allocation). Reimbursement is effected on a "last-dollar-in" basis and is based upon actual eligible expenses incurred less actual revenue generated.

- Unit of Service Funding:

This method, also referred to as fee-for-service funding is based upon establishing a set fee or rate of reimbursement for each authorized unit of service rendered by a Provider Agency to eligible clients. The fee or rate may be set through negotiation with the OMH/MR or may be established by DPW or a designated third party such as Blue Cross. DPW requirements and/or restrictions related to unit of service funding are set forth in Sections 4300.111 through 4300.118 of the Title 4300 Fiscal Regulations.

.15 The Agency is able to provide program services by utilizing funds received from the following sources:

- First Party Revenue:
 - Program Service Fees: Payments made by the client or a legally responsible relative for services rendered. These payments are commonly referred to as client liability and the amount of such liability (if any) is determined in accordance with 55 PA. Code CH 4305.

SECTION 6340 (CONT.)

- Third Party Revenue:
 - Medicaid: Payments made for the delivery of psychiatric (medical) services to clients certified as categorically or medically needy under the Title XIX - Medical Assistance Program. Payments are in accordance with pre-determined rates and are for only those medical services specified in the Pennsylvania Annual Medicaid Plan. These payments may be from the Pennsylvania Department of Public Welfare, or Community Behavioral Health (CBH).
 - Private Insurance: Payments made on behalf of clients for services eligible for health care coverage such as Blue Cross/Shield; HMO's; private insurance carriers; union benefits, etc.
- Other Revenue:
 - Room and Board Charges: Payments made by or on behalf of clients for the provision of room and board within residential programs funded by the OMH/MR. Charges are assessed in accordance with 55 PA. Code CH. 6200.
 - Other Income: Other income sources would include interest earned on revenue and/or advance payments received from OMH/MR; service or production contract revenue; contributions; gifts and bequests; other miscellaneous income.
- OMH/MR Funding:
 - OMH/MR Allocation: Payments are made to the Provider based upon the program funding and units of service contracts previously described.

.16 When examining Agency revenues the auditor is to consider the following items which are the revenue requirements of Title 55, Department of Public Welfare Section 4300.158.

- Allocations from the Department are to defray part of the cost of county programs authorized by the act and approved by the Department. Income for the amounts paid for the same purpose from a public or private source directly to participating counties, facilities or individuals shall be deducted from approved expenditures to determine the amount eligible for Departmental participation.
- The Department will not participate in costs for a mentally disabled person until the person, who has been admitted or committed, or is receiving services or benefits under the act, has exhausted his eligibility and receipt of benefits under other private, public, local, Commonwealth or Federal programs.
- Unrestricted donations and gifts shall be considered as income to reduce gross eligible expenditures in arriving at expenditures eligible for Departmental participation.

SECTION 6340 (CONT.)

- Donations and gifts may be used for paying expenses which are eligible or ineligible for Departmental participation if given or restricted by the donor for that purpose.
- Donations and gifts from fund-raising organizations may be used for paying expenses which are eligible or ineligible for Departmental participation if given or restricted by the fund-raising organization for that purpose.
- Interest earned on Departmental funds shall be considered as other income to reduce total expenditures in arriving at eligible expenditures for Departmental participation.

.17 Audit procedures for program funded contracts should include the following:

- Does the Agency have a system in place to adequately account for all applicable income received or earned by the Agency and that such income was properly reported to OMH/MR.
- That first and third party revenue is maximized prior to billing OMH/MR for services.
- That third party billings for the program are fully recorded and that re-billings are submitted on claims which have been denied for payment.
- That first and third party payments are recorded and reported to OMH/MR for all services delivered through June 30th recognizing any applicable reserves for uncollectable amounts (after pursuing all means of collecting on payments as discussed above).
- For Agencies which report retained revenue to OMH/MR, determine if amount reported is consistent with current OMH/MR policies and such funds have been restricted and utilized for OMH/MR use only. The Schedule of Adjustments on the Program Activity Invoice Summary must be completed to report any changes to retained revenue previously reported in the invoice.
- That clients which have been billed to OMH/MR have been previously determined to be ineligible for Medical Assistance or have no private insurance coverage. (This procedure only entails an examination of information available at the Agency (on a test basis) and does not intend or require contact with any Provider clients.)

.18 Audit procedures for unit of service contracts should include the following:

- Does the Agency have a system in place which:
 - Accumulates the units of service by client, by type and bills those units to OMH/MR.
 - Maximizes first and third party revenue prior to billing OMH/MR for services.

SECTION 6340 (CONT.)

- That clients which have been billed to OMH/MR have been previously determined to be ineligible for Medical Assistance or have no private insurance coverage. (This procedure only entails an examination of information available at the Agency (on a sample basis) and does not intend or require contact with any Provider clients.)
- Utilizing the "Service Rendered Report and Invoice" - MH/MR Form 13 (*sample enclosed as Exhibit 4*), determine that:
 - Service units reported on the form are supported by Agency and client records and that the units agree in amount, type of service and date service was rendered.
 - Rate per unit billed to MH/MR is contractually correct by each type of service.
 - Appropriate deductions have been reported for any first or third party revenue in columns 13, 14 or 15 on the form.
- That Agency reimbursement for inpatient and partial hospitalization services comply with:
 - Policies and limitations prescribed in Sections 4300.111 through 4300.118 of the Title 4300 Fiscal Regulations.
 - OMH/MR maximum rate of reimbursement for inpatient services is the Community Behavioral Health (CBH) per diem. Providers may negotiate lower rates based upon the actual cost of providing psychiatric inpatient services; however, if the CBH rate is used, the Provider must maintain copies of CBH rate authorization letters for each Inpatient Provider for whom reimbursement is requested from the OMH/MR. Providers must maintain rate authorization letters for both the interim and final audited rates.
 - OMH/MR maximum rate of reimbursement for partial hospitalization prescribed by DPW in the current Medical Assistance Fee Schedule for respective adults or children's services and for services which do or do not offer transportation services.
 - Policies and procedures prescribed in OMH/MR Memo #475, revised March 25, 1981. (*Enclosed as Exhibit 5*)

Retained Revenue:

.19 Retained revenue realized by a Provider must be accounted for in a restricted fund designated solely for use in OMH/MR funded services. The use of these funds is discretionary and is not subject to prior approval of OMH/MR as long as the funds are expended for OMH/MR funded services. Chapter 4300.108 of the Pennsylvania Code for County Mental Health and Mental Retardation Fiscal Manual, requires:

SECTION 6340 (CONT.)

- a. *The Department will participate in an allowance for service providers to retain revenues, accruing at the close of the contract period, in excess of eligible expenses realized under the contract.*
- b. *The Department's participation will be limited to an amount not to exceed 3.0% of the total gross revenues applicable to the contract.*
- c. *The Department will participate in an allowance for retained revenue only when the County explicitly approves retained revenue by including specific provisions in the contract. Retained revenue may be included in the contract budget, be allowed as an incentive for agencies to operate efficiently and pursue third-party revenues or allowed in combination as a budget item and efficiency incentive.*
- d. *The contract shall identify the accounting unit or entity for computing revenues in excess of eligible expenditures. It may be an organizational unit, service or activity. It shall include only those expenditures and revenues associate with providing services under the contract and to which the retained revenue allowance applies. The objective is to match revenues and expenses with the accounting entity and the provision of services.*

.20 The auditor is to perform auditing procedures in order to determine the amount of retained revenue and that the Provider Agency has complied with the retained revenue provision of the:

- Regulations cited above in 4300.108
- OMH/MR contract provisions
- Policies and procedures as prescribed in the Annual Budget and/or Invoice/Expenditures Reporting Instructions, and fund restrictions as specified in Section 6340.19 of this Guide.

Medicaid Waiver:

.21 In order to satisfy requirements imposed by the Federal Health Care Financing Administration (HCFA) and the Pennsylvania Department of Public Welfare (DPW), the Philadelphia Office of Mental Health and Mental Retardation implemented special reporting requirements for the 2176 Medicaid Waiver Program. The Philadelphia Office of Mental Health and Mental Retardation (OMH/MR) implemented an automated system to generate Services Rendered Reports (SRR) which provides the financial data to prepare the MR "2176" Waiver Project Report. This report is submitted to the DPW on a quarterly basis. The service costs generated through the SRR are a result of calculating units of service, reported by contract providers to the Research and Information management (RIM) component of the OMH/MR, times provider approved budget rates, by type of service. The MR "2176" Wavier Project Report is used by DPW to prepare Federal reimbursement claims through the Medicaid program.

SECTION 6340 (CONT.)

In FY 1999, the OMHMR adopted similar reporting procedures to address the requirements of the Infant, Toddlers, and Families Medicaid Waiver which was implemented by DPW in its Early Intervention Program in January, 1999.

.22 In the automated system, residential reporting is accomplished on an exception basis with the contract providers' obligation primarily being to advise the OMH/MR of client admissions, absences (absences are defined as 24 consecutive hours not in residence) or discharges not reflected in monthly reports issued by OMH/MR. Providers are also obligated to report individuals' absences from Waiver Residential Programs on a monthly basis on the Monthly Waiver Residential Program Absence Report (*Exhibit 6*).

.23 Waiver Day Program Service Units (Adult Developmental Training, Facility Based Vocational Services and Community Integrated Employment) are reported by providers through monthly reports submitted either electronically or on manually prepared forms. Specialized therapy services and Early Intervention services are also reported in a like manner.

.24 Audit procedures relating to the above would require an assessment of the Agency's control procedures and resultant reporting of client admissions, discharges and absences from residential programs.

Audit procedures are to include, on a test basis, a determination that the services reported are documented (i.e. by attendance records).

Personnel Action Plan:

.25 The Personnel Action Plan (PAP) is a system to monitor, approve, and audit personnel transactions and costs in Agencies providing MH/MR services through program-funded contracts with the OMH/MR.

.26 Under PAP, all program-funded positions are classified into one of several broadly defined functional categories. A maximum salary reimbursement rate is established for each category. A maximum reimbursement rate for benefits cost is also established. Under the DPW 4300 Regulations, effective July 1, 1987, a total compensation option is available. This permits the County to reimburse Agencies for wages and benefits costs up to the combined total of the State's salary and benefits maximum reimbursement rates added together.

Agencies are at liberty to pay salaries or benefits above or below PAP reimbursement rates, but OMH/MR and the State will support such costs only to the extent that they do not exceed PAP maximums or approved contract budget amounts.

.27 Compliance with PAP policies and procedures is a contract requirement. Failure to comply will result in disallowances, and corrective actions will be required. Non-compliance will also result in non-payment of invoices.

.28 The auditor should determine Agency compliance with the following provisions as required in Section 7.0 of the OMH/MR Manual and report any deficiencies in the accountants' report on compliance or internal accounting control, as appropriate.

SECTION 6340 (CONT.)

- Agencies must develop a manual of personnel policies and procedures, and a current copy must be on file at all times with OMH/MR. At a minimum, the Agency Personnel Manual must contain specific statements of compliance with:
 - Pennsylvania Human Relations Act 56.
 - Governor's Code of Fair Practices.
 - Title VI of U.S. Civil Rights Act of 1964, as applicable to any Federally assisted program.
 - Act 33 of 1985, to amend the Pennsylvania Child Protective Services Law, for Agencies providing services to children.
 - Philadelphia Fair Practices Act, for Agencies operating in Philadelphia County.
 - The Agency Personnel Manual must also contain written Agency policies regarding: Recruitment, selection, appointment, probationary periods; classification and pay determination; increments; leave management (hours of work, vacation, sick leave, holidays, overtime/compensatory time, other leaves with or without pay); training, and tuition reimbursement; insurances and retirement plans; promotions; performance evaluations; appeals and grievances; separations/terminations.
 - Agencies must maintain a current organization chart showing lines of authority, position number, PAP codes, and incumbent names. In addition, a personnel roster must be maintained which shows position number, PAP code, incumbent name and social security number, and current salary.
 - All employee job positions must be approved on the PAP at a maximum salary reimbursement rate. Prior-approval by OMH/MR is required to establish new job positions. Agencies are at liberty to pay salaries or benefits above or below PAP reimbursement rates, but OMH/MR and the State will support such costs only to the extent that they do not exceed PAP maximums or approved contract budget amounts.
- (Note: The auditor must include checking job positions and pay rates of any employee selected for testing (as required in Section 307 of the Guide) to the PAP).
- The maximum reimbursement for psychiatric consultations will be at the prevailing rates not to exceed the amounts listed in Exhibit 8 per consultation hour for Board-eligible psychiatrists per consultation hour for Board-certified psychiatrists where such services are provided through a contractual agreement and do not exceed 22 hours/ week.

SECTION 6340 (CONT.)

In any case where a contract psychiatrist works in excess of a 15 hour week, written justification as to why this individual is not a half-time salaried employee must be presented to the Office of Mental Health and Mental Retardation before any reimbursement will be committed.

Any Agency which reimburses a psychiatrist on an hourly rate must do so on the basis of a signed contract, and must maintain that contract for at least five years after the period of the contract. Please note the requirements for contracts as identified in the Title 4300 MH/MR Program Fiscal Manual.

- The maximum fringe benefit percentage rate to be applied in determining eligible compensation can be found in Exhibits 7 and 8.

Administration:

.29 For the purpose of accounting and reporting, administration is defined as general managerial functions or activities which are supportive to but not an intrinsic part of the provision of direct services. These administrative functions or activities include executive supervision, personnel management, accounting, auditing, legal services, purchasing, billing, community board activities, activities associated with management information systems (does not include maintenance of individual client case records), and clerical activities which are supportive to these administrative functions or activities.

.30 The auditor should determine Agency compliance with the following provisions as required in Section 6.07.03 (Subpart D) of the OMH/MR Manual and report any deficiencies in the accountants' report on compliance or internal accounting control, as appropriate.

- All administrative costs whether allocated directly or by formulae to program activities must be included within administration and must not be reported as direct expenses of a program activity.
- The Agency is to have, in place, a method of properly allocating administration costs. The method of allocation is at the discretion of the Agency as long as it is verifiable and results in an equitable distribution among program activities. **(The auditor must identify the method of allocation and express an opinion on the equitableness of the Agency's cost allocation plan/method as prescribed in Section 4300.94 of the Title 4300 Regulations.)**

Cost Allocations/Indirect Costs:

.31 Contracted Agencies are required to determine and assign the actual costs related to the provision of program services. The auditor should determine Agency compliance with the following provisions as required in Section 6.07.03 (Subsection C) of the OMH/MR Manual and report any deficiencies in the accountants' report on compliance or internal accounting control, as appropriate. **The auditor must state the method(s) of allocating costs or revenues.**

SECTION 6340 (CONT.)

Costs and or revenues

- The allocation method used by the Agency should be practical, reasonable, and verifiable and must result in an equitable distribution of costs and revenue. Records must be maintained and an audit trail established for initial budget estimates and amounts subsequently invoiced to the OMH/MR. Methods of allocation used for a specific program activity must be consistently applied in budgeting and invoicing.
- Where staff working on MH/MR programs are not directly assignable and work on multiple program activities on a significant or regular basis, then the time and related benefit costs must be allocated among activities. (A "significant basis" is defined as at least ten percent (10%) of total time worked. A "regular basis" means once a week, bi-weekly, etc.). Based upon this required allocation, specific requirements are as follows:
 - Documentation must be maintained in support of the actual time allocation as well as for initial budget estimates.
 - Staff must be required, on a daily basis, to complete a schedule which identifies hours worked by a specific program activity.
 - The time schedule must be signed by both the employee and his/her supervisor.
- Other (non-personnel) direct program costs not chargeable to a specific activity shall be prorated based on the overall ratio resulting after the allocation of staff and other assignable program costs.
- Client-specific costs (e.g. specialized therapy) or revenue (e.g. room and board charges or client liability) must be directly allocated and cannot be a part of a general distribution method. If an Agency can allocate common or shared costs directly, then appropriate records must be maintained in support of the direct allocation (e.g. staff time records).
- The charging of indirect costs to a program must be in accordance with all requirements prescribed in section 4300.94 of the State DPW 4300 Regulations. In situations where a "program activity" is serving a mixed population whose services are funded by 2 or more DPW categorical allocations, costs or revenues must be directly assigned to the specific client/populations. If such costs or revenues cannot be assigned directly to the specific client/population, then the Contracting Agency must develop appropriate methods of allocating common or shared costs and revenues.

SECTION 6340 (CONT.)

Other Matters:

.32 The following matters should be addressed by the auditor in determining the Agency's compliance with program regulations. Any deficiencies should be reported in the accountants' report on compliance or internal accounting control. (The reference at the conclusion of each requirement is a reference to the OMH/MR Manual.)

a. Employee Leave:

The cost of employee leave allowable/recognized during the fiscal year is for leave actually paid and not for time earned/accrued but not paid. (6.07.03 - Subsection A)

b. Interest Expenses and Earnings:

Interest expenses are considered eligible expenditures if incurred in compliance with the Title 4300 MH/MR Program Regulations and if these expenses are within the Agency's authorized allocation. Interest earnings also must be considered as a revenue offset against eligible expenditures in determining the level of financial participation by the OMH/MR in program activities.

Records must be maintained by the Agency in support of actual interest charges or earnings which are to be assigned to program activities funded by the OMH/MR. If separate bank accounts are not maintained, a practical, reasonable, and verifiable method(s) must be developed to support debt service charges or interest earnings assigned to program activities funded by the OMH/MR. Debt service charges which result from payment sanctions imposed by the OMH/MR or which are due to spending in excess of the levels authorized by the OMH/MR are not eligible for reimbursement. (6.07.03 - Subsection E)

c. Depreciation Allowance:

OMH/MR will participate in a usage payment (depreciation allowance) for fixed assets (excluding real estate), acquired on or after July 1, 1987, which are not expensed or amortized as expenditures paid by OMH/MR funding. A depreciation allowance is not permitted for fixed assets acquired prior to July 1, 1987. To claim a depreciation allowance, the conditions specified in Section 4300.105 must be met. (6.09.01 - Subsection E1)

d. Chief Executive Officer - Maximum Reimbursement (Unit of Service Funding):

The Pennsylvania Department of Public Welfare (DPW) 4300 Regulations, effective July 1, 1987, establish a new title, definition, and variable salary maximum reimbursement rates for contract service Provider Agency Directors.

SECTION 6340 (CONT.)

The terms Catchment Area Services Director (CA SD, defined in Memorandum 44), Executive Director, Agency Director, or Limited Agency Director, have been replaced in PAP usage by the term Chief Executive Officer. The title is defined by DPW as follows: "The Chief Executive Officer (CEO) is the principal officer to whom all Agency staff are subordinate and whose authority is circumscribed only by a Board of Directors." (7.28)

The reimbursement maximums, which the auditor is to determine are being adhered to by the Agency, are enclosed as *Exhibit 7*.

.33 For all OMH/MR Providers, excluding Private License Facilities, there is a bi-annual "Fiscal Site Visit" that is conducted by personnel of the Providers respective OMH/MR fiscal office. The visit prompts written correspondence to the Provider's Executive Director detailing the visit's findings. The auditor should obtain a copy of the most recent site visit letter and determine what corrective action the Organization has implemented to resolve any findings noted in the letter. A lack of corrective action by the Organization would indicate a compliance deficiency.

Interim Care Facilities

.34 Interim Care Facilities are funded by OMH/MR on a unit of service basis. The reimbursements are contingent upon receipt by OMH/MR of the "Interim Care Report and Invoice", Form 55-M-2331 (*Exhibit 9*), or the "Service Rendered Report and Invoices", Form MH/MR-13 (*Exhibit 4*), from the Provider for each month of service. These invoices, however, use an interim per diem rate stipulated in the contract. The OMH/MR will reconcile and reimburse the final contract cost and per diem based on the certified audit submitted by the Provider.

.35 This audit will need to specifically comply with section 4300.116(b)(3) which requires the following:

- Verification that the units of service billed were provided and billed at the proper rate.
- Establishment of actual unit costs.

Client Funds

.36 Regulations established by the Pennsylvania Department of Public Welfare (55 Pa. Code Ch. 6400) require that residents of facilities for the Mentally Retarded have the right to manage their personal financial affairs, or to have their funds maintained in an account for them, if they are unable to do so themselves. They have the right to receive, purchase, have and use personal property.

.37 Mental Retardation Bulletin #600-88-08, "Administration and Management of Client Funds," also establishes requirements for the handling of the financial affairs for clients in community residential facilities.

SECTION 6340 (CONT.)

.38 The use of funds received from Social Security or Supplemental Security Income benefits is subject to Federal regulations (Social Security Act - Section 205 (J)(1); Social Security Operations Manual - Section 1631 (a)(2)(A)). Provider Agencies may apply for and serve as "representative payees" for clients of the program who are unable to handle their own finances, or whose family/guardian/next friend is unable, unwilling or absent to handle the person's finances. Representative payees must adhere to Social Security Administration (SSA) guidelines for the management and use of these benefits.

.39 The OMH/MR with the issuance of Section 6.12 of the OMH/MR Manual has supplemented the above-mentioned regulations and has elaborated on the accounting and permissible expenditure of the funds of clients who live in County funded residences. The following are useful references relating to client funds:

- Mental Retardation Bulletin 6000-88-08(g)(4), November 7, 1988.
- State Bulletin mandates that the Provider's system of internal control over client funds be evaluated and that a representative sample of client accounts be tested as part of the process.
- Office of Mental Health and Mental Retardation Manual Section 6.12 (January 1989)

.40 Where the Agency being audited has a program which includes client funds, the auditor is required to perform certain procedures regarding the Agency's management's administration of client funds. Regarding this policy statement the auditor is expected to:

- Read and become familiar with the requirements of OMH/MR Manual Section 6.12.
- As part of a review of the Agency's internal control structure, include in such a review of management's control policies and procedures over client funds in accordance with OMH/MR Manual Section 6.12.
- Perform, on a test basis, a check of Agency records regarding client funds to determine adherence to OMH/MR Manual Section 6.12 - Client Funds Appendix "Fiscal and Accounting Procedures." At a minimum, this test check must include:
 - A determination that the type of records to be maintained have been established and are in use.
 - A test check that documentation to support the client fund transactions recorded exist and meet OMH/MR Section 6.12 requirements.

SECTION 6340 (CONT.)

Continuing Participation Allowance

.41 For regulations concerning the continuing participation allowance, please refer to: (1) PA Code Title 55 Public Welfare DPW 4300.87, (2) OMH/MR Manual Section 6, page 24, e-2-a and (3) Chapter 4300 County Mental Health/Mental Retardation Program Fiscal Manual - Questions and Responses from regional Orientation Sessions dated 6/5/87.

.42 Audit procedures for continuing participation allowance should include a determination whether the agency has adhered to the following requirements:

- Has the 8% continuing participation allowance been invoiced to OMH/MR for debt-free real estate?
- Is the 8% continuing participation allowance based on original cost of the building or on the fair market value whichever is the lesser amount?
- Has the 8% continuing participation allowance been invoiced only for improvements and renovations made within one year of the date of acquisition?
- Has the appraisal for the property been determined by an individual who holds an approved designation?
- To qualify for continuing participation allowance, donated property must not be restricted for use in the county program and the 8% continuing participation allowance for the donated property must be based on the fair market value at the time of donation.

SECTION 6350 - SUPPLEMENTAL FINANCIAL SCHEDULES AND REPORTS

.01 The Organization's audit report must include the following supplemental financial schedules for each City of Philadelphia – Office of Mental Health/Mental Retardation contract, and special purpose auditors' reports, in addition to the financial statements and auditors' reports as specified in Sections 400 and 500 of this Audit Guide. A designation has been made for those supplemental schedules and reports required for a "single audit" report (Section 400) or a "program audit" report (Section 500). The auditor will be required to issue an opinion on the Supplemental Schedules listed below (MH/MR and Interim Care Facilities) as specified in Section 400 of this Audit Guide.

.02 The supplemental financial schedules and reports for MH/MR and Interim Care Facilities Programs are as follows:

SECTION 6350 (CONT.)

Mental Health/Mental Retardation

<u>Supplemental Financial Schedule/Report</u>	<u>Section Ref. to Sample Format</u>	<u>Single Audit Report</u>	<u>Program Audit Report</u>
• Audited Program Activity Invoice Summary (1)	6350.03	Yes	Yes
• Schedule of Adjustments on Program Activity Invoice Summary (2)	6350.04	Yes	Yes
• Statement of Units of Service (3)	6350.05	Yes	Yes
• Audited Cost Settlement Report (CSR) (4)	6350.06	Yes	Yes
• Audited Early Intervention Cost Settlement (EICSR) (5)	6350.07	Yes	Yes
• Independent Auditors' Report on Cost Allocation Plan - Audited Period (6)	6350.08	Yes	Yes
• Independent Auditors' Report on Cost Allocation Plan - Upcoming Budget Period (6)	6350.09	Yes	Yes

Explanatory Notes:

- (1) The auditor is to utilize the Agency prepared Audited Program Activity Invoice Summary (PAIS) report as the financial statement. The completed schedule must be signed by the Agency Executive Director and the auditor.
- (2) **The (PAIS) included in the audit report must be based on audited expenditures and revenues. It is unacceptable to include in the audit, the unaudited PAIS submitted with the final invoice.** The auditor is required to prepare a schedule that will illustrate the original reported amount, the audited amount, and the difference, where applicable. A schedule must be included in the Audit Report detailing all adjustments between the original Final Program Activity Invoice Summary submitted to the OMH/MR, and the Audited Program Activity Invoice Summary. **If no audit adjustments occurred or if the adjustments have no effect on the final invoice, this must be stated on the audited PAIS and on the Schedule of Adjustments to the PAIS.** Where the Program Activity invoiced amounts were revised, the auditor is required to designate on the "audited" report by an asterisk (*), the amounts which are revised.

SECTION 6350 (CONT.)

(2) (Continued)

If a revised final Program Activity Invoice Summary is submitted to the OMH/MR after the initial final Program Activity Invoice Summary, a separate adjustment column must be included in the Audit Report. The reconciliation schedule along with the explanation must be clear and concise as to what program activity, expenditure, revenue and net to be funded was effected. (Only those activities/categories adjusted are to be presented on the schedule of adjustments.)

The format for presenting the adjustments on the **Schedule of Adjustments on the PAIS** is as follows:

Original Final	(If necessary)		
Program Activity	Revised Final		Audited Program
<u>Invoice Summary</u>	<u>Program Activity</u>	(If necessary)	<u>Activity Invoice</u>
<u>Adjustments</u>	<u>Invoice Summary</u>	<u>Adjustments</u>	<u>Summary</u>

(3) **If the auditor has no adjustments to the Agency submitted Program Activity Invoice Summary, the auditor must submit a Schedule of Adjustments stating that no adjustments have been made to the submitted invoice.**

(4) **The (EICSR) included in the audit report must be based on audited expenditures, revenues and units of service. It is unacceptable to include in the audit, the unaudited EICSR that was submitted with the final invoice. If no audit adjustments occurred or if the adjustments have no effect on the final invoice, this must be stated on the audited PAIS. Where the invoiced amounts were revised, the auditor is required to designate on the "audited" report by an asterisk (*), the amounts which are revised numbers.**

(5) The Commonwealth of Pennsylvania Department of Public Welfare, Mental Health Bulletin No.OMH-94-06 states that the county program is responsible for determining any variances between unaudited and audited Cost Settlement Reports (CSR), reporting any changes to state grant funding and requesting Medical Assistance Management

Information System (MAMIS) Gross Adjustments. In order to enable the City of Philadelphia OMH/MR to adhere to these reporting requirements, subrecipient agencies are to prepare the CSR and submit such to OMH/MR and their independent auditors must provide an opinion on the CSR as part of their independent auditor's report on supplemental financial schedules.

The provider agency is to submit the Final Invoice CSR to OMH/MR with the "unaudited" line at the top of the report checked off. The CSR that is included in the audited financial statements must have the "audited" line at the top of the report checked off (the unaudited check at this time is to be removed.) The CSR report "audited" must include any and all changes required on any reported data so that the auditor may render an opinion on the schedule. If the unaudited CSR report includes errors or requires changes it must be redone for the correct audited amounts.

SECTION 6350 (CONT.)

Please refer to Exhibit 16 in this guide for instructions on the CSR.

- (6) The Commonwealth of Pennsylvania, Department of Public Welfare, Title 4300.94 requires agencies to "obtain an opinion from a public accounting firm on the equitableness of its administrative cost allocation plan." (The cost allocation plan's methodology is at the discretion of the Agency; however, it shall result in a fair and equitable distribution of costs and shall be in direct relation to actual benefits accruing to the services to which costs are charged. **The auditor must state the method(s) of allocating costs or revenues.**)

Interim Care Facilities

<u>Supplemental Financial Schedule/Report</u>	<u>Section Ref. to Sample Format</u>	<u>Single Audit Report</u>	<u>Program Audit Report</u>
• Audited Program Activity Invoice Summary (1)	6350.03	Yes	Yes
• Statement of Units of Service (2)	6350.05	Yes	Yes
• Independent Auditors' Report on Cost Allocation Plan - Audited Period (3)	6350.08	Yes	Yes
• Independent Auditors' Report on Cost Allocation Plan - Upcoming Budget Period (3)	6350.09	Yes	Yes

Explanatory Notes:

- (1) The auditor is to present on this schedule the audited actual eligible costs as determined in compliance with all applicable provisions of the DPW 4300 County MH/MR Fiscal Manual.
- (2) The auditor is to complete this form which reflects the audited summary of services rendered to the OMH/MR and the resulting payments based on actual unit costs. This schedule also shows the computation of the audited unit cost. If the form identifies a surplus, the amount will be recouped by the OMH/MR; however, if the deficit situation exists, it is considered the liability of the Provider. If a Provider is being reimbursed under multiple rates, a form should be completed for each rate.

The client population classification must be completed in order to determine the percentage of state funded clients. If the percentage of state funded clients exceeds fifty percent (50%) the establishment of actual unit cost rate will be based upon the allowable costs standards. See Section 4300.116 of the State DPW 4300 Regulations.

SECTION 6350 (CONT.)

If the percentage is below fifty percent (50%) the Department will participate in the fee charged the general public and the Provider is not required to negotiate or determine unit costs based on allowable cost standards.

- (3) The Commonwealth of Pennsylvania, Department of Public Welfare, Title 4300.94 requires Agencies to "obtain an opinion from a public accounting firm on the equitableness of its cost allocation plan." (The cost allocation plan's methodology is at the discretion of the Agency; however, it shall result in a fair and equitable distribution of costs and shall be in direct relation to actual benefits accruing to the services to which costs are charged.) **The auditor must state the method(s) of allocating costs or revenues.**

SECTION 6350.04

ABC NOT-FOR-PROFIT CORPORATION
Office of Mental Health/Mental Retardation
* Schedule of Adjustments on Program Activity Invoice Summary
July 1, 20XX to June 30, 20XX

Contract Number XXXXXX
Code (Case Management XXXX)

<u>Program Activity</u>	<u>Total Per Invoice</u>	<u>Total Per Audit</u>	<u>Adjustment/ Difference</u>
Personnel	\$ xxxx	\$ xxxxx	\$ xx (A)
Operating	xxx	xxx	<xx> (B)
Administration	xx	xx	xx (C)
** Retained revenues allowance	<u>xx</u>	<u>xx</u>	<u>xx</u> (D)
Total	xxxx	xxxx	xx
Revenue	<u>xxxx</u>	<u>xxxx</u>	<u>xx</u> (E)
Net to be funded	<u>\$ xxx</u>	<u>\$ xxx</u>	<u>\$ x</u> (F)

Explanation of Adjustment/Difference:

- (A) Accrual of salaries and applicable benefits as of June 30, 20XX.
- (B) Reclassification of expenses from operating.
- (C) Reclassification of expenses correctly chargeable to administration.
- (D) Previous adjustments have resulted in more/less available as retained revenue.
- (E) The \$ xx difference results from:

1. Accrual of revenue at June 30, 20XX not recorded by Agency.	\$ xx
2. Adjustment for Medicaid billing on denied payments collected, not previously recorded	<u>x</u>
	<u>\$ xx</u>

- (F) Resultant effect due to previous adjustments.

NOTE

- * This schedule must be included even if the auditor has no adjustments. The schedule heading would remain and the auditor is to make a statement on the schedule that there were no adjustments to the Program Activity Invoice Summary.
- ** Any changes to retained revenue allowance to amounts previously reported on the year end invoice must be reflected on this schedule as an adjustment/difference.

STATEMENT OF UNITS OF SERVICE PROVIDED UNDER CONTRACT TO THE PHILADELPHIA COUNTY MH/MR PROGRAM

<u>Center</u>	<u>Supplied Under the Contract</u>	X	<u>Audited Unit Cost Rate</u>	=	<u>Gross Costs</u>	<u>Less (1) Revenue</u>	<u>Net Eligible Costs</u>
<u>Facility Name</u>			\$ _____		\$ _____	\$ _____	\$ _____

DETAIL OF UNIT COST RATE PER FACILITY (2)

AUDITED UNIT COST = _____ ACTUAL ELIGIBLE COST _____ = \$ _____ # Units
 TOTAL UNITS

DETAIL OF REVENUE

<u>Center</u>	<u>Client Fees</u>	<u>Private Health Insurance</u>	<u>Medical Assistance</u>	<u>Other Third Party Fees</u>	<u>Other* Income</u>	<u>SSI</u>	<u>Total Revenue</u>
<u>Facility Name</u>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Total amount received on this contract from Philadelphia County MH/MR Program \$ _____

Less Net Eligible Cost _____
 Surplus or (Deficit) _____

- * Please Identify (1) Should Equal Total in Detail of Revenue
- (2) Calculation to be Completed

Client Population Classification

_____ Total number of clients.
 _____ Total number of State/County funded clients.
 _____ Total number of Philadelphia County funded clients.

SECTION 6350.06

DEPARTMENT OF PUBLIC WELFARE
COMMUNITY-BASED MEDICAID INITIATIVES
AUDITED COST SETTLEMENT REPORT (CSR)

HEADER DATA: INTERIM _____
FINAL _____

COUNTY/JOINDER: _____ OPERATED BY: _____ FISCAL YEAR: 1999-00
PROVIDER NAME: _____ COUNTY: _____ PROGRAM: _____
PROVIDER TYPE: _____ SERVICE ACTIVITY: _____
PROVIDER MA ID #: _____ PROVIDER: _____ REVISION #: _____

	Actual Units	Budgeted Units	Budgeted Expenditures
1. Service Delivery Analysis			
a. MA (FFP) Eligible Units	_____	_____	_____
b. Non-MA (Non-FFP) Units	_____	_____	_____
c. Combined Units	0	0	_____

2. Expenditures

a. Total Program Expenditures	_____	
b. Less: Retained Revenue Allowance	-	_____
c. Less: Other Expenses Not Allowable for Federal Reimbursement	_____	_____
d. Expenditures Eligible for DPW State/Fed Participation		\$0

3. Revenues

(1) MAMIS Federal Revenue	_____	
(2) Match Funds for 3(1)	_____	
(3) Revenues Supporting Non-FFP Units	_____	
a. Net Program Revenues (1+2+3)		\$0
b. Revenues Supporting Expenditures from 2b & 2c	+	\$0
c. Total Program Revenues		\$0

4. Expenditures Minus Revenues (2d-3a) Underpayment / (Overpayment) \$0

5. Service Delivery

	Actual Units	Actual Rate	Reconciled Revenues
a. MA (FFP) Eligible Units	_____ x	ERR =	ERR
b. Non-MA (Non-FFP) Units	_____ x	(2d/5c Units)=	ERR
c. Combined Units	0 x	(round to 4 d=	ERR

6. Reconciliation

a. FFP	$\frac{ERR}{(5a)}$	-	$\frac{\$0}{3(1) + 3(2)}$	=	ERR
b. Non-FFP	$\frac{ERR}{(5b)}$	-	$\frac{ERR}{3(3)}$	=	ERR

7. State/Federal Split of Difference:

a. FFP	$\frac{ERR}{(6a)}$	x .5382 =	$\frac{ERR}{\text{Federal - Underpayment (Overpayment)}}$
b. FFP	$\frac{ERR}{(6a)}$	x .4618 =	$\frac{ERR}{\text{State - Underpayment (Overpayment)}}$
c. Non-FFP	$\frac{ERR}{(6b)}$	x 1.00 =	$\frac{ERR}{\text{State - Underpayment (Overpayment)}}$

BFO/CSR
5/99

SECTION 6350.06 (CONT.)

**DEPARTMENT OF PUBLIC WELFARE
COMMUNITY-BASED MEDICAID INITIATIVES
AUDITED COST SETTLEMENT REPORT (CSR)**

8. Reconciliation Recap

Overpayment			
a.	<u>ERR</u>	MAMIS Gross Adjustment Requested	<u>ERR</u>
Underpayment			
b.	<u> </u>	MAMIS Gross Adjustment Requested to Initiate Payment Complete State Match Verification	<u> </u>

STATE MATCH VERIFICATION

PROVIDER INFORMATION			
Provider Name			
0			
Provider MA ID Number		Service Activity	
Service Dates			
Begin	End	Units of Service	State Match Paid
7/1/98	6/30/99	Gross Adjustment	

Signature	Title	Date

c. No MAMIS Gross Adjustment Requested; State match unavailable
in current fiscal year

Signature and Title of Person Completing CSR	Name of Provider	Date

Signature and Title of Person Reviewing and Accepting CSR	Name of County/Joinder	Date

I certify that the interim reconciliation of the rate negotiated for this Medicaid Initiative for the period shown is true and correct to the best of my knowledge, and is reflective of accrued Medicaid revenues, and minimal service delivery requirement as prescribed by the Department.

County MH/MR Administrator Signature	Date

CSR SUMMARY

A. Total Program Expenditures (2a)	<u> </u>
B1. MAMIS Federal Revenue Reported on line 3(1)	
B2. MAMIS gross adjustment requested (section 8)	<u>ERR</u>
B. Total Adjusted MA revenue (B1 + B2)	<u>ERR</u>
C. Other revenue (A minus B)	<u>ERR</u>

AUDITED EARLY INTERVENTION COST SETTLEMENT REPORT

<p>EARLY INTERVENTION COST SETTLEMENT REPORT City Of Philadelphia Department Of Public Health Office Of Mental Health & Mental Retardation</p>	<p>AGENCY: _____ PROGRAM ACTIVITY: _____ The amounts reported herein were verified by the audit and conform to the rules and regulations as stipulated in the City of Philadelphia Audit Guide. EXECUTIVE DIRECTOR: _____ AUDITOR: _____</p>	<p>CODE: _____</p>	<p>DATES SUBMITTED: _____ PERIOD COVERED: _____ From : _____ To : _____</p>										
ACTUAL COST													
CLASSIFICATION	SOCIAL WORK	HEALTH SERV	NURS SERV	NUTRN. SERV.	OCCUP. THER.	PHYS. THER.	PSYCH. SERV.	SPEECH PATH.	INITI SCREEN	HEARING SENS.	SERVICE COORD.	SPEC INSTR.	TOTAL
1. PERSONNEL													0
2. OPERATING													0
3. ADMINISTRATION													0
4. TOTAL ELIGIBLE	0	0	0	0	0	0	0	0	0	0	0	0	0
5. OTHER REVENUE													0
6. NET COST	0	0	0	0	0	0	0	0	0	0	0	0	0
FEE REVENUE													
7. DIRECT SERVICE UNITS													0
8. COLLATERAL UNITS													0
9. TRAVEL UNITS													0
10. MISSED APPOINTMENTS													0
11. TOTAL BILLABLE UNITS	0	0	0	0	0	0	0	0	0	0	0	0	0
12. AUTHORIZED RATE													0
13. TOTAL FEES	0	0	0	0	0	0	0	0	0	0	0	0	0
14. MAIPI FEES													0
15. COUNTY FEES	0	0	0	0	0	0	0	0	0	0	0	0	0
FEES vs. COST COMPARISON													
16. TOTAL FEES (per line 14)	0	0	0	0	0	0	0	0	0	0	0	0	0
17. NET COST (per line 6)	0	0	0	0	0	0	0	0	0	0	0	0	0
18. SURPLUS/(DEFICIT)	0	0	0	0	0	0	0	0	0	0	0	0	0
DIRECT RATE COMPARISON													
19. NET COST (per line 6)	0	0	0	0	0	0	0	0	0	0	0	0	0
20. DIRECT UNITS (per line 7)	0	0	0	0	0	0	0	0	0	0	0	0	0
21. ACTUAL RATE	0	0	0	0	0	0	0	0	0	0	0	0	0
22. BUDGETED RATE													0
23. DIFFERENCE	0	0	0	0	0	0	0	0	0	0	0	0	0

SECTION 6350.08

**INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE WITH SPECIFIED
INDIRECT COST ALLOCATION REQUIREMENTS**

Board of Directors

(Name of Organization)

We have examined *(Name of Organization)*'s compliance with allocating indirect costs reflected in the City of Philadelphia, Department of Public Health, Office of Mental Health and Mental Retardation program activity summary as required by the Commonwealth of Pennsylvania, Department of Public Welfare, Section 4300.94 of the Title 4300 Regulations during the year ended June 30, 20XX. Management is responsible for *(Name of Organization)*'s compliance with those requirements. Our responsibility is to express an opinion on *(Name of Organization)*'s compliance based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, including examining, on a test basis, evidence about *(Name of Organization)*'s compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on *(Name of Organization)*'s compliance with specified requirements.

In our opinion, *(Name of Organization)* complied, in all material respects, with the aforementioned requirements for the year ended June 30, 20XX.

This report is intended solely for the information and use of the audit committee, management, and the City of Philadelphia Department of Public Health and is not intended to be and should not be used by anyone other than these specified parties.

(Accounting Firm's Signature)

City, State
(Report Date)

SECTION 6350.09

INDEPENDENT ACCOUNTANT'S REPORT ON COST ALLOCATION
(For Upcoming Budget Year)

At your request, we have performed the procedures enumerated below with the respect to the administrative costs distribution included in the Line Item Budget for the year ended June 30, 20XX submitted by the *(Name of Organization)* to the City of Philadelphia, Department of Health. Our review was made solely to assist you in your filing requirements with the City of Philadelphia, Department of Public Health.

The procedures we performed are summarized as follows:

- a. We reviewed a schedule contained within the 20XX Line Item Budget which reflected the allocation factors utilized in distributing administrative costs.
- b. We confirmed our understanding of the method of allocating administrative costs through a review of supporting work papers and by discussions with management responsible for allocation factors.
- c. We compared the *(Name of Organization)*'s method of allocating costs to those requirements as specified in Section 4300.94 of the Title 4300 Regulations Related Methods for Allocating Indirect Costs in order to determine whether the cost allocation is in compliance with those regulations.
- d. We compared the allocation methods used between the current fiscal year and prior fiscal year to determine consistency between years. The cost allocation method is *(describe method)*.

The Commonwealth of Pennsylvania, Department of Public Welfare, Section 4300.94 of Title 4300 Regulations state "The overall objective of the allocation process is to distribute the indirect costs of the Agency to its various services or cost categories in reasonable proportion with the benefits provided to these services or cost categories." The Regulations require that the method used result in a fair and equitable distribution of costs which shall be in direct relation to actual benefits accruing to the services to which costs are charged.

Because the above procedures do not constitute an audit made in accordance with generally accepted auditing standards, we do not express an opinion on the amount of administrative costs distributed to the Center nor on any other amounts contained within the June 30, 20XX budget submitted to the City of Philadelphia, Department of Public Health. Had we performed additional procedures or had we conducted an audit in accordance with generally accepted auditing standards, other matters might have come to our attention that would have been reported to you. This report relates only to the items specified above and does not extend to any financial statements of the *(Name of Organization)*, taken as a whole.

SECTION 6350.09 (CONT.)

This report is intended for the information of the audit committee, management, and the City of Philadelphia, Department of Public Health. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

(Signature)

(Date)

MH/MR - EXHIBITS

TABLE OF CONTENTS

EXHIBIT DESCRIPTION

1	Determination of Maximum Liability Form
2	Community Living Arrangements Group Home Programs Room and Board Agreement
3	Sample PA 162 Form
4	Service Rendered Report and Invoice Form MH/MR-13
5	OMH/MR Memo #475, Revised March 25, 1981
6	Monthly Waiver Residential Program Absence Report
7	Personnel Action Plan (PAP) Effective January 1, 1997 and January 1, 1998
8	Reimbursement Rates for Psychiatric Physicians (Effective February 8, 1995)
9	Interim Care Report and Invoice, Form 55-M-2331
10	Child Health Appraisal Form
11	Prescription for Early Intervention Services
12	Individual Family Service Plan (IFSP), effective 11/1/96
13	Individual Family Service Plan, effective prior to 11/1/96
14	Multidisciplinary Evaluation for Early Intervention Services
15	Individualized Family Service Plan Review/Revision Cover Page Packet
16	Mental Health Bulletin on Cost Settlement Policy and Procedures

E. LIVING ALLOWANCE (4305.36(9))

1. # of Dependents _____ times \$1080 = III.E.1_

2. _____ plus (1c) \$9000 = III.E.2 _____
(III.E.1)

III. E2 _____

E. OTHER DEDUCTIONS _____

(Specify on back of this form)

Can include net business loss

G. TOTAL

- 1. Mandatory Deductions (III.A.9) _____
- 2. Child Care Expenses (III.B) _____
- 3. Medical Expenses (III.C.9) _____
- 4. Real Estate Taxes (III.D) _____
- 5. Living Allowance (III.E.2) _____
- 6. Other (III.F) _____
- 7. TOTAL

III. G7 _____

IV. DETERMINING ADJUSTED FAMILY INCOME

_____ minus _____ = IV _____
 Total Family Income (II.F) Total Deductions (III.G.7) Adjusted Family Income

Use this amount in determining monthly maximum liability from Appendix A or B.

V. TURN TO APPENDIX A OR B AND DETERMINE MONTHLY MAXIMUM LIABILITY

Enter these amounts below.

Non-Residential Maximum Liability - Appendix A _____

Residential Maximum Liability - Appendix B _____

COMMENTS: A copy of these regulations was offered to the liable person during the liability determination meeting and were advised of their right to appeal the liability determination.

Date

Signature of Person Completing Form

I hereby certify that this information is true and correct to the rest of my knowledge and listings.

Date

Signature of Liable Person

This Exhibit should be obtained from either the subrecipient or the Department of Health.

This Exhibit should be obtained from either the subrecipient or the Department of Health.

**TYPE OF SERVICE CODE
(Column 2)**

- 1 Short-Term Inpatient
- 2 Partial
- 3 Vocational Rehabilitation
- 4 Social Rehabilitation and Training
- 5 Interim Care
- 6 Group Homes
- 7 Outpatient
- 8 Emergency

**RENDERED BY CODE
(Columns 6 - 9)**

- 1 Psychiatrist
- 2 Other physician
- 3 Psychologist
- 4 Social worker, caseworker
- 5 Nurse
- 6 Speech or hearing therapist
- 7 Rehab counselor
- 8 Mental health worker
- 9 Other

**OTHER CODE
(Column 10)**

- 01 Initial Evaluation
- 02 Extended evaluation
- 03 Individual psychotherapy
- 04 Electro-shock therapy
- 05 Anesthesia for electro-shock
- 06 Neurologic evaluation
- 07 Neurologic (follow-up)
- 08 Electroencephalogram
- 09 Psychobiological evaluation
- 10 Projective test battery
- 11 Human figure drawings
- 12 Roschach
- 13 Sentence completion
- 14 Thematic apperception test
- 15 Bender Gestalt
- 16 Speech evaluation
- 17 Audiologist training
- 18 Hearing aid evaluation
- 19 Audiologic evaluation
- 20 Dactylogic therapy
- 21 Hospital visit by a psychiatrist
- 22 Other (specify)

TYPE OF FUNDING

- 1 On staff of county administrator
- 2 Program funded
- 3 Fee-for-service

**CLIENT STATUS CODE
(Column 11)**

- 1 Further service required and will be rendered
- 2 Transferred to another service-record code of referral service - use disposition codes on CDL
- 3 Discontinued from service - client will no longer receive service from the agency
- 4 Terminated by the BSU - client has been terminated from the county MH/MR program by the BSU

This Exhibit should be obtained from either the subrecipient or the Department of Health.

CITY OF PHILADELPHIA
PERSONNEL ACTION PLAN (PAP)
Revised DECEMBER 23; 1997 Effective
JANUARY 1, 1998

OFFICE OF MENTAL HEALTH AND MENTAL RETARDATION
REIMBURSEMENT RATES FOR NON-PHYSICIANS
JANUARY 1, 1998

Exhibit 7

7.44 Compensation Schedule:

1. CEO (Refer to Section 7.28 for PAP category definition)

State Pay Range	Multiple Services Providers		Single Service Providers		MAXIMUM SALARY REIMBURSEMENT RATES			MAXIMUM COMBINED COMPENSATION (Salary Plus 35.49% Benefits Rate)		
	37.5 HRS.	40 HRS.	37.5 HRS.	40 HRS.	Hourly	37.5 HRS.	40 HRS.	Hourly	37.5 HRS.	40 HRS.
54	\$ 7,000,000		\$ 7,000,000		\$ 91,873	\$ 97,998	\$ 46.97	\$ 124,479	\$ 132,778	\$ 63.64
53		\$ 7,000,000	\$ 87,942	\$ 93,805	\$ 84,128	\$ 89,736	\$ 44.96	\$ 119,152	\$ 127,096	\$ 60.92
52	\$ 5,000,000		\$ 80,489	\$ 85,855	\$ 77,027	\$ 82,162	\$ 43.01	\$ 113,984	\$ 121,583	\$ 58.27
51		\$ 5,000,000	\$ 72,098	\$ 76,905	\$ 72,098	\$ 76,905	\$ 41.15	\$ 109,055	\$ 116,325	\$ 55.75
50	\$ 3,000,000		\$ 67,502	\$ 72,002	\$ 67,502	\$ 72,002	\$ 39.38	\$ 104,364	\$ 111,322	\$ 53.36
49		\$ 3,000,000	\$ 63,159	\$ 67,370	\$ 63,159	\$ 67,370	\$ 36.86	\$ 97,686	\$ 104,198	\$ 49.94
48	\$ 1,000,000		\$ 60,440	\$ 64,470	\$ 60,440	\$ 64,470	\$ 36.86	\$ 97,686	\$ 104,198	\$ 49.94
47		\$ 1,000,000	\$ 55,335	\$ 59,024	\$ 55,335	\$ 59,024	\$ 34.51	\$ 91,458	\$ 97,555	\$ 46.76
46	\$ 500,000		\$ 50,000	\$ 54,000	\$ 50,000	\$ 54,000	\$ 32.29	\$ 85,574	\$ 91,279	\$ 43.75
45		\$ 500,000	\$ 46,000	\$ 50,000	\$ 46,000	\$ 50,000	\$ 32.29	\$ 85,574	\$ 91,279	\$ 43.75
44	\$ 300,000		\$ 41,891	\$ 45,891	\$ 41,891	\$ 45,891	\$ 30.90	\$ 81,891	\$ 87,350	\$ 41.87
43		\$ 300,000	\$ 38,229	\$ 42,229	\$ 38,229	\$ 42,229	\$ 28.29	\$ 74,974	\$ 79,972	\$ 38.33
42	\$ 200,000		\$ 34,949	\$ 38,949	\$ 34,949	\$ 38,949	\$ 28.29	\$ 74,974	\$ 79,972	\$ 38.33
41		\$ 200,000	\$ 31,740	\$ 35,740	\$ 31,740	\$ 35,740	\$ 27.07	\$ 71,740	\$ 76,523	\$ 36.68

Annual rates are approximates derived by multiplying the hourly rate by 1,956 (for a 37.5 hours work week) and by 2,086.4 (for a 40 hours work week) and rounding to the nearest dollar.

CITY OF PHILADELPHIA
 PERSONNEL ACTION PLAN (PAP)
 Revised DECEMBER 23, 1997; Effective JANUARY 1, 1998

OFFICE OF MENTAL HEALTH AND MENTAL RETARDATION
 REIMBURSEMENT RATES FOR NON-PHYSICIANS

Exhibit 7 (Cont.)

7.44 Compensation Schedule (Cont.): PHILA. PAP CATEGORY: (Refer to Sections 7.29 to 7.42 for PAP Category definitions)	State PAP Code	State Pay Range	MAXIMUM SALARY REIMBURSEMENT RATES		MAXIMUM COMBINED COMPENSATION (Salary Plus 35.49% Benefits Rate)		
			37.5 HRS.	40 HRS.	37.5 HRS.	40 HRS.	
2. Multiple Component Services Dir.	MCSD	49	\$ 72,098	\$ 76,905	\$ 97,686	\$ 104,198	\$ 49.94
3. Component Director	CD	48	\$ 72,098	\$ 76,905	\$ 97,686	\$ 104,198	\$ 49.94
4. Unit Director	UD	46	\$ 63,159	\$ 67,370	\$ 85,574	\$ 91,279	\$ 43.75
5. Supervisor, Provider of Service	S-POS	45	\$ 63,159	\$ 67,370	\$ 85,574	\$ 91,279	\$ 43.75
6. Provider of Service 3	POS	44	\$ 60,440	\$ 64,470	\$ 81,891	\$ 87,350	\$ 41.87
7. Provider of Service 2	POS	38	\$ 46,396	\$ 49,489	\$ 62,862	\$ 67,053	\$ 32.14
8. Provider of Service 1	POS	35	\$ 41,545	\$ 44,315	\$ 56,290	\$ 60,043	\$ 28.78
9. Administrative Services Director	ASD	45	\$ 63,159	\$ 67,370	\$ 85,574	\$ 91,279	\$ 43.75
10. Administrative Supervisor	AA	42	\$ 55,335	\$ 59,024	\$ 74,974	\$ 79,972	\$ 38.33
11. Administrative Assistant/Specialist	AA	38	\$ 46,396	\$ 49,489	\$ 62,862	\$ 67,053	\$ 32.14
12. Clerical Supervisor	CA	31	\$ 32,626	\$ 34,801	\$ 44,205	\$ 47,152	\$ 22.60
13. Clerical Assistant	CA	30	\$ 32,626	\$ 34,801	\$ 44,205	\$ 47,152	\$ 22.60
14. Program/Maintenance Supervisor	PMA	35	\$ 41,545	\$ 44,315	\$ 56,290	\$ 60,043	\$ 28.78
15. Program/Maintenance Assistant	PMA	30	\$ 32,626	\$ 34,801	\$ 44,205	\$ 47,152	\$ 22.60

Annual rates are approximates derived by multiplying the hourly rate by 1,956 (for a 37.5 hours work week) and by 2,086.4 (for a 40 hours work week) and rounding to the nearest dollar.

CITY OF PHILADELPHIA
PERSONNEL ACTION PLAN (PAP)
Revised FEBRUARY 12, 1997; Effective
JANUARY 1, 1997

OFFICE OF MENTAL HEALTH AND MENTAL RETARDATION
REIMBURSEMENT RATES FOR NON-PHYSICIANS
JANUARY 1, 1997

Exhibit 7 (Cont.)

7.44 Compensation Schedule:

1. CEO (Refer to Section 7.28
for PAP category definition)

State Pay Range	Multiple Services Providers		MAXIMUM SALARY REIMBURSEMENT RATES				MAXIMUM COMBINED COMPENSATION (Salary Plus 35.49% Benefits Rate)	
	Single Service Providers	37.5 HRS.	40 HRS.	37.5 HRS.	40 HRS.	40 HRS.	HOURLY	
54	\$ 7,000,000	\$ 86,983	\$ 92,782	\$ 44.47	\$ 117,854	\$ 125,711	\$ 60.25	
53	\$ 7,000,000	\$ 82,387	\$ 87,879	\$ 42.12	\$ 111,626	\$ 119,067	\$ 57.07	
52	\$ 5,000,000	\$ 79,903	\$ 85,229	\$ 40.85	\$ 108,260	\$ 115,477	\$ 55.35	
51	\$ 5,000,000	\$ 76,460	\$ 81,557	\$ 39.09	\$ 103,596	\$ 110,502	\$ 52.96	
50	\$ 3,000,000	\$ 73,154	\$ 78,031	\$ 37.40	\$ 99,117	\$ 105,725	\$ 50.67	
49	\$ 3,000,000	\$ 70,005	\$ 74,672	\$ 35.79	\$ 94,850	\$ 101,173	\$ 48.49	
48	\$ 1,000,000	\$ 68,480	\$ 73,045	\$ 35.01	\$ 92,783	\$ 98,968	\$ 47.44	
47	\$ 1,000,000	\$ 64,098	\$ 68,371	\$ 32.77	\$ 86,847	\$ 92,636	\$ 44.40	
46	\$ 500,000	\$ 61,321	\$ 65,409	\$ 31.35	\$ 83,083	\$ 88,622	\$ 42.48	
45	\$ 500,000	\$ 59,991	\$ 63,990	\$ 30.67	\$ 81,281	\$ 86,700	\$ 41.55	
44	\$ 300,000	\$ 57,409	\$ 61,236	\$ 29.35	\$ 77,783	\$ 82,968	\$ 39.77	
43	\$ 300,000	\$ 53,731	\$ 57,313	\$ 27.47	\$ 72,801	\$ 77,654	\$ 37.22	
42								
41	\$ 100,000	\$ 50,269	\$ 53,620	\$ 25.70	\$ 68,110	\$ 72,650	\$ 34.82	

Annual rates are approximates derived by multiplying the hourly rate by 1,956 (for a 37.5 hours work week)
and by 2,086.4 (for a 40 hours work week) and rounding to the nearest dollar.

CITY OF PHILADELPHIA
PERSONNEL ACTION PLAN (PAP)
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OFFICE OF MENTAL HEALTH AND MENTAL RETARDATION
REIMBURSEMENT RATES FOR NON-PHYSICIANS

Exhibit 7 (Cont.)

7.44 Compensation Schedule (Cont.): PHILA. PAP CATEGORY: (Refer to Sections 7.29 to 7.42 for PAP Category definitions)		State PAP Code	State Pay Range	MAXIMUM SALARY REIMBURSEMENT RATES			MAXIMUM COMBINED COMPENSATION (Salary Plus 35.49% Benefits Rate)		
				37.5 HRS.	40 HRS.	HOURLY	37.5 HRS.	40 HRS.	HOURLY
2. Multiple Component Services Dir.	MCSD	49	\$ 70,005 \$	74,672 \$	35.79 \$	94,850 \$	101,173 \$	48.49	
3. Component Director	CD	48	\$ 68,480 \$	73,045 \$	35.01 \$	92,783 \$	98,968 \$	47.44	
4. Unit Director	UD	46	\$ 61,321 \$	65,409 \$	31.35 \$	83,083 \$	88,622 \$	42.48	
5. Supervisor, Provider of Service	S-POS	45	\$ 59,991 \$	63,990 \$	30.67 \$	81,281 \$	86,700 \$	41.55	
6. Provider of Service 3	POS	44	\$ 57,409 \$	61,236 \$	29.35 \$	77,783 \$	82,968 \$	39.77	
7. Provider of Service 2	POS	38	\$ 44,069 \$	47,007 \$	22.53 \$	59,709 \$	63,689 \$	30.53	
8. Provider of Service 1	POS	35	\$ 39,492 \$	42,124 \$	20.19 \$	53,507 \$	57,074 \$	27.36	
9. Administrative Services Director	ASD	45	\$ 59,991 \$	63,990 \$	30.67 \$	81,281 \$	86,700 \$	41.55	
10. Administrative Supervisor	AA	42	\$ 52,558 \$	56,062 \$	26.87 \$	71,210 \$	75,958 \$	36.41	
11. Administrative Assistant/Specialist	AA	38	\$ 44,069 \$	47,007 \$	22.53 \$	59,709 \$	63,689 \$	30.53	
12. Clerical Supervisor	CA	31	\$ 31,668 \$	33,779 \$	16.19 \$	42,906 \$	45,767 \$	21.94	
13. Clerical Assistant	CA	30	\$ 31,668 \$	33,779 \$	16.19 \$	42,906 \$	45,767 \$	21.94	
14. Program/Maintenance Supervisor	PMA	35	\$ 39,492 \$	42,124 \$	20.19 \$	53,507 \$	57,074 \$	27.36	
15. Program/Maintenance Assistant	PMA	*30	\$ 31,668 \$	33,779 \$	16.19 \$	42,906 \$	45,767 \$	21.94	

Annual rates are approximates derived by multiplying the hourly rate by 1,956 (for a 37.5 hours work week) and by 2,086.4 (for a 40 hours work week) and rounding to the nearest dollar.

MAXIMUM ALLOWABLE RATES OF REIMBURSEMENT
FOR PSYCHIATRIC PHYSICIANS

For Salaried Psychiatrists:

	<u>Psychiatric Physician 1</u>	<u>Psychiatric Physician 2</u>	<u>Psychiatric Physician 3</u>
A. Base Allowable Reimbursement Maximum Rates (including benefits)	\$ 111,449.78	\$125,148.61	\$125,148.61
B. Service Payment (retention)	13,000.00	13,000.00	13,000.00
C. Adequate Performance Payment	6,000.00	6,000.00	6,000.00
D. Board Certification	5,000.00	5,000.00	5,000.00
E. Board Certification and Practicing in Forensic or Child Psychiatry	<u>5,000.00</u>	<u>5,000.00</u>	<u>5,000.00</u>
TOTAL: Allowable Reimbursement Maximum Rate	<u>\$140,449.78</u>	<u>\$154,148.61</u>	<u>\$154,148.61</u>

This Exhibit should be obtained from either the subrecipient or the Department of Health.

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