

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

SECTION 6310 (CONT.)

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 Blue Cross.

.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
Intensive Case Management	93.778	Medical Assistance Program (Medicaid)
(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

SECTION 6320 (CONT.)

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

Note: For current fiscal year, OMH/MR does not have federal awards from Community Support Programs and MHSIP.

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

- 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."
- Governor's Council Fiscal Management Guidelines, Fiscal Management Guidelines for County Drug and Alcohol Programs.
- 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:

SECTION 6320 (CONT.)

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 Agreements:

.07 It has been standard practice for OMH/MR to include in its advance payments of Community Mental Health Centers (CMHC) an estimated sum to cover the cost of inpatient billings. The estimated sum is derived from the CMHC's inpatient billings against County funds for the preceding two fiscal years and is advanced in the same proportion as the advance against the general allocations.

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

SECTION 6330 (CONT.)

.08 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.

.09 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;
- 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.

.10 The audit procedures should include a check that there is evidence of Letters of Agreement between a CMHC and its primary Inpatient Provider. In addition, check that the agreement contains the items above. (*A sample letter of agreement is enclosed as Exhibit 2.*)

Agency Client Service Recordkeeping:

.11 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.

.12 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:

SECTION 6330 (CONT.)

- (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

.13 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:

.14 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.

.15 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.

.16 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;

SECTION 6330 (CONT.)

- 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.

.17 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

.18 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.

.19 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.
- A State plan amendment allows MA billing retroactive to July 1, 1990 for: persons admitted to a hospital, skilled nursing facility (SNF), intermediate care facility (ICF), or an intermediate care facility for the mentally retarded (ICF-MR). All retroactive billing must be thoroughly documented.
- Approval for billing MA for persons admitted to a private psychiatric facility or a State mental hospital is currently pending. Notice will be transmitted to Providers when approval is obtained.
- 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.

.20 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.

SECTION 6330 (CONT.)

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).

.22 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.

.23 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.

.24 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.

Family Based Mental Health Service Program

.25 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.

.26 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.
- A State plan amendment allows MA billing retroactive to July 1, 1990 for persons receiving Family Based Mental Health Services. Persons receiving services who are ineligible for Federal Financial Participation (FFP) can be funded from County Mental Health allocation.

SECTION 6330 (CONT.)

- 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.

.27 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.

.28 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.

.29 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.

.30 Family Based Services required matching reporting on operations. This requires that an authorized representative must certify that State matching funds are available for

SECTION 6330 (CONT.)

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.

.31 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

.32 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

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. Also note that page two of the CSR is filled out by the county office, and not by the provider agency.

.33 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:

.34 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.

SECTION 6330 (CONT.)

.35 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 3.*) 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:

.36 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.

.37 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 4 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.

SECTION 6330 (CONT.)

Adult Day Care (ADC) Program:

.38 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.

.39 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.

Vocational Day Program:

.40 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.

.41 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.

SECTION 6330 (CONT.)

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:

.42 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.

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

Competitive Employment:

.44 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.

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

Supported Employment:

.46 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.

SECTION 6330 (CONT.)

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

Early Intervention Program (EIP):

.48 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.

.49 Services are provided in the home 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).

.50 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.

.51 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, and 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.

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.

SECTION 6330 (CONT.)

- 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.
- 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:

.52 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.

.53 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 Nonmajor 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).

SECTION 6340 (CONT.)

- b. Interim Care Facilities (Section 6340.34 and 6340.35).
- c. Client Funds (Section 6340.36 to 6340.40).

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

SECTION 6340 (CONT.)

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.

.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

SECTION 6340 (CONT.)

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 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 basis of accrual accounting. (6.07.03-A)

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.

SECTION 6340 (CONT.)

.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.
- 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, a managed care entity 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.

SECTION 6340 (CONT.)

- 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.
- 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 uncollectible 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.)

SECTION 6340 (CONT.)

.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.
- 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 5*), 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 audited Blue Cross per diem. Providers may negotiate lower rates based upon the actual cost of providing psychiatric inpatient services; however, if the Blue Cross rate is used, the Provider must maintain copies of Blue Cross 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.

The interim Blue Cross rate is used as the basis for invoicing in the current year. Adjustments to the audited rate should be accomplished through the year-end audit where possible, or as a prior year adjustment in the succeeding fiscal year invoice.

SECTION 6340 (CONT.)

- 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 6*)

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:

- 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.