

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The IME Program Integrity (PI) unit conducts audits on all Medicaid Provider types including HCBS providers. Any suspected fraud is turned over to the Department of Inspection and Appeals Medicaid Fraud and Control Unit. The PI Unit must open a minimum of 60 cases for provider reviews during each quarter—while 100% of fraud referred cases are reviewed, the vendor is contractually required to audit a minimum of 60 cases in the quarter referred by DHS. Reviewed cases must include providers who exceed calculated norms for rates and units as well as a random sample. Reviews are also incorporated through referrals and complaints received. All reviews include monitoring a statistically representative sample of paid claims and service documentation to detect such aberrancies as up-coding or code creep. This monitoring may involve desk reviews or provider on-site reviews. PI must also perform on-site reviews on at least 5% of provider cases opened during the quarter. This translates into a minimum of 3 on-site reviews per quarter. They must also include analysis of provider practice patterns and reviews of medical records in the provider's setting. PI must initiate appropriate action to recover erroneous/inappropriate provider payments on the basis of its reviews. They must work with the Core MMIS contractor to accomplish required actions on providers, including requests to recover payment through the use of credit and adjustment procedures. During a desk review the provider is required to submit records for review. The purpose of the site visit is to verify that the information submitted to the State is accurate and to determine compliance with Federal and State enrollment requirements.

PI must report findings from all reviews to DHS, including quarterly written reports (or more frequent if requested) detailing information on provider utilization review summary findings and provider on-site review activity. Requests for provider records by the PI unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)"d" to document the basis for services or activities provided. Audits are conducted in accordance with 441 Iowa Administrative Code 79.4(3) – 5 (<http://dhs.iowa.gov/sites/default/files/441-79.pdf>). Should the State require self-audit, the proscribed methodology for sampling and review is determined on a case-by-case basis, and is generally determined based on the nature and scope of the issue identified.

The DHS fiscal agent also conducts audits on providers of HCBS. The 100 highest billing providers (account for over 70% of year's expenditures) are identified and reviewed on a 3-5 year cycle. This sample is compared to the reviews conducted by the PI Unit to avoid duplication. An electronic program is utilized to randomly pick member files from the list of potential providers as well as the months to be reviewed. From the statistically representative sample, 10% of member files are reviewed to ensure proper billing procedures and supporting service documentation. Providers are also subject to Payment Error Rate Measurement (PERM) audits. The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review.

The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. All HCBS cost reports will be subject to desk review audit and, if necessary, a field audit.

MCOs are responsible for safeguarding against the potential for and investigating reports of suspected fraud and abuse. MCOs are required to fully cooperate with the DHS PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR 0455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and submitted to DHS for review and approval. On a monthly basis, the MCO must submit an activity report to DHS, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives and recoupment totals. The MCO must, at minimum, include the name and NPI of provider reviewed, reason for review, review outcome, provider referrals to Iowa's Medicaid Fraud Control Unit, providers suspended and terminated, provider recoupment amount, provider payment reductions, providers denied enrollment/reenrollment, and State fiscal year to date summary information.

MCOs must also coordinate all PI efforts with IME, DPH and Iowa's Medicaid Fraud Control Unit. MCOs must have in place a method to verify whether services reimbursed were actually furnished to members as billed by providers, and must comply with 42 CFR 455.23 by suspending all payments to a provider after DHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by DHS or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.416

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-1a: Number and percent of reviewed paid claims for which the units of service were coded as specified in the approved waiver. Numerator = # of reviewed paid claims that were coded as specified Denominator = # of reviewed paid claims

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Contracted entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Program Integrity Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. These providers are reviewed quarterly.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

FA-2a: Number and percent of reviewed paid claims for which the units of service lacked supporting documentation. Numerator = # of reviewed paid claims lacking supporting documentation Denominator = # of reviewed paid claims

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The Program Integrity unit requests service documentation from providers and cross-walks with claims. This data is inductively analyzed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Program Integrity unit requests service documentation from providers and crosswalks with claims. This data is inductively analyzed.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-3a: Number and percent of reviewed exception to policy (ETP) requests for which rates were paid using the methodology other than specified in the approved waiver. Numerator = # of reviewed ETPs that were paid using methodology other than as specified; Denominator = # of reviewed paid claims.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Medical Services Unit reports quarterly on ETP trends. This data is analyzed inductively.
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is stored in in a spreadsheet and reported on a monthly and quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments, require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a monthly and quarterly basis.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCOs	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Personal emergency response, behavior programming, family counseling and training, adult day care, prevocational service, supported employment, respite, specialized medical equipment, and home and vehicle modifications are reimbursed by fee schedules.

Supported community living rates are based on a retrospectively limited prospective rate configured the IME's rate setting unit in coordination with the provider.

Respite provided by home health agencies that used the maximum Medicare rate converted to a fifteen-minute unit.

Consumer directed attendant care services are reimbursed based on the agreement of the participant and the provider. For services that the participant self-directs (i.e., self-directed personal attendant care, individualized directed goods and services, and self-directed community support and employment), the participant negotiates a rate for the entity providing services, goods, and supports, except for the FMS and ISB services, where the IME has a fee schedule with an upper rate limit for those services. Providers of case management services shall be reimbursed their provider-specific fee for FFS.

Consumer directed attendant care services are reimbursed based on the agreement of the participant and the provider. For services that the participant self-directs (i.e., self-directed personal attendant care, individualized directed goods and services, and self-directed community support and employment), the participant negotiates a rate for the entity providing services, goods, and supports, except for the FMS and ISB services, where the IME has a fee schedule with an upper rate limit for those services. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

Once selected, the waiver services are entered into the participant's service plan for use in CCO. ISIS will automatically calculate a monthly "cap amount" and a "budget amount" based on the type and amount of waiver service entered into the service plan. The cap amount is used to ensure the participant stays within the program dollar limits such as the monthly level of care cap. The budget amount is the amount of funds available to the participant to purchase goods and services to meet the participant's assessed needs. The participant is notified by the service worker, case manager, health home coordinator, or community-based case manager of the initial budget amount and any change to the monthly budget amount. The participant will use the monthly budget amount to purchase goods and services to meet their assessed needs. The participant's assessed needs are considered the type and amount of waiver services that were authorized in the service plan to create the CCO budget. For example, if consumer directed attendant care services are authorized in the plan and converted to a CCO budget, the budget must be used to meet CDAC needs that have been assessed as needed by the participant. The participant using CCO is self-directing their services. This means they have both budget and employer authority. A participant has the authority to hire and fire employees, establish wages and purchase goods and services to get their needs met. If a participant is efficient in using the monthly budget to get all their assessed needs met and there are additional budget funds remaining, they can use the funds to purchase additional goods and services in the current month or put the funds into a saving account for use in future months.

For consumer directed attendant care, the participant and provider negotiate a rate within the upper rate limit set by the IME. The participant or the legal representative is responsible for: (1) selecting the person or agency that will provide the components of the attendant care services; (2) determining the components of the attendant care services to be provided with the person who is providing the services to the participant; (3) completing form 470-3372, the HCBS Consumer-Directed Attendant Care Agreement with the provider with both parties signing it. Form 470-3372 must be provided to and signed by the service worker, case manager, health home coordinator, or community-based case manager before services begin. Participants will give direction and training for activities to maintain independence that are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described in form 470-3372. When CDAC is part of the participant's service plan, a copy of the completed form 470-3372 becomes an attachment to and part of the service plan. Before the provision of services, the service worker, case manager, health home coordinator, or community-based case manager must review and approve form 470-3372 for appropriateness of the services and the number of units of service identified as well as the provider's training and experience. (As the state Medicaid agency, DHS has oversight responsibility for CDAC providers.) CDAC requests that exceed the median cost (units) must be reviewed and approved by the Iowa Medicaid Enterprise (IME).

For transportation, the rate is fee schedule, provider's are paid at the providers rate not to exceed the upper rate limit at 441 79.1(2).

Prevocational service rates are fees schedules based on a rate that is contracted with the local county, or in the absence of a county contract rate, the provider's rate not to exceed the upper rate limit.

Interim medical monitoring and treatment service rates are a cost based rate for home health aide or nursing services provided by a home health agency. The Iowa Medicaid Enterprise, through the provider auditing and rate setting unit, is responsible for rate setting.

441 Iowa Administrative Code 79.1 sets forth the principles governing reimbursement of providers of medical and health services. Specifically, “[t]he basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider’s allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department’s methodology without making any additional charge to the member. Reimbursement types are described at 441 Iowa Administrative Code 79.1(1), located here: <http://dhs.iowa.gov/sites/default/files/441-79.pdf>

Payment levels for fee schedule providers of service will be increased or decreased upon direction of the Iowa Legislature through Medicaid appropriations. There is no set cycle for the Legislature to increase or decrease HCBS provider rates. The provider rates are established in Iowa’s Administrative Rules. The legislature can direct IME to increase or decreased provider rates through a legislative mandate. If so, then IME changes the Iowa Administrative Rules accordingly. All provider rates are part of Iowa Administrative Code and are subject to public comment any time there is change. This information is on the website as well as distributed to stakeholders when there is a change. Rate determination methods are set forth in Iowa Administrative Code and subject to the State’s Administrative Procedures Act, which requires a minimum twenty-day public comment period. A public hearing by the state agency to take comments is not required unless at least twenty-five persons demand a hearing, though Agency’s often schedule a public hearing regardless of the number of comments received. The state agency may revise a rule in response to comments received but is not required to do so. At the time of service plan development, the case managers shares with the members the rates of the providers, and the member can chose a provider based on their rates. When a service is authorized in an participant’s comprehensive services plan, the providers of services receive a Notice of Decision (NOD), which indicates the participant’s name, provider’s name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.

MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. To estimate the fee-for-service population in Waiver Year 2, the State assumed that the same number of unique individuals would receive services for the waiver year, although the payment basis will be blended between fee-for-service and managed care based on the waiver effective date and managed care implementation date. As such, the average cost per unit is illustrated as a combination of that assumed previously for the fee-for-service population blended with the applicable portion of the year at the assumed managed care unit cost rates. The cost per unit for services delivered under managed care were developed as the fee-for-service cost per unit amounts grossed up to reflect total capitation payment reimbursement representing the average LTSS blended capitation rate for the rate cells. Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO’s contract with the State.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State’s claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For fee-for-service participants, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and shall be processed by the IME Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.

Providers shall submit a claim form that accurately reflects the following: (1) the provider’s approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.

The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestones for the case manager. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider's contract with the MCO. Providers may not bill Medicaid directly for services provided to MCO members.

Provider billing manuals and fee schedules are available on the IME website: <http://dhs.iowa.gov/ime/providers/csrp>.

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I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

- No. State or local government agencies do not certify expenditures for waiver services.
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

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I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS system edits to make sure that claim payments are made only when an individual is eligible for waiver payments and when the services are included in the service plan. An individual is eligible for a Medicaid Waiver payment on the date of service as verified in ISIS. The billing validation method includes the date the service was provided, time of service provision, and name of actual person providing the service. Several entities monitor the validity of claim payments: (1) the service worker, case manager, or health home coordinator ensures that the services were provided by reviewing paid claims information made available to them for each of their members through ISIS; (2) the Iowa Department of Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided; (3) the IME Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member

is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the individual is eligible for waiver payments on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the enrollee's approved plan of care. The MCOs are also responsible for program integrity functions with DHS review and oversight.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Payments for waiver services for fee-for-service enrollees are made by DHS through the MMIS. Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

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I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For fee-for-service enrollees, for the self-direction option of the waivers, payments will be made to a financial management service, which will be designated by the state as an organized healthcare delivery system to make payments to the entities providing support and goods for members that self-direct. The financial management service must meet provider qualifications established by the state and pass a readiness review approved by the state and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by provide periodical audits. Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual.

The fiscal agent mails to entities providing supports and goods for members that self-direct information how they can bill Medicaid directly if they choose. IME exercises oversight of the fiscal agent through both the ISIS system and through our "Core" unit. The Core unit performs a myriad of functions for the Iowa Medicaid Enterprise including, but not limited to, processing and paying claims, handling mail, and reporting. This unit also maintains and updates the automated eligibility reporting system known as ELVS. IME has regularly scheduled meetings with Core that has thresholds of measurements they are required to meet to assure quality.

When a provider has been enrolled as a Medicaid provider, IME Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: <http://dhs.iowa.gov/policy-manuals/medicaid-provider>.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

N/A

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I-3: Payment (3 of 7)

- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.
- Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability**I-3: Payment (4 of 7)**

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

The two State Resource Centers (Woodward and Glenwood) are the only two state agencies that provide community based services on the Intellectual Disabilities waiver. They provide Supported Community Living, Supported Employment and respite services.

Appendix I: Financial Accountability**I-3: Payment (5 of 7)**

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report.
Select one:

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability**I-3: Payment (6 of 7)**

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

For fee-for-service enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between DHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between DHS and the MCOs.

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g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid providers can choose to subcontract to non-enrolled providers for the provision of Home and Vehicle Modifications. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract. Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to participants. When the service worker, case manager, health home coordinator or community-based case manager has assessed the need for any waiver service, the member is offered the full choice of available providers. The participant has the right to choose from the available providers; the list of providers is available through the service worker, case manager, health home coordinator or community-based case manager, and is also available through the IME and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria is met.

The Financial Management Services entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. Iowa Medicaid Enterprise (the state Medicaid agency) executes a provider agreement with the OHCDS providers and MCOs contract with an IME enrolled Financial

Management Services solution. The Financial Management Services provided by the OHCDs is voluntary and an alternative billing and access is provided to both waiver participants and providers. Participants have free choice of providers both within the OHCDs and external to these providers. Providers may use the alternative certification and billing process developed by the Iowa Medicaid Enterprise. Participants are given this information during their service plan development. Providers are given this information by the OHCDs. The Designated OHCDs reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement. Annually each provider will be recertified as a qualified provider. Employer/employee agreements and timesheets document the services provided if waiver participants elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service participants, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's ISIS system. Financial oversight and monitoring of the OHCDs is administered by the Iowa Medicaid Enterprise through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDs Financial Management Services, which is subject to DHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by DHS.

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board****a. Services Furnished in Residential Settings. *Select one:***

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

As specified in Iowa Administrative Code, Iowa does not reimburse for room and board costs, except as noted for providers of out of home respite services. The provider manuals contain instructions for providers to follow when providing financial information to determine rates. It states that room and board cannot be included in the cost of providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. That fee schedule has no allowance for room and board charges. Respite provided by a home health agency is limited to the established Medicare rate.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by the Iowa Medicaid Enterprise.

All providers of waiver services are subject to a billing audit completed by the Department of Human Services Bureau of Purchased services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:***

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No.** The State does not impose a co-payment or similar charge upon participants for waiver services.
 Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
 Coinsurance
 Co-Payment
 Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: