

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 Iowa Department of Human Services has developed a computer system, the "Individualized Services Information System" or "ISIS," to support the waiver programs. The purpose of ISIS is to assist workers involved in these programs to process applications, starting with an initial entry from the ABC system through approval or denial. Upon approval, Case Managers use ISIS to provide the Iowa Medicaid Enterprise (formally called the fiscal agent) with information and approval to make payments on behalf of a member. The member's service plan information is tracked in ISIS until that member is no longer accessing a waiver program. There are certain points in the ISIS process that will require contact with designated DHS central office personnel and other outside entities. These contacts must be made in order for the ISIS process to proceed. These contacts may include the Medicaid arbitrator, HCBS waiver program managers, contacts for HCBS waiver slots and waiting lists, the Iowa Medicaid Enterprise and IME Medical Services. A person applying for HCBS waiver normally starts with an income maintenance (IM) worker entering information into the Department's Automated Benefit Calculation (ABC) system. The ABC system passes pertinent information about the case to ISIS. Then ISIS kicks off key tasks (called a "milestone") for the IM worker who entered the original data into ABC. This key task is the first in a series of milestones for actions by case managers, IME Medical Services and many others. These milestones form a workflow taking a request for a facility or waiver program to denial or final approval. In addition, the Department of Human Services Bureau of Purchased Services performs both a financial and performance audits of Medicaid Providers.

The billing audit is to ensure:

- HCBS providers appropriately and accurately document the provision of services so that claims paid by the Department are eligible for reimbursement
- To limit the risk of providers having to refund payments to the Department because they have submitted ineligible claims
- To limit the risk of the Department losing or having to return matching federal funds because of having paid ineligible claims.

At the end of each state fiscal year, an analysis of payments, recoupments and other risk related factors will be used to select and prioritize providers for billing audits to be conducted during the next auditing year (from October 1 to September 30). The Bureau of Purchased Services will analyze payments; recoupments and other risk related factors from the previous State fiscal year and create a prioritized list of providers by program selected for audit in September of each calendar year. Note: This selection process is only intended to be used as a tool by the Department to better focus its risk management efforts and resources. It is not meant to, nor does it limit the right of the Department to audit any provider at anytime at the Department's sole discretion.

Selection Criteria

The primary factors that will be used by the Bureau to select and prioritize providers for audit are:

- Total payments to the agency in the previous State fiscal year.
- Payments for each program to the agency in the previous State fiscal year.
- Recoupments from the agency during the previous State fiscal year.
- The ranking of each program offered by an agency compared to the same program provided by other agencies.

Possible Problems

- Issues identified in the provider's cost report that raise questions about a provider's financial stability, appropriate cost allocation, evidence of undisclosed or inappropriate sub-contractual or related party relationships, or compliance with HCBS requirements.
- Issues identified by department staff that raise questions about a providers financial stability or programmatic viability or compliance with HCBS requirements.
- Issues identified by other government agencies, by other provider agencies, or the public that raise questions about a provider's stability or programmatic viability or compliance with HCBS requirements.
- Providers that are completing a Provider Improvement Plan (PIP) as a result of a previous billing audit or certification

review.

- Providers that were sanctioned during the previous state fiscal year.
- Providers suspected of fraud or falsifying documentation.

Other factors that will be used by the Bureau to select and prioritize providers for audit are:

- Length of time since last billing audit.

All providers will be audited at least once every 5 years and more often if resources allow.

Exception:

Providers who receive only minimal HCBS payments, will not be prioritized for audit because of length of time since their last billing audit. Upon termination if a provider has not been audited for 2 or more years and they have received payments in excess of \$100,000 in the time period since their last billing audit.

- Providers experiencing high growth or high staff turnover.
- Providers experiencing a large increase in HCBS payments or experiencing a large increase in the number of sites from which they are providing services.
- Providers who are experiencing rapid staff turnover or who are adding high numbers of either the staff who provide and document service delivery or the staff who train and/or supervise these staff.
- A combination of high growth and a high number of new staff.

In addition, a few providers not otherwise selected may be selected at random for audit. The Bureau will analyze the above factors at the end of each fiscal year, create a prioritized list of providers by program selected for audit in September of each calendar year and provide this list to the Management Analysts

The Bureau of Purchased Services has a policy in place on the procedure for reporting non-compliance to the provider and to the Bureau of Long Term Care. In cases of suspected Medicaid Fraud, The Iowa Department of Inspections and Appeals is responsible for investigating.

Along with focused audits through the Bureau of Purchased Services, the IME SURS unit conducts audits on all Medicaid Providers including HCBS providers. Any suspected fraud is turned over to the Department of Inspection and Appeals Medicaid Fraud and Control Unit (contracted by DHS).

The SURS Unit must open a minimum of 60 cases for provider reviews during each calendar quarter including Brain Injury waiver providers. All cases referred from DHS must be opened in the quarter referred. Review cases must include both providers who exceed calculated norms, and a random sample of providers who do not exceed norms.

The SURS Unit must conduct reviews of providers (including Brain Injury waiver) based on SURS exception criteria reflected in the above SUR Subsystem reports. These reviews must include monitoring a representative sample of paid claims to detect such aberrancies as "up-coding" or "code creep". This monitoring will involve both in-house or desk reviews and provider on-site reviews.

SURS must perform on-site reviews on at least five percent (5%) of the provider cases (including Brain Injury waiver) opened during the quarter. This translates into a minimum of three (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. SURS must initiate appropriate action to recover erroneous or 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.

SURS must report findings from all reviews to DHS on a quarterly basis. This must include written reports at least quarterly (or more frequently, if requested) detailing information on provider utilization review summary findings and provider on-site review activity.

The Auditor of the State has the responsibility to conduct periodic independent audit of the Brain Injury waiver under the provisions of the Single Audit Act.

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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:

Number and percent of claims paid at the correct rate.

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):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: Medicaid contractor entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

Other Specify:

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of claims paid for services not documented.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: Medicaid contractor entity	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	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):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and percent of claims coded as specified in the waiver application.

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):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval =
Other Specify: Medicaid contractor entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	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):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

- 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.

- 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.

Discovery: Audits - HCBS audits are conducted by the Department of Human Services Fiscal Management Bureau, the IME Service and Utilization Review Services (SURS) and the Iowa Department of Inspections and Appeals (DIA). These reviews assure that services are rendered as approved by the service plan and claims are coded correctly and reimbursed in a timely manner. On-site audits may be random, targeted, or both depending on the identified issues. There are also desk audits in which the reviewer sends a certified letter to the provider requesting documentation. Desk audits may also be random, a targeted audit, or both. Audits are conducted with both agency and individual providers. Both Fiscal Management and SURS reviews are conducted on an ongoing basis throughout the year. The DIA fraud investigation unit becomes involved with provider reviews based on referrals from Fiscal Management, SURS auditor and State staff.

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.

Remediation – Claims Payments – With an integrated data warehouse system, ISIS assists workers in processing and tracking requests, as well as approval of claim payments. Allowed rates and approved services are passed to the MMIS system where the claims are processed and paid. Payment information is passed back to the ISIS system for notification of claim payments.

OVERSIGHT - IME Core Services generates reviews continuously from daily to annual information that is compared to their contract-based benchmarks. The Medicaid Director, Contract Administration Office and the Bureau of Long Term Care monitor performance. As a contract-monitoring tool, information contained in this report verifies that individual claims are accurately paid in a timely fashion.

Remediation: Case Managers/Service Workers have access to the ISIS that identifies the individual service utilization, including paid and denied claims.

Improvement: An Individualized Services Information System workgroup meets monthly to evaluate the system and review/implement suggestions for improvement.

Remediation: Information and reports are presented monthly to the Bureau of Long Term Care. The Bureau also reviews annual reports. Identified problems are addressed through payback of funds, corrective action requirements, and changes in policies.

Improvement: The Quality Management Committee reviews and evaluates available data and submits recommendations for improvement and policy changes to the Bureau of Long Term Care.

Weekly meetings are held to identify provider or individual issues where program corrective action is warranted and the steps to ensure that corrective action or action plan is implemented or developed by the provider within 30 days.

- 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):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify:

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.

Goal: I-1 To modify ISIS and SURS reporting procedures

Begin generating a monthly ISIS report showing claims paid for more than the approved rate.
BLTC 12/1/2009

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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, Specilaized Medical Equipment and Home and Vehicle Modifications are reimbursed by Fee Schedules. Fee schedules are fees for the various procedures involved that are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale costs, or an actual acquisition cost of the product to the provider, or product costs included as part of the fee schedule.

Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the following methodology:

Fee for service with cost settlement. Effective July 1, 2009, 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.

- (1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).
- (2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.
- (3) The methodology for determining the reasonable and proper cost for service provision assumes the following:
 1. The indirect administrative costs shall be limited to 20 percent of other costs.
 2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
 3. The rates a provider may charge are subject to limits established at 79.1(2).
 4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

Respite, supported community living, and supported employment rates are based on a retrospectively limited prospective rate configured the IME's rate setting unit in coordination with the provider except for respite provided by home health agencies that used the maximum Medicare rate converted to an hourly rate. Fee schedules are used for providers of respite who are hospitals, nursing facilities, ICF/MR's, RCFs, child care centers, and foster group care.

Consumer Directed Attendant Care Services are reimbursed based on the agreement of the member and the provider. For services that the member self directs (self directed personal attendant care, individualized directed goods and services, and self directed community support and employment) the member negotiates a rate for the entity providing services, goods and supports, except for the Financial Management Service and Independent Support Broker service which will be negotiated by the Iowa Medicaid Enterprise.

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, an upper daily maximum fee.

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.

All provider rates are part of Iowa Administrative Rules 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. 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.

- 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:

Providers shall submit claims on a monthly basis for waiver services provided to each individual served by the provider agency.

Providers may submit manual or electronic claim forms:

- Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.
- Electronic claims shall utilize the HIPAA compliant software, PC-ACE Pro32 and shall be processed by the Iowa Medicaid Enterprise/Provider Services Unit.

Providers shall submit a claim form that accurately reflects the following:

- The provider's approved Medicaid waiver provider number
- The appropriate waiver procedure code(s) that correspond to the waiver services authorized in the service worker's service plan (case plan).
- The appropriate waiver service unit(s) and fee that corresponds to the case manager service plan (case plan).
- The IME/Provider Services Unit issues provider payments on the second and fourth Mondays of each month.

The ISIS system edits insure that payment will not be made for services that are not included in an approved service

plan (plan of care). Any change to ISIS data generates a new program request. The program request culminates in a final milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

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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 ISIS system provides for edits to make sure that all claims are made only when an individual is eligible for waiver payments and when the services are included in the plan. The Iowa Department of Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided. The Case Manager also ensures that the services were provided by reviewing in ISIS paid claims information made available to them for each of their members. 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.

- 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:

Each HCBS waiver program is given a alpha code to identify the program type. This code is passed from ISIS into MMIS for each individual on the HCBS Brain Injury waiver.

All services in the BI waiver program are paid through the MMIS system. The Consumer Choices Option has only one service that is payable through MMIS - the Financial Management Service (FMS). The other Consumer Choices Option services (individual support broker, self directed personal care, self directed community and employment supports, and individual directed goods and services) are paid by the FMS and are not directly paid through MMIS. The Financial Management Service bill the MMIS for services and goods and will make payments to member employed workers and entities that provide supports and goods for members that self-direct. All payments will be tracked through ISIS. In addition, the Financial Management Service will supply to the state quarterly reports on what and who was paid. The Financial Management Service will be subject to yearly audits. Providers may receive payment from the Medicaid agency directly but must be enrolled as a Medicaid provider to do so.

Currently reconciliation of claims for services are being completed on a monthly basis by IME data warehouse and policy staff. This is reviewed at the waiver monthly meetings. An annual audit is conducted with the FMS service.

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:

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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 the self-direction option of the waivers, payments will be made to a financial management service, who 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 qualification 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.

The fiscal agent mails to entities providing support 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. IME has regularly scheduled meetings with Core that has thresholds of measurements they are required to meet to assure quality.

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.

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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.

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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 Brain Injury waiver. They provide Supported Community Living, Supported Employment and Respite services

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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:

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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.

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I-3: Payment (7 of 7)

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:

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. The Financial Management Services provided by the OHCDS is voluntary and an alternative billing and access is provided to both waiver participants and providers. Members 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. Members 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 vender receiving Medicaid reimbursement. Annually each provider will be recertified as a qualified provider. Employer/employee agreements and timesheets document the services provided if waiver member elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase 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 performed the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process.

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:

The counties are responsible for the payment of the non-federal share of BI waiver services for members at the ICF/MR level of care that have legal settlement within the county who are coming onto the waiver from an ICF/MR facility or who have been receiving other services for which the county has been financially responsible or would become liable due to the person's reaching majority. Counties levy property taxes to pay for waiver services. The state initially pays the non-federal share of waiver services

through from the general Medicaid appropriation funds, then bills the counties on a monthly basis for the non-federal share owed by each county.

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 HCBS Waiver Provider Manual contains instruction for providers to follow when providing financial information to determine rates. The Iowa Administrative Code rules and HCBS Provider Manual states that room and board cannot be included in the cost of providing services. For the Supported Community Living and Respite services, providers must submit rate setting info to the Iowa Medicaid Enterprise, Audit and Rate setting unit for rate approval.

The IME Audit and Rate Setting unit reviews the financial information prior to approving any rate to assure that all costs are appropriate for the service. The Financial and Statistical (F&S) form that is used for reporting all appropriate costs for waiver services is submitted by the provider and then reviewed by the IME Audit and Rate setting unit. In addition, all providers of waiver services are subject to a billing audit completed by the Department of Human Services Bureau of Purchased Services and the Service Utilization Review (SURS) unit at the Iowa Medicaid Enterprise.

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: