that the QIS strategy will be periodically reviewed at DDP QIS meetings, for the purpose of generating recommendations to improve system efficiency and consistency by the staff who invest time and effort in gnerating the performance measure data. DDP QIS recommendations will be shared with DDP management staff for the purpose of making changes based on the implementation of the process. The DDP Quality Council (consisting of consumers, provider staff, and self-advocates, professional advocates, DDP staff parents, service providers and others always has the opportunity to share thoughts with DDP staff at their meetings. DDP will remain responsive to the concerns of these groups and others in the updating of the performance measures, the processes used to collect this information, and the best ways to summarize and share the information with interested individuals and entities.

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).

Contract Audit Requirements

The following language from the FY 09 contracting template applies to contractors of DDP waiver funded services:

8.1 The Contractor, in accordance with 18-4-311, MCA and other authorities, must maintain for the purposes of this Contract an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP), as interpreted by the Department, and to any other accounting requirements the Department may require.

8.2 The Department or any other legally authorized governmental entity or their authorized agents may at any time during or after the term of this Contract conduct, in accordance with 5-13-304, MCA and other authorities, audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the Contractor through this Contract and assuring the appropriate administration and delivery of services provided through this Contract.

8.3 The Contractor, for purposes of audit and other administrative activities, in accordance with 18-1-118, MCA and other authorities, must provide the Department and any other legally authorized governmental entity or their authorized agents access at any time to all the Contractor□s records, materials and information, including any and all audit reports with supporting materials and work documents, pertinent to the services provided under this Contract until the expiration of six (6) years from the completion date of each respective State fiscal year.

8.4 The State and any other legally authorized governmental entity or their authorized agents may record any information and make copies of any materials necessary for the conduct of an audit or other necessary administrative activity.

8.5 A non-profit contractor, if receiving $500,000 or more in federal funds from any and all federal funding sources, must comply with the accounting and audit requirements of Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" and the provisions of OMB Circular "A-122, Cost Principles for Non-Profit Institutions" concerning the use of the funds provided under this Contract.

8.6 A for-profit contractor must comply with the accounting and audit requirements in 45 CFR 74.26(d) and the cost principles and procedures for commercial organizations in 48 Subpart CFR 31.2 concerning the use of the funds provided under this Contract in the version in effect on the date this Contract is signed by both parties. Pursuant to 45 CFR 74.26(d), a "for-profit" organization may either have an audit conducted in accordance with the Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" or the Government Auditing Standards.

For non-profit corporations receiving $500,000 or more in federal funds from any and all funding sources, or for-profit

corporations, the contractor is responsible to have yearly audits conducted in accordance with the contract provisions above. The DPHHS Quality Assurance Division conducts annual desk reviews of these audits to identify substantial risk in integrity and to establish the effectiveness of the corporations internal controls.

For non-profit corporations receiving less than $500,000 in federal funds from any and all federal funding sources, the Quality Assurance Division is responsible for conducting limited scope audits using agreed upon procedures.

The Montana Department of Public Health and Human Services Quality Assurance Division (QAD) began using the Service Utilization Review (SURS) methodology, effective 7/1/08. The SURS process helps ensure the integrity of provider invoicing, based on assurances that agreed upon services have been delivered in accordance with the Individual Cost Plans. In addition to random SURS reviews for providers reimbursed with Medicaid funds under fee based reimbursement systems, the DDP incorporated the review of paid claims histories as part of the DDP QA process. The following activities will apply effective immediately with CMS approval of the CAW:

DDP will annually conduct audits of paid claims histories for a sample month of invoices for every child in the waiver. In addition to the DDP QIS review of documentation supporting the delivery of waiver funded services as invoiced by the provider, parents will be asked if services and supports were delivered in accordance with their understanding of the plan of care. Problems noted by the DDP QIS will be documented on a Quality Assurance Observation Sheet to ensure a mutual understanding of the auditing issues. The DDP Regional Manager will review all audit-related correspondence between the DDP QIS and the waiver service provider. In situations when serious auditing exceptions are noted by the DDP QIS, the Regional Manager will notify the DDP central office, including the DDP Community Services Bureau Chief, the DSD Fiscal Manager and the DDP Program Director for guidance. DDP management staff will make decisions regarding the implementation of any or all of the following options: expansion of the auditing sample size by the DDP QIS, the request for a SURS review and/or the notification of the Department of Justice Medicaid Fraud Unit. Consequences for provider misuse of funds may include the return of DDP funds, provider corrective action and/or termination of the provider contract.

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.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The Department assures financial accountability in the reimbursement of services. The numerator is the number of individuals for whom adequate documentation exists to support the delivery of services as invoiced for a sample month. The denominator is the number of individuals receiving at least one month of services during the review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contact notes, staff log notes, employee timesheets and payroll records.

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:	✓ **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:
The number and percent of individuals receiving FMS services whose bills paid by the FMS match the wage rate agreed upon in the timesheet. The numerator is the number

of participants with FMS billing records that match the wage rate agreed upon in the timesheet. The denominator is the number of participants using FMS services

Data Source (Select one):
Record reviews, off-site
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:	✓ **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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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.
All DDP-funded services, except for material goods available under adaptive equipment, environmental modifications and individual goods and services are reimbursed under a rates methodology system (fee based). Client's have Individual Cost Plans (ICPs) loaded into the Agency Wide Accounting Client System (AWACS). AWACS functions as the client tracking and payment system. Units of service can only be billed when they have been prior authorized in AWACS. Providers may request a Quality Assurance Division (QAD) SURS review for the purpose of helping ensure their documentation efforts are adequate and meet QAD requirements. Copies of the SURS review tool used by QAD reviewers are available from the DDP upon request.

The Department has the quality assurance review elements in place to ensure the annual QA review of a monthly sample of services and supports reimbursed with waiver funds for every child served in the waiver. In addition to SURS reviews and the DDP annual review process, DDP staff may be contacted by parents, case managers, consumers, advocacy groups representing service recipients or other persons acting on behalf of the service recipient if scheduled services are not delivered in accordance with the plan of care, or financial fraud or misuse of funds is suspected.

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.
Isolated auditing issues may be documented and resolved via the Quality Assurance Observation Sheet (QAOS)process. More systematic or egregious auditing problems result in a DDP request to the QAD Audit Bureau for a State level audit. If poor business practices related to the documentation used to verify the delivery of waiver services are in evidence, the Department may require the development of a corrective action plan and compliance with agreed upon timeframes for resolution of the problems. Financial fraud could result in the return of funds to the State and/or the termination of the Department contract. Misuse of funds, poor or inadequate service delivery documentation and QAD audit findings are reported in the annual QA Review Reports for affected agencies, and these issues would be summarized in the CMS 372 report program section.

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**
	Continuously and Ongoing
	Other Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

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.
The implementation of a fully compliant V3.5 Quality Improvement Strategy related to the performance of providers in delivering agreed upon services, and documenting the delivery of these services will result in the implementation of a revised DDP QA review process effective on the date of waiver approval. DDP QA and Waiver Specialist staff will aggregate all the performance measures in the Children's Autism Waiver based on commpleted annual reviews of all Children's Autism Waiver service providers. DDP staff will have create a summary report and will include recommendations for DDP management staff. The purpose of the annual summary report to DDP management is twofold:

1. Systemic issues and compliance problems in providers' delivery of waiver services would be clearly communicated, based on hard data. This information would be very useful in developing or updating policy, rule and contract and waiver language related to the delivery of services and service provider performance expectations.

2. Problems in the implemenation of the review tool based on the waiver performance measures would be shared with DDP management staff. QA staff and others may have better ways to gather the performance measure data. Perhaps performance measures need to be dropped, added or modified to better meet the needs of DDP in reviewing provider performance. Changes in waiver monitoring activities would requires a waiver amendment request.

In summary, the aggregation of the provider specific annual review report data into a statewide summary report, coupled with system improvement recommendations for DDP management staff for the purpose of decision making will substantially contribute to DDP's continuous quality improvement efforts.

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).

The DPP rates methodology system applies to all DDP provider contracts. The contracts will not change significantly from year to year by provider, although contract adjustments in the rates for services may occur based on legislative appropriations for general provider rate increases, direct care staff salary enhancements, or other adjustments made to rates by the DDP.

There is opportunity for input and testimony via various forums and public notices related to the rate setting process. The rates advisory committee is the primary entity responsible for reviewing data and assisting the DDP in setting rates. The rates advisory committee comprised of DDP staff, the rates contractor, providers, a family member, a Legislator, as well as members from advocacy groups such as Disability Rights Montana, People First, and Montana Council on Developmental Disabilities. Lastly, the rates advisory committee included the liason of the Montana Association of Contractors of Developmental Disabilties Services provider group. The rates advisory

committee generally met monthly until 2007. Through the first half of 2008, the committee met on a quarterly basis. This committe remains a working committee and will continue to meet as needed, as the DDP continues to refine the rates used in the reimbursement of waiver services.

37.34.913 MEDICAID HOME AND COMMUNITY
SERVICES PROGRAM: REIMBURSEMENT (1) Reimbursement under the Medicaid home and community services program is only available for services specified in the recipient's individual plan of care.

(2) Reimbursement for services is at those rates that are available under the terms of the contract that the department enters into with providers of services.

The Montana Developmental Disabilities Program has fully converted its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for its Medicaid Home and Community-Based Services (HCBS) waiver program effective 7/1/08. This conversion has been initiated in response to direction from the Montana State legislature and guidance from the federal Centers for Medicare and Medicaid. There are three major components to the DDP rate initiative:

1. Direct Care Staff Time as the Billable Unit: With the exception of adaptive equipment / environmental modifications and transportation, all provider reimbursement is based upon the amount of direct care staff time delivered to the consumer by the provider. In order to meet the conditions for payment, the consumer must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively employed and providing the specified service as outlined under the unit definition and plan of care.

Direct training services delivered to individuals in group settings are billed and reimbursed as follows:
The rate for children's autim training services (CAT) is based on an hourly unit, predicated on a one to one staff to client ratio. If two children are receive an hour an hour of training from one CAT trainer, the rate is the same, but each child would be billed for 30 minutes of service. If the year 1 rate $22.98/hour, each child would pay $11.49 based on one hour of training delivered in a setting with a one to two staff to client ratio. if a child receives 30 minutes of one to one training, the provider would be reimbursed for 1/2 hour of service. If the year one rate is $22.98/hour, the provider would be reimbursed in the amount of $11.49. Fifteen minutes of CAT service would be reimbursed at the rate of $5.75.

□ Direct Care Staff Definition: Direct care staff are those individuals whose primary responsibility is the day to day support of people with disabilities, training and instruction, and assistance with and management of activities of daily living. Direct care workers can be either employees of an agency, or may be self-employed, so long as 85% of their work activities include daily supports to people with disabilities.

□ Billable Unit: The term □billable unit□ is used to describe the amount of service provided. The term □Hours□ refers to a Direct Care Staff Hour. For services using this billable unit, agencies are reimbursed for each direct care staff hour provided. The term □Month□ refers to a single month billing unit. For services using this billable unit, agencies are reimbursed a fixed monthly amount for all direct care hours provided to those people enrolled in their service for an entire month. Monthly rates are used when individual support needs can vary widely on a daily basis.

2. Standardized Cost Centers: All provider reimbursement rates consist of four cost centers. These cost centers are:

---Direct Care Staff Compensation

---Employee-Related Expenses

---Program Supervision and Indirect Expenses

---General & Administrative Expenses

□ Holiday Coverage factor: Each residential provider may identify up to ten (10) holidays per fiscal year; direct care staff hours provided on those days will be compensated at 1.5 times normal salary which providers must pass on to direct care staff.

Policies and Rules governing rates reimbursement are available from the DDP upon request.

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:

Provider invoices flow directly from providers to the State's claims payment system.

Payments are made to reimburse providers for services to persons enrolled and eligible for Medicaid at the time services were rendered. Verification of Medicaid eligibility is accomplished by an electronic interface between AWACS and TEAMS. If a person is not Medicaid eligible at the time the payment is approved by the DDP regional office administrative assistant, the name of the ineligible recipient is highlighted. Payment is not made until it is verified that the service recipient was open for Medicaid for the dates services were delivered as specified on the provider invoice. Payment is withheld if the service recipient was not open for Medicaid when services were delivered. Claims payments are reviewed and approved monthly.

The AWACS service detail codes are loaded monthly onto electronic pre-populated invoices based on the most recent Individual Service Record (ISR) forms loaded into AWACS. The ISR reflects service detail as authorized by the individual's ICP. At the time that services are approved for payment, there is no third party review of the accuracy or validity of the provider□s claim for reimbursement, but the recipient is verified in terms of being enrolled in the waiver, and currently eligible for Medicaid. AWACS has contraints that ensure that only those services pre-authorized on the ICP can be billed, up to, but not exceeding, the annual amount approved on the ICP. Failure to deliver services specified in the plan of care may not be caught during the monthly billing process, but audit exceptions and DDP QA review discoveries can and have resulted in the return of funds to the Department.

Providers may bill for services for which they are qualified to deliver, in accordance with a service recipient's plan of care and ICP. Providers of services may subcontract for the delivery of waiver services if the provider has been designated as an Organized Health Care Delivery System in their DDP Contract. In this case, the provider with a DDP contract has the option of reimbursing another waiver service provider, at a rate equal to or less than the approved medicaid rate. The provider with the DDP contract is responsible for processing claims, maintenance of documentation, and the verification of the credentials of the subcontracting entity. The provider with a DDP contract is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the individual cost plan, and the the applicable qualified provider standards for the service. The provider with the DDP contract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and DDP reviewers to verify the delivery of services in accordance with the aforementioned requirements.

Professional services such as OT, PT, Speech and other such services that are not reimbursable under the State Plan (different in amount, scope or duration) may be reimbursed under the OHCDS model of service delivery. The providers of such services could choose to contract directly with the DDP and have a DD contract for the purpose of delivering services, but for the relatively small number of dollars and units of service involved, this option is not considered cost effective.

Appendix I: Financial Accountability

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.)*

Appendix I: Financial Accountability

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:

Payments are made to reimburse providers for services to persons enrolled and eligible for Medicaid at the time services were rendered. Verification of Medicaid eligibility is accomplished by an electronic interface between AWACS and TEAMS. If a person is not Medicaid eligible at the time the payment is approved by the DDP regional office administrative assistant, the name of the ineligible recipient is highlighted. Payment is not made until it is verified that the service recipient was open for Medicaid for the dates services were delivered as specified on the provider invoice. Payment is withheld if the service recipient was not open for Medicaid when services were delivered. Claims payments are reviewed and approved monthly.

The AWACS service detail codes are loaded monthly onto electronic pre-populated invoices based on the most recent Individual Service Record (ISR) forms loaded into AWACS. The ISR reflects service detail as authorized by the individual's ICP. At the time that services are approved for payment, there is no third party review of the accuracy or validity of the provider□s claim for reimbursement, but the recipient is verified in terms of being enrolled in the waiver, and currently eligible for Medicaid. AWACS has contraints that ensure that only those services pre-authorized on the ICP can be billed, up to, but not exceeding, the annual amount approved on the ICP. Failure to deliver services specified in the plan of care may not be caught during the monthly billing process, but audit exceptions and DDP QA review discoveries can and have resulted in the return of funds to the Department.

In the current fee-based rates system, the SURS process conducted by the Quality Assurance Division will help ensure the financial integrity of provider billing practices. The DDP Annual QA review process based on QIS sample reviews of the documentation maintained for the services delivered to children served in this waiver is another assurance that services were provided in accordance with the individual cost plan and the plan of care. Problems noted in comparing the delivery of services with the Individual Cost Plans can and have resulted in requests for a QAD audit of the provider.

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:

The basis for the draw of federal funds and the claiming of expenditures on the CMS-64 follows:

When the expenditures identified in I-2.b. post to the Statewide Accounting Budgeting Human Resource System (SABHRS), federal funds are drawn down from the Smartlink system, via the Internet. Medicaid is a Cash Management Improvement Act (CMIA) grant; therefore, electronic fund transfers are drawn immediately, and warrants are drawn on a six day clearance pattern. These expenditures are claimed on the appropriate waiver form on the CMS-64, which is then reconciled quarterly to the SABHRS system.

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:

Appendix I: Financial Accountability

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:

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.

Appendix I: Financial Accountability

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: *Complete item I-3-e.*

The only public providers receiving payment from the DDP for waiver services are the public transportation providers.

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.

Appendix I: Financial Accountability

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:

Preface- The following OHCDS language applies to those situations in which a family chooses to have some or all of their waiver services provided by an agency designated by the DDP as an OHCDS. Parents who make this choice are not limited from choosing individuals with a DDP contract to provide other CAW services. In all cases, the family may choose to have individuals with a DDP contract provide and or all of the their CAW services. In addition to these options, a family may choose to have their WCCM service provided by one child and family service provider, or by an individual WCCM with a DDP contract (as outlined in Appendix C), their PDM service from a different child and service provider, or by an individual with a DDP contract (as outlined in Appendix C) and their children's autism training service from a third provider agency or an individual with a DDP contract (as outlined in Appendix C). There are no limitations in parental choice of CAW service providers.

OHCDS Model:

a) Entities may be designated as an OHCDS in DDP's provider contract. All Child and Family service providers are designated by the DDP as OHCDS. Providers are designated as OHCDS to enable the provider with the DDP contract to subcontract with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency contracting with the DDP. This also enables the service recipient free choice of service provider; the C&F providers will subcontract for the provider specified by the service recipient. Any person or agency providing services under a subcontract with an agency with a DDP contract must meet the DDP qualified provider standards for the provision of the service. It is the responsibility of the agency with the DDP contract to ensure: 1) the qualified provider standards for the subcontracted service are met and; 2) documentation is maintained by the agency with the OHCDS designation to support this requirement.
(b) All providers of waiver services may choose to contract directly with the DDP. The potential service provider would request a provider enrollment package from the DDP. After the required enrollment documentation has been reviewed and approved by the DDP Regional Manager and subject to a successful onsite review of the physical site (if applicable) by the DDP, the applicant would achieve qualified provider status. The provider would then be enrolled as a Montana Medicaid Provider, although payment would flow through AWACS and not through the MMIS. The provider would have a DDP contract, and would be accountable for meeting all the conditions and terms as outlined in the DDP contract. Contracts are signed by the provider Board Chairperson and by the Administrator of the Disability Services Division. The annual QA review process reviews documentation serving to verify that providers meet the terms and conditions of the contracts on an annual and ongoing basis.
(c) Service recipients are free to request the services of any qualified provider, as outlined in previous sections. Case managers are responsible for providing information to recipients and families regarding available service providers as part of the planning and pre-planning meeting process. Providers currently subcontract with various providers of professional and therapy services, in response to the expressed desires of the recipient and/or family.
(d) All expenses associated with subcontractor payments are reported on the monthly invoices. These expenses are based on the AWACS service option code assigned to the specific service category. Applicable qualified provider standards for all waiver service providers are reviewed annually, as outlined in section (b), above.
(e) The provider agency designated as an OHCDS is accountable for maintaining documentation verifying the credentials of subcontracted staff. The QA review process reviews the qualified provider documentation for staff providing the services outlined in the plan of care and the ICP. The DDP QIS may choose to verify the professional licensure or certification status at the Montana Department of Labor website, in addition to reviewing the certification or licensure records of subcontracted staff maintained by the provider agency designated as an OHCDS.
(f) Financial accountability is maintained as follows: Providers of services may subcontract for the delivery of waiver services if the provider has been designated as an Organized Health Care Delivery

System in their DDP Contract. In this case, the provider with a DDP contract has the option of reimbursing another waiver service provider, at a rate equal to or less than the approved Medicaid rate. There can be no payment made to the provider with the DDP contract for processing claims, maintenance of documentation, and verification of credentials of the subcontracting entity, when the subcontracted entity bills at the Medicaid rate. The provider with a DDP contract is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the individual cost plan, and the the applicable qualified provider standards for the service. The provider with the DDP contract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and DDP reviewers to verify the delivery of services in accordance with the aforementioned requirements. The DDP QA financial review occurs annually for every client and for every service received by the client in the Childrens Autism Waiver. The additional assurance of family survey questions linked to the delivery of services outlined in the plan of care, the individual cost plan and the sampled monthly invoice reduces the potential for fraudalent billing and the misuse of Medicaid funds.

Case managers may be employed by an agency designated as an OHCDS. Case management may also be provided by indiviuals with a DDP contract. The use of the Waiver 5 form reduces the potential for providers to withold choice of service provider options from the family. In addition, the DDP QIS family survey will provide further assurance that families always retain the option of selecting a new or different provider for ANY of the services authorized in the plan of care and individual cost plan.

The following protections help reduce the potential for conflict of interest in the provision of services:

1. The parents have the right to approve or deny any of the planning meeting (IFSP) outcomes.
2. The W-5 freedom of choice form is reviewed with the parents annually by the DDP QIS. This form and the W-5 addendum section helps ensure that parents understand their choices related to services, providers and dispute resolution/fair hearing rights. The W-5 form specifies that parents retain the right to request a fair hearing at any time.
3. Annual consumer satisfaction surveys are sent to all families by C&F provider staff. These results are summarized in the DDP QA Review Report. 100% of families in the CAW participate in this survey.
4. 100% of plans of care (IFSP) are reviewed and approved by the DDP QIS.
5. Choice of provider is clearly spelled out in the notification letter from the DDP central office upon an applicant□s selection for waiver services.
6. C&F providers have their dispute resolution processes and protocols reviewed annually by the DDP QIS, as part of the DDP annual QA review process of provider policies. Provider policies specify that parents can to go straight to the fair hearing process, if desired.
7. Prior authorization by the DDP Regional Manager will be needed in 100% of all cases when the staff person providing WCCM to a child will also be providing the PDM service to the same child. Prior to approving this arrangement, the RM or designee will contact the child□s parent to ensure their service provider options are fully understood. Parental understanding of the right to choose another person to provide their PDM service, and/or to choose another individual or another agency provider to provide their PDM service or WCCM will be ensured.

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:
Do not complete this item.

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:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	21749.28	6520.00	28269.28	221438.00	5649.00	227087.00	198817.72
2	40649.37	6651.00	47300.37	225867.00	5762.00	231629.00	184328.63
3	41342.76	6784.00	48126.76	230384.00	5877.00	236261.00	188134.24
4	23173.26	6919.00	30092.26	234992.00	5994.00	240986.00	210893.74
5	43012.78	7058.00	50070.78	239692.00	6114.00	245806.00	195735.22

Appendix J: Cost Neutrality Demonstration