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 Department of Public Health and Human Services (Department) provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. The Department does not require waiver providers to secure an independent audit of their financial statements. Paid claims reports will be run by the Senior and Long Term Care (SLTC) Division of the Department on a monthly basis (or as needed). These reports will depict the services utilized, the number of waiver participants using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability will be assessed. Case managers and financial managers are required to prior authorize waiver services. They inform Xerox of the allowed services and the number of units or dollar amount for which providers are permitted to bill for each member. The Quality Assurance Division (QAD) of the Department will conduct financial audits upon request of the SLTC Division.

Case management providers are required to conduct internal audits of their records to ensure the waiver member files include the necessary documentation to support the member's identified needs. The person centered plans must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file.

Community Services Bureau (CSB) staff of the SLTC Division will complete desk audits of case management teams every three years or as necessary. The desk audits include waiver paid claims by waiver member and by service. The State Plan expenditures are reviewed to ensure State Plan funds have been used prior to waiver funds. The claims are compared with the cost sheet and person centered plan to ensure the waiver member is receiving the services identified on the cost sheet. Any discrepancies are discussed with the case management teams and they are provided assistance in the development of a quality improvement plan.

The Surveillance Utilization Review (SURS) of the QAD conduct provider audits by reviewing records provided by the provider. When an overpayment is identified through the SURS process, SURS staff discusses the overpayment details with the provider and requests the overpayment by a formal notice. Providers are notified of their fair hearing rights through the notification from SURS staff. If fraud is identified providers can be sanctioned and be discontinued as a Medicaid and Medicare provider. The findings are sent to Office of Inspector General (OIG) and the licensing board of the provider.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (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

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/percent of claims submitted using the appropriate procedure codes and rates. The numerator is the number of claims submitted using the appropriate procedure codes and rates. The denominator is the total number of claims submitted.

Data Source (Select one):
Financial records (including expenditures)

If ‘Other’ is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ State Medicaid Agency</td>
<td>☐ Weekly</td>
<td>☑ 100% Review</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Monthly</td>
<td>☐ Less than 100% Review</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☐ Quarterly</td>
<td>☐ Representative Sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence Interval =</td>
</tr>
<tr>
<td></td>
<td>✗ Annually</td>
<td>☑ Stratified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Describe Group:</td>
</tr>
<tr>
<td>☐ Other Specify:</td>
<td>☐ Continuously and Ongoing</td>
<td>☐ Other Specify:</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Other</td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

06/23/2021
Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☒ Annually</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Weekly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☐ Monthly</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Quarterly</td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
<tr>
<td>☐ Continuously and Ongoing</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
</tbody>
</table>

Performance Measure:
Number/percent of claims that were paid in accordance with the reimbursement methodology on the date that services were provided. The numerator is the number of paid claims that were paid in accordance with the reimbursement methodology on the date that services were provided. The denominator is the total number of paid claims for individuals who receive waiver services.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☒ Weekly</td>
<td>☒ 100% Review</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Monthly</td>
<td>☐ Less than 100% Review</td>
</tr>
</tbody>
</table>
### Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☒ Annually</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Weekly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☐ Monthly</td>
</tr>
<tr>
<td>☐ Other Specify:</td>
<td>☐ Quarterly</td>
</tr>
<tr>
<td>☐ Other Specify:</td>
<td></td>
</tr>
</tbody>
</table>

06/23/2021
Performance Measure:
Number of claims that are coded and paid only for services rendered. The numerator is the number of claims that are coded and paid only for services rendered. The denominator is the total number of claims coded and paid.

Data Source (Select one):
Record reviews, on-site
If ‘Other’ is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☐ Weekly</td>
<td>☒ 100% Review</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Monthly</td>
<td>☐ Less than 100% Review</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☒ Quarterly</td>
<td>☐ Representative Sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence Interval =</td>
</tr>
<tr>
<td>☐ Other Specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other Specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☐ Weekly</td>
</tr>
</tbody>
</table>

06/23/2021
Responsible Party for data aggregation and analysis (check each that applies):

<table>
<thead>
<tr>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Operating Agency</td>
</tr>
<tr>
<td>□ Sub-State Entity</td>
</tr>
<tr>
<td>□ Other Specify:</td>
</tr>
</tbody>
</table>

Performance Measure:
Number of claims submitted that are consistent with the participant's service plan. The numerator is the number of claims submitted and paid that are consistent with the participant's service plan. The denominator is the total number of claims submitted and paid.

Data Source (Select one):
Record reviews, on-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                                              |
| □ Operating Agency                                                  |
| □ Sub-State Entity                                                   |
| □ Other Specify:                                                     |

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:
### Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☐ Weekly</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Monthly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☐ Quarterly</td>
</tr>
<tr>
<td>☐ Other Specify:</td>
<td>☒ Annually</td>
</tr>
<tr>
<td>☐ Continuously and Ongoing</td>
<td>☐ Other Specify:</td>
</tr>
</tbody>
</table>

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

### Performance Measures

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

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

Performance Measure:
Number of rates consistent with the approved rate methodology throughout the five year waiver cycle. Numerator is the number of rates consistent with the approved rate methodology. The denominator is the total number of rates throughout the five year waiver cycle.

Data Source (Select one):
Record reviews, on-site
If ‘Other’ is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>[x] State Medicaid Agency</td>
<td>[ ] Weekly</td>
<td>[x] 100% Review</td>
</tr>
<tr>
<td>[ ] Operating Agency</td>
<td>[ ] Monthly</td>
<td>[ ] Less than 100% Review</td>
</tr>
<tr>
<td>[ ] Sub-State Entity</td>
<td>[ ] Quarterly</td>
<td>[ ] Representative Sample</td>
</tr>
<tr>
<td>[ ] Other Specify:</td>
<td>[x] Annually</td>
<td>Confidence Interval =</td>
</tr>
<tr>
<td>[ ] Continuous and Ongoing</td>
<td>[ ] Other Specify:</td>
<td></td>
</tr>
<tr>
<td>[ ] Other Specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

The CSB staff will conduct audits of case management teams every three years to perform an audit of participant records to ensure the waiver services are aligned to address the identified needs, the cost sheet matches services provided and paid claims support services authorized.

b. Methods for Remediation/Fixing Individual Problems
i. Describe the States 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.

Claims that do not have the appropriate procedure codes and/or rates are denied by the MMIS system. Claims that are suspended because of Medicaid eligibility are forwarded to the Department for review and action. Depending upon the number and reasons for denials, training will be made available to providers by Conduent or the Department. CSB staff will always assist providers who encounter on-going problems with the billing system.

In instances in which claims are incorrectly paid, providers will be required reimburse the Department. If the provider fails to do so, the amount owed will be recouped from future claims submitted.

ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☒ Weekly</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Monthly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☐ Quarterly</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☒ Annually</td>
</tr>
</tbody>
</table>

06/23/2021
### c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- **No**
- **Yes**

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

### Appendix I: Financial Accountability

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

#### a. Rate Determination Methods.
In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).
In November 2019, the Montana DPHHS Senior and Long Term Care Division facilitated the establishment of an assisted living work group to address identified provider barriers and work collaboratively to resolve and develop solutions to resident access and provider sustainability. Together, the workgroup analyzed the Medicaid population served in assisted living facilities, the number of assisted living providers across the state, the existing market, the costs of providing adult residential services, and comparing the data to costs associated with service delivery within a higher level of care.

It was determined that providers have become, and continue to be, increasingly financially limited in their ability to care for residents in congregate care settings predominantly citing historically low reimbursement rates. As a result, providers have had to face difficult decisions on whether to become a Medicaid provider or limit the admissions of Waiver enrolled individuals into their facility. For example, a provider survey conducted by a third-party advocacy group in January 2017 identified that “Nearly 50% of all providers do not serve Medicaid clients. About 75% of those who do accept Medicaid limit the number of clients they are willing to serve. Many limit participation to a very small number”.

Calculations of residential habilitation rate adjustments included the following discussion of: 1) the number of assisted living providers across the state and how the number of providers accepting waiver Medicaid residents impacts access to waiver services, 2) the employment and provider agency costs in addition to salaries, 3) calculate a rate that would reasonably cover employee wage increases, employing additional staff, and procuring and providing targeted training opportunities, and 4) The termination of the care calculation sheet for assisted living facilities that resulted in the average unsustainable daily rate of $69.00 per day.

The requested rates are as identified:

Residential Habilitation- Assisted Living Facilities and Adult Foster Homes- Increase to $104.00 per day from a maximum rate of $78.80 per day.
Residential Habilitation- TBI/AR- Increase to $165.77 per day from $109.78 per day.
Residential Habilitation- Group Home- Increase to $206.58 per day from $158.91 per day.

The increased rates were calculated by starting with a ‘base’ rate for assisted living facilities at one-half the average of the state’s nursing home rate of $208 per day. The TBI/AR and Group Home rates were calculated by increasing at the same percentage as the previous base rate to the adjusted base rate of $104, which was 51%. The calculation is outlined as follows:

Base Rate Calc = 50% of NH Rate: $208 X 50% = $104.00
TBI/AR Rate Calc = Same increase as Current Base Average Paid Rate of $69 to new rate of $104
$104 – 69 = 35; 35 divided by 69 = 51%
$109.78 X 51% = 55.99; 109.78 + 55.99 = $165.77
Group Home Rate Calc = Increase by the difference of the Current Base Average Paid Rate of $69 and the Current Group Home Rate of $158.91 or 1.30 (158.91 – 69 = 89.91; 89.91 divided by 69 = 1.30)
$158.91 X 1.30 = $206.58

To verify the that the requested rate corrects for the items of concern, employee wage increases, employing additional staff, and procuring and providing targeted training opportunities the CPI index was used from 2000 forward. Calendar year 2000 was used to account for wage enhancement programs that were not available to assisted living providers but were provided to long term care facilities. The calculations are represented as follows:

<table>
<thead>
<tr>
<th>CY</th>
<th>CPI</th>
<th>RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>0.034</td>
<td>69.90</td>
</tr>
<tr>
<td>2001</td>
<td>0.028</td>
<td>71.86</td>
</tr>
<tr>
<td>2002</td>
<td>0.016</td>
<td>73.01</td>
</tr>
<tr>
<td>2003</td>
<td>0.023</td>
<td>74.69</td>
</tr>
<tr>
<td>2004</td>
<td>0.027</td>
<td>76.70</td>
</tr>
<tr>
<td>2005</td>
<td>0.034</td>
<td>79.31</td>
</tr>
<tr>
<td>2006</td>
<td>0.032</td>
<td>80.85</td>
</tr>
<tr>
<td>2007</td>
<td>0.028</td>
<td>87.34</td>
</tr>
<tr>
<td>2009</td>
<td>-0.004</td>
<td>86.99</td>
</tr>
<tr>
<td>2010</td>
<td>0.016</td>
<td>88.38</td>
</tr>
<tr>
<td>2011</td>
<td>0.032</td>
<td>91.21</td>
</tr>
<tr>
<td>2012</td>
<td>0.021</td>
<td>93.12</td>
</tr>
</tbody>
</table>
2) Historically, it has been found that when residents exhibit adverse behaviors, such as verbal and physical aggression, wandering, elopement, frequent falls, and impulsive behaviors and/or actions, assisted living facilities are often compelled to issue residents an involuntary 30-day eviction notice. If discharges are rendered successful, residents often are inappropriately hospitalized, placed in skilled nursing facilities, or settings specializing in mental health intervention until stabilized. It is estimated that approximately 10-15% of the Medicaid population, enrolled in the Big Sky Waiver program, would directly benefit from the enhanced behavioral management rate. As indicated previously, the enhanced rate would allow an assisted living provider to secure additional direct care staff, provide regular and ongoing training and education opportunities, and have more incentive to pursue advanced licensure while expanding their scope of care.

To best support the Assisted Living Behavior Management rate and demonstrate cost-neutrality, Big Sky Waiver evaluated current adult residential services and rate scales. Furthermore, in September 2020, the Big Sky Waiver program conducted a survey requesting feedback from assisted living facilities. The survey was built to determine if a rate increase would provide at-risk individual’s greater access to necessary services isolated to behavioral support and enhanced memory care. Of the respondents, 58.33% indicated the facility provides memory care and 61.54% indicated they provide services to individuals exhibiting difficult behaviors.

Collectively, 76.92% of respondents indicated that increased reimbursement rates would prompt the provider to admit additional Medicaid residents within this targeted demographic into their facility. Big Sky Waiver also requested information identifying the provider’s average private pay rates. On average, the base is approximately $3,562.00 monthly, median is $4,203.00 monthly, and the maximum is $4,597.00 monthly. Big sky Waiver also requested the facilities estimate an ‘adequate’ Medicaid reimbursement rate for serving individuals with difficult behaviors or enhanced memory care needs. This average rate was determined to be $4,860.00 monthly or $162.00 per day. The daily rate provided in the surveys received was a range from $120.00 to $200.00 per day.

It was determined the rate would be set at mid-point from the low rate to the average rate which calculated to $141.00 per day.

3) Year four (4) Rate methodology is as follows:

- **Group Homes**
  
  $206.58 - $157.48 = $49.10 / 2 = $24.55 Final $206.58 - $24.55 = Total $182.03

- **Assisted Living Facility and Adult Foster Homes**
  
  $104.00 - $76.36 = $27.64 / 2 = $13.82 Final $104.00 - $13.82 = Total $90.18

- **Specialized Assisted Living Facilities and Child Foster Care**
  
  $165.77 - $108.79 = $56.98 / 2 = $28.49 Final $165.77 - $28.49 = Total $137.48

- **Payments for waiver services will be consistent with efficiency, economy and quality of care and will be enough to enlist enough providers. Services will be reimbursed via fee for service; there will be no interim rates, no prospective payments, and no cost settlements.**

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:
Waiver service providers bill Montana Medicaid through the MMIS system. Payments are issued directly to the providers; no funds are retained by the Department. All services are prior authorized by provider and by units.

Edits are in place with MMIS to ensure all services are allowable and reimbursed at the appropriate rate. The providers are enrolled as Medicaid waiver providers in the MMIS. Each provider has a charge file of the services (procedure codes) that they are approved to provide. These files are updated annually with the appropriate fiscal year reimbursement rate and the services. Department staff provides the information to the fiscal intermediary for updating.

Members are initially entered into the Medicaid eligibility system (CHIMES) as Medicaid and waiver eligible. The eligibility file is transferred nightly to the MMIS.

MMIS has edits to ensure the person receiving the service is eligible for the service, and the prior authorization and provider charge file are reviewed. If all is appropriate, the claim is paid. If there is an error anywhere in this process, the claim is denied.

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:
The states MMIS (Conduent) has a recipient eligibility system that verifies eligibility for Medicaid and the waiver. Case management teams or financial managers prior authorize all services in the members service plan. These prior authorizations are submitted to the states fiscal intermediary (MMIS). Case managers receive monthly utilization reports from providers documenting units of service provided. These reports are compared to individual service plans, compiled and forwarded to the Community Services Bureau. The data is tabulated and further compared to paid claims data from MMIS.

Utilization reports, cost sheets and service plan for the sampled members are reviewed to determine the date of the claim is within the period authorized by the plan of care, in the amount and type of service as specified in the plan of care. Inappropriate claims billed will be recouped.

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) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

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

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

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

Describe how payments are made to the managed care entity or entities:
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.
- [x] The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- [x] 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:

Financial managers (FM) operate as limited fiscal agents and make payment for the member in the participant directed option (Bonanza option). The FM submits claims to Medicaid for payment and monitors expenditures. Quarterly utilization reports are reviewed by the Community Services Bureau staff.

- [ ] 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:*

- [x] 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.
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:

  iii. Contracts with MCOs, PIHPs or PAHPs.

  - 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.

○ This waiver is a part of a concurrent 21115/?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 21115 waiver specifies the types of health plans that are used and how payments to these plans are made.

○ If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:

The Department sets reimbursement for room and board in residential settings. Upon admission, providers are notified that the waiver will not cover the cost of room and board for the recipient. The cost calculation sheet utilized by the case managers to determine reimbursement for services has a line item for room and board, which is identified as the responsibility of the member.

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

06/23/2021
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: