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).

Provider agencies that are under contract with the Operating Agency and receive over $750,000 in Operating Agency funding are required to have an independent audit of their financial statements on an annual basis. If the Operating Agency performs rate calculations or expense and revenue analysis, provider agencies are required to submit revenue and expense data by program in a consolidated financial report form prescribed by the Operating Agency, regardless of overall funding level. Individual providers and businesses that are not under contract with the Operating Agency are not required to obtain and submit audits on their financial information. However, the Operating Agency reserves the right to audit any provider at any time.

The audits entail a complete and total financial and organizational review of the provider, including everything from financial to accounting processes, as well as sample business transactions. The audits are conducted in accordance with Governmental Accounting Standards (GAS). The Operating Agency performs desk reviews and a sample of on-site audit reviews of the required independent audits on an annual basis. Copies of the audits and consolidated financial reports are on file with the Operating Agency. The types of findings and discrepancies reported by auditors may include segregation of duties, issues with internal controls, inability to accurately prepare financial statements, misappropriation of funds, eligibility of services, accurate reporting of billings, and inappropriate costs.

This independent audit is an Operating Agency requirement and the Single Audit Act of 1984 (Act) and the Single Audit Act Amendments of 1996 do not apply to this Waiver. Medicaid payments received as reimbursement for providing services to Medicaid eligible individuals are not considered Federal awards under the Act and therefore providers are exempt from Federal audit requirements for these payments.

The Medicaid and Operating Agencies work cooperatively to review rates and provider claims. The MA delegates to the OA the financial oversight of claims.

The OA reviews 100% of claims verifying the following:
1)The individual was eligible and enrolled in the waiver on the date of service, and,
2)The rates were paid in accordance with the reimbursement methodology.

In addition, the Operating Agency reviews rate calculations anytime there is a significant change in the computerized information management system. The Medicaid agency also reviews the residential rate components calculated by the Operating Agency for accuracy and validity whenever residential providers receive a rate increase. Although the room and board component of a residential rate is not claimed for FFP, it is still an integral factor in the calculation of a residential rate and is included in the Medicaid Agency review.

Further, the OA selects a representative sample of claims and conducts post-payment reviews to verify whether the services were approved in the person centered plan. The OA summarizes the post payment review data and provides quarterly reports to the MA of their findings and any remediation activities (on an individual and systemic basis). Remediation may include clarifying policy, retraining staff, providing technical assistance, voiding claims, increased monitoring, conducting focused reviews, or developing plans of correction, as appropriate.

The Medicaid Agency performs a validation review based on the OA report to verify that post-payment review procedures were followed and appropriate remediation actions were taken. The MA's validation review includes an assessment and review of the internal controls established by the OA. The MA assesses the appropriateness of established controls and performs tests to provide reasonable assurance that the established controls are followed. The MA uses the data warehouse to verify that claiming errors were corrected by crediting CMS with any applicable FFP. As a result of the validation review, the MA works with the OA to modify and strengthen internal controls as needed.

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 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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
I1 Number and percent of reviewed waiver service claims submitted for FFP that are specified in the participant's person centered plan. N: Number of claims reviewed that were specified in the PCP. D: Total number of claims in the representative sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Comparison of claims with person centered plans in sample

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 = 95%
☐ **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:
I2 Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered. N: Number of claims submitted for participants who were Medicaid eligible on the date the service was provided. D: All waiver claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA MIS automated reports

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:
I3 Number and percent of waiver claims reviewed that were submitted using the rate developed in accordance with the rate methodology approved waiver. N: Number of claims with correct rate. D: All claims in representative sample.

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	Frequency of data collection/generation *(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 = 95%
☐ 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:

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:
I4 Number and percent of waiver claims reviewed that were confirmed to have been provided. N: Number of claims reviewed with required documentation of service delivery. D: All claims in representative sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Comparison of claims with approved rates

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 = 95%
☐ **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:

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 Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

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.
The OA is responsible for seeing that individual issues are resolved.

38I: Upon discovery, the OA analyzes claims processing logic to identify errors and correct claim rate errors on both an individual and systemic level (to prevent repeat errors).

39I: Upon discovery, determination of waiver eligibility and if participant is eligible, no further action. If participant is ineligible, adjust claim.

40I: Upon discovery, if the provider is no longer providing services or the participant is no longer receiving services, no further action is taken. If the participant is still actively receiving services, request a copy of the current PCP to determine if the need for the service is addressed. If the services are needed and addressed in the current PCP, no further action is taken. If the services are needed and not included in the current PCP, require an updated PCP from the ISC. If the service is not needed by the participant, terminate the service.

The OA may impose sanctions on providers which fails to comply with conditions stipulated in the provider contract. Sanctions include, but are not limited to, payment suspension, loss of payment, and enrollment limitations, or other actions up to and including contract termination.

The OA provides summary reports of remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. QMC meeting summaries document the actions taken.

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**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
✓ Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	✓ Annually
	Continuously and Ongoing
	Other Specify:

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

- (●) No
- ( ) Yes

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

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).

Rate determination methods for each waiver service are outlined below.

Adult Day Care
The Adult Day Care rate is based on the rate used by the Illinois Department on Aging in their Waiver program for elderly persons, adjusted to include a transportation factor based on the Department on Aging's transportation rate.

Residential Habilitation
Community-Integrated Living Arrangement (CILA) rates have been calculated using individualized model rate methodologies since 1994. The models (24 hour, host family, intermittent and family) fund components based on individual needs and the size of the home. Rates are based on system-wide provider cost data where possible and proxy values where necessary or appropriate. Rates have been subject to cost of living adjustments when enacted. Community Living Facility (CLF) and some CILA rates from legacy programs are calculated based on past individual provider cost reports. Rates are subject to cost of living adjustments when enacted and may be adjusted based on rate appeals.

Community Day Services
The statewide, standard fee-for-service hourly rate is based on allowable costs from historical grant-funded site-based Developmental Supports. It includes the following components:

• Direct Support Staff Wages;
• Direct Support Staff Supervision;
• Employment Related Expenditures, e.g. benefits, FICA, Unemployment Insurance, Workers' Compensation Insurance;
• Professional Support Staff;
• Program Related Supplies, e.g., program materials, printing;
• Transportation Costs, e.g., vehicle operation costs, vehicle maintenance, insurance;
• Ownership/Occupancy Costs (Property Insurance, Maintenance costs, Utilities; and
• Administrative Overhead costs, e.g., Administrative Salaries, Office Space, Staff Training Costs, other allocated overhead.

Supported Employment - Individual Employment Support and Supported Employment – Small Group Supports
The statewide, standard fee-for-service hourly rate is based on allowable costs from historical grant-funded Supported Employment Programs. It includes the following components:
• Job Coach Staff Wages;
• Job Coach Staff Supervision;
• Employment Related Expenditures, e.g. benefits, FICA, Unemployment Insurance, Workers' Compensation Insurance;
• Professional Support Staff;
• Program Related Supplies; program materials, printing;
• Transportation Costs, e.g., vehicle operation costs, vehicle maintenance, insurance; and
• Administrative Overhead costs, e.g., Administrative Salaries, Office Space, Staff Training Costs, other allocated overhead.

Personal Support/Temporary Assistance Services
Rates for Personal Support and Temporary Assistance are negotiated between the participant, guardian (as applicable) or representatives and the providers with assistance from the Information and Assistance in Support of Participant Direction provider. The negotiated rates are specified in the Service Agreement and are subject to review and approval by the Operating Agency on either a targeted or sample basis. These rates are not subject to cost of living adjustments.

Home and Vehicle Modifications, Adaptive Equipment (including Assistive Technology)
Rates are usual and customary. Payments are subject to prior approval by the Operating Agency. Two bids are required for approval. Per-participant five-year cost limits and specific cost limits on rental housing governing the use of these services.

Non-medical Transportation
Statewide mileage rates are set by the Operating Agency. Per-trip rates are usual and customary charges. The rate is subject to cost of living adjustments when enacted by the General Assembly and signed by the Governor.

Emergency Home Response Services
The statewide rates for installation and monthly basic service are adopted from the rates established in October 2006 by the Department on Aging for their elderly waiver program.

Training and Counseling For Unpaid Care Givers
The counseling rate for unpaid care givers is identical to the standard statewide rate currently used in the waiver for participants receiving Individual Counseling services. The rate is based on available cost data for licensed social workers on contract with traditional developmental disabilities agencies. The rate is subject to cost of living adjustments when enacted. Reimbursement for training for unpaid care givers is based on usual and customary charges for the tuition or fees to attend the program. Transportation, meals and lodging to attend training are not included. Reimbursement for training for unpaid care givers is not subject to cost of living adjustments.

Behavior Intervention and Treatment
There are two rate levels for this service based on provider qualifications. The higher rate (Level I) is based on a weighted combination of Bureau of Labor Statistics wage for licensed clinical psychologists, provider survey results and a comparison to bargaining agreement wages for state employees. The lower rate (Level II) is set at 80% of the higher rate. Both rates are subject to cost of living adjustments when enacted.

Behavioral Services (Psychotherapy and Counseling) and Skilled Nursing

These rates are based on available cost data for clinical psychologists, social workers and nurses on contract with traditional developmental disabilities agencies. The rates are subject to cost of living adjustments when enacted.

Physical Therapy, Occupational Therapy, and Speech Therapy
These rates are based on rates for these services in the Medicaid State Plan, converted to an hourly rate.

Information and Assistance in Support of Participant Direction
This a standard, statewide, hourly fee-for-service rate.

24-Hour Stabilization Services
The rates for this service are initially established through a Request for Applications process. Through this process, the State compares the proposed rates of willing providers. A standard methodology is developed for the waiver service with variation based upon a number of factors defined below. The required components that are used to establish the rate are:

• Direct support staff wages;
• Professional staff wages and clinical contracts, e.g., QIDPs, Behavior Analysts, nurses, etc.;
• Employment-related expenditures, e.g., employee benefits, FICA, unemployment insurance, workers' compensation, etc.;
• Program-related expenditures, e.g., supervision, supplies, etc.;
• Utilization factors;
• Administration, e.g., administrative salaries, staff travel, office space and expenses; and
• Transportation of individuals.

The following additional factors may influence the standard methodology and are the basis for rate variations. When all factors are equal, the rates produced by the standard methodology would be the same.
• Provider rates may vary due to geographic differences.
• A differential may be included in the rate for the level of expertise and skill of specific professional staff; the differential will again be uniform across all providers.

Once the rates are established, rates may be adjusted through contractual amendments subject to cost of living increases appropriated by the Illinois General Assembly, through negotiations during contract renewals, or through subsequent calls for Request for Applications.

Established rates are published on the Operating Agency's website at: http://www.dhs.state.il.us/page.aspx?item=38992. The rates published for 24-Hour Stabilization services are actual rates for services.

RFAs are posted on a website used by all State agencies to list contracting opportunities with the State. This website is referred to as the Illinois Procurement Bulletin (IPB). Vendors of all types can register on the IPB to do business with the state, to review requests for information or proposals, and receive updates on procurement rules and requirements. The RFA for this service used the IPB website. We believe this process is an effective means to identify all qualified and willing providers and to compare their costs.

The State anticipates there may be geographic differences in the wages of direct support staff, as well as those of professional staff. We believe there may also be geographic differences in the pricing of clinical contracts such as those with behavior therapists, nurses, etc. There may also be differences in administrative components, employment related costs, and transportation expenses. We also anticipate differences in room and board components; however, those components will not be included in the claiming rate submitted for Medicaid match. We anticipate one vendor will be operating in the Cook County area near Chicago; the other vendor would be operating in Central Illinois in a relatively more rural area.

The Illinois General Assembly reviews funding allocations on an annual basis. We cannot predict, however, how frequently the Administration and General Assembly may consider COLAs for various services.

Public Act 100-0023 was recently enacted to fund a minimum of a $0.75 per hour wage increase for front-line personnel, including, but not limited to direct support persons, aides, front-line supervisors, qualified intellectual disabilities professionals, nurses, and non-administrative support staff working in community-based provider organizations serving individuals with developmental disabilities. The intent of the wage increase is to improve wages and/or benefits for the above referenced categories of employees. The $0.75 per hour wage increase is

intended to benefit all covered employees and to be applied across the board. It is expected that all covered employees will receive the wage and corresponding fringe benefit increase effective August 1, 2017.

The MA retains and exercises final authority over payment rates. It does so in collaboration with the OA, which develops the proposed rates and shares the proposed rates and methodology with HFS for its approval.

General
All rate methodologies are established by the Operating Agency and reviewed and approved by the Medicaid Agency. The Medicaid Agency solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with Federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, a listing of all covered services and corresponding rates is made available to participants and guardian (when applicable), family members, Information and Assistance in Support of Participant Direction providers, ISC's and providers. Copies of rate methodologies are on file with the Medicaid Agency and the Operating Agency.

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 Payment
Waiver funding is appropriated to the Operating Agency primarily from the State's General Revenue Fund.

The Operating Agency maintains a computerized payment system that includes authorization for each participant, payments to providers, units of service delivered to each participant, and payment and claiming rates per unit of service.

The payment system contains edits to ensure that payments are made only to providers that are properly enrolled for the services delivered and that payment is made at the correct payment rate. There is a three-party Medicaid Waiver provider agreement (HFS 1413A,R-2-01) between the provider, the Operating Agency and the Medicaid Agency. This agreement contains language that the provider voluntarily reassigns payment to the Operating Agency (OA). If a provider chooses not to assign payment to the Operating Agency, the provider will sign the standard Medicaid provider agreement (HFS-1413).

Payments for some services, such as participant-directed Personal Support services where the participant exercises employer authority, flow through the Financial Management Service (FMS) entity and are paid and transmitted to the Operating Agency (DHS) system for claims processing.

Operating Agency Claims Processing
Information from the Operating Agency computerized payment system feeds into the computerized claiming system that contains edits to ensure that the participant has been determined to meet the ICF/IID level of care prior to the date of service. The Operating Agency claiming system picks up the established claiming rate and compares it with the actual payment rate; the lower of the two is the amount claimed. Finally, the Operating Agency claiming system subtracts from the Waiver claim the spenddown obligation of each participant, if any (available on a monthly extract from the Medicaid Agency MMIS system).

Medicaid Agency Claims Processing
The Operating Agency Waiver claiming data are transmitted to the Medicaid Agency via a weekly computer tape exchange. The Waiver subsection of the MMIS matches the participant against the recipient eligibility file to ensure Medicaid eligibility on the date of service and matches the provider against the provider enrollment file to ensure that the provider is enrolled as a Waiver provider with the Medicaid Agency. The Waiver subsection includes edits for Waiver claims that conflict with other Waiver and hospital, nursing home, hospice facility, or ICF/IID claims and rejects Waiver claims that are duplicative or incompatible.

Federal matching funds are deposited into the State's General Revenue Fund. A small portion of the federal matching funds is deposited into a dedicated fund to be used to fund community services for individuals with developmental disabilities.

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:

Provider billings are validated by the Operating Agency (OA) to verify the effective date of each Waiver service authorized in the participants person centered plan and the participant's level of care eligibility. Providers are required to certify billings are true and accurate.

Provider claims are further validated by applying MMIS processing edits and by conducting Operating Agency (DHS) post-payment reviews. See also Appendix I-1 for additional information on post-payment reviews. Through post-payment reviews, the Operating Agency, based on a representative sample of claims, confirms that services were in accordance with the person centered plan.

When inappropriate billings are identified, the OA either ensures the provider voids the billing or the OA voids the billing itself in the electronic payment system. This initiates a recoupment of overpayments. This action in turn automatically voids the claim for Federal Financial Participation.

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:

  Under an interagency agreement with the Medicaid Agency, the Operating Agency makes payments from a central computer system. On a weekly basis, Waiver claims are edited and sent to the Medicaid Agency for Medicaid claiming. The audit trail is established through State agency approved rates, person centered plan authorization, documentation of service delivery, and computerized payment and claiming systems cross-matched with the Medicaid Agency, MMIS system.

  The OA performs a post payment review, based on a representative sample of waiver claims. The post payment review looks at whether the services were specified in the person centered plan. The OA reviews a representative sample of claims to determine whether the individual was eligible on the date of services. The OA reviews a representative sample of waiver claims to determine whether the rates paid are in accordance with the reimbursement methodology. The OA submits a quarterly report to the MA with their findings and remediation activities. The MA conducts a validation review based on the quarterly reports to verify that the OA followed their post payment review procedures and verifies that appropriate remediation actions were taken.

- ○ **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:

Under an interagency agreement with the Medicaid Agency, the Operating Agency or a Financial Management Service (FMS) entity, as described in Appendix E, makes payments directly to providers of Waiver services. The Operating Agency then sends electronic claims via computer tape based on the paid services to the Medicaid Agency for further adjudication and Federal Waiver reimbursement purposes.

☐ **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:

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:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **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.

The Operating Agency (OA)

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. *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.**
- ○ **This waiver is a part of a concurrent v 1115/v 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 v 1115 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**
- [x] **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:

Funds are directly appropriated by the Illinois General Assembly from the General Revenue Funds to the OA (DHS). A portion of the funds are deposited into a dedicated fund for services to persons with developmental disabilities. The funds are not transferred.

- [ ] **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 Operating Agency sets individualized rates for a participant in a Residential Habilitation setting based on a rate methodology that is comprised of the following components:
• Room and Board Component - reimburses community providers for keeping a home in normal operation.
• Program Component - reimburses community providers for providing habilitation services and supports, including training, protective oversight, supervision and other assistance to participants with a developmental disability living in a residential setting.
• Transportation Component - reimburses community providers for providing general transportation to and from community locations that are not day program sites or places where Medicaid State Plan services are delivered.
• Administration Component - reimburses community providers for general staff supervision and overhead related to the delivery of residential supports.
• Individual Supports Component - reimburses community providers for supports that are specific to a participant's needs that are not covered elsewhere.

The Operating Agency determines waiver claims for Residential Habiliation services based on the Program, Transportation, Administration and Individual Supports components of the rates. The Room and Board Component is excluded when calculating Waiver claims.

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:*

- [x] **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:*

- [x] **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: