

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 service 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). Most post-payment reviews are done annually while some targeted reviews are done on an as needed 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.

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Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability 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 service plan. Numerator: Number of claims reviewed that were specified in the ISP. Denominator: Number of claims sampled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Comparison of claims submitted for FFP with service plans

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

I2 Number and percent of waiver service claims reviewed that were submitted for participants who were Medicaid Waiver eligible on the date that the service was delivered. Numerator: Number of claims submitted for participants who were Medicaid Waiver eligible on the date the service was provided. Denominator: All waiver claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Comparison of claims with enrollment data or database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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

I3 Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the approved waiver application. Numerator: Number of claims with correct rate. Denominator: All claims reviewed in representative sample.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

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

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Operating Agency annually conducts a statistically valid review of Waiver claims to ensure the appropriate waiver reimbursement methodology was used and that it was applied correctly.

The Operating Agency also annually conducts a statistically valid review of Waiver participants to ensure the participant was Medicaid eligible on the date of service and that services were actually delivered. These desk reviews can include documentation reviews of eligibility assessments, attendance records, work logs, phone logs, travel logs, appointment schedules, progress notes, etc. If needed, phone interviews with guardians and providers may be included.

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 reviews the issues and identifies the most appropriate response. General responses may include work with participants and their providers, retraining staff, voiding claims, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual findings are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

ii. Remediation Data Aggregation

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

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

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

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).

The rate setting method for each service category is as follows:

Residential Habilitation. Residential Habilitation rates are governed by 89 Ill. Admin. Code, Subchapter c, part 356 available at <http://ilga.gov/commission/jcar/admincode/089/08900356sections.html>. A provider-specific, cost-based prospective per diem rate is calculated for each new provider based on budgeted costs for new programs. Rates are then based on audited historical costs, reported to the State on the Consolidated Financial Report after the first year of operation. Rates may also be adjusted as described in Part 356.70:

Increases in reimbursable cost can be granted by the Department for the following reasons and in the following categories:

- 1) Mechanical or clerical errors were committed by the Department.
- 2) There has been a substantial decrease in external government grants which the Department determines seriously limits the ability of the agency to deliver required services to Department clients, to the extent that such revenues were considered available when the Department approved the reimbursable cost of the provider.
- 3) The Agency was able to document and justify that the Department's treatment of its historical cost data resulted in an inequitable application of the rate-setting process.
- 4) Mechanical or clerical errors were committed by the provider on required cost reports and used by the Department in the calculation of reimbursable costs.

The State establishes a claiming rate to correspond with the Residential Habilitation payment rate. While the State includes a room and board component in its payment method, all room and board components are excluded from the amount claimed for Medicaid matching funds.

Adaptive Equipment and Assistive Technology

Rates are usual and customary. Payments are subject to prior approval by the Operating Agency. Two bids are required for this approval. There are per-participant five-year cost limits governing the use of these services.

Behavior Intervention and Treatment. There are two statewide rate levels for this service based on provider qualifications. Both levels reflect standard, hourly, fee-for-service rates. The Level I rate is based on a weighted combination of Bureau of Labor Statistics wages for licensed clinical psychologists, provider survey results and a comparison to bargaining agreement wages for state employees. The rate includes fringe benefit costs, administrative overhead and assumptions about billable hours. The Level II rate is set at 80% of the Level I rate. The 80% adjustment factor is based on observations from other behavioral health programs with similar rate differentials and recognizes the different level of education, training and experience for Behavior Consultant Level II.

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.

The fee-for-service schedule that includes Information about payment rates for all Waiver services is available at <http://www.dhs.state.il.us/page.aspx?item=38992>.

- 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 and a dedicated fund for developmental disability services. The Operating Agency (DHS) maintains a computerized payment system that includes authorization for each participant, payments to providers, units of service delivered to each eligible 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-9-06) between the provider, the Operating Agency and the Medicaid Agency. This agreement contains language that the provider voluntarily reassigns payment to the Operating Agency (DHS). Copies of the 1413A will be on file with the Medicaid Agency.

If a provider chooses not to assign payment to the Operating Agency, the provider will sign the standard Medicaid provider agreement (HFS-1413). The Medicaid Agency will then pay that provider directly. The Operating Agency notifies providers of this option through the Waiver provider manual.

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/IDD 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. For residential habilitation services, the established claiming rate is the maximum claiming rate approved by the Operating Agency based on program components of the rate (excluding room and board). For residential habilitation services, the Operating Agency's actual payment rate is sometimes less than the established claiming rate, depending on the participant's ability to pay toward the cost of care. 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 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 also ensures the service

is covered under the Waiver. The MA MMIS edits the Waiver claims for hospital and LTC claims that are duplicative. The MA deposits the Federal Financial Participation (FFP) associated with this Waiver into a dedicated fund to be used by the Operating Agency for developmental disability services.

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

c. Certifying Public Expenditures *(select one)*:

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

Select at least one:

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

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

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

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

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 (DHS) to verify the effective date of each Waiver service authorized in the participant-centered service plan and the participant's level of care eligibility. Providers are required to certify billings are true and accurate.

Provider billings are further validated by applying MMIS processing edits and by conducting Medicaid Agency (HFS) and Operating Agency (DHS) post-payment financial reviews. See also Appendix I-1 for additional information on post-payment reviews.

The Operating Agency annually conducts a statistically valid review of Waiver claims to ensure the appropriate waiver reimbursement methodology was used and that it was applied correctly.

The Operating Agency also annually conducts a statistically valid review of Waiver participants to ensure the participant was Medicaid eligible on the date of service and that services were actually delivered. These desk

reviews can include documentation reviews of eligibility assessments, attendance records, work logs, phone logs, travel logs, appointment schedules, progress notes, etc. If needed, phone interviews with guardians and providers may be included.

- 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.

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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, support plan authorization, documentation of service delivery, and computerized payment and claiming systems cross-matched with the Medicaid Agency, MMIS system.

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

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

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I-3: Payment (2 of 7)

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

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

- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

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

Under an interagency agreement with the Medicaid Agency, the Operating Agency will make payments directly to providers of Waiver services. The Operating Agency will then send claims based on these paid services electronically to the Medicaid Agency for further adjudication and Federal waiver reimbursement purposes.

The Operating Agency notifies providers of the option to bill the Medicaid Agency directly through the Waiver provider manual.

The MA will conduct a sample review of the findings from the reports and verify that the OA followed their post payment review procedures and verify that appropriate and timely remediation activities were taken.

The Operating Agency 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 service plan. The OA reviews 100% of claims to determine the following: 1) whether the individual was eligible on the date of services; and 2) whether the rates are in accordance with the reimbursement methodology. The OA submits a quarterly report to the MA with their findings and remediation activities. The Medicaid Agency conducts a validation review based on the report to verify that the OA followed their post-payment review procedures and verifies that appropriate remediation activities were taken. These reports are reviewed during Quality Management Committee meetings and evaluated for trends, patterns, and proactive remediation.

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

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

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I-3: Payment (3 of 7)

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

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

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

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I-3: Payment (4 of 7)

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

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

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

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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:

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

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

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

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I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

The Operating Agency pays the providers directly.

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 g 1115/g 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 g 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
 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 Fund to the OA. 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 payment rates for Child Group Home providers based on a methodology that is comprised of the following components:

- Room and Board Component - reimburses community providers for keeping a home in normal operation. This component is not claimed for Federal reimbursement.
- 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 school 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.

The Operating Agency sets waiver claiming rates for residential services based on the Program, Transportation and Administration components of the payment rates. The Room and Board Component is excluded in calculating Waiver claiming rates.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

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

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

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

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

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

i. **Co-Pay Arrangement.**

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

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

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

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

a. **Co-Payment Requirements.**

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

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