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).

DHCS is responsible for performing the Single Audit Act. In cases where administration of a waiver is delegated to another agency, that agency is responsible for collecting the information from their contractors. Once collected, the Single Audit data is sent to the DHCS Audits and Investigations Division. Service providers contracted under a Waiver Agency and HCBA Waiver providers are not subject to the requirement of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104- 146).

DHCS regularly reviews provider payments as part of internal monitoring and oversight. Claims data is run through a business objects portal and allows the State to monitor which services being provided, at what frequency, and to which participants. All of this information allows the State to validate the information that is documented in the POT and in the LOC determination/redetermination. If DHCS finds a discrepancy, an audit may be triggered prior to the annual scheduled audit.

a. DHCS will review claims data on a quarterly basis to identify any unusual claiming patterns or anomalous high costs that may not be supported by a participant's LOC or POT. This Waiver Renewal is based on an aggregate cost cap; therefore, individual billings that appear higher or lower than expected would be considered a discrepancy.

b. The quarterly audits referenced above are DHCS audits of costs to verify that claims are appropriate, and may trigger an on-site review. An annual audit is also conducted by the Waiver Agency to monitor provider performance and adherence to waiver requirements. The annual audits are on-site Waiver Agency QAR and/or electronic record reviews, which review Waiver participant records, progress notes, assessments, re-assessments, screening documents, timeliness of action, Waiver participant plans of care, documentation of the audit trail, verification of service delivery, Waiver participant satisfaction and any other pertinent documentation. In areas of the state where there is no Waiver Agency, DHCS will visit providers on-site and/or conduct electronic record reviews to review the information and documentation above. The quality review referenced in the application refers to the annual QAR.

c. The results of the QAR include corrective action as appropriate. The Waiver Agency responds to DHCS; Letters of Finding with a formal CAP to address any deficiencies. Upon initial approval of the CAP, DHCS monitors the resolution process of the Waiver Agency to assess the remediation of the deficiency(ies). DHCS may, at its discretion, conduct an on-site follow-up visit to the Waiver Agency to evaluate the effectiveness of the new practice(s), and/or request submission of records for additional review by DHCS. The Waiver Agency does not receive a CAP approval letter until complete resolution has been verified by DHCS. Technical assistance is provided throughout the process on an as needed basis. DHCS provides ongoing technical assistance to Waiver Agency and requires quarterly reports from each Waiver Agency that include updates on enrollment levels, fiscal performance, and quality assurance activities. DHCS communicates regularly via telephone, email, and periodic meetings with the Waiver Agency.

d. DHCS conducts quarterly discovery activities based on a random representative sample size (confidence interval of 95% +/- 5%) of all Waiver claims to identify any discrepancies. DHCS will access either MIS/DSS or CMIPS to obtain evidence that a claim submitted by a Waiver Agency was billed appropriately for the HCBA Waiver provider delivering HCBA Waiver services and was reimbursed at the established rate for the service. DHCS uses the QARs to gather data for the Financial Accountability Review, which analyzes Waiver Agency and statewide trends to verify that payments are made timely to direct service providers, billed appropriately to the state, and assurance of Waiver Agency fiscal solvency. DHCS will provide problem resolution with technical assistance and training to the Waiver Agency, when necessary. Within 30 days of the Financial Accountability Review, DHCS will present an analysis of the findings to the Waiver Agency. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the Waiver Agency. DHCS will follow up on the effectiveness of any remedial action within 30 days. Remedial actions will be re-evaluated at the next scheduled QAR. DHCS refers issues concerning fraud to DHCS' Audits & Investigations (A&I) Division.

Payments for Waiver services are made through the approved California Medicaid Management Information System (CA-MMIS). The CA-MMIS Division administers the Medi-Cal claiming system and manages the State's third party FI contract.

Health Insurance, Portability and Accountability Act (HIPPA) compliant procedure Codes (HCPCS) are unique to each waiver service. Each Waiver Agency and Waiver service provider is only eligible to bill for the waiver services they have delivered. The billing is via standardized billing forms and claims are submitted to the FI for payment. Only recognized Medi-Cal providers are eligible to receive payment for providing for waiver services.

All claims processed through the FI are subject to random post adjudication, pre-payment verification for detection of errors, irregularities, and potential for waste, fraud or abuse. Specific criteria for appropriate claims processing has been established and measurements against these criteria occur weekly before the release of payments. The FI verifies that claims

selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment.

DHCS' A&I Division is responsible for ensuring the fiscal integrity and medical necessity of Medi- Cal program services, including the HCBA Waiver. All claims submitted by Waiver and State Plan providers are subject to random review regardless of provider type, specialty, or service rendered.

A&I verifies that claims have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional documentation may result in suspension from the Medi-Cal program, pursuant to Welfare and Institutions Code, §14124.2, or collection of overpayments. A&I has three branches that conduct reviews using various methodologies to monitor program integrity and the validity of claims for reimbursement.

The A&I Medical Review Branch (MRB) performs essential medical reviews of non-institutional providers. Providers may also be subject to a more comprehensive review on a weekly basis known as a pre-checkwrite review. This review is based on a set of criteria, such as irregular billing patterns, designed to identify potential fraud or abuse. Providers selected for this more comprehensive review will receive an on-site visit by A&I staff. Many of these reviews result in program removal, monetary penalties, or less intrusive sanctions and utilization controls.

MRB also conducts Medi-Cal provider anti-fraud activities that include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program.

MRB staff work closely with claims processors and data storage providers in data mining and extracting processes, as well as the performance of the annual Medi-Cal Payment Error Study.

The A&I Financial Audits Branch performs cost settlement and rate setting audits of institutional providers, i.e. hospitals, nursing facilities, and certain clinics.

The A&I Investigations Branch conducts investigations of suspected Medi-Cal beneficiary fraud as well as preliminary investigations of provider fraud. A&I IB is also responsible for coordinating provider fraud referrals to the California State Department of Justice (DOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to the DOJ via the A&I IB.

A&I IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. A&I IB serves as DHCS principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

DHCS examines the provider records and compares the records with the authorized services. If the received claim is correct, DHCS will authorize payment through CMIPS. DHCS will contact A&I if claims are incorrect, to conduct a more detailed financial analysis in the event of suspicious billing practices. The state conducts routine audits, based on data mining and claim review, of all Medi-Cal billers, to verify the accuracy of paid claims.

Individual, unlicensed providers of WPCS claims are paid through DSS' IHSS program, CMIPS, developed and managed by HP Enterprise Services. HP Enterprise Services will continue to oversee the CMIPS system. CMIPS validates provider claims with authorized hours and will reject any claim that exceeds the monthly authorized hours. If the received claim is correct, CMIPS will authorize payment.

Electronic Visit Verification (EVV) Compliance

EVV is a telephone and computer-based system that electronically verifies in-home service visits. EVV systems are used to verify the type of service being provided; the individual receiving the service; date of the service; location of service delivery; the individual providing the service; and the time the service begins and ends. Pursuant to subsection I of §1903 of the Social Security Act (42 U.S.C. 1396b), all states must implement EVV for Medicaid-funded personal care services by January 1, 2020 and Home Health Care Services by January 1, 2023. California was granted a one-year good faith effort extension to implement EVV for Medicaid-funded Personal Care Services.

California is currently working to bring all of its EVV impacted programs into compliance with the CURES Act, and has been working closely with stakeholders to bring on a solution vendor in the third quarter of 2021 to implement an EVV

solution for personal care services by January 1, 2022.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures 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:
 # and % of waiver claims that were paid at appropriate levels for rendered services, in accordance with Waiver Agency-approved TAR and the Primary Care Physician-signed POT. Numerator: Number of waiver claims that were paid at appropriate levels for rendered services, in accordance with Waiver Agency-approved TAR and the Primary Care Physician-signed POT / Denominator: Quality review sample size

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% +/-5%
☐ **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:
 # and % of claims that were paid at the approved and published Medi-Cal reimbursements rates. Numerator: Number of claims paid at the approved and published Medi-Cal reimbursement rates / Denominator: Quality review sample size

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DHCS conducts ad hoc discovery activities based on a random representative sample size of all Waiver claims. DHCS will access either MIS/DSS or CMIPS to obtain evidence that a claim submitted by a Waiver Agency was billed appropriately for the HCBS Waiver provider delivering HCBA Waiver services and was reimbursed at the established rate for the service. DHCS uses the QPRs and QARs to gather data for the Financial Accountability Review which analyzes Waiver Agency and statewide trends to verify that payments are made timely to direct service providers, billed appropriately to the state, and assurance of Waiver Agency's fiscal solvency. DHCS will provide problem resolution with technical assistance and training to the Waiver Agency, when necessary.

Within 30 days of the Financial Accountability Review, DHCS will present an analysis of the findings to the Waiver Agency. Based upon the findings and level of compliance, remediation actions will be developed (CAP) and implemented within 30 days by the Waiver Agency. DHCS will follow up on the effectiveness of any remedial action within 30 days. Remedial actions will be re-evaluated at the next scheduled QAR. DHCS notifies A&I about issues concerning fraud.

ii. Remediation Data Aggregation

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

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

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).

Public comments on rate determination methods are solicited during public meetings and through the public comment period(s). DHCS held three technical workgroups in which comments were solicited for rate determination.
Below is a description of the rate methodologies used to establish payment rates for HCBA Waiver services.

DHCS FEE SCHEDULE RATE METHODOLOGY:
Adoption of published provider rates can be found in the Current California Medi-Cal Fee Schedule published at:
https://files.medi-cal.ca.gov/Rates/RatesHome.aspx

The HCBA Waiver rates are established through the State's Medi-Cal fee-for-service schedule, which are included in the DHCS Access Monitoring Review. Waiver members are case managed to monitor utilization of services and providers. Providers agree to the rates established in the fee schedule, which remain compliant with SSA a(30)(A). The fee schedule is updated annually due to Federal/State mandates, annual HCPCS updates, or more frequently if necessary, such as a result of increases to minimum wage. When new rates are established or changes to existing rates are made, the state submits an Operating Instruction Letter to the FI to update the rates. The FI has edits and audits in place to pay the established rates based on the fee schedule. DHCS confirms the fee schedule is identical to State Plan service rates.

On June 27, 2018, the Governor Brown signed Senate Bill 856 (Stats. 2018, ch. 30, §44, Item 4260-101-3305), which appropriated Proposition 56 funds, in part, to increase Medi-Cal rates for home health services and to increase payments for ICF DD-CNC services. The appropriation was applied to increase the payment rates for private duty nursing provided by RNs, LVNs, and CHHAs; and to increase payments for ICF DD-CNC non-ventilator and ventilator dependent services. The increases were adopted through the annual Medi-Cal budget process, which affords various opportunities for stakeholder participation. These increases did not result in a change to the rate methodologies.

Most adjustments to rates are tied to the annual HCPCS process (which may adjust codes/rates across multiple services and provider types), or other state/federal authorized/mandated adjustments. DHCS develops a policy justification for rate changes, outlines authorities relevant and needed to adjust the rates, and works with the FI to update rates.

DHCS Fee-For-Services Rates Division, in collaboration with ISCD have oversight responsibility for rate setting.

The services listed below (Family Training, Habilitation Services, Private Duty Nursing, and Respite) are based on the published provider rates paid to either an RN employed by an HHA or an RN that is an INP, an LVN employed by an HHA or an LVN INP, or an CHHA employed by an HHA that provides intermittent private duty nursing.

In areas where there are no Waiver Agencies, the state will continue to pay the existing published Medi-Cal provider rates found in the current Medi-Cal Fee Schedule. Adoption of published provider rates applies to the care management and like services paid to either an RN that is an Individual Nurse Provider (INP) and/or an LVN INP that provides community transition services, and/or transitional case management to Waiver participants. Rates paid for HCBA Waiver care management services to individual providers are published and updated, if applicable, in the Medi-Cal Provider Manual and notice of updates are sent to Medi-Cal providers by U.S. mail or by e-mail.

Continuous Nursing and Supportive Services are based on the published provider rates paid to a CLHF that were negotiated and agreed upon.

The DD/CNC, non-ventilator dependent and the DD/CNC, ventilator dependent waiver services rates were determined by adding the cost of sufficient nursing hours to provide nursing care that corresponds to each of the two LOCs provided by an ICF/DD-CN waiver provider to the State Plan approved daily rate authorized for an ICF/DD-N facility. The ICF/DD-N rate is set by the DHCS FFS Rates Development Division. These facilities are licensed and paid according to residents' LOC and the number of beds. Providers for developmentally disabled consumers have rates set above the median as the result of a court settlement in 1990. The basis of this methodology is that these providers are disproportionate share providers that typically have higher than 95% Medi-Cal census. In the case of the waiver, the census is 100% Medi-Cal beneficiaries.

The ICF/DD-CN waiver rates are published annually in the Medi-Cal Long Term Care Provider Manual. The effective date is August of each year. The rate methodology used for the ICF-DD-N is found in the State Plan:
https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

HCBS SERVICE:

• Family Training
• Habilitation Services
• Private Duty Nursing – RN, LVN, CHHA
• Respite
• Continuous Nursing and Supportive Services
• DD/CNC Non-Ventilator and Ventilator Dependent Services

HOURLY RATE METHODOLOGY:
Hourly rates established locally by county government/authorities are negotiated between each individual county and its contractors, consistent with applicable regulation promulgated by CDSS or DHCS.

HCBS SERVICE:
• Waiver Personal Care Services (WPCS)
• Respite (if provided by an unlicensed personal care provider)
• Paramedical Services

MEDIAN RATE METHODOLOGY:
In areas where Waiver Agencies are available, the State applies the median rate to the HCBA Waiver's Comprehensive Care Management service that would allow contracted Waiver Agencies to facilitate and receive fair reimbursement for delivery of HCBA Waiver services.

This methodology requires that rates negotiated with new providers may not exceed the Department's current median rate for the same service, or the statewide current median rate, whichever is lower. This methodology is defined in California Welfare and Institutions Code §4691.9 the Department may negotiate a rate that exceeds the median rate if necessary in order to pay employees no less than the statewide minimum wage or to provide a minimum of 24 hours or three days of paid sick leave annually. The rationale for negotiated rates will be reviewed by a Nurse Evaluator and Analyst from DHCS during the annual QARs.

While the law sets a cap on negotiated rates, the rate setting methodology for applicable services is one of negotiation between the Department and prospective provider. Pursuant to law the Department and provider must maintain documentation on the process to determine, and the rationale for granting any negotiated rate (e.g. cost-statements), including consideration of the type of service and any education, experience and/or professional qualifications required to provide the service.

The HCBA Waiver offers personal and attendant care services to waiver participants who request and are eligible for medically necessary services. Waiver participants who utilize the HCBA WPCS or paramedical services must also be eligible for and receive the IHSS State Plan benefit. WPCS, paramedical services, and IHSS are subject to the federal Department of Labor Fair Labor Standards Act (FLSA) requiring compensation for overtime and travel and wait time. California is compensating WPCS, paramedical, and IHSS providers time and a half for any hours worked over 40 in a workweek and limited travel time for providers who serve more than one participant.

The negotiation regulations for WPCS and unlicensed Respite are found in Welfare and Institutions Code §12302 and §10102, which state that State reimbursement can be available only within the constraints imposed by the annual budget act and state allocation plan, all of which must be reflected in state-approved individual county plans. Counties that exceed the constraints, run the risk of not receiving full reimbursement if the cost overrun was due to non-state mandated costs, i.e., costs within county control, or more expensive modes used beyond amounts approved in an individual county plan. The State verifies that the rates for WPCS, paramedical services, and unlicensed Respite are equitable based on the county's minimum wage rate to which it is equivalent. The rate for these services cannot exceed the county minimum wage rate.

HCBS Service:
• Case Management
• Community Transition Services
• Transitional Case Management

USUAL AND CUSTOMARY RATE METHODOLOGY:
Per California Code of Regulations (CCR), Title 17, §57210(19), a usual and customary rate "means the rate which is

regularly charged by a vendor for a service that is used by both Medi-Cal members and/or their families and where at least 30% of the recipients of the given service are not Medi-Cal members or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a Medi-Cal member and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual who is not a Medi-Cal member, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act."

HCBS SERVICE:
• Environmental Accessibility Adaptations
• Personal Emergency Response (PERS) (activation and monthly service charge)
• Medical Equipment Operating Expense

Environmental Accessibility Adaptations: The Waiver Agency secures the provider that has the lowest bid.

PERS and Medical Equipment Operating Expense: The Waiver Agency secures the provider with the lowest bid. Medical Equipment Operating Expenses are payable if over $20 up to a maximum of $75.

Rates paid for HCBA Waiver services are published in the Medi-Cal Provider Manual and the Current California Medi-Cal Fee Schedule and notices of updates are sent to Medi-Cal providers by U.S. mail or by e-mail notices.

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:

The Waiver Agency is responsible for prior authorization of all HCBA Waiver services, verifying that the requested services are in accordance with the participant's POT, and that the services are medically necessary. HCBA Waiver service providers are responsible for submitting a TAR to the Waiver Agency for prior authorization of all HCBA Waiver services, except WPCS and paramedical services benefit. The Waiver Agency reviews the TAR for medical necessity and to verify services are authorized in accordance with the participant's POT. Claims for services are paid to Waiver providers after the service is rendered.

DHCS CA-MMIS Division has overall responsibility for processing payments of Medi-Cal claims for provided services. The CA-MMIS Division oversees the contract with the FI that is responsible for managing the CMS approved CA-MMIS.

Waiver Agencies, and HCBA Waiver providers in areas where there is no Waiver Agency, submit claims to the Medi-Cal FI for services rendered using either a CMS 1500, UB 92 or UB 04 claim form. In areas where there are Waiver Agencies, HCBA Waiver providers may bill Medi-Cal directly, rather than through the Waiver Agency; however, authorization to provide services must be adjudicated through the Waiver Agency and the provider must provide proof of the service authorization from the Waiver Agency when submitting claims to the FI for payment. These claims are subject to all established requirements for processing directly through the CA-MMIS system.

The FI processes claims for services, resulting in one of four possible actions:
1. Paid (claim is paid);
2. Denied (claim is denied);
3. Suspended (FI staff perform further research); or
4. Additional information is requested (a Resubmission Transmittal Document (RTD) is sent to the provider requesting additional information).

Claims passing all edits and audits are approved on a daily basis, and the Medi-Cal FI forwards a payment tape to the State Controller's office for a weekly checkwrite, and the provider is notified through a Remittance Advice Detail form.

WPCS claims by unlicensed individual care providers are paid through CDSS' CMIPS.

The CMT authorizes WPCS and/or paramedical service hours by contacting DHCS to determine if the participant is authorized to receive In-Home Support Services (IHSS), and how many hours of IHSS they are currently authorized to receive. If the CMT determines it is necessary to authorize WPCS and/or paramedical hours, they submit a WPCS and/or paramedical authorization letter to DHCS to enter the authorized number of WPCS hours into the CDSS' CMPIS. DHCS notifies the Waiver Agency when the participant's WPCS and/or paramedical service hours are in CMPIS, and then sends timecards to the providers with instructions on how to report the service hours provided to the waiver participant.

WPCS and paramedical service providers submit monthly timesheets signed by the waiver participant or legal representative/legally responsible adult(s), to the County social services' office for review and approval. The timesheets are reconciled with the authorized number of hours in CMIPS and in accordance with the POT. The County Social Services' office authorizes payment for claimed hours of service, documenting the hours worked, the rate of payment, and the gross amount approved for payment. CMIPS generates a payment tape daily that is sent to the State Controller's Office where a payroll warrant is issued to the provider.

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:

In areas where they operate, Waiver Agencies are responsible for prior authorization of all HCBA Waiver services and verification that the requested services are in accordance with the participant's current POT and are medically necessary.

In areas with no Waiver Agency, DHCS is responsible for prior authorization of all HCBA Waiver services, verification that the requested services are in accordance with the participant's current POT, and are medically necessary. HCBA Waiver providers are responsible for direct submission of claims to the FI.

Claims for waiver services must meet either the CA-MMIS or CMIPS requirements for processing, including program edits and audits. Submitted claims are reviewed to verify that all required information is present.

There are several layers of validation to verify that the individual was eligible for Medicaid waiver payment on the date of service, when the service was included in the participant's approved service plan, and the services were provided, before a claim is paid. Payment will only be made for services provided to eligible and enrolled Waiver participants. After enrollment, services must be documented in their POT and must be authorized before the service is provided; therefore, the participant must be eligible on the date of service. DHCS conducts annual QARs to review utilization and verify services were provided in accordance with the primary care physician signed POT. The FI has edits and audits in place to pay only valid claims. DHCS only pays the tiered Comprehensive Case Management rate to Waiver Agencies based on the participant's assessed level of case management acuity.

In areas where there is no Waiver Agency, CA-MMIS pays the HCBA Waiver Case Management rate per the Medi-Cal fee schedule, directly to the provider.

Completed claims processed through CA-MMIS are run against system edits and audits to verify:
• Services are prior authorized;
• Satisfactory Medi-Cal eligibility status;
• Participants are enrolled in the HCBA Waiver;
• Providers are an enrolled Waiver Agency or HCBA Waiver provider;
• Claims are not duplicates;
• Claims are paid per the published rates;
• Participants were not institutionalized during the time covered by the claim; and
• Appropriate HCBA Waiver procedure codes are used.

Completed WPCS claims processed through CMIPS are run against system edits and audits to verify:
• Services are pre-authorized;
• Participants are authorized to receive services through IHSS and enrolled in the HCBA Waiver program;
• Providers are enrolled as a WPCS or paramedical service provider authorized to provide services to the HCBA Waiver participant;
• Claims are not duplicates;
• Claims do not exceed maximum authorized hours; and
• Participants were not institutionalized for more than seven days during the time covered by the claim.

DHCS conducts annual QARs to verify services are provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such

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

CMIPS is the statewide database, managed by CDSS, that is used for case management, payroll, and reports for WPCS and paramedical service reimbursement. CMIPS supports case management and payroll functions for the IHSS program, and HCBA Waiver WPCS and paramedical services. IHSS is not a waiver service.

CMIPS provides the state with a web based case management platform and provides centralized processing of IHSS, WPCS, and paramedical service timesheets for the entire state. These functions support timely data verification, assist with reducing fraud, and allow case management and payroll data to be tracked and monitored using a single platform.

IHSS, WPCS, and paramedical service providers have the option to submit either a paper timesheet or to submit a timesheet via the Electronic Timesheet System (ETS). All paper timesheets are processed at a centralized processing location in Chico, CA. The ETS option allows providers to submit their timesheet online using a tablet, smartphone, laptop, or computer. The ETS system interfaces with CMIPS and providers who utilize ETS are paid in the same manner as providers who utilize paper timesheets. CDSS is responsible for ensuring IHSS, WPCS, and paramedical service providers are paid each month.

Every month, CDSS provides DHCS with a formatted file comprised of WPCS and paramedical utilization data. The file represents all of the claims for WPCS and paramedical services that CDSS paid during the month. The data is loaded into the DHCS data warehouse and assigned a T-MSIS file type when reported. CDSS then invoices the California Department of Health Care (DHCS) for FMAP/FFP funding for IHSS and any cost associated with facilitating WPCS and Waiver paramedical services. DHCS' Accounting Branch enters the FMAP into the quarterly CMS 64 report.

Separately, flat rate payments for HCBA Waiver Comprehensive Care Management services are based on monthly enrollment numbers and participants' assessed case management acuity levels. At the end of each month, DHCS runs an enrollment report in MedCompass to verify the number of enrolled participants served by each Waiver Agency. The report identifies the number of participants at each level of case management acuity and the corresponding payment totals. Staff within ISCD generate monthly invoices based on the MedCompass reports and submit the invoices to DHCS' Accounting Branch for validation and reporting purposes. Upon approval, DHCS' Accounting Branch sends the invoices to the State Controller's Office for checkwrite.

All required enrollment and case management documentation is uploaded and stored in MedCompass for auditing purposes and both DHCS and the State Controller's Office comply with applicable State and Federal fiscal and reporting requirements, which includes the basis for the draw of federal funds and claiming of these expenditures on the CMS-64. Payments made by DHCS to Waiver Agencies for comprehensive care management services are captured by DHCS' Accounting Branch and input in to T-MSIS submissions.

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ **No. The state does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The state makes supplemental or enhanced payments for waiver services.**

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Some Waiver Agencies are local county governments. They receive the same monthly Comprehensive Care Management reimbursement rates for providing Comprehensive Care Management services as is received by all Waiver Agencies providing the same services. The rate does not exceed reasonable costs incurred in furnishing this service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ◉ **The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

ii. Organized Health Care Delivery System. *Select one:*

- ○ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ◉ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

The Waiver Agency services are procured through the State contracting process that involves a Solicitation for Application (SFA). After the SFA process each agency must obtain a Medi-Cal provider number through the DHCS Provider Enrollment Branch, Payment Systems Division for processing.

Disclosure / Program Integrity

Federal regulations require providers of Medicaid programs to monitor and enforce program integrity by requiring providers to disclose certain information. Medi-Cal satisfies these federal regulations for disclosure and deters fraud and abuse by requiring providers to complete DHCS 6207, the Medi-Cal Disclosure Statement form. The DHCS 6207 is submitted to the Payment Systems Division, DHCS for processing.

Provider Qualifications / Requirements

Waiver Agencies may be local governmental or private nonprofit and for-profit organizations, which are procured through an SFA.

In areas where there is a Waiver Agency, providers are not required to contract with the Waiver Agency. They may provide services as long as they are enrolled in Medi-Cal and determined to be a qualified waiver provider based on the provider qualifications outlined in the Waiver application. If qualified providers choose not to contract with the Waiver Agency, they will receive the HCBA Waiver FFS rate.

Waiver Agencies are responsible for prior authorization of all HCBA Waiver services and verification that the requested services are provided in accordance with the participant's current POT, and are medically necessary.

In areas where there is no Waiver Agency, DHCS is responsible for prior authorization of all HCBA Waiver services and verification that the requested services are in accordance with the participant's current POT and are medically necessary. HCBA Waiver providers are responsible for direct submission of claims to the FI.

Informing New Enrollees

Once an individual is determined to be eligible to enroll in the HCBA Waiver, a qualified care manager describes the HCBA Waiver services, limitations, requirements, and any feasible alternative programs, including the option of being institutionalized. The qualified care manager answers any questions the interested individual/applicant may have.

Enrollment and Selections

In order to enroll in the HCBA Waiver, a completed HCBA application packet must be submitted to DHCS for enrollment review to evaluate the applicant's medically necessary needs and eligibility qualifications.

Waiver Agency Requirements

The State requires Waiver Agencies to have a formal contract in place with DHCS to establish Waiver Agency administrative and comprehensive care management requirements; and that contracted Waiver Agencies obtain a Waiver Provider agreement from each Waiver service provider, before providing services to a participant. All Waiver Provider Agreements are uploaded in MedCompass.

Monitoring of Waiver Agency providers

DHCS performs annual QARs of all Waiver Agencies. During the QARs, DHCS verifies that the amount billed by a Waiver Agency for waiver services is equal to the amount it expends to provide services plus the amount paid to subcontractors / vendors. DHCS reviews policies and procedures, billing reports, vendor invoices, participant files, provider files, staff licensure, etc. DHCS samples vendor claims by comparing invoices billed to the Waiver Agency to POTs and claims for which the Waiver Agency was reimbursed by Medi-Cal. DHCS reviews Waiver Agency's contracting process meets DHCS' requirements, that vendors are qualified, that appropriate services and amount of services are being billed in accordance with the Waiver

Participant's POT, and the appropriate provider is providing these services, during the annual QAR. If DHCS finds that there are discrepancies, an audit of the provider prior to the scheduled, annual audit may occur.

Freedom of Choice of Providers

DHCS maintains an approved waiver provider list from which waiver participants are able to choose providers. Providers not on that list and requested by a participant are required to apply to enroll in Medi-Cal and become a waiver provider to provide Waiver services.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ○ **This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ○ **If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.**

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that

make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ○ **The following source(s) are used**

  Check each that applies:

  - ☐ **Health care-related taxes or fees**
  - ☐ **Provider-related donations**
  - ☐ **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Waiver participants residing in a CLHF or an ICF/DD-CN pay the facility directly for the provision of room and board at the beginning of the month, from their SSI/SSP income, retaining the Personal Needs Allowance as governed by regulation. The CLHF and ICF/DD-CN bill the Medi-Cal program for the care they render to the participant at the end of the month, only billing for the days in which the participant was enrolled in the HCBA Waiver.

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: