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).

As established in rule and reinforced through signed provider agreements, HCBS providers are required to permit Iowa Medicaid, its designee or other governmental entities acting in its official capacity to examine any documents or records to ascertain information that payments made for claims of services were properly reimbursed by the Medicaid program. The Iowa Medicaid Program Integrity and Compliance Bureau (PIC) conduct audits and investigation of all Fee-For-Service (FFS) claims submitted by all Medicaid Provider types including HCBS providers. Iowa Medicaid contracts with a program integrity vendor to support its program integrity and compliance operations. The Managed Care Plans (MCPs or MCOs) special Investigation Unit (SIU) conducts audits and investigation of all Encounter claims submitted by providers receiving Medicaid reimbursement through the managed care plans. Any credible allegation of fraud identified by the PIC or SIU unit is referred to the Department of Inspection and Appeals Medicaid Fraud and Control Unit (MFCU) for further investigation for fraud.

Should the State require a provider to perform a self-review, the prescribed methodology for review is determined on a case-by-case basis and is generally determined based on the nature and scope of the issue identified. The state compares the results of the MCO PI efforts to the results achieved in past years. However, MCO operations tend to rely more on prior authorization of services and pre-payment claims editing to control costs, and as such this type of comparison will not be straightforward and may not provide useful information. When the PIC vendor identifies an overpayment for FFS claims, a Preliminary Report of Tentative Overpayment (PROTO) letter is sent to the provider. The PROTO letter gives the provider an opportunity to ask for a re-evaluation and they may submit additional documentation at that time. After the re-evaluation is complete, the provider is sent a Findings and Order for Repayment (FOR) letter to notify them of any resulting overpayment. Both the PROTO letter and the FOR letter are reviewed and signed off by state PIC staff prior to mailing. The FOR letter also includes appeal rights to inform the provider that they may appeal through the State Fair Hearing process. When overpayments are recovered, claims adjustments are performed which automatically results in the FFP being returned to CMS. The OHCDS Medicaid audit is subject to the same standards and processes as outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the HHS PIC Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and submitted to HHS for review and approval. The MCOs are also required to make referral to Iowa Medicaid and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to HHS, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the Iowa Medicaid PIC Unit, the Iowa Medicaid Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

The PIC bureau conducts audits of MCP payments made to network providers. Under section I.9 of the contract, any improper payments made to a provider by MCPs may be subject to oversight audit and overpayments identified may be subject to recovery by Iowa Medicaid.

I.9. Overpayment Audits by Agency or Designee.

I.9.01. Recovery of Overpayments from Contractor. The Agency or its Designee may audit Contractor's Provider Claims and recover from the Contractor the identified Provider Overpayments by following the procedures in this Section.

I.9.02. Notice. If the Agency identifies a Provider Overpayment owed to the Contractor, the Agency shall send notice to the Contractor identifying the Overpayment.

I.9.03. Payment. On or before the thirtieth (30th) day following the date of the notice, the Contractor shall either pay the Agency the amount identified as a Provider Overpayment or shall dispute the Overpayment in writing to the Program Integrity Director or other Agency representative designated by the Agency.

I.9.04. Payment Disputes. If the Contractor disputes the Overpayment, the Program Integrity Director or other Agency representative will consider the Contractor's dispute and shall notify the Contractor of its final decision on or before the thirtieth (30) day following the date the written dispute is received. The Agency has the sole discretion to uphold, overturn, or amend an identified Overpayment. If the Contractor disputes the Overpayment and the Agency's final decision identifies an Overpayment, the Contractor shall pay the Agency the identified Overpayment on or before the tenth (10th) business day following the final decision.

I.9.05. Extensions. If the Contractor makes a written request on or before the due date for the payment of the Overpayment, the Agency, through its Program Integrity Director or other Agency representative may, in its sole discretion, grant an extension of time within which the Contractor must pay the Overpayment.

I.9.06. Contractor Recovery from Providers. Where the Agency has identified an Overpayment and the Contractor has been required to pay the amount of the Overpayment to the Agency, the Contractor shall recover the Overpayment from the Provider and may retain the Overpayment recovered.

I.9.07. Offsets. If the Contractor fails to repay an Overpayment identified under these procedures, the Agency may offset the amount of the Overpayment owed by the Contractor against any payments owing to Contractor under this Contract.

I.9.08. Agency-Identified Overpayments. If the Agency discovers and identifies an improper payment or overpayment after twenty-four (24) months from the date the claim was paid, the Agency will recover the identified Overpayment from the Contractor, unless the improper payment or overpayment was the result of an Agency error. The Contractor shall not recover Overpayments for which it did not discover or issue a, overpayment finding to the Provider. The Contractor may dispute the Agency's notice of findings in accordance with the Payment Integrity Audit process.
As part of the EQR process, the contractor performs onsite reviews of the MCOs that include processes that impact waiver providers and members. Reviews include credentialing files, critical processes such as service authorization validation, claims processing, training and care coordination.

The State reviews monthly, quarterly, annual reports and compliance plans to provide oversight on the MCO programs. Each MCO has meetings monthly with the State and the Medicaid Fraud Control Unit (MFCU) to review fraud waste and abuse referral information and provide any updates regarding open investigations. Monthly fraud waste and abuse referrals, audits/investigations, closed cases, overpayment letters, overpayments collected, among other numerical values are tracked and trended with the previous year's data on a dashboard updated monthly.

MCO oversight is conducted regularly to validate correct reporting. The PIC unit reviews of MCO claims to ensure providers are billing and rendering services appropriately. The PIC unit notifies the MCOs of any review findings for them to pursue further PI activities with the provider.

MCOs must also coordinate all PI efforts with Iowa Medicaid and Iowa's MFCU. MCOs must have in place a method to verify whether services reimbursed were furnished to members as billed by providers and must comply with 42 CFR Part 455 by suspending payments to a provider after HHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by HHS or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.

The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. All HCBS cost reports will be subject to desk review audit and, if necessary, a field audit. However, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

Electronic visit verification (EVV) assists in validating the provision of services and monitoring the accuracy of payments for waiver services to providers. Iowa requires that MCOs have EVV information for all required personal care and home health care services. Iowa reviews aggregate EVV compliance reports to understand utilization trends and EVV compliance. Program integrity oversight of EVV claims data will be reviewed for accuracy and improper payments are identified and remedied as outlined undersection I.9 of the contract. The following 1915(c) waiver service codes for EVV are: S5125 - Attendant Care Services Per 15 Minutes, S5130 Home Maintenance Support Per 15 Minutes, T1019 - Self-Directed Personal Care Services Per 15 Minutes, T1002-IMMT HHA RN Services 15 Minutes, and T1003-IMMT HHA LPN/LVN Services Up To 15 Minutes, T1004-IMMT Home Health Aid Services Up to 15 Minutes, T1021 Home Health Aid per visit, T1030 Nursing Care RN per visit , and T1031 Nursing Care LPN per visit

Iowa Medicaid currently does not require EVV for FFS. Iowa Medicaid will continually reassess FFS EVV implementation. Iowa accepts and calculates the FMAP reduction.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

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

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
FA-a1: Number and percent of FFS claims paid for services provided to waiver members for which there is a corresponding prior authorization. Numerator: Number of FFS claims paid for services provided to waiver members for which there is a corresponding prior authorization.; Denominator: Total number of reviewed paid claims

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% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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: Contracted Entity	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
FA-a2: Number and percent of clean claims that are paid by the managed care organizations within the timeframes specified in the contract. Numerator: number of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator: number of Managed Care provider claims.

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 =
☒ **Other** Specify: Contracted entity including MCO	☒ **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: Contracted Entity including MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
FA-a3: Number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided.
Numerator: Number of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided;
Denominator: Number of paid claims

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 =
☒ **Other** Specify: Contracted Entity	☐ **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:
FA-b1: Number and percent of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology; Denominator: # of capitation payments to the MCO's.

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 =
☒ **Other** Specify: Contracted Entity including MCO	☐ **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: Contracted Entity	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

The Program Integrity unit samples provider claims for quality. These claims are cross-walked with service documentation to determine error associated with coding and documentation. This data is reported on an adhoc basis. MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care and Oversight. MCO contractual definition of a clean claim: A claim that has no defect or impropriety (including any lack of required substantiating Documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

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.

When the Program Integrity & Compliance Operations Unit (PICOU) discovers situations where providers have improperly billed for services or there is missing documentation to support billing of services, the PICOU communicates findings of overpayment and recoup the overpaid amount from the provider. If the findings do not result in an overpayment, the PICOU will notify the provider of no recoupment and provide education and/or technical assistance, if appropriate to prevent future occurrence. When the lack of supporting documentation and incorrect coding appear to be pervasive, the PICOU may review an expanded sample of claims and make referral to Medicaid Fraud Control Unit (MFCU) if there are indictors of fraud. The HHS may suspend payments to the provider pending the outcome of the investigation by MFCU.

The data and case information gathered from this process is stored in the Program Integrity tracking system.

If during the review of capitation payments HHS determines that a capitation payment was made in error, the Encounter claim is recouped or adjusted to correct the payment.

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).

441 Iowa Administrative Code (IAC) Chapter 79 sets forth the principles governing reimbursement of providers of medical and health services. specifically, "The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

Services under this waiver are reimbursed based on a set fee schedule. This includes the services authorized under the Consumer Choices Option (CCO) Self-Direction Budgets. Providers are reimbursed at the set rate regardless of geographic location within the state. Iowa Medicaid sets the upper rate limit for those services as published on the HHS Iowa Medicaid Fee Schedule webpage. The Fee Schedules were last updated July 1, 2026, and are posted online https://hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/covered-services-rates-and-payments/fee-schedules.

For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by HHS Iowa Medicaid according to the Medicare reimbursement method described in section 1834(a) of the Social Security Act (42 U.S.C. 1395m), payment for durable medical equipment. Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent. Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost, plus 10 percent. For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality. Payment for used equipment shall not exceed 80 percent of the purchase allowance. No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies in accordance with 441 Chapter 79.

Fee schedules are determined by HHS Iowa Medicaid with advice and consultation from the appropriate professional group at the time the fee schedule is developed. Individual service rate adjustments are made periodically to correct any rate inequity. The legislature can direct Iowa Medicaid to increase or decrease rates through a legislative mandate. There is no set cycle for the legislature to change rates. Iowa Medicaid will change the rates accordingly. All providers rates are subject to public comment any time there is a change in reimbursement methodology. Rate determination methods are set forth in IAC and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period. How the State solicits public comments on rate determination methods can be found in Main, section 6-I. When the legislature appropriates increases for provider agency reimbursement rates the CCO rates for waiver services are increased by the same percentage.

During service plan development, the case manager shares with the member the rates of the providers, and the member can choose a provider based on their rates. When a service is authorized in a member's service plan, the providers receive a Notice of Decision, which indicates the participant's name, provider's name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.

HCBS reimbursement methodologies are reviewed every five years, at a minimum. When the department reviews reimbursement levels for adequacy; historical experience, current reimbursement levels, experiences in other states, and network adequacy are considered. The results of the benchmarking indicate whether the rates are adequate to maintain an ample provider network or if legislative appropriation is necessary to increase or align rates. HCBS reimbursement rates were last increased for dates of service beginning July 1, 2024.

HCBS Prevocational Services, Respite, and Supported Employment reimbursement rates were last increased for dates of service beginning August 1, 2025, all other services were last increased for dates of service beginning July 1, 2024.

Oversight of the rate determination process is conducted by Iowa Medicaid. The Iowa Medicaid Provider Cost Audit and Rate Setting unit, compiles the data needed to complete the rate calculations, prepares the report, performs the review of calculations and reports, and submits the report to Iowa Medicaid for review and approval. Iowa Medicaid budget analyst and actuary review the rate calculations to determine accuracy.

MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. MCO rates are blended between fee-for-service and managed care capitated payments based on the anticipated percentage of unduplicated participants per delivery system.

The following services may be rendered via telehealth under this waiver: positive behavioral support and consultation, supported employment, and peer mentoring. When services are delivered via telehealth, reimbursement is the same as if the services were rendered in person.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:

For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers submit electronic claim forms. Electronic claims must utilize a HIPAA compliant software and shall be processed by the Iowa Medicaid Provider Services Unit.

Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number and Medicaid legacy number for waiver enrollment; (2) the appropriate waiver service procedure code(s) and modifier(s) that corresponds to the waiver services authorized in the member's service plan; (3) the dates of service; and (4) the appropriate number of waiver service unit(s) and the service rate that corresponds to the service. The member’s name and state Medicaid identification number is required on all claim forms.

Specific to the CCO program, the FMS is responsible to process and pay invoices for approved goods and services included in the members' CCO budgets, maintain documentation and monitor that payments are reflected in the member’s CCO budget. All support employees that a CCO member hires must complete service documentation and timecards and submit them to the FMS to be paid for services. All other goods and services purchased that are listed in the member’s CCO budget must be submitted to the FMS with a receipt or invoice in order for payment to be made.

Iowa Medicaid issues FFS provider payments weekly. The MMIS system edits ensure that payment will not be made for services that are not included in an approved service plan in IoWANS. Any change to IoWANS data generates a new authorization milestone for the case manager. The IoWANS process culminates in a final IoWANS milestone that verifies an approved service plan and approved service span has been entered into IoWANS. IoWANS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider’s contract with the MCO.

Appendix I: Financial Accountability

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

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

◉ **No. state or local government agencies do not certify expenditures for waiver services.**

○ **Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b)

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

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

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

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS system includes edits to make sure that payments for claims are made only when a member is eligible for waiver services and when the services are included in the member's service plan. A member's eligibility for payment of waiver services on the date of service as verified by an authorized service plan in IoWANS. The billing validation method includes the date the service was provided, time of service provision, and the state ID of the member receiving the service. Several entities monitor the validity of claim payments: (1) case manager ensures that the services were provided by reviewing paid claims information made available to them for each of their members through IoWANS; (2) the Iowa Medicaid Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the member is eligible for waiver services on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the member's approved plan of care. The MCOs are also responsible for program integrity functions with HHS review and oversight.

When inappropriate billings are discovered (i.e.: overpayments determined) the provider is notified in writing of the overpayment determination. Providers are given the opportunity to review the overpayment and provide additional information to support the claims for payment. Based on the final notice of overpayment, the provider either submits a refund check to Iowa Medicaid or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance. Providers have the right to request a State Fair Hearing when they dispute a finalized overpayment request.

Meanwhile, the overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred, and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal-dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.

For the Consumer Choices Option, the FMS is responsible to provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused and promptly report and return unused funds to Iowa Medicaid within 60 days of identification. The FMS is responsible for monitoring timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years and provide to the department an annual independent audit of the financial management service.

As described in I-1, EVV is currently only applicable to personal care services and home health care services delivered under managed care. The EVV system assists the managed care plans in validating the provision of services and monitoring the accuracy of payments for waiver services to providers. The EVV vendor reviews all service documentation entries prior to submitting the claims for payment to the MCOs. Iowa Medicaid reviews aggregate EVV compliance reports to understand utilization trends and EVV compliance.

Prevention of member coercion:
Case managers are responsible for facilitating and coordinating the interdisciplinary team for each member and ensuring the unencumbered right of the member to choose their services and the provider for each service that will meet the member's needs.

Iowa Medicaid HCBS QIO observes a random sample of interdisciplinary team (IDT) meetings conducted by case managers. This allows the HCBS QIO to note any member coercion in choice of providers. HCBS QIO staff then requests the final signed, approved service plan to ensure that the plan includes the services, units and providers chosen by the member. Any changes and omissions require follow-up by the HCBS QIO for resolution by the FFS case manager

or MCO.

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:

Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number and Medicaid legacy number for waiver enrollment; (2) the appropriate waiver service procedure code(s) and modifier(s) that corresponds to the waiver services authorized in the member's service plan; (3) the dates of service; and (4) the appropriate number of waiver service unit(s) and the service rate that corresponds to the service. The member’s name and state Medicaid identification number is required on all claim forms.

Iowa Medicaid issues provider payments weekly. The MMIS system edits ensure that payment will not be made for services that are not included in an approved IoWANS service plan. Any change to IoWANS data generates a new authorization milestone for the case manager. The IoWANS process culminates in a final IoWANS milestone that verifies an approved service plan has been entered into IoWANS. IoWANS data is updated daily into MMIS.

For payments made by Iowa Medicaid: Providers are informed about the process for billing Medicaid directly through annual provider training, Iowa Medicaid informational bulletins, and the Iowa Medicaid provider manual. When a provider has been enrolled as a Medicaid provider, Iowa Medicaid Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa HHS website at: https://hhs.iowa.gov/about/policy-manuals/medicaid-provider

Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

The claim details submitted for payment is reviewed and reconciled by Iowa Medicaid and supporting claim detail is maintained. Payment for these services is recorded in the state’s accounting system. The accounting records and claim detail provide the audit trail for these payments.

For CCO enrollees the Financial Management Service (FMS) provider receives Medicaid funds on behalf of the member based on the member's approved monthly budget. The FMS is the employer of record and performs the following services:
• Receive Medicaid funds in an electronic transfer.
• Process and pay invoices for approved goods and services included in the individual budget.
• Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
• Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
• Processing all judgments, garnishments, tax levies, or other withholding on an employee’s pay as may be required by federal, state, or local laws.
• Preparing and issuing employee payroll checks.
• Preparing and disbursing IRS Forms W-2 and W-3 annually.
• Processing federal advance earned income tax credit for eligible employees.
• Refunding over-collected FICA, when appropriate.
• Refunding over-collected FUTA, when appropriate
• Assist the member in completing required federal, state, and local tax and insurance forms.
• Establish and manage documents and files for the member and the member’s employees.
• Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

○ **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:

For payments made by Iowa Medicaid:
Providers are informed about the process for billing Medicaid directly through annual provider training, Iowa Medicaid informational bulletins, and the Iowa Medicaid provider manual.

When a provider has been enrolled as a Medicaid provider, Iowa Medicaid Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The provider billing manual is also available on the Iowa HHS website at: https://hhs.iowa.gov/about/policy-manuals/medicaid-provider

Members' employees through the CCO program are issued instructions on billing through the FMS. MMIS will not allow payment for services authorized through CCO.

Iowa Medicaid exercises oversight of the fiscal agent through both the IoWANS system and through our Core Unit.

Payment for services by the FMS include:
Adult Day Care
Prevocational Services
Respite Edit Service
Supported Employment
Home Health Aide
Nursing Care Services
Specialized Medical Equipment
Financial Management Services
Independent Support Broker
Individual Directed Goods and Services
Assisted Living
Assistive Devices
Attendant Care
Community Transition Services
Companion
Family Training Edit Service
Home and Vehicle Modifications
Home Maintenance Support
Home-Delivered Meals
Interim Medical Monitoring and Treatment
Nutritional Counseling
Peer Mentoring
Personal Emergency Response System or Portable Locator System
Positive Behavioral Support and Consultation
Skilled Attendant Care
Transportation

The FMS shall perform all of the following functions:
(1) Receive Medicaid funds in an electronic transfer.
(2) Process and pay invoices for approved goods and services included in the individual budget.
(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
(6) Verify for the member an employee’s citizenship or alien status.
(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee’s pay as may be required

by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
(8) Assist the member in completing required federal, state, and local tax and insurance forms.
(9) Establish and manage documents and files for the member and the member's employees.
(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
(13) Establish a customer services complaint reporting system.
(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
(15) Develop a business continuity plan in the case of emergencies and natural disasters.
(16) Provide to the department an annual independent audit of the financial management service.
(17) Assist in implementing the state's quality management strategy related to the financial management service."

This information is included in the amendment in Appendix E-1-a.

For payments made by the MCO:
For MCO enrollees, for the self-direction option of the waivers, payments will be made to a financial management service, which will be designated by the state as an organized healthcare delivery system to make payments to the entities providing support and goods for members that self-direct. The financial management service must meet provider qualifications established by the state and pass a readiness review approved by the state and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by completing periodical audits.

Iowa Medicaid exercises oversight of the fiscal agent through both the IoWANS system and through our Core Unit. The Iowa Medicaid Core unit performs a myriad of functions for the Iowa Medicaid including, but not limited to, processing and paying claims, handling mail, and reporting. This unit also maintains and updates the automated eligibility reporting system known as Eligibility and Verification information System (ELVS). Iowa Medicaid has regularly scheduled meetings with Core to review the thresholds of the performance measures they are required to meet to assure quality.

☒ **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.

N/A

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:

The Woodward State Resource Center is the only state agency that provides community-based services including Home and Vehicle Modification, Respite, and Transportation.

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.

For fee-for-service members, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between HHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between HHS and the MCOs.

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:

Enrolled Medicaid Home and Vehicle providers may choose to subcontract to non-enrolled businesses for the provision of Home and Vehicle Modifications and Assistive Devices. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract

Enrolled Medicaid Home and Vehicle providers who sub-contract with non-enrolled businesses for the provision of home and vehicle modifications or assistive devices must assure that the subcontractor is contractually obligated to abide by the rules and standards applicable to the services. The member's case manager is responsible for ensuring that the services were provided in accordance with the member's service plan and in accordance with rules and standards for the applicable service.

Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to members.

When a member has been assessed to have a need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the case manager or community-based case manager and is also available through Iowa Medicaid and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria are met.

The Financial Management Services (FMS) entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. Iowa Medicaid executes a provider agreement with the FMS providers and MCOs contract with an Iowa Medicaid enrolled Financial Management Services solution. Members have free choice of providers. Members are given this information during their service plan development. The FMS reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement.

Employer/employee agreements and timesheets document the services provided if waiver members elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service members, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's IoWANS. Financial oversight and monitoring of the OHCDS is administered by the Iowa Medicaid through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDS Financial Management Services, which is subject to HHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by HHS.

The OHCDS Medicaid audit is subject to the same standards and processes as outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the HHS PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and submitted to HHS for review and approval. The MCOs are also required to make referral to Iowa Medicaid and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to HHS, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the Iowa Medicaid PI Unit, the Iowa Medicaid Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

A provider must enroll with Medicaid prior to being eligible to enroll with a managed care organization. They are not required to contract with a MCO as this is a provider/MCO contractual arrangement. However,

Medicaid will notify the MCO of all providers eligible to provide services.

Each MCO has different systems that maintain authorized service plans. Many of the services are prior authorized and claims are adjudicated against the authorizations.

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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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:

As specified in Iowa Administrative Code, Iowa does not reimburse for room and board costs, except as noted for providers of out of home respite services. The provider manuals contain instructions for providers to follow when providing financial information to determine rates. It states that room and board cannot be included in the cost of providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. That fee schedule has no allowance for room and board charges. Respite provided by a home health agency is limited to the established Medicare rate.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit and Rate Setting Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by Iowa Medicaid.

All providers of waiver services are subject to a billing audit completed by the Department of Health and Human Services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

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: