Appendix I: Financial Accountability

APPENDIX 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).

Waiver services are furnished through the managed care entities, and therefore, the §1915(b) waiver financial accountability requirements apply.

With respect to the integrity of the payments to the managed care entities, the CHC-MCO agreements provide, in part, the following:

"The CHC-MCO shall cause, and bear the costs of, an annual agreement audit to be performed by an independent, licensed Certified Public Accountant. The agreement audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be digitally submitted to OLTL, Bureau of Finance via the E-FRM system no later than June 30 after the contract year is ended…. The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the CHC-MCO, its subcontractors or Providers."

The CHC-MCO agreements also contain a provision allowing the Commonwealth to conduct financial, compliance, and performance audits, in addition to audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with the contract terms and conditions.

Using monthly encounter data, OLTL will ensure payments to the CHC-MCOs are for eligible persons properly enrolled in the waiver.

<u>Electronic Visit Verification (EVV)</u>
The Department of Human Services will be using an Open Vendor Model to implement and comply with EVV system requirements in accordance with section 12006 of the 21st Century CURES Act. Since Pennsylvania has chosen to utilize an open vendor model, visit capture technology varies across EVV vendors. Generally, the methods used to capture visits include mobile phone applications, telephonic entry via a landline telephone, and fixed verification devices. The specific waiver services included in the EVV system are Personal Assistance Services, Participant-Directed Community Supports and Respite (unlicensed facility).

APPENDIX I-2: Rates, Billing and Claims

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).

Under CHC, the method of determining the capitation rate is subject to the 1915(b) requirements and criteria. The Commonwealth has contracted with an actuarial firm to develop the actuarially sound capitation payment rates on an annual basis.

There was a 1% annual unit cost trend was included as an estimate of potential future fee schedule unit cost growth during the prospective time period including inflationary growth in services paid at cost such as Assistive Technology, Specialized Medical Equipment & Supplies, etc. The 1% factor was informed by BLS employment cost index trends and actual historical fee schedule rate increases that OLTL has made.

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 services are billed through a managed care entity. The CHC-MCO billings to the state are made in accordance with the provisions of the §1915(b) waiver and provider billings to the managed care entity are made in the terms of the provider's contract with the managed care entity.

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.*)

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 waiver services are billed through a managed care entity. The CHC-MCO billings to the state are made in accordance with the provisions of the §1915(b) waiver and provider billings to the managed care entity are made in the terms of the provider's contract with the managed care entity.

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-3: Payment

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

○	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
●	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:
	The Department will compute Capitation payments using per diem rates. Using wire transfer or electronic funds transfer, the Department will make a monthly payment to the CHC-MCO by the 15th day of the month for each participant enrolled in the CHC-MCO. The Department will not make a Capitation payment for a Participant Month if the Department notifies the CHC-MCO before the first of the month that the individual's MA eligibility or CHC-MCO Enrollment ended prior to the first of the month. The Department will recover Capitation payments for participants who were later determined to be ineligible for managed care or for payments made for deceased participants after their date of death.

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.
	Providers will not be paid by the State for services not included in the State's contract with managed care entities.

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.

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. *Complete item I-3-e.*

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:

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.
	Capitation payments made to CHC-MCOs may be reduced or returned, in part, to the State. The CHC-MCO Agreements contain provisions for a Risk Corridor, High Risk Pool, a Medical Loss Ratio and a Member Enrollment Mix Adjustment. These risk mechanisms are retrospective or prospective risk adjustments and/or budget neutral.

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:
	a. Service Coordination agencies may provide those services outlined in Appendix D-1-b and D-2-b through an OHCDS only during the 180-day continuity of care period for each implementation phase. Such requests are reviewed and approved by OLTL and the CHC-MCO prior to any service provided through the OHCDS arrangement. This arrangement is expected to end no later than June 30, 2020. b. Providers who are not affiliated with an OHCDS must enroll in the Pennsylvania Medical Assistance program and seek inclusion in the CHC-MCO's provider network. c. As described in Appendix D-1-b and D-2-b, individuals are fully informed of their right to choose from any qualified provider that is part of the CHC-MCO's provider network and are not required to utilize the OHCDS arrangement. As noted above, providers who are not affiliated with an OHCDS must enroll in the Pennsylvania Medical Assistance program and seek inclusion in the CHC-MCO's provider network. d. Through provider/SC oversight and monitoring, as well as through information garnered through service plan and encounter data, the CHC-MCOs monitor services provided through an OHCDS to ensure that the OHCDS has contracted only with providers meeting established qualifications. e. Through these oversight mechanisms, OLTL will also ensure that the arrangements meet State and Federal requirements. f. The full amount of service dollars is passed through for the provision of service. g. The State assures financial accountability when an OHCDS arrangement is used by monitoring individual service plans and claims paid to the OHCDS entities through the provider and SC monitoring processes performed by the CHC-MCOs. The state ensures that the payment to the OHCDS does not result in excessive payments through the established process of paying only the cost of the service or good provided.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
○	**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.

●	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
○	**This waiver is a part of a concurrent §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.**

APPENDIX I-4: Non-Federal Matching Funds

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:

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:

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-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:

In accordance with 42 CFR 441.310(a)(2), the Commonwealth does not pay the cost of room and board and did not include costs associated with room and board in the capitation rate development process. The CHC-MCOs will negotiate rates with each residential service provider based upon the assessed medical and functional needs and circumstances of each participant receiving services in a residential setting. These rates specifically exclude room and board.

APPENDIX 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-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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.** (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

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*:

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

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	**Basis**

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
○	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

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: