December 30, 2009

FS 2009-02
HCBS/FE WAIVER REWENAL
Sections 1.3; 3.1; 3.4; and 3.5

	SECTION			PAGE	STAKEHOLDER COMMENT	KDOA RESPONSE
1	Over all	n/ a	n/a	n/a	K4A has noticed some discrepancies with the use of AAA vs. CME. It is our understanding that all programs except Medicaid should refer only to AAAs. With the Medicaid, it would be our preference that you use the term AAA/CME. Targeted Case Management is just one of many services provided by the Area Agencies on Aging. A CME can only provide TCM.	Definition of CME will be added to FSM Section 1.1; it is in reference to TCM that the term CME is used as the provider of this service
2	1; 3; 5	n/ a	TOC	n/a	Section 1 Table of contents (and subsequent section tables of contents) (no page #) - could you insert page numbers?	No change
3	1.3	2		1 of 7	Please define "grievance." Is it more than just a complaint or being grouchy? Must it be in writing? Must it be obtained first hand from the aggrieved party involved?	Section 1.3.3 indicates OAA only and is not part of this revision; no change
4	1.3	2	n/a	1 of 7	Please define the term "grievance". Is it more than just a "complaint" or "being grouchy"? Must it be in writing? Must it be obtained firsthand from the aggrieved party involved?	Section 1.3.3 indicates OAA only and is not part of this revision; no change
5	1.3	3	A	1 of 7	~~1.3.2.B. / pg 1 of 7:~~ By a strict interpretation of this section, AAAs are expected to provide a "written grievance procedure" for Information & Assistance, Newsletter, Screenings, Health Education, Outreach, Advocacy, and all other OAA services (many of which may be very brief, single events, some even over the telephone)? That is not doable, nor logical.	Section 1.3.3 indicates OAA only and is not part of this revision; no change
6	1.3	3	A	1 of 7	By a strict interpretation of this section, AAAs are expected to provide a "written grievance procedure" for Information & Assistance (I & A), Newsletter, Screenings, Health Education, Outreach, Advocacy, and all other OAA services? You don't really expect that do you?	Section 1.3.3 indicates OAA only and is not part of this revision; no change
7	1.3	3	B	1 of 7	The sentence probably should have a comma after "…OAA services" if you use a comma after "below".	Section 1.3.3 indicates OAA only and is not part of this revision; no change
8	1.3	3	B1	1 of 7	Recommend you end the sentence after "… each customer." And begin a new sentence with "However, they…". It otherwise is too long a sentence	Section 1.3.3 indicates OAA only and is not part of this revision; no change
9	1.3	3	B3	2 of 7	The word "or" at the end of this sentence indicates that paragraph 3 "or" paragraph 4 may happen, but not both. The same does not apparently hold true for paragraphs 1 & 2. Recommend the word "or" be removed.	Section 1.3.3 indicates OAA only and is not part of this revision; no change

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10	1.3	4	B; C	2 of 7	The way this section reads, the SS-12 form "must" be given once we determine a person qualifies for Information & Assistance, Newsletter, Screenings, Health Education, Outreach, Advocacy, etc., when in some cases we never have physical contact with that "customer". It makes absolutely no sense to put form SS-12 in every newsletter, or to read it to every person who calls on the telephone. The cost of doing this would be astronomical, especially in tight budget times.	Section 1.3.3 indicates OAA only and is not part of this revision; no change
11	1.3	3	C	2 of 7	The way this sentence reads is that an AAA must send an NOA (grammatically it should be "a" NOA) for any and all grievances, for any OAA program. This is a major change of policy. First, non AAA CMEs apparently do not need to follow this procedure, as they are not mentioned. Second, AAAs apparently "must" follow this policy only for OAA programs, (that is how it reads). So what if a customer has a grievance on SHICK, HCBS, or SCA? The way this section is written, apparently nothing "must" happen? Is that your intent? If so, that is not logical. How do you send a NOA to someone on the phone who refuses to give you their address?	Section 1.3.3 indicates OAA only and is not part of this revision; no change
12	1.3	5	A	3 of 7	We do not keep a case file on every customer in every OAA or non-OAA program. By default, the way this paragraph is worded, we would be required to do so. Current budgetary constraints will not allow us to do this, nor is it practical.	Section 1.3.3 indicates OAA only and is not part of this revision; no change
13	1.3	5	B1	3 of 7	"For all programs…" is unrealistic, and not doable.	"Programs" refer to OAA, SCA, and HCBS/FE and does not mean specific services such as I&A, newsletters, etc.; refer to program manuals for applicable NOA requirements
14	1.3	5	C1	3 of 7	… actions the agency…" again seems to indicate that CMEs, as opposed to Area "Agencies" on Aging, are exempt. Please clarify.	Will change reference to AAA/CME
15	1.3	5	C1	3 of 7	The way this sentence reads, a customer must be given a NOA, as an adverse action, if we cannot provide the "quantity of service" they have requested, no matter how exaggerated or ridiculous their request may be. So if Mrs. Smith wants four meals of fried chicken every day, we need to treat that as an adverse action since we cannot provide her that? That's how it reads. That is illogical!	No change; if the customer disagrees with the units of services to be provided, he or she has the right to appeal that decision. The TCMs need to be logical in determining when a NOA is required.
16	1.3	5	D1ai	4 of 7	If the action is adverse: i. implement the change effective per customer request (add) by interrupting the previously approved POC; and ii change the KAMIS plan of care with an effective date to allow 10 day notice . Without this addition it is not clear how to implement the client requested change and still meet the 10 day notice in KAMIS.	Change made to clarify

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17	1.3	5	D1ai	4 of 7	which is regards *(sic)* to adequate NOAs being sent when a customer requests an adverse action. The new wording states that the change be implemented effective per the customer request, but the requests that the change in KAMIS be made to allow a 10 day notice. This in my opinion is very confusing and needs some clarification. My concerns are that the subject is the sending of adequate notice, yet it refers to 10 day notice which is timely notice, so that is a contradiction. A second concern is that customer's most often say I want the change effective immediately, so implementing per customer request, but allowing 10 days is also frequently going to be a contradiction. Is KDOA trying to say that an adverse action requires a timely notice even though it is requested by the customer? If so they should say that, because the way the draft is currently written is totally ambiguous.	See #16
18	1.3	5	D5	4 of 7	Recoup the overpayment from whom? Based upon whose "failure?" Which provider must be notified? Just any that may be effected, or all providers providing any service?	Change made to clarify
19	1.3	5	D5	4 of 7	1.3.5.D.5. / pg 4 of 7: "Recoup the overpayment" from whom? Based upon whose "failure"? Which provider must be notified? Just any that may be effected, or all providers providing any type of service to that customer?	See #18
20	1.3	5	D6	4 of 7	You are now mentioning CMEs responsibilities, but they were not mentioned before this page. Which is it?	AAA means SCA, OAA only; AAA/CME means SCA, OAA, and FE; CME means FE only
21	1.3	6	n/a	5 of 7	What is the definition of an appeal? Must it be in writing? Does it apply to all programs? Are there time constraints? Are there prescribed forms?	No change; refer to Rights and Responsibilities Form SS-12
22	1.3	6	D	6 of 7	"Department" is not defined in the FSM (at least not in this section). Are we to assume that it means KDOA? Likewise, all prior sections have referred to AAA, agency, or CME - not Contractee/Grantee. Are these terms synonymous? If so, please state that they are.	Definition in Section 1.1; changes made to clarify
23	1.3	7	n/a	7 of 7	By the words "… written policies…", do you mean that we must have written policies specifically on affirmative action? Or on ADA compliance? Or concerning what? This is not clear.	Change made to clarify
24	3.1	n/a	TOC	n/a	Is it necessary to have a table of contents for each subsection of chapter 3, especially since the overall chapter Table of Contents lists the all the subsections?	No change
25	3.1	n/a	TOC	n/a	For those sections "reserved", which were "revoked" earlier, are they really reserved for something, or are they really still just revoked? Since this is a major re-do of the FSM, is it appropriate to re-number sections, so there are not sections that are not used?	No change

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26	3.1	1	n/a	1 of 14	CMEs are not mentioned, nor are they defined. Shouldn't they be?	Definition for CMEs will be added to FSM Section 1.1
27	3.1	4	A	2 of 14	CMEs are not mentioned. Can a TCM be a TCM without a CME? I didn't think they could.	No change; a TCM must be affiliated with a CME; TCM qualifications are standardized
28	3.1	4	B3	3 of 14	"… a AAA…" should be changed to read "… an AAA…".	No change
29	3.1	8	B5b	9 of 14	TCM Required Contact - Clarify if the contact may occur within the quarter or if QR will review to a strict 90 days from last contact.	No change; training will clarify one contact within each calendar quarter
30	3.1	8	B5b	9 of 14	When does a "quarter" begin? Should we use the QR quarter definitions or is it defined by the last home visit?	No change; we will use calendar quarters
31	3.1	8	B5b	9 of 14	When does a quarter begin? Please define	See #30
32	3.1	8	D	9 of 14	Does this section apply to CMEs that are not AAAs? It reads like it does not.	Language changed to clarify; includes CMEs
33	3.1	10	A	10 of 14	Does this policy include time to review documents on a periodic basis? Some TCM's may review documents as part of the quarterly monitoring visit, paying particular attention to documents which QR will also review.	No change; training will include clarification of monitoring and other follow-up activities in Sec. 3.1.5.D
34	3.1	10	A	10 of 14	more clarification on what is billable for the QR process. Is the time spent with the referral and response document billable? Writing up the response etc.	See #33
35	3.1	10	A2	10 of 14	Concerned raised over not being able to bill for Quality Review process?	No change
36	3.4	1	A	2 of 20	Adding the written policy to exclude ALF residents from Adult Day Care is good. This gives the TCM a specific policy to reference on the NOA, as we just had this issue come up again in Kansas City.	Thank you
37	3.4	1	C	7 of 20	Confirm that there is no grandfathering with the addition of an exclusion on spouse, guardian, conservator, person authorized as an active DPOA for health care decisions, etc ...be paid to provide Agency Directed Attendant Care for the customer. We do have customers in our area that do have an Agency Directed Attendant Care worker that acts on their behalf or is the DPOA. This will be a change for them, the worker and the agencies since many have gotten around the self-direct acting on behalf exclusion in the past by being agency employed. Negative action therefore timely notice will be required to remove this.	No change; training will clarify that grandfathering will not be allowed
38	3.4	1	C	9 of 20	~~Bottom of page 10 2nd to last paragraph~~ "in the opinion of the attending physician or licensed professional nurse and then in last sentence of the paragraph state RN. Which is correct language. Make it consistent.	Change made to provide clarification for licensed professional nurse

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39	3.4	1	C / I	10 of 20; 17 of 20	The TCM and the customer or their representative will use discretion in determining if the selected attendant can perform the needed services. Outline steps and remediation process to resolve this. Self direct choice of attendance has been hands off choice of the client. We can make an action plan after the fact to try to address things that aren't being done per the CSW but it is not an easy road.	No change; training will address this issue
40	3.4	1	E	13 of 20	Medication Reminder- since this is no longer an extension of PERM, is there going to be an installation fee included with the service similar to PERM?	No change; installation for PERM may also be used for Medication Reminder
41	3.4	1	G	15 of 20	Super! The Oral Health Services Worksheet was very difficult to get returned by the provider.	Thank you
42	3.4	1	H	16 of 20	Personal Emergency Response- Was there discussion to remove "once lifetime" for this service?	Yes, KDOA received many requests from CMs to revise this limitation
43	3.4	1	I	17 of 20	Excellent response to change Sleep Cycle Support to self-direct, as this is reality in the field. Just wondering if there are any agency staffed cases currently? And if so, will these be grand-fathered?	There are a few agency staff cases; these individuals will need to change to self-direct
44	3.4	1	I	17 of 20	Would KDOA consider drafting a sample report form to be used by the support worker?	Clarification has been made
45	3.4	1	I	17 of 20	need a sample that can be given to the worker etc. Most of the workers will ask for this or need assistance with understanding when to complete this report to the case manager. For the amount they get paid is this asking too much??	See #44
46	3.4	1	J	19 of 20	Wellness Monitoring - increase frequency to every 2 weeks or monthly. We have many frail clients that could benefit greatly by this intervention more frequently.	No change
47	3.4	2	n/a	20 of 20	Would KDOA consider adding a 3rd column to the rate chart to include the POC codes (ATCR, MADC, PERM, etc.)? Please?	Yes, change will be made
48	3.4	2	n/a	20 of 20	please add the poc codes to the chart (good idea Rik)	See #47
49	3.5	4	D3	4 of 28	Policy assumes CME is at fault. If provider starts services without authorization, it cannot be the responsibility of the CME to pay for what was not authorized.	No change; training will be provided to TCMs on this issue
50	3.5	4	D3	4 of 28	The term "CME" is used here, but not defined anywhere in section 3.5, nor 3.1. Shouldn't the term be defined somewhere in Chapter 3 of the FSM, if not in Chapter 1 general definitions??? (As a general rule, an abbreviation should be spelled out, and preferably defined in a written document, before it is used.)	See #26; change will be made to spell out abbreviation
51	3.5	4	D3	4 of 28	The statement denoting that the CME will be responsible to pay the provider for services, assumes that the CME is entirely at fault. If the provider(s) start services without authorization, (and we all know that sometime this has happened), it cannot be the responsibility of the CME to pay for what has not been authorized.	See #49

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52	3.5	4	E2	5 of 28	Again you are using abbreviation terms that have not been defined before their use - in fact many are defined or spelled out after this section (see subsection 3.5.4.E.4.). A person unfamiliar with the acronyms would likely not understand them until they read further in the FSM.	See #50
53	3.5	4; 12	E2k; D	5 of 28; 20 of 28	Both state the CME is responsible to "maintain the required original forms". In transfer cases the receiving CME only has the copies. Change to "maintain the required forms..."	Change was made
54	3.5	4	E	6 of 28	Policy assumes CME is at fault. If provider starts services without authorization, it cannot be the responsibility of the CME to pay for what was not authorized.	See #49
55	3.5	4	E7+	6 of 28	~~3.5.4.E.4 / pg 6 of 28:~~ This statement also states that the CME will be responsible to pay the provider for services, and assumes that the CME is entirely at fault. If the provider(s) start services without authorization, (and again we all know that sometimes this has happened). Again, it cannot be the responsibility of the CME to pay for what has not been authorized.	See #49
56	3.5	5	n/a	7 of 28	There is nothing that we can find in the proposed changes that address the necessity of a self directed customer to have a written back up plan if they are a "red flag" disaster case. I know that Krista mentioned this is a requirement during a recent telephonic training, but we could not find it in the FSM.	Policy will be added once the system is developed according to the HCBS/FE waiver Work Plan timeline
57	3.5	5	C	8 of 28	Development of the Plan of Care for Long Term Insurance and Veterns Benefits. Request this is removed. It will be a stalmate in the field. If not removed, Define Aid & Attendence and explain/ellaborate how the TCM is to determine the cost of care left over. (using our Mediciad ATCR2X rate?)	No change; this will be covered in training
58	3.5	5	C1a	8 of 28	What if the customer does not do this? What if they do not know if they qualify for Veteran's Benefits? Since there are no standardized LTC insurance policies, there are no standardized insurance benefits (like Medigap policies have). Whose job is it to decipher what is, or isn't covered, under a LTC insurance policy? What if local providers will not accept coverage, or are not enrolled providers? I respect what you are trying to accomplish with this change, but we need a lot more details ironed out before this becomes "policy".	See #57
59	3.5	5	C2	9 of 28	Can the customer still receive TCM if all other FE tasks are covered by insurance or VA benefits?	No; funding may be available under OAA if CM services are needed
60	3.5	5	C2	9 of 28	Can the customer still receive TCM if all other FE tasks are covered by insurance or VA benefits? If not, what, if any, type CM can they receive?	See #59
61	3.5	5	E1	11 of 28	If a customer is going to be discharged from a hospital or nursing facility...add assisted living facility. Clients move from non HCBS/FE ALF to community because they cannot afford it and need HCBS/FE services started just immeniently as hospital or nursing home discharged clients.	No change

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62	3.5	5	E5	12 of 28	This criteria does not make sense. Isn't this every client or is this in case of TCM or other error? If so can you state this in the criteria so it is clear.	Change was made
63	3.5	5	E5	12 of 28	The two semicolons should be commas instead, as the entire sentence is one complete thought.	Change was made
64	3.5	5	F	12 of 28	As we often have client obligations that change more than once per month, must the TCM "… review the POC with the customer…" every time the client obligation changes? (We have had as many as five changes for the same client in one month.) Is there a monetary limit necessary for review? (We have had client obligation changes by SRS for just one cent). What is the procedure to be followed when SRS back dates a change in client obligation? (We had one case where SRS back dated a client obligation by 15 months - whose responsibility is it to fix that mess?)	Language changed to clarify; it is the responsibility of the eligibility worker, the TCM, and the provider to fix any issues related to back-dating
65	3.5	5	F4	12 of 28	With monthly client obligation changes, must the TCM review the POC with the customer every time the obligation changes? Is there a monetary limit needed for this policy? (We had a customer receive a one cent change) How do we handle a back dated obligation change done by SRS? (We had one go back 15 months and made a change. Who should fix that mess?)	See #64
66	3.5	6	B3c	14 of 28	A new written POC that has a system POC and contains the following? Should say "written POC that matches the KAMIS POC and contains the following". Also on vii remove the and at the end of the sentence.	Language changed to clarify
67	3.5	16	n/a	26 of 28	The first parentheses mark is missing from the sentence after "…Authority,"	Change was made
68	3.5	16	F	28 of 28	3.5.16.F. / pg 28 of 28: What will KDOA do with the review data? Nothing in the FSM says anything about this. Nothing puts in writing the 100% standard expected by CMS, and now KDOA, for all QA issues. Nothing seems to address the remediation process. Nothing addresses "other" corrective actions should remediation not work. I know we discussed this in the workgroup - what is the proposed process and policy? If is it not in policy, how can KDOA expect to enforce it?	Change was made
69	Appx	All	n/a	Appx	Really appreciate the new appendix. Excellent addition to the FSM!	Thank you
70	Appx	All	n/a	Appx	Appendices: can these be paginated at the bottom with the appendix number? This would help find them easier.	Change was made
71	Appx	All	n/a	Appx	Appendices: can they be paginated at the bottom of each page with the appendix number? That would help find them more easily.	See #70

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72	App x	B	n/a	Appx B	Appendix B: Billing: process for when someone is approved but units occurred in the previous month. Example: cm called on the 29th of the month to schedule the assessment, assessment is scheduled for the 2nd so process for billing the units on the 29th of the month.	Change was made
73	App x	E	n/a	Appx E	Add "TCM may send NOA to client/provider, authorizing AT Request once AT Request Worksheet Approval received". At the moment people may think they still have to wait for KAMIS approval to come back.	Language added to 3.5.4.E.7; Appendix E has been clarified
74	3.4	1	C	7 of 20	Request exception for adult care home staff who have relatives as residents and are acting as their DPOA	Language added to provide an exception; see KAR 26-41-101 and KAR 26-42-101
75	3.1	8	B5b	9 of 14	Does e-mail count as a customer contact?	Language clarified; training will address specific issue