



KDADS FMS Manual

Question and Answers

Response due by 5:00 pm on March 23, 2015

1. List of Acronyms

The list of acronyms has been updated including two additions. Please review updates in RED.

2. Definitions

- a. Are the terms “Care Manager/Supports Coordinator” the same and interchangeable?

The definition has been corrected to say “Care Coordinator” to minimize confusion. However, the terms are the same and interchangeable.

- b. Under Employer Authority, the second bullet says “collecting and processing direct service workers’ timesheets; and” Because of the use of AuthentiCare is required, how can an employer do this? Also, this is the responsibility of the FMS provider.

Clarifying language was added to the definition that this information is collected and processed using the AuthentiCare@KS system. Additionally, the participant is the employer, and the FMS provider should have a policy and procedure established that will support the participant in this role and provide an opportunity for him or her to verify the time submitted and validate the time worked to avoid duplication and errors.

- c. The “pay period” definition of two consecutive work weeks excludes weekly payrolls.

This language has been updated to reflect different types of payroll periods. FMS providers must have a clear policy and procedure for addressing payroll, which includes a clearly defined workweek and pay period.

- d. Is the “work week” definition of “ending on Saturday” required, or can an employer set a different workweek?

The participant can set a different workweek as long as it is clearly defined and consistent. This language has been updated to reflect different types of work week. FMS providers must have a clear policy and procedure for addressing payroll, which includes a clearly defined workweek and pay period.

3. Some of the roles, responsibilities and duties for participant-employers and care coordinators (such as choice and back up plans) reference activities that have historically been the role of the case manager and/or CDDOs.

Under the FMS model in Kansas, the participant is the employer and should be supported to fulfill that role. Under managed care, several entities are responsible for supporting the participant-employer. FMS providers should maintain policies and procedures that support a participant-employer, including keeping copies of back up plans and back up staffing designations and having policies that support choice of provider. The participant should ensure the workers are aware of any employer-specific information.

4. Some questions were related to the Participant-Direction section of the Manual that describes the CMS expectations of states developing services under the HCBS waivers, such as “establishing special qualifications for the workers or agencies that participants select to provider services,” “disregard for statewideness,” or “election of employer and/or budget authority.”

This section is informational and helps describe the CMS rules around HCBS and participant-direction. States may limit services or determine that services may only be available in rural areas or only serve individuals who demonstrate an assessed ability to self-direct their care without limited assistance.

5. Involuntary Termination of Self-Direction may occur if the participant is or may be at risk of abuse, neglect and exploitation does this have to be confirmed by KDCF APS or KDCF CPS?

Depending on the potential abuse, neglect, and exploitation, the participant must be at risk or confirmed for abuse, neglect or exploitation from the Department of Children and Families of abuse, neglect, and exploitation for the Adult Protective Services and Child Protective Services.

6. Does the FMS provider “report payroll, tax and other administrative duties to the participant ‘on a regular basis’ to ensure participant control, choice and self-direction in participant services according to the FMS provider’s policy?”

Yes, the FMS provider should have clear policy to meet this expectation.

7. Qualified FMS Provider Requirements, Provider Competencies: How does the FMS provider “[d]emonstrate the ability to monitor, identify and report instances of potential fraud, waste, and abuse to the “appropriate authorities” and “ensure correct claims billing for HCBS Program participants directing their care”?

FMS providers should have policy and procedure to monitor, identify and report instances of potential fraud, waste and abuse. The policy should identify how the FMS provider will report allegations of fraud, waste and abuse to KDADS (potential overlap of workers between FMS providers), the Managed Care Organization (consumer risk or participation), the Department of Children and Families (consumer fraud), the Attorney General’s Medicaid Fraud Control Unit (DSW and provider fraud), and/or the KDHE’s Office of Inspector General.

While FMS providers cannot catch all fraud and prevent all duplication of reimbursement, the FMS provider should have a robust policy and procedure for monitoring submission of claims, identifying potential duplication, and reporting potential cases of fraud or questionable activity to mitigate fraud, waste and abuse.

8. The manual shows an annual liability of \$500,000. Not sure of what “annual liability” means- most liability coverage does not reference an annual limit, but a limit of coverage per occurrence and aggregate. Also, most CDDO affiliation for I/DD requires \$ 1,000,000 rather than \$ 500,000.

The section on annual insurance liability will be revised to reflect that FMS providers should have appropriate insurance liability of no less than \$500,000 in accordance with contract requirements with the managed care organization or affiliation agreements with a CDDO.

9. What is the exception criteria for the mandatory use of Authenticare® KS that must be granted by KDADS to use paper timesheets?

This section of the manual will include the additional language explaining the IVR exception process and the applicable exceptions such as language barriers and hearing or visual impairment that may limit the direct service worker’s ability to use Authenticare® KS. Exceptions must be granted annually

and a copy of the exception included in the participant's file for the direct service worker. An approved exception extends only to that DSW for the specific participant. If the DSW workers for a different participant, an exception will need to be requested by and granted for the new participant for that DSW.

10. There were a number of comments and questions related to authorizations not being entered timely and appropriately in the AuthentiCare® Ks system by the Managed Care Organizations for initial or renewal authorizations, which causes services delays.

KDADS is working with the Managed Care Organizations to develop a report and performance measure around the submission of authorizations into AuthentiCare® to ensure timely and accurate authorizations or in the system.

11. What is the reporting requirement for the compliance audit?

The Compliance Audit occurs in the years that do not require a GAAP-compliant audit. This audit will be more clearly developed in compliance with OMB Circular A-133 and in accordance with state and federal laws and regulations. It will consist of a financial report and program review to ensure compliance with the FMS Provider Agreement, Manual and waiver policy.

12. Why is there inconsistency in the notice periods for FMS providers voluntarily terminating agreement as an FMS provider?

The 90 day notification period is preferred and the language indicates that an FMS provider *may* choose to terminate with at least 90 days prior notice of written notice of termination or non-renewal. However, the next section is the minimum requirement of at least 30 days prior notice of non-renewal or termination in order to provide the MCO Care Coordinator time to identify provider capacity, meet with the participant and update the plan of care and authorizations and submit them in AuthentiCare® KS timely. The 30 day notification for participants is

13. What are the informed consent forms and what is their purpose? Specifically, what formats are expected?

FMS providers should have forms for consent of release of information that indicates the participant knows what the information will be used for and who is being authorized to access or receive the information. At a minimum the Informed Consent Form should include the participant's MCO, KDADS, and CDDO if applicable,

14. What are the policies and procedures regarding having information accessible about (9) Grievances and "appeals and how to address emergencies and concern" and (10) "Representative or Back-up Staff Designation Form" and what does it mean?

FMS providers should have policies and procedures that ensure participants are able to access information about how to file grievances and appeals, including complaints against the FMS provider as well as how the individual may address emergency situations, such as the backup staff does not arrive on time or the worker is unable to clock in and out. Additionally, the FMS provider should have forms available that address Representative Designation and Back-Up Staff Designation. There is no established format for the Back Up Staff Designation Form; however, it must be signed by the participant and include information about how the participant may utilize the back-up staff to cover when a DSW is unable to work. A copy of the Representative Designation Form will be provided to FMS providers

15. What does “the FMS may process a change in participant’s enrollment status . . . “ when a participant terminates FMS?

When a participant no longer receives participant-directed services such as personal care services, sleep cycle support, or respite, the FMS provider should take the appropriate steps to close the authorizations in and the participant’s file for the FMS provider according to the FMS provider’s policies and procedures in accordance with established MCO and state requirements.

16. KDADS needs to provide training to FMS providers on how to obtain an FEIN so compliance with KDADS can be achieved.

The National Center for Participant Directed Services presented a webinar designed for Kansas FMS providers about how to assist participants in obtaining a federal employer identification number (FEIN). This presentation has been shared with KDADS and will be available on the KDADS website for providers under trainings.

17. What are the prohibited offenses and limitations for background checks for direct service workers?

Direct Service Workers should have a background check through the Kansas Bureau of Investigation background check, Office of Inspector General exclusion list check, and DCF abuse, neglect and exploitation registry check. The list of prohibited offenses will be added to the end of the FMS Manual as an appendix.

18. Who are the vendors and independent contractors?

If an FMS provider must have policies and procedures regarding any vendors and independent contractors and the maintenance of their files and documentation. A vendor or independent contractor could be a subagent or contracted service used by the FMS Provider.

19. What is a subagent?

FMS providers are authorized to use a subagent for payroll duties. The FMS provider must have policies and procedures that ensure the subagent establishes and maintains files in an accurate, complete, secure and confidential manner and in accordance with state and federal laws and regulations.

20. "Client obligation assignments to FMS service is generally excluded and should only be assigned by the MCO to the FMS provider as a last resort;" however, the MCO DOES assign this to the FMS, and withholds from the payment to the FMS provider. This is standard practices and needs classification.

KDADS will revise the FMS Manual language to reflect the following "Client obligation assignments to FMS monthly is generally excluded and should not be assigned by the MCO to the FMS provider." Client obligation, however, can be assigned to personal care services and other participant directed services when they are the highest cost service on the plan of care. Generally, client obligation is not assigned to the personal care services if a higher cost service like residential or day supports is also on the plan of care.

21. The MCO may terminate a participant’s access to services for repeated reports of failure to pay client obligation. How many offenses before services are closed and participant dropped from the Medicaid program?

FMS providers should have policies and procedures and contractual obligations with participants about when the MCO will be notified that a participant is has failed to pay the client obligation, which is required for continued Medicaid eligibility.

22. How can the FMS provider find out about hospitalizations, institutional stays, and correcting time as appropriate to ensure no duplication of services for billing?

The FMS provider should be a Medicaid enrolled provider and have access to the MMIS as part of the KMAP system to check for changes in level of care coding. The FMS providers should have policies and procedures to address duplication of services and billing. The FMS Provider may also contact the care coordinator if there are questions about the status of a participant.

23. For Information and Assistance, what are the available Medicaid programs for referrals?

FMS providers should refer participants and DSW to appropriate Medicaid programs by making referrals to the Aging and Disability Resource Center (ADRC), training through the College of Direct Supports offered through Interhab, Families Together, or other education opportunities.

24. What bank charges must be absorbed by the FMS provider?

If the FMS provider overdraws or has bank charges to their account, these charges cannot be used to decrease the DSW reimbursement

25. The manual still states that FMS providers should have a Worker's Compensation plan that covers all workers, should this be changed?

The latest version of the FMS has not been changed related to Worker's Compensation until after the responses to the Worker's Compensation survey have been submitted and reviewed. Once language for this section is finalized, it will be added and emailed to the listserv. Although an FMS provider is authorized to get a blanket coverage to cover the employees of participants, the participant is not required to have worker's compensation for employees if he or she has total annual payroll is under the statutory limit (approximately \$20,000 a year) or if her or she employs family relatives according to state law. However, a participant may elect to have worker's compensation even if they are not required to carry worker's compensation.

26. Which rate does the FMS provider take the worker's compensation, unemployment and taxes from?

The FMS provider should deduct worker's compensation, unemployment and taxes as appropriate from the DSW reimbursement rate. However, parents who are employed by their adult children cannot have FICA, FUTA or SUTA taken from the DSW reimbursement rate.

27. If a child is in foster care and can no longer self-direct their care, what is the timeframe for this transition to occur?

KDADS is working with DCF to develop a three-month transition plan that will allow the MCOs time and opportunity to build capacity to serve children in foster care who need agency-directed services. The goal is to complete the transition by July 1, 2015 to coincide with the expected approval date of the TBI, IDD, PD and FE renewals and SED, Autism and TA amendments.

Additional questions and comments will be received through 5:00 pm on Monday, March 23, 2015. A Final version of Questions and Answers will be posted on Friday, March 27, 2015. The KDADS FMS Manual will be final and effective on Wednesday, April 1, 2015. Questions and comments can be submitted to KDADS at HCBS-KS@kdads.ks.gov.