

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES



6.5. Participant-Directed Services and Supports

Financial Management Services
Manual

Home and Community Based Programs
Effective April 10, 2015

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Kansas Department for Aging and Disability Services

Community Services and Programs Commission

Home and Community-Based Services (HCBS)

Programs

6.5. Financial Services Manual (FMS)

Participant-Directed Services and
Supports

SECTION I

A. Manual Overview & Introduction

Effective April 10, 2015

(Last Revised: December 21, 2015)

A. Introduction

Section I

1. Manual Overview

a. Description of the Manual

This manual contains or incorporates the official policies, procedures and operational protocols for Financial Management Services (FMS) providers for participant-directed services under the following programs:

- Autism
- Frail Elderly
- Intellectual/Developmental Disability
- Physical Disability
- Technology Assisted
- Traumatic Brain Injury
- Money Follows the Person

b. Purpose of the Manual

The purpose of the FMS Provider manual is to:

1. Explain how providers are enrolled and qualified to provide services;
2. Establish the standards that each provider must meet;
3. Identify acceptable methods to document compliance with the standards; and
4. Describe the review process used to determine the provider's initial and ongoing compliance with these standards.

c. Use of the Manual

The Kansas Department for Aging & Disability Services (KDADS) and contracted entities use this manual to determine whether a provider qualifies to provide a specific service under a specific program. Following enrollment, this manual is used to establish the basis upon which the provider is annually reviewed to provide the service(s) or is disqualified from the waiver or program. The FMS Provider manual is intended to assist FMS providers in performing the roles and responsibilities consistent with all applicable authorities and ensure KDADS and contracted entities make sound judgments about compliance issues, including the quantity and quality of service provided and the health and welfare of the participants in the waiver. The FMS Provider manual also is used, in conjunction with the HCBS program and approved waiver, to assure compliance with the state assurances and quality improvement strategies.

d. Policy Memorandum

It is intended that policy memorandum issued by KDADS will be used in conjunction with the Financial Management Services Manual. Between manual revisions, all policy memorandum describing new policies or changes to policies noted in this revision of the manual shall be kept with the manual until the next revision is published. Policy memorandum and policy updates for public comments are available online at www.kdads.ks.gov.

e. Maintenance of the Manual

This manual is developed and revised through a policy and procedure review process conducted by KDADS. Each section of the Manual is maintained and updated independently with cross-references to the appropriate sections of the Manual.

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2. Administrative Overview

a. KanCare – Medicaid and Long-Term Supports and Services

As of January 1, 2013, KanCare is the system through which the State of Kansas administers Medicaid. KanCare includes long-range changes to the delivery system by encouraging transition away from institutional care and toward services that can be provided in individuals' homes and communities. On February 1, 2014, 8,500 Kansans on the HCBS program for intellectual and developmental disabilities (HCBS-IDD) had their long-term services and supports included into KanCare to improve coordination with their physical and behavioral health services and supports. KanCare delivers whole-person, integrated care to over 400,000 Medicaid-eligible Kansans across the State.

Under KanCare, Kansas contracts with three health plans, or managed care organizations (MCOs), to coordinate integrated health care for nearly all Medicaid beneficiaries. KanCare health plans provide physical health services such as doctor appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, and nursing facility care, plus additional (or value-added) services. The goals of KanCare are to improve overall health outcomes while slowing the rate of cost growth over time. This is accomplished by providing the right care, in the right amount, in the right setting, at the right time.

The Kansas Department of Health and Environment (KDHE), the single state Medicaid agency, and the Kansas Department for Aging and Disability Services (KDADS), the operating agency, administer KanCare. KDADS administers the home and community-based programs that provide participant-directed services for aging and disabled individuals.

b. Kansas Department for Aging & Disability Services (KDADS)

On July 1, 2012, the Kansas Department on Aging was renamed the Kansas Department for Aging and Disability Services (KDADS), and the Disability and Behavioral Health section of the Kansas Department for Children and Families (formerly Kansas Department of Social and Rehabilitative Services) was moved to KDADS. Home and Community Based Services (HCBS) Programs and Behavioral Health Services (BHS) are a part of the Community Services and Programs (CSP) Commission of KDADS and provide state and federally funded programs.

c. HCBS Programs

The State of Kansas utilizes several CMS programs to provide a full array of Medicaid and Medicare benefits that provide quality care for dual eligible enrollees, improves care coordination, and reduces administrative burdens under KanCare, the State of Kansas's integrated Medicaid delivery system. Collectively, these programs are referred to as the Home and Community-Based Services (HCBS) Programs and includes the 1915(c) waivers, PACE and MFP federal programs and Quality Assurance and Program Integrity.

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Home and Community Based Services (HCBS) programs under the 1915(c) waivers, funded through the Centers for Medicare and Medicaid Services (CMS), allow for the coverage of long-term services and supports for a variety of targeted populations groups, such as people with intellectual disabilities, and/or physical disabilities to receive services in their home or community. HCBS first became available in 1983 when Congress added section 1915(c) to the Social Security Act, giving states the option to receive a waiver of Medicaid rules governing institutional care. In 2005, HCBS became a formal Medicaid State plan option. Kansas and several other states include HCBS services in their Medicaid State plans.

KDADS administers seven (7) HCBS Programs for aging and disabled adults and children through the following 1915(c) waivers: Autism, Frail Elderly (FE), Intellectual/Developmental Disability (IDD), Physical Disability (PD), Technology Assisted (TA), Traumatic Brain Injury (TBI), and Severe Emotional Disturbance (SED), and the Money Follows the Person (MFP) federal grant, which supports transitions from institutional settings for the FE, PD, TBI and IDD programs.

d. Guiding Principles

KDADS holds the following principles and expects all providers apply these principles to their business with the KDADS and its participants:

Partnerships – HCBS Programs utilize the strengths and connections of partnerships (community and state) to achieve the vision of HCBS Programs.

Innovation – HCBS Programs embrace new processes, methods, services and/or partnerships to improve the services and supports provided to the participants.

Respect – HCBS Programs respect the rights and choices of organizational partners and people with disabilities, and recognizes individual's capabilities, strengths and potential.

Freedom of Choice – HCBS Programs recognize that people have the right to make daily choices about their lives and lifestyles according to their functional abilities.

Person-Centered – HCBS Programs recognize the importance of person-first language and person-centered services, supports, and planning to support an individual in achieving his or her goals and preferences.

Independent Living – HCBS Programs support individuals in accessing integrated and supported employment, integrating into home and community with supported and independent living, and achieving personal independence in all areas of life

In support of the independence, choice and control of the participant and independent living philosophy, the FMS functions as administrative support and a fiscal service entity to reduce the employer-related burden and enhance choice and control for participant-employers. To that end, the FMS recognizes the rights of participant-employers to self-direct care. FMS providers should remain neutral with regard to employment decisions reserved for participant-employers. Employment decisions made by participant-employers include, but are not limited to, independently hiring, training, directing, managing, supervising and dismissing employees.

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3. Acronyms and Definitions

a. Acronyms

ADRC	Aging & Disability Resource Center
CDDO	Community Developmental Disability Organization
CIL	Center for Independent Living
CMS	Centers for Medicare & Medicaid Services
DCF	Kansas Department for Children and Families
DSW	Direct Service Worker
EVV	Electronic Visit Verification
FE	Frail Elderly
F/EA	Fiscal/Employer Agent
FMS	Financial Management Services
HCBS	Home and Community Based Services
I & A	Information and Assistance
IDD	Intellectual/Developmental Disability
ISP	Integrated Service Plan
IVR	Interactive Voice Response
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
MCO	Managed Care Organization
PCS	Personal Care Services
PD	Physical Disability
POC	Plan of Care
TA	Technology Assisted
TBI	Traumatic Brain Injury

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b. Definitions

Care Coordinator is the individual assisting the participant in accessing needed waiver services and other state plan services, as well as medical, social, educational and other services regardless of the funding source through which access to services is gained. Care Coordinators work with the participant to identify, coordinate and facilitate services.

Common Law Employer is, under common law rules, an individual or organization that has the right to direct and control how a person (engaged by an individual/organization) performs the services provided. This control refers not only to the result to be accomplished (outcome) by the work but also the means and details by which that result are accomplished, even if the employer gives the person he/she engages freedom of action.¹

Community Service Provider is an individual or organization who meets the requirements as described in the HCBS program standards to provide home and community based services.

Compliance Audit is a program and fiscal filing and audit requirement of balance sheet, revenue and expense activity and program compliance for programs funded fully or in part by Medicaid funds through the HCBS programs.

Direct Service Worker is an individual who meets the requirements as described in HCBS waiver or program standards and is employed by the participant to provide assistance and support to the participant, such as personal care services, in accordance with the participant's Integrated Service Plan/Plan of Care.

Employment Taxes are taxes imposed on employees and employers by the Federal Insurance Contribution Act (FICA), sections 3101 and 3111 of the Code, the tax imposed on employers by the Federal Unemployment Tax Act (FUTA), section 3301 of the Code and Federal income tax withholding, section 3402 of the Code.

Employee is, under common law rules, anyone who performs services for a person or organization where the person/organization has the right to direct and control what will be done and how it will be done. This control refers not only to the result to be accomplished (outcome) by the work but also the means and details by which that result is accomplished, even if the person/organization gives the individual they engaged freedom of action.

¹ IRS website, http://www.irs.gov/publications/p15a/ar02.html#en_US_2015_publink1000169467

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Employer Authority is when participants exercise the full range of decision-making authority over their direct service workers and the full array of support is available to participants.² Functions included under employer authority include:

- Verifying workers' citizenship status;
- Collecting and processing direct service workers' timesheets; and
- Processing payroll including the management of federal, state and local employment-related taxes and insurances (or engaging an entity to perform this function on the participant's behalf).³

Employer-Related Tasks are payroll and invoice payment responsibilities that the Government or FMS performs on behalf of participants and/or their surrogates. These tasks are further described in Section III.

Financial Management Services (FMS) is a service that provides payroll, invoice processing and payment, fiscal reporting services, employer orientation, and skills training, and other fiscal-related and administrative services to participants choosing to exercise employer authority through self-direction under an HCBS Program. The FMS provider must operate as either a Vendor Fiscal/Employer Agent (F/EA) or as a Government Fiscal/Employer Agent (F/EA), in accordance with §3504 of the IRS code and Revenue Procedure 70-6 and 80-4, respectively, as modified by IRS Proposed Notice 2003-70. Kansas uses the Vendor Fiscal/Employer Agent.

Integrated Service Plan (ISP) or Plan of Care (POC), represented throughout this manual as ISP/POC, is the plan that details the services a participant needs and wants and the provision of these services. The ISP is developed by the Care Coordinator, participant and the participant's support team.

Kansas Department for Aging & Disability Services (KDADS) is the operating agency for state and federally-funded services, supports, and programs for aging and disabled individuals in Kansas and is responsible for administering the home and community-based services waivers authorized under section 1915(c) of the Social Security Act.

Participant is a person determined by the Kansas Department for Aging & Disability Services (KDADS) to be eligible for Medicaid-funded home and community-based waiver services and chooses to self-direct their care. In this manual, the use of "participant" may also refer to the individual's representative.

Participant-Direction is a service model where participants have the right to exercise decision making authority over some or all of the services they need to live in their community and accept the responsibility for taking a direct role in managing these services. It is an alternative to provider management of services and promotes

² CMS Version 3.5 HCBS Waiver Application Instructions, Appendix E, p.191.

³ IRS Proposed Notice 2003-70, Question & Answer 6, p.10.

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personal choice and control over their services and how they are delivered. Some self-directing program participants share authority with or delegate authority to a representative (i.e., a family member, friend or other person close to the participant). The designation of a representative enables minor children and adults with cognitive impairments to participate in self-direction programs.

Pay Period is the work period as established by the FMS provider and/or defined by the Kansas Department of Labor for payday requirement, including pay periods such as weekly, bi-weekly, bi-monthly, 1st through the 15th, etc.

Per Member Per Month (PM/PM) is a payment method established by KDADS that reimburses an FMS for administrative services rendered based on a flat rate of payment for each participant, each month.

Person-Centered Plan is the plan that details the supports a participant needs and wants including formal and informal supports for achieving goals, addressing barriers, and ensuring choice, independence and person-centered focus in the service planning process. The PCP is developed by the Care Coordinator, case manager, participant and the participant's support team, as applicable

Plan of Care (POC) or Integrated Service Plan (ISP), referred to throughout this manual as ISP/POC, is the plan that details the services a participant needs and wants and the provision of these services. The ISP/POC is developed by the Care Coordinator, participant and the participant's support team.

Reporting Agent is an accounting service, franchiser, bank, service bureau or other entity authorized to perform one or more acts on behalf of an employer, including signing and filing Forms 940 and 941 and making Federal tax deposits for the taxes reported on those forms.

Representative is a family member, friend or other person who is close to and chosen by the participant who shares the authority, with the participant, for managing the participant's services and supports and the direct service workers who provide them. This authority must reflect the desires and preferences of the participant and may include being the common law employer of the participants' direct service workers when appropriate. A participant's representative cannot also be his/her direct service worker.

Vendor Fiscal/Employer Agent (F/EA) is a vendor entity that applies for and receives approval from the Internal Revenue Service (IRS) to be an employer agent, in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by Proposed Notice 2003-70, on behalf of participants performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for the requirements of back-up withholding, as applicable. The FMS performs

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other fiscal and reporting tasks as required by KDADS and as described in this document.

Work Week is a seven-day period, such as starting on Sunday and ending at midnight on Saturday.

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4. Applicable Authority

a. CMS Authority – www.cms.gov

- CMS Technical Guidance
- HCBS Program Waiver Application – www.kdads.ks.gov

b. Federal Authority

Deficit Reduction Act of 2005

Section 1915 of the Social Security Act

Section 1915(c) of the Act authorizes a waiver of certain Medicaid rules for home and community based services and allows states to provide services and supports through participant-direction, also referred to as participant-direction or self-direction, and provides for a vehicle for individuals to receive Medicaid-funded supports like FMS to support participant-directed activities.

Section 1115 of the Social Security Act

Section 1115 of the Act gives the Secretary of Health and Human Services wide-ranging authority to grant states waivers of federal Social Security Act provisions for the purpose of demonstrating alternative approaches to service delivery. When a state is interested in testing such alternative approaches, this waiver authority provides states with a means to obtain relief from statutory requirements that stand in the way of implementing such approaches.

Vendor Fiscal/Employer Agent

- *Internal Revenue Code §3504*
- *Internal Revenue Procedure 70–6, 1970–1 C.B. 420 and as modified by IRS Proposed Notice 2003–70)*

IRS Forms 2678 Instructions - Delegate Agent Tasks to a Reporting Agent

c. State Authority

KSA 39-7,100 [Home and community based services program], KSA 65-6201, and any related and applicable Kansas Administrative Regulations regarding home and community-based services, Medicaid and self-direction.

KSA 44-500 *et al* [Worker's Compensation] – Information available online at <http://www.dol.ks.gov/WorkComp/Default.aspx>

Kansas Department for Aging and Disability Services

Community Services and Programs Commission

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SECTION II

B. Participant-Direction

Effective April 10, 2015

(Last Revised: December 21, 2015)

B. Participant-Direction

Section II

1. Overview of Participant-Direction (Self-Direction)

Participant-direction, also referred to as self-direction or consumer-direction, means that participants, or their representatives, if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The participant-directed service delivery model is an alternative to traditionally delivered and managed services, such as agency-directed services. Participant-direction of some or all HCBS services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process. However, with choice and control come responsibilities, including those associated with being an employer, such as management of payroll and employment-related taxes.

a. Brief History

Nationally, self-direction really began in the late 70s and early 80s; mainly in small, boutique, state-funded-only programs that often were limited to working age folks with physical disabilities. The concept was very popular and grew over time so that by the 1990s, it began to be specifically included as an option within federal programs such as the four state Robert Wood Johnson Cash and Counseling Demonstration beginning in 1997. The Supreme Court's *Olmstead* decision of 1999 added further submit to this focus on consumer-control and self-direction at the federal level. This time period culminated at the turn of the millennium with President Bush's "New Freedom Initiative" that included, for the first time, a Medicaid HCBS template for states to include self-directed options called the "Independence Plus" template. Currently, almost every State in the country has at least one self-directed program.

- 1) **Supports for Self-Direction.** Federal policy provides that states can obtain Medicaid federal financial participation (FFP) when they provide certain key supports to participants who direct their services. These supports include:
- 2) **Administrative Assistance.** These services include performing financial transactions on behalf of participants (e.g., paying workers that participants employ, deducting payroll taxes, etc.) along with tracking expenditures and disbursements for individual participant employers.
- 3) **Information & Assistance in Directing HCBS.** Assistance may include counseling participants about available services and supports; helping them to acquire the skills to manage their individually employed workers; assisting them to locate workers and services; and obtaining other benefits and community resources.
- 4) **Safeguards.** States are expected to implement certain basic safeguards on behalf of participants who direct their services, which includes ensuring that services are not interrupted when an individual elects to transition from self-direction to provider-managed services and ensuring that participants have an individualized backup plan to handle service delivery breakdowns.

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b. Basic Features of Self-Direction of Medicaid HCBS

- 1) Under the provisions of §1915(c) of the Act, a state may obtain federal waivers to furnish HCBS to participants who require the level of care that is provided in a Medicaid-reimbursable institutional setting but choose to be supported in the community. This waiver authority has emerged as one of the principal vehicles (along with State Plan coverage of personal care/assistance) by which states secure Medicaid federal financial participation in the costs of supporting older persons and participants with disabilities in the community. A state may operate one or several waivers.

The §1915(c) waiver authority permits a state to:

- 1) Target HCBS to a state-specified group of Medicaid participants by securing a waiver of comparability;
- 2) Furnish a state-defined package of HCBS to waiver participants; and,
- 3) Specify the number of persons who may participate in a waiver program.

The §1915(c) waiver statute identifies certain services (e.g., case management, personal care, supported employment, respite) that a state may include in its waiver benefit package. A state may also propose to cover additional services beyond those specified in the Act, subject to CMS review and approval. By operating a §1915(c) waiver, a state may provide (a) services that it could not otherwise offer under its Medicaid State Plan; (b) services that it could offer under the State Plan but does not; and, (c) services that it offers under the State Plan but in an amount greater than allowed under the State Plan.

States principally target waiver services to the following groups of Medicaid participants - older persons, people with physical disabilities, people who have experienced a brain injury, children with serious emotional disturbances, children and adults with intellectual and other developmental disabilities, children with special health care needs, people with AIDS , and technology-dependent individuals

- 2) KDADS operates seven 1915(c) HCBS Programs for children and adults: Autism, Frail Elderly, Intellectual/Developmental Disability, Physical Disability, Technology Assisted, Traumatic Brain Injury, and Severe Emotional Disturbance. While each authority has unique elements, certain basic features of self-direction cut across the authorities. These features include:
 - a) **Individual Election of Self-Direction.** Participants are allowed to opt in or out of self-direction and utilize agency-directed services and there should be no service breaks during transition periods. This feature recognizes that not all participants may want to assume the responsibilities that self-direction entails.

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- b) **Participant-Led Service Planning Process.** The participant (or a personally selected personal representative) should be positioned to lead the service planning process, including having the authority to manage their direct service worker in addition to exercising free choice of provider, a longstanding right under federal Medicaid law.
- c) **Individual Authority Over Service Delivery.** Participants are able to determine how and when services are delivered, which includes specifying the elements of the services that will be delivered (within the approved scope of the service(s) on the plan of care), scheduling the delivery of services, and establishing any additional special qualifications for the workers or agencies that participants select to provide services.
- d) **Managing Workers.** Participants function as the employers of their workers, which includes exercising authority over the selection, supervision, and management of workers. The participant is the legal employer of their workers and provide for the use of fiscal/employer agents to pay workers and file payroll taxes on their behalf.

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2. Self-Direction in HCBS Programs

a. Background

Since the inception of the §1915(c) waiver program in 1981, some states (e.g., Kansas, Oregon, Washington, Wisconsin) have incorporated limited forms of self-direction in their waivers. In 1989, the Kansas Legislature passed House Bill 2012, which allowed individuals on the HCBS Medicaid waivers to arrange for and direct their own personal attendant care. K.S.A. 65-6201 allows consumers age 16 years of age and older to self-direct their own personal in-home care. Participants are responsible for recruiting, training, and managing their attendants.

Some tasks, termed ‘Health Maintenance Activities,’ require delegation from a nurse or physician. The Nurse Practice Act of 2001 (K.S.A. 65-1124) included language that referred to the statute, and allowed for the performance of a nursing procedure by a person when that procedure is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgment and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse.

In 2004, CMS—in collaboration with several state agency associations that have operational responsibility for HCBS service delivery—undertook a major revision of the standard §1915(c) waiver application. The revised application, released in 2005 (updated releases in 2008 and 2015), requires states to describe in detail the critical operational features of their waivers and places a stronger emphasis on waiver service quality assurance/quality management than did the previous application. In conjunction with the release of the new application, CMS also released comprehensive technical guidance to states concerning various dimensions of the design and operation of §1915(c) waivers. An important feature of the revised waiver application is the inclusion of a distinct part (Appendix E) that is devoted to “participant-direction” of waiver services. Appendix E is designed to permit a state to incorporate self-direction into the operation of any §1915(c) waiver.

b. 1915(c) Elements

When states elect to include a self-direction option in a §1915(c) waiver, they have the latitude to shape the option along several dimensions, including:

- 1) **Disregard of Statewideness.** A state may elect to offer the self-direction option in all parts of the state or limit it to specific areas or regions.
- 2) **Disregard of Comparability.** A state may decide to make its self-direction option available to all waiver participants or limit its availability to specified groups of participants
- 3) **Direction by a Representative.** A state may allow services to be directed by a representative selected by the waiver participant.

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- 4) **Specification of Self-Directed Services.** A state may specify which waiver services—some or all—may be directed by participants.
- 5) **Election of Employer and/or Budget Authority.** A state may elect to offer participants the employer authority, the budget authority—or both—over the services they may direct. In each instance, a state may limit the extent of the authority that participants may exercise.
- 6) **Coverage of Individual-Directed Goods and Services.** A state may elect to include the coverage of “individual-directed goods and services” in its waiver.

c. Design Features

When a state offers a self-directed services option, CMS expects that such processes will take into account any special considerations that might attend self-direction. Additional §1915(c) waiver operational dimensions relate to self-direction of waiver services. These include service planning (and associated risk assessment processes) and some elements of quality management. For example, a state is expected to ensure that service plans provide for backup services when appropriate and provide safeguards for health, safety and welfare of the participant. As part of its design of a §1915(c) waiver self-direction option, a state also must address the following topics:

- 1) **Information About Self-Direction.** Inform waiver participants about the benefits and potential risks of self-direction as well as their responsibilities when they elect to direct their HCBS.
- 2) **Financial Management Services.** Provision of financial management services (FMS) on behalf of participants who direct their waiver services. The §1915(c) waiver statute does not permit the payment of Medicaid dollars directly to waiver participants through the use of a “cash option.” Thus, the use of an intermediary to perform financial transactions on behalf of participants is necessary. States may offer financial management services as a waiver service or contract for such services as a Medicaid administrative function.
- 3) **Assistance in Support of Self-Direction.** Information and assistance available to participants who direct their services and wish to avail themselves of such assistance. This assistance may take the form of a distinct waiver service (e.g., by covering counseling), a case management/support coordination activity, an administrative activity, or a combination of all three.
- 4) **Transition.** Transition of waiver participants who voluntarily decide to discontinue self-direction to agency-delivered services. In particular, a state must ensure that such participants continue to receive critical services during the transition period.
- 5) **Termination from Self-Directed Option.** Circumstances when it will terminate participants’ use of the self-direction option and provide for their transition to agency-delivered services. As with voluntary transitions, a state must ensure the participants continue to receive critical services during the transition period.

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3. Overview of Financial Management Services

FMS provides fiscal accountability for state and local government agencies and safeguards for individuals enrolled in self-direction programs and their workers by ensuring that payroll, applicable employee insurance policies such as unemployment and/or workers' compensation and vendor payment tasks are performed timely, accurately and in accordance with federal, state, and local rules and regulations.

In general, the FMS and Agency with Choice FMS models appear to be more popular than other models with states implementing self-direction programs. While many participants only want to hire and manage their workers and therefore prefer the agency with choice model, the FMS model affords participants a greater degree of choice and control over their services and workers than other FMS models because it allows participants to be the employer of their workers. This level of choice and control is the hallmark of self-direction.

Until recently, Kansas operated a hybrid model between the Agency with Choice FMS model and the Vendor Fiscal Employer Agent (F/EA) model of financial management services. During this period, Kansas submitted waiver renewals to completely transition to the vendor fiscal employer agency (F/EA) mode. The F/EA model provides participants with control and independence to employ direct service workers (DSWs) and provides participant with information and assistance to ensure they have support in their role as the employer of the direct service workers. This manual assists the FMS providers in providing administrative support and information and assistance consistent with the Kansas's goals and CMS's expectations for participant-directed services and supports.

Financial Management Services (FMS) is an HCBS service available for the participant or designee (a designated person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to participant-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Fiscal/Employer Agent (F/EA) model. FMS service is available to participants who reside in their own residence or in the home of a family member and have chosen to participant-direct their services.

In the F/EA model, the participant retains the responsibility as the employer. FMS supports will be provided through a third party entity that has an established provider agreement with the Secretary of KDADS and is contracted with a KanCare managed care organization (MCO). FMS provider will support the participant in accordance with terms specified in the KDADS FMS agreement and this manual.

The FMS must have an FMS Policies and Procedures Manual developed for the specific type of F/EA employed. The manual shall describe the policies, procedures and internal controls to ensure the proper operation of the F/EA in accordance with federal, state and local tax, labor, workers' compensation and program rules and regulations, (including the use of a reporting agent or subagent). When the F/EA also is a direct service provider, the F/EA must have documented policies, procedures and internal controls in place to

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ensure that participants have the right and ability to select the service provider of their choice.

B. Participant-Direction

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4. Participant-Direction in Kansas

a. Overview of Kansas FMS Model

Within the participant-directed model and Kansas state law (K.S.A. 39-7,100), participants have the right to “make decisions about and direct the provisions of services which includes, but not limited to selecting, training, managing, paying and dismissing of a direct service worker.”

The participant, or participant’s designated representative, has decision-making authority over certain services and takes direct responsibility for managing these services with the assistance of a Financial Management Services (FMS) provider. Kansas FMS support is available to participants under the employer authority using the CMS-approved Vendor Fiscal Employer Agent (F/EA) model.

FMS support is available for the participant or designee (a designated person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to participant-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the employer authority model of FMS services. FMS service is available to participants who reside in their own residence or in the home of a family member and have chosen to participant-direct their services.

In the F/EA model, the participant retains the responsibility as the common law employer. FMS supports will be provided through a third party entity that has an established provider agreement with the Secretary of KDADS and is contracted with a KanCare managed care organization (MCO). FMS provider will support the participant in accordance with terms as specified in the signed agreement and this manual.

Services in support of participant-direction are offered whenever a waiver affords participants the opportunity to direct some or all of their waiver services. Two core service definitions are provided: (a) information and assistance in support of participant direction and (b) financial management services.

FMS providers assist the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks.

b. Programs

HCBS – Autism: This program provides services to children with a diagnosis on the Autism Spectrum Disorders to receive early intensive intervention treatment and allow primary caregivers to receive needed support through services.

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HCBS – Frail Elderly (FE): This program provides an option for qualified, Medicaid-eligible Kansas seniors (over 65) to receive community based services, such as personal care, assistance with household tasks, and health services, as an alternative to nursing facility care. The program promotes independence within the community in the most integrated environment.

HCBS – Intellectual/Developmental Disability (IDD): This program serves individuals age 5 and over who meet the definition of intellectual disability and/or developmental disability (IDD) or are eligible for care in an Intermediate Care Facility for people with intellectual disabilities (ICF-ID).

HCBS – Physical Disability (PD): This program serves physically disabled (PD), Medicaid-eligible Kansans between the ages of 16 to 65 who meet the level of care criteria for nursing facility placement and Social Security standards for physical disability.

HCBS – Technology Assisted (TA): This program serves chronically ill or medically fragile, Medicaid-eligible Kansans from birth through 21 years of age who are dependent upon a ventilator or medical device to compensate for the loss of vital bodily function, requires substantial, ongoing, hospital-level daily care by a nurse or other qualified caregiver under the supervision of a nurse to avert death or further disability.

HCBS – Traumatic Brain Injury (TBI): This program serves Medicaid-eligible Kansans who have sustained a traumatic brain injury (TBI) between the ages of 16 and 65 who meet the criteria for TBI rehabilitation hospital placement by providing critical services needed after injury to improve recovery and minimize further disability until the individual has improved enough to no longer need these short-term waiver services.

Money Follows the Person (MFP): This federal demonstration grant is intended to help residents of qualified institutional settings (Intermediate Care Facilities/Intellectual Disabilities, Nursing Facilities) to move back into community settings. The grant award period ends in 2016.

c. Services

- 1) Each program has a number of services and supports designed to assist an individual in living in their home or communities. Each service and support has specific requirements and limitations, which the participant must follow when directing his or her care.
 - a) Services will be prior authorized and coordinated by the KanCare MCO Care Coordinator and arranged for, and provided under the participant, designated representatives or legally responsible party's written authority,

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and paid through an enrolled FMS consistent with and not exceeding the individual's approved Integrated Service Plan/Plan of Care.

- b) Services must occur in the home or community location meeting the setting requirements as defined in the "HCBS Setting Final Rule". Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual disability (ID), or institution for mental disease are not covered and will not be reimbursed.
- 2) Each HCBS Program has specific, CMS-approved services with established definitions, provider qualifications, requirements, benefits and limitations. MCO approve the participant's needed services according to the HCBS Program rules as authorized on the ISP/POC.
- a) Authorized services can be provided and reimbursed based on the assessed needs of the participant as identified on the participant's ISP/POC.
 - b) Services should provide necessary assistance to participants in their home and community. Home is where the individual make his/her residence, and must not be defined as institutional in nature and must comply with the HCBS final rule setting.
 - c) A DSW may not perform any duties not delegated by the participant or participant's representative with the authority to direct services or duties as approved by the participant's physician and must be identified as a necessary task in the ISP/POC.
 - d) HCBS waiver services may not be provided by the parent or legal guardian for the minor waiver Participant and/or the participant's spouse. A spousal exception must be submitted to the MCO and receive written approval prior to a spouse being authorized to provide supports.
 - e) A court-appointed guardian or durable power of attorney may not provide supports and services for the participant nor direct the care of the employees of the participant when a conflict of interest exists or when a designated representative is appointed.
 - f) All agency-directed and participant-directed services requiring the use of the AuthentiCare@KS for time and attendance must be generated using the IVR/EVV system through telephonic check-ins and check-outs or the approved mobile application. Participants may have both agency-directed and self-directed services on an ISP/POC if allowed under the participant's HCBS Program.

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- g) Individual or legally responsible individual with the authority to direct services who may at some point determine that they no longer want to participant-direct his/her service will have the opportunity to receive the previously approved waiver service, without penalty.

d. Conflict of Interest

- 1) Guardian or activated Durable Power of Attorney as paid DSW for the participant
 - a) When a court appointed guardian proposes to or does provide supports or services for the participant and directs the care and employees of the participant, the court-appointed guardian must:
 - i. Provide documentation from the court that all potential conflict of interest concerns have been mitigated in accordance with KSA 59-3068, or
 - ii. If the court determines that all potential conflict of interest concerns have not been mitigated, the court-appointed guardian can either select a paid caregiver to provide the participant's services or appoint a designated representative to direct the participant's care.
 - b) When an activated durable power of attorney proposes to or does provide supports or services for the participant and directs the care and employees of the participant, the activated durable power of attorney must:
 - i. Provide documentation of the revocation of the durable power of attorney and no longer direct the care and supports on the participant's behalf.; or
 - ii. Select a paid caregiver to provide the participant's services and supports or appoint a designated representative to direct the participant's care.
 - c) An exception to the criteria may be granted by the State when a participant and guardian or activated durable power of attorney lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence and provide additional oversight to monitor service provision.
- 2) Designated Representative
 - a) A designated representative must be appointed by the court-appointed guardian or activated durable power of attorney authorized to act on the participant's behalf if he or she is also a paid care provider.
 - b) The appointment of a designated representative does not usurp or otherwise change the rights or responsibilities of a court-appointed guardian or as authorized in the durable power of attorney.
 - c) The appointment of a designated representative must in writing, be at least for the period of the ISP/POC, be documented in the ISP/POC, in the individual's file and in the person-centered plan and be made at least

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annually.

- d) The designated representative will:
 - i. Act as the approving agent for services provided, by verifying time and attendance for court appointed guardians or other direct service workers hired to provide services.
 - ii. Hire, fire, manage, train, and monitor direct service workers, including the paid court-appointed guardian and other direct service workers.
 - iii. Attend all ISP meetings and represent the individual receiving services for determination of service options and identifying qualified providers.
 - iv. Attend all Individualized Education Plan (IEP) meetings with the school and individual's support team.
 - v. Participate in the person-centered planning process and make appropriate decisions regarding participant-direction.
- e) The designated representative will not:
 - i. Serve in any other capacity as designated representative for the court-appointed guardian.
 - ii. Displace the guardian in legal and appropriate activities of a court-appointed guardian including the appointment of a designated representative.
- f) The court-appointed guardian or activated durable power of attorney, paid to provide services to the individual, may:
 - i. Contribute information for the functional needs assessment.
 - ii. Contribute information for the development of the integrated service plan of care and the person-centered support plan.
 - iii. Participate fully in the ISP team as a team member.
- g) The court-appointed guardian or activated durable power of attorney, paid to provide services to the individual, may not:
 - i. Override team decisions, or contributions of the designated representative.
 - ii. Determine the hours of service for which he or she will be paid
 - iii. Determine his or her rate of pay
 - iv. Sign the integrated service plan of care to authorize services
 - v. Serve as the employer of record and hire, fire, direct or manage the other direct service workers.

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5. Roles & Responsibility for Participant-Direction

a. Participant-Employer

The participant is the sole employer of the DSW. The FMS provider is responsible for provision of I & A to assist the participant with understanding his/her role and requirements as the employer and his/her responsibilities under participant-direction. These include, but are not limited to:

- 1) Employer related responsibilities, such as:
 - a) Hire the DSWs who provide the participant's services according to the participant's integrated service plan or plan of care;
 - b) Determine tasks to be performed by DSW(s) and where and when they are to be performed in accordance with the approved and authorized ISP/POC;
 - c) Manage and supervise the day-to-day HCBS activities of DSW(s);
 - d) Ensure DSW has resources and training on the use of the AuthentiCare® KS IVR system;
 - e) Verify time worked by DSW(s) was delivered according to the ISP/POC; and approve and validate time worked verbally, in writing, and/or electronically;
 - f) Maintain control and oversight of his or her DSW to prevent fraud, waste, abuse and ensure compliance with federal and state rules and regulations;
 - g) Ensure DSW(s) are aware of their employment requirements and job responsibilities upon signing the Employment Service Agreement ;
 - h) Ensure the DSW(s) is aware of the employer's requirements and job responsibilities between their participant-employers and the FMS provider:
 - o Develop an emergency worker back-up plan in case a substitute DSW is ever needed on short notice or as a back-up (short-term replacement DSW).
 - o Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.
 - o Inform the FMS provider of any changes in the status of DSW(s), such as changes of address or telephone number, in a timely fashion.
 - o Participate in required quality assurance visits with MCOs, and State Quality Assurance Staff, or other Federal and State authorized reviewers/auditors, such as CDDO quality assurance reviewers.
 - i) Promptly inform the FMS provider of the date dismissal of a DSW to

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avoid potential duplication or billing errors.

- j) Promptly inform the FMS provider of any changes in the status of the participant or participant's representative, such as the participant's address, telephone number or hospitalizations.
 - k) Understand and comply with federal and state policies and procedures.
- 2) Understand the roles and responsibilities of the FMS provider, such as
- a) Provide payroll and administrative assistance to the employer by ensure all state and federal taxes are properly withheld and paid in accordance with state and federal requirements, including:
 - i. Policies related to FMS agreement with the employer
 - ii. Process for the participant to report work-related injuries incurred by DSW(s) to the FMS provider to process worker's compensation claims on behalf of the participant.
 - iii. Process for notifying FMS provider of any changes in circumstances including dates of dismissal for DSW and work-related injuries for worker's compensation claims.
 - b) Provide information, assistance and referral to employers as requested to enable participants or representatives to independently direct and manage HCBS services and employees in such areas as:
 - i. Provide information about all aspects of participant-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
 - ii. Explain how to set up training on the use of the IVR system as the required tool for reporting of direct service worker's time and attendance;
 - c) Submit documentation required for completing background checks and notifying the employer of the results, including whether the potential employee meets the program qualifications or has any prohibited offenses.
 - d) Process verified time worked for employee and pay DSWs according to the rate established by the participant-employer.
 - e) Collect appropriate client obligation from the participant based on the amount determined by the State.
 - f) Notify the appropriate entities if there is suspicion of abuse, neglect and exploitation or Medicaid fraud, waste and abuse.

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- 3) Understand the roles and responsibilities of the MCO Care Coordinator, such as:
 - a) Assist the participant to identify immediate and long-term needs and to develop options to meet those needs including accessing identified supports and services;
 - b) Assist the participant to develop a backup plan in the event the direct service worker does not report to work;
- 4) Involuntary Termination of Self-Direction: The MCO may terminate the option for self-direction and an offer agency-directed services according to the approved KDADS policy when one or more of the following occurs:
 - a) The participant/representative fails to fulfill the responsibilities and functions required, including, ensuring:
 - i. The client obligation is paid to the provider, if applicable;
 - ii. The DSW adequately performs the services as outlined in the ISP/POC;
 - iii. The participant manages and monitors the DSW in accordance with HCBS Program policy and state and federal rules and regulations;
 - iv. The participant has not abused or misused the self-directed option.
 - b) Obtained evidence the participant is or may be at risk of imminent harm to the participant's health, safety, or welfare, and is unable or unwilling to remedy the risk:
 - i. As documented by the MCO on one or more occasions; and/ or
 - ii. As confirmed by the Kansas Department of Children and Families (DCF) Adult Protective Services (APS)
 - c) Obtained evidence the participant/representative has abused or misused the self-directed care option, such as, but not limited to, the participant/representative has:
 - i. Repeatedly failed to pay the client obligation as required;
 - ii. Directed the DSW to provide, and the DSW has provided paid services beyond the scope of the Plan of Care or scope of service definition, such as paid attendant care or sleep cycle support;
 - iii. Directed or allowed the DSW to provide HCBS paid services beyond the scope of the Plan of Care authorized services, such performing tasks to support the home and pets when the participant is out of town on in an institutional setting;

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- iv. Directed the DSW to not provide paid services supports and required the DSW pay the participant a portion of the DSW's pay;
- v. Committed fraudulent acts or obtained Medicaid eligibility through fraud;
- vi. Submitted and/or approved signed time sheets or electronic visit verifications (EVV) for services beyond the scope of the ISP/POC or for time and services that were not provided;
- vii. Directed or allowed the DSW to provide care and services while in an institutional setting such as a hospital or nursing home;
- viii. Directed or allowed the DSW to provide care and services beyond the limitations of their training, or the training of the DSW for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the participant.

b. FMS Provider

- 1) The FMS provider will ensure participants directing their services and supports receive administrative assistance related to payroll, taxes, unemployment, worker's compensation and related tasks. The FMS provider will maintain a participant-employer file, including related tax documentation and direct service worker documentation needed to perform FMS duties.
- 2) FMS will also provide employer-related information and assistance to the participant as part of their FMS functions. This service does not duplicate other waiver services including case management. Where the possibility of duplicate provision of services exists, the participant plan of care shall clearly delineate responsibilities for the performance of activities.
- 3) Understands individuals choosing to participant-direct their services may choose any qualified FMS provider who has a current KDADS agreement and is contracted with their selected KanCare managed organization.
- 4) FMS Providers must also maintain comprehensive policies and procedures (detailed within this manual), including but not limited to the following:
 - a. Policies and procedures for billing Medicaid, in accordance with approved rates, for services authorized on the ISP/POC;
 - b. Policies and procedures for billing FMS administrative fees;
 - c. Policies and procedures to receive and disburse Medicaid funds, track disbursements, and provide reports, including, but not limited to:
 - i. Reports to participants for billing/disbursements on their behalf
 - ii. Reports to the State of Kansas, as requested

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- 5) Policies and procedures to ensure proper/appropriate background checks are conducted on all individuals (FMS providers and DSWs) in accordance with program requirements; and
- 6) Policies and procedures to ensure participants follow the pay rate reimbursement limits when setting DSWs' pay rates;
 - a. Clear identification of how this will occur;
 - b. Prohibition of wage/benefit setting by FMS provider; and
 - c. Prohibition of "recruitment" of self-direct individuals (HCBS waiver participant and/or DSW staff) by enticements or promises of better wages and/or benefits through improper use of Medicaid funds;
- 7) Policies and procedures to ensure proper/appropriate processing of time worked, disbursing of pay checks, filing of taxes, and other associated responsibilities;
- 8) Policies and procedures regarding the provision of I&A services;
- 9) Policies and procedures regarding a backup plan and efforts to develop, implement, and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency;
- 10) Policies and procedures to ensure correct disbursement of pay to DSWs, including identifying, reporting, and mitigating potential fraud, waste and abuse;
- 11) Policies and procedures for reporting cases of abuse, neglect and exploitation and Medicaid fraud, waste, and abuse to the state or other required entities; and
- 12) Policies and procedures regarding dispute resolution process about employer-related grievances.

c. KanCare MCO

- 1) The MCO will ensure persons seeking or receiving participant-directed services have been informed of the benefits and responsibilities of the participant-direction. The MCO is also responsible to do the following, but not limited to:
 - a) Obtain participant's written appointment of designated representative (legal or non-legal), initially and annually;
 - b) Assist the participant in developing an emergency backup plan;
 - c) Inform the participant's responsibility for payment of applicable client obligations;

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- d) Inform the participant of the process for changing or discontinuing an FMS provider;
 - e) Inform the participant of the process for voluntarily terminating an FMS provider;
 - f) Inform the participant of the process for involuntary termination of participant-direction in accordance with state/federal policy, including applicable appeal rights;
 - g) Inform the participant that agency-directed service option can be made at any time if the participant no longer desires to participant-direct his/her service(s);
 - h) Inform the participant of DSW's required use of the AuthentiCare®KS IVR system to report time and attendance, task performed and submission of claims for time worked;
 - i) Provide a list of FMS agents within their network to choose from; and
 - j) Coordinate the care, services and support for the participant.
- 2) The MCO must Ensure timely authorization including entering authorizations into the AuthentiCare® KS system prior to the beginning of the first of a month for a smooth transition to ensure continuity of services.
- 3) The MCO is responsible for informing the participant that he/she must exercise responsibility for making the choice to participant-direct his/her personal care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that was made.
- a. The choice to agency-direct or participant-direct will be presented to the person initially and annually during his/her plan of care planning process, or at any time requested by the participant or the representative directing services on behalf of the participant.
 - b. The MCO will maintain documentation of the participant's choice of participant-direction.
- 4) In addition to offering choice of FMS providers, the MCO is responsible to do the following:
- a) Provide the participant with information on how to reach the MCO Care Coordinator;
 - b) Inform the FMS provider when prior authorization has been approved or modified;

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- c) Inform the participant of the requirement to pay client obligation to the provider assigned the client obligation on the ISP/POC;
- d) Inform the FMS provider when the participant is hospitalized, is no longer authorized or the participant has elected to discontinue receiving participant-directed services.

Kansas Department for Aging and Disability Services

Community Services and Programs Commission

Home and Community-Based Services (HCBS)

Programs

6.5. Financial Services Manual (FMS)

Participant-Directed Services and Supports

SECTION III

C. FMS Provider Qualifications

Effective April 10, 2015

(Last Revised: December 21, 2015)

C. Qualified FMS Providers Requirements

Section III

1. Definition of FMS

a. CMS Definition

The Centers for Medicare and Medicaid Services (CMS) defines Financial Management Services as:

A service/function that assists the family or participant to:

- 1) manage and direct the distribution of funds contained in the participant-directed budget;
- 2) facilitate the employment of staff by the family or participant by performing as the participant's agent such employer responsibilities as processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and
- 3) performing fiscal accounting and making expenditure reports to the participant and/or family and state authorities.

b. IRS Definition

Under IRS rules, an entity acting as an "employer agent" for participants performs all that is required of an employer for wages paid on the employer's behalf and all that is required of the payer for requirements of backup withholding, as applicable.

- 1) It receives, disburses, and tracks reimbursement, payroll and taxes for participants' direct service workers; assists participants with completing participant enrollment and worker employment forms; conducts criminal background checks of prospective workers; and verifies workers' information (i.e., social security numbers, citizenship or legal alien verification documentation).
- 2) It also prepares and distributes payroll including the withholding, filing, and depositing of federal and state income tax withholding and employment taxes and locality taxes; processes and pays vendor invoices for approved goods and services, as applicable; generates reports for state program agencies, counselors (also called support brokers, support coordinators, and other names), and participants; and may arrange and process payment for workers' compensation and health insurance, when appropriate.

For detailed information about the employer agent responsibilities under the Internal Revenue Service, please review IRS Rev. Proc. 70-6, 1970-1 C.B. 420 as modified by IRS Proposed Notice 2003-70.

C. Qualified FMS Providers Requirements

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2. Qualified Provider Requirements

All FMS providers must meet established provider qualifications prior to being contracted and credentialed with a KanCare Managed Care Organization (MCO) and providing FMS services. Qualified providers must have a valid FMS Agreement with KDADS, Medicaid Provider Agreement with the Kansas Medical Assistance Program (KMAP), and meet all other provider qualifications as outlined in the agreement, the applicable HCBS Program, and in this policy.

a. Provider Qualifications

To be considered a qualified FMS provider, the provider must meet Federal, KDADS and MCO requirements prior to providing FMS for participant-directed services. To enroll as an FMS provider for HCBS Programs, each FMS must meet the following provider qualifications prior to providing FMS for participants directing their care under an HCBS Program operated by KDADS:

- 1) Valid KDADS FMS Agreement
- 2) Kansas Medicaid Provider Agreement and valid KMAP Number
- 3) Registration and good standing with the Secretary of State's office, if required
- 4) Community Developmental Disability Organization's (CDDO) Affiliate Agreement, if serving participant's on the HCBS-IDD Program
- 5) Proof of Insurance – liability, worker's compensation, unemployment, and others
- 6) Financial solvency, including accepted GAAP or compliance audit, as required
- 7) Required Policies and Procedures Manual for FMS Operations
- 8) Federal Employer Identification Number as employer agent in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70

b. Provider Competencies

FMS Providers must meet Federal, state and HCBS Program requirements. To serve self-directing participants of HCBS programs, an FMS should be able to meet the following expectations:

- 1) Be an enrolled provider in the Kansas Medical Assistance Program;
- 2) Meet the FMS provider qualifications as outlined in this document;
- 3) Operate in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70 and any other future revenue procedures, notices or publication promulgated by the IRS in the future;
- 4) Operate in compliance with the Standards as outlined in this document and maintain documentation to support its compliance with these standards;
- 5) Demonstrate the capacity and continued capacity to perform the required responsibilities as identified in the Compliance Audit, onsite review, or FMS

C. Qualified FMS Providers Requirements

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- recertification review;
- 6) Support the principles and philosophy of KDADS's home and community-based programs as described in Section II.3 above;
 - 7) Have management and staff that are knowledgeable and have experience in providing FMS and working with persons with disabilities and chronic conditions;
 - 8) Comply with Medicaid requirements related to collecting client obligation and applying third party liability for all participants receiving HCBS Program services and supports;
 - 9) Have a sound financial and reporting structure to efficiently serve participants;
 - 10) Maintain books, records, documents, and other evidence of expenditures in with generally accepted accounting principles (GAAP);
 - 11) Make all books, records and documents available for inspection by the KDADS, the MCOs, or other state and federal authorities, as applicable, and without prior notice;
 - 12) Report all suspected cases of neglect, abuse, and exploitation of participants applying for or receiving waiver services within 24 hours of awareness to the appropriate authorities;
 - 13) Comply with all relevant federal, state and local laws related to payroll, taxes, withholding, reporting, insurance, and related criteria;
 - 14) Demonstrate its capacity to develop and implement an information system to manage FMS-related records and files effectively;
 - 15) Conduct FMS activities separate and distinct from the agency-directed function if the organization is a direct care service provider and/or a supports coordination/care management provider for the KDADS;
 - 16) Secure FMS provider personnel, office space, documentation and records to ensure confidentiality and HIPAA compliance of all FMS records;
 - 17) Report payroll, tax and other administrative duties to the participant on a regular basis to ensure participant control, choice and self-direction in participant-directed services;
 - 18) Demonstrate 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;
 - 19) Utilize AuthentiCare® KS for authorizations, billing, claims, reporting, and tracking direct service workers;
 - 20) Demonstrate knowledge of and ability to stay current with federal, state and local tax, labor, workers' compensation insurance and program regulations related to the KDADS's HCBS Programs, Medicaid, the delivery of FMS, and household employers and domestic service workers; and
 - 21) Demonstrate the ability to select, contract with and oversee the performance of a reporting agent effectively, if it so desires and as applicable.

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c. Provider Documentation

Each individual or organization interested in providing Financial Management Services (FMS) are required to submit the following documentation, including a signed Provider Agreement, to the KDADS prior to contracting with the MCO(s) to provide FMS services.

1) KDADS FMS Agreement

- a) The KDADS FMS Agreement must be executed annually and will be required before providing FMS or to continuing provide FMS. Additionally, all FMS providers are required to execute the KDADS Business Associates Agreement (BAA).
- b) The KDADS FMS Agreement, KDADS BAA and enrollment requirements are available on the KDADS website (www.kdads.ks.gov)
- c) A new FMS provider is subject to a readiness review and must submit financial documentation prior to receiving an approved agreement from the Secretary of KDADS.

2) Medicaid Provider Agreement

- a) The Medicaid Provider Agreement can only be obtained upon the presentation of a valid, approved KDADS/ FMS Provider Agreement.
- b) Obtain valid KMAP Number for billing purposes.
- c) Medicaid provider enrollment requirements are available on the [KMAP](http://www.kmap.ks.gov) website.

3) Registration with the secretary of state's office (www.sos.ks.gov), if required:

- a) The entity must be in good standing with all Kansas laws/business requirements.
- b) Owners/principles/administrators/operators must have no convictions of embezzlement, felony theft, or fraud and must not have any conviction identified on the list of prohibitive offenses.
- c) Owner, primary operator, and administrator of the FMS business must live in a separate household from participant receiving services from the FMS business.
- d) Business is established to provide FMS to more than one participant.

4) Required Tax Documentation

- a) In order to qualify to provide Financial Management Services (FMS), the service provider must be a Vendor Fiscal/Employer Agent (F/EA) FMS provider operating under §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70, respectively.

C. Qualified FMS Providers Requirements

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- b) Have or obtain a separate federal employer identification number (FEIN) used only for filing federal tax forms and making federal tax payments for the participant employers' it represents.
- c) If the FMS does not already have an FEIN, the FMS should complete and submit IRS Form SS-4: *Application for Employer Identification Number*.

5) CDDO Affiliate Agreement

- a) Required if serving HCBS-IDD Program participants
- b) One executed Affiliate Agreement is required for every CDDO catchment area in which the FMS provider will operate and serve HCBS-IDD Program participants

6) Insurance, defined as:

- a) Minimum Liability Insurance (liability with a \$500,000 minimum or as required)
- b) Workers compensation insurance
 - i. Meets all requirements of the State of Kansas (www.dol.ks.gov)
 - ii. Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
- c) Unemployment insurance
- d) Other insurances (if applicable)

7) Financial solvency

- a) An FMS provider must be able to demonstrate initial and continuing financial solvency with evidence that 30 days coverage of operational costs are met (**Note:** Cash requirements will be estimated using the past quarter's performance from the date of review, or, if a new entity, the provider must estimate the number of participant that they reasonably expect to serve using nominal costs.)
- b) Each individual, entity or company applying as an FMS provider must supply financial documentation for review. This documentation must include:
 - ii. The three most current bank statements;
 - iii. An open letter of credit (statement[s] from bank/lending institution), if applicable;
 - iv. A current balance sheet; and
 - v. A schedule of anticipated monthly expenditures.
- c) Each individual, entity or company providing FMS must supply financial documentation for review as detailed in Section VIII Quality Assurance and Program Integrity. This documentation must include:
 - i. Independent GAAP audit by a certified public accountant
 - ii. Program and Financial Compliance Audit

C. Qualified FMS Providers Requirements

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8) Policies and Procedures

An FMS provider must prepare and maintain a comprehensive FMS Policies and Procedures Manual that contains written policies, procedures and internal controls for all required FMS tasks, including those performed by a reporting agent or subagent, as applicable, and related communication and oversight tasks.

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3. Existing FMS Providers

Existing FMS providers must meet all provider qualifications annually, have an active contractual agreement with an MCO or MCOs and be in good standing with the terms and conditions of the current agreement, including compliance with existing financial and compliance audit requirements, in order to be approved for a renewed agreement with Secretary of KDADS. (*See terms listed in signed FMS/ KDADS agreement*).

C. Qualified FMS Providers Requirements

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4. Provider Enrollment

Enrolled FMS providers will furnish Financial Management Services according to Kansas model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.

To become an enrolled FMS provider with the MCO, an FMS provider must take the following steps:

a. Meet all of the Provider Qualification requirements

- 1) Submit the signed KDADS FMS Agreement and supporting documentation of Provider Qualification to KDADS for determination of initial qualification
- 2) Complete an onsite FMS Certification and Readiness Review prior

b. Submit the Standard Credentialing Application

- 1) Submit the Standard Credentialing application and indicate service type and HCBS Programs with the executed agreements and supporting documentation of Provider Qualification to the MCO for contracting and credentialing
- 2) Review the MCO Provider Enrollment criteria and process for guidance on the MCO Enrollment Process.

C. Qualified FMS Providers Requirements

Section III

5. Access to AuthentiCare® KS

Upon MCO Enrollment, the FMS provider will receive appropriate information such as web-based training and instructions for billing through KMAP and the MCO billing portal and the EVV system, AuthentiCare® KS

The enrolled FMS provider must request access to AuthentiCare® KS to set up initial access and training on the EVV system including data entry for new direct service workers, how to run reports, how to submit claims and third party liability information, and how to verify time worked.

a. Use of AuthentiCare® KS

- 1) DSWs for agency-directed and participant-directed services are required to utilize the IVR system to document time worked and activities relating to service delivery. The utilization of the IVR is necessary to meet documentation requirements in order to support claims submitted for reimbursement of services rendered.
- 2) Use of AuthentiCare®KS is mandatory for participant-directed services and agency-directed personal care services.
- 3) Participant-Directed services should not begin until appropriate authorizations are entered into the AuthentiCare® Kansas system by the participant's MCO.

b. Helpful Information:

Access to AuthentiCare: www.authenticare.com/kansas

Client Services HelpDesk: AuthentiCare.Support@firstdata.com or 1-800-441-4667

C. Qualified FMS Providers Requirements

Section III

6. Annual Monitoring and Recertification

- a. Existing FMS providers must have an active contractual agreement with an MCO or MCO(s) and be in good standing with the terms and conditions of the current KDADS FMS Agreement in order to be approved for a renewed agreement with Secretary of KDADS. (*See terms listed in signed FMS/ KDADS agreement*).
- b. Each FMS provider will be reviewed and approved at least annually by the KDADS, which includes annual review of qualifications. The purpose of the annual review is to ensure that the provider continues to meet standards and that the highest quality services are provided to each participant. Only FMS providers who are annually reviewed and approved by the KDADS may continue to provide FMS for participant-directed services for the HCBS Program.
- c. The basis upon which a provider is and remains approved to provide services include:
 - 1) Verification of the provider's continued qualification;
 - 2) Submission, acceptance and approval of an independent financial audit by a certified public accountant that follows generally accepted accounting principles or compliance audit;
 - 3) Submission, acceptance and approval of a compliance summary for program and financial compliance with the HCBS Programs in years that an independent financial GAAP-compliant audit is not required in accordance with establish policy;
 - 4) Results of an initial FMS certification review and any subsequent review conducted by KDADS within six (6) months from the date a new FMS begins serving participants;
 - 5) Results of annual or quality assurance reviews, including unannounced visits conducted by KDADS and satisfactorily addressing all elements of any plan of correction that is prepared as a result of an initial, annual, quality assurance or unannounced review conducted by the KDADS; and
 - 6) Verbal and written feedback from participants on the quality of services, information and assistance rendered by the FMS provider.
- d. The review methods that the KDADS will use during the initial FMS certification review, annual recertification review and quality assurance review process include:
 - 1) Conducting FMS reviews through combination of desk reviews and onsite reviews of compliance with this manual, state, federal and waiver requirements;

6.5. Financial Services Manual (FMS) Participant-Directed Services and Supports

C. Qualified FMS Providers Requirements

Section III

- 2) Generating reports and reviewing trends of manual entries in AuthentiCare® KS system;
- 3) Issuing plans of correction to FMS providers based on the findings of the applicable FMS certification/recertification reviews;
- 4) Reviewing FMS's response to any plans of correction as a result of a FMS certification or recertification review and determining if the FMS has successfully addressed the items included in the plan, which includes the standards included in this document;
- 5) Conducting any unannounced monitoring visits, quality assurance reviews, and program integrity audits as deemed necessary; and
- 6) Reviewing the FMS's records to ensure that their contents are complete.

C. Qualified FMS Providers Requirements

Section III

7. Termination

a. Voluntary Termination

- 1) An FMS provider may choose to terminate being an FMS provider at any time by giving written notice of the termination or non-renewal at least ninety (90) days prior to the date of termination stated in the written notice.
 - a) Notice must be provided to the KDADS and the Managed Care Organization, or as otherwise specific in each MCO's Provider Manual, to allow sufficient time for the Care Coordinator/Case Manager to offer choices of FMS providers or agency-directed services and avoid service disruption.
 - b) Notice must be in writing to the KDADS and MCO and a subsequent notice must be sent to each participant-employer.
 - c) Notice to KDADS should include a notice related to the location of files and documentation, record retention, final audit reporting, process for return of excess funds.
- 2) The FMS Provider must notify the participant(s) and their respective MCO at least thirty (30) calendar days advance in writing of its intent not to renew or regarding termination, and follow relevant requirements in the MCO Provider Manual and MCO contract with the FMS provider related to termination or loss of qualification to provide contracted services.
 - a) MCOs should authorize new FMS providers and update the ISP/POC according to waiver expectations and timelines to ensure continuity
 - b) New FMS providers will be authorized on the ISP/POC for the first of the month following authorization. Authorizations should be approved and updated by the MCO in AuthentiCare® KS prior to the first of the month to allow for a smooth transition to ensure continuity of services.
- 3) FMS providers terminating the KDADS agreement and no longer choosing to provide FMS services must:
 - a) Maintain confidential records and ensure all FMS-related documents remain secure or are relinquished to KDADS for retention and storage;
 - b) Complete accounting and reporting requirements within 6 months of termination or non-renewal;
 - c) Ensure transfer of records, information, and documentation needed by the participant-employer, direct service worker, MCO, and/or FMS provider to prevent a lapse in service during the termination process.
 - d) Notify consumers of their intent to terminate the provider agreement and how to obtain information and make a choice of providers;

C. Qualified FMS Providers Requirements

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- e) Assist the participant(s), if requested, in transitioning the DSW, including relevant information to the new FMS provider; and
- f) Ensure FMS continues until a new FMS provider has been selected and started providing FMS to the participant. The FMS provider cannot discontinue providing services in the middle of a month.

b. Involuntary Termination

- 1) An FMS Provider may be involuntarily terminated by KDADS or the MCO for a number of reasons, including but not limited to:
 - a) Avoid harm to the public such as exploitation of self-directing participants
 - b) Prevent or mitigate fraud, waste and abuse or response to credible allegations of fraud from Medicaid Fraud Control Unit (MFCU)
 - c) Protection of public funds as identified by the KDADS FMS Agreement, the FMS Provider Manual and applicable state and federal laws.
 - d) Failure to comply with audit requirements
 - e) Failure to substantially comply with HCBS Program and Financial Compliance audits
 - f) Failure to substantially comply with FMS qualifications and provider requirements in the KDADS FMS Agreement, the FMS Provider Manual and applicable state and federal laws.
- 2) KDADS may terminate an FMS Provider Agreement without prior notice and upon making the determination that termination is necessary to avoid harm to the public, to prevent or mitigate fraud and abuse, or to protect public funds;
 - a) KDADS, recognizing that time is of the essence, may exercise any and all other remedies available by law, including but not limited to termination of the KDADS FMS Provider agreements or delay in payment until KDADS verifies provider's performance, such as continued qualification to provide FMS; and
- 3) The MCO may terminate an FMS Provider contract according to the terms of the contract and the MCO Provider Manual and in a manner consistent with this manual.

Kansas Department for Aging and Disability Services

Community Services and Programs Commission

Home and Community-Based Services (HCBS)

Programs

6.5. Financial Services Manual (FMS)

Participant-Directed Services and Supports

SECTION IV

D. General FMS Duties

Effective April 10, 2015

(Last Revised: December 21, 2015)

D. General FMS Duties

Section IV

1. Policies and Procedures

a. Requirements of Policies and Procedures

- 1) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
- 2) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
- 3) Establish and maintain policies and procedures consistent with this manual; and
- 4) Allow inspection and review of policies and procedures as requested and at least annually as part of the annual review/recertification process.

b. Required Policies and Procedures

FMS providers are required to have comprehensive policies and procedures, as detailed in the manual, include, but are not limited to:

- 1) Policies and procedures for billing Medicaid, in accordance with approved rates, for services authorized on the ISP/POC;
- 2) Policies and procedures for billing FMS administrative fees;
- 3) Policies and procedures to receive and disburse Medicaid funds, track disbursements, and provide reports, including, but not limited to:
 - a) Reports to participants for billing/disbursements on their behalf
 - b) Reports to the State of Kansas, as requested
- 4) Policies and procedures to ensure proper/appropriate background checks are conducted on all individuals (FMS providers and DSWs) in accordance with program requirements; and
- 5) Policies and procedures to ensure participants follow the pay rate reimbursement limits when setting DSWs' pay rates;
 - a) Clear identification of how this will occur;
 - b) Prohibition of wage/benefit setting by FMS provider; and
 - c) Prohibition of "recruitment" of self-direct individuals (HCBS waiver participant and/or DSW staff) by enticements or promises of better wages and/or benefits through improper use of Medicaid funds;

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- 6) Policies and procedures to ensure proper/appropriate processing of time worked, disbursing of pay checks, filing of taxes, and other associated responsibilities;
- 7) Policies and procedures regarding the provision of I&A services;
- 8) Policies and procedures regarding a backup plan and efforts to develop, implement, and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency;
- 9) Policies and procedures to ensure correct disbursement of pay to DSWs, including identifying, reporting, and mitigating potential fraud, waste and abuse;
- 10) Policies and procedures for reporting cases of abuse, neglect and exploitation to and fraud, waste, and abuse to the state; and
- 11) Policies and procedures about grievances designed to ensure DSWs can address relevant issues, such as hours paid differing from hours worked, untimely pay checks, bounced pay checks, other FMS-related issues.

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2. Enrollment

a. Enrolling Participants with FMS

- 1) Under the F/EA model, participants are required to have their own federal employer identification number for the purposes of filing taxes and withholding on their behalf. A participant who self-directs their care must:
 - a) Have participant-directed services, such as personal care services, authorized on his/her ISP/POC;
 - b) Obtain and maintain a federal employer identification number (FEIN) for the purposes of filing taxes;
 - i. A participant without a guardian who chooses to self-direct is the employer, the FEIN is in his/her name, and the participant may appoint a designated representative to assist or direct the participant's care;
 - ii) A participant with a guardian who participant-directs, the person is the employer and the FEIN is in his/her name, and the participant may appoint someone to act as representative.
 - iii) A minor participant who participant-directs, is the minor participant is the employer and the FEIN is in the minor participant's name, but a parent or legal guardian is appointed to act as the representative.
 - iv) For a minor participant in custody of the Secretary of the Department of Children and Families, the State will not participant-direct services and the child should have choice of agency-directed services as identified on the ISP/POC. During 2015, there will be a transition period to allow service providers and MCOs to develop capacity and update all ISP/POCs impacted.

b. Enrolling the DSW

- 1) FMS provider will consult with the participant to establish the DSW wage and reimburse the DSW (DSW) the agreed upon reimbursement rate set by the participant within the allowable range.
- 2) The DSW reimbursement rate will be set by the participant within the Medicaid reimbursed rate minus all required tax withholdings, unemployment and worker's compensation deductions. Limitations to FMS provider use of DSW worker fund:
 - a) FMS provider may not utilize any portion of the DSW fund for the purpose administrative service or any other use by the Provider.
 - b) DSW fund shall be deposited by the FMS provider in an account in which such deposits may be traced to and accounted for each respective participant.
 - c) DSW fund is subject to Medicaid rules and regulations and therefore, no portion can be utilized without the express direction of the respective Participant. The FMS provider shall not determine the use of such funds.

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- d) FMS provider must provide a form to collect information from the DSW to determine if the employee meets one of the criteria to be FICA/FUTA or SUTA exempt per Section 3 of IRS Publication 15 and Kansas law.
- c. FMS providers are required to have policies and procedures consistent with this manual for enrolling participants and DSWs.
 - 1) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - 2) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - 3) Have a participant FMS enrollment package of information that contains all required information and forms and is clear and easy for the participant to understand and to complete;
 - 4) Have a DSW enrollment package of information that contains all required information and forms and is clear and easy for the DSW to understand and to complete;
 - 5) Informed Consent Forms for release of protected health information related to HIPAA and consent from the participant for the FMS provider to talk to someone on their behalf;
 - 6) Have information accessible for aging and disabled individuals in alternative formats, if needed, that includes information about:
 - a) Required use of AuthentiCare@KS for time and attendance;
 - b) How to obtain a federal employer identification number (FEIN);
 - c) Contact information for the FMS provider;
 - d) FMS-Employer agreement indicating the FMS provider's roles and responsibilities, payday schedule to DSWs, and other requirements;
 - e) FICA, FUTA, SUTA, worker's compensation and related exceptions for certain DSWs, such as a parent working for a child;
 - f) Role and responsibility of participant and his/her representative;
 - g) Enrollment Forms Check List with instructions for completing appropriate IRS forms, including
 - i. Form SS-4, *Application for Employer Identification Number*
 - ii. Form 2678, *Employer/Payer Appointment of Agent*
 - iii. Form 8821, *Tax Information Authorization* and instructions;
 - h) Safety information such as how to report abuse, neglect and exploitation;
 - i) Grievances and appeals and how to address emergencies and concern consistent with supporting the participant as the employer;
 - j) Representative or Back-up Staff Designation Form; and
 - k) Other FMS-related documents that will allow FMS providers to serve as a reporting agent and assist an individual in directing his/her care as an employer of DSWs.

D. General FMS Duties

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3. Transition, Termination & Notification

a. Transfer between FMS Providers

When a participant transitions from one FMS provider to another for any reason, the FMS processes the change to a participant's enrollment status in AuthentiCare®KS in an accurate, complete and timely manner. The FMS Provider must perform the tasks for transition and fully cooperate with the KDADS, MCOs and their designees when a participant choose to transfer from one FMS to another for any reason.

b. Termination of FMS for Participant

- 1) Self-direction is outlined in the waiver application for each Home and Community Based Services (HCBS) program. An individual who uses self-direction (also referred to as participant-direction) may voluntarily terminate self-direction, or the MCO may involuntarily terminated self-direction based on different factors for each program.
- 2) When the participant ceases to use FMS permanently for any reason, the FMS may process a change in a participant's enrollment status with the FMS provider in AuthentiCare®KS in an accurate, complete and timely manner.
- 3) FMS Providers must:
 - a) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - b) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - c) Revoke IRS Forms 2678 and 8821 with the participant, when appropriate (FMS maintains the form in the participant's file and does not submit it to the IRS);
 - d) Retire the participant employer's FEIN, when appropriate, and maintain a copy of the documentation of the FEIN retirement in the participant's archived file;
 - e) Maintain copies of the documentation of the filing and payment of the participant's final federal and state taxes in the participant's archived file;
 - f) Maintain copies of documentation of voluntary or involuntary termination of self-direction in the participant's file for the DSW according to the retention policy requirements;
 - g) Ensure continued FMS through the remainder of the authorization until appropriate alternative services; as appropriate;

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- h) Terminate the participant's workers' compensation insurance policy, submit any premium refund to KDADS as excess funds according to the requirements for returning excess funds, and maintain documentation of termination in the participant's archived file.

c. Termination of DSW as Participant's Employee

- 1) As part of their administrative responsibility, the FMS provider may process a change in a participant's DSW's employment status, at the direction of the participant, when the DSW is no longer employed by the participant.
- 2) FMS Providers must:
 - a) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - b) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - c) Upon approval of the participant, process final payroll documents and ensure appropriate time is recorded, verified, and submitted for final payment to the DSW;
 - d) Obtain and maintain any termination documentation received from the participant or other source in the participant's file and in AuthentiCare@KS, as appropriate;
 - e) Inform the participant that a DSW is not eligible to provide services based on information related to a background check
 - f) Office of Inspector General (OIG) exclusion list check (<http://exclusions.oig.hhs.gov/>), abuse, neglect and exploitation registry check, or other check resulting in notification of a prohibited offense consistent with KSA 39-970 & 65-5117, and update information and documentation in AuthentiCare@KS;
 - g) Update AuthentiCare@KS with the termination reason including the termination date; and
 - h) Terminate the participant's workers' compensation insurance policy, submit any premium refund to KDADS as excess funds according to the requirements for returning excess funds, and maintain documentation of termination in the participant's archived file.

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4. Files and Documentation

a. Files Requirements

- 1) The FMS provider will comply with the provisions of KSA 39-7,100 [Home and community based services program] and KSA 65-6201. The provider will develop and implement procedures, internal controls, and other safeguards that reflect Kansas state law (the guiding principles of participant-direction) to ensure participants have full control of directing the services and DSW(s) without excessive restrictions or barriers.
- 2) The procedures, internal controls, and other safeguards must be written and must include, at a minimum:
 - a) An assurance that the participant or participant's representative, not the FMS provider, determines the terms and conditions of work (when and how the services are provided, such as establishing work schedules, determining work conditions [for example, smoking restrictions in the home, conditions for dismissal] and tasks to be performed);
 - b) Internal controls to ensure the participant or participant's representative is afforded choice and control over workers without excessive restrictions or barriers;
 - c) A process to respond, within a reasonable time frame, to contact from the participant or participant's representative informing the FMS provider of the decision to dismiss a particular DSW;
 - d) A process for the participant or participant's representative to pay the DSW(s) or for the self-directing participant or participant's representative to delegate the DSW(s) payment by direct deposit, first class mailing, or other means through the FMS provider agency staff;
 - e) Ensure the self-directing participant or participant's representative have the name and contact information of the FMS provider agency staff who can address their issues;
 - f) A mechanism to process the DSW's human resource documentation and payroll in a manner that is efficient and supports the participant's or participant's representative's authority to select, recruit, hire, manage, dismiss, and train DSWs;
 - g) Information for the DSW that outlines the completion of time keeping process, wages, benefits, pay days, work hours, and the participant's self-direct preferences.

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b. Establishing and Maintaining Files and Documentation

- 1) FMS Responsibility:
 - a) The FMS establishes and maintains current and archived files and documentation for participants, representatives, DSWs, direct service providers and vendors including independent contractors and themselves and their subagent or reporting agent, as appropriate in a confidential and secure manner and for the time period required by the applicable federal, state and local agencies.
 - b) The FMS is responsible for addressing federal, state and local tax questions for the time they represented the participant as their employer agent regardless of which FMS is providing FMS at the time an inquiry is received.
 - c) Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, KDADS FMS Provider Agreement, MCO contract terms, or by Medicaid Provider Agreement.
- 2) FMS must:
 - a) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - b) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - c) Establish and maintain current participants'/representatives', files in an accurate, complete, secure and confidential manner and for the required period of time as mandated by applicable federal, state and local rules and regulations. The files should include, but not be limited to the following documents:
 - i. Employee application
 - ii. Background check
 - iii. Medical release
 - iv. Informed consent
 - v. FEA and consumer contracts
 - vi. Appropriate IRS forms
 - d) Establish and maintain appropriate archived and retrievable files in an accurate and secure manner for the required period of time as mandated by applicable federal, state and local rules and regulations. Files should not be limited to information contained in this manual for:
 - i. Participants'/representatives' files
 - ii. DSW Files
 - iii. FMS Subagent Files

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- e) Establish and maintain a Disaster Recovery Plan for maintaining back-up files and for restoring software and files, as needed;
- f) Establish and maintain a File Security and Confidentiality Plan for maintaining the confidentiality and security of participant and participant employee provider files;
- g) Make all documentation and records available for inspection to KDADS, MCO, CDDO or their designee or federal authorities without prior notice;
- h) Make all documentation and records pertaining to participants about their DSWs, direct care service providers and vendors available to participants upon request.

c. Participant's Files

- 1) The FMS provider should have separate files for each participant. Files may be physical or electronic, but must be secured and readily available to review by the MCO or KDADS for quality assurance reviews. Documentation may be stored in more than one location including partial documentation in AuthentiCare®KS and in a filing cabinet with references to AuthentiCare®KS documentation or electronic files.
- 2) Minimum requirements: Information needed in a Participant's (or Representative's) File:
 - a) Demographics:
 - i. Participant's/representative name, address, phone number,
 - ii. Medicaid ID number and Managed Care Organization, and
 - iii. emergency contact person;
 - b) FMS Required Forms:
 - i. Signed FMS-Employer Agreement;
 - ii. Signed employer/employee agreement;
 - iii. Informed Consent Forms;
 - iv. Representative Designation Form (including relationship of the representative to the participant);
 - v. Copy of the Reporting or Subagent Informed Consent Form, if applicable;
 - vi. Copy of Individual Service Plan/Plan of Care and updates;
 - vii. Copy of Backup Plan and/or Backup Staff Designation Form, as appropriate;

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- c) Appropriate IRS Forms:
 - i. Copy of completed and signed Form 2678, Employer Appointment of Agent, and IRS Notice of Approval;
 - ii. Copy of letter retiring program participant's FEIN, when applicable;
 - iii. Copy of participant's Form SS-4 and federal employer identification number (FEIN);
 - iv. Copy revoked IRS Form 2678, and any related correspondence from the IRS, as applicable;
 - v. Copy of completed and signed IRS Form 8821, Tax Information Authorization;
 - vi. Copy of IRS Form 8821 renewal (as applicable) and any related correspondence from the IRS, as applicable;
 - vii. Copy of IRS Form 8821 revocation (as applicable) and any related correspondence with the IRS, as applicable;
- d) Notifications/Letters:
 - i. Voluntary Termination of Participant Directed Services Form, Letter or documentation, if applicable;
 - ii. Involuntary Termination of Participant Directed Services Form, letter or other documentation, if applicable;
 - iii. 3160s, 3161s sent or received
 - iv. Documentation for transitioning the program participant from their current FMS to a new F/EA
- e) Reports
 - i. Employer Return of Income Tax Withheld (for remittance monthly, semi-monthly) including final return filed (even if its zero reporting) or copies of proof of filing if return filed electronically;
 - ii. Copies of documentation of all payments of state income tax withholding or payment of receipt if payments are made electronically;
 - iii. Copies of filing and payments of income tax withholding for non-resident employees, as applicable;
 - iv. Copies of documentation can be maintained electronically in accordance with state and federal law.
- f) Other Withholdings
 - i. Copies of proof of payment of states taxes for participant or payment receipt even payment is made electronically;
 - ii. Copies of all participant-specific state unemployment insurance benefits payments;
 - iii. Copies of workers' compensation insurance policies, premium invoices and documentation of payments, refunds and all notices

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and correspondence according to FMS policy and procedures in accordance with state laws and regulations

- iv. Copies of the IRS Form W-3, if IRS Forms W-2 are filed in paper rather than electronically;
- v. Copies of any DSW Termination Form/notification;
- vi. Documentation related to transitioning a program participant from one FMS to another as described in Attachment A.

d. DSW Files

- 1) The FMS should establish and maintain current DSWs' files in an accurate, complete, secure and confidential manner and for the required period of time as mandated by applicable federal, state and local rules and regulations. Documentation may be stored in more than one location including partial documentation in AuthentiCare®KS and in a filing cabinet with references to AuthentiCare®KS documentation or electronic files.
- 2) Minimum Requirements: DSW files are to include, but not be limited to the following documents:
 - a) Demographics
 - i. DSW's name, address, social security number, verification of social security number, FEIN (as applicable) and occupation;
 - ii. FMS-DSW Agreement regarding administrative tasks;
 - iii. Dates of employment for each worker
 - b) Background Checks
 - i. Copy of Kansas Bureau of Investigation (KBI) background check results that does not reveal a prohibited offenses consistent with KSA 39-970 & 65-5117 (<https://www.kdads.ks.gov/docs/default-source/SCC-Documents/Health-Occupations-Credentialing/crc-offenses-listrevised-7-01-11.pdf?sfvrsn=0>)
 - ii. DCF Abuse Registry for Child Protective Services (CPS) and Adult Protective Services (APS)
 - iii. Office of Inspector General's Exclusion list check (<http://exclusions.oig.hhs.gov/>)
 - c) Taxes & Withholding
 - i. Determination that the worker is a paid family member who is exempt from paying into FICA and/or FUTA per IRS Publication 15 and SUTA
 - Under the Affordable Care Act, parents employed by their son or daughter are exempt from FICA and FUTA.
 - Under Kansas law, parents employed by their son or

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daughter are exempt from State Unemployment Insurance Tax (see KDOL <http://www.dol.ks.gov/files/pdf/kcns430.pdf>).

- ii. Determination whether the participant's worker, under Kansas law, is a qualifying family member who is exempt from worker's compensation calculations and requirements:
 - Please refer to federal or state law regarding other individuals who may be exempt from some or all withholding requirements (KS 35-505).
 - Maintain documentation of participant's election to accept worker's compensation if the participant is not otherwise required to maintain worker's compensation.
 - iii. Copies of completed IRS Forms, as applicable, including but not limited to:
 - W-2 and W-2(c), as applicable;
 - Copy of IRS Forms W-4, *Employee's Withholding Allowance*;
 - Copy of IRS Forms W-5, *Earned Income Credit Advance Payment* (as applicable) and documentation related to the processing of Advanced Federal Earned Income Credit, as applicable;
 - iv. Copies of documentation regarding any FICA refunds processed (employee portion) and copies of cancelled refund checks;
 - v. Copies of documentation related to direct deposit or debit card payroll option, as applicable; and
 - vi. Documentation that applicable taxes have been withheld and deposited;
- d) Copies of documentation regarding any judgments, garnishments and tax levies or any related holds on the worker's pay as may be required by federal or state government;

e. Subagent

- 1) If the FMS provider uses a subagent for payroll and taxes, the FMS provider should establish and maintain current subagent and reporting agent files in an accurate, complete, secure and confidential manner and for the required period of time as mandated by applicable federal, state and local rules and regulations.
- 2) Minimum Requirements: Subagent files should include, but not be limited to the following documents:
 - a) Copy of documentation that the subagent is registered with the State Secretary of State and other related documentation, as required;
 - b) Copy of documentation verifying financial viability;

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- c) Tax Forms:
 - i. Aggregate filings of IRS Forms 941(federal income tax withholding and FICA [Social Security and Medicare]) with individual-level income tax withholding and FICA filing back-up for each program participant/worker;
 - ii. Aggregate payments of FICA and federal income tax withholding and the individual-level tax payment back-up for each program participant/worker;
 - iii. Documentation of the receipt of aggregate FICA refunds and documentation on the individual-level related to FICA refunds (employers and employees);
 - iv. Aggregate filings of IRS Forms 940 (FUTA) and the individual FUTA filing back-up for each program participant;
 - v. Aggregate payment of FUTA and the individual-level payment back-up for each program participant;
- d) All communications with federal, state and local tax, labor and workers' compensation insurance, and KDADS, FMS, Care Managers/Service Coordinators, etc., as applicable; and
- e) Other documentation, as applicable.

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5. Segregation of Duties

a. Agency-Directed Services providers

- a) FMS provider who owns, manages, controls or participates with a third party entity who provides agency-directed HCBS services shall not:
 - 1) Influence, directly or indirectly, a Participant to select the Agency for the provision of agency attendant care services; or
 - 2) Engage in any other conduct whatsoever with such Agency which might create an actual or perceived conflict of interest.
- b) FMS providers must have policies and procedures that ensure appropriate administrative firewalls to ensure compliance with the FMS manual and avoid potential conflict of interest or undue influence

b. Guardian or Legal Representative

- 1) FMS provider, its employees and/or agents, cannot be the Guardian, activated Durable Power of Attorney, or activated Medical Power of Attorney of an HCBS participant the FMS Provider serves. FMS provider is responsible for ensuring the following:
 - a) If the FMS Provider is the court-appointed guardian of the participant, the guardian should take immediate steps to:
 - i. Facilitate the appointment of a successor guardian; or
 - ii. Ensure the participant is transferred to a different FMS provider.
 - b) If the FMS Provider is the activated durable or medical power of attorney for the participant, the FMS Provider should take the immediate steps to:
 - i. Facilitate the appointment of an alternate durable or medical power of attorney; or
 - ii. Ensure the participant is transferred to a different FMS provider
- 2) Owners-operators and employees of the FMS provider may not serve as guardian or legal representative or direct the care of a participant served by the Provider. The Provider may have guardians or legal representatives of participants serving as members of the board who are not affected by this prohibition, but who may otherwise be required to disclose the potential conflict of interest to the court and comply with applicable waiver requirements and mitigation procedures related to the HCBS programs.

D. General FMS Duties

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6. Confidentiality & HIPAA Compliance

- a. Establish and maintain all required records and documentation, to include a file for each participant per State of Kansas regulations, policies, and procedures and in accordance with Medicaid provider requirements. All files must be maintained in a confidential, HIPAA-compliant manner.
- b. FMS provider will comply with confidentiality requirements in accordance with U. S. Department of Health & Human Services, Centers for Medicare and Medicaid Services Medicaid regulations, 42 C.F.R. 431.300 *et seq.*, as such:
 - 1) Provider shall maintain the confidentiality of information about individuals learned in performing the duties required by this Agreement, including the individual's name; address; telephone number; past or present receipt of any state or federal program services; family, social, or economic circumstances; medical data, including diagnoses and past history of disease, impairment, or disability; income and other financial information; State agency evaluation of personal or medical information; program eligibility; or third-party liability for payment for program services to any person or entity.
 - 2) Provider shall not prepare and publish, or permit the preparation and publication of, any electronic or written report disclosing confidential information about any individual in a manner which permits the identification of that individual.
 - 3) Provider shall not disclose or permit the disclosure of any confidential information about any individual without the prior informed consent of the individual or of the individual's representative, unless the disclosure is required by court order, to enable the delivery of services for which the individual or the individual's representative has requested or applied, for Medicaid program administration, or by this Agreement.
 - 4) Provider shall further develop and maintain policies and procedures, which protect the confidentiality of and guard against the unauthorized disclosure of confidential information about individuals obtained through the performance of this Agreement. Provider's policies and procedures shall be binding on their employees, agents, and independent Contractors and describe the penalties and sanctions imposed for violations of those policies and procedures.

D. General FMS Duties

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7. Record Retention

All records created, maintained or prepared that relate or pertain to FMS must be retained and safeguarded for a minimum of five years following termination of the KDADS FMS Agreement, or later, depending on other state or federal rules.

a. Medicaid Records and Records with Protected Health Information (PHI):

State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later.

b. Tax Records:

Generally, FMS providers should keep all employment tax records for at least 4 years after the date that the tax becomes due or is paid, whichever is later. However, best practice recommends keeping records for up to six years because the IRS has up to six years to audit a participant if income is under reported by more than 25%.

c. Audits:

In addition to any other audit requirement contained herein, such records shall be made readily available to any other party to this Agreement, an independent auditor retained by any Party herein, the Secretary of the Department of Health & Human Services, the U.S. Comptroller General, the Auditor of the Kansas Legislative Division of Post Audit, or their designees.

d. Costs:

Each Party shall bear the costs of storing, retrieving, and producing its records created and required to be kept under this Agreement. Provided, however, that the Party requiring such audit shall pay the cost of the same. Provider shall cooperate with any auditing party and/or entity.

D. General FMS Duties

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8. Client Obligation

a. Determination

- 1) The Department of Children and Families determines financial eligibility, which includes computing a client obligation. The client obligation is a monthly amount the individual is responsible for paying toward his or her cost of care each month. The client obligation is the amount of income in excess of the appropriate income standard for Medicaid eligibility for the HCBS Program.
- 2) Some individuals may not have a client obligation for services, regardless of monthly income, such as SSI recipients.
- 3) Countable income is considered in determining the client obligation and client obligation may be reduced by allowable medical expenses.\
- 4) If a participant may have allowable medical expenses that need to be reported, the FMS provider should refer the participant to the local Department of Children and Families (DCF) to determination. Retroactive determinations will not be made for incorrect client obligations due to client error, such as failure to report a change; however.

(See *KEESM manual*: <http://content.dcf.ks.gov/ees/keesm/current/keesm8270.htm>)

b. Collection:

- 1) FMS provider must collect assigned participant's portion of the client obligation from the participant and may not utilize Medicaid reimbursed dollars to cover the participant's client obligations.
- 2) FMS administrative reimbursement is excluded from client obligation assignment;
- 3) Client obligation may be assigned to participant-directed services as indicated on the participant's ISP/POC, and the FMS provider is responsible for collecting the client obligation from the participant. This amount cannot be waived.
- 4) The FMS provider must not use any part of this reimbursement for the purpose of paying the participant's client obligation and employee's wages, tax payments or other required withholding amounts.

c. Verification:

- 1) Client obligations can change monthly and may result in retroactive determinations that may impact reimbursement and recoupments. FMS providers are responsible for confirming client obligation each month, and MCOs are responsible for updating the authorizations and notifying the FMS provider of any changes to client obligation, including retroactive determination, that may impact reimbursement.

D. General FMS Duties

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- 2) To identify a participant's potential client obligation, FMS providers should refer to MMIS/KMAP for amount verification.
- 3) Additionally, the MCOs should update the ISP/POC or authorizations to identify the correct client obligation and the provider responsible for collecting it. Notification to the provider should be made in advance of the 1st of each month unless retroactive determination is made.

d. Termination:

- 1) An FMS provider may notify the MCO if a participant fails to pay client obligation with thirty days of prior notice of the unpaid client obligation.
 - a) The notice should include the following:
 - i. The amount of past due unpaid client obligation
 - ii. Information about how to pay the client obligation or make arrangements to bring the client obligation current
 - iii. The due date for paying the client obligation or making payment arrangements, and
 - iv. The date notice will be sent to the MCO of failure to pay client obligation and the MCO's need to assist the individual in selecting a different FMS provider
 - v. The last date the FMS provider will provide services to the participant if client obligation is unpaid.
 - b) The FMS provider must have policies and procedures that include:
 - i. Informing the participant of the requirement to pay the monthly client obligation as assigned by DCF;
 - ii. Informing the participant of the process for making the monthly payment;
 - iii. Describing the process for notifying the MCO if client obligation is not paid timely or in accordance with an established payment arrangement with the FMS provider; and
2. Informing the participant that failure to pay client obligation could impact eligibility for services. For repeated reports of failure to pay client obligations, the MCO may notify DCF of the participant's failure to pay client obligation and terminate a participant's access to services. The FMS provider must notify the participant at least 10 calendar days in advance of termination after notifying the MCO of the intent to terminate the participant due to failure to pay client obligation as required.

D. General FMS Duties

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9. AuthentiCare® Kansas

a. Required Use of AuthentiCare®

- 1) All FMS providers are required to use the IVR system, AuthentiCare® Kansas, for time records, DSW documentation, billing and claims, and reports related to administrative functions.
 - a) DSWs are required to use of AuthentiCare®KS for reporting of time and attendance; and
 - b) FMS providers are required to use AuthentiCare®KS for filing electronic claims for the FMS administrative reimbursement and DSW reimbursement.
 - c) Participants who choose to participant-direct his/her services must comply with the required use of the IVR system for DSWs to submit time worked, including having the ability and equipment needed to utilize the system.
- 2) A participant's failure to comply with program requirement will be at risk for involuntary termination of participant-direction opportunity.

b. Documentation Requirements:

- 1) All documents created, maintained or prepared that relate or pertain to HCBS consumers shall be retained and safeguarded for a five-year period following termination FMS services/ agreement. Documentations must be made available to KDADS upon request in accordance with the terms set forth in the KDADS/ FMS Provider Agreement.
- 2) Documentation is required for services provided and billed to Medicaid programs for the purpose of a post payment review, reimbursement will be recouped if documentation is not complete.

c. AuthentiCare®KS:

- 1) Documentation for time and attendance must be collected by using the IVR system, AuthentiCare®KS or the approved mobile application.
- 2) Electronic or paper documentation must, at a minimum, include the following:
 - a) Identification of the waiver service being provided
 - b) Identification of the participant receiving the service (first and last name)
 - c) Identification of the authorized staff member
 - d) Date of service (MM/DD/YY)
 - e) Date FMS claims were validated and documentation supporting services were provided in that month

D. General FMS Duties

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- 3) Written documentation must, at a minimum, include the following:
 - a) Identification of the waiver service being provided
 - b) Participant's printed name (first and last)
 - c) Participant's Medicaid identification number
 - d) Date of service (MM/YY)
 - e) Participant's signature approving time and attendance
- 4) The participant's printed name and signature must be on the completed Service Agreement
- 5) Written documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

d. Limitations

- 1) FMS cannot be provided by the guardian, activated durable or medical power of attorney, or the legal representative of the participant.
- 2) Only one FMS provider will be authorized on a ISP/POC per month.
- 3) Access to this service is limited to participants who direct some or all of their services.
- 4) FMS service may be provided once authorized by the MCO Care Coordinator and authorization is added to the Authenticare®KS IVR system.

Kansas Department for Aging and Disability Services

Community Services and Programs Commission

Home and Community-Based Services (HCBS)

Programs

6.5. Financial Services Manual (FMS)

Participant-Directed Services and
Supports

SECTION V

E. Administrative Support

Effective April 10, 2015

(Last Revised: December 22, 2015)

E. Administrative Support

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1. Administrative Support for Participant-Direction

a. FMS Administrative Functions

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:

- 1) Processing of time worked and the provision of quality assurance;
- 2) Preparation and disbursement of qualified DSW payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
- 3) Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
- 4) Provide assistance to ensure the basic minimum qualifications set by the State is met in order to ensure participant safety, health and welfare.
- 5) Assist participant in obtaining the federal employer identification number (FEIN);
- 6) Ensure timely filing of claims, taxes, withholdings, and disbursements;
- 7) Submit claims for HCBS services in accordance with approved rates, as validated by the participant and authorized by MCO, including FMS administrative supports
- 8) Report information to the participant, in the aggregate, about DSW time records, payroll, withholdings, worker's compensation, and unemployment;
- 9) Collect the participant's portion of the client obligation form the participant if assigned to a participant-directed service on the participant's ISP/POC;
- 10) Establish FMS-Employer agreements;
- 11) If requested, provide information, assistance and referral to the participant in establishing an employer/employee service agreement.
- 12) Receive and disburse Medicaid funds, track disbursements and provide financial reports as agreed upon in the FMS/KDADS agreement.
 - a) Process for reporting to the participant semi-annually billing/disbursement of Medicaid funds on their behalf
 - b) Process for submitting financial reports to KDADS as required by FMS agreement

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- c) Account for excess funds from the DSW reimbursement rate and return to the State in a timely manner.
- 13) Ensure proper/appropriate background checks are conducted on all individuals (FMS provider and DSW) in accordance with program requirement.
- 14) Ensure that participants follow the pay rate procedures in accordance with federal/state requirements when setting DSWs' pay rates and provide policies and procedures that provide information:
 - a) Clearly identifying of how this will occur
 - b) Prohibition of wage/benefit setting by FMS provider
 - c) Prohibition of "recruitment" of self-direct individuals (HCBS waiver participants/customers and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.
- 15) Ensure proper/appropriate processing of time worked, disbursement of pay checks, filing of taxes and other associated responsibilities.
- 16) Enroll participants, including enrollment and employment materials and enroll DSWs, including tax forms;
- 17) Assure the participant and DSWs have a written and clear process address administrative issues such as hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other grievances; and
- 18) Develop and maintain a current operating policies and procedure manuals
- 19) Provider regular and semi-annual reports to the participant for billing or disbursements on the participant's behalf and complete annual tax reporting; and
- 20) Report to the State of Kansas as part of program oversight, as requested.

b. Administrative Tasks

- 1) The FMS provider ensures participants are given participant orientation and skills training in an accessible and culturally sensitive manner and in accordance with the philosophy of self-direction.
- 2) The FMS providers must enroll Participants and DSWs consistent with section 6.5.D.3 of this manual.
- 3) FMS provider will consult with the participant and reimburse the Direct Service Worker (DSW) the agreed upon reimbursement rate set by the participant within the allowable range and not less than the State minimum wage.

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- a) The DSW reimbursement rate will be set by the participant within the Medicaid reimbursed rate minus all required tax withholdings, unemployment and worker's compensation deductions. Limitations to FMS provider use of DSW worker fund:
 - i. FMS provider shall not utilize any portion of the DSW fund for the purpose administrative service or any other use by the Provider.
 - ii. DSW fund shall be deposited by the FMS provider in an account in which such deposits may be traced to and accounted for each respective participant.
 - iii. DSW fund is subject to Medicaid rules and regulations and therefore, no portion can be utilized without the express direction of the respective Participant. The Provider shall not determine the use of such funds.
 - b) The FMS provider ensures participants are given effective and accessible participant orientation and skills training in a culturally sensitive manner and in accordance with the philosophy of self-direction.
- 4) As part of administrative support, the FMS provider must provider information and assistance to participant, as needed, related to employer duties, including, but not limited to:
- a) Required use of AuthentiCare® for electronic visit verification and recording clock in/clock out for DSWs;
 - b) Establishing a process for reviewing workplace safety issues and strategies for effective management of workplace injuries;
 - c) Informing DSWs' of their right to file unemployment and workers' compensation insurance claims when appropriate;
 - d) Reporting hospitalizations, institutional stay, and correcting time as appropriate to ensure no duplication of services for billing and claims;
 - e) HCBS Program requirements and limitations for participant-directed services and expectations that DSW provide only services listed on the ISP/POC;
 - f) Prohibition on supplementation of services on the ISP/POC, reporting standards for suspicion of fraud, waste and abuse, and reasons for termination of participant-direction (self-direction) for behavior of the participant; and
- 5) As part of administrative support, the FMS provider should refer participants and representatives who may need and desire additional skills training or technical assistance to the Care Coordinator or Case Manager, if on HCBS-IDD Program.

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2. IRS Filing and Documents

- a. FMS providers must assist the participant in obtaining an FEIN and ensure appropriate state and federal withholdings and applicable deductions for processing accurate payroll consistent with state and federal rules and regulations.
- b. To ensure compliance with, the FMS provider must:
 - 1) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - 2) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - 3) Maintain a copy of any applicable, executed IRS forms in each participant's file, including forms needed for annual renewal;
 - 4) Renew the applicable, executed IRS forms with participants on a periodic basis per Form instructions;
 - 5) Apply for (through the completion and submission of the IRS Form SS-4 *Application for Employer Identification Number*) and obtain a separate Federal Employer Identification Number (EIN) for the sole purpose of filing and paying federal employment taxes and insurances and other required IRS forms on behalf of participants it represents as employer agent.
 - a) Maintain a copy of the completed Form SS-4, separate FEIN and associated IRS correspondence in the FMS's files;
 - b) Apply for (through the completion and submission of the IRS Form SS-4, *Application for Employer Identification Number*, and obtain a Federal Employer Identification Number (EIN) for each participant it represents as employer agent;
 - c) Maintain a copy of the completed IRS Form SS-4 and Notice of FEIN in each participant's file;
 - 6) Apply for employer agent authorization from the IRS for all participants enrolled in the applicable self-directed service programs by filing one application (IRS Form 2678, *Employer/Payer Appointment of Agent*) with the IRS per Form instructions;
 - 7) Maintain a copy of the employer agent application (Form 2678) for all participants in applicable self-directed service programs in the FMS's and participant's file
 - 8) Receive written employer agent authorization from the IRS to be the employer agent for the applicable participant-directed service programs through the receipt of an IRS LTR 1997C, *Notice of Appointment*, for each participant it represents as employer agent;

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- 9) Maintain a copy of the Notice of Appointment in the FMS's for file each participant; and
- 10) Execute and submit an IRS Form 8821, *Tax Information Authorization* with each participant it represents as employer agent. If a subagent or reporting agent is used, the entity should be listed on the Form as a second appointee.

c. Worker's Compensation

- 1) FMS effectively broker workers' compensation insurance for participants in accordance with Kansas workers' compensation insurance law.
 - a) Worker's Compensation is an insurance policy that is provided by the employer to pay employee benefits for job-related injuries, disability or death.
 - b) If eligible, coverage for benefits are paid at the employer's expense and coverage begins on the first day on the job.
- 2) The present law (see K.S.A. 44-505) covers all Kansas employers except for those in certain agricultural pursuits or those with a gross annual payroll of \$20,000 or less.
 - a) Per K.A.R. 51-11-6, the provision in K.S.A. 44-505 excludes the payroll of workers who are members of the employer's family. This exclusion does not apply to corporate employers.
 - b) Employers with payrolls of \$20,000 or less can opt in and obtain workers compensation coverage for their employees, if they choose to do so.
- 3) The FMS must:
 - a) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - b) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - c) Manage the initial application and receipt of workers' compensation insurance policies for participants;
 - d) Manage the renewal of workers' compensation insurance policies for participants;
 - e) Manage the payment of participant's workers' compensation insurance premiums;
 - f) Provide wage information to workers' compensation insurer(s) to determine DSW's benefits, when requested; and

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- g) Maintain the following information related to workers' compensation insurance in the participant's file:
 - i. Workers' compensation insurance application and renewal documentation;
 - ii. Workers' compensation insurance policies;
 - iii. Workers' compensation premium documentation;
 - iv. DSW wage documentation for determining workers' compensation insurance benefits; and
 - v. Relevant workers' compensation insurance audit-related documentation.

d. Payroll Processing

- 1) FMS process and distribute DSWs' payroll and related federal, state and local employment-related taxes and insurance in compliance with all federal, state and local employment-related tax and insurance requirements and in an accurate, completed and timely manner. The FMS provider must:
 - a) Generate and disburse payroll checks to all participants' DSWs within the time period required by KS Department of Labor for each pay period;
 - b) Process all taxes and withholding including unemployment, worker's compensation, all judgments, garnishments, tax levies or other related holds on DSWs' pay as may be required by federal or state governments;
 - c) If the FMS provider offers direct deposit, process direct deposit of DSWs' payroll checks, as requested and maintain copies of direct deposit documentation in the DSWs' files;
 - d) Have a system for managing improperly cashed or issued payroll checks, stop payment on checks, and for the re-issuance of lost, stolen or improperly issued checks including:
 - i. Maintenance of a log of voided and reissued checks, including all pertinent information;
 - ii. Proper authorization of all stop payments and re-issuances; and
 - iii. Timeframe for re-issuance of checks (i.e., within three (3) business days of notification of lost/stolen check) and issuance of stop payment request;
 - e) Determine if the DSW is a family member who is exempt from FICA and/or FUTA and SUTA or worker's compensation (i.e., spouse or parent of minor child who is the participant-employer).

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- 2) The FMS provider must:
 - a) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - b) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - c) Establish and manage worker's compensation, including:
 - i. Processing the initial application, renewal and receipt of workers' compensation insurance policies for participants;
 - ii. Withholding on appropriate worker's compensation, as applicable;
 - iii. Paying participant's DSW workers' compensation insurance premiums;
 - iv. Providing wage information to workers' compensation insurer(s) to determine DSW's benefits, when requested; and
 - v. Determining if a DSW is a non-resident of Kansas and the appropriate method to be used for state income tax withholding;
 - d) Maintain documentation on DSW's non-resident status in DSWs' files;
 - e) Work with participant to verify DSWs' hourly wages are in compliance with federal and Kansas Department of Labor wage and hour rules for domestic service workers;
 - f) Develop and produce timesheets and instructions for DSWs;
 - g) Verify and process DSW time records and provide a report or accounting to the participant for approval of time worked, as requested;
 - h) Maintain copies of any approved exceptions and corresponding time sheets in DSW's file;
 - i. FMS providers should have a policy and procedure for participants regarding the processing of time worked in excess of the ISP/POC;
 - ii. FMS provider must have a written agreement with the participant indicating the FMS provider's policy, consistent with state and federal rules and regulations, regarding payment to DSW who work in excess of the ISP/POC; and
 - iii. Absent an established policy and written agreement, the FMS must process the participants' DSW for all hours worked as approved by the participant, even if the DSW timesheets indicate more hours were utilized than are available in the participants' ISP/POC. The FMS will not be able to receive reimbursement from the MCO without prior approval and authorization updated by the MCO in AuthentiCare®KS.

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- i) Process all judgments, garnishments, tax levies or other related holds on DSWs' pay as may be required by federal or state governments and maintain copies of judgments, garnishments, tax levies, and other related hold documentation in DSWs' files, if applicable;
- i) Research and resolve any tax notices received from the IRS, KS Department of Revenue and KS Department of Labor regarding DSW tax liabilities/liens, including all pertinent information and step to resolution;
- j) Maintain documentation of all tax notices received from the IRS, KS Department of Revenue and KS Department of Labor regarding DSW tax liabilities/liens including all pertinent information and step to resolution;
- k) Process appropriate documentation for DSWs who no longer work for a participant within 10 days of receipt of notice; and
- l) Maintain documentation on relationship of participant to worker in DSWs' files.

b. End of Year Tax and Other Activities

- 1) Each year, the FMS provider must file appropriate end of year taxes for each participant in accordance with state and federal rules and regulations
- 2) The FMS activities shall include, but are not limited to, the following:
 - a) Update participant and worker address or phone number changes prior to mailing out tax information in January of each year;
 - b) Process refunds of over collected FICA for eligible participants (to DPW) and DSWs in accordance with IRS and KDADS directive;
 - c) Maintain documentation related to FICA refunding in each applicable participant's and DSW's file;
 - d) Process, file and distribute IRS Forms W-2, *Wage and Tax Statement* for all DSWs and in accordance with IRS instructions for agents. As part of this process, the total gross payroll per the Form W-2 should be reconciled to the calendar year's total gross payroll;
 - e) Verify that each DSW's social security number matches the name and date of birth information obtained from SSA's *Business Services Online* prior to submitting IRS Forms W-2 to SSA each calendar year;
 - f) Maintain copies of the federal copy of Forms W-2 and related documentation in each DSW's file;
 - g) Maintain copies of IRS Forms as applicable in FMS and/or participant's file;

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3. Reporting Agent Authorization (Subagent)

a. Use of Reporting Agents

- 1) The FMS's use of a reporting agent must be in compliance with IRS Revenue Procedure Code 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70, as applicable, KDADS and MCO requirements and the duties and responsibilities listed in this manual.. The reporting agent must operate in compliance with IRS Revenue Procedures 2003-69 and 96-16 and Publication 1474.
- 2) The subagent may process payroll, taxes and withholding, but only the FMS may bill the KanCare MCO for FMS administrative reimbursement and DSW reimbursement based on time worked under the participant's authorized ISP/POC.
- 3) Per IRS, a reporting agent has no liability for any unfulfilled federal tax obligations including penalties and interest related to the tasks it performs for the FMS and participant-employer. Liability rests with the FMS and the participant-employer.

b. Delegation to Reporting Agents

- 1) At the discretion of and with the approval of KDADS, a FMS may delegate FMS tasks to only one reporting agent per IRS Form 2678 instructions.
- 2) To delegate certain FMS duties to a reporting subagent, the FMS provider must:
 - a) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - b) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - c) FMS providers must submit an IRS Form 2678 to and receive authorization from the IRS for each participant-employer it represents as an employer agent. They also must obtain IRS tax information authorization to communicate with IRS staff about participant-employers' federal tax filings and payments.
 - d) Execute an IRS Form 8655, *Reporting Agent Authorization*, with the reporting agent. The reporting agent is not liable for any unfulfilled federal income tax withholding or employment tax obligations including penalties and interest.

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SECTION VI

F. Information, Assistance & Referral

Effective April 10, 2015

(Last Revised: December 21, 2015)

F. Information, Referral, and Assistance

Section VI

1. Information and Assistance Design

a. CMS Definition

Information and Assistance (I&A) is a service/function that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.

b. FMS Design

Under the F/EA model, I&A is a vital support for participant direction. This primary function of the FMS support model is essential to the participant's understanding of his/ her role as the sole employer of a direct service worker. Information and Assistance (I&A) is a service available to provide information, including independent resources, and assistance in the development of options to ensure participants understand the responsibilities involved with directing their services. Practical skills training is offered to enable participants, their families, and/or representatives to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring DSWs, managing workers, effectively communicating, and problem-solving. The extent of the assistance furnished to the participant will be determined by the participant or his/her representative and the FMS provider.

F. Information, Referral, and Assistance

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2. I&A Duties

a. General

- 1) Information and Assistance has been incorporated into the definition and requirements of the FMS provider.
- 2) Information and Assistance (I&A) is a service available to provide information, including independent resources, and assistance in the development of options to ensure beneficiaries understand the responsibilities involved with directing their services.
 - a) Practical skills training is offered to enable self-directing beneficiaries, their families, and/or representatives to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring direct service workers, managing workers, effectively communicating, and problem-solving.
 - b) The extent of the assistance furnished to the self-directing beneficiary will be determined by the self-directing beneficiary or beneficiary's representative.
- 3) I&A services may include activities that nominally overlap with the provision of information concerning participant-direction provided by an MCO Care Coordinator or targeted case manager. However, this overlap does not allow the FMS provider to be involved in the development of the individual service plan and/or other planning documents or assessments. The Kansas "Self-Direction Tool Kit" is recommended as a resource for I&A.
- 4) Information and Assistance is limited to participants who direct some or all of their HCBS program services. Through this service, information may be provided to the participant about:
 - a) person centered planning and how it is applied;
 - b) the range and scope of individual choices and options;
 - c) the process for changing the plan of care and individual budget;
 - d) the grievance process;
 - e) risks and responsibilities of self-direction;
 - f) free of choice of providers;
 - g) individual rights;
 - h) the reassessment and review schedules; and,
 - i) such other subjects pertinent to the participant and/or family in managing and directing services.

F. Information, Referral, and Assistance

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b. Employer-Related I&A

- 1) FMS provider will provide employer related information and assistance to the participant as part of their administrative function.
- 2) FMS provider will provide education to the participant and information to the DSW on the following:
 - a) Medicaid programs
 - b) Participant-direction program
 - c) DSW employment requirements
 - d) Establishing employer/employee agreements
 - e) Reporting of time and attendance on AuthentiCare®KS
 - f) Verification of time and attendance
 - g) Reporting abuse, neglect and exploitation.
- 3) FMS will provide information and assistance (program rules and employer resources) to the participant relating to participant-direction and his/her role as an employer and ensures participant is aware and accepts his/her responsibilities as an employer.
- 4) In addition to the responsibilities above, the FMS provider is must ensure the participant understands the responsibilities associated with participant-direction and will provide necessary information and assistance to ensure the participant understand his/her role as an employer. The FMS provider supports the participant with information and assistance that includes at a minimum the following:
 - a) Participant's role as the employer for DSW to manage or help manage DSWs, or appointed a designated representative;
 - b) Explanation of the FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the participant and the FMS provider
 - c) How the participant can establish the wage of the DSW(s)
 - d) How the participant can select DSW(s)
 - e) Information for referring the DSW to the FMS provider for completion of required human resources and payroll documentation.
 - f) Steps for the participant to work in cooperation with the FMS provider to ensure all employment verification and payroll forms are completed.
 - g) How the participant can negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties, including work schedule.

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- h) How the participant can provide or arrange for appropriate orientation and training of DSW(s).
- i) Participant's responsibility to determine schedules of DSW(s).
- j) Explanation of the terms of I&A supports requested by the participant is outlined in the FMS/ Participant Service Agreement.

c. Information

- 1) I&A services will provide information to the participant, as needed, about:
 - a) Participant's right to person-centered planning opportunities
 - b) Range and scope of participant's choices and options
 - c) MCO and State grievance and appeals processes
 - d) Risks and responsibilities relating to participant-direction
 - e) Participant rights and responsibilities relating to participant-direction
 - f) Importance of ensuring DSW's health and safety during the course of his or her duties to reduce potential injuries and workers compensation insurance claims. This may include participation in training by the participant on how best to care for the participant ensure health and safety for the participant and the worker.-directing participant.
 - g) Participant's maintenance of Medicaid financial and HCBS program eligibility by participating in annual review.
 - h) Importance of keeping the FMS provider agency, eligibility assessor agency and MCO Care coordinator informed of up to date contact information, any planned or unplanned absences or hospitalization.
 - i) Other relevant resources or information that will assist the participant and/or family in managing and directing services and living independently and safely in the community in the most integrated setting
 - j) FMS may direct the participant to the Kansas "Self-Direction Tool Kit" is recommended as an optional resource.

d. Assistance

I&A services may provide assistance to the participant with:

- 1) Defining service goals, needs, and resources to be conveyed to the DSW
- 2) Identifying and accessing services, supports, and resources as it pertains to participant-directed related activities
- 3) Learning practical management skills training (such as hiring, managing, and terminating workers; problem solving; conflict resolution)

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- 4) Recognizing and reporting critical events (such as fraudulent activities, abuse, neglect or exploitation)
- 5) Managing services, supports and workers
- 6) Development of risk management agreements;
- 7) Recognizing and reporting critical events; and
- 8) Other areas related to managing services and supports

e. Referral

- 1) FMS providers will refer the participant to the participant's MCO care coordinator, IDD case management and/or the appropriate community, state and federal resource, service, or support depending on the participant's need. An appropriate referral should be made, as appropriate, to enhance information and assistance and includes, but is not limited to, the following:
 - a) MCO Care Coordinator/IDD Case Manager
 - b) KanCare Ombudsman
 - c) State Agencies (DCF, KDADS, KDHE, etc)
 - d) Assessing Entity (ADRC, CDDO, CMHC, KVC)
 - e) Community Supports such as Centers for Independent Living, Community Developmental Disability Organizations, Community Mental Health Centers, and Area Agencies on Aging
 - f) Support Groups and other services or supports, requested or needed
- 2) Referral resources are available on the KDADS website at www.kdads.ks.gov and included in Section G, Resources and Forms, for additional information.

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SECTION VII

G. Billing and Claims

Effective April 10, 2015

(Last Revised: December 21, 2015)

G. Billing and Claims

Section VII

1. General Billing and Information

a. Billing

- 1) FMS providers must bill claims for services (agency-directed, self-directed, or FMS Administrative Reimbursement) according to the appropriate MCO Provider Billing Manuals and/or KMAP FMS Billing Manual.
- 2) FMS providers should verify eligibility and authorization prior to billing for DSW reimbursement. Failure to check member eligibility and/or obtain prior authorization may result in services performed not being reimbursed.
- 3) FMS must:
 - a) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
 - b) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
 - c) Receive and maintain participant's initial and updated ISP/POC the MCO using the AuthentCare@KS;
 - d) Bill MCO for direct service worker claims through the AuthentCare@KS for services rendered in accordance with KDADS HCBS Program requirements and MCO Provider Requirements
 - e) Have appropriate process for reconciling hours and services billed and paid, including verifying time and attendance with the participant and ensuring no duplication of billing by:
 - i. Having an appropriate process and policy for determining and verifying when a participant is admitted to a nursing facility or hospital the length of stay;
 - ii. Having an appropriate process and policy to preventing billing the MCO for the period of time during a participant's stay in a nursing facility or hospital; and
 - iii. Ensuring the participant has reviewed and approved time and attendance for DSWs.
 - iv. Having an appropriate process and policy for identifying, mitigating and reporting suspicions of fraud, waste and abuse
- 4) FMS providers should ensure that billing records support the amounts claimed on the provider claim form, CMS-1500 or other approved/required method established by the State or the MCO for proper claims processing and have billing records that contain sufficient and current participant and service information and required documentation.

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b. Claims

- 1) The FMS provider is reimbursed for administrative; and information and assistance supports that are billable to KanCare MCO at the agreed upon rate per member per month.
 - a) FMS supports (T2040 U2, 1 unit= 1 month) claims can be submitted with the diagnosis code 780.99 via the AuthentiCare@KS system.
 - b) Consistent with the KDADS FMS Agreement, the FMS provider must not use any part of this reimbursement for the purpose of paying the participant's client obligation and employee's wages, tax payments or other required withholding amounts.
- 2) Initial claims must be billed within the timeframe allowed under the MCO Provider Agreement terms as specified in each MCO's Provider Manual.
 - a) Resubmission of any suspended, rejected or denied claims, as appropriate, must be billed within the timeframe allowed under the MCO Provider Agreement as specified in the MCO Provider Manual.
 - b) Claims submission and disputes must be submitted as specified in the MCO Provider Manual
- 3) Claims for DSW reimbursement for services rendered should not to exceed the negotiated and/or established HCBS Program DSW Reimbursement rate(s).
- 4) FMS providers should not reduce the billed amount on the claim by the client obligation assigned to the participant by DSW each month because the client obligation will automatically be deducted as claims are processed.
- 5) The dates of service on the claim must match the dates approved on the ISP/POC and cannot overlap.
- 6) Medicaid is the payor of last resort and is a secondary payor to all other insurance programs (including Medicare). Claims should be billed only after payment or denial has been received from such carriers.
 - a) Per 42 CFR §433.139(b), if the probable existence of TPL (such as Medicare or health insurance) is established at the time a claim is filed, Medicaid must reject the claim and return it to the provider for a determination of the amount of liability
 - b) Third-party liability (TPL) is often referred to as "other insurance." Other insurance is considered a third-party resource for the participant. Third-party resources can be health insurance (including Medicare), casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been

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- assigned legal responsibility for the health care of one or more beneficiaries.
- c) Acceptable TPL documentation guidelines can be found in the Web Claim Submission Process and Paper Billing Process sections of the KMAP TPL Manual and/or the MCO Provider Manual.
 - d) At the time the FMS provider obtains participant information, the provider should also determine if additional insurance resources exist. When they exist, these resources must be identified on the claim in order for the claims to adjudicate properly.
- 7) For certain situations, services approved on an ISP/POC and provided the same day a participant is hospitalized or in a nursing facility may be allowed, but only in the following limited situations:
- a) HCBS services provided the date of admission, if provided PRIOR to beneficiary being admitted;
 - b) HCBS services provided the date of discharge, if provided FOLLOWING the beneficiary's discharge;
 - c) HCBS case management provided 30 days prior to discharge; and
 - d) Emergency Response Services.

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2. General Claims

a. FMS Administrative Reimbursement

- 1) FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct service workers.
- 2) FMS are paid on a monthly basis. While a participant is temporarily hospitalized, the monthly payment would not need to be cancelled or changed as long as the participant is using participant-directed services during the month.
- 3) FMS provider is reimbursed for administrative; and information and assistance supports that are billable to KanCare MCO at the agreed upon rate per member per month.
 - a) FMS supports (T2040 U2, 1 unit= 1 month) claims can be submitted with the diagnosis code 780.99 via the AuthentiCare@KS system.
 - b) The FMS provider must not use any part of this reimbursement for the purpose of paying the participant's client obligation and employee's wages, tax payments or other required withholding amounts.
- 4) In the event either party (participant or FMS provider) terminates their relationship at any time within the month, the FMS provider must continue to provide supports for the duration of the month the provider is billing for.
- 5) The FMS provider must follow the process for closing services with the participant in accordance with federal, state and MCO policies and procedures.

b. Direct Service Worker Reimbursement Rate

- 1) FMS assures Medicaid funds received for the purpose of reimbursing DSW service will be used solely for the participant- directed services for which the FMS provider has received reimbursement for. The FMS provider shall not, in any circumstance use the funds for administration, working capital, other participant's workers, recruiting or other day-to-day business use.

By way of example, and not of limitation, if Participant "A" had \$1.50 remaining following payment to his/her Direct Service Worker and the taxing authorities, the Provider could not use such overage to pay Participant B's Direct Service Worker a higher wage rate.

- 2) Funds received on behalf of the participant, and within the scope of the FMS responsibilities, shall be deposited in accordance with the FMS provider agreement in which such deposits shall be individually accounted by participant. As required by 42 CFR 443.300 *et seq*, residual funds not dispersed to a participant's DSW in accordance with federal and state laws, rules and

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regulations shall be returned in accordance with the FMS provider agreement.

3. Documentation Requirements

a. Written Documentation Required

- 1) Written documentation is required for services provided and billed to the MCO or through KMAP.
- 2) Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.
- 3) Documentation needs to be a report, database, spreadsheet, or invoice that must, at a minimum, include the following:
 - a) Identification of the waiver service being provided
 - b) Participant's printed name (first and last)
 - c) Participant's Medicaid identification number
 - d) Date of service (MM/YY)
 - e) Notes of any I&A tasks provided during contacts within the month
- 4) The beneficiary's printed name and signature must be on the completed Service Agreement prior to the start of service delivery.

b. Electronic Documentation

- 1) For services required to use the IVR system in AuthentiCare® KS, time and attendance must be recorded using the IVR system.
- 2) Any claims created, corrected or otherwise adjusted in the AuthentiCare®KS must have appropriate documentation attached.
- 3) Electronic Documentation, at a minimum, must include the following:
 - a) Identification of the waiver service being provided
 - b) Name of the beneficiary receiving the service(s)
 - c) Date of service (MM/YY)
 - d) Notes of any I&A tasks provided during contacts within the month
 - e) Beneficiary's signature authorizing the use of the electronic documentation system at the start of service delivery
 - f) Electronic documentation of service delivery is allowed when meeting both documentation and signature standards as outlined above.

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c. Benefits and Limitations

- 1) HCBS Program services, including benefits and limitations, are outlined for HCBS Program participants in the specific HCBS Program Manuals, KMAP Manuals, and HCBS Manuals.
- 2) The participant or designated representative cannot receive payment for the administrative functions he or she may perform.
- 3) Only one FMS provider is to be authorized on a ISP/POC per month.
- 4) Access to this service is limited to beneficiaries or their representatives who direct some or all of their services.

d. Recoupment and Post-Payment Review

- 1) Post payment review may be completed by the MCO or the State to ensure compliance with requirements from the Centers for Medicare and Medicaid Services (CMS) at any time.
 - a) The Centers for Medicare and Medicaid Services (CMS) requires each state allowing submission of electronic claims to perform random sample reviews to ensure program compliance and integrity.
 - b) This process entails randomly selecting claims that have been submitted electronically. If randomly selected, the provider will receive a letter requiring acceptable documentation to be returned showing the claim was properly submitted.
- 2) For post payment review, reimbursement will be recouped if documentation is not complete.
 - a) Acceptable documentation requirements are identified in this manual, the appropriate KMAP Billing Manual, and MCO Provider Manual.
 - b) The documentation, along with a copy of the original letter, must be submitted within the time-frame identified in the letter.
 - c) Failure to follow the post payment review instructions or to submit the required documentation within the required time-frame or submission of unacceptable documentation may result in the claims being recouped.

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SECTION VIII

H. Quality Assurance and Program Integrity

Effective April 10, 2015

(Last Revised: December 21, 2015)

H. Quality Assurance and Program Integrity

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1. Quality Assurance Program

- a. FMS providers must develop, implement, and maintain an internal quality assurance program that monitors for:
 - 1) Participant's satisfaction;
 - 2) Correct submission of DSW's time worked ;
 - 3) Correct payroll distribution;
 - 4) Correct withholding of taxes, insurance and worker's compensation;
 - 5) Identification, mitigation, and report of abuse, neglect and exploitation of an adult or child; and
 - 6) Identification, mitigation and report of fraud, waste and abuse including inaccurate or duplicate time, attendance and billing
- b. FMS providers must comply with quality assurance activities of the MCO, State, and CDDO, if applicable, including, but not limited to, :
 - 1) Fiscal or programmatic audits or reviews;
 - 2) Announced or unannounced quality assurance reviews;
 - 3) Verification of compliance with the FMS agreement and the FMS Policy Manual;
 - 4) Investigations for fraud, waste, abuse, neglect and/or exploitation;
 - 5) Review of year-end payroll and tax information and reports as related to wages, taxes and insurances paid;
 - 6) Review of policies, procedures, and practices; and
 - 7) Generate and distribute additional information and reports as requested by the participant, KDADS, MCO or their designee.

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2. Reporting Requirements

a. Reports of abuse neglect and exploitation (www.dcf.ks.gov).

- 1) If an FMS provider suspects a child is being abused or neglected, please telephone the Kansas Protection Report Center at 1-800-922-5330. Telephone lines are staffed 24 hours a day. In the event of an emergency contact your local law enforcement or call 911. For more information go to Child Protective Services.
- 2) If an FMS provider suspects and adult is being abused, neglected or exploited in the community, please telephone the Kansas Protection Report Center at 1-800-922-5330. Telephone lines are staffed 24 hours a day. In the event of an emergency contact your local law enforcement or call 911. For more information go to Adult Protective Services.
- 3) As a mandatory reporter, an FMS provider must report child or adult abuse or neglect electronically, using the Kansas Intake/Investigation Protection System. When using the electronic report please make note of the first question at the top of the form indicating child or adult type of report.

b. Reports of fraud, waste and abuse

- 1) If an FMS provider suspects duplicate time records or DSW abuse, contact the KDADS Program Integrity Coordinator by calling 785-296-4986 or email hcbs-ks@kdads.ks.gov, subject line: Program Integrity Report.
- 2) If an FMS provider suspects consumer fraud, waste or abuse, contact the Managed Care Organization by contacting the appropriate MCO representative.
- 3) If an FMS provider suspects Medicaid fraud, waste or abuse, contact the Attorney General's Medicaid Fraud Control Unit by calling 1-866-551-6328 or 785-368-6220 or file a report at <https://ag.ks.gov/about-the-office/contact-us/file-a-complaint/medicaid-fraud>

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3. Financial Reporting

a. Annual Reporting Requirements

- 1) FMS provider will comply with the following annual audit requirement:
 - a) Within six (6) months following end of the initial Agreement, and every third year thereafter, the FMS provider will submit an independent financial (Generally Accepted Accounting Principles (“GAAP”), CPA-certified) audit.
 - b) By way of example and not of limitation, if a Provider’s initial Agreement would end on December 31, 2015, the Provider would need to have a GAAP audit not later than June 30, 2016, for the period January 1, 2015, through December 31, 2015. Similarly, if a Provider’s third agreement term would end on December 31, 2018, the Provider would need to have a GAAP audit not later than June 30, 2019 for the period January 1, 2018 through December 31, 2018. In addition, during the “off years” in which a GAAP/cash basis audit is not required, the Provider shall have a Compliance Audit no later than June 30th for the prior contract year. Both the GAAP and Compliance Audit shall be at the Provider’s expense. If, however, the Provider is not on a calendar accounting year, the audit dates above shall be six (6) months following the end of the Provider’s respective fiscal year.
- 2) A financial audit will be conducted upon termination of KDADS/ FMS Provider Agreement. The Provider shall have an audit provided by KDADS within ninety (90) calendar days of voluntary or involuntary termination. Such audit shall be at the Provider’s expense.
- 3) If, however, and for whatever reason, KDADS does not timely receive the audit, KDADS may audit the Provider and may charge the expense(s) for such audit to the Provider. If this provision is invoked, FMS provider agrees to timely reimburse KDADS for the expense(s) of such audit.

b. Independent Financial Audit Requirements

- 1) For years in which a CPA conducted audit is required, the provider must submit a copy of the audit report, plus any additional documentation or correspondence from the CPA, such as letters to management and/or the board of directors.
- 2) Filing extensions for the required CPA audits may be granted by the KDADS Audit Manager. Extensions will be granted on a case-by-case basis. No extension will be granted for more than 60 days. Only one extension will be granted to a provider for any given filing period.

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- 3) The filing deadlines for the above required audits and reports will be 30 days from completion, or within 6 months of the end of the provider's fiscal year end, whichever is earlier. Any delinquent audits or reports will be rejected or accepted on a case-by-case basis, rejection of the audit or report may result in the provider being terminated as a qualified FMS provider.
- 4) All required audits, reports, and other documentation should be submitted electronically to the following e-mail address: CPAAUDITS@kdads.ks.gov

c. Compliance Audit (Program and Financial)

- 1) In the years in which a CPA conducted audit is not required, the provider must submit the financial report form provided by the Department, plus an applicable balance sheet.
- 2) The compliance audit will consist of a review of financial records and substantial compliance with program requirements, including provider qualifications. The compliance audit will be completed in conjunction with the annual review. FMS providers will submit the required financial records and program reporting tool to the KDADS FMS Program Manager.
- 3) Filing extensions for the required compliance audits may be granted by the KDADS FMS Program Manager. Extensions will be granted on a case-by-case basis. No extension will be granted for more than 60 days. Only one extension will be granted to a provider for any given filing period.
- 4) The filing deadlines for the above required audits and reports will be 30 days from completion, or within 6 months of the end of the provider's fiscal year end, whichever is earlier. Any delinquent audits or reports will be rejected or accepted on a case-by-case basis, rejection of the audit or report may result in the provider being terminated as a qualified FMS provider.
- 5) All required audits, reports, and other documentation should be submitted electronically to the following e-mail address: CPAAUDITS@kdads.ks.gov

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4. Excess Funds

a. Managing Public Funds

FMS receives, disburses and tracks Medicaid and State funds in an accurate and timely manner and in accordance with Federal and State requirements. The KDADS may, at any time and at its discretion, audit the F/EA's administration and use of the public funds.

FMS must:

- 1) Have FMS written policies and procedures and safeguards related to the completion of the tasks listed below;
- 2) Have written internal controls, including segregation of duties, related to the completion of the tasks listed below;
- 3) Establish and maintain an accounting and information system for receiving and disbursing Medicaid funds and for tracking all transactions and balances;
- 4) Establish a bank account into which all payments received from Medicaid and the State
 - a) Prohibit the withdrawal of funds except for payment of employer, direct service provider/vendor and administrative tasks as described in this manual; and
 - b) Maintain, to the extent legally permissible, in a manner that prevents creditors of the FMS from in any way encumbering or acquiring funds in the bank account.
 - c) Account for disbursement of DSW reimbursement rates, which means to the ability to trace deposits and reimbursements, itemize and report excess funds to the consumer level.
- 5) Any bank charges (i.e., stop payment fees) must be absorbed by the FMS and not reduce the balance of the bank account;
- 6) Ensure that funds deposited into the bank account are not used by the FMS or by any other agent or third party to satisfy, temporarily or otherwise, any FMS liability or for any other purpose, except as provided under these Standards;

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b. Return of Excess Funds

- 1) FMS assures Medicaid funds received for the purpose of reimbursing DSW service will be used solely for the participant-directed services for which the FMS provider has received reimbursement for. The FMS provider shall not, in any circumstance use the funds for administration, working capital, other participant's workers, recruiting or other day-to-day business use.
 - a) *By way of example, and not of limitation, if Participant "A" had \$1.50 remaining following payment to his/her Direct Service Worker and the taxing authorities, the Provider could not use such overage to pay Participant B's Direct Service Worker a higher wage rate.*
 - b) In addition, funds received from KDADS for DSW reimbursement must be deposited by the FMS provider in an account(s) in which such deposits may be traced to and accounted for the provision of participant-directed services. In other words, while Agency and FMS funds may be deposited into the same account, the Provider shall trace and account for such funds on a participant basis regarding both Attendant Care services and FMS services.
- 2) When overpayments (excess funds) to and FMS providers is made for DSW reimbursement rates that are not disbursed to the DSW, the FMS provider must return the federal funds when overpayments are identified (see 42 CFR 433.300 and in K.A.R 30-5-61a)
 - a) Excess funds shall be returned within 180 calendar days following the expiration of the FMS Agreement term;
 - b) The FMS provider may request in writing an exception in that at least 90% of such excess funds would be remitted within the 180 day time period with up to a 10% balance being remitted not later than 60 calendar days following the initial payment. For example, if a Provider had \$10,000 in excess funds and its exception was granted, \$9,000 of such amount would be due within 180 days following the expiration of the FMS Agreement term, with the remaining balance of \$1,000 being due 60 days following the initial payment.
- 3) Excess funds accumulated from Medicaid funds received for the purpose of reimbursing DSW's wage will be accounted for by the FMS provider and return all excess funds to KDADS in accordance with the terms of the KDADS/ FMS provider agreement.
 - a) The check payable should be made payable to the Kansas Department for Aging and Disability Services.

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- b) The check should be remitted to KDADS Accounting/Fiscal Services Manager at 503 S. Kansas Ave. Topeka, KS 66603-3404.
- c) The check should be accompanied with the following information:
 - i. Time period for the funds;
 - ii. Medicaid Billing ID number;
 - iii. Provider NPI; and
 - iv. FMS Organization's name and contact information;
 - v. Certification that the enclosed amount is all excess funds from DSW reimbursement received during the period as evidenced by the total amount of DSW reimbursement received, the amount of DSW reimbursement disbursed, and how the disbursement was applied (*i.e.* worker's compensation, wages, payroll taxes); and
 - vi. Signature of authorized representative
- 5) If the FMS provider has no excess funds for the requested time period, the FMS provider should submit a signed certification from the authorized representative and/or accountant that the FMS provider had no excess funds for the requested time period.
 - a) The certification should be sent to KDADS Accounting/Fiscal Services Manager at 503 S. Kansas Ave, Topeka, KS 66603-3404.
 - b) The certification should include the following information:
 - i. Time period for the funds;
 - ii. Medicaid Billing ID number;
 - iii. Provider NPI; and
 - iv. FMS Organization's name and contact information;
 - v. Certification that FMS provider had no excess funds from DSW reimbursement received during the period as evidenced by the total amount of DSW reimbursement received, the amount of DSW reimbursement disbursed, and how the disbursement was applied (*i.e.* worker's compensation, wages, payroll taxes);
 - vi. Signature of authorized representative.

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SECTION IX

I. Forms and Resources

Effective April 10, 2015

(Last Revised: December 21, 2015)