

WORK

Work Opportunities Reward Kansans

Program Manual



Working **Healthy**
Making health care work

Kansas Personal Assistance Program for
Employed People With Disabilities

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I. SUMMARY

Kansas Medicaid currently provides personal assistance services to children and adults with cognitive, developmental, mental, and physical disabilities, and those who are frail and elderly, through six Home and Community Based Services (HCBS) Waivers. These waivers include the Developmental Disability (DD), Frail Elderly (FE), Physical Disability (PD), Serious Emotional Disturbance (SED), Technologically-Assisted children (TA), and the Traumatic Brain Injury (TBI) Waivers. The Kansas Department on Aging (KDOA) administers the FE Waiver, and the Kansas Department of Social and Rehabilitation Services (SRS) administers the remaining five waivers.

In September 2006, the Kansas Health Policy Authority (KHPA), the single Medicaid state agency, received approval from the Centers for Medicare and Medicaid Services (CMS) for a Medicaid State Plan Amendment (SPA) submitted under Section 6044 of the Deficit Reduction Act of 2005, “State Flexibility in Benefit Packages”. The SPA provides a package of services, including assessment, personal assistance services, independent living counseling, and assistive services, for individuals with developmental disabilities, physical disabilities, and traumatic brain injury, whom are eligible for the Kansas Medicaid Buy-In program, *Working Healthy*. CMS also approved the use of the “cash and counseling” model, allowing a direct cash payment to individuals who choose to act as their own fiscal manager. This Medicaid State Plan package of services is titled *WORK: Work Opportunities Reward Kansans*.

KHPA expects the number of people with severe cognitive and physical disabilities who enter the workforce will increase if personal assistance and related services are provided at a sufficient level in the home, at work, and in the community. KHPA also hopes that participants will increase the number of hours worked, increase their income, and self-report better health-related outcomes and improved quality-of-life as a result of the combination of *Working Healthy* and *WORK*. KHPA believes that *WORK*, combined with the work incentives of *Working Healthy*, will promote employment of people with significant disabilities.

KHPA believes that the “cash and counseling” model is the next logical step for promoting adult self-sufficiency, community integration, and employment. *WORK* will go a step beyond consumer direction, which Kansas already practices in its HCBS Waiver Programs, by allowing consumers to truly control their services through person-centered planning, management of their own funds, and flexibility in terms of how they purchase their services. Consumers will be given the opportunity to choose how to obtain services in the most cost-effective and innovative manner.

WORK is designed to provide eligible enrollees with optimum control of their lives by allowing them to purchase personal assistance services in alternative ways that will meet their unique needs using a monthly cash allocation, decide whether they want to self-direct or have **an agency direct their care**, determine whether to use the services of an Independent Living Counselor or manage their care independently, decide whether to use the fiscal management service **designated by KHPA** or act as their own fiscal manager, and choose providers with whom they feel the most comfortable rather than have to use mandated providers based on disability or geographical location.

KHPA staff designed *WORK* in conjunction with consumers who will eventually enroll in the program, advocates, community providers, and SRS staff.

II. PROGRAM OPERATION OVERVIEW

1. Kansas Health Policy Authority (KHPA)

KHPA is responsible for the following:

- supporting independence, self-sufficiency, and employment for people with disabilities enrolled in *WORK*;
- administering *WORK*;
- developing *WORK* policies and procedures;
- developing, coordinating, and providing *WORK* outreach and training activities for consumers and providers;
- offering web-based fiscal management training and assessment, and web-based self-direction training;
- communicating, via the ES-3160 and other methods, with SRS HCBS Waiver Program Managers, Benefits Specialists, Eligibility Workers, and community based Independent Living Counselors, the status of all *Working Healthy/WORK* participants;
- referring potential *WORK* participants to the Assessment Contractor;
- approving the Individualized Budget, and Emergency Back-Up Plan;
- entering the approved plan of services into the Medicaid Management Information System (MMIS);
- in conjunction with the consumer, determining the initial date for allocation payment;
- providing prior authorization for assistive services;
- approving the use of carry over funds;
- reviewing the monthly financial accounts of consumers who perform their own fiscal management; and
- assuring quality at all levels of service in the *WORK* program.

2. Social and Rehabilitation Services (SRS)

SRS is responsible for the following:

- promulgating associated *WORK* policies and procedures that support the KHPA policies and procedures;
- training Eligibility Workers;
- providing *WORK* outreach and training for consumers and providers (Benefits Specialists);
- assisting potential consumers to access *WORK*; including orientation to *WORK*, benefits planning, reviewing option of *WORK* versus an HCBS Waiver, obtaining proof of employment, referring interested individuals to the KHPA *WORK* Program Manager for assessment (Benefits Specialists);
- determining eligibility for *Working Healthy* and *WORK* and communicating the outcome to the KHPA Program Manager, Benefits Specialists, and Independent Living Counselors (Eligibility Workers);
- assisting consumers to access Independent Living Counseling and Fiscal Management Services (Benefits Specialists);
- communicating movement to or from *WORK* to waiver Program Managers, Eligibility Workers, and Independent Living Counselors (Benefits Specialists);
- maintaining a list of consumers leaving a waiver to enroll in *Working Healthy/WORK* and, in the event these individuals are no longer eligible for *Working Healthy/WORK*, re-instating waiver services (HCBS Program Managers);
- maintaining a list of consumers who choose to leave a waiver waiting list in order to enroll in *Working Healthy/WORK* and, in the event these individuals are no longer eligible, re-instating them onto the waiting list at the slot they would have achieved had they not left the waiting list (HCBS Program Managers); and
- communicating to the KHPA Program Coordinator the status of all *Working Healthy/WORK* participants to ensure that there is no disruption in services (HCBS Program Managers, Benefits Specialists, and Eligibility Workers).

3. Assessment Contractor(s)

KHPA will contract with one or several community providers who have experience with working age adults with developmental disabilities, physical disabilities, and traumatic brain injury. KHPA may contract with only one organization that will provide assessments statewide, or may choose to contract with several organizations to cover various regions of the state.

The Assessment Contractor will be responsible for the following:

- making an initial contact to schedule an assessment within two working days of receiving a referral from the Program Manager;
- providing an initial assessment within twenty working days of the initial contact to determine eligibility for *WORK*;
- providing annual re-assessments, and re-assessments if there is a significant need to revise the plan of services;
- communicating assessment results to participants;
- determining the allocation for purchasing services using the assessment;
- explaining the methodology used to calculate the allocation to the consumer;
- submitting the assessment results, Choice Form, and allocated amount to the KHPA Program Manager;
- providing resource information, including Independent Living Counselors and fiscal management organizations;
- providing responses to requests for information; and
- maintaining records for each individual assessed per K.A.R. 30-5-301.

The KHPA Assessment Contractor(s) may **not** provide any other *WORK* services, including Independent Living Counseling, fiscal management, personal assistance services, or assistive services.

4. Community Organizations

Community organizations such as Centers for Independent Living (CILs), community organizations that provide services for individuals with traumatic brain injury (both subject to K.S.A. 65-5101), and Community Developmental Disability Organizations (CDDOs) or their affiliates (both subject to K.S.A. 65-5101) will be responsible for:

- assisting Consumers in self-directing their services;
- providing Independent Living Counseling (limits specified in K.A.R. 30-5-302 apply);
- supporting consumers in the coordination of resources and services, and advocating for independence;
- assist consumers to access web-based or other self-direction training;
- assisting customers to access mandatory web-based training and assessment, for those who choose to act as their own Fiscal Manager;
- assisting in the development of, and obtaining approval for, the Individualized Budget;
- assisting consumers in locating providers of personal assistance services, checking references, and obtaining criminal background checks;
- assisting to access assistive services, including assistive technology, Durable Medical Equipment (DME), and related supports;
- assisting consumers to access other needed services;
- advocating with employers for reasonable accommodation and other employment needs;
- communicating any changes in status, needs, problems, etc., to the appropriate KHPA and SRS staff, and
- maintaining documentation of services provided per K.A.R. 30-5-301; and
- submitting all required paperwork in a timely fashion.

5. State Licensed Home Health Agencies

State Licensed Home Health Agencies are subject to K.S.A. 65-5101 and K.S.A. 65-5102, and will be responsible for:

- directing services on behalf of consumers;
- providing Independent Living Counseling services;
- coordinating and paying for personal assistance services for consumers who choose not to self-direct their services;
- assisting consumers to access other needed services;
- assisting in the development of , and obtaining approval for, the Individualized Budget;
- assisting to access assistive services, including assistive technology, Durable Medical Equipment (DME), and related supports;
- advocating with employers for reasonable accommodation and other employment needs;
- communicating any changes in status, needs, problems, etc., to the appropriate KHPA and SRS staff, and
- maintaining documentation of services provided, and submitting all required paperwork in a timely fashion.

6. Fiscal Manager

The fiscal manager for individuals enrolled in *WORK* is responsible for the following:

- obtaining a Federal Employer Identification Number (FEIN) and Kansas Withholding tax account number for each consumer utilizing the organization's fiscal management services;
- maintaining individually identifiable checking and carryover accounts for each individual, and assisting them in establishing an Individual Development Account (IDA), if available;
- ensuring that consumers are informed of the procedures and forms used to report hours worked and/or a change in workers;
- adhering to generally accepted finance and accounting practices and procedures;
- auditing, and cooperating in external audits, of consumer accounts;
- monitoring the paperwork submitted by the consumer for timeliness, accuracy, and completeness;
- paying attendant wages consistent with time sheets signed by consumers;
- withholding, paying, and complying with all Federal and State reporting requirements for any applicable taxes, unemployment insurance, worker's compensation, benefits, and any other fees required by State or Federal law; and
- providing monthly reports to the consumer and KHPA, which include:
 - individual receiving the allocation and demographic information;
 - allocation received;
 - fiscal management fee;
 - payments made to each attendant;
 - taxes, unemployment insurance, worker's compensation, and other benefits withheld;
 - payments made for alternative services;
 - total funds disbursed; and
 - carryover account balance.

7. Consumers

Consumer Rights

- Consumers have the right to information that will help them to make an informed choice regarding whether they want to enroll in *Working Healthy* and *WORK*.
- Consumers enrolled in *WORK* have the right to have personal services, inside and outside of the home, at a level that supports employment.
- Consumers have the right to timely enrollment in *WORK*.
- Consumers have the right to a person-centered planning process, when developing the Assessment, Individual Choice Forms, Individualized Budgets, and Emergency Back-Up Plans.
- Consumers have the right to the supports needed to develop their Assessments and Individualized Budgets, including any or all of the following; a representative, family, friends, or Independent Living Counselor.
- Consumers have the right to self-direct their services, or to choose an agency to direct their services on their behalf.
- Consumers have the right to provide their own fiscal management once they have successfully completed a mandatory Fiscal Management Training program.
- Consumers have the right to all of the services they are entitled to through the Kansas Medical Assistance Program (KMAP).
- Consumers have the right to have personal or program issues reviewed by KHPA and, if necessary, a plan of action by KHPA to correct any problems.
- Consumers have the right to report abuse, neglect, and exploitation to SRS.
- Consumers have the right to file a grievance regarding *WORK* or appeal actions taken by KHPA, the Contractor, or a provider.

Consumer Responsibilities

- Consumers have the responsibility to obtain the necessary information that will help them to make an informed choice whether they want to participate in *WORK*.
- Consumers have the responsibility to ensure that their Assessment includes the supports necessary to ensure that they can live and work safely in their home and community.

- Consumers have the responsibility to keep appointments for the initial assessment and annual re-assessments.
- Consumers have the responsibility to ensure that the services and costs listed on their Individualized Budget reflect what is included in their Assessment.
- Consumers have the responsibility to complete an Emergency Back-Up Plan that ensures adequate coverage in the event that their employees do not come, and indicates that they have made provisions for their safety in the event of a natural or any other form of disaster.
- Consumers have the responsibility of signing the Choice form to indicate informed choices have been made;
- Consumers have the responsibility to pay a premium monthly in a timely manner, and to keep abreast of their payments at all times.
- Consumers have the responsibility to complete their six-month eligibility desk review, providing their Eligibility Worker with all necessary paperwork in a timely manner.
- Consumers are responsible to understand and accept the responsibilities and risks of managing their own care, as well as having knowledge of their rights, **or** designating a representative who understands their needs and is willing to accept the responsibilities and risks of managing their care; **or** choosing a state licensed Home Health agency, CDDO or Affiliate Agency willing to manage their care on their behalf;
- Consumers choosing to manage their attendants will be responsible for the following:
 - becoming familiar with, and being able to complete, all required paperwork;
 - deciding whether to obtain a background check for attendant(s);
 - determining reimbursement rates and benefits;
 - pay, or hire a Fiscal Management Service to pay attendant wages, applicable taxes, unemployment insurance, workers' compensation, benefits, and any other withholdings required by State or Federal government;
 - reviewing and signing attendant time sheets to verify that the number of hours provided by attendants are correctly recorded before submitting to the Fiscal Management Service;
 - reviewing invoices for services rendered or items purchased, and signing to verify the accuracy before submitting to the Fiscal Management Service;
 - reporting emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to SRS Adult Protective Services (see K.S.A. 39-1430); and
 - bringing to the attention of KHPA staff or an Independent Living Counselor any concerns they have regarding the quality of their attendants and/or services.
 - Maintaining supporting documentation for all payments for a five-year period

- Consumers have the responsibility to budget their allocation in a way that meets their individual needs, to spend the funds only on those services and/or goods that are consistent with independence and employment and within the parameters established by KHPA.
- Consumers have the responsibility to submit timesheets to be paid with costs that do not exceed the allocation and Individualized budget total monthly amount.
- Consumers choosing to assume fiscal management will be responsible to maintain separate checking and carryover accounts for *WORK* funds, and will provide a monthly report to KHPA which includes the following;
 - funds received;
 - payments made to each attendant;
 - taxes, unemployment insurance, worker's compensation, and other benefits withheld;
 - funds spent on alternative purchases;
 - total funds disbursed;
 - amount of monthly allocation not disbursed;
 - checking account balance; and
 - carryover account or IDA balance for approved purchase(s).
- Consumers have the responsibility to request the permission of KHPA to use unexpended funds from their allocation to establish a carryover account or Individualized Development Account.
- Consumers have the responsibility **not** to spend their allocation on anything prohibited by KHPA or KMAP.
- Consumers must understand that the inappropriate use of Medicaid funds is considered Medicaid fraud, and that they may be held liable and prosecuted for such misuse; and
- Consumers have the responsibility to report and account for any unexpended funds from their allocation.
- Consumers have the responsibility to return any unexpended funds to KHPA if they disenroll from *WORK*.
- Consumers have the responsibility to inform their Eligibility worker when they are no longer employed, and to contact their Benefits Specialist to set up an Employment Plan if they want to remain in *WORK* during the six months "grace" period.
- Consumers have the responsibility to communicate any changes in status, needs, problems, etc. to the appropriate KHPA and SRS staff.

- Consumers have the responsibility to inform KHPA or their Independent Living Counselor in a timely manner if they wish to return to an HCBS waiver or waiver waiting list.

8. Representatives

Representatives acting on behalf of individuals will be responsible for the following:

- acting on behalf of, or assisting, participating individuals, and willing to accept the responsibilities of managing their care, including the responsibilities of the consumer listed above.
- a guardian, conservator, or an individual acting on behalf of a customer cannot choose himself/herself as the paid attendant.
- guardians and/or conservators are not allowed to benefit financially from their interactions with the ward and/or conservatee they represent (see K.A.R. 30-5-302)

Representatives may **not** be paid to provide personal assistance services, fiscal management, or Independent Living Counseling. They can assist consumers with these services in an unpaid capacity.

Note - For the purposes of this manual, any time the words consumer/consumers is used it will also mean “and/or representative”.

III. ELIGIBILITY AND ENROLLMENT

1. Eligibility Criteria

The following individuals are eligible for *WORK*:

- eligible for the Kansas Medicaid Buy-In, *Working Healthy*, including;
 - age 16 through 64;
 - determined disabled by the Social Security Administration;
 - earned income verified by FICA/SECA payments;
 - countable net income no higher than 300% of the Federal Poverty Level;
 - assets no higher than \$15,000; and
 - a Kansas resident;
- individuals who demonstrate a need for Activities of Daily Living (ADL) and whose level of care is similar that required for the DD, PD, and TBI HCBS waivers or waiting lists*.
- competitively** employed in an integrated*** setting, earning the federal hourly minimum wage, and earning at least \$65.00 per month; and
- residing in a home or property that is **not** owned, operated, or controlled by a provider of services not related by blood or marriage.

*It is important to note that *WORK* is not a waiver program, and rules for participating are different from HCBS.

** Competitively employed is defined as work performed in the competitive labor market on a full or part-time basis for which individuals are compensated at or above the federal minimum wage, but not less than the customary wage and level of benefits paid a non-disabled individual performing the same or similar work.

*** Integrated setting is defined as a community setting where individuals with the most severe disabilities interact with non-disabled individuals, other than non-disabled individuals who are providing services for them, to the same extent that non-disabled individuals in comparable positions interact with other persons.

2. Enrollment Process

A referral for *WORK* can come from any source, e.g., self-referral, family member, Benefits Specialist, Case Manager, Eligibility Worker, Independent Living Counselor, etc.

Consumers receiving services through HCBS Waivers, or consumers on waiver waiting lists, may contact their Eligibility Workers and indicate their interest in *WORK*. Eligibility Workers will refer interested individuals to the *Working Healthy* Benefits Specialist in their region.

Individuals not already receiving services may contact SRS and begin the application process with an Eligibility Worker. Benefits Specialists will be available to discuss *Working Healthy* and *WORK* with these individuals. Once their Eligibility Worker determines them eligible for *Working Healthy*, they will follow the same process as consumers already in the system.

Benefits Specialists will assist consumers to enroll, including orienting them to *WORK*, providing benefits planning, and reviewing the options of *WORK* versus an HCBS Waiver.

If consumers indicate they would like to enroll in *Working Healthy* and *WORK*, Benefits Specialists will informally determine whether they meet the *Working Healthy* eligibility requirements and, if so, refer them to the KHPA *WORK* Program Manager. The Program Manager will contact the Assessment Contractor to schedule a *WORK* assessment.

Following the assessment, the Assessment Contractor will inform the Program Manager whether consumers require *WORK* services based on the extent of their functional limitations. The Program Manager will inform the Eligibility Worker and Benefits Specialist whether consumers have been determined eligible for *WORK*. Eligibility Workers will then enroll consumers in *Working Healthy* and *WORK*, and inform the *WORK* Program Manager, HCBS Waiver Program Manager, and the Benefits Specialist via the ES-3161 and other methods of communication.

If the assessment results do not indicate a need for *WORK*, the Program Coordinator will refer consumers to Benefits Specialists to discuss options available to them, including enrollment in *Working Healthy* without *WORK*.

3. Loss of Employment

Consumers who become unemployed for medical reasons or are laid off or fired may remain in *Working Healthy* and *WORK* a maximum of six months following the loss of employment. Continued eligibility during a period of unemployment is contingent upon actively seeking employment. Consumers must make a concerted effort to return to work. This may include applying for employment services through Kansas Rehabilitation Services (KRS), seeking employment services from the Kansas Workforce system, or obtaining placement services through an employment agency. Consumers who plan to seek new employment, or return to previous employment, must contact the *Working Healthy* Benefits Specialists in their region and set up a Plan for Employment. If a Benefits Specialist determines that no effort is being made, the Plan for Employment will be canceled and *Working Healthy*/*WORK* eligibility will cease.

Consumers who are unable to locate employment, or determine that their medical condition will not allow them to return to work, should notify the Benefits Specialist as soon as possible during the six-month “grace” period for a smooth transition back to an HCBS waiver, or HCBS waiver waiting list.

4. Dis-enrollment

Consumers may voluntarily dis-enroll from *WORK* at any time. Consumers who are no longer employed, and whose six months re-employment plan has elapsed, will be required to dis-enroll from the program. As the premise of *Working Healthy* and *WORK* are “do no harm”, consumers who were previously on an HCBS Waiver will have the option of returning to that waiver. Consumers who were on a waiting list for a waiver will have the option of returning to the waiting list in the order they would have achieved had they not left the waiting list. The *WORK* Program Manager and their Independent Living Counselor will assist consumers to return to HCBS Waivers or waiting lists. Eligibility Workers may determine eligibility for other Medicaid coverage.

Consumers will be required to “spend down” any assets acquired during their enrollment in *Working Healthy/WORK* in order to meet the income limits required of HCBS waiver participants, or other category of Medicaid eligibility.

IV. ASSESSMENT AND CONSUMER CHOICE

1. Assessment Process

Upon receiving a referral from the Program Manager, the Assessment Contractor will contact individuals within two business days to schedule a time to complete the assessment. The assessment itself will be completed within twenty (20) business days of the initial contact with consumers, subject to the preference of the consumer.

The *WORK* Assessment Instrument is designed to determine whether an individual can perform Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) with or without assistance, the amount of time it requires to perform such activities with or without assistance, and the amount of assistance that may be needed to perform such activities. Based on this information, eligibility for *WORK* will be determined.

Working together, the Assessment Contractor and the consumer will employ the *WORK* Assessment Instrument in order to determine the extent of the consumer's functional limitations and whether *WORK* services are needed in order to live and work in the community. To be eligible for *WORK* services, consumers must demonstrate the need for assistance with ADLs, such as bathing, dressing, eating. A need for assistance with IADLs only, such as house cleaning, yard work, shopping, etc., does not meet the level of care required for *WORK* eligibility.

Consumers are responsible to be available for the initial and re-assessments. If unavailable, they must notify the assessment contractor, and are responsible for re-scheduling the assessment. Consumers who miss the deadline for their re-assessment will no longer be eligible for *WORK* services.

2. Consumer Choice Form

Following a determination of eligibility, consumers will be asked to complete and sign the Consumer Choice Form as an indication that they are making an informed choice to enroll in *WORK*. The Consumer Choice Form includes:

- decision to enroll, or not to enroll, in *WORK*;
- understanding of the allocation and agreement to spend it appropriately;
- decision to self-direct or agency-direct their services;
- decision to use an Independent Living Counselor or not;
- understanding of the impact of the allocation on benefits;
- confidentiality;
- transitioning between *WORK* and HCBS waivers; and
- signature.

V. MMIS Data Entry

1. Medicaid Management Information System (MMIS) Entry

The Program Manager will enter the services approved for *WORK* into the Medicaid Management Information System (MMIS). Entering the approved services and a start date into the MMIS will trigger the monthly allocation and payment of claims for Independent Living Counseling and Assistive Services.

The approved services entered into the MMIS will include:

- demographic information;
- Independent Living Counselor (if employed);
- monthly allocation amount;
- date services, including allocation, will begin and end;
- prior authorization for assistive services; and
- previous Home and Community Based Service (HCBS) Waiver, Waiver waiting list, and eligibility.

2. Independent Living Counseling

Consumers may use the services of an Independent Living Counselor as needed to support self-direction, independent living, and employment. Independent Living Counseling is capped at 480 units (120 hours) annually or ten hours per month. If consumers exceed the monthly cap, they or their Independent Living Counselor may ask the Program Manager to allow them to increase the cap for that month. They can then decrease the number of hours used in later months. If for some reason usage exceeds the annual cap, the consumer or Independent Living Counselor may document the reason additional hours are needed and request an exception from the Program Manager.

3. Allocation Approval

The assessment contractor is responsible for submitting the allocation amount to the Program Manager. The Program Manager will review the assessment to ensure that it has all necessary demographic data, appears to meet the consumers needs based on their functional limitations and health status, that the allocation is consistent with services needed, whether an Independent Living Counselor or fiscal manager will be employed, and that all documentation adheres to state and federal rules, regulations and requirements. If available, the consumer's HCBS waiver Plan of Care and expenditure history will be reviewed and compared to the assessment and allocation for consistency. The Program Manager will then either approve the allocation amount, or send it back to the assessment contractor and consumer for revision.

VI. MONTHLY ALLOCATION AND INDIVIDUALIZED BUDGET

1. Monthly Allocation Determination

The cash allocation will be based on the needs identified during the assessment. The assessment contractor will be responsible for determining the amount of the monthly allocation, informing the consumer of the total dollar value authorized, explaining the methodology for calculating the allocation, explaining policies that the consumer must apply to the management of the individual budget, and procedures the consumer must follow to request an adjustment of the individualized budget.

Consumers who require personal assistance services will have access to such services at home, at work, in the community, during the day, evenings, and weekends. The allocation for the participant to pay for these services will be based on their individual needs. A determination will be made whether the consumer needs personal assistance services to perform personal tasks throughout the day, when assistance is needed, and how many hours of assistance per day the consumer requires. The number of hours of personal services needed per day will be the basis for the monthly allocation.

Note – The monthly allocation does **not** count as income or resources for eligibility purposes, and will not be used in the determination of your premium. Consumers who move to HCBS waivers, or leave *WORK* for any reason, must return any remaining allocation to KHPA within 30 days. If they do not, the remaining allocation may be considered income or resources when determining Medicaid eligibility and HCBS client obligation. KHPA will also seek to re-coup any unspent allocation.

2. Monthly Allocation Formula

The following is the formula for determining the amount of money a consumer will receive per month for personal services:

Y = Hours of service required per day
7 = Days in the week
4.33 = Weeks per month
\$13.25 = Hourly rate
Z = Monthly allocation amount

$$Y \times 7 \times 4.33 \times 13.25 = Z$$

3. Allowed Usages for Monthly Allocation

The monthly allocation will be sent to the consumers or their fiscal agent at the beginning of each month. The allocation may be used to purchase services or goods that support the consumer to live independently and avoid placement in a long-term care facility. Purchases must meet a need listed on the Individualized Budget. Examples of what the allocation may be used for include:

- payment for personal assistance in the home, at work, and in the community; that individuals without disabilities typically perform without assistance;
- background checks for providers of personal services;
- all applicable payroll deductions;
- emergency back-up care;
- alternative methods of purchasing personal assistance, e.g., laundry service;
- payment for equipment that will substitute for personal assistance, e.g., microwave oven;
- smoke/carbon monoxide detectors and batteries; and
- indoor sprinkler system.

The allocation is only to be used for personal assistance or services that allow an individual to function independently, maintain employment, promote health and safety, and avoid admission into a nursing home or other long-term care facility. It may not be used for any other reasons. Examples of what the allocation may **not** be used for include:

- *Working Healthy* premium payments;
- Plan for Achieving Self-Support (PASS);
- gifts for workers, families, friends;
- loans for workers;
- payment for someone to be your representative;
- rent or mortgage payments;
- utility payments (gas, electric, sewage, water);
- clothing;
- groceries (with the exception of special foods required to maintain nutritional status);
- lottery tickets;
- entertainment;
- entertainment devices such as television, DVD players, iPods;
- alcohol or tobacco products; and
- items available through another source, such as employers or Vocational Rehabilitation.

Consumers may contact their Independent Living Counselor or the *WORK* Program Manager if uncertain about the appropriate use of the allocation.

Consumers are not allowed to submit timesheets with costs that exceed their monthly allocation amount. If timesheets are submitted to the Fiscal Manager that exceed the monthly allocation the consumer will be invoiced and expected to make up the amount over the agreed upon allocation and budget. The KHPA reserves the right to request a consumer to put increased management into place and/or to require a consumer to use agency-directed services or leave the program if necessary.

4. Allocation Accounts and Monthly Reporting

Allocated funds must be kept in separate *WORK* checking account, and all expenditures accounted for on the Monthly Allocation Report Form. The fiscal manager must prepare a monthly report of expenditures and carryover funds, and send it to the Program Manager. The fiscal manager is required to maintain documentation for all funds paid out for a minimum of five years. Reports and documentation of expenditures must be available at the request of KHPA or designated auditors.

Consumers managing their monthly allocation independently must send the Monthly Allocation Report to the *WORK* Program Manager for review at the end of each month. The monthly report must include expenditures and carryover. Consumers managing their own monthly allocation are expected to maintain documentation of all payments and purchases for a minimum of five years. Reports and documentation of expenditures must be available at the request of KHPA or designated auditors.

5. Documentation of Expenditures

Documentation of all *WORK* expenditures, including bank records, bills, invoices, and receipts, must be maintained by consumers or the fiscal manager. Allocation checking and carryover fund accounts will be randomly audited by the KHPA or their designee, and consumers or the fiscal manager must provide supporting documentation for all expenditures contained on monthly reports. Documentation should be maintained for a minimum of five years.

6. Development of the Individualized Budget

Development of the Individualized Budget is directed by the consumer/representative and designed to specify how allocated funds will be used to pay for personal services. The services of an Independent Living Counselor may be employed to assist in developing the budget. The process may also include significant individuals identified by the consumer who are able to serve as important contributors to the process.

The Individualized Budget should include the following:

- services to be obtained directly from hired workers, community agencies, and/or independent contractors;
- name(s) of the worker(s) or provider(s), number of hours, hourly rate of pay, number of hours of service, applicable payroll deductions, and total cost;

- alternative service substitutes for personal assistance;
- cost of each alternative service;
- any variable expenditures that provide alternative support;
- fiscal management fees, if applicable;
- cost of the emergency alert system installation and maintenance, if consumers choose this option;
- use of carry-over funds; and
- non-paid supports.

Consumers have the flexibility to pay personal assistants different rates, e.g., to pay an attendant at a higher rate to provide personal care, such as bathing, than an attendant who does laundry and cooking. Consumers also have the flexibility to purchase their services in alternative ways, e.g., pay a neighbor to mow the lawn. They may also make monthly payments for equipment that will reduce their need for personal assistance services, e.g., a front loading washer and dryer that allows them to do their own laundry without help. Monthly payments on equipment must replace payments made to an attendant to perform that service.

Consumers should also list unpaid supports on the Individualized Budget, e.g., a family member or friend providing emergency back-up or performing tasks that would typically require payment.

The Program Manager will review and approve Individualized Budgets prior to the release of Medicaid funds. The review will include whether the budget includes all of the required elements and meets the needs of the consumer.

7. Procedure to Review and Adjust the Monthly Allocation and Individualized Budget

The assessment contractor will conduct a re-determination annually and, if any changes have occurred in the consumer's condition or functional needs, work with the consumer to revise the Assessment, and assign a new allocation. The consumer will develop a new Individualized Budget that reflects the new allocation, and submit it to the Program Coordinator for approval.

If there is a change in the consumer's condition or needs prior to the annual review date, or if any quality issues occur, the consumer may request an adjustment to the allocation. The Contractor will re-assess the consumer's needs, and work with the consumer and any other support people the consumer chooses to include in the process, to develop a revised Individualized Budget with services and supports that meet those needs identified and submit it to the Program Manager for approval.

8. Carryover Funds

Use of Carryover Funds

Consumers may carry-over small amounts of unused monthly allocation, and use this for specific purposes. Accumulated funds may remain in their *WORK* checking account for one month following the month they were to be expended in order to allow all checks to clear. Accumulated funds must be moved to and maintained in a separate *WORK* account and reported on the Monthly Allocation Report. Use of carry-over funds must be listed in the Individualized Budget and approved by the Program Manager. Carryover funds may be used to purchase the following:

- small items that will result in increased independence and a decreased need for personal assistance, e.g., a microwave oven to heat pre-cooked or frozen meals rather than having an assistant prepare meals (requests should be submitted to the Program Manager explaining how the equipment is related to the disability and increases independence);
- advertising costs to recruit personal assistants;
- background checks for personal assistants;
- additional attendant care related to temporary increased need, emergency back-up care, or health insurance and leave for a personal attendant; and
- health or safety items such as Diabetic shoes or carbon monoxide and smoke detectors.

Restrictions

Consumers may not use accumulated funds for the following:

- save for, or purchase outright, high cost items such as a washer or dryer;
- purchase home modifications; and
- purchase any item not related to their disability.

Accumulated funds will be reviewed each month. Only small amounts of funds may be accumulated; large amounts of accumulated funds will result in the monthly allocation being decreased the following month. It may also result in the need to review the assessment and reduce the number of hours. For example, if 25% of the monthly allocation has accrued, the allocation for the following month may be decreased by that same amount. Accruing a full months allocation typically results in the following months allocation being held.

The monthly allocation may also be decreased to more accurately reflect the needs of the consumer. The Program Manager is available to explain to the consumer the reasons for the decrease in the monthly allocation. Consumers will have the opportunity to indicate if extraordinary circumstances contributed to the excessive accumulation of funds, e.g., an inability to find a worker necessitating a family member performing the services without pay.

The monthly allocation may not be used to provide supports when a consumer is away from the home for a hospital stay or vacation.

9. Allocation as Income and Assets

The monthly allocation does not count as income for other programs such as Social Security or Food Stamps. Allocations transferred to a designated carryover account, if the purpose of the savings is documented in the Individualized Budget, does not count against the \$15,000 asset limit.

10. Recouping Funds

In the event that consumers dis-enroll from *WORK*, they are expected to inform the Program Manager and return any unexpended funds to Kansas Medicaid within 30 days. If the savings are not returned voluntarily, the Kansas Medicaid program will re-coup the funds.

11. Mismanagement of Funds

Consumers who mismanage or make inappropriate or incorrect payments using their *WORK* allocation will no longer be permitted to manage their funds and will be required to have an agency direct their services. Consumers will also be required to reimburse KHPA for funds spent inappropriately. KHPA reserves the right to report Medicaid fraud to the Office of the Attorney General.

Organizations providing fiscal management or Independent Living Counseling for *WORK* consumers are expected to inform the Program Manager if they are concerned about how funds are being expended.

VI. Emergency Back-Up Plan

Consumers will be asked to carefully consider, and to document, their resources in the event of an emergency. Included on the plan must be who will provide emergency back-up assistance, their address, and telephone numbers. Who should be notified in the event of an emergency, and their contact information, must be included. Other aspects of emergency back-up will be covered. Consumers will be asked to indicate if they have installed smoke and carbon monoxide detectors and, if so, where. Consumers dependent on technology should indicate how their technology will be powered in the event of a power outage; evacuation plans in the event of a natural or man-made disaster should be considered, and whether personal assistants or local emergency personnel have agreed to assist in the evacuation process. If consumers use service animals or have pets, how they are to be cared for in the event of an emergency should be documented on the Emergency Back-Up Plan.

The Emergency Back-Up Plan will be submitted to the *WORK* Program Manager for approval alone with the Individualized Budget. The Program Manager will review the Emergency Back-Up Plan to determine whether the emergency provisions are adequate. If not, consumers may be asked to review and revise the Plan.

VII. TRAINING

1. Self-Direction Training

Consumers interested in Self-direction Training will have the option to participate in web-based training found on the *Working Healthy* website located at <http://www.workinghealthy.org>. There will also be a link to a website that offers a second Self-Direction Training curriculum.

Consumers who do not have access to a computer or the web may contact the Program Manager to obtain a hard-copy of the Self-Direction Training curriculum. Consumers are free to work individually on the training, with an Independent Living Counselor, representative, or anyone else able to assist them.

This optional training will encompass a variety of topics, including recruiting, interviewing, negotiating rates and performing reference checks, hiring, training, and supervising attendants, recognizing and receiving good attendant services, etc.

2. Fiscal Management Training

An On-Line Fiscal Management Training will also be offered via the *Working Healthy* website. This training is mandatory for consumers who wish to act as their own fiscal manager. It is also mandatory for representatives acting on behalf of consumers. The training will provide consumers with the necessary information, tools, and resource material related to the responsibilities and fiscal obligations as an employer of personal assistants (household employees). The training will include sections on how to obtain an Federal Employer Identification Number (FEIN) and other requirements to become an employer of personal assistants/household employees, how to pay employees on an established schedule, how to pay all applicable taxes and other payroll deductions, how to provide proof of paying payroll deductions, and to understand the consequences for not making and sending deductions to the appropriate federal and state agencies.

Upon completion of their training, consumers, or their representatives, will be required to take and pass a proficiency test before managing their fiscal affairs. Consumers or representatives who have previous experience managing their fiscal affairs will have the option of taking the test and receiving a passing score. Upon receiving a passing score to demonstrate their proficiency, they may assume the role of Fiscal manager. Once the training and test is successfully completed, the program will generate a certificate stating successful completion. A copy of this certificate must be sent to the Program Manager.

VIII. SERVICES

I. Services “Cashed Out”

The following services will be paid by consumers using monthly allocation:

1. Personal Services

Consumers may self-direct their care independently, with the assistance of a representative, and/or with the assistance of an Independent Living Counselor. Consumers may also choose an agency to direct their care on their behalf. Consumers and their Independent Living Counselors are responsible for choosing the agency to provide services and to negotiate an approvable rate for those services.

a. Human Assistance

Personal Services is defined as one or more persons assisting a person with a disability with tasks that the disabled individual would typically do for him/herself in the absence of a disability. Such tasks can be related to personal needs as well as work-related needs. Assistance may be provided at home, in the community, or at work. Such services may include assisting the consumer in accomplishing any Activity of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs).

ADLs include bathing, grooming, toileting, transferring, feeding, and mobility. Health maintenance activities such as monitoring vital signs, supervising and/or training others on nursing procedures, ostomy care, catheter care, enteral nutrition, assistance with or administering medicines, wound care, and range of motion may be provided, including when they are delegated by a physician or registered nurse in accordance with K.S.A. 65-6201 (b)(2)(A), and are documented in the Assessment.

IADLs include shopping, housecleaning, meal preparation, laundry, lawn care. In order to receive assistance with IADLs, consumers must demonstrate a need for assistance with ADLs.

Personal Assistants are reimbursed at a rate determined by the consumer within the parameters established by the allocation. Personal Assistants may be paid different hourly rates based on their responsibilities.

Consumers may choose to use any individual capable of providing the assigned tasks, including legally liable relatives as paid providers of the services. Consumers should be aware that the income of a legally liable relative will be counted as household income, and may increase the consumer's premium, or to become ineligible for *Working Healthy*, and consequently *WORK*, because the household income exceeds the program income limit. Attendants must be 18 years of age to provide paid support for ADL's. Attendants who are 14-18 years of age may provide paid support for IADL's and can work up to 8 hours per day, 40 hours per week as long as they don't start work until after 7:00am and finish by 9:00pm. During the school year they can work no more than 3 hours per day, 18 hours per week and must be done by 7:00pm.

Consumers are strongly encouraged to obtain background checks on any providers of personal services with whom they are not familiar. The monthly allocation may be used to purchase background checks. Consumers are also strongly encouraged to obtain references from previous employers, as well as personal references.

Personal services cannot be reimbursed by any other entity, such as Vocational Rehabilitation.

b. Alternative Assistance

Personal Services also includes alternative and cost-effective methods of obtaining assistance that increase independence, or are a substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance. For example, utilizing a food or laundry service rather than having a personal assistant prepare meals or do the laundry. Flexibility and cost efficiency should be considered when deciding upon alternative assistance.

Consumers must demonstrate that the purchase of alternative assistance is a cost-effective method of obtaining assistance that increases independence, or is a substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

Monthly payments on equipment which increases independence must result in a decrease in the need for human assistance for that same task, e.g., monthly payments on a washer/dryer that is accessible must eliminate the need for a personal attendant to perform this task, thus decreasing the hourly amount paid for human assistance. Use of the allocation to make monthly payments on equipment will result in a decrease in the monthly allocation once the entire purchase is made. Using the example above, the purchase of the washer/dryer eliminates the need for a personal attendant to do the laundry, thereby decreasing the monthly allocation to pay the attendant to perform that task.

c. Work Related Needs

Work related needs include activities necessary to sustain paid employment, such as understanding job responsibilities, interacting appropriately with other employees and the general public and appropriate work behavior, practicing safety measures, symptoms management, etc. Cueing and prompting is considered an appropriate work-related personal service. Work-related services are typically of a nature the person would perform him/herself in the absence of a disability.

Consumers receiving personal services may not reside in a home or property that is owned, operated, or controlled by a provider of services not related by blood or marriage.

Personal services cannot go beyond the scope of the Medicaid program and subsume an employer's responsibilities under Title I of the Americans with Disabilities Act (ADA), and the Kansas Act Against Discrimination. Employer responsibilities include reasonable accommodations that would allow a person with a disability to perform his/her job. Examples include eating, going to the bathroom, interacting with customers, supervisors, and other staff, and symptoms management.

II. Services Paid Fee-for-Service

a. Assistive Services

Assistive Services

Assistive Services includes any item, piece of equipment, product system, or home modification, which is used to increase, maintain, or improve independence and/or employment. Purchase or rent of new or used assistive technology is limited to those items not covered by Medicaid under the State Plan. (Assistive Services funds may not be used to modify garages, fences, yards or out-buildings.)

Assistive Services also includes any service that directly assists an individual with a disability in the selection, acquisition, or use of assistive technology. Consumers may choose, and designate payment for, the provider of their choice. Such services may not include any services already covered by Medicaid under the State Plan. Environmental modifications may be purchased in rented apartments or homes.

The assistive service(s) authorized will be based on the individual and his/her situation, must be medically necessary, and do at least one of the following: increase the consumer's ability to live independently and maintain employment, improve the consumer's health and safety, or prevent nursing home or other institutional placement.

Medical necessity refers to a health intervention that meets the following guidelines:

- be recommended by the treating physician or other appropriate licensed professional in the area of expertise; medical documentation is required (a medical practitioner cannot establish medical necessity outside his/her area of expertise);
- treat a medical condition;
- provide the most appropriate level of service and is known to be effective in improving health outcomes; and
- cost-effective for the condition being treated when compared to alternative interventions.

Assistive Services must be prior authorized by the Program Manager must prior authorize. Consumers must submit a completed Request for Assistive Services Form, a statement of medical necessity from their medical provider, and a minimum of two bids to the Program Manager. When approval is granted the Program Manager will provide an approval letter to the consumer

Examples of Assistive Services

- dentures
- home modifications to increase access, including ramps, grab bars
- emergency alert devices (installation)
- environmental control units
- lifts
- communication devices
- hearing aids and batteries
- insulin pumps and pump supplies
- low vision aids
- motorized wheelchairs or scooters, and repairs
- specialized footwear (Diabetic, Orthopedic)
- specialty beds (such as hospital), specialty mattresses, mattress covers, bed rails
- cost of obtaining and replacing service dogs and other service animals;
- vehicle adaptations (adaptations only)

Examples of Exempted Items

- air conditioners, furnaces, space heaters, humidifiers/de-humidifiers, air purifiers, water purifiers
- appliances such as blenders, microwaves, refrigerators, washers, dryers
- exercise equipment, indoor exercise pools
- heating pads, heat lamps, vaporizers
- home renovations not related to accessibility
- hot tubs, whirlpools
- modifications to buildings in which the consumer does not reside, e.g., garages and sheds
- fence or yard repairs
- surgeries
- water beds
- vehicles

Medicaid is the payor of last resort. Participants must exhaust funding through other sources, including private health insurance, Vocational Rehabilitation, Kansas Accessibility Modification Program (KAMP), community block grants, etc., before requesting assistive services through Medicaid.

b. Independent Living Counseling

Independent Living Counseling is available for consumers who want assistance in setting up and coordinating their services. Independent Living Counseling is an optional service. Consumers who believe they can develop their Individualized Budget and Emergency Back-Up Plan and coordinate all of their services independently may do so. Consumers who choose not to utilize the services of an Independent Living Counselor may work directly with the Program Manager for Individualized Budget and emergency Back-Up Plan approval, prior authorizations, and scheduling of re-assessments. KHPA reserves the right to require consumers to use this service if it is needed for safety or health issues.

Independent Living Counseling has an annual cap of 480 units (one unit = 15 minutes), or 120 hours; however exceptions may be made for consumers who require additional hours. Consumers are not required to use the maximum number of Independent Living Counseling hours that are available each year.

Independent Living Counselors cannot provide personal services or act as a fiscal agent for consumers for whom they are providing Independent Living Counseling. They may, however, be the employees of an agency that provides personal assistance or fiscal management services for consumers.

i). Independent Living Counselor Qualifications

Independent Living Counselors must meet the following qualifications:

- employed by a Center for Independent Living (CIL), Community Developmental Disability Organization (CDDO) or CDDO affiliate, or a licensed Home Health Agency (HHA) that is enrolled as a provider of Independent Living Counseling services;
- a minimum of six months' experience with a disability as recognized by the Rehabilitation Act of 1973; or
- a minimum of one year professional experience providing direct services, including case management (working directly with people with a variety of disabilities); and
- an understanding of independent living philosophy with at least twelve hours of standardized training in the history and philosophy of independent living annually provided by a CIL or the State Independent Living Council of Kansas (SILCK); and
- completed and passed the web-based WORK Independent Living Counseling examination;
- completed a two-hour *WORK* orientation; and
- participate in all state mandated *WORK* and independent living counseling training to ensure proficiency of the program and services rules, regulations, policies, and procedures set forth by the KHPA.

ii). Independent Living Counselor Responsibilities

Independent Living Counselors may perform any of the following:

- demonstrate evidence of consumer involvement at all stages of services and Individualized Budget and Emergency Back-Up Plan development;
- assist in the development of, and obtaining approval for, the Individualized Budget and Emergency Back-Up Plan;
- assure that the Individualized Budget accurately reflects coordination in accordance with the Assessment, consumer health status, service needs;
- assure that choice of providers, emergency back-up plan, and documentation adheres to state and federal rules, regulations and requirements;
- assist in accessing web-based self-direction training;
- assist consumers to access the training and supports to develop the skills necessary to self-direct services, organize workplace accommodations, and otherwise meet goals for independent living;
- assist consumers to locate providers of personal assistance services;
- assist with interviewing, hiring, supervising, and terminating a personal attendant;
- assist consumers in determining and locating alternate, cost-effective methods for purchasing services;
- assist in documenting the need for assistive services, and locating providers of assistive services and supports;
- assist in developing the Emergency Back-Up Plan, locating emergency back-up care and emergency assistance;
- assist in planning for, documenting the use of, and setting up a carryover account for, excess allocated funds;
- assist consumers who do not want to administer their allocation in locating a Fiscal Manager;
- assist consumers who choose to be their own Fiscal Manager administer to access mandatory web-based training and assessment,
- assist in documenting expenditures and submitting documentation in a timely manner;
- assist consumers to maintain and or increase independence and employment and access other systems that will enhance independent living and/or employment;

- assist consumers to determine accommodations needed and to obtain these from employers;
- assist with locating and maintaining other services such as, but not limited to, child care, transportation, and modifications to homes or vehicles;
- provide training and supports to develop the necessary skills to self-direct services, organize workplace accommodations, and otherwise meet goals for independent living;
- coordinate the services of individuals who choose not to self-direct their services;
- monitor and evaluate on a regular basis to assure consumers are being provided services according to the Assessment and Individualized Budget;
- communicate any changes in status, needs, problems, etc., to the appropriate KHPA and SRS staff;
- assist in reporting emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to SRS Adult Protective Services (see K.S.A. 39-1430 and K.S.A. 39-1431);
- assist in scheduling re-assessments for *WORK*;
- assist with dis-enrolling from the program and accessing an HCBS waiver, or waiver waiting;
- assure that the number of service units reimbursed per consumer shall not exceed 480 units (120 hours) per year for Supports Brokerage unless prior authorization has been obtained;
- submit all required paperwork in a timely fashion;
- assure that all documentation adheres to state and federal rules, regulations, and requirements; and
- demonstrate, through surveys, that 95% of consumers receiving services report overall satisfaction with quality, access and adequacy of services.

IX. CONSUMER INFORMATION

1. Premium Payments and Re-Payment Agreements

Working Healthy premiums are billed monthly. Premium payments are due by the end of each month. It is imperative that *WORK* consumers remain current with their premium payments. During the six-month eligibility review, workers determine whether consumers are current in premium payments. If not, consumers must set up a re-payment agreement.

During a re-payment period, consumers must pay their current monthly premium, **and** one-sixth of the amount in arrears. Re-payment deadlines are very strict. Consumers who miss the monthly deadline will lose their *Working Healthy* coverage and *WORK* services. Eligibility Workers will determine eligibility for other Medicaid coverage, including the Medicaid coverage they had prior to enrollment in *Working Healthy*. If they choose to do so, consumers will return to the HCBS waiver, or waiver waiting list, from which they came.

2. Eligibility Reviews

Eligibility for *Working Healthy* is conducted every six months. In addition to determining whether consumers are current with premium payments, Eligibility Workers will ask consumers to submit other paperwork as well. It is crucial for consumers to submit the required paperwork within the designated timeline. If this paperwork is not received, consumers will lose their *Working Healthy* coverage and *WORK* services. Eligibility Workers will determine eligibility for other Medicaid coverage, including the Medicaid coverage they had prior to enrollment in *Working Healthy*. If they choose to do so, consumers may also return to the HCBS waiver, or waiver waiting list, from which they came.

3. Third-Party Liability

Consumers are required to report any third party coverage they have when applying for Medicaid. Providers are required to report if there is third party liability when they file a Medicaid claim on behalf of a consumer. SRS will utilize the State Verification Exchange System (SVES) to determine Medicare entitlement. The contractor for the Kansas MMIS has a contractor who determines whether consumers have Medicare and/or other third party coverage, as well as the scope of the coverage.

X. PROVIDERS

1. Enrollment

Community organizations wishing to provide *WORK* Assessments, Independent Living Counseling, or Assistive Services, must enroll with the KHPA MMIS contractor as a *WORK* provider. This is true even if the community organization is enrolled as a provider of the same, or similar, HCBS waiver services. All enrollment paperwork must be completed and submitted to the MMIS contractor prior to the provision of, or billing of, services.

Providers will have to enroll with the *WORK* Provider Type, and indicate the *Work* Provider Specialties they plan to provide.

- **Provider Type** - The Provider Type assigned to *WORK* is 56. This code indicates that a provider has enrolled to provide at least one of the services available through *WORK*.

- **Provider Specialties include:**
 - **506 (Independent Living Counseling)** – Community organizations eligible to enroll as providers of Independent Living Counseling are CDDOS or CDDO Affiliates, CILS, or licensed Home Health Agencies. Employees of these community organizations must meet the training requirements for an Independent Living Counselor.

 - **522 (Assessment)** – Community organizations eligible to enroll as providers of *WORK* Assessments must be selected by the KHPA. The Assessment Contractor(s), or any agency connected with them cannot provide any other *WORK* services, including independent living counseling, personal services, assistive services, or fiscal management.

 - **526 (Assistive Services)** – Community organizations eligible to enroll as providers of Assistive Services must meet standards set in K.A.R. 129-5-108, or one be of the following: CDDO or CDDO Affiliate, CIL, or Home Health Agency.

2. Procedure Codes

When filing claims for services provided, providers must use the correct Procedure Codes. The Procedure Codes for *WORK* services are:

- T1023 – Assessment (Prior Authorization required);
- T1016 - Independent Living Counseling – reimbursed at the rate of \$10.60 per unit (limit of 480 units annually; Prior Authorization required for additional units); and
- S5165 - Assistive Services – Cap of \$7,500.00 per year (Prior Authorization required).

Copies of the manual as well as all forms, trainings, provider and consumer information can be found on the *Working Healthy/WORK* website.
www.workinghealthy.org

XI. APPEALS

1. Grievance

A complaint about, but not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or KHPA employee, or failure to respect the rights of consumers. A grievance can be made verbally or in writing. A grievance may be filed within six months (180 days) of a consumer's dissatisfaction with the situation. Consumers will be contacted within four working days to determine the specifics of the situation. Disposition of the grievance will be within 30 calendar days. If the disposition of the grievance cannot be completed in this timeframe, the consumer will be notified of the expected date of the disposition.

2. Actions

Consumers have the right to appeal actions of the KHPA. An action is defined as the denial or limited authorization of a requested service, including the type of level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility. Dissatisfied consumers may request an internal appeal, or go directly to a fair hearing.

3. Internal Appeal

An internal appeal may be filed verbally, but must be followed by a written request for an internal appeal. The internal appeal must be filed within 30 calendar days of the receipt of the notice or action. The internal appeal must be resolved within 30 calendar days or, if not resolved, the appellant must be notified of the expected day of resolution. The final resolution, with extension, shall be no more than 45 calendar days from the day the appeal is received. Consumers dissatisfied with the internal appeal resolution may make a written request for a Fair Hearing.

4. Fair Hearing

Consumers dissatisfied with the appeal resolution may make a written request for a Fair Hearing to the Office of Administrative Hearings. The request must be in writing within 30 days of the notice of the appeal resolution, with three additional days added to allow for delivery via mail. All hearing dates, resolutions, and notifications will follow the timelines prescribed by the Office of Administrative Hearings within 90 days of when the appeal is filed. The decision of the Hearing Office will be based on the facts presented, and the laws and regulations related to the issue. The appellant must be notified by mail of the decision. Consumers dissatisfied with a decision have the right to file a petition for a Judicial Review in the appropriate District Court within 30 days of the order being issued.

XII. QUALITY ASSURANCE

1. Provider Capacity and Capabilities

KHPA is confident that existing provider networks will be sufficient to support *WORK* and will work to ensure that:

- the Assessment Contractor(s) chosen to perform assessments will be able to do so in a timely fashion;
- a sufficient number of community providers will be available, including CDDOS, CILS, and state licensed Home Health agencies, to provide Independent Living Counseling services;
- consumers will be able to locate people who provide personal assistance services, possibly with the assistance of CDDOS, CILS, and state licensed Home Health agencies, and other community providers;
- consumers will be able to identify alternative methods for obtaining personal services; and
- a fiscal management service will be available for individuals who choose not to manage their allocation.

2. Consumer Access

For *WORK* to be successful it is essential that consumers are knowledgeable about the services available and able to access them, and assures that:

- marketing of *WORK* will be a thorough, statewide effort to ensure that consumers and providers have sufficient information regarding the new demonstration;
- consumers will have a clear understanding of *WORK* eligibility criteria, how to enroll, what services are provided, etc.;
- eligibility for *WORK* will be determined within 30 days of application;
- *WORK* will have no waiting list;
- consumers will have the support necessary to develop their Individualized Budget; and
- consumers will be able to locate personal assistants, Independent Living Counselors, and fiscal management services.

3. Consumer-Centered Service Planning and Delivery

Consumers will be integral to the *WORK* planning process, including:

- Benefits Specialists will be available to provide benefits planning, orientation, and assistance to make as informed choice regarding *WORK*;
- the Contractor(s) will perform the assessment in a timely and professional manner;
- the consumer and Contractor will develop the Assessment together, and include significant persons and/or an Independent Living Counselor in the development process as the consumer desires;
- consumers will be able to develop their Individualized Budgets, and to include significant persons and/or and an Independent Living Counselor in the development process;
- consumers are free to hire personal assistants of their choice, to pay them a wage within the parameters of their allocation, and to schedule personal assistants to meet their personal needs;
- consumers will be able to use their allocation to purchase their personal assistance in alternative ways if they deem it more cost-effective and still meet their needs;
- consumers will be able to choose an Independent Living Counselor from a variety of community providers, including but not limited to, CDDOS, CILS, and state licensed Home Health agencies;
- consumers will not be limited to providers specific to their disability, nor are they limited to providers specific to their geographic areas;
- consumers who do not feel the need for an Independent Living Counselor are free to coordinate their services without one, however, KHPA reserves the right to require consumers to use this service if it is needed for safety or health issues, and;
- consumers who wish to are free to perform their own fiscal management once they have successfully completed a Fiscal Management training program, or to use the fiscal agent chosen by KHPA.

4. Consumer Safeguards

While respecting the right of consumers to control and direct their supports, KHPA is also committed to their health and safety, including the following safeguards:

- consumers, with the assistance of significant persons and/or an Independent Living Counselor if desired, will develop their emergency back-up plan, document this on the KHPA Emergency Back-Up Plan form, and submit to KHPA for approval;
- consumers will maintain a copy of the Emergency Back-Up Plan and make it available to the appropriate individual;
- KHPA will review the Emergency Back-Up Plan to determine whether the necessary safeguards, and either approve the plan, or return it to the consumer with recommendations;
- KHPA will maintain approved Emergency Back-Up Plans on file;
- consumers will have the option to obtain background checks on their personal attendants;
- consumers will be educated about Medicaid fraud and abuse, and its consequences;
- consumers have the right to appeal any decisions related to *WORK*;
- consumers may file a grievance expressing dissatisfaction with aspects of *WORK*;
- KHPA will investigate all crises or critical events;
- consumers will be given information about abuse, neglect, exploitation, and fiduciary abuse, and provided with the SRS contact information for reporting purposes;
- SRS will collect and maintain data regarding the number of reports of abuse, neglect, exploitation, and fiduciary abuse, whether founded or unfounded, and the action taken; and
- SRS will analyze this data for patterns indicating problems within the program, and inform the KHPA Program Manager in order that program adjustments may be made.

5. Consumer Outcomes and Satisfaction

i. Outcomes

- Consumers with developmental, head injury and physical disabilities, as well as those with severe and persistent mental illness, requiring personal attendant services to live and work in the community, will have these services available to them.
- Consumers with developmental, head injury and physical disabilities, as well as those with severe and persistent mental illness, requiring personal attendant services to live and work in the community, will be able to enroll in *Working Healthy*.
- The *WORK* demonstration will result in an increasing number of people with developmental, head injury and physical disabilities, and severe and persistent mental illness, becoming employed.
- The *WORK* demonstration will result in improved ability to live and work in the community, as perceived by consumers accessing the demonstration.

ii. Satisfaction

Consumers will be given the opportunity to complete *WORK* satisfaction surveys following the first six months of enrollment and annually thereafter, which will assess such issues as:

- satisfaction with the Contractor;
- satisfaction with the Supports Broker, if using one;
- satisfaction with Fiscal Management Services, if using one;
- satisfaction with their personal attendants;
- satisfaction with the SRS staff involved in *WORK*; and
- overall satisfaction with *WORK*.

Consumers will also be given the opportunity to complete “*Quality of Life*” surveys related to the *WORK*, which will assess such issues as:

- perceived impact on their ability to live independently;
- perceived impact on their ability to access their community;
- perceived impact regarding ability to maintain or enhance employment opportunities;
- perceived impact on their economic status; and
- perceived impact on their health status.

Consumers who dis-enroll from *WORK* will receive a survey requesting the following information:

- reason(s) for leaving;
- whether any of their needs were unmet while enrolled on the waiver; and
- whether they received assistance from KHPA, Benefits Specialists, or Independent Living Counselors to access other services; and
- Benefits Specialists will conduct face-to-face interviews of *WORK* enrollees annually to discuss their satisfaction with services, the program, etc.

6. Systems Performance

Systems performance will be measured in a number of ways, including:

- consumer' satisfaction with *WORK*;
- consumers' perception of the impact of *WORK* on the their quality-of-life;
- financial auditing of the use of allocated funds;
- number of complaints received, and outcomes of the complaints;
- number of grievances filed, and outcomes of the grievances;
- number of appeals filed, and outcomes of the appeals;
- number of reports of abuse, neglect, exploitation, and fiduciary abuse, and actions taken;
- number of Medicaid Fraud and Abuse investigations related to *WORK*;
- contractor input;
- provider organizations input;
- advocacy organizations input; and
- *Working Healthy* Advisory Council input.

XIII. GLOSSARY OF TERMS

Abuse –Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult, including:

- infliction of physical or mental injury;
- any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable of resisting or declining consent to the sexual act due to mental impairment or disease or due to fear of retribution or hardship;
- unreasonable use of physical restraint, isolation or medication that harms or is likely to harm an adult;
- unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician’s orders or as a substitute for treatment, except where such conduct or physical restraint is in the furtherance of the health and safety of the adult;
- a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult;
- fiduciary abuse; or
- omission or deprivation by a caretaker or another person of goods or services that are necessary to avoid physical or mental harm or illness.

Activities of Daily Living (ADL) – Includes bathing, grooming, toileting, transferring, feeding, and mobility. Health maintenance activities such as monitoring vital signs, supervising and/or training others on nursing procedures, ostomy care, catheter care, enteral nutrition, assistance with or administering medicines, wound care, and range of motion may be provided, including when they are delegated by a physician or registered nurse in accordance with K.S.A. 65-6201 (b)(2)(A), and are documented in the Assessment.

Adult Protective Services – Department of Social and Rehabilitation Services (SRS) program charged with intervention activities directed towards safeguarding the well-being and general welfare of adults in need of protection. The intent of Adult Protective Services is to protect the most vulnerable adults from harm while safeguarding their civil liberties.

Advocate - An advocate is one who speaks on behalf of another.

Agency Directed – Services are coordinated and directed by an agency rather than the consumer.

Affiliate - Is defined in K.S.A. 39-1803 (b) as an entity or person that meets standards set out in rules and regulations adopted by the secretary relating to the provision of services and that contracts with a Community Developmental Disabilities Organization (CDDO).

Allocation – Funds allotted monthly for consumers to purchase personal services.

Assessment – Face-to-face interview and evaluation with an authorized assessor to determine the need for personal services at home, in the community, and at work. This document will delineate what services are needed by the consumer when the services are needed, providers and/or natural supports who will provide the service, total number of hours needed, and funds allocated monthly to purchase services.

Assistive Services - Any item, piece of equipment, product system, or environmental modification, which is used to increase, maintain, or improve independence and/or employment, and any service that directly assists an individual with a disability in the selection, acquisition, or use of assistive technology.

Attendant Care – Services providing assistance with daily living, self-care, and mobility which enables individuals with disabilities to carry out activities of everyday life in their home and community rather than in an institution,

Benefits Specialist – Staff person located trained to evaluate the impact that employment and earnings will have on an individual’s federal, state, and local benefits, which will allow consumers to make an informed choices about employment or increasing earnings.

Cash and Counseling – Nickname for programs that allows funds to be paid directly to, and managed by, consumers, in order to purchase personal services.

Center for Independent Living (CIL) – A consumer-run, community based, non-residential, private, and not for profit organization whose primary function is to provide at least the following five core services: independent living skills training, advocacy, peer counseling, information and referral services, and de-institutionalization.

Community Developmental Disability Organization (CDDO) - Any community mental retardation facility organized pursuant to K.S.A. 19-4001 through 19-4015, established and operating as of the effective date of K.A.R. 30-64-01 et seq.

Competitive Employment - Work performed in the competitive labor market on a full or part-time basis for which individuals are compensated at or above the federal minimum wage, but not less than the customary wage and level of benefits paid a non-disabled individual performing the same or similar work.

Choice Form – A document signed by a consumer indicating he/she has made an informed choice regarding whether to enroll in *WORK*, use a fiscal manager, Independent Living Counselor, etc.

Consumer – A person receiving services.

Cost Effective - The cost of utilizing a service is recovered by the savings generated from avoiding necessary utilization of a more expensive service.

Cost Efficient - Using all of the available formal and informal service systems to meet individual needs.

Crises/Critical Event - Any event with negative consequences that is substantial or significant in an individual's life.

Developmental Disability Waiver – A Home and Community Based Services (HCBS) waiver that serves individuals age 5 and up, meeting the definition of mental retardation or developmental disability, and eligible for ICF/MR level of care.

Durable Medical Equipment (DME) – Is defined as equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is appropriate for use in the beneficiary's home; and
- generally is not useful to a person in the absence of illness or injury.

Effective Date - The date on which a program or service begins and on which provider can be reimbursed for services.

Eligibility – Meeting the enrollment criteria for a Medicaid program, including *Working Healthy* and *WORK*.

Eligibility Worker – An SRS employee who reviews applications for Medicaid services determines whether criteria is for a specific category of services, enrolls applicants by entering their data into KAECSES, the eligibility data system.

Emergency Back-Up Plan – A document detailing how services will be provided if the scheduled worker cannot come to work, and in the event on man-made or natural disasters.

Exploitation – Misappropriation of an adult's property or intentionally taking an unfair advantage of an adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

Fair Hearing - The opportunity to be heard or to present one's side of a case, free from prejudice or favoritism.

Fiduciary Abuse – A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult who takes, secretes, or appropriates their money or property to any use or purpose not in the due and lawful execution of such person's trust or benefit.

Federal Insurance Contributions Act (FICA) – United States employment tax imposed in an equal amount on employees and employers to fund federal programs for retirees, the disabled, and children of deceased workers. The FICA tax pays for Social Security and Medicare. The Federal Insurance Contributions Act is codified as 26 U.S.C.

Fiscal Manager – Manages, and maintains an accounting of, the monthly allocation on behalf of the *WORK* participant.

Grievance – A verbal or written expression of dissatisfaction regarding, but not limited to, quality of care or services provided.

Health Maintenance Activities - Services authorized by a nurse or doctor that are performed by a personal care attendant. Including, but not limited to monitoring vital signs, ostomy/catheter care and medication administration/assistance.

Home and Community Based Services (HCBS) - Services provided in accordance with a federally approved waiver to the Kansas Medicaid State Plan which are designed to prevent unnecessary use of institutional services at a cost no higher than that of institutional care.

Home Health Agency (HHA) - A public or private agency or organization that provides, for a fee, one or more home health services at the residence of the consumer. The HHA must be licensed by the Kansas Department of Health & Environment and/or Medicare certified.

Independent Living Counseling - Services designed to coordinate and integrate all other services required in the individual's Assessment.

Independent Living Counselor (ILC) - An individual certified by state standards and performing the functions of an ILC as defined in the *WORK* Provider Manual and the *WORK* Program Manual. The goal of the ILC is to foster and maximize a consumer's independence through his/her individual strengths by providing accurate information regarding the available choices, and assisting them to access these services.

Individual Development Account (IDA) – A savings account typically administered and matched by community-based organization and used for home purchases, education and training, and small business start-up. In Kansas, an IDA may also be used for assistive technology.

Individualized Budget – A personalized blueprint indicating how the allocation will be utilized, including who will be paid, how much, and for what services.

Informal Services - Any needed or desired service provided voluntarily to a consumer by any organization, agency, friend or family member at no cost to the Medicaid program. This is also referred to as “natural supports.”

Integrated Setting – Integrated setting is defined as a community setting where individuals with the most severe disabilities interact with non-disabled individuals, other than non-disabled individuals who are providing services for them, to the same extent that non-disabled individuals in comparable positions interact with other persons.

Instrumental Activities of Daily Living (IADL) – Housecleaning, laundry, meal preparation, laundry, money management, lawn care, telecommunications, and transportation.

Kansas Health Policy Authority (KHPA) – The state agency responsible for administering the Medicaid program, as well as other health programs, in Kansas.

Level of Care - Functional needs of consumers, as determined through an assessment or reassessment, based on the ability to perform ADLs and IADLs during the normal rhythms of the day, and taking into consideration risk factors.

Medicaid Management Information System (MMIS) - The system used to pay the claims for services provided, and data for reporting purposes.

Neglect – The failure or omission by one’s self, caretaker, or another person, to supply or provide goods or services that are reasonably necessary to ensure safety and well-being and/or to avoid physical or mental harm or illness.

Normal Rhythms of the Day -The average time frame in which an individual without a physical disability typically completes clusters of ADLs and IADLs.

Nursing Facility - A facility which: a.) meets state licensure standards; b.) provides health related care and services, prescribed by a physician; and c.) provides residents with 24 hour per day, seven days per week, licensed nursing supervision for ongoing observation, treatment, or care for long term illness or injury.

Personal Care Attendant - Person who provides physical assistance with Activities of Daily Living, Instrumental Activities of Daily Living, and health maintenance activities for individuals who are unable to perform one or more of these activities independently.

Personal Emergency Response - 24 hour a day on-call support to a consumer having a medical or emergency need.

Personal Services - One or more persons assisting a person with a disability with tasks that the disabled individual would typically do for him/herself in the absence of a disability. Such tasks can be related to personal needs as well as work-related needs. Assistance may be provided at home, in the community, or at work. Such services may include assisting the consumer in accomplishing ADLs and Instrumental IADLs.

Personal Services also includes alternative and/or cost-effective methods of obtaining assistance that increases independence, or are a substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance. For example, monthly payments on a front loading washer and dryer, eliminating the need for an assistant to perform this task, purchasing a microwave oven and heating meals rather than having an assistant prepare meals, utilizing a laundry service rather than having a personal assistant do the laundry, contracting with a lawn service versus having a personal assistant mow the lawn, etc.

Physical Disability Waiver –An HCBS Waiver that serves individuals age 16-64, determined disabled by SSA, needing assistance with the Activities of Daily Living, and eligible for nursing facility care.

Prior Authorization – Approval of a service by a designated agency representative before it can be provided and billed.

Program Manager – Agency person responsible for coordinating all activities related to *WORK*.

Quality Assurance – A set of activities intended to monitor standards regarding support services.

Reassessment - A review and evaluation of the consumer’s continued need for services, typically completed annually or if the consumer experiences a significant change in condition.

Recipient - A person receiving services.

Representative – A person acting in an unpaid capacity who assists an individual with the disability in presenting his/her point of view, making an informed choice, and assisting in choosing and obtaining services.

Reimbursement - The dollar value assigned to a covered service.

Self-Advocate – A person needing support services who makes choices and decisions regarding his/her chosen lifestyle.

Self-Direction - An option allowing consumers to live and work safely in the community while directing their own services.

Self-Employment Contributions Act of 1954 (SECA) - A tax law that requires the owners of small businesses-such as S corporations, partnerships, and sole proprietorships-to pay a tax of 15.3 percent of their net income from self-employment to cover their own Social Security, Medicare, and Old Age Survivors and Disability Insurance (OASDI) costs.

Social and Rehabilitation Services (SRS) – The agency that determines eligibility for Medicaid and Working Healthy. SRS is also responsible for other human service programs.

Spend Down – A Medicaid term used to describe the difference between the consumer’s countable income and the Medicaid income limit. Consumers with funds above the Medicaid limit must “spend down” their excess income on medical expenses before receiving a Medicaid card.

Stakeholder - Any person with a disability, individual or entity with an interest in the lives of persons with disabilities.

Supports – Assistance that enables a person to live and work in the community.

Termination Date - The last day on which a program or service will be reimbursed. This date should not extend beyond the last day of Medicaid eligibility.

Timely Filing - The receipt by the agency or its fiscal agent of a claim for payment from a provider for services provided to a Medicaid program consumer. The claim for payment should be submitted no later than 12 months after the date the claimed services were provided.

Third Party Liability – Any health insurance besides Medicaid that must pay for services before Medicaid pays. The Medicaid program by law is intended to be the payer of last resort; that is, all other available resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

Traumatic Brain Injury Waiver – An HCBS waiver that serves individuals age 16-65, having traumatic, non-degenerative brain injury resulting in residual deficits and disabilities, and eligible for inpatient care in a Head Injury Rehabilitation Hospital.

Work-Related Needs - Activities necessary to sustain paid employment, such as understanding job responsibilities, interacting appropriately with other employees and the general public and appropriate work behavior, practicing safety measures, symptoms management, etc. Cueing and prompting is considered an appropriate work-related personal service. Work-related services, or cued/prompted are typically of a nature the person would perform him/herself in the absence of a disability.

XIV. APPLICABLE KANSAS ADMINISTRATIVE REGULATIONS AND KANSAS STATUTES

Following are the Kansas Statutes (K.S.A.) and Administrative Regulations (K.A.R) that apply to *WORK*:

K.A.R. 30-5-301 - Provider participation.

(a) Each provider shall meet the provider participation requirement specified in K.A.R. 30-5-59, including record keeping requirements, and the following additional requirements: (1) All assessment records; (2) All plan of care records, and (3) All case file documentation records.

K.A.R. 30-5-302 – Limitations for independent living counselors.

(a) An independent living center shall not use any consumer as an independent living counselor when that consumer receives services from the same independent living counseling agency.

K.A.R. 129-5-118 – Scope of federally qualified health center services.

Pertains to the scope of federally qualified health center services and cost reimbursement principals for federally qualified health center services and other ambulatory services.

K.S.A. 39-1430 – Abuse, neglect, or exploitation of certain adults; definitions.

This section refers to reporting the abuse, neglect, and exploitation of the certain persons which the law defines as “Mentally Ill, Incapacitated and Dependent Persons.”

K.S.A. 39-1431 – Abuse, neglect or exploitation of certain adults; reporting abuse, neglect or exploitation or need of protective services; persons required to report; penalty for failure to report; posting notice of requirements of act.

This section on the reporting of abuse, neglect or exploitation delineates those individuals who are required to report such incidents and states the penalty for failure to do so.

K.S.A 39-1803 – Definitions.

This section defines (e) “Community service provider” means a community developmental disability organization or affiliate thereof.

K.S.A. 65-1124 – Acts which are not prohibited.

This section refers to acts which are NOT prohibited by law. The most important of which is letter ‘m’ which states that “no provisions of this law shall be construed as prohibiting performance of attendant care services directed by or on behalf of an individual in need of in home care as the terms “attendant care services” and “ individual in need of in home care” are defined.

K.S.A. 65-5101 – Definitions.

This section defines Home Health Agencies and Centers for Independent Living.

K.S.A. 65-5102 – Home health agencies required to be licensed.

An entity that is a home health agency may not provide services with the exception of non medical attendant services, unless it is licensed.

K.S.A 65-6201 – Individuals in need of in-home care; definitions.

This section includes the definitions described above and sets the exemption to the nurse practice act by defining health maintenance activities: includes but are not limited to, catheter irrigation, administration of medications, enemas and suppositories; and wound care, if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home.