



*Work Opportunities
Reward Kansans*

WORK

Program Manual



Working Healthy
Making health care work

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This manual and all of the *WORK* forms are available online at
<http://www.kdheks.gov/hcf/workinghealthy/work.htm>

Table of Contents

KANCARE 6

PROGRAM DESCRIPTION..... 7

 1. *WORKING HEALTHY* 7

 2. *WORK OPPORTUNITES REWARD KANSANS (WORK)*..... 7

ELIGIBILITY 9

 1. ELIGIBILITY FOR *WORKING HEALTHY*..... 9

 2. ELIGIBILITY FOR *WORK* 9

ENROLLMENT/DISENROLLMENT 10

 1. ENROLLMENT 10

 2. DIS-ENROLLMENT 11

NEEDS ASSESSMENT 12

 1. ACTIVITIES OF DAILY LIVING (ADLs)..... 12

 2. INSTRUMENTAL ACTIVITES OF DAILY LIVING (IADLs) 12

 3. WORK RELATED SERVICES 13

CONSUMER AGREEMENT FORMS AND EMERGENCY BACK-UP PLANS 14

 1. Consumer Agreement Form..... 14

 2. Emergency Back-Up Plan..... 14

SERVICES 16

 1. PERSONAL SERVICES 16

 a. Definition of Personal Services..... 16

 b. Self-Direction of Personal Services 16

 c. Agency-Direction of Personal Services 17

 d. Self and Agency Direction of Services 17

 e. Background Checks for Personal Assistants..... 17

 f. Personal Services Restrictions 18

 2. ASSISTIVE SERVICES 18

 a. Definition of Assistive Services..... 18

 b. Alternative Funding Sources..... 20

 c. Medical Necessity 20

 d. Prior Authorization for Assistive Services..... 20

 e. Assistive Service Requests..... 21

f.	Assistive Service Verification.....	21
g.	Medicaid Fraud and Abuse	21
h.	Assistive Services Restrictions	21
3.	INDEPENDENT LIVING COUNSELING.....	22
a.	Independent Living Counselor Responsibilities	22
b.	Independent Living Counselor Qualifications	23
c.	Independent Living Counseling Restrictions	24
	PAYMENT FOR SERVICES	25
1.	PERSONAL SERVICES	25
a.	Monthly Allocation.....	25
b.	Formula to Determine the Monthly Allocation.....	25
c.	Allowed and Disallowed Usages of the Monthly Allocation.....	26
d.	Adjusting the Monthly Allocation	27
e.	Monthly Allocation Restrictions	27
f.	Individualized Budget.....	28
g.	Carryover Funds.....	29
h.	Allowed uses of carryover funds	29
i.	Prohibited uses of carryover funds.....	30
j.	Mismanagement of Funds.....	30
2.	PAYMENT FOR ASSISTIVE SERVICES AND INDEPENDENT LIVING COUNSELING	31
	FISCAL MANAGEMENT.....	33
1.	CUSTOMER SERVICE	33
2.	EMPLOYER-OF-RECORD	33
3.	EMPLOYEES AND OTHER SERVICE PROVIDERS	34
	CONSUMER RESPONSIBILITIES AND RIGHTS.....	36
1.	CONSUMER RESPONSIBILITIES	36
2.	CONSUMER RIGHTS	37
	GRIEVANCES AND APPEALS	39
1.	MCO GRIEVANCE/APPEAL PROCESS	39
a.	Grievance	39
b.	Appeal	39
c.	Expedited Appeal.....	39

3. STATE APPEAL PROCESS..... 39

- a. State Fair Hearing 39
- b. KDHE State Appeals Committee (SAC) 40
- c. Judicial Review 40

KANCARE CONSUMER OMBUDSMAN..... 40

GLOSSARY OF TERMS..... 41

APPLICABLE KANSAS ADMINISTRATIVE REGULATIONS AND KANSAS STATUTES..... 49

KANCARE

The State of Kansas' Medicaid program became KanCare on January 1, 2013. The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. Consumers in KanCare will receive all the same services provided under the previous Medicaid delivery system, plus additional services. In addition to the services that were available to Medicaid consumer prior to 2013, the three health plans offer new services to their members, such as preventative dental care for adults, heart/lung transplants and bariatric surgery.

Kansas contracted with three new health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. Each Medicaid consumer is assigned to one of the KanCare health plans. The KanCare health plans are required to coordinate all of the care a consumer receives.

The administration of KanCare within the State of Kansas is carried out by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS). The Department of Children and Families (DCF) continues to determine eligibility for adults with disabilities who are in KanCare.

This manual details the policies and procedures of the *Work Opportunities Reward Kansans (WORK)* program under KanCare.

PROGRAM DESCRIPTION

1. WORKING HEALTHY

Working Healthy, the Kansas Medicaid Buy-In program, is an employment incentive program designed for people whose income exceeds the Medicaid limit, but whose health needs are significant. Medicaid Buy-In programs were authorized under the Ticket-to-Work and Work Incentives Improvement Act of 1999 (TWWIIA) to encourage people to work, increase their income, and accumulate assets in order to reduce long term reliance on public supports.

Consumers eligible for *Working Healthy* are those typically in a Medicaid eligibility category called “Medically Needy”. People in this category only receive Medicaid health care coverage once they “spend down” their excess income on medical expenses during a six-month period. Every six months the “spend down” period starts over.

Working Healthy incentivizes employment by allowing people to increase their income without incurring a higher “spend down” or losing their eligibility for Medicaid coverage completely. *Working Healthy* substitutes an affordable premium for the “spend down”.

Working Healthy Benefits

In addition to eliminating spend down and substituting a more affordable premium, other benefits include:

- consistent Medicaid coverage
- ability to earn more income without loss of medical coverage
- savings up to \$15,000 per household
- unlimited retirement accounts
- assistance with Medicare expenses
- in some instances, payment of employer premiums
- benefits planning and assistance
- *WORK* services
- Medicaid coverage even when determined by Social Security to be “Medically Improved”

2. WORK OPPORTUNITIES REWARD KANSANS (WORK)

Consumers eligible for *Working Healthy* who need assistance with activities of daily living receive personal assistance services through *Work Opportunities Reward Kansans*, or *WORK*. *WORK* includes an assessment to determine the need for personal assistance service, Personal Assistance Services (PAS), Independent Living Counseling (ILC), and Assistive Services.

While the services may seem similar, *WORK* is not a Home and Community Based Services (HCBS) Waiver. *WORK* was authorized under the Deficit Reduction Act (DRA) of 2005,

Section 6044 - State Flexibility for Medicaid Benefit Packages. Section 6044 provided a mechanism for states to create a “benchmark” or “benchmark-equivalent” benefits packages, tailored to meet the needs of a specific Medicaid group as an alternative to the State’s Medicaid Plan, waiving comparability.

Unlike Kansas HCBS Waivers, *WORK* employs a Vendor Fiscal/Employer Agent model. This model goes beyond consumer self-direction, i.e., hiring, training, supervising, and terminating workers, by providing consumers with employer and budget authority. In this model, consumers who choose to self-direct their services are the Employer of Record, and a vendor performs the standard fiscal management duties on behalf of the consumer. The funds for personal assistance and alternatives to personal assistance are provided up front to the vendor, and the vendor makes payments based on an Individualized Budget developed by the consumer.

Note: Consumers accessing *WORK* services may select a representative to act or assist them to manage their services. Throughout this document, where the words consumer or consumers are used, the words representative or representatives may be substituted. Representatives may assist consumers to manage their services in an unpaid capacity. Representatives may not be paid to provide personal assistance services, fiscal management, or Independent Living Counseling.

Guardians and conservators cannot provide services paid by *WORK* funds.

ELIGIBILITY

1. ELIGIBILITY FOR *WORKING HEALTHY*

To be eligible for *Working Healthy*, an individual must:

- be 16-64 years of age
- meet the Social Security definition of disability
- have verified earned income which is subject to FICA/SECA taxes
- earn a minimum of \$65.01/month, if employed by an employer, or earn \$85.01 a month, after employment related expenses are deducted
- have earnings at or above the federal minimum wage (unless self-employed)
- be a Kansas resident

The Department of Children and Families (DCF) eligibility workers determine eligibility for *Working Healthy*. Managed Care Organization (MCO) Case Managers complete an assessment to determine whether consumers eligible for *Working Healthy* are eligible for *WORK* services, and inform the DCF eligibility worker by completing the 3161 form and sending these to the DCF eligibility workers.

2. ELIGIBILITY FOR *WORK*

To be considered for *WORK* services, consumers must meet the *Working Healthy* eligibility listed above. In addition, consumers must

- be receiving services on the Intellectual/Developmental Disability (I/DD), Physical Disability (PD), or Traumatic Brain Injury (TBI) Waivers, or
- be on the waiting lists to receive services through these waivers, or
- demonstrate a need for a similar level of care as individuals on these waivers DD, PD, or TBI waivers or waiver waiting lists.

Individuals with physical disabilities and traumatic brain injury must demonstrate a need for assistance with ADLs in order to be eligible for *WORK* services and receive assistance with IADLs. Demonstrating the need for ADL's is sufficient even if hours are not added to the allocation total due to natural supports. 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.

Individuals with intellectual/development disabilities may demonstrate a need for hands-on assistance with ADLs, and/or cuing or prompting to perform ADLs, and/or assistance with IADLs and work-related supports.

ENROLLMENT/DISENROLLMENT

1. ENROLLMENT

A referral for *Working Healthy*/*WORK* may come from any source. Consumers not already receiving services may contact the DCF and begin the application process with an eligibility worker. Consumers receiving services through HCBS Waivers, or on waiver waiting lists, may contact their DCF eligibility worker and indicate their interest in *Working Healthy* and *WORK* services.

Consumers interested in *Working Healthy*/*WORK* will be referred to the Benefits Specialist in their region. Benefits Specialists assist people to enroll in *Working Healthy* and to access services through *WORK*. They provide an orientation to *Working Healthy* and *WORK*, benefits planning, and review the option of *WORK* versus an HCBS Waiver and other options. If the consumers are interested in *Working Healthy*/*WORK*, the Benefits Specialist will informally determine

- whether the consumer meets the *Working Healthy* eligibility criteria, and
- does the consumer appear to have a need of *WORK* services.

If so, the Benefits Specialist will refer the individual to a DCF eligibility worker for a formal determination of *Working Healthy* eligibility, and to the *WORK* Program Manager for a *WORK* needs assessment.

The *WORK* Program Manager will refer eligible consumers to their MCO Case Manager for a *WORK* needs assessment. Following the needs assessment, the Case Manager will inform the *WORK* Program Manager whether the consumer needs *WORK* services to live and work in the community. If services are needed, the *WORK* Program Manager will coordinate a start date for *WORK* services with the consumer, MCO Case Manager, Independent Living Counselor, and DCF.

WORK services begin on the first day of the month (there is no retroactive eligibility for *WORK* services). Before *WORK* services can begin, the assessment must be complete and the monthly allocation determined, an Individualized Budget must be submitted and approved, all Employer-of-Record and Employee paperwork must be complete, and the 3160 form sent to DCF by the 18th of a month for a *WORK* case to open the first day of the following month.

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

2. DIS-ENROLLMENT

Consumers who are no longer employed are no longer eligible for *Working Healthy*, and therefore no longer eligible for *WORK* services. DCF will close their case as *Working Healthy/WORK*, possibly determining eligibility for other Medicaid coverage.

Consumers who were previously on HCBS Waivers will have the option of returning to those waivers. Consumers who were on waiting lists for waivers 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, MCO Case Manager and the Independent Living Counselor will assist consumers to return to HCBS Waivers or waiting lists.

Consumers may also voluntarily choose to leave *Working Healthy/WORK* at any time, and the above process will still apply.

NEEDS ASSESSMENT

In order to determine the need for personal assistance, an assessment must be completed. The MCO Case Manager will contact the consumer to schedule an initial assessment or re-assessment. The MCO Case Manager is responsible for making an initial contact to schedule a new assessment within two business days of receiving a referral from the Program Manager, and must administer the initial assessment within twenty business days of the initial contact to determine eligibility for *WORK* services.

The *WORK* Needs Assessment Instrument is designed to determine whether a consumer can perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and Work Related Services. Consumers may have anyone they wish, such as a family member, representative, Independent Living Counselor, etc., participate in the assessment.

Consumers are responsible to be available for the initial and re-assessments. If unavailable, they must notify their MCO Case Manager, 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.

1. ACTIVITIES OF DAILY LIVING (ADLs)

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 *WORK* Needs Assessment.

The Case Manager will assess to determine whether the consumer can perform the various ADLs with or without hands on assistance or cuing and prompting, the amount of time it requires to perform such activities with or without assistance or with cuing and prompting, and the amount of physical assistance or cuing and prompting that may be needed to perform such activities. Consumers with physical disabilities or traumatic brain injury must demonstrate a need for physical assistance with ADLs in order to receive services through *WORK*. Consumers with intellectual/developmental disabilities may demonstrate a need for physical assistance, or cuing and prompting, to perform ADLs.

2. INSTRUMENTAL ACTIVITES OF DAILY LIVING (IADLs)

Members who have demonstrated a need for assistance with ADLs will also be assessed to determine the need for physical assistance, or cuing and prompting, to perform Instrumental Activities of Daily Living (IADLs). IADLs include housecleaning, laundry, meal preparation, money management, lawn care/snow removal, and transportation. Transportation is only provided for personal needs such as traveling to and from work and shopping. Employment

related transportation, including traveling for the job from one site to the other locally or long-distance, to airports, etc., is the responsibility of the member's employer or, if the member is self-employed, the responsibility of the member. Transportation for medical appointments is provided through the MCO non-emergency medical transportation provider, and must be scheduled with that provider.

3. WORK RELATED SERVICES

Work Related Services include the supports necessary for consumers with intellectual and/or developmental disabilities to maintain paid employment. Work Related Services may include assistance to learn job responsibilities, assistance when learning new job responsibilities, assistance to understand how to interact appropriately with other employees and the general public, assistance to understand appropriate work behavior, assistance to practice safety measures, assistance with symptoms management, and assistance with determining what modifications may be necessary to enable consumers to perform their job.

Work-Related Services cannot go beyond the scope of the Medicaid program or subsume an employer's responsibilities under Title I of the Americans with Disabilities Act or the Kansas Act Against Discrimination. For both consumers employed by an employer or those self-employed, assistance related to performing the job is the responsibility of the employer. Examples include assistance with filing, copying, employment-related travel, interpreting, etc.

CONSUMER AGREEMENT FORMS AND EMERGENCY BACK-UP PLANS

1. Consumer Agreement Form

Once consumers have been determined eligible for *Working Healthy* and in need of *WORK* services, they will be asked to complete the *WORK* Consumer Agreement Form. Completing and signing this form indicates that they are making an informed choice to receive *WORK services*, they have made choices related to *WORK* services, and that they are willing to comply with all *WORK* policies and procedures.

The Consumer Agreement Form includes the following choices:

- to participate/not participate in *WORK*
- self-direct/not self-direct services
- have/not have a representative
- request/not request background checks

The Consumer Agreement Form also includes the following information:

- information regarding the monthly allocation and agreement to spend the funds consistent with *WORK* policies and procedures
- information regarding the impact of the monthly allocation on Social Security and other benefits
- information regarding the right to confidentiality
- information regarding transitioning between *WORK* and an HCBS Waiver

Finally, the Consumer Agreement Form includes Consumers Rights and Responsibilities. Signing this form indicates that consumers understand their rights and responsibilities while they are receiving *WORK* services, and that they are willing to comply with all *WORK* policies and procedures.

2. 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

- names and contact information of persons that will provide emergency back-up assistance in the event a personal assistant does not report to work
- name and contact information of persons that should be notified in the event of an emergency

Other aspects of emergency include

- whether smoke and carbon monoxide detectors have been installed and the location (the monthly allocation can be used to purchase and install these devices)

- for consumers dependent on technology, how their technology will be powered in the event of a power outage
- evacuation plans in the event of a fire or natural or man-made disaster, including whether personal assistants or local emergency personnel have agreed to assist in the evacuation process
- for consumers using service animals or pets, how they will be cared for in the event of an emergency.

The Emergency Back-Up Plan must be submitted to the *MCO* Case Manager for approval along with the Individualized Budget. The Case 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.

SERVICES

1. PERSONAL SERVICES

a. Definition of Personal Services

Personal Services include:

- One or more persons physically assisting an individual with, or cuing/prompting an individual, to perform ADLs and IADLs in the home and at work.
- Alternative and cost-effective methods of obtaining assistance to the extent that expenditures would otherwise be used for human assistance, e.g., meal or laundry service or purchase of equipment that decreases the need for human assistance
- Assisting, or cuing or prompting, an individual with an intellectual/developmental disability to learn job responsibilities, interact appropriately with other employees and the general public, practice appropriate work behavior, practice safety measures. It may also include assistance with symptoms management and assistance with determining what modifications may be necessary to enable consumers to perform their job.

b. Self-Direction of Personal Services

Individuals may self-direct their services. Those who choose to self-direct their services are the Employer-of Record, and perform all employer responsibilities such as recruiting, interviewing, hiring, training, scheduling, etc, their Personal Assistants (PAs). Those who self-direct their services are responsible for verifying that the hours billed accurately reflect hours worked.

Consumers interested in self-direction training have the option to participate in web-based *WORK Self Direction Training and Assessment*, or to review the [Kansas Self-Direction Toolkit](http://www.kdheks.gov/hcf/workinghealthy/work.htm), both located at <http://www.kdheks.gov/hcf/workinghealthy/work.htm>. Consumers may work individually on the training, with an Independent Living Counselor, representative, or anyone else able to assist them. This optional training encompasses a variety of topics, including recruiting, interviewing, negotiating rates and performing reference checks, hiring, training, and supervising PA's, recognizing and receiving good PA services, etc.

Consumers choosing to self-direct their services are responsible for:

- recruiting, hiring, training, scheduling, evaluating, and terminating their PAs
- completing and submitting all required FMS paperwork to become the Employer-of-Record, as well as ensure that the PAs that they hire have completed and submitted all of their employee paperwork
- deciding whether to obtain a criminal background check for their PAs (**consumer's are strongly encouraged to obtain background checks for PAs they plan to hire**)
- obtain employer and personal references for their employees
- determining reimbursement rates for services
- reviewing and signing PA time sheets to verify that the number of hours provided by PA's are correctly recorded before submitting to FMS provider

- reviewing invoices for services rendered or items purchased, and signing to verify the accuracy, before submitting to the FMS provider
- completing the FMS paperwork indicating that a PA is no longer working for them
- reporting emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to DCF Adult Protective Services (see K.S.A. 39-1430)
- notifying KDHE staff, MCO Case Manager or an Independent Living Counselor, of any concerns they have regarding the quality of their services.

c. Agency-Direction of Personal Services

Consumers may prefer not to direct their services, and instead may choose a State Licensed Home Health Agency to direct services on their behalf. When this option is chosen, the agency is the Employer-of-Record, and is responsible for recruiting, hiring, training, terminating, etc. The agency also decides the hourly wage of its employees, and determines where PAs work.

State Licensed Home Health Agencies are subject to K.S.A. 65-5101 through K.S.A. 65-5117.

d. Self and Agency Direction of Services

Consumers may have a combination of agency-directed services, where some of their personal assistants are the employees of an agency and the agency directs these attendants, and some of the personal assistants are self-directed and the consumer is the Employer-of-Record and directs these attendants.

e. Background Checks for Personal Assistants

Consumers who self-direct their services are strongly encouraged to obtain background checks on personal assistants. Consumers are also strongly encouraged to obtain references from previous employers, as well as personal references. The monthly allocation may be used to purchase background checks. Background checks can be done by the fiscal management services (FMS) provider designated by the MCO to provide fiscal management for *WORK* participants.

It is not permissible to use the *WORK* allocation to hire a person who is a registered sex offender. To obtain information about registered sex offenders, contact:

<http://www.accesskansas.org/kbi/ro.shtml> and <http://www.city-data.com/so/Kansas.html>.

Note: Providers of *WORK* services are subject to the Office of Inspector General's (OIG) Exclusions Verification Program. These are federally mandated regulations, *Sections 1128 and 1156 of the Social Security Act*, established to fight waste, fraud, and abuse in Medicare, Medicaid and other Health & Human Services (HHS) programs. OIG requires all health care entities participating in Medicaid/Medicare funded programs to routinely check the OIG's List of Exclusion Individuals/Entities (LEIE), and ensure that any new and current

employees that appear on LEIE list are not compensated for any and all services delivered with Medicaid/Medicare funds.

f. Personal Services Restrictions

Personal Services are also limited or restricted in the following ways:

- Consumers with physical disabilities or traumatic brain injury must demonstrate a need for physical assistance with ADLs in order to receive Personal Services. Consumers with intellectual/developmental disabilities may demonstrate a need for physical assistance, or cuing and prompting, to perform ADLs.
- Consumers cannot use the *WORK* monthly allocation to hire a person with a history of abuse (emotional, physical, sexual, or fiduciary), neglect and/or exploitation of children or vulnerable adults.
- Work Related Services cannot go beyond the scope of the Medicaid program or subsume an employer's responsibilities under Title I of the Americans with Disabilities Act or the Kansas Act Against Discrimination.
- IADLs are not covered if there is a capable person residing with the consumer receiving *WORK* services. Capable persons are spouses, parents, and adult children. Roommates living in the same residence are responsible for their share of house cleaning, lawn mowing, and snow removal.
- Consumers cannot live in a residence operated by a provider agency or organization that also provides the personal assistance service. As long as the operator of the home is not providing the personal assistance services, the individual may live in a provider operated home. If consumers are living in a provider operated residence, they must either self-direct their services or choose an outside agency that is not in any way connected with the provider operated residence to direct their personal services on their behalf.
- Personal Assistants cannot work more than 40 hours per week; nor can PAs be paid overtime. Consumers using more than 40 hours per week of services will have to hire additional PAs to provide their services.
- Personal services for the care of pets are only provided for one certified service pet.

2. ASSISTIVE SERVICES

a. Definition of Assistive Services

Assistive Services includes items, equipment, product systems, home or vehicle modifications that

- contribute to the consumer's health and safety and/or ability to maintain employment and independence
- are related to the individual's disability and functional limitations
- are medically necessary documented by appropriate medical personnel
- may include services which directly assist individuals with a disability in the selection, acquisition, or use of assistive technology.

Examples of Covered and Excluded Assistive Services

Covered Assistive Services

- dentures
- home modifications to increase access, e.g., grab bars, raised toilet seats, lowered counters (home modifications requests may require photographs and diagrams.)
- ramps (removal of porches or decks and/or adding porches or decks are the responsibility of the consumer)
- emergency alert installation
- environmental control units (to control items within the home such as lights or door locks)
- electric lifts
- hearing aids and batteries
- insulin pumps and pump supplies
- low vision aids for home use
- seating and positioning
- specialized wheelchairs
- wheelchair or scooter batteries repairs
- specialized footwear (Diabetic, Orthopedic)
- beds (such as hospital), mattresses, mattress covers, bed rails used in medical situations
- cost of obtaining and replacing service dogs and other service animals;
- vehicle modifications

Excluded Items

- clothing
- food or nutritional supplements
- shoes of a non-medical nature
- computers, laptops, IPAD, cell phones
- environmental units such as air conditioners, furnaces, space heaters, humidifiers/dehumidifiers, 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
- yard repairs
- surgeries
- water beds

- beds and mattresses of a non-medical nature, e.g., Sleep Number beds
- vehicles and vehicle repairs
- modifications to buildings in which the consumer does not reside, e.g., garages and sheds
- fences or out-buildings
- removal or addition of decks or porches
- home remodeling
- assistive technology and durable medical equipment covered under the Kansas Medicaid State Plan
- assistive technology to allow or improve access at the place of employment**

b. Alternative Funding Sources

Medicaid is the payor of last resort. Consumers receiving services through the *WORK* program 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. Prior to making a request for home modifications for a rental home, FHAA reasonable accommodations modification rights must be explored with property owner/landlord.

c. Medical Necessity

In order to receive assistive services through the *WORK* program, the medical need for the assistive service must be demonstrated. Medically necessary is defined as:

- treating a medical condition
- recommended by the treating physician or other appropriate licensed professional in the area of expertise (a medical practitioner cannot establish medical necessity outside his/her area of expertise)
- providing the most appropriate level of service considering potential benefits and harms to the individual
- known to be effective in improving health outcomes
- cost-effective for the condition being treated when compared to alternative interventions (the usual and customary rate is used when approving assistive services).

d. Prior Authorization for Assistive Services

Assistive services must be prior authorized by the MCO Case Manager. There is no entitlement for assistive services for consumers receiving services through the *WORK* program. Assistive services are prior authorized on a case-by-case basis, based on individual need and situation, as well as cost-effectiveness. Assistive services are limited to those assistive technology and durable medical equipment not already covered under the Kansas Medicaid State Plan.

The MCO Case Manager has the right to request any documentation necessary to determine the need for assistive services. In some cases photographs and/or diagrams may be requested. Approval will only be granted after full and complete information has been submitted for review

by the MCO Case Manager. In some situations, assistive services or home modifications will only be prior authorized if they result in a reduction of the need for personal assistance services. If the approval of an assistive service is contingent upon decreasing your need for personal assistance, it will be discussed with you before the request is approved or denied.

e. Assistive Service Requests

Consumers must submit a **Request for Assistive Services** form, a statement of medical necessity from the appropriate medical provider, and a minimum of two bids to their MCO Case Manager.

Once a request packet is complete, the MCO Case Manager will review the information and notify the consumer and Independent Living Counselor, in writing, whether the request is approved or denied and, if approved, which bid is acceptable.

f. Assistive Service Verification

Prior to claims submission, consumer's are required to sign the **Assistive Service Verification and Satisfaction** form, verifying that they received the assistive technology, that it is working, and that they are satisfied with it. In the case of home modifications, a consumer's signature indicated that the work is complete, and that they are satisfied with the modifications.

Claims should be submitted to the consumer's MCO. Assistive services claims may only be submitted by providers of *WORK* assistive services who have contracts with the consumer's MCO.

g. Medicaid Fraud and Abuse

Providing fraudulent information when submitting a request for Medicaid funding of assistive services, or selling items that were purchased with Medicaid funds, is considered Medicaid fraud and abuse and will be reported to the Office of the Kansas Attorney General.

h. Assistive Services Restrictions

- Assistive Service purchases do not include durable medical equipment (DME) or other technology already provided under the Medicaid State Plan.
- Assistive Service purchases do not include technology or modifications that are the responsibility of the employer as an accommodation under the Americans with Disabilities Act (ADA).
- Assistive Service purchases do not include technology or modifications necessary for self-employed consumers to operate their business.
- Assistive 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 of employer responsibilities, whether self-employed or working for an employer, include but are not limited to devices to facilitate communication such as

computers, Ipads, low vision aids to access print materials, vehicle modifications for work-related travel, modification of office furniture, restroom modifications etc.

- While home modifications may be purchased in rented apartments or homes, consumer must verify that they will remain for two years at a residence that receives home modifications.

3. INDEPENDENT LIVING COUNSELING

a. Independent Living Counselor Responsibilities

Independent Living Counselors are available to assist consumers to self and/or agency-direct their services, and request assistive services funds. Independent Living Counseling has an annual cap of 480 units (one unit = 15 minutes), or 120 hours; however exceptions may be made on a case-by-case basis 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 Counselor responsibilities include:

- becoming familiar with *WORK* program policies and procedures, and conveying that information to consumers
- discussing options available through *WORK*, and assisting consumers to complete the *WORK* choice form
- assisting consumers in accessing the training and supports needed to develop the skills to self-direct services, organize workplace accommodations, and otherwise meet goals for independent living;
- assisting consumers in accessing web-based or other self-direction training
- assisting consumers to develop the Individualized Budget, including
- assuring that the Individualized Budget accurately reflects the services determined necessary during the *WORK* assessment
- assisting consumers to decide on providers reimbursement and add in payroll deductions while remaining within the parameters of their monthly allocation
- assisting consumers in determining and locating alternate, cost-effective methods for purchasing services
- assisting in planning for, and documenting the use of, any excess (carry-over) funds remaining from the monthly allocation
- assisting consumers in developing the Emergency Back-Up Plan, locating emergency back-up care and emergency assistance
- assisting consumers to obtain approval for the Individualized Budget and Emergency Back-Up Plan from their MCO Case Manager
- entering the approved Individualized Budget into the FMS web portal

- assuring that the consumer’s choice of providers, alternative services, Emergency Back-Up plan, use of the monthly allocation, and documentation adheres to state and federal rules, regulations and requirements
- assisting consumers to locate providers of personal assistance services
- assisting consumers with interviewing, hiring, supervising, and terminating personal assistants
- assisting consumers to obtain agency-directed services
- ensuring that agency-directed services are consistent with the assessment, are reflected in the budget, and that these costs are commensurate with the monthly allocation payment methodology
- assisting in documenting the need for assistive services, and locating providers of assistive services and supports
- assisting consumers to complete and submit required paperwork for Vendor F/EA FMS
- assisting in documenting expenditures and submitting documentation in a timely manner
- assisting consumers to maintain and or increase independence and employment and access other systems that will enhance independent living and/or employment
- assisting consumers to determine accommodations needed, and how to obtain these from employers
- communicating any changes in status, needs, problems, etc., to the consumer’s MCO Case Manager
- assisting to document the need for, and apply for, assistive services funding
- reporting emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to the MCO Case Manager and/or the DCF Adult Protective Services (see K.S.A. 39-1430 and K.S.A. 39-1431);
- assisting with dis-enrolling from the program and accessing an HCBS waiver, or the waiver waiting list
- assuring 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
- submitting all required MCO paperwork in a timely fashion
- assuring that all documentation of services adheres to MCO requirements.

b. 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 completed at least twelve hours of standardized training annually; and
- completed a two-hour *WORK* orientation;
- completed and passed the web-based *WORK* Independent Living Counseling examination; 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 KDHE.

NOTE: The provider agency is responsible for ensuring that Independent Living Counselors employed by them provide services that are clear of conflicts of interest or fiduciary abuse.

c. Independent Living Counseling Restrictions

- Independent Living Counselors cannot provide personal services or act as a representative for consumers for whom they are providing Independent Living Counseling.
- Individuals with intellectual or developmental disabilities receiving services through *WORK* cannot receive ID/DD Waiver Targeted Case Management (TCM). Once eligibility for *WORK*, TCM through the ID/DD Waiver ends.
- Individuals receiving services through *WORK* cannot obtain Independent Living Counseling and agency-directed services from the same agency. If an Independent Living Counselor works for an agency that also provides personal assistance services, or their agency is any way connected to the provider of personal assistance services, the Independent Living Counselor must assist the consumer to find an outside agency to direct services on behalf of the consumer. In the event that the consumer wants to continue to receive personal assistance services from the agency for which the IL Counselor works, the IL Counselor must assist the consumer to locate a new IL Counselor who works for another agency.

PAYMENT FOR SERVICES

1. PERSONAL SERVICES

a. Monthly Allocation

Consumers in the *WORK* program utilize a monthly allocation to pay for their Personal Services. The amount of the monthly allocation is based on the amount of services needed. Once the needs assessment is completed, the MCO Case Manager will determine the monthly allocation. The MCO Case Manager is responsible for determining the dollar amount of the monthly allocation, and informing the consumer of the total dollar value authorized.

The monthly allocation will be sent to a designated fiscal management organization 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 identified in the *WORK* assessment, and listed on the consumer's Individualized Budget.

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 KDHE within 30 days. If they do not, the remaining allocation may be considered income or resources when determining Medicaid eligibility and HCBS client obligation. KDHE will also seek to re-coup any unspent allocation.

b. Formula to Determine the Monthly Allocation

Self-Directed Services - The following is the formula for determining the amount of money consumers who are self-directing their services will receive per month for personal services:

Hours of Assistance Needed Per Day x 7 x \$13.25 x 4.33 – 10% = Monthly Allocation

7 = Days in the week

\$13.25 = Hourly rate

4.33 = Average number of weeks per month

10% = Fiscal Management and Worker's Compensation coverage fees

Agency-Directed Services - The following is the formula for determining the amount of money consumers who have agency-directed services will receive per month for personal services:

Hours of Assistance Needed Per Day x 7 x \$13.25 x 4.33 – 3% = Monthly Allocation

7 = Days in the week

\$13.25 = Hourly rate

4.33 = Average number of weeks per month

3% = Fiscal Management

Agency and Self-Directed Services Combined

Consumers who both self-direct and purchase agency directed services follow the formula for Self-Direction.

c. Allowed and Disallowed Usages of the Monthly Allocation

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 monthly allocation may be used for include:

- advertising for personal assistants
- background checks
- personal assistant's hourly wages
- all applicable payroll deductions
- alternative methods of purchasing personal assistance, e.g., laundry service;
- payment for equipment that will substitute for personal assistance or ensure safety, e.g., microwave oven, smoke/carbon monoxide detectors and batteries.

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
- payments to representatives
- rent or mortgage payments;
- vehicles or vehicle repairs
- utility payments (gas, electric, sewage, water);
- clothing;
- groceries or nutritional supplements; (supplements)
- 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.

d. Adjusting the Monthly Allocation

The MCO Case Manager will conduct reassessments annually. If changes have occurred in the consumer's condition or functional needs, these will be documented in the *WORK* Assessment Tool and the monthly allocation will be revised. The consumer, with the assistance of the Independent Living Counselor, will develop a new Individualized Budget that reflects the new allocation, and submit it to the MCO Case Manager for approval. If there is a change in the consumer's condition or needs prior to the annual review date, the consumer and/or Independent Living Counselor may request an adjustment to the allocation. The MCO Case Manager will reassess the consumer's needs, and the consumer and Independent Living Counselor must develop a revised Individualized Budget with services and supports that meet those needs identified, and submit it to the MCO Case Manager for approval.

Note: The *WORK* Program Manager and/or MCO Case Manager may also request a new assessment at any time.

e. Monthly Allocation Restrictions

The following restrictions apply to the monthly allocation:

- While *WORK* permits consumers to have more control over the funds to purchase their services, these are Medicaid funds used to purchase very specific Medicaid covered services. KDHE reserves the right to restrict how these funds are spent. Consumers must develop an Individualized Budget indicating how they plan to spend their money allocation to purchase services, and the MCO Case Manager must approve this budget. Case Managers have the right to approve or deny what is purchased, how much is purchased, how much is paid for services, etc.
- Paying for services that are not approved, or that have not been provided, will result in the consumer having to leave the program, and a report to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU).
- Consumers cannot exceed their monthly allocation. If timesheets are submitted to the fiscal management vendor that exceed the monthly allocation, the consumer will be invoiced and expected to pay the amount over and above the monthly allocation.
- Using more than one PA at a time during the day may be permissible with written justification from the consumer and approval from the *WORK* Program Manager (additional PA's). An example of this would be, the consumer has a PA providing ADL support (bathing) and at the same time has another PA providing IADL support (cleaning and laundry). This overlap with PA's must also be indicated on each timesheet and the tasks of each PA must be documented on each timesheet during the overlap.
- The monthly allocation may not be used for a PA to work in the home during a time that the consumer is not also in the home to supervise.
- PA hours may not be used during a consumer's hospital stay but may accrue to be used during recuperation in the home.

- It is not permissible to use the WORK allocation to pay for overtime. Time worked over 40 hours a week is considered overtime and fiscal management vendor is required to pay time-and-a-half for hours worked over the 40 per week. Available hours of assessed support may be significantly reduced when paying time-and-a-half. Exceptions to the overtime rule may be considered for approval on an Individualized Budget on a case-by-case basis if they meet the following criteria:
 - the consumer lives in a rural area where recruiting and retaining additional PA's is difficult
 - hours of support are assessed for nighttime assistance and it becomes difficult to find PA's to work these hours
 - the consumer has several PA's scheduled and does not rely on just one PA or family member to provide all the assessed support hours.

KDHE reserves the right to require consumers to put increased management into place, require the consumer to have an agency direct their services, or to leave the program if they do not follow the program policies and procedures contained in this manual.

f. Individualized Budget

Once consumers know how much their monthly allocation will be each month, they must develop an Individualized Budget indicating how their funds will be spent. Development of the Individualized Budget is directed by the consumer 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 scope and amount of services paid for in the Individualized Budgets must reflect the scope and amount of needs identified in the *WORK* Assessment Tool. Any time the monthly allocation changes, consumers must revise their Individualized Budgets to reflect the new allocation.

Individualized Budgets must be reviewed and approved by the MCO Case Manager before services can begin. The review will include whether the budget includes all of the required elements and meets the needs of the consumer.

Individualized Budgets 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;
- any variable expenditures that provide alternative support and the cost;
- how carry-over funds will be spent.

Consumers have the flexibility to pay attendants 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.

g. Carryover Funds

Consumers may carry-over small amounts of unused funds from the previous month's monthly allocation. Carry-over funds may be used for specific purposes. The intent to use these funds must be documented on the consumer's Individualized Budget under "Use of Carry-Over Funds", and approved by the MCO Case Manager.

Monthly allocation funds not spent 45 days after the pay period will be moved into a Carry-over Account. No more than 15% of the discounted monthly allocation is considered carry-over. Funds over and above budget will be "swept" and returned to the MCO. Purchases using carryover funds are limited to 15% of the discounted monthly allocation. Any funds above 15% of the monthly allocation will be "swept" quarterly from the Carry-over Account and returned to the MCO.

Note: Consistently carrying-over the monthly allocation on a regular basis may result in a new assessment and a reduction in the monthly allocation in order to accurately reflect the needs of the consumer.

h. Allowed uses of carryover funds

Carry-over 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, kitchen items (requests should be submitted to the MCO Case Manager explaining how the equipment is related to the disability and increases independence)
- health, safety and emergency equipment such as fire extinguishers, carbon monoxide and smoke detectors
- advertising costs to recruit PA's
- background checks for PA's (except for consumers with agency-directed services)
- additional personal assistance related to temporary increased need or emergency back-up care
- leave for PAs (limited to the number of hours worked by PA during a one week period and no more than one week per year)
- assistance with PA health insurance premiums.

Note: Leave for PAs is based on the availability of carryover funds, and given at the discretion of the consumer for which the PA works. Leave is limited to one week per PA per year, and can only cover the number of hours typically worked by a PA during a one week period. Leave does not accrue; there is no leave payout at the end of a year or if a PA resigns. Leave must be documented and submitted on the timesheet in which the leave was taken, and must be clearly documented as leave.

i. Prohibited uses of carryover funds

Carry-over funds may not be used to purchase, or to save for, the following items:

- high cost items such as a washer or dryer
- home modifications
- small items not related to their disability
- loans for workers
- payment for someone to be a representative
- rent or mortgage payments
- utility payments
- clothing
- groceries
- lottery tickets
- entertainment
- entertainment devices
- vehicles and vehicle repairs
- alcohol or tobacco products
- items related to the disability that would be available through another funding source.

j. 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 KDHE for funds spent inappropriately and KDHE reserves the right to remove them from the program. Their MCO Case Manager and their Independent Living Counselor will assist consumers who came from them to return to HCBS Waivers or waiting lists. Eligibility Workers may determine eligibility for other Medicaid coverage.

Independent Living Counselors and the fiscal management organization are required to inform the *WORK* Program Manager if they have concerns regarding how Medicaid funds are expended. Misuse of the funds provided by Medicaid for personal services is considered Medicaid fraud and abuse. Suspected fraud and abuse will be reported to the Office of the Attorney General Medicaid Fraud and Abuse Unit.

2. PAYMENT FOR ASSISTIVE SERVICES AND INDEPENDENT LIVING COUNSELING

Assistive Services and Independent Living Counseling are paid by the MCO. Providers of these services must contract with MCOs in order to be paid for these services. Both Assistive Services and Independent Living Counseling require prior authorization.

Working Healthy/WORK Billing Codes

Population

26 – *Working Healthy* Basic Eligibility

27 – *Working Healthy* Medically Improved

Level of Care

WK - *WORK*

A Population Code of 26 or 27, combined with a Level of Care code of WK indicates that a consumer is eligible for *Working Healthy* and receiving *WORK* services.

Provider Type

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

Provider Specialty

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.

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.

Procedure Codes

T1016 - Independent Living Counseling – reimbursed at the rate of \$10.60 per unit (limit of 480 units annually; Prior Authorization required for additional units)

S5165 - Assistive Services

FISCAL MANAGEMENT

MCOs contract with a fiscal management organization to manage the *WORK* monthly allocation for members.

1. CUSTOMER SERVICE

The fiscal management organization is responsible for providing a customer service system that includes:

- a toll free number
- a fax number and fax capabilities
- a web-based portal
- internet/e-mail communication system that meets Federal and State accessibility requirements
- translation and interpreter services
- print materials in alternate formats

The fiscal management organization is also responsible for providing orientation and assistance to consumers, their employees and other providers of services related to using their service, understanding their role, completing forms, timesheet completion and submission process, and the process for submitting invoices for approved goods and services.

2. EMPLOYER-OF-RECORD

Consumers who self-direct their services are the Employer-of-Record (EOR). Fiscal management responsibilities for the Employer-of-Record (EOR) include:

- providing orientation and assistance to consumer/representative-employers related to using the Vendor F/EA, understanding their role as their PA's employer, the information and completing the forms included in the consumer/representative-employer enrollment packet and attendant employment packet; the timesheet completion and submission process, and the process for submitting invoices for approved goods and services;
- producing and distributing employer packets that contain all required general information about the fiscal management organization, all required forms and explanations and examples of how to complete the forms, including
 - Form SS-4 - Application for Employer Identification Number
 - IRS Form 2678 - Employer /Payer Appointment of Agent
 - IRS Form 2848 - Power of Attorney and Declaration of Representative
 - IRS Form 8821 – Tax Information Authorization
 - KS Dept of Labor Form K-CNS 032- Employer Representative Authorization
 - KS Dept of Labor - Employer Status Report
 - Forms specific to the fiscal management organization

- collecting and monitoring the required information for accuracy, completeness and timeliness, and processing it
- obtaining a separate *Federal Employer Identification Number (FEIN)* for consumers who choose to self-direct their services and are the Employer-of-Record; retiring it when it is appropriate to do so; resolving any issues with any previously held *FEINs*
- obtaining an IRS Form 2678, *Employer Appointment of Agent*, for each consumer and revoking it when appropriate to do so
- obtaining an IRS Form 8821, *Tax Information Authorization*, for each consumer and revoking it when appropriate to do so
- obtaining Kansas Withholding tax account number for each consumer and retiring it when appropriate to do so
- obtaining a Kansas Department of Labor *Employer Representative Authorization (Form K-CNS 032)* for each consumer and revoking it when appropriate to do so
- obtaining a Kansas Unemployment Insurance (UI) tax account number for each consumer, and retiring it when appropriate to do so
- processing criminal background checks on prospective attendants at the request of the consumer
- providing the following orientation and assistance, including
 - the services of the fiscal management organization
 - understanding their role as employer
 - information to complete forms included in the employer and attendant enrollment packets
 - timesheet completion and submission process and the process for submitting invoices for approved goods and services

3. EMPLOYEES AND OTHER SERVICE PROVIDERS

The fiscal management organization is responsible for the following for the personal assistant (PA) providing *WORK* services for self-directing consumers:

- producing and distributing employee packets that contain general information about the fiscal management organization and all required forms, including
 - employment application
 - federal and state forms and instructions (e.g., IRS Form W-4, state Form W-4, if applicable, US CIS Form I-9, IRS Notice 797)
 - any required agreements or consent forms (e.g., to conduct criminal background checks)
- performing background checks and OIG Exclusion Verification checks
- collecting and monitoring the required information for accuracy, completeness and timeliness, and processing them
- paying attendant wages consistent with original time sheets signed by the employer and in accordance with federal and state department of labor wage and hour laws

- distributing, collecting, monitoring the accuracy of, and processing PA timesheets
- receiving, reviewing and processing invoices for approved goods and services and paying vendors in accordance with KDHE requirements and maintaining documentation in the vendor's file
- processing refunds for over collected FICA in an accurate and timely manner at the end of the calendar tax year, and maintaining documentation in the PA's file
- preparing, filing and distributing IRS Forms W-2, *Wage and Tax Statement* for PAs in accordance with IRS instructions for agents and electronically if filing 250 or more IRS Forms W-2, and maintaining documentation in each PA's file
- preparing, filing and distributing an IRS Form W-3, *Transmittal of Wage and Tax Statement*, when necessary and maintaining documentation in each consumer/representative-employer's file
- process payment to eligible independent contractors (those that have been verified through the filing of an IRS Form SS-8, *Determination of Worker Status for Purposes of Federal Employment Taxes and Income Tax Withholding* and submission of an IRS Form W-9, *Request for Taxpayer Identification Number Certification*) and maintaining documentation in each independent contractor's file;
- processing IRS Form 1099-Misc for any eligible independent contractor that has been paid \$600 or more in a calendar tax year and maintain documentation in each independent contractor's file;
- providing worker's compensation insurance policies and paying premiums for consumer/representative-employers; and
- filing and paying federal income tax withholding, FICA and FUTA for personal assistants

CONSUMER RESPONSIBILITIES AND RIGHTS

1. CONSUMER RESPONSIBILITIES

- Consumers are responsible for complying with *WORK* program policies and procedures as laid out in the *WORK* Program Manual. **Note:** Consumers unwilling to follow these program policies and procedures will be required to leave the program.
- Consumers have the responsibility to provide DCF eligibility staff, in a timely and complete manner, with all paperwork needed to complete annual eligibility and six-month desk reviews, without a disruption in services.
- Consumers are responsible for paying their *Working Healthy* premium monthly by the date specified on their statement.
- Consumers have the responsibility to obtain all necessary information to enable them to make an informed choice regarding whether they want *WORK* services.
- Consumers have the responsibility to be available for their MCO Case Manager to conduct their initial assessment, and annual re-assessments, at the date and time agreed upon.
- Consumers have the responsibility to accurately report their need for services during the *WORK* assessment. **NOTE:** Falsifying the needs for services will result in removal from the program and be reported to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU).
- Consumers have the responsibility to ensure that the services and costs listed on their Individualized Budget reflect the needs identified during their *WORK* 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 to sign all sections of the Consumer Agreement form, indicating the informed choices they have made, as well as their willingness to comply with the *WORK* program policies and procedures.
- Consumers are responsible to understand and accept the responsibilities and risks of directing 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 directing their care; **or** choosing a state licensed Home Health agency, CDDO or Affiliate Agency willing to direct care on their behalf.
- Consumers have the responsibility to complete all of the paperwork required by the FMS provider in a thorough and timely manner to ensure that their PAs and providers are paid in a timely manner.
- Consumers have the responsibility to spend their monthly allocation on those services and/or goods that are consistent with independence and employment and within the

parameters established by KDHE, and to spend no more than the amount allotted to them monthly.

- Consumers have the responsibility to verify time worked by signing time sheets. Falsification of time sheets, either by the consumer or PA will result in removal from the program and will be reported to the MFCU.
- Consumers have the responsibility to submit timesheets in the timeframe identified by the FMS provider.
- Consumers are responsible to request the permission of their MCO Case Manager to spend carry-over funds.
- Consumers have the responsibility **not** to spend their allocation on anything prohibited by KDHE and/or MCO.
- Consumers have the responsibility to inform DCF eligibility staff when they are no longer employed, and to contact their Benefits Specialist to set up a Temporary Unemployment Plan if they want to remain in *WORK* for a four month “grace” period.
- Consumers have the responsibility to communicate any changes in status, needs, problems, etc. to the appropriate DCF, KDHE, or MCO staff.
- Consumers have the responsibility to inform their MCO Case Manager or Independent Living Counselor in a timely manner if they wish to return to an HCBS waiver or waiver waiting list.

Note: Inappropriate use of Medicaid funds is considered Medicaid fraud, will be reported to the Office of the Attorney General Medicaid Fraud Control Unit, and may result in prosecution.

2. CONSUMER RIGHTS

- Consumers have the right to information that will assist them in making an informed choice regarding whether they want to enroll in *Working Healthy* and *WORK*.
- Consumers have the right to timely enrollment in *WORK*.
- Consumers have the right to a person-centered planning process with all aspects of *WORK*, including the assessment, development of the Individualized Budget and Emergency Back-Up Plan, and completing the Consumer Agreement form.
- Consumers have the right to have the assistance of a representative, family, friends, or Independent Living Counselor with all aspects of *WORK* mentioned above.
- Consumers have the right to self-direct their services, choose an agency to direct services on their behalf, or to a combination of both self and agency-direction. KDHE does reserve the right, however, to require consumers to have a family member, representative, or agency direct their services if there are concerns about the ability to self-direct their services.
- Consumers have the right to have criminal background checks conducted on their personal assistance providers.

- Consumers have the right to file a grievance with the MCO regarding *WORK* services, or appeal actions taken by the MCO to KDHE.
- Consumers have the right to report abuse, neglect, and exploitation to DCF.

GRIEVANCES AND APPEALS

1. MCO GRIEVANCE/APPEAL PROCESS

Consumers who disagree with decisions made by their MCO Case Manager regarding *WORK* services have the right to file a grievance or request an appeal with the MCO.

- a. **Grievance** - Consumers must file a grievance within 180 of days of the action taken by the MCO. The MCO must acknowledge in writing the grievance was received within 10 business days; 98% of all grievances must be resolved in 30 business days. If the MCO believes an additional 30 business days may be needed to resolve the grievance, this request must be made to KDHE/DHCF two business days in advance of the 30 business day deadline. 100% of grievances must be resolved in 60 business days.
- b. **Appeal** – Consumers who have experienced an adverse action with an MCO may appeal the decision through the MCO defined process within 30, plus 3 calendar days if mailed, of the adverse action. The MCO must inform the member of the action in a notice. This notice is called a “Notice of Action.” The MCO must send a letter to the member within five business days acknowledging receipt of the appeal request. The MCO must resolve the appeal within 30 business days.

Note: Consumers may request a State Fair Hearing (SFH) with the Office of Administrative Hearings (OAH) at the same time that they appeal an action taken by their MCO, or wait until after the MCO makes a final decision and then request a SFH if dissatisfied with the MCO’s final decision.

- c. **Expedited Appeal** – Consumers may file an expedited appeal when the consumer’s health requires a decision made as expeditiously as possible. MCOs must resolve an expedited appeal within three days. If more time is needed to gather additional information the MCO may request the additional time from KDHE/HCF. When an expedited appeal is requested, the member may not file a SFH concurrently.

Consumers should refer to their MCO’s member handbook for information regarding how to file a grievance or request an appeal with their MCO. MCO member handbooks can be found on the MCO’s website. MCO websites can be reached via the KanCare website at <http://www.kancare.ks.gov/>.

3. STATE APPEAL PROCESS

- a. **State Fair Hearing** - Consumers dissatisfied with the MCO decision may make a written request for a Fair Hearing to the OAH. This can be done at the same time the consumer is appealing a decision with the MCO, or after the MCO makes their decision. The request must be in writing within 30 days of the notice of the decision, with three additional days added to allow for delivery via mail (33 days). All hearing dates, resolutions, and notifications follow the timelines prescribed by the Office of Administrative Hearings. If neither the consumer nor the State request that the KDHE State Appeals Committee

(SAC) review the decision, the decision becomes final thirty (30) days from the date of the order.

To file a State Fair Hearing, consumers should write a letter within 30 plus 3 calendar days if mailed of the adverse action. The letter should be sent to

Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, Kansas 66612

- b. KDHE State Appeals Committee (SAC)** – If consumers or the State disagree with the decision of the OAH they may request, within 15 days of the OAH decision, that the KDHE State Appeals Committee (SAC) review the decision. The KDHE SAC reviews the appeal and the OAH Initial Order, and issues a Final Order. A party has the option of appealing the decision to District Court. Should a party seek judicial review, then, pursuant to K.S.A. 77-613(b), the request for judicial review must be filed within 30 days from the date of the Final Order.
- c. Judicial Review** - Consumers dissatisfied with the decisions of the KDHE SAC have the right to file a petition for a Judicial Review in the appropriate District Court within 30 days of the Final Order being issued.

KANCARE CONSUMER OMBUDSMAN

The KanCare Consumer Ombudsman is available to help consumers who receive long-term care services through MCOs. The Ombudsman can help consumers:

- understand their KanCare plan and how to use their benefits
- understand their bills and how to handle them
- with service problems when other help is not available directly through an MCO or provider
- understand where to take their problems with KanCare, such as the MCO grievance and appeals process and the State fair hearing process
- obtain answers when they feel their rights have been violated
- contact the people in charge

The Ombudsman will also provide information and refer consumers who have problems that the Ombudsman cannot resolve.

The KanCare Ombudsman can be reached at this toll-free number **1-855-643-8180**.

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
- 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 (APS) – Department for Children and Families (DCF) 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 – A person who speaks or writes in support or defense of a person, cause, etc.

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 – For the purposes of this manual, funds allotted monthly for *WORK* 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 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 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 Vendor F/EA FMS, 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.

Department for Families and Children (DCF) – The agency that determines eligibility for Medicaid and Working Healthy. DCF is also responsible for other human service programs.

Developmental Disability Waiver – A Home and Community Based Services (HCBS) waiver that serves individuals' age five (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 a provider can be reimbursed for services.

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

Eligibility Worker – A DCF 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, or in the event of a man-made or a natural disaster.

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 Management Service (FMS) – An entity that operates in accordance with §3504 of the IRS code, Revenue Procedure 70-6 and Proposed Notice 2003-70, as applicable. The entity manages, and maintains an accounting of, the monthly allocation on behalf of the *WORK* participant, processes attendants’ payroll including federal and state income tax withholding and employment-related taxes, department of labor and workers’ compensation insurance requirements. It also produces and distributes reports to KDHE and consumers containing allocation, payroll and other expense information as required by KDHE.

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 assist people to self-direct their services and manage their monthly allocation, and provide information and referral regarding community resources.

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.

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.

KanCare - The State of Kansas' Medicaid program. Kansas has contracted with three new health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare program began in January 2013. The administration of KanCare within the State of Kansas is carried out by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS).

Kansas Department for Aging and Disability Services (KDADS) – The state agency responsible for administering the Medicaid HCBS waiver programs, Mental Health and Substance Abuse, and State Hospitals and Institutions.

Kansas Department of Children and Families (DCF) – The state agency responsible for determining Medicaid eligibility for adults who are disabled or elderly.

Kansas Department of Health and Environment (KDHE) – The state agency responsible for administering the Medicaid program, as well as other health programs. KDHE maintains financial management, policy, and contract oversight of the KanCare program

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.

Managed Care Organization (MCO) - Health plan, or managed care organization (MCO), hired by the state to coordinate health care for nearly all Medicaid beneficiaries.

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 Assistant - Person who provides physical assistance with ADLs, IADLs, health maintenance activities, and work related supports 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 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 an MCO or a designated KMAP 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.

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.

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. 30-5-59. Provider Participation Requirements.

Refers to the pre-requisites for participation in, and payment from, the Medicaid/Medikan programs.

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

Refers to providers meeting the provider participation requirements 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.

Refers to Independent Living Centers not allowing any consumers to work as Independent Living Counselors when they are receiving services from the Independent Living Center.

K.A.R. 30-6-88 Disabled individuals with earned income; determined eligibles

Provides the eligibility criteria for the Kansas Medicaid Buy-In program, *Working Healthy*.

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. 39-7, 100 - Home and community based services program; definitions; program requirements; demonstration projects.

Pertains to the right of consumers to choose the option to make decisions about, direct the provisions of and control the attendant care services received by such individuals including, but not limited to, selecting, training, managing, paying and dismissing of an attendant; and that providers, where appropriate, shall include individuals in need of in-home care in the planning, startup, delivery and administration of attendant care services and the training of personal care attendants.

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

Pertains 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.

Delineates those individuals who are required to report abuse, neglect or exploitation and states the penalty for failure to do so.

K.S.A 39-1803 – Definitions.

Defines (e) “Community service provider” to mean a Community Developmental Disability Organization or affiliate thereof.

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

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 – 5117 – Home Health Agencies

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

65-5101: Definitions.

65-5102: Home health agencies required to be licensed.

65-5103: Application for license; annual fee.

65-5104: Issuance of license; grounds for suspension or revocation; annual report and annual fee; posting; not transferable or assignable; temporary operating permit; statistical reports; reciprocal agreements with bordering states.

65-5105: Survey inspections.

65-5106: Same; written report; list of deficiencies; exit interview; copies of report.

65-5107: Complaint against home health agency; investigation and hearing; notice.

65-5108: Refusal to issue, suspension or revocation of license; grounds; hearing.

65-5109: Rules and regulations; application.

65-5110:

65-5111: Injunction to restrain violations.

65-5112: Act not applicable to certain individuals or organizations.

65-5113: Disposition of moneys.

65-5114: Violation of act; misdemeanor.

65-5115: Home health aides; requirements for employment; instruction and examination; examination fee, disposition.

65-5116: Unlicensed employees prohibited from prefilling insulin syringes; penalty.

65-5117: Operation of home health agency precluded, when; access of secretary of health and environment to certain records; background check of employees, civil liability, fee for

information request; provision of criminal history record information by secretary; licensed or registered professional service providers, volunteers and certain employees exempt; report of convictions and adjudications by the Kansas bureau of investigation.

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.