Kansas
Department of Health and Environment

Work Opportunities Reward Kansans

WORK

Program Policy Manual

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KanCare

Kansas WH Working Healthy WORK

This manual and all the *WORK* forms are available online at https://www.kancare.ks.gov/consumers/working-healthy/working-healthy/work

CONTENTS

100 - INTRODUCTION

This manual details policies and procedures for *Work Opportunities Reward Kansans (WORK)*. *WORK* is the long-term care program that provides supports for people eligible for *Working Healthy (WH)*. Unlike other Medicaid long-term care programs, people eligible for *WH* do not receive services through Home and Community Based Service (HCBS) waivers. Instead, they can receive a Medicaid State Plan package of services which is called *WORK*.

WORK is not an HCBS program and is not governed by the same policies as HCBS programs. The Kansas Department of Health and Environment (KDHE) is responsible for the oversight of both *WH* and *WORK*. The Kansas Department of Aging and Disability Services (KDADS) is responsible for overseeing HCBS Waivers in Kansas.

KDHE DISCLAIMER

Pursuant to K.A.R 129-6-84(4)(c), KDHE reserves the right to require members to have increased management, including a representative and/or an agency directed services, or to leave the program, if they do not follow the program policies and procedures contained in this manual.

KANCARE

The State of Kansas' Medicaid program moved to managed care for most of its Medicaid beneficiaries on January 1, 2013. Kansas contracted with three Managed Care Organizations (MCOs) to coordinate health care for nearly all Medicaid beneficiaries. Now called KanCare, each Medicaid beneficiary is assigned to an MCO or health plan. MCOs manage the care received by their members, including physical health, behavioral health, pharmacy, and long-term care.

KDHE is responsible for the administration of KanCare. KDHE also responsible for KanCare eligibility determinations for individuals who are disabled and/or elderly effective January 1, 2016. Eligibility is determined by KDHE staff, assisted by a contractor selected by the State who is responsible for gathering the information needed to determine eligibility. Individuals who want KanCare coverage may complete an application online at ApplyForKancare.ks.gov. For assistance, or to obtain paper applications, they can call 1-800-792-4884. Those who want to fax in applications and supporting documentation should use the fax number 1-844-264-6285.

KDADS manages most Medicaid long term care programs, including all HCBS waiver programs, for individuals with disabilities and the elderly.

NOTE: All forms referenced within this document can be found on line at the following website: https://www.kancare.ks.gov/consumers/working-healthy/working-healthy/work .

200 – WORKING HEALTHY

Working Healthy (WH) is the Kansas Medicaid Buy-In program. Medicaid Buy-In programs are a work incentive, authorized under the Ticket-to-Work and Work Incentives Improvement Act of 1999 (TWWIIA), designed to encourage people to work, increase their income and accumulate assets, while not jeopardizing their health care.

WH is specifically designed for people whose health care needs are significant but whose income exceeds the Medicaid limit. This category of Medicaid coverage is 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 spenddown period starts over. A Spenddown is a major disincentive to employment, as the more individuals earn, the higher their spenddown becomes and the less likely they are to access Medicaid. *WH*, on the other hand, substitutes an affordable monthly premium in lieu of spenddown, thus incentivizing employment by allowing people to increase their income without incurring higher spenddown or losing their eligibility for Medicaid coverage completely.

ELIGIBILITY

To be eligible for *WH*, a member 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.

BENEFITS

In addition to eliminating spenddown and substituting a more affordable premium, other *WH* benefits include:

- ➢ full and consistent Medicaid coverage
- ➢ allowable income up to 300% of the Federal Poverty Level (FPL)
- ➢ allowable savings up to $15,000 per household
- ➢ unlimited retirement accounts
- ➢ assistance with Medicare expenses
- ➢ payment of employer premiums in some instances
- ➢ benefits planning and assistance.

- Medicaid coverage when determined by Social Security to be "Medically Improved."
- personal assistance and other services provided through a program called *WORK*.

300 – WORK OPPORTUNITIES REWARD KANSANS (WORK)

WORK is the program through which people enrolled in *WH* receive personal assistance services (PAS). *WH* beneficiaries cannot receive HCBS waiver services. In addition to PAS, *WORK* services include Supported Employment Support Services, Assistive Technology, and Independent Living Counseling (ILC).

ELIGIBILITY

KDHE reserves the right to require additional documentation of a member's disability and/or conditions.

To receive *WORK* services, people must be eligible for *WH*, and

1. be receiving services through one of the following HCBS waivers: Intellectual/Developmental Disability (I/DD), Physical Disability (PD), or Brain Injury (BI) Waivers, or
2. be on the waiting lists to receive services through these **waivers (waiver screenings must have been conducted within the last 12 months or new waiver screenings will be required)**, or
3. screened for I/DD, PD, or BI waiver eligibility before a *WORK* assessment can be conducted.

Additional Eligibility Criteria

A. KDHE reserves the right to require additional documentation of a member's disability and/or conditions.
B. To receive *WORK* Services, members with physical disabilities must demonstrate a need for physical assistance with a minimum of two ADLs, i.e., getting in and out of bed, bathing and personal hygiene, dressing, toileting, eating, assisting to put on prosthetic or orthotic devices, and support during the night for toileting and re-positioning. Members with intellectual/developmental disabilities or traumatic brain injury must demonstrate a need for physical assistance, or cuing/prompting, to perform ADLs and/or demonstrate a need for Supported Employment.
C. *WORK* does not provide support for individuals who have behavioral health conditions, unless they have documentation from a physician that they have a physical condition or conditions that limits their ability to perform Activities of Daily Living (transferring, toileting, bathing, dressing, eating) without 'hands on' assistance.
    i. Assistance to deal with anxiety attacks, angry outbursts, eating disorders, depression, etc., are not provided as these are behavioral health issues that require professional help.

BENEFITS

Members eligible for *WORK* may receive one or more of the following services:

- Personal Assistance Services
- Supported Employment Support Services
- Assistive Technology
- Independent Living Counseling

400 - ENROLLMENT

Individuals interested in *WH/WORK* should contact the *WH* Benefits Specialist serving their region.

1. Benefits Specialists provide an orientation to *WH/WORK,* and if members appear to be eligible for *WH* and indicates a need for *WORK* services, the Benefits Specialists will refer them to the *WORK* Program Manager.
2. This is an informal determination; KDHE eligibility staff are responsible for a formal *WH* eligibility determination.

Once a Benefits Specialist makes a referral, the following steps will be taken.

1. The *WORK* Program Manager determines whether the individual is currently receiving services through an HCBS waiver, or on an HCBS waiver waiting list. Although individuals may be eligible for a *WORK* needs assessment based on their HCBS waiver eligibility, this does not mean that they will receive the same services that they received on a waiver.
    a. If so, the Program Manager will request that the MCO to schedule a *WORK* needs assessment.
    b. If not, the Program Manager will schedule a screening to determine whether the member is eligible for HCBS waiver services.
        i. If the member is determined eligible for waiver services, a *WORK* assessment will be conducted following the screening.
        ii. If the member is not determined eligible for waiver services, a *WORK* needs assessment will not be performed as the member is not eligible for *WORK* services.
2. WORK needs assessment will be requested for members meeting the criteria.
    a. Following the needs assessment, the MCO will send the *WORK* Program Manager the assessment tool indicating whether the member requires services.
        i. If services are needed, the *WORK* Program Manager will coordinate a start date for the member based on completion of all other required paperwork.
        ii. If the assessment does not indicate a need for *WORK* services, the *WORK* Program Manager will refer the member to a Benefits Specialists to discuss options available, including enrollment in *WH* without *WORK* services.

3. Members eligible for *WORK* services will be assigned to an MCO Care Coordinator.
    a. The MCO Care Coordinator will assist the member to locate an Independent Living Counselor (ILC). The ILC is responsible for assisting the member to locate service providers and complete all paperwork.

***WORK* services cannot begin until members are first determined eligible for *WH*. *WORK* services always begin on the first day of the month; there is no retroactive eligibility for *WORK* services.**

Before *WORK* services can begin, the following paperwork must be completed:

1. An Individualized Budget is developed and submitted to the MCO Care Coordinator for approval. Budget must be approved before *WORK* can begin.
2. An Emergency Backup Plan is developed and submitted to the MCO Care Coordinator for approval. The Emergency Backup Plan must be a viable plan, or it will not be approved. This must be approved before *WORK* can begin.
3. The *WORK* Consumer Agreement form signed and submitted.
4. All fiscal management paperwork for both the *WH/WORK* member and the member's providers must be completed, submitted, and approved by the Fiscal Management Services (FMS) provider.

Once all the above are completed, the *WORK* Program Manager will coordinate a start date. A member must be "good to start" by the 18th of the month for the member's case to open the first day of the following month. (See Appendix A – *WORK* Initial Start Workflow)

Short term nursing facility stay.

1. Members leaving *WORK* with a change in LTC coding for a short term stay in a nursing facility who are discharged within 60 days after the month of admittance may be reopened for *WORK* at any time during the month of discharge if there is a current assessment and budget.
    a. Due to the need for coordination, members are encouraged to notify the *WORK* Program Manager of admittance and discharge dated so the *WORK* Program Manager can coordinate the reopening of *WORK* services.
2. Members who are not discharged within 60 days after the month of admittance will remain closed and may require a new *WORK* referral to open.

500 - DISENROLLMENT

Members can choose to leave *WORK* at any time. *WORK* services normally end on the last day of the month.

Members who lose *WH* eligibility will also lose *WORK* services.

1. Members who become unemployed for any reason, e.g., illness, layoff, termination, etc., are no longer eligible for *WH*, therefore they are no longer eligible for *WORK* services.
2. KDHE eligibility staff will close *WH/WORK*, possibly determining eligibility for other Medicaid coverage, including transitions to Home and Community Based Services.

WORK services may terminate if the member is choosing to not utilize services for 6 consecutive months or if the member choses to fail to comply with program policies.

600 – LOSS OF EMPLOYMENT

To be eligible for *WH* and receive *WORK* services, members must be employed. Permanent or temporary loss of employment, including temporary loss due to medical conditions, **must be reported to the KanCare Clearinghouse within ten days of the loss occurring**. Failure to do so may result in a member not being eligible for a Temporary Unemployment Plan (TUP). If MCO Care Coordinators or *WORK* Independent Living Counselors (ILCs) become aware that a member is no longer working and that the member has not reported this, they are responsible for informing the *WORK* Program Manager.

Members who become temporarily unemployed and intend to return to work may be eligible for *WH/WORK* up to four months. The four-month period begins the month following the month that the member becomes unemployed; the member must complete a Temporary Unemployment Plan (TUP) and obtain approval by a Benefits Specialist. Benefits Specialists have wide discretion regarding whether they approve a TUP.

TEMPORARY UNEMPLOYMENT PLAN (TUP)

Members must have an approved Temporary Unemployment Plan (TUP) in place to maintain medical coverage under *WH* and continue to receive *WORK* services. Members who are not currently employed for any reason, including but not limited to illness, injury, layoff, termination, and temporary absences may be eligible for up to four months of *WH* coverage. Members who are unemployed for any reason should be referred to a Benefits Specialist to file a TUP. The member must cooperate with the Benefits Specialist in this process. Failure to cooperate with establishment of the TUP will result in termination of *WH* coverage.

The purpose of the TUP is to establish a plan to return to work. *WH* is a 'work incentive' and the TUP should not be used as a tool to work for short periods in return for four months of KanCare coverage. Benefits Specialists have much leeway in the establishment of the plan, taking into consideration such factors as illness, ability to return to a current job, viability of the plan to obtain a new job, employment history, frequent periods of unemployment, requesting two or more TUPs in a one-year period, etc. Benefits Specialists have the right to limit the plan to less than four months if they feel this is appropriate. Benefits Specialists also have the right to reject a proposed TUP based on history or if they do not believe it will result in employment.

The TUP period begins the month following the month unemployment began. If the member is cooperating with the Benefits Specialist, and all other eligibility factors are met, coverage may be provided through the last day of the TUP period. Any required eligibility review, either an annual eligibility review or a six-month desk review, must be completed as requested during this period. Regular reporting requirements also continue to apply.

Members who have not returned to work at the end of the specified period are no longer eligible for *WH*. Coverage may be provided under other Medicaid programs, such as Medically Needy, if the members continue to be eligible for Medicaid.

700 – SAFETY NET

WORK provides a safety net for members coming from a waiver or waiting list and will operate with the following provisions:

Individuals who:

- choose to participate in *WORK* and are currently on a waiver waitlist will remain on the waiting list and advance based on the date they were added.
- are offered HCBS waiver services while participating in *WORK* are free to choose between *WORK* or the HCBS Waiver. If they choose *WORK*, they will be considered eligible for the waiver if *WORK* should close.
- are on an HCBS waiver that leave the waiver to participate in *WORK* will have the option of returning to that waiver if *WORK* should close.

The *WORK* Program Manager and MCO Care Coordinator will assist members to return to HCBS Waivers or waiting lists. Members may also voluntarily choose to leave *WH/WORK* at any time, and the above process will still apply.

800 – EXCEPTIONS TO POLICIES

There are no guarantees that a submitted exception will be approved. *WORK* is not required to make exceptions to any policy or procedures.

All exceptions are looked at on a case-by-case basis. Exceptions are at the discretion of the MCO or KDHE. Exceptions must be approved before implementation.

For an exception to be reviewed for approval, the following questions must be answered, and documentation submitted.

1. Will the exception result in a reduction of PAS services?
2. Is the exception cost effective?
3. Is the need for the exception in part based on the member living in a rural area with very limited resources?

4. How is conflict of interest mitigated?
5. Is there other justification that should be considered for an exception approval?

900 - REPRESENATIVES, CONSERVATORS, GUARDIANS, POWER OF ATTORNEY

The words representative and representatives may be used as a substitute for the word's member and members throughout this manual.

WORK REPRESENTATIVE

Members may select representatives to assist them in managing their services. Representatives are not required to have any type of legal authority to assist the member in directing services, however members may choose guardians, conservators, and those with Power of Attorney (POA) to act as their representative. While members may have representatives to assist them, *WORK* is a program which promotes independence, and they are still expected to be involved in all decision making related to their services.

LIMITATIONS / RESTRICTIONS

1. Representatives cannot be paid to provide any *WORK* services to the members for whom they are representatives, including Personal Assistance Services, Supported Employment Supports, Assistive Services, Independent Living Counseling and Fiscal Management Services.
2. Representatives may not employ members for whom they are representatives in any capacity.
3. Independent Living Counselors or MCO Care Coordinators may not act as a representative for *WORK* members for whom they are providing services.

CONSERVATORS, GUARDIANS, POWER OF ATTORNEY

Members may have conservators, guardians, and those with Power of Attorney (POA) to assist them to direct their services. Conservators, guardians, and those with POA cannot be a paid provider of services.

LIMITATIONS / RESTRICTIONS

1. Conservators, guardians, and individuals with POA cannot be paid to provide any *WORK* services, including Personal Assistance Services, Supported Employment Supports, Assistive Services, Independent Living Counseling and Fiscal Management Services.
2. Conservators, guardians, and individuals with POA may not employ the member in any capacity.
3. Independent Living Counselors or MCO Care Coordinators may not act as conservators, guardians, or have POA for *WORK* members for whom they are the providing services.

1000 – *WORK* SERVICES

WORK services have limitation and requirements. Services are non-medical. If a member needs medical services or care in the home, the member must request these services from the MCO.

PERSONAL ASSISTANCE SERVICES (PAS)

Personal Assistance Services include:

1. One or more persons physically assisting an individual with, or cuing/prompting an individual, to perform Activities of Daily Living (ADLs) at home and at work.
2. *WORK* personal care services are non-medical.
   A. *WORK* members are responsible for self-directing the provision of health maintenance activities such as monitoring vital signs, supervising and/or training others on medical procedures, ostomy care, catheter care, enteral nutrition, assistance with or administering medicines, wound care, and doctor prescribed 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.
3. One or more persons physically assisting an individual with, or cuing/prompting an individual, with Instrumental Activities of Daily Living (IADLs) at home and in the community.
   A. Using and paying for more than one Provider at a time may be permissible with written justification and approval from the MCO. An example of this would be, the member needs more than one Provider to lift them safely during bathing or dressing. This overlap with Providers must also be indicated on each timesheet and the tasks of each Provider must be documented on each timesheet during the overlap.
4. Assistance with ADLs and IADLs is not provided for members who are performing similar tasks at their place of employment.
   A. Members employed as Housekeepers / Janitors can't get assistance to clean; Lawn Care worker can't get assistance to mow; etc.
5. Members can purchase alternative and cost-effective ways of meeting needs that would otherwise require human assistance, e.g., home delivered meals or laundry services.
   A. Members can purchase equipment that decrease the need for human assistance, e.g., microwave oven to heat pre-cooked / frozen meals, medication dispenser, etc. Equipment purchases must demonstrate cost-effectiveness by decreasing their need for human assistance. Equipment that may not be purchased includes (but not limited) to computers, laptops, tablets, cell phones, home security systems, etc.

1. LIMIATIONS / RESTRICTIONS / REQUIREMENTS

Limitations, restrictions, and requirements for PAS.

A. AGE RESTRITIONS AND REQUIREMENT

I. Self-directed providers must be 18 years of age or older to provide paid support for ADLs.

II. Self-directed providers who are 14-18 years of age may be paid to provide limited support for IADLs. Hours of employment are limited by the Employment Standards as determined by the Department of Labor

a. Any child under 14 - 16 years of age

1. Cannot be employed before 7 a.m., or after 10 p.m., on days preceding a school day.
2. Cannot be employed more than eight hours per day, or 40 hours per week when school is not in session.
3. Can be employed when the minor is under 16 years of age and ONLY when such minor is not enrolled in or attending any secondary school.

b. Any child under 18 years of age:

c. Cannot be employed in any activity which has been declared by Rule or Regulation of the Secretary of Labor to be dangerous or injurious to the life, health, morals, or welfare of a minor.

B. BACKGROUND CHECKS

I. All providers (including self-directed personal care attendants) are required to obtain and pass State and national criminal history background checks on prospective employees.

II. Background checks include (but are not limited to) the Kansas Bureau of Investigation, Kansas Adult Abuse, Neglect, Exploitation Central Registry and/or Child Abuse and Neglect Central Registry. Nurse Aid Registry, and Motor Vehicle screen.

III. Individuals without clear backgrounds may not provide *WORK* services. Any provider of services found to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement under Medicaid funding. The list of prohibited offenses is in the Appendix.

IV. Background checks are not paid for by the Member. The member's MCO pays for background checks.

C. INFORMAL SUPPORT POLICY (ISP)

I. Assistance with IADLs is prohibited when a member lives in a shared residence.

II. The ISP applies whether the other adults work inside or outside of the home.

III. The ISP applies to, but not limited to,

a. Family members include spouses, parents, children, siblings aged eighteen and above, other family relatives.

b. Significant relationships include boy/girlfriend, fiancé, partner, and divorced spouse.

c. Roommates.

D. MEMBER MUST BE PRESENT

I. Providers may not be paid to provide support when the member is not present.

II. Members are expected to be present to directly supervise these activities.
III. In rare cases, an exception may be made. This is done on a case-by-case basis.
IV. Providers may not be paid for cuing/prompting by phone. Any cuing/prompting needs to be face-to-face.

E. MINOR CHILDREN OR OTHER FAMILY MEMBERS

I. Minor Children or Other Family Members
II. *WORK* personal assistance services and other services do not include care required by minor children or any other family members. Violation of the will result in termination of *WORK* services.

F. MONITORING OR RESTRICTING

I. *WORK* does not help monitor member's internet, telephone, social interactions, etc.
II. *WORK* does not help restrict food intake or other activities.

G. OVERTIME

I. Members may not use their *WORK* allocation to pay self-directed providers above 40 per week.

H. PAYMENT IN FULL

I. *WORK* services are paid using Medicaid funds and is therefore subject to Medicaid policies.
II. Participating *WORK* Providers or Suppliers must agree to accept Medicaid reimbursement as payment in full.
III. *WORK* Providers of PAS cannot bill over what a member has budgeted.
IV. *WORK* Providers cannot bill members above what Medicaid or *WORK* has agreed to pay.

I. PROVIDER OPERATED HOME

I. Members living in a provider operated home generally do not qualify for *WORK* services.
II. If a member lives in a provider operated home, services cannot be paid to the provider operating the home.

J. RANGE OF MOTION (ROM) AND EXERCISE

I. ROM must be prescribed and overseen by a doctor; specific ROM instructions from the doctor must be included in the MCO file. Doctor's notes must include the diagnosis of which ROM is needed. Time will be limited to 15 minutes per day and provided in the member's home.
II. Exercise must be ordered by a doctor and note must include the diagnosis for which the exercise is needed. Time will be limited to 30 minutes per day whether within the member's home or at a gym. The 30-minute limitation includes time for changing clothes, showering and transportation.

K. SERVICE ANIMAL

I. Support is only provided for the care of one service animal.
II. Care is limited to feeding, watering and, if appropriate, walking the service animal. No support related to grooming or vet visits.
III. A service animal is defined as a dog that has been individually trained to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability. A dog in training is not a service animal until training has been successfully completed.
IV. People with disabilities have the right to train the dog themselves and are not required to use a professional service dog training program.
V. Members must be able to demonstrate the services performed by the animal during the assessment.
VI. Emotional Support Animals and/or Comfort Animals are not considered service animals under the ADA and are not covered under *WORK* services. NOTE: If there is a diagnosis of PTSD a support animal is considered a service animal.

L. TRANSPORTATION

I. If a member has a driver's license no transportation time will be approved.
II. Transportation is limited to travel to/from work, shopping, and banking. *WORK* does not provide transportation for activities such as church, AA meetings, social outings, to/from the gym, etc.
III. Transportation required to perform job responsibilities is not provided as it is the responsibility of the employer to provide this whether the member is self-employed or employed by an employer.
IV. NEMT to/from medical appointments must be obtained from the member's MCO. *WORK* services may not be used to pay for medical transportation.

M. VEHICLE RESTRICTIONS

I. *WORK* services do not include assistance with purchasing, insuring, cleaning, maintaining, or repairing vehicles.
II. *WORK* funds may not be used for vehicle rental of any kind.

N. WEIGHT LOSS

I. *WORK* does not provide support for dieting related to weight loss or caloric restriction to prevent overeating.
II. *WORK* does not provide support for exercise related to weight loss.

2. PAS PROVIDER QUALIFICATIONS

A. SELF-DIRECTED PROVIDERS

I. Members receiving *WORK* service are free to establish their own qualifications for the providers they self-direct. However, they must follow the program policies listed under Limits/Restrictions/Requirements for PAS.
II. Members are required to obtain background checks on self-directed providers of PAS. The member's MCO pays for background checks.
III. Members are strongly encouraged to obtain references from previous employers, as well as personal references for any self-directed providers they hire.

B. AGENCY DIRECTED PROVIDERS

I. Agencies providing *WORK* services must be a KMAP provider and be certified / licensed by the State (in accordance with K.S.A. 65-5102) or affiliated with a CDDO. Agencies must conduct background checks on staff providing *WORK* services.
II. While the agency is the employer of the care givers / staff, the member is responsible for:
   a. scheduling when care givers provide assistance,
   b. explaining personal preferences when receiving assistance,
   c. supervising daily activities,
   d. notifying the agency if problems arise,
   e. and verifying when care givers have worked during the scheduled time.

SUPPORTED EMPLOYMENT

1. Services for members who, because of their disabilities, need support to maintain an individual job.
   A. Member must be employed in competitive or customized employment.
   B. Member can be self-employed in an integrated work setting in the general workforce.
   C. Member is Compensated for employment at or above the minimum wage but not less than is customary for individuals without disabilities.
   D. Member is covered at the same level of benefits as the employer pays for similar work performed by individuals without disabilities.
2. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce.
3. Supported Employment Services are individualized.
4. Supported Employment included Job Coaching supports and one-on-one support.
   A. One-on-One Support - Members requiring one-on-one support may receive support up to the number of hours of paid employment that they work each week, e.g., 10 hours of supported employment can be provided for 10 hours of paid employment. *WORK* one-on-one support is not provided on a long-term basis. The expectation is that one-on-one support should decrease as the member continues the job. The member's MCO CC will review the need for supported employment quarterly and reduce the number of hours accordingly.
   B. Consultation/Technical Assistance – Members requiring intermittent assistance of a consultative and technical nature may receive a maximum per month of ¼ of the hours the member works

per week, e.g., a member working 20 hours per week may receive up to 5 hours per month of employment support. Providers of this type of Job Coaching / Employment Support must be certified by a national certifying body to provide this.

1. SUPPORTED EMPLOYEMNT SERVICES INCLUDE

A. Support to learn new or evolving job responsibilities.
B. Support to increase accuracy and/or speed.
C. Support to learn how to exhibit appropriate work behavior.
D. Support to interact appropriately with other employees and the public.
E. Support to practice safety measures at work.
F. Consultation, and provision of technical assistance, with the employer to deal with employment related issues and/or job-related adaptations or modifications.

2. SUPPORTED EMPLOYMENT LIMITATIONS / RESTRICTIONS

A. Supported Employment Services does not include payment for supervision, training, and adaptations or supports typically available to other workers without disabilities filling similar positions in the business.
B. Supported Employment 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.
C. Supported Employment Services may be decreased or eliminated based on whether members learn their job responsibilities, exhibit appropriate work behavior, interact appropriately with co-workers and the public and practice safety measures.
D. Supported Employment Services may be re-instated if members require the service again to maintain employment or learn new job responsibilities.
E. For self-employed, Supported Employment does not include the expenses associated with starting up or operating a business, including but not limited to:
    I. assistance with business travel
    II. assistance with, or performing, day-to-day operations or financial management of the business.
    III. organizing and/or setting up work areas or work tasks
    IV. verifying whether work is performed accurately.
    V. scheduling business-related activities and/or meetings
    VI. obtaining business related materials

3. SUPPORTED EMPLOYMENT PROVIDER QUALIFICATIONS

A. Community service providers who have staff trained and certified staff by a national training and certifying body, such as employment specialists, job specialists, job coaches, supported

employment specialists, etc., who provide technical assistance to members, co-workers, and employers to assist in maintaining employment.

I. Community service providers are typically paid a higher hourly rate to work with the employer because of their training and certification.

B. Individuals hired by members directly, or through community providers, who work one-on-one with members to help them learn new or evolving job responsibilities, to increase accuracy or speed, to interact appropriately with other employees and the public, to practice safety measures at work, and/or to provide transportation to and from work.

I. Ideally, these individuals should be trained and supervised by a certified supported employment specialist.

ASSISTIVE SERVICES

WORK Assistive Services includes equipment, product systems, or environmental and home/vehicle modifications that are medically necessary, increase health, safety, and independence, and are not already provided under KanCare.

1. ASSISTIVE SERVICES INCLUDE

Assistive Services items include, but not limited to:

- Dentures
- Home modifications to increase access in the member's home, including grab bars, raised toilet seats, roll-in showers, lowered counters.
- Ramps (removal of porches or decks and/or adding porches or decks are the financial responsibility of the member).
- 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 in wheelchairs
- Specialized wheelchairs
- Wheelchair or scooter batteries and repairs
- Specialized footwear (Diabetic, Orthopedic)
- Hospital beds
- Mattresses, mattress covers, and bed rails used in medical situations.
- Cost of obtaining and replacing accredited service.
- Vehicle adaptations, based on the member's disability.
- Services which directly assist individuals with a disability in the selection, acquisition, or use of assistive technology.

2. ASSISTIVE SERVICES RESTRICTIONS

Restricted items include, but not limited to:

- ⊗ Food or nutritional supplements
- ⊗ Clothing
- ⊗ Shoes of a non-medical nature
- ⊗ Computers, laptops, IPAD's, cell phones
- ⊗ Environmental units such as air conditioners, furnaces, space heaters, humidifiers/de-humidifiers, air purifiers, water purifiers
- ⊗ Appliances such as blenders, microwaves, refrigerators, washers, dryers
- ⊗ Exercise equipment
- ⊗ Indoor/outdoor exercise pools
- ⊗ Heating pads, heat lamps, vaporizers
- ⊗ Home renovations not related to accessibility.
- ⊗ Hot tubs, Jacuzzis, saunas, spas, whirlpools, swimming pools, or similar items
- ⊗ Yard cleaning, yard repairs
- ⊗ Surgeries not already covered under KanCare.
- ⊗ Non-medical beds and water beds
- ⊗ Household furniture
- ⊗ Recliners
- ⊗ Home remodeling, including but not limited to movement of walls, replacement of carpets or floors, painting, etc.
- ⊗ Vehicles and vehicle repairs
- ⊗ Modifications to buildings in which the member does not reside, e.g., garages and sheds.
- ⊗ Adding or repairing fences or out-buildings
- ⊗ Adding, removing, or replacing decks or porches
- ⊗ 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.

3. ASSISTIVE SERVICES LIMITATIONS

A. There is no entitlement for assistive services. Each request is reviewed on a case-by-case basis, taking into consideration medical necessity, appropriateness, and cost-effectiveness, and the request if then approved or denied. If approved, the MCO will prior authorize the purchase.

B. If approved by the MCO and prior authorized, *WORK* Assistive Services has an annual cap of $7,500. This does not mean that members are entitled to receive $7,500 per year, nor does the annual cap transfer, or accrue, from year-to-year.

C. *WORK* Assistive Services does not include durable medical equipment (DME), or other technology already provided under KanCare (Medicaid State Plan services), nor will it extend the amount, duration or scope of technology covered under KanCare.
D. *WORK* Assistive Services cannot be authorized retroactively. If complete paperwork is not submitted for approval and prior authorized by the MCO, payment will be denied.
E. *WORK* Assistive Services does not include technology or modifications that are the responsibility of the employer as an accommodation under the Americans with Disabilities Act (ADA).
F. *WORK* Assistive Services does not include technology or modifications necessary for self-employed members to operate their business.
G. *WORK* 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, iPad, low vision aids to access print materials, vehicle modifications for work-related travel, modification of office furniture, restroom modifications etc.
H. While *WORK* home modifications may be prior authorized in rented apartments or homes, members must verify that they will remain a minimum of two years in a residence receiving the home modification.

4. ASSISTIVE SERVICES REQUIREMENTS

A. DOCUMENTATION OF ASSISTIVE SERVICES

Members must submit the following to their MCO for an assistive service request to be considered:

- ✓ KDHE Request for Assistive Services form, or form specified by MCO Care Coordinator
- ✓ a statement of medical necessity from the appropriate medical provider
- ✓ alternative funding sources that have been explored and why these are not viable.
- ✓ a minimum of two bids to their MCO Care Coordinator
- ✓ pictures and/or diagrams, if requested by the MCO

Once the MCO Care Coordinator receives all the information, MCOs will review the information following their process. Once all required documentation has been submitted, the MCO Care Coordinator will have 20 business days to approve or deny the request. Members and their Independent Living Counselors will be notified in writing whether the request is approved or denied and, if approved, which bid is acceptable.

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, Medicaid Fraud and Abuse Unit.

B. MEDICAL NECESSITY

To receive Assistive Services through the *WORK* program, medical necessity must be demonstrated. Members must provide documentation of the medical necessity for the assistive service.

Medically necessity is defined as:

- treating a medical condition
- recommended by the treating physician or other appropriate licensed professional in 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).

C. ALTERNATIVE FUNDING SOURCES FOR ASSISTIVE SERVICES

As Medicaid is the payor of last resort, members receiving services through the *WORK* program must make a reasonable effort to exhaust funding through other sources for Assistive Services, including private health insurance, Vocational Rehabilitation, Kansas Accessibility Modification Program (KAMP), community block grants, etc., before making a request. Prior to making a request for home modifications for a rental home, FHAA reasonable accommodations modification rights must be explored with property owner/landlord.

D. PRIOR AUTHORIZATION FOR ASSISTIVE SERVICES

Assistive services are prior authorized by the MCO on a case-by-case basis, based on medical necessity, appropriateness of the request, and cost-effectiveness. The MCO Care Coordinator has the right to request any documentation necessary to determine the need for assistive services. In some situations, photographs and/or diagrams may be requested. An assistive service request will only be forthcoming after full and complete information has been submitted to the MCO. Incomplete information will result in a denial.

In some situations, assistive services, home modifications or vehicle 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 the member's decreasing need for personal assistance services, it will be discussed with the member before the request is approved or denied.

E. PAYMENT

Claims should be submitted to the member's MCO. Assistive services claims may only be submitted by providers of *WORK* assistive services who have contracts with the member's MCO. Assistive Services is paid by the MCO once a provider files a claim for the services they have provided. Only Assistive Services that have been prior authorized by the MCO will be paid. Assistive Services is not paid via the monthly allocation.

Assistive Services providers are responsible for:

- Verifying prior authorization by the member's MCO before providing the Assistive Service(s)
- Assuring that the member receives, and is satisfied, with the Assistive Service(s).

Prior to claims submission, members are required to sign the **Assistive Services Verification and Satisfaction** form verifying that they received the Assistive Service(s), that it is working and that they are satisfied with it. In the case of home and vehicle modifications, a member's signature indicates that the work is complete, and that the member is satisfied with the modifications.

Participating Provider or Supplier—In Medicaid, participating providers agree to accept Medicaid reimbursement as payment in full.

INDEPENDENT LIVING COUNSLING

Independent Living Counseling is a service designed to assist members to self-direct their *WORK* services. Independent Living Counseling is not Targeted Case Management, and the responsibilities of a *WORK* Independent Living Counselor (ILC) are not the same as a Targeted Case Management (TCM) service. ILCs provide members with assistance to navigate program processes, paperwork, and budgets. ILCs may provide education, assistance, and guidance with eligibility, assisting to make choices within the program, development of Individualized Budgets and Emergency Backup Plans, and assistance with fiscal management services. ILCs offer information and tools, such as the on-line self-direction training, to assist members to self-direct services and manage budgets and may assist members to access these tools.

ILCs must become completely familiar with the *WORK* Program Manual and are responsible for knowing all program policies and procedures, as well as staying abreast of revisions to program policies and procedures and conveying these to members receiving *WORK* services and/or their representatives. ILCs must participate in any training required by KDHE or MCOs

1. QUALIFICATIONS

Independent Living Counseling may only be provided by Independent Living Counselors who meet the qualifications stated in the Kansas Medical Assistance Program (KMAP) Provider Manual, including:

- All ILCs, whether employed by an agency or working independently, must be enrolled as a Kansas Medical Assistance Provider (KMAP)
- have a minimum of six months' experience with a disability as recognized by the Rehabilitation Act of 1973; **or**
- have a minimum of one-year professional experience providing direct services, including case management (working directly with people with a variety of disabilities)
- complete a two-hour *WORK* orientation.
- complete and pass the KDHE web-based *WORK* Independent Living Counseling examination on KS Train
- complete at least twelve hours of standardized training annually; 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.

NOTES

1. Individuals listed on the Health and Human Services Office of the Inspector General Office Exclusion List, or on the Kansas Medicaid Program Integrity Terminated Provider List, may not be providers of *WORK* Independent Living Counseling.
2. Provider agencies that employ Independent Living Counselors are responsible for ensuring that Independent Living Counselors employed by them provide services that are clear of conflicts of interest or fiduciary abuse.

2. RESPONSIBILITIES

ILCs must be completely familiar with *WORK* program policies and procedures, keep abreast of revisions to these policies and procedures and be able to convey these policies and procedures to members. ILCs are required to sign a statement that they have read the manual and that they know the program policies and procedures contained in the manual.

ILCs must give at least two weeks' notice if they can no longer provide *WORK* ILC services for the member. ILCs must notify the member and complete an ILC change form to submit this to the MCO and *WORK* Program Manager.

ILCs must contact new members monthly and see face-to-face quarterly for the first year in the program. ILCs must see preexisting members face-to-face a minimum of quarterly.

ILC responsibilities include:

1. Assisting Member to Navigate *WORK* Program Policies

- Conveying *WORK* program policies to members and ensuring that they understand them including member's rights and responsibilities related to the *WORK* program.
- Assist members to send *WH* premiums to the correct address. (ILCs should not handle or mail premium payments without the member present).
- Assuring that the member's/representative's budget, backup plans, choice of providers, choice of alternative services, use of the monthly allocation, and documentation of Independent Living Counseling services adheres to *WORK* program policies as well as any state and federal rules, regulations and requirements that apply.

2. Assisting Member to Develop, Complete, and Submit Forms
   - Assisting members to complete and submit *WORK* documents, e.g., Individualized Budget, other budget forms if applicable, *WORK* Member Agreement form, Emergency Backup Plan, Fiscal Management Forms, etc.
   - Assisting members to accurately and thoroughly complete and submit required paperwork to fiscal management service (FMS) providers. To assist member to complete and submit paperwork (such as budgets) to providers of services such as Home Health agencies and alternative support providers.
   - Assisting members to complete and submit annual eligibility and six-month review paperwork.
   - Assisting members to document the need for assistive services and locate providers of assistive services.
3. Manage providers.
   - Assisting members to locate and/or terminate providers of personal assistance services, providers of alternative services such as PERS and meal support, and emergency backup care and emergency assistance.
   - Assisting members to interview, hire, supervise, and terminate personal assistants.
   - Assisting members to locate agency-directed services, negotiating hourly payments, ensuring that agency-directed services are consistent with the assessment and are reflected in the budget, and that these costs are commensurate with the monthly allocation payment methodology.
   - Assuring that the member understands the importance of verifying time worked by the provider, and the significance of the member's/representative's signature on the time sheet(s).
   - Assisting members to document and submit requests for reimbursements to the FMS provider in a timely manner.
   - Assisting members to coordinate non-emergency medical transportation (NEMT).
   - Monitoring to ensure that members are receiving the services that they are paying for.
   - Assisting members to dis-enroll from *WORK* service.
4. Attend *WORK* Assessments
   - Attending *WORK* assessment to assure knowledge of needed supports and services when developing *WORK* budget.
5. Connecting Member with Trainings and Services

- Assisting members to connect to other services, such as Vocational Rehabilitation or affordable housing.
- Connecting the member to a Benefits Specialist for any information related to state or federal benefits counseling (DDS referrals, completing *WORK* activity reports, expedited reinstatements, application for Federal benefits, etc.) that require SSA contact and information.
- Assisting members to develop the skills necessary to self-direct services by helping them access one of the two on-line training programs provided on the *WH* website, or any other available tool.

6. Reporting Changes
   - Communicating any changes in status, needs, problems, etc., to the member's MCO Care Coordinator.
   - Reporting emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to the MCO Care Coordinator and the DCF Adult Protective Services (see K.S.A. 39-1430 and K.S.A. 39-1431).
   - Notifying the *WORK* Program Manager and/or the MCO Care Coordinator when it appears that a member is not capable of self-directing services and requires a representative or agency directed services.
   - Reporting health and safety concerns to the *WORK* Program Manager and/ or the MCO Care Coordinator when it appears that a member's health and/or safety are in jeopardy.
   - Reporting to the *WORK* Program Manager when individuals/representatives or personal assistants are not following *WORK* program policies and procedures.
7. Participate in a minimum of 12 hours of training relevant to the provision of independent living counseling services. Training is based on a calendar year. Verification of training received must be sent to the *WORK* Program Manager, who will communicate the completed training to the MCOs.

3. LIMITS AND RESTRICTIONS

A. ILCs are expected to always provide conflict free Independent Living Counseling, including but not limited to, the following:
   I. ILCs cannot provide personal assistance services for any *WORK* member.
   II. ILCs cannot act as a representative, guardian, or POA for any *WORK* member on their caseload, receiving services from the ILC's privately operated agency, or receiving services by the agency for which the ILC is employed.
   III. An ILC's family member cannot be employed by any *WORK* member that is on the ILC's caseload, receiving services from the ILC's privately operated agency, or receiving services by the agency for which the ILC is employed.
   IV. An ILC's family member cannot provide assistive technology/assistive technology services or perform home modifications for any *WORK* member that is on the ILC's caseload, receiving services from the ILC's privately operated agency, or receiving services by the agency for which the ILC is employed.

V. ILCs cannot handle, or be involved with, any personal funds of members, including, but not limited to, cash, checking and savings accounts, premium payments, and SECA payments.

B. Members with intellectual or developmental disabilities receiving services through *WORK* cannot receive ID/DD Waiver Targeted Case Management. Once eligibility for *WORK*, TCM through the ID/DD Waiver ends.

C. Members receiving services through *WORK* cannot obtain Independent Living Counseling and agency-directed services from the same agency. If an ILC 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 ILC must assist the member to find an outside agency to direct services on behalf of the member. If the member wants to continue to receive personal assistance services from the agency for which the IL Counselor works, the IL Counselor must assist the member to locate a new IL Counselor who works for another agency.

D. ILCs may not bill for the following:
   I. Advocacy
   II. Assistance with, or testifying at, appeals.
   III. Travel
   IV. Anything not specified in the *WORK* Program Manual under Independent Living Counselor Responsibilities.

4. REQUIREMENTS

A. ILCs must meet all standards, certifications and licenses required, including but not limited to professional license/certification if required; adherence to KDHE's training and professional development requirements; maintenance of a clear background as evidenced through background checks of; KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screen.

B. Any provider of services found to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

C. Documentation
   I. All Independent Living Counseling services must be documented on the *WORK* Independent Living Counseling Services form**.** Alternative forms may only be used if they include the same information found on the *WORK* ILC Services form and must be approved by the *WORK* Program Manager. ILCs are required to include the following information on the form:
      a. Member's Name
      b. IL Counselor's Name
      c. IL Counselor's Agency
      d. Date of Service
      e. Beginning Time of Service Provided
      f. Ending Time of Service Provided
      g. Service Type (indicate by number listed to left of ILCs responsibilities in the *WORK* Program Manual)

h. Description of Service Provided (include a narrative that supports the Service Type listed on the form)
i. How Service Provided (indicate face-to-face, telephone)
j. If Other, Please Explain (indicate any other method of service provision)
k. ILCs must sign the documentation form monthly. The ILC's signature verifies that the ILC has provided the documented services to the member.

II. Documentation Review

a. ILCs must always remain current in their documentation. ILCs must provide the State and/or MCOs with documentation of services provided within 10 days of a request made by the State and/or MCO. ILCs must maintain copies of their documentation of services provided for a minimum of five years, or longer based on the contractual requirements of the MCOs.
b. MCOs will randomly review ILC's documentation on a regular basis. Problematic documentation will be returned to the ILC for correction. Continued problems with documentation will result in a corrective action plan. Recoupment of payments is also a possibility. Suspicion of Medicaid fraud will be reported to KDHE and the Attorney General's Office.
c. Documentation may also be reviewed if there are concerns about billing, documentation of services or services provided.
d. KDHE expects the MCOs to review for the following:
    - ✓ Is the name of member present?
    - ✓ Is the ILC Agency name present?
    - ✓ Is the ILC name present?
    - ✓ Is the date(s) of service provided to member present?
    - ✓ Is the beginning time(s) of service present?
    - ✓ Is the ending time(s) of service present?
    - ✓ Is this a billable activity?
    - ✓ Is the Service Type code present?
    - ✓ Is the description of the service provided consistent with the Service Type?
    - ✓ Is the description of the service provided consistent with a billable service?
    - ✓ Is the description of the service provided consistent with the units billed?
    - ✓ Is the description of how the service was provided present?
    - ✓ Is the documentation signed and dated by the member?
    - ✓ Is the documentation signed by the member within the required time frame?
    - ✓ Is the documentation signed and dated by the ILC?

5. PAYMENT FOR SERVICES

Independent Living Counseling is paid by the MCOs once ILCs file a claim for the services they have provided. Independent Living Counseling is not paid via the monthly allocation. Providers of

Independent Living Counseling must be enrolled in the Kansas Medical Assistance Program (KMAP) and contracting with the member's MCO to provide this service and receive payment.

A. Independent Living Counselors are responsible for:
   - ✓ assuring that Independent Living Counseling services billed for have been provided to the member.
   - ✓ assuring that the number of service units reimbursed per member shall not exceed 480 units (120 hours) per budget year unless prior authorization has been obtained.
   - ✓ assuring that Independent Living Counseling services provided are documented and adhere to the requirements specified in the *WORK* Program Manual.

B. Units
   I. *WORK* Independent Living Counseling is to be billed in units of 15 minutes, i.e., one unit = 15 minutes. There is a limitation of 480 annual units. A unit is reimbursed at $18.75 per unit. Units should be billed for services provided.
   II. *WORK* Independent Living Counseling can bill up to 40 units (10 hours) during the 30-day period prior to enrollment in *WH/WORK*.
   III. Exceptions to the 480 annual units limit may be made by the MCO Care Coordinator on a case-by-case basis. The requesting IL Counselor will have to provide documentation supporting why additional assistance is required.

WORK MCO SERVICE COORDINATION

Member receiving *WORK* services receive Service Coordination through their MCO. MCOs assign members a Care Coordinator. MCOs are responsible for all service coordination specified in their contract with KDHE. For members receiving *WORK* services, this includes:

- completion of *WORK* assessments
- ensuring Individualized Budgets reflect assistance specified during the assessment.
- approving Individualized Budgets
- responding to questions regarding health care benefit
- providing clarification regarding coverage and services
- providing information re: behavioral health services, non-emergency medical transportation, and value-added benefits and other resources/services offered through the MCO.
- ensuring that members are receiving the assistance identified during the *WORK* assessment.
- reviewing, approving, and monitoring Individualized Budgets
- taking appropriate action if budgeted services are not being provided (notify the ILC of issues which arise)
- approving the use of carryover funds
- adjusting the monthly allocation if additional care is needed because of a temporary medical condition.

- obtaining approval for assistive service requests
- referring members to other resource agencies

1. LIMITATIONS / RESTRICTIONS / REQUIREMENTS

Members receiving *WORK* services do not receive Targeted Case Management (TCM). They receive Service Coordination through their MCO, and Independent Living Counseling services to assist them in directing their services.

2. PAYMENT

Care Coordinators work for, and are paid by, MCOs.

1100 - ASSESSMENT OF NEED FOR ASSISTANCE

An initial need for assistance assessment is performed in the member's home to determine the monthly allocation with which the member will purchase services. Members must actively participate in the assessment. Assessments are performed by MCO Care Coordinators.

During this assessment process, the member's needs will be assessed for:

1. need for personal assistance based on documented disability/medical condition(s),
2. risks and safety,
3. layout of the home environment,
4. and for people with intellectual/developmental disabilities, need for Supported Employment support services, will be assessed.

A re-assessment is performed in the member's home annually. Paid providers of personal care serviced are not permitted to weigh in on the assessment or answer questions on the member's behalf, even if they are a family member. Members may request a re-assessment at any time if they experience changes in their physical condition(s) or living situation such as in the loss of an Informal Support Provider(s) residing with the member. Requesting increased hours meant to specifically increase the allocation when the member is using a high-cost provider is prohibited. The *WORK* Program Manager and/or MCO Care Coordinator may also request a new assessment at any time. (See Appendix B – *WORK* Re-assessment flow chart).

1. Medical documentation of members physical condition(s) may be requested by the Care Coordinator and/or KDHE. If requested, the documentation must be provided before the assessment is finalized. Employment information may also be requested by the assessor, MCO and/or KDHE. If so, the information must be provided before the assessment is finalized.
2. *WORK* can't provide over 24 hours a day of supports to members. The only exception to this limitation is where a two-person lift is required for health and safety of the member.

3. Support hours maybe reduced to reflect actual time used and hours may only be increased, if there is a change in the member's health, current employment situation, or living situation.
4. Members have the responsibility to be available for the *WORK* assessor to conduct their initial assessment and any re-assessments at the date and time agreed upon. Members who do not have assessments performed by the required date will have their *WORK* services discontinued.
5. Assessors and MCO Care Coordinators are required to review the rate of carryover funds prior to a reassessment to determine whether there is a pattern of carrying over more than 15% quarterly and reduce the monthly allocation to accurately reflect the needs of the member. Assessors and MCO Care Coordinators will look at the member's use of services based on billing and timesheets of the provider to determine whether there is a pattern of non-use during times the member is assessed to need assistance.

WORK ASSESSMENT

The assessor will use the *WORK* Monthly Allocation and Assessment Tool to determine the member's need for assistance. *WORK* is not required to make exceptions to an assessment or any policies that govern *WORK* services.

1. ACTIVITIES OF DAILY LIVING (ADLS)

Include the following:

A. Personal Hygiene and Grooming
B. Dressing
C. Prosthetic / Orthotic / Medical Device(s)
D. Toileting
E. Eating
F. Other ADLs
    I. Transferring
    II. Doctor ordered ROM.
    III. Night Support
        a. Night support is only provided for members who require hands-on care on a nightly basis. Hands-on care includes re-positioning, tracheotomy care, and care for chronic incontinence if documented by a physician.
        b. The Fair Labors Standards Act (FLSA) requires that PAs providing assistance at night must be paid for all hours worked during the night unless they are able to obtain five uninterrupted hours of sleep. FLSA also requires that personal assistant must be paid minimum wage or above.
        c. When an assessment indicates that a member requires personal assistance during the night, eight hours per night, seven days per week, can be added to the member's assessment.

d. Members residing in a shared home with another adult (18 years and older) will not have their monthly allocation increased. Adults living in the shared home are expected to provide night support without payment. If the adult(s) in the home chooses not to provide night support, the member can receive an increase in his/her monthly allocation for night support but will need to select either an agency or a provider living outside of the home to provide support.

e. An exception can be allowed if a member cannot find an agency or other providers living outside of the home to provide night support.

1. Criteria for the exception:

i. Provide documentation that no agency or providers within a 30-mile radius of the member's home is available to provide night support. This documentation must be provided before an exception can be approved.

2. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

A. Medication Management
B. Meal Planning / Preparation / Cleanup
C. Shopping
D. Housekeeping
E. Laundry
F. Money Management
G. Other IADLs

I. Accompaniment to medical appointments and help with paperwork.
II. Safety in the community.
III. Doctor ordered exercise.
IV. Personal Emergency Response System.
V. Mowing and Snow Removal.

3. SUPPORTED EMPLOYMENT

A. Members with an intellectual/development disability or brain injury can be assessed to determine their need for Supported Employment at their place of employment.
B. One-on-One Supported Employment
C. Job Coaching Support Employment

4. ASSESSMENT PROCESS

During assessments, each ADL and IADL will be assessed separately to determine the following:

- Can the member perform tasks independently?
- How much time does it take for the member to perform task independently?

- Note: Time above what the *WORK* Assessment tool reflects in the Time per Task Guide must have supporting documentation and/or justification for time to be approved by the MCO and/or KDHE.

- Does the member need assistance but currently use unpaid natural supports to perform the task?
- If natural supports are used, a description of the nature of the natural supports.
- Does the member require cuing and prompting to perform the task, and the amount of time this requires?
- Does the member live in a shared residence/home?
- Does the need for assistance reflect the disability or medical condition?
- Does the member use any assistive aids and what are the aids?

5. RISK ASSESSMENT

The member's home environment will be assessed to determine whether any health or environmental risks are present, including:

- home and neighborhood safety
- presence of safety equipment such as carbon monoxide detectors, smoke detectors, and fire extinguishers
- functioning utilities
- emergency egress
- abuse, neglect and/or exploitation issues

1200 – MONTHLY ALLOCATION, INDIVIDUALIZED BUDGET, FISCAL MANAGEMENT, AND EMERGENCY BACKUP PLAN

A. MONTHLY ALLOCATION

Personal Assistance Services and Supported Employment are paid from the member's monthly allocation, which is determined during the assessment. Following the *WORK* assessment, assessors determine the total number of hours of assistance members require to live and work in their home and communities. Assessors then use a formula established by the State to translate hours of assistance into a dollar amount which becomes the monthly allocation members use to purchase their services.

The *WORK* monthly allocation is comprised of federal and state Medicaid dollars specifically to purchase personal assistance service and supported employment services for members eligible to receive *WORK* services. KDHE, the Medicaid single state agency in Kansas, reserves the right to restrict how the monthly allocation is spent. While *WORK* permits members to have some control over how funds are used to purchase services, these are Medicaid funds which may only be used to purchase very specific Medicaid covered services and subject to restrictions imposed by KDHE.

The monthly allocation does not count as income or resources for eligibility purposes and will not be used in the determination of the member's *WH* premium.

Members who are no longer receiving *WORK* services for any reason must return any portion of the monthly allocation that is unspent to the MCO within 90 days of *WORK* services ending. If they do not, the remaining allocation may be considered income or resources when determining Medicaid eligibility and HCBS client obligation.

1. MONTHLY ALLOCATION FORMULA

The following are the formulas for determining the amount of money members receive per month to pay for assistance:

A. PAS

I. 16 = maximum hours of daytime support

$16.50 = daytime hourly rate

II. 8 = maximum hours of night support

$11.50 = night support recommended hourly rate

B. Supported Employment

I. $50.00 = Job Coaching hourly rate

a. Number of hours based on number of employment hours.

b. Hour per week of employment x 25% = total available hour per month. (20h x 25% = 5h per month).

II. $25.00 = 1:1 Supported Employment hourly rate

b. Number of hours based on number of employment hours.

c. For every hour of employment 1 hour of 1:1 Support can be allowed.

d. 1:1 Support is temporary and reduces at a minimum of 25% every 3 months.

C. Formula to convert hours to allocation.

h = hours per week, H = hours per month

4.33 = average number of weeks per month

h x 4.33 = H x hourly rate = monthly allocation

D. Monthly allocation is then reduced by either 3% or 10%. The amount is used to pay for Fiscal Management. The Fiscal Management agency will pay invoices, process payroll, and pay Worker's Compensation Fees on behave of the member.

3% = if the member agency directs supports, the monthly allocation will be reduced by 3%. This cost less due to only invoices are paid. This means no payroll to process and no Worker's Compensation.

10% = if the member self-directs support, or if the member does a combination of agency and self-direction, the monthly allocation will be reduced by 10%. This cost more due to payroll and Worker's Compensation.

2. USE OF THE MONTHLY ALLOCATION

The monthly allocation may be used to pay for costs related to personal assistance services, alternative methods of personal assistance services, and Supported Employment support services. Examples include:

- advertising for providers
- hourly wages up to 40 hours per week per Self-Directed Provider
- all applicable payroll deductions for Self-Directed Provider
- alternative methods of purchasing personal assistance, e.g., meal or laundry service
- Mowing/snow removal
- Supported Employment supports.
- reimbursement for public transportation
- payment for equipment which ensures safety, e.g., emergency life support, smoke/carbon monoxide detectors and batteries, fire extinguishers.
- fiscal management services administrative fee
- Worker's Compensation premiums

3. LIMIATIONS / RESTRICTIONS

WORK allocation cannot be used to pay for anything that goes beyond the scope of *WORK* as laid out in the *WORK* Program Policy manual. Members should contact their MCO Care Coordinator, Independent Living Counselor, or the *WORK* Program Manager if uncertain about the appropriate use of the allocation.

Examples of what the allocation may not be used for, including but not limited to the following:

- *WH* premiums or Plan for Achieving Self-Support (PASS) Plan for Achieving Self-Support (PASS)
- Loans or gifts for workers, friends, or family members.

- Payments to representatives, conservators, guardians, or those with POA.
- Payments of household bills, e.g., rent/mortgage, utilities (gas, electric, water, etc.), phones/internet/cable.
- Payments for repairs to home, including cleaning, weeding, spraying, gardening, landscaping, pruning, etc. of yard, .
- Cannot purchase, rent, repair, or maintain vehicles, including insurance or fuel.
- Payments for or purchasing of entertainment or devices, such as TV, laptop/computer/tablet/printer, gaming consoles, etc.
- Purchase of clothing, including clothing for employment.
- Purchase of food or nutritional supplements, alcohol, tobacco products, etc.
- Payment or purchase of items available through another source, such as employers or Vocational Rehabilitation.
- Payments or purchases that are not related to the member's disability.
- Paying for services exceeding the monthly allocation (which may result in a denial of payment by the FMS provider) or paying for services that are not included in the Individualized Budget and have not been approved by the MCO Care Coordinator.
- Paying for services that have not been provided (*WORK* services may be terminated and a report made to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU) if a member verifies work that was not provided.
- Paying for additional hours of support to return home from a medical facility stay when leaving the medical facility is not recommended.

4. ADJUSTING THE MONTHLY ALLOCATION

The Assessor will conduct annual reassessments. If changes have occurred in the member's physical condition and function, this will be documented in the *WORK* Assessment Tool and the monthly allocation will be revised. The member, 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 Care Coordinator for approval.

If there is a temporary change in the member's physical condition and function prior to the annual review date, the member may request an adjustment to the allocation. The MCO Care Coordinator will assess the member's need for a temporary revision, determine the additional assistance needed, calculate a new monthly allocation, and indicate the length of the time that the new monthly allocation will be in place. The member and the ILC must develop a revised Individualized Budget and submit it to the MCO Care Coordinator for approval.

B. INDIVIDUALIZED BUDGET

1. DESCRIPTION

Once members know the amount of their monthly allocation, they must develop an Individualized Budget indicating how their monthly allocation will be used to pay for personal and employment services. ILCs are available to assist members to develop and seek approval for their Individualized Budgets.

The Individualized Budget allows members to indicate whether they will purchase their personal assistance and employment supports from an individual, an agency or in an alternative way. Members also indicate whom they will hire, how much they will pay, the number of hours the workers or agencies will provide, etc. Members 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. Members 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.

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.
    - If a provider is not listed on the budget or on the Emergency Backup Plan document, that provider cannot be paid for WORK services. The budget drives what providers are authorized to be paid for supports / services provided to the member.
    - If a member terminates or hires new providers but does not update the budget, the member would be responsible for paying out of pocket for any supports / services used.
- alternative service substitutes for personal assistance.
- any variable expenditures that provide alternative support and the cost.
- how carryover funds will be spent.

Individualized Budgets must reflect the amount, duration and scope of assistance identified during the *WORK* assessment. Service hours must be comparable to the number of hours for which members have been assessed. Members must choose agencies whose hourly compensation rate is like the hourly rate on which the monthly allocation is based. When a high-cost agency is chosen by the member and less than 70% of assessed hours are available, a Budget Service Schedule will be required to demonstrate how the hours will be used. The member will need to sign the *WORK* Member Agreement page 4 that they understand they will not have access to all hours assessed and agree to hold KDHE harmless. KDHE reserves the right to deny approval for Individualized Budgets which decrease the number of hours of assistance received by members.

Any time the monthly allocation changes, members must revise their Individualized Budgets to reflect the new allocation amount.

Individualized Budgets must be reviewed and approved by the MCO Care Coordinator before services can begin. The review will include whether the budget includes all the required information, meets the needs of the member, and reflects the amount, duration and scope of assistance identified during the *WORK* assessment. A Questionnaire and a Budget Service Schedule may be required when it appears that the member is receiving significantly less assistance than the member was assessed needing, due to a high hourly reimbursement rate.

2. CARRYOVER FUNDS

Monthly allocation funds not spent 45 days after the pay period will be moved into a carryover account. Members may use carryover funds for specific purposes. The intent to use these funds must be documented on the member's Individualized Budget under "Use of Carryover Funds," and approved by the MCO Care Coordinator.

At the end of each quarter, any amount above 15% of the discounted monthly allocation will be "swept" and returned to the MCO.

MCO Care Coordinators are required to review the rate of carryover funds prior to a reassessment to determine whether there is a pattern of carrying over more than 15% quarterly and reduce the monthly allocation to accurately reflect the needs of the member.

3. ALLOWED USED OF CARRYOVER FUNDS

When requesting the use of carryover funds, the following must be included in the request before the request is approved.

1. What the funds are to be used for, e.g., PAS self-directed provider paid leave, purchase of small item that increased independence and reduces the need for personal assistance, smoke detectors, etc.
2. The specific number of hours if requesting paid leave or additional hours of support.
3. The specific cost of the request.
4. The date of purchase or services.

All requests must be approved before an item or service is provided.

Carryover funds may be used to purchase the following:

1. 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 Care

Coordinator explaining how the equipment is related to the disability, increases independence, and is cost effective)
2. health, safety, and emergency equipment such as fire extinguishers, carbon monoxide and smoke detectors
3. advertising costs to recruit Providers.
4. additional personal assistance related to temporary increased need or emergency backup care.
5. leave for Self-Directed Providers (limited to the number of hours worked by Self-Directed Provider during a one-week period and no more than one week per year)

NOTE: Leave for Self-Directed Providers is based on the availability of carryover funds and given at the discretion of the member. Leave is limited to one week per Self-Directed Provider per year and can only cover the number of hours typically worked by a Self-Directed Provider during a one-week period, e.g., a Self-Directed Provider that works 10 hours per week may only receive 10 hours of leave. Leave does not accrue; there is no leave payout at the end of a year or if a Self-Directed Provider resigns, nor does leave carryover into the next year. Leave must be documented and submitted on the timesheet in which the leave was taken and must be clearly documented as leave.

4. PROHIBITED USES OF CARROVER FUNDS

In addition to limits and restrictions of the use of the *WORK* allocation, carryover funds may not be used to purchase, or to save for, the following items:

- high-cost items
- incontinence products
- payment for extermination of pests in the home
- payment for deep cleaning because of hoarding, animals, dirt, etc.
- items related to the disability that would be available through another funding source.

C. FISCAL MANAGEMENT

All monthly *WORK* allocations are managed by a fiscal management organization. MCOs contract with a fiscal management services (FMS) provider to manage the *WORK* monthly allocation on behalf of their members. Members who receive services must use the FMS provider designated by their MCO.

Some examples of what the FMS provider is responsible for include, but are not limited to, the following:

- providing orientation and assistance to members, 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.
- providing a toll-free Customer Service line
- providing fax capabilities

- providing a secure internet/e-mail communication system that meets Federal and State accessibility requirements and Health Insurance Portability and Accountability Act (HIPAA)
- providing print materials in alternate formats (e.g., Braille)
- processing all employer, employee, vendor paperwork, e.g., time sheets, provider invoices, member reimbursement, etc.
- filing all employer paperwork and employee paperwork as required by state and federal law.
- performing background checks on personal assistants
- performing Office of Inspector General (OIG) verification checks and notifying the MCO when there is a problem.
- paying Worker's Compensation premiums
- paying employees and vendors in a timely fashion
- filing and paying federal income tax withholding, FICA and FUTA, state income tax, and Unemployment Insurance for personal assistants
- preparing, filing, and distributing IRS forms
- notifying MCOs if there are problems.
- accounting for all expenditures
- providing monthly reports to the MCOs

D. EMERGENCY BACKUP PLAN

Following the development of the Individualized Budget, members will be asked to carefully consider, and document, their resources in the event of an emergency. Members are responsible for ensuring that their emergency backup plan is viable. If a member finds themselves without provider support, the emergency backup plan is to be used until the member can hire new providers or until current providers are again able to provide support.

ILCs are available to help members develop their emergency backup plan.

Included on the plan must be:

- name(s) and contact information of person(s) that will provide emergency backup assistance in the event a personal assistant does not report to work.
- name(s) and contact information of persons that should be notified in the event of an emergency.
- 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 members dependent on technology, how their technology will be powered in the event of a power outage.
- for members with service animals or pets, how the pets will be cared for in the event of a hospitalization or emergency.

Emergency Backup Plans must include individuals, or agencies, that are aware of, and have agreed to, help if personal assistants are unable or unwilling to perform their job duties. Those listed in the Plan must be located within the same area as the member; they cannot live in another area of the state or out-of-state.

The Emergency Backup Plan is submitted to the MCO Care Coordinator for approval along with the Individualized Budget. The Care Coordinator will review the Emergency Backup Plan to determine whether the emergency provisions are adequate. If not, members may be asked to review and revise the plan.

1300 - DIRECTING SERVICES AND MEMBER AGREEMENTS

The *WORK* program is designed to give members more control. With this control comes responsibility. Members may self-direct their services, have an agency direct service on their behalf, or a combination of both.

Covered Services—Services and supplies for which *WORK* will reimburse. Covered Services are identified on the *WORK* Individualized Budget.

Participating Provider or Supplier—In Medicaid, participating providers agree to accept Medicaid reimbursement as payment in full.

A. SELF-DIRECTION

1. DESCRIPTION

Members may self-direct their services. Members who choose to self-direct their services are the Employer-of-Record, and are responsible for the following:

- recruiting Providers
- interviewing Providers
- performing former employer and personal reference checks for the Providers
- negotiating and setting hourly wages for Providers within the parameters of their assessed needs and monthly allocation
- hiring Providers
- training Providers
- scheduling Providers
- referring potential Providers to their FMS provider to perform background checks.
- ensuring that Providers have completed and submitted all required employee paperwork to their FMS provider.
- reviewing invoices for services rendered or items purchased, and signing to verify the accuracy, before submitting to the FMS provider

- verifying for the FMS provider that the hours listed on Self-Directed Provider time sheets accurately reflects hours worked.
- terminating Providers if necessary
- completing the FMS paperwork indicating that a Provider is no longer working for them.
- providing references for former Providers, as appropriate

Web-based self-direction trainings are available on the *WH* website located at the following web address: https://www.kancare.ks.gov/consumers/working-healthy/working-healthy/work

- The ***Kansas Personal Assistance Supports and Services (K-PASS) Self-Direction Toolkit*** includes a step-by-step format with a mix and match option which provides members with the information and tools needed to self-direct any component of their personal assistance services.
- The ***WORK Self-Direction Training and Assessment*** was developed for members with more limited reading comprehension skills. This training encompasses a variety of topics, including recruiting, interviewing, negotiating rates and performing reference checks, hiring, training, and supervising Self-Directed Providers, recognizing, and receiving good Self-Directed Provider services, etc.

B. AGENCY DIRECTION

Members who do not want to self-direct their services may select a certified home health agency or CDDO affiliate to provide services on their behalf. Members who choose agency directed services are not the Employer-of-Record; the agency selected is the employer. Members still manage their monthly allocation and, with the assistance of their ILC, select an agency that offers personal assistance services and negotiate an hourly rate with an agency that is within the parameters of their monthly allocation. While the agency is the employer of the Provider (s), the member is responsible for the following:

- scheduling Providers
- explaining personal preferences when receiving assistance
- supervising daily activities
- notifying the agency if problems arise
- verifying that Providers have worked during their scheduled time.

C. COMBINATION SELF AND AGENCY DIRECTION

Members may choose to self-direct some of their PAS, while using an agency to direct other PAS. When members choose this option, they are the Employer-of-Record for the Self-Directed Provider they are self-directing, and the agency is the Employer-of-Record for the staff employed by them.

D. MEMBER AGREEMENT FORM

Members will be asked to complete the *WORK* Member Agreement Form at the same time the Individualized Budget is developed. 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 Member Agreement Form includes the following choices:

- to participate/not participate in *WORK*.
- self-direct/not self-direct services
- have/not have a representative.

The Member 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 HCB*S* Waiver

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

1400 - PROVIDER ENROLLMENT

A. AGENCY DIRECTED PERSONAL CARE PROVIDER ENROLLMENT

1. Provider must be a KMAP provider and one of the following:
   a. Certified Home Health agency.
   b. CDDO affiliate to provide services on their behalf.
   c. A licensed provider of personal care for individuals.
2. Provider must complete the Fiscal Management paperwork for the Fiscal Manager so the Agency can be paid.

B. SELF-DIRECTED PERSONAL CARE PROVIDER ENROLLMENT

1. Provider is not required to be a KMAP provider.
2. Provider must complete the Fiscal Management paperwork for the Fiscal Manager so the provider can be paid.
3. Provider must pass a background check.

4. Provider may not start working until all the Fiscal Management paperwork and background check has been completed and the provider is "good-to-go."

C. ALTERNATIVE SUPPORT PROVIDER / VENDER ENROLLMENT

1. Provider is not required to be a KMAP provider .
2. Provider/Vender must complete the Fiscal Management paperwork for the Fiscal Manager so the Provider/Vender can be paid.

D. ASSISTIVE SERVICES AND INDEPENDENT LIVING COUNSELING PROVIDER ENROLLMENT

To bill for Assistive Services and Independent Living Counseling providers must be enrolled in the Kansas Medical Assistance Program (KMAP) as a *WORK* service provider **(Provider Type 56)** with a Provider Specialty of Assistive Services **(Provider Specialty 526)** and/or Independent Living Counseling services **(Provider Specialty 506)**. Providers must use the procedure codes for Assistive Services (**S5165)** and/or Independent Living Counseling **(T1016)** to receive payment for providing these services.

Provider Specialty

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: DME provider, dentist, orthotics, and prosthetics vendors, CDDO or CDDO Affiliate, CIL, or Home Health Agency.

506 (**Independent Living Counseling) –** Community organizations and individuals are eligible to enroll as providers of Independent Living Counseling. All providers of this service must meet the training requirements for an Independent Living Counselor.

Procedure Codes

S5165 - Assistive Services

T1016 - Independent Living Counseling – reimbursed at the rate of $18.75 per unit (limit of 480 units annually; Prior Authorization required for additional units)

- *WORK* Independent Living Counseling can bill up to 40 units (10 hours) during the 30-day period prior to enrollment in *WH/WORK*.

E. WORKING HEALTHY / WORK CODES

Population

26 – *WH* Basic Eligibility

B4 – *Working Health* Disabled Eligibility

27 – *WH* Medically Improved

B5 – *WH* Medically Improved Disabled

Level of Care

WK - *WORK*

Population Codes 27 and B5 should also be used in determining the *WH* beneficiary receiving *WORK* services. This Population Code combined with a Level of Care code of WK (250) indicate that a member is eligible for *WH* 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*.

1500- MEMBER RIGHTS AND RESPONSIBILITIES

A. MEMBER RIGHTS

- Members have the right to information that will assist them in making an informed choice regarding whether they want to enroll in *WH* and *WORK,* and assistance in completing the Member Agreement form.
- Members have the right, once all program requirements are met and paperwork completed, to timely enrollment in *WORK*.
- Members have the right to a person-centered planning process with all aspects of *WORK,* including an assessment to determine what services are needed to live and work in the community, and the development of an Individualized Budget and Emergency Backup Plan.
- Members have the right to choose a representative to act on their behalf.
- Members have the right and the responsibility to be involved in directing their services, even if they choose to have a representative to act on their behalf.
- Members have a right to choose who they want involved in the planning of their *WORK* services.
- Members have the right to self-direct their services, choose an agency to direct services on their behalf, or choose a combination of both self and agency-direction. **KDHE reserves the right to require**

members to have a representative or agency direct their services if KDHE has concerns about their ability to self-direct their services.

- Members have the right and responsibility to have criminal background checks conducted on their personal assistance providers.
- Members have the right to know what services have been provided by their Independent Living Counselor.
- Members have the right to file a grievance or appeal a decision by the MCO or KDHE regarding *WORK* services.
- Members have the right and responsibility to report abuse, neglect, and exploitation to DCF Children or Adult Prevention and Protection Services.

B. MEMBER RESPONSIBILITIES

- Members are responsible for complying with *WORK* program policies and procedures as laid out in the *WORK* Program Manual. **Note: Pursuant to K.A.R 129-6-84(4)(c), KDHE reserves the right to require members to have increased management, including a representative and/or agency directed services, or to leave the program, if they do not follow the program policies and procedures contained in the *WORK* Program Manual.**
- Members have the responsibility to obtain all necessary information to enable them to make an informed choice regarding whether they want *WORK* services.
- Members have the responsibility to provide Medicaid eligibility staff, in a timely and complete manner, all paperwork needed to complete annual eligibility and six-month desk reviews, without a disruption in services. Members who do not complete this paperwork will have their *WH* cases closed, and *WORK* services will end.
- Members are responsible for paying their *WH* premium monthly by the date specified on their statement. Members who do not pay premiums will have their *WH* cases closed, and *WORK* services will end. Members whose payments are in arrears must pay all premiums in full before their *WORK* services can continue.
- Members have the responsibility to inform 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.
- Members have the responsibility to inform their MCO Care Coordinator or Independent Living Counselor in a timely manner if they wish to return to an HCBS waiver or waiver waiting list.

- Members have the responsibility to be available for the *WORK* assessor to conduct their initial assessment, and annual re-assessments, at the date and time agreed upon. Members who do not have re-assessments performed by the required date will have their *WORK* services discontinued.

- Members 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).**

- Members choosing to direct their own care are responsible to understand and accept the responsibilities and risks of directing their own care; **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 to direct care on their behalf.

- Members have the responsibility to ensure that the services and costs listed on their Individualized Budget reflect the needs identified during their *WORK* assessment.

- Members 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.

- Members have the responsibility to verify that the time sheets, invoices, or documentation of service providers are accurate, and signing these to verify that they received the services being billed. **Falsification of time sheets, either by the Member or Provider will result in removal from the program and will be reported to the MFCU.**

- Members have the responsibility to submit timesheets in the timeframe identified by the FMS provider.

- Members have the responsibility to request the permission of their MCO Care Coordinator to spend carryover funds.

- Members have the responsibility **not** to spend their allocation on anything prohibited by KDHE and/or MCO. **Note: Inappropriate use of Medicaid funds is considered Medicaid fraud, which will be reported to the Office of the Attorney General Medicaid Fraud Control Unit and may result in prosecution.**

- Members have the responsibility to complete an Emergency Backup Plan that ensures adequate coverage if their employees do not come, and that they have made provisions for their safety in the event of a natural or any other disaster.

- Members have the responsibility to sign all sections of the Member Agreement form, indicating the informed choices they have made, as well as their willingness to comply with the *WORK* program policies and procedures.

- Members have the responsibility to complete all paperwork required by the FMS provider in a thorough and timely manner to ensure that their Providers are paid in a timely manner.
- Members have the responsibility to conduct themselves in a courteous manner. If a member becomes verbally or physically abusive, profane, bullies or sexually harasses a provider of services, including *WORK* Providers, MCO staff, KDHE staff and ILCs, and staff the member can be removed from the *WORK* program.

1600 - GRIEVANCES, APPEALS, FAIR HEARINGS, STATE APPEAL COMMITTEE, JUDICIAL REVIEW

A. MCO GRIEVANCE / APPEAL PROCESS

Members who are dissatisfied about any matter other than an adverse benefit determination made by their MCO related to their *WORK* services have the right to file a grievance. Members who disagree with an adverse benefit determination made by their MCO related to their *WORK* services have the right to file an appeal with the MCO.

GRIEVANCE

Members may file a grievance at any time. The MCO must acknowledge in writing the grievance was received within 10 business days; 98% of all grievances must be resolved and a grievance resolution letter issued to the member in 30 calendar days. If the MCO believes an additional 14 calendar days may be needed to resolve the grievance, this request must be made to KDHE/DHCF two business days in advance of the 30 calendar days deadline. 100% of grievances must be resolved and a grievance resolution letter issued to the member in 60 calendar days.

APPEAL

Members who disagree with an adverse benefit determination made by an MCO related to their *WORK* services may appeal the decision. The MCO must inform the member of the adverse benefit determination in a notice. This notice is called a "Notice of Adverse Benefit Determination." Members may submit an appeal with their MCO within 60 calendar days of the date on the notice of adverse benefit determination. If the Notice of Adverse Benefit Determination was mailed, three calendar days are added. The MCO must send a letter to the member within five calendar days acknowledging receipt of the appeal request. The MCO must resolve 100% of appeals and issue a Notice of Appeal Resolution within 30 calendar days.

CONTINUATION OF BENEFITS:

If you ask for an appeal, you may be able to keep your current level of services while you wait for your appeal decision. To request continuation of benefits, you will need to submit a request to your MCO within 10 calendar days from the mail date of the Notice of Adverse Benefit Determination.

If your services continue until the appeal decision, you may have to pay back any assistance you receive if the decision is not in your favor.

EXPEDITED APPEAL

Members may file a request for an expedited appeal when the member's health requires a decision made as expeditiously as possible. When an expedited appeal is requested, the MCO will determine if the request meets the criteria for an expedited decision. If the request meets the criteria, the MCO must resolve 100% of expedited appeal requests and issue a Notice of Appeal Resolution within 72 hours. If more time is needed to gather additional information, the MCO may request the additional time from KDHE/DHCF. If the request does not meet the criteria, the MCO will resolve the request and issue a Notice of appeal Resolution within 30 calendar days.

Members should refer to their MCO's member handbook for information regarding the MCOs specific grievance and appeal process and follow the steps in the handbook. MCO member handbooks can be found on the MCO's website.

B. STATE FAIR HEARING

Members who disagree with a decision made by their MCO in response to their appeal may file a request for a State Fair Hearing. Members must complete the appeal process prior to requesting a State Fair Hearing. The Kansas Office of Administrative Hearings (OAH) must receive the State Fair Hearing request within 120 calendar days of the date of the Notice of Appeal Resolution. If the Notice of Appeal Resolution was mailed, three calendar days are added. Members may also request an expedited fair hearing if the member's request for an expedited appeal met the criteria for an expedited decision, but the MCO upheld their adverse benefit determination. Members may request a State Fair Hearing verbally or in writing. A verbal request may be made in person or by telephone with their MCO. A written request may be made in person, by mail, by fax, or by email to their MCO. A written request may be made by fax or by mail to OAH. All hearing dates, resolutions, and notifications follow the timelines prescribed by OAH. If neither the member nor the State request that the KDHE State Appeals Committee (SAC) review the hearing decision (the Initial Order), the decision becomes final 30 calendar days from the date the Initial Order was served.

A State Fair Hearing request form may be found at https://www.kancare.ks.gov/consumers/mco-state-fair-hearings. Written requests for a State Fair Hearing should be mailed or faxed to:

Office of Administrative Hearings

1020 S. Kansas Ave.

Topeka, KS 66612

Fax: (785) 296-4848

Continuation of Benefits: If you ask for a hearing, you may be able to keep your current level of services while you wait for your hearing decision. To request continuation of benefits, you will need to submit your

request to your MCO within 10 calendar days from the mail date of the Notice of Appeal Resolution. If your services continue until the hearing decision, you may have to pay back any assistance you receive if the decision is not in your favor.

C. KDHE STATE APPEALS COMMITTE (SAC)

If a member or the State disagrees with the Initial Order decision made by OAH, either party may request, within 15 calendar days of the date the Initial Order decision was served, that the KDHE State Appeals Committee (SAC) review the decision. If the Initial Order was served by mail, three calendar days are added to the 15 calendar days. If you ask for a review by the KDHE SAC, you do not have the option of having your current level of services continue. The KDHE SAC reviews the decision in OAH's Initial Order. Following a SAC review, the decision by SAC becomes the Final Order. The Final Order is effective on the date the Final Order is served.

D. JUDICIAL REVIEW

If a member or the State disagrees with the decision of the KDHE SAC, either party may file a petition for a Judicial Review in the appropriate District Court. Should either party seek judicial review, then, pursuant to K.S.A. 77-613(b), the request for judicial review must be filed within 30 calendar days from the date the Final Order was served.

1700 - KANCARE OMBUDSMAN

The KanCare Member Ombudsman is available to help Members who receive long-term care services through MCOs. The Ombudsman can help members:

- 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 Members who have problems that the Ombudsman cannot resolve.

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

APPENDEX

ACRONYMS TO KNOW

ADA = Americans with Disabilities Act	**APS** =Adult Protective Services
BI = Brain Injury	**CDDO** = Community Development Disability Organization
DCF = Department of Child and Family Services	**DHCF** = Division of Health Care Finance
EVV = Electronic Visit Verification	**FHAA** = Fair Housing Amendments Act
FICA = Federal Insurance Contributions Act (Federal Taxes)	**FLSA** = Fair Labors Standards Act
FMS = Fiscal Management Services (FMS)	**FPL** = Federal Poverty Level
FUTA = Federal Unemployment Tax Act	**HCBS** = Home and Community Based Services
HIPAA = Health Insurance Portability and Accountability Act	**I/DD** = Intellectual / Developmental Disability
ILC = Independent Living Counselor	**IRS** = Internal Revenue Services
ISP = Informal Support Policy	**KAMP** = Kansas Accessibility Modification Program
KBI = Kansas Bureau of Investigation	**KDADS** = Kansas Department of Aging and Disability Services
KDHE = Kansas Depart of Health and Environment	**KEES** = Kansas Eligibility Enforcement System
KMAP = Kansas Medical Assistance Provider	**K-PASS** = Kansas Personal Assistance Supports and Services
KSA = Kansas Statutes Annotated	**LTC** = Long Term Care
MCO = Managed Care Organization	**MCO CC** = MCO Care Coordinator
MFCU = Medicaid Fraud Control Unit	**NEMT** = Non-Emergency Medical Transportation
OAH = Kansas Office of Administrative Hearings	**OIG** = Office of Inspector General
PAS = Personal Assistance Services	**PASS** = Plan for Achieving Self-Support
PD = Physical Disability	**PERS** = Personal Emergency Response System
POA = Power of Attorney	**PTSD** = Post Traumatic Stress Disorder
ROM = Range of Motion	**SAC** = State Appeals Committee
SECA = Self-Employed Contributions Act (Federal Taxes)	**SSA** = Social Security Administration
STEPS = Support and Training for Employing People Successfully	**TCM** = Targeted Case Management
TUP = Temporary Unemployment Plan	**TWIIA** = Ticket-to-Work and Work Incentives Improvement Act
WH = Working Healthy	**WHBS** = Working Healthy Benefit Specialist
WH/WORK = Working Healthy / WORK	**WORK** = Work Opportunities Rewards Kansans
WPM = WORK Program Manager	

CURRENT AND NEW PROHIBITED OFFENSES

Adult Care Homes & Home Health Agencies KSA 39-970, 65-5117	HCBS X = existing prohibition KSA 39-2009	**OFFENSE** Note: Green shading denotes a new prohibition for this type of facility.	**PROHIBITED** Does Not Expire * ⇩	Expires 6 Yrs. ⇩
21-5301 21-3301	X	Attempt to commit a prohibited offense [1]	See Key	
21-5302 21-3302	X	Conspiracy to commit a prohibited offense [2]	See Key	
21-5303 21-3303	New	Criminal solicitation to commit a prohibited offense [3]	See Key	
21-5401 21-3439	X	Capitol Murder (Felony)	Yes	
21-5402 21-3401	X	First degree murder (Felony)	Yes	
21-5403 21-3402a 21-3302	X	Second degree murder (Felony)	Yes	
21-5404 21-3403	X	Voluntary manslaughter (Felony)	Yes	
21-5405 21-3404	X	Involuntary manslaughter (Felony)		6 Years*
21-5407 21-3406	X	Assisting suicide (Felony)	Yes	
21-5412(b) 21-3410	X	Aggravated assault (Felony)		
21-5412(d) 21-3411	X	Aggravated assault on a law enforcement officer (Felony)		6 Years*
21-5414 21-3412a	X	Domestic Battery (Felony)		6 Years*
21-5413(c) 21-3413	X	Battery against a law enforcement officer (Felony)		6 Years*
21-5413(b) 21-3414	X	Aggravated battery (Felony)		6 Years*
21-5413(d) 21-3415	X	Aggravated battery against a law enforcement officer (Felony)		6 Years*

21-5415(a) 21-3419	X	Criminal threat (Felony)	6 Years*
21-5415(b)21-3419(a)	X	Aggravated criminal threat (Felony)	6 Years*
21-5408(a) 21-3420	X	Kidnapping (Felony)	6 Years*
21-5408(b) 21-3421	X	Aggravated kidnapping (Felony)	6 Years*
21-5409(a) 21-3422	X	Interference with parental custody (Felony)	6 Years*
21-5409(b) 21-3422(a)	X	Aggravated interference with parental custody (Felony)	6 Years*
21-5420(a) 21-3426	X	Robbery (Felony)	6 Years*
21-5420(b) 21-3427	X	Aggravated robbery (Felony)	6 Years*
21-5428 21-3428	X	Blackmail (Felony)	6 Years*
21-5424 21-3435	X	Exposing another to a life-threatening communicable disease (Felony)	6 Years*
21-5417 21-3437	X	Mistreatment of a dependent adult or Mistreatment of an elder person. (Misdemeanor or Felony)	Yes
21-5427 21-3438	X	Stalking (Felony)	6 Years*
21-5405(a)(3) 21-3442	X	Involuntary manslaughter while driving under the influence (Felony)	6 Years*
21-5426(a) 21-3446	X	Human Trafficking (Felony)	Yes
21-5426(b) 21-3447	X	Aggravated Human Trafficking (Felony)	Yes
21-5413(f) 21-3448	X	Battery against a mental health employee (Felony)	6 Years*
21-5421 21-3449	X	Terrorism (Felony)	6 Years*
21-5422 21-3450	X	Illegal use of weapons of mass destruction (Felony)	6 Years*
21-5423 21-3451	X	Furtherance of Terrorism or Illegal Use of Weapons of Mass Destruction (Felony)	6 Years*

21-5503 21-3502	X	Rape (Felony)	Yes
21-5506(a) 21-3503	X	Indecent liberties with a child (Felony)	Yes
21-5506(b) 21-3504	X	Aggravated indecent liberties with a child (Felony)	Yes
21-5504(a) 21-3505	X	Criminal sodomy (felony)	6 Years*
21-5504(b) 21-3506	X	Aggravated criminal sodomy (Felony)	Yes
21-5513 21-3508	X	Lewd and lascivious behavior (Felony)	6 Years*
21-5508(a) 21-3510	X	Indecent solicitation of a child (Felony)	Yes
21-5508(b) 21-3511	X	Aggravated indecent solicitation of a child (Felony)	Yes
21-6420 21-3513	X	Promoting prostitution (Felony)	6 Years*
21-5510 21-3516	X	Sexual exploitation of a child (Felony)	Yes
21-5505(a) 21-3517	X	Sexual battery (Felony)	Yes
21-5505(b) 21-3518	X	Aggravated sexual battery (Felony)	Yes
21-5512 21-3520	X	Unlawful sexual relation (Felony)	6 Years*
21-5507 21-3522	X	Unlawful voluntary sexual relations (Felony)	6 Years*
21-5509 21-3523	X	Electronic solicitation (Felony)	6 Years*
21-5604(a) 21-3602	X	Incest (Felony)	6 Years*
21-5604(b) 21-3603	X	Aggravated incest (Felony)	6 Years*
21-5605(a) 21-3604	X	Abandonment of a child (Felony)	6 Years*
21-5605(b) 21-3604(a)	X	Aggravated abandonment of a child (Felony)	6 Years*

21-5601(b) 21-3608(a)	X	Aggravated endangering a child (Felony)	6 Years*
21-5602 21-3609	X	Abuse of a child (Felony)	6 Years*
21-5607(b) 21-3610(b)	X	Furnishing alcoholic beverages to a minor for illicit purpose (Felony)	6 Years*
21-5603 21-3612	X	Contributing to a child's misconduct or deprivation (Felony)	6 Years*
21-5801 21-3701	New	Theft (Felony)***	6 Years*
21-5430	X	Distribution of a controlled substance causing great bodily harm (Felony)	6 Years*
21-5606 21-3605	X	Criminal nonsupport (Felony)	6 Years*
21-5610 21-3423	X	Interference with custody of a committed person ** (Misdemeanor or Felony)	6 Years*
21-5416 21-3425	X	Mistreatment of a confined person ** (Misdemeanor or Felony)	6 Years*
21-5425 21-3445	X	Unlawful administration of a substance ** (Misdemeanor or Felony)	6 Years*
21-5708 21-36a08 21-4214	X	Unlawful obtainment or sale of a prescription–only drug ** (Felony)	6 Years*
21-5823 21-3710	New	Forgery ** (Felony)	6 Years*
21-5828 21-3729	New	Criminal Use of a Financial Card ** (Felony)	6 Years*
21-5925 21-3844	New	Any violation of Kansas Medicaid Fraud Control Act ** (Felony)	6 Years*
21-5927 21-3846	New	Making false claim, statement or representation to the Medicaid program ** (Felony)	6 Years*
21-5928 21-3847	New	Unlawful acts relating to the Medicaid program ** (Felony)	6 Years*
21-5929 21-3856	New	Obstruction of a Medicaid fraud investigation ** (Felony)	6 Years*
21-5924 21-3843	New	Violation of a protective order; extended protective orders, penalties ** (Felony)	6 Years*

21-6107 21-4018	New	Identity theft: identity fraud **(Felony)	6 Years*
21-6412 21-3727 21-4310 21-4311	New	Cruelty to animals ** (Misdemeanor or Felony)	6 Years*
21-6422	New	Commercial sexual exploitation of a child (Felony)	Yes
39-0720	New	Social welfare fraud ** (Misdemeanor or Felony)	6 Years*
21-4301 21-4301a 21-6401	New	Promoting obscenity or promoting obscenity to minors ** (Misdemeanor or Felony)	6 Years*
21-5703 65-4159 21-36a03	X	Unlawful manufacturing of controlled substances ** (Felony)	6 Years*
21-5705 65-4161 21-36a05 65-4163	X	Unlawful cultivation or distribution of controlled substances ** (Felony)	6 Years*
21-5707 21-36a07	X	Unlawful manufacture, distribution, cultivation, or possession of controlled substances using a communication facility** (Felony)	6 Years*
21-5710 21-36a10	X	Unlawful distribution of drug precursors and drug paraphernalia ** (Felony)	6 Years*
21-5713 21-36a13 65-4152	X	Unlawful distribution or possession of a simulated controlled substance ** (Felony)	6 Years*
21-5406	New	Vehicular Homicide (Felony)	6 Years*
NOTE:		Similar Statutes of Other States & Federal Government.	
6 Years* - For this type of conviction the individual is prohibited until six or more years have elapsed since completion of the sentence imposed or the applicant was discharged from probation, a community correctional services program, parole, post release supervision, conditional release, or a suspended sentence; or if the applicant has been granted a waiver of such six-year disqualification.			

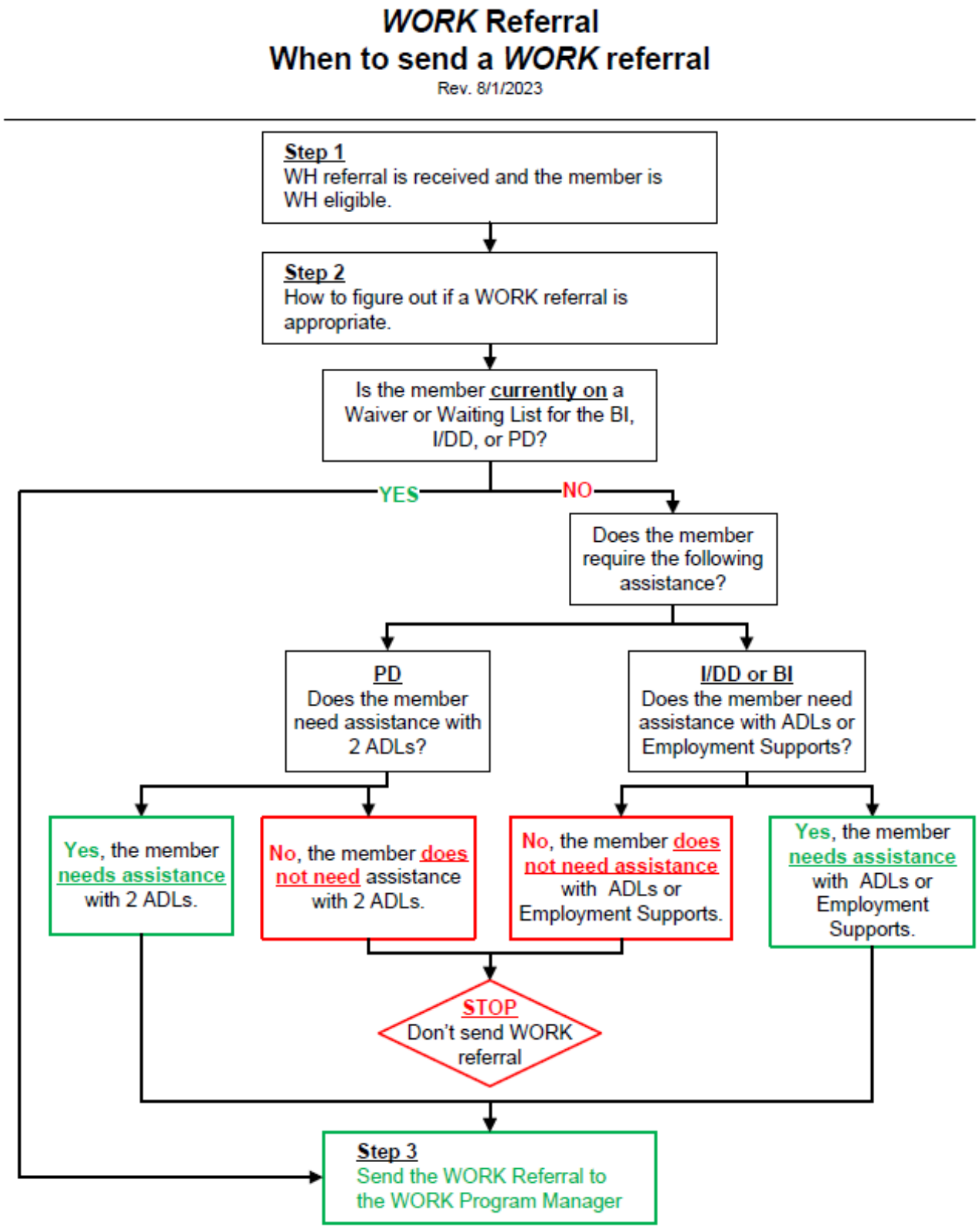
*Waivers - An individual who has been disqualified for employment due to conviction or adjudication of the offenses marked by a single asterisk * may apply to the secretary for aging and disability services for a waiver of such disqualifications if five years have elapsed since *completion* of the sentence for such conviction.
Yes, the individual is prohibited. The prohibition does not expire, and waivers are not available.

** Note: A prohibition for these offenses became effective on July 1, 2018. An individual shall not be prohibited due to a conviction of these offenses who is employed by a center, facility, hospital, or provider of services on or before July 1, 2018, and is *continuously* employed by the same center, facility, hospital, or provider of services or to any person during or upon successful completion of a diversion agreement.

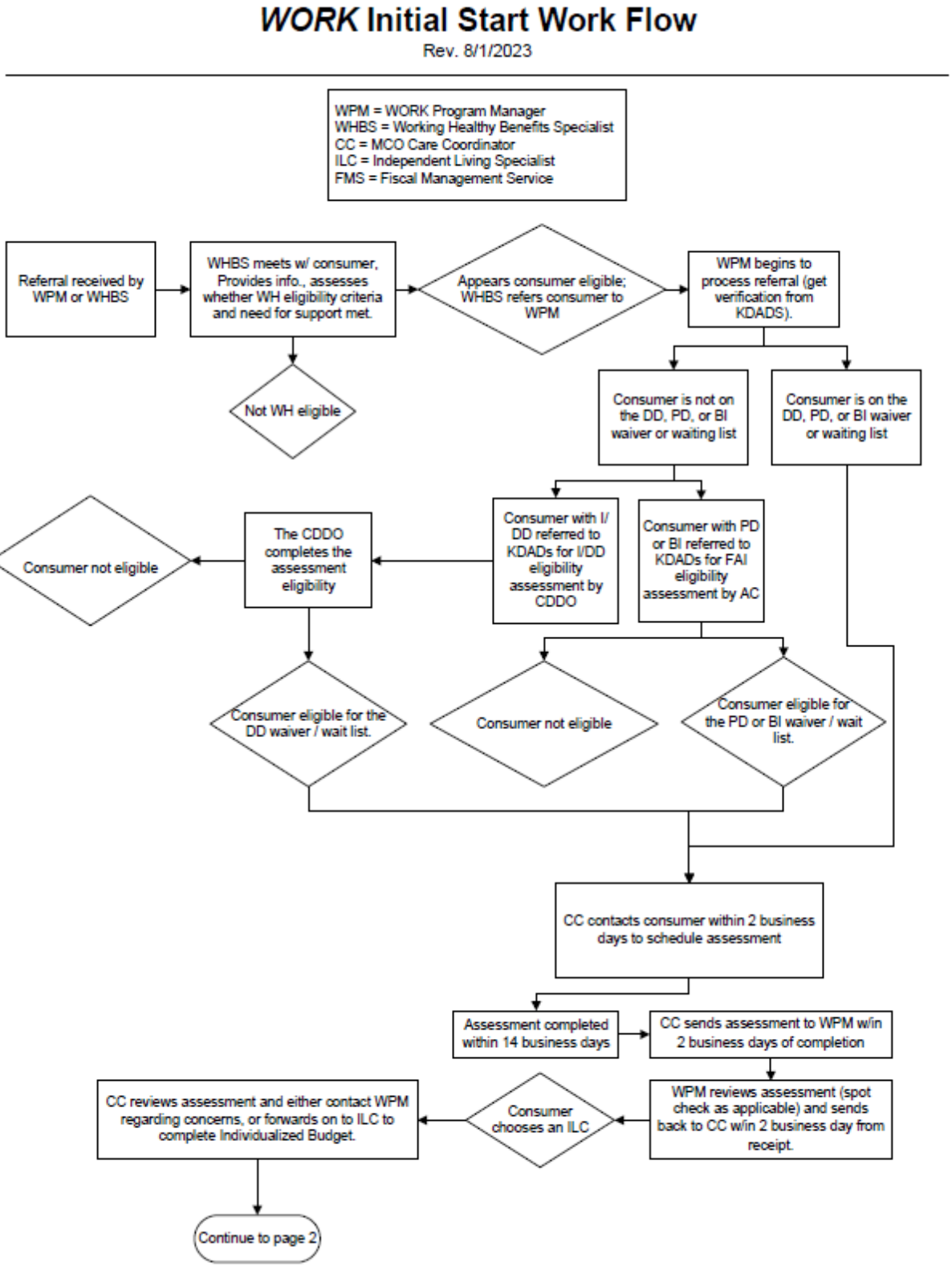
*** Note: A prohibition for this offense became effective on July 1, 2010. Further, an individual shall not be prohibited due to a conviction of Felony Theft if the individual is employed by an adult care home or home health agency on July 1, 2010, and *continuously* employed by the same adult care home or home health agency.

[1,2,3] Convictions for attempt to commit, conspiracy to commit, or criminal solicitation to commit any offense listed above which carries a prohibition that does not expire will result in a prohibition that does not expire. Convictions for attempt to commit, conspiracy to commit, or criminal solicitation to commit any offense listed above which carries a six-year prohibition will result in a six-year prohibition.

WORK REFERRAL PROCESS

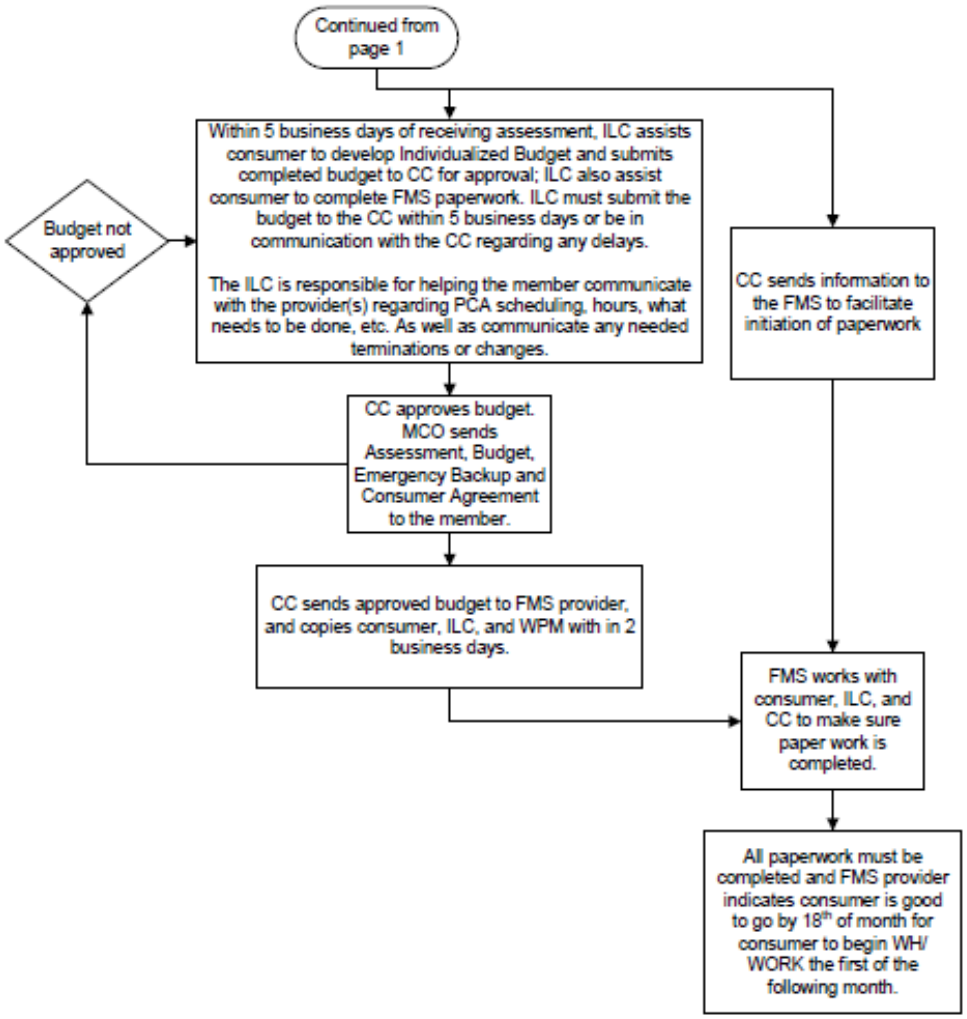


ENROLLMENT IN WORK PROCESS

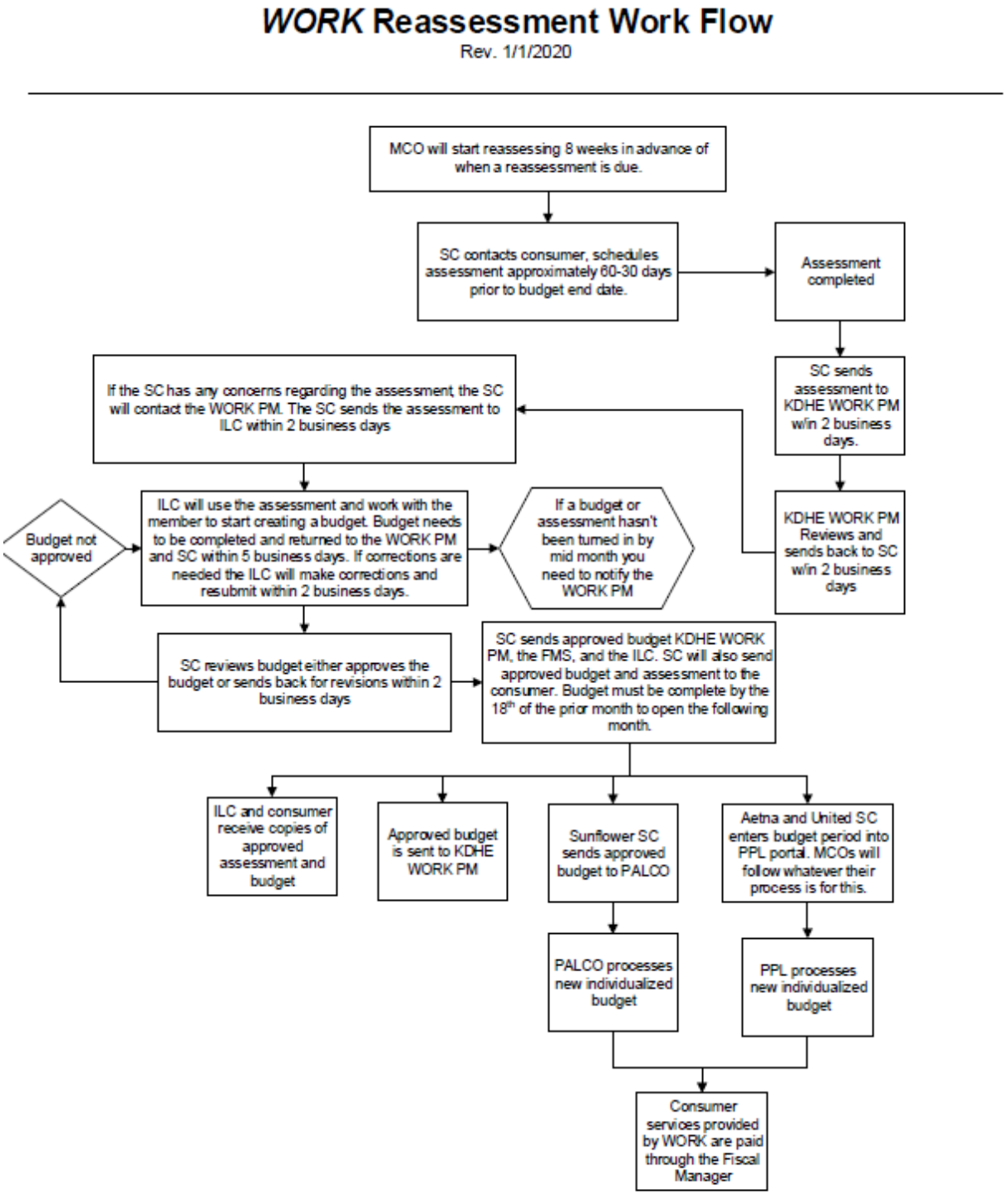


WORK Initial Start Work Flow

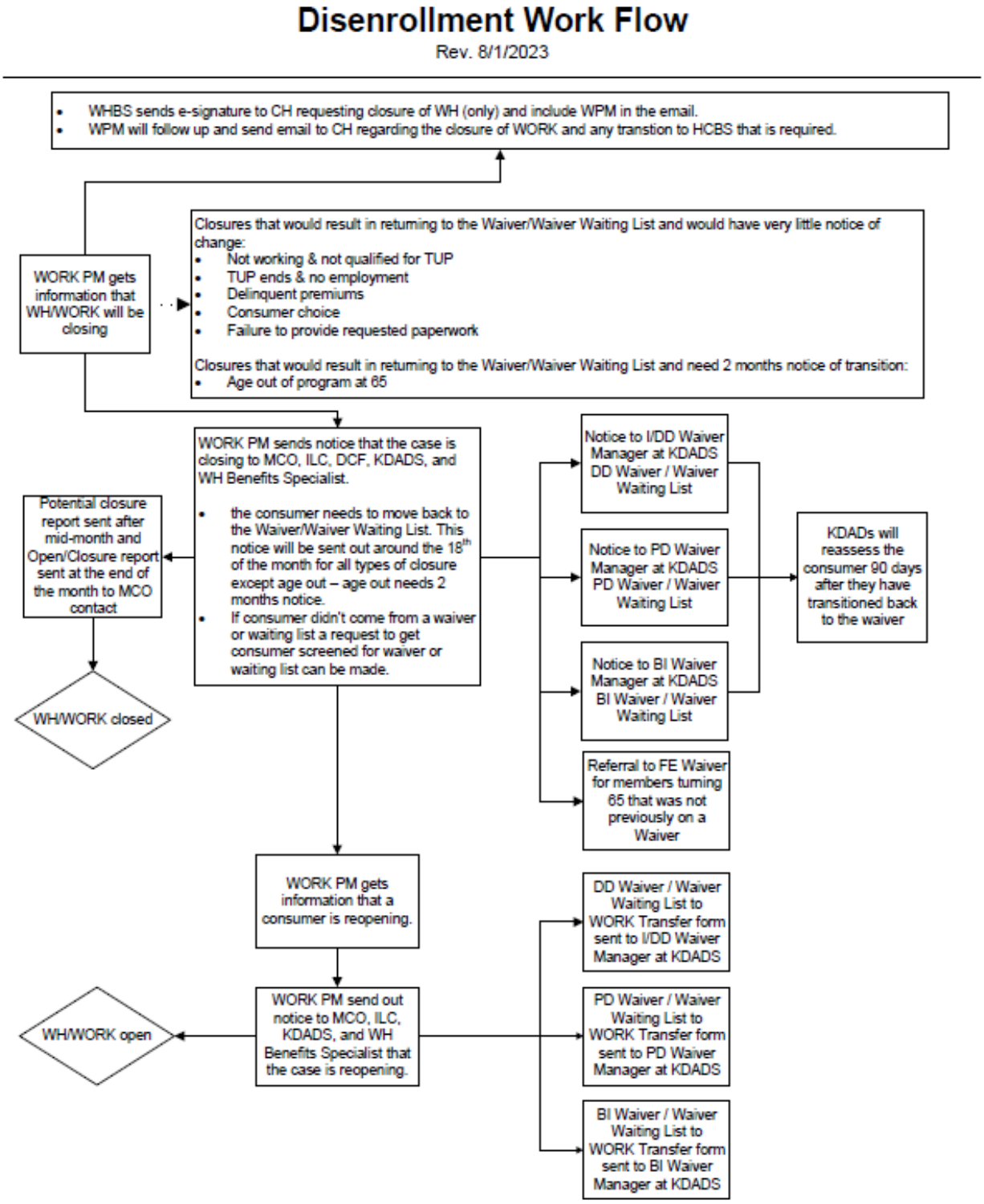
Rev. 8/1/2023



WORK REASSESSMENT PROCESS



DISENROLLMENT PROCESS



KANSAS ADMINISTRATIVE REGULATIONS

KAN. ADMIN. REGS. § 129-6-50

Section 129-6-50 - Determined eligibles, general eligibility factors.

Kan. Admin. Regs. § 129-6-50

The general eligibility requirements in K.A.R. 129-6-51 through 129-6-60 and in K.A.R. 129-6-63 shall be eligibility factors applicable to determined eligibles, except as specified in those regulations. Certain eligibility requirements may be waived by the secretary and additional eligibility requirements may be adopted by the secretary for all, or designated areas, of the state for the purpose of utilizing special project funds or grants or for the purpose of conducting special demonstration or research projects.

Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.

KAN. ADMIN. REGS. § 129-6-84

Section 129-6-84 - Medicaid determined eligibles, eligibility factors specific to *WORK.*

(a) To be eligible for participation in the medical assistance program under this regulation, each person shall meet the following requirements:

(1) Meet the general eligibility requirements of K.A.R. 129-6-50.

(2) be eligible for and receiving assistance under K.A.R. 129-6-88.

(3) be employed in a competitive, integrated work setting in which work is performed in the competitive labor market on a full-time or part-time basis for which individuals are compensated at or above minimum wage, but not less than the customary wage and level of benefits paid to a nondisabled individual for the same or similar work. The work shall be performed in a setting typically found in the community in which individuals with the most severe disabilities interact with nondisabled individuals according to the duties and responsibilities of the position; and

(4) be determined by an assessor authorized by the secretary to need *WORK* services to live and work in the community.

(b) The financial eligibility and premium requirements of K.A.R. 129-6-88 shall be applicable.

(c) Each individual's participation in *WORK* shall be based on the individual's voluntary acceptance of and agreement with the regulatory and policy requirements of the program in accordance with a participation agreement. An individual's refusal or failure to comply with

the regulatory and policy requirements of the program shall be the basis for termination of the individual's participation in the program.

Kan. Admin. Regs. § 129-6-84

Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.

KAN. ADMIN. REGS. § 129-6-88

Section 129-6-88 - Disabled individuals with earned income; determined eligibles.

(a) Each applicant and each recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the following specific eligibility requirements:

(1) Each individual shall be at least 16 years old but less than 65 years old.
(2) Each individual shall meet the blindness or disability requirements of K.A.R. 129-6-85.
(3) Each individual shall have earned income that is subject to federal insurance contributions act (FICA) taxes.

(b) Financial eligibility shall be based on a percentage of the official federal poverty-level income guidelines as specified in K.A.R. 129-6-103(a)(11), which shall be used as the income standard for the number of persons in the assistance plan and any other persons whose income is considered. Monthly applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. For an individual to be eligible under this regulation, the monthly applicable income shall not exceed the poverty level established for the base period. If the individual also owns nonexempt real or personal property with a resource value more than $15,000, which shall include any nonexempt resources of all family group members, that individual shall not be eligible under this regulation.

(c) For everyone whose monthly applicable income is at least 226 percent but not greater than 300 percent of the official federal poverty-level income guidelines for the applicable family size, a monthly premium amount shall be assessed. This premium amount shall not exceed 7.5 percent of the monthly applicable income based on the official federal poverty-level income indicated for the applicable family size. Failure to pay the premium shall result in ineligibility.

(d) Each individual who is temporarily unemployed but intends to return to work shall continue to be eligible for coverage for not more than four months if all other eligibility factors are met.

Kan. Admin. Regs. § 129-6-88

Authorized by and implementing K.S.A. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014; amended by Kansas Register Volume 42, No. 22; effective 6/16/2023.

KANSAS STATUES ANNOTATED

65-6201. INDIVIDUALS IN NEED OF IN-HOME CARE; DEFINITIONS.

As used in this act:

a) "Attendant care services" means those basic and ancillary services which enable an individual in need of in-home care to live in the individual's home and community rather than in an institution and to carry out functions of daily living, self-care, and mobility.

b) "Basic services" shall include, but not be limited to:
   1) Getting in and out of bed, wheelchair, or motor vehicle, or both.
   2) assistance with routine bodily functions including, but not limited to:
      A) Health maintenance activities.
      B) bathing and personal hygiene.
      C) dressing and grooming; and
      D) feeding, including preparation and cleanup.

c) "Ancillary services" means services ancillary to the basic services provided to an individual in need of in-home care who needs one or more of the basic services, and include the following:
   1) Homemaker-type services, including but not limited to, shopping, laundry, cleaning, and seasonal chores.
   2) companion-type services including but not limited to, transportation, letter writing, reading mail and escort; and
   3) assistance with cognitive tasks including, but not limited to, managing finances, planning activities, and making decisions.

d) "Health maintenance activities" include, 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.

e) "Individual in need of in-home care" means any functionally disabled individual in need of attendant care services because of impairment who requires assistance to complete functions of daily living, self-care, and mobility, including, but not limited to, those functions included in the definition of attendant care services.

f) "Physician" means a person licensed to practice medicine and surgery.

History: L. 1989, ch. 191, § 1; L. 1990, ch. 233, § 5; April 26.

Revisor's Note:
For sections included in this act, see comparative table of sections in constitutions volume.

Law Review and Bar Journal References:
"Model Disability and Family Support Act of 1991," Janet E. Garlow, H. Rutherford Turnbull, III and David Schnase, 39 K.L.R. 783, 811 (1991).

Attorney General's Opinions:
Attendant care services for person receiving in-home care are exempt from unlawful practice of nursing provided registered nurse has approved person to self-direct care. 2002-49.

65-5102. HOME HEALTH AGENCIES REQUIRED TO BE LICENSED; TEMPORARY LICENSE; PENALTY FOR VIOLATION.

Any agency, including Medicare and Medicaid providers, that provides one or more of the home health services, supportive care services or attendant care services specified in K.S.A. 65-5101, and amendments thereto, or that holds itself out as providing one or more of such services, or as a home health agency shall be licensed in accordance with the provisions of this act. Any agency found to be providing services meeting the definition of a home health agency without a license shall be notified of the agency's need to become licensed. The agency shall be offered a 60-day temporary license to continue operating during the pendency of an application for licensure. If the agency fails to obtain licensure within 30 calendar days, the secretary for aging and disability services shall assess a fine on the agency in accordance with this act. The secretary shall not grant a temporary license to any unlicensed agency that is providing services in a way that presents imminent harm to the public.

History: L. 1984, ch. 335, § 2; L. 1990, ch. 233, § 2; L. 2017, ch. 17, § 3; July 1.

Cross References to Related Sections:
Pharmacies authorized to place certain drugs with home health agencies, see 65-1659.

KANSAS ECONOMIC AND EMPLOYMENT SERVICES MANUAL (KEESM)

2664 WORKING HEALTHY (WH)

Home > 2000 General Eligibility > 2600 Requirements Specific to Medicaid and MediKan Programs > 2660 Medical Only Coverage Related to the SSI Program (MS/CI) > 2664 Working Healthy (WH) > 2664 Working Healthy (WH)

Medical coverage is available to persons with disabilities who have earned income and who meet the requirements of this section. Coverage for this group is provided under authority of the Ticket to Work and the Work Incentives Improvement Act of 1999 (TW-WIIA) and is available beginning July 1, 2002.

Persons eligible for Working Healthy do not have a spenddown, however a premium may be required as noted below. The full Medicaid benefit package is available to those eligible and persons are not subject to managed care. A referral to the HIPPS program per 2912 is required for all program participants.

Persons must also meet Social Security's disability criteria. Because of this, all persons potentially eligible for Working Healthy also meet categorical criteria for other Medicaid programs (MS/spenddown, SI, QMB, etc.). It is most often in the client's best interest to be found eligible under the Working Healthy program as opposed to the regular medically needy (or spenddown) group. When processing a medical application for an employed person, coverage must first be considered under Working Healthy. However, if the MS determination results in no spenddown, the client is placed in MS/spenddown, not Working Healthy. If a premium would be required, the individual must agree to pay the premium prior to enrolling in Working Healthy including premiums for prior months.

Coverage under the limited Medicare Savings Programs (QMB and LMB) must be considered as well and would not be impacted by the decision to enroll in Working Healthy. Persons eligible for coverage as an SSI recipient, including deemed recipients such as those eligible under the 1619(b) provisions, are not eligible for Working Healthy as they shall remain covered under the SI program.

Working Healthy recipients are not eligible for HCBS per 8200, however, personal services may be available through the WORK program (see 8400). Persons entering a nursing facility for a period exceeding the temporary stay criteria of 8113 are not eligible for Working Healthy coverage. Ongoing eligibility for a current Working Healthy recipient entering one of these living arrangements must be determined using the provisions applicable. A new application is not required.

To support persons with disabilities currently working or wishing to work, regional Benefits Specialists are located throughout the state. Because increased income or assets can result in the loss or reduction of other benefits (e.g., Section 8 housing), persons must understand the impact increased earnings will have on these other benefits. Benefits Specialists are available to provide this type of service and planning. They have been trained in the various state and federal programs and are a key piece to successful employment. The Benefits Specialists will also be able to discuss any personal care services (attendant care) available to the individual and make appropriate referrals for such services. To ensure that all Working Healthy eligibles are aware of the service, a referral to the regional Benefits Specialist shall be made for every person working or expressing interest in employment. The decision to cooperate with the Benefits Specialist shall not impact eligibility under the Working Healthy group.

2664.1 GENERAL ELIGIBILITY REQUIREMENTS

The general eligibility criteria of act in own behalf (2110), cooperation (2120), SSN (2130), citizenship and alienage (2140), and residency (2150) must be met.

The assistance planning rules of 4310 are also applicable. LTC and HCBS recipient spouses and parents are not included in the plan. Spouses or parents who otherwise meet the requirements of the MS program (i.e., elderly, or disabled) shall have a separate plan, but are not excluded from the plan nor are Working Healthy participants excluded from the plan of the spouse. Separate case numbers are required if two MS plans exist in the same family group.

Persons convicted of medical assistance fraud per 11221 (3) are not eligible.

2664.2 AGE AND BLINDNESS/DISABILITY REQUIREMENTS

Persons must be age 16 or over but under age 65. Coverage may be provided through the end of the month of the individual's 65th birthday. Persons must also meet the disability/blindness criteria of 2662. There is no requirement that the person must have received Social Security disability or SSI benefits in the past. In addition, a referral directly to DDS may also be applicable per 2662.1.

2664.3 EARNED INCOME REQUIREMENT

Persons must have verified earned income. For Working Healthy, earned income is income received from wages or self-employment resulting from the performance of services (see 6300) which meets the following criteria:

1. Social Security/OASDI or Medicare Tax Withholding: Evidence of payment or withholding of these taxes must be presented to participate in Working Healthy. These taxes are paid under the Federal Insurance and Contributions Act (FICA). The FICA tax is applicable to most wage and salary payments as employers are required to withhold FICA payments from earned income. Employer letters or statements as well as paycheck stubs may be used to verify FICA withholding. In addition, wages reported on the Kansas Employment Security (KES) 'BASI' system also meet this requirement. Generally, the absence of FICA withholding indicates the employer does not consider the individual to be an employee and such income would not be considered earned income for purposes of qualifying for Working Healthy. However, instances exist where wages are not subject to FICA withholding by federal law, such as wages received by a student from the college or university in which the student is enrolled (e.g., a graduate teaching assistant) and certain earnings of a non-resident alien. Eligibility may be approved in these instances if earnings are received and there appears to be an employer-employee relationship. Questionable situations may be referred to KDHE-DHCF Policy Staff for review. Income received in-kind, even if received in return for labor, does not meet the definition.

   For the self-employed, Social Security and Medicare tax is paid through the Self-Employment Contributions Act (SECA) rather than FICA. Persons claiming self-

employment income must have made at least one SECA payment in the past year for the business or self-employment enterprise currently in operation to meet the earned income requirement for Working Healthy. Regular SECA payments must continue to be made and verified for continued eligibility. Verification of payments must minimally be presented annually. There is no eligibility under Working Healthy for a self-employed individual until and unless evidence that the individual is subject to paying SECA taxes is presented. Examples of acceptable proof of SECA taxes includes but is not limited to the following:

a. Tax return including Self-Employment forms filed within the last 12 months (12 months payment requirement can be extended if the current year is not yet due as the tax forms will show the SECA taxes due).

   Note: Individuals that are self-employed are subject to SECA tax payments, however, they may not owe SECA taxes after credits and deductions are applied. Therefore, it is important to note that Working Healthy self-employment criteria is met once the consumer has provided evidence that they are self-employed and subject to SECA taxes.

b. Payment voucher dated within the last 12 months (includes individuals newly self-employed that have not filed the previous year's tax return yet.

2. Countable Monthly Earned Income Exceeds the Standard Earned Income Disregard: Countable earned income or self-employment income must exceed the standard earned income disregard of 7240 (2), currently $65.00 per month. For this test, countable income is determined after all applicable income-producing costs, Impairment Related Work Expenses and Blind Work Expenses have been considered. If there is no remaining income after application of these disregards, there is no eligibility for Working Healthy.

   Example 1: The applicant earns $10/week at a local restaurant. Converted gross income equals $43.00 ($10/week times 4.3 = $43.00). No IRWE or BWE expenses are reported. The applicant fails the earned income requirement since countable earned income is less than the $65.00/month earned income disregard.

   Example 2: The applicant earns $65.01/month as an occasional night relief clerk at a motel. No IRWE or BWE expenses are reported. The applicant meets the earned income requirement since countable earned income exceeds the $65.00/month earned income disregard.

   a. Minimal Earnings Level of the Hourly Federal Minimum Wage (not applicable to self-employment): Earned income must be at or above the hourly federal minimum wage. Wages below this level are not considered earned income for Working Healthy purposes. For individuals with multiple jobs, the requirement is met if one

position is paid at least he federal minimum wage and countable earnings exceed the standard deduction described above.

To find the current minimum wage click this https://www.dol.gov/general/topic/wages/minimumwage then scroll down and click on 'What is the Minimum Wage?'

NOTE: Earned income that is specifically exempt would not be considered in determining the $65.00 per month countable earned income threshold. However, exempt earned income would be considered in determining the minimum wage requirement.

Example: The individual has $300.00 per month earned income that is exempt under the Older Americans Act. That $300.00 could be used to determine if the individual is earning at least minimum wage but could not be used to determine if they meet the $65.00 per month threshold.

2664.4 FINANCIAL REQUIREMENTS

Financial eligibility exists if countable resources do not exceed the limit in 5130 and countable income does not exceed the limit in 7430 (4). Countable income is established per 7240. Also see 7531. The methodologies, exemptions, and disregards applicable to the spenddown program apply. In addition, see 5430 (20) regarding retirement funds and 6410 (34) regarding deposits into Individual Development Accounts (IDA). These exemptions are applicable only to the Working Healthy program.

Coverage is established under a spenddown for Working Healthy (WH) program. One-month base periods apply [see 7330 (1)].

Twelve (12) month review periods are applicable. A special income reviews every 6 months to establish the premium amount must also be completed.

REQUIREMENTS FOR CURRENT MEDICAL RECIPIENTS

When a current Medicaid recipient becomes eligible for Working Healthy, coverage must be adjusted as follows:

1. For persons moving from HCBS, Working Healthy begins the month following the month HCBS services end (see 8272.2). Any HCBS obligation due in the final month would still be applicable.

2. For persons moving from LTC to Working Healthy, coverage is adjusted the month the change occurs.

If an existing 6-months base period exists when Working Healthy (WH) eligibility begins. The existing base period is shortened to end the month prior to the month WH

eligibility begins. One-month bases apply thereafter. If a premium is applicable, the person must choose Working Healthy prior to taking action. WH eligibility may be backdated up to three months prior to the month of request, provided all WH criteria are met.

PRIOR MEDICAL COVERAGE

Prior medical eligibility per 7330 (2) is available for those meeting the criteria.

ONGOING ELIGIBILITY

1. Eligibility continues until the end of the review period if all applicable general, financial, and non-financial eligibility criteria continue to be met, including cooperation with the six-month desk review. The change reporting requirements of the spenddown program apply, and eligibility must be adjusted accordingly, given timely and adequate notice as required except for changes resulting in decreased premium amounts (see 2668.5 (1)) and persons temporarily unemployed (see 2668.7).

2664.5 PREMIUM REQUIREMENT

A monthly premium will be charged for coverage under the Working Healthy group for plans with income more than 225% of the federal poverty level for an individual and two-person household or 178% for a three-person household. The premium amount is based on a sliding scale keyed from the poverty level percentage of the assistance plan. The rate is based on net countable income (gross income less disregards). See F-8 Kansas Medical Assistance Standards for current premium levels and rates. Premium levels and/or amounts are adjusted annually based on changes in the federal poverty level guidelines.

a. Individuals eligible for Working Healthy coverage shall not be approved for any month, including prior medical requests, until the individual has agreed to pay the premium for all months if a premium is required. The client shall be given an estimated premium based on net countable income and given the option of Working Healthy coverage or, if otherwise eligible, the potential of Medically Needy or MSP coverage. In some cases, HCBS may also be an option for the client. To ensure the client has been informed, the ES-3165 Working Healthy and Premium Information form may be given to the potential premium payer at intake or sent after an estimated premium has been computed. The client may sign the form indicating his or her knowledge of the premium, however, submitting the form is not a requirement as verbal acknowledgement of the premium and agreement to pay the premium by Eligibility Staff, Benefit Specialist, or other agency personnel is acceptable. A note or other written communication is also acceptable. No prior agreement is required for cases without a premium obligation.

b. Premiums for prior medical periods are determined based on actual, countable income for the month. Varying premiums may result if income or household size fluctuates between base periods in the prior period. Prior to approving coverage for

any prior month with a premium obligation, the individual must agree to pay the premium for all months [see a. above].

NOTE: The 1-person plan shall be used to determine the premium level for a single individual. The 2–3-person plan shall be used to determine the premium level for a married couple (including when only one of them is a recipient). The 2–3-person plan shall also be used for a child under the age of 18 who is living with one or both parents.

American Indian/Alaska Native recipients are exempt from the premium requirement. These individuals may participate in the Working Healthy program without a premium. The classification of an individual as American Indian/Alaska Native is based on client statement and requires no further verification.

Premium amounts are not reduced or offset by other medical expenses. Persons or organizations outside of the family group may pay the premium. Premiums are due monthly, but eligibility is not impacted until the individual is a full 2 months behind in paying the premium amount [see (2) below].

The eligibility worker is responsible for determining the premium obligation. Any required premium will be entered on KEES and will be communicated to the premium billing vendor through an automated report. The premium billing vendor is responsible for premium billing, collection, and monitoring. Eligibility staff are required to communicate with the premium billing vendor regarding status requests on specific cases.

Monthly premium notices will be sent by the premium billing vendor to all plans subject to a premium. The initial premium statement will be mailed on either the 1st or 15th of the month, depending on when coverage is authorized. Subsequent monthly premium statements will then be mailed on the 1st day of the month. For new premium cases, the premium amount for the current period and any prior period will be reflected on the premium statement. The initial billing statement will reflect the current month and any prior months. The premium bill will also reflect past premium amount(s) due. All premium payments are due on the last day of the month. Premium payments are to be sent to the following address: KanCare Premium Billing, P.O. Box 842195, Dallas, TX 75284-2195. Information regarding premium status (current overdue) is available to eligibility staff by accessing the premium billing system.

PREMIUM CHANGES

As indicated in 2664.4 (3), all applicable changes must be reported. However, changes increasing the amount of countable income (e.g., amount of income, IRWE or family size) and therefore, increasing or establishing a premium obligation, shall not be acted upon until the next scheduled 6-month desk review or full review. Changes decreasing the amount of countable income which decrease or eliminate the premium obligation are acted upon effective the month following the month the change is reported. In all other situations, the amount of the premium is not adjusted until the next scheduled review or 6-month desk

review, if the premium was correctly determined. Incorrect premiums must be corrected per 2664.5 (4).

IMPACT ON ELIGIBILITY

Although premiums are due monthly, non-payment of premiums shall not impact eligibility until the individual is a full 2 months behind in making payment. Once the individual is a full 2 months behind in payments, coverage under the Working Healthy program is terminated effective the last day of the next month, allowing for timely notice.

Persons may be reinstated without additional action if payment is made which lowers the overdue amount to less than 2 full premiums by the last day of the month of closure. The client must report payment of the premium to eligibility staff in these situations. Persons in the plan remain ineligible for Working Healthy coverage until the delinquency is cured. However, eligibility under other categories shall be provided without regard to the delinquent Working Healthy debt if all other eligibility factors are met.

When a former Working Healthy recipient requests Working Healthy coverage be reopened, a check of the premium billing system is necessary to determine if there are overdue premiums before coverage is approved. All overdue premium amounts must be paid in full before an otherwise eligible individual may be reapproved for coverage.

6-MONTH DESK REVIEW

To redetermine any applicable premium obligation, a desk review shall be conducted between regularly scheduled reviews.

Because the purpose of the review is to re-budget income, earned income must be verified at the 6-month review. Other questionable eligibility factors may also be verified at this point, but it is not necessary to routinely verify other eligibility factors with this review. The 6-month review is applicable to all Working Healthy households, including those eligible without a premium. Coverage terminates on the last day of the 6-month period for persons who fail to respond to the request for the 6-month desk review or who fail to cooperate with the process. As with a regular eligibility review, coverage may continue if the individual is behind no more than two full months of premium payments.

The 6-month desk review shall generally occur 6 months following initial Working Healthy approval and 6 months following each subsequent review. The 6-month period begins with the first month of Working Healthy eligibility and ends on the last day of the sixth month. The prior medical period is not considered when establishing the 6-month period. However, if the regular review period ends prior to the sixth month, the 6-month desk review is waived. For example, the review period of an ongoing HCBS case expires 12-31-02. The person converts to Working Healthy 09-01-02. A 6-month review would not be needed because the regular review will occur before the sixth month (05-03). Coverage may continue if the individual is behind no more than two full months of premium payments.

PREMIUM ADJUSTMENTS

A. **Overstated Premiums** - When the agency determines a premium has been overstated for a prior period, immediate action to correct future premiums shall be taken. In addition, a premium is adjusted for a prior period in the following situations:

   i. An agency error resulted in the incorrect premium; or

   ii. A timely reported change could not be acted upon timely and resulted in the incorrect premium.

   Failure on the part of the client to report a change timely shall not result in an adjusted premium for a prior period.

B. **Understated Premiums** - When the agency determines a premium has been understated for a current or prior period, immediate action to correct future premiums shall be taken given timely and adequate notice requirements. An overpayment may be established for prior periods. Overstated premiums can be adjusted retroactively if the client was given notice of the correct premium amount, and the correction regards a billing issue only.

   Current or future premiums shall never be adjusted to account for understated or overstated past premiums. All requests for adjustments shall be sent to the Benefits Specialist Team Leader, who will determine if refunds or billing modifications are appropriate to account for the adjustment. All other refund requests shall also be sent to the Benefits Specialist Team Leader.

WORKING HEALTHY PREMIUM HARDSHIP

Two months of delinquent Working Healthy premiums may be waived if discontinuing Working Healthy coverage creates an undue hardship on the individual. The individual's financial needs due to unforeseen circumstances must be demonstrated in each hardship claim. Undue hardship exists only if the individual can demonstrate actual, not merely probable hardship.

Undue hardship does not exist when payment of the premiums causes the individual inconvenience or might restrict his or her lifestyle. It must put the individual at risk of losing their Working Healthy coverage due to delinquency per 2664.5 (2).

a. **Evidence to Support a Claim of Undue Hardship** – The individual must supply evidence to support the claim of undue hardship. The evidence should be directly related to the claim of undue hardship.

   i. The individual must demonstrate that he or she would be deprived of medical care, food, shelter, or other necessities of life. Hardship may be demonstrated

by documentation of one or more unforeseen circumstances as noted in the following list. Comparable reasons may also be considered, but considerable documentation is necessary and must be approved by the KDHE-DHCF Eligibility Policy Team.

1. Housing
    - Consumer is homeless.
    - Consumer is more than 30 days behind in rent or mortgage payment.
    - Consumer has received an eviction or foreclosure notice.
2. Utilities
    - Consumer received a shut-off notice from their utility company (gas, electric, oil, water, or telephone).
    - Consumer has one or more utilities shut off, one or more of their utility companies is refusing to deliver services because they cannot pay.
3. Medical Expenses
    - Consumer has medical and/or dental bills that KanCare or another insurance provider does not cover for which reasonably prevents them from paying their premium. These bills may be for them or someone else in the immediate family that they are financially responsible for (such as a child or spouse).

b. **Hardship Timeframes** – To be considered a hardship, the request and documentation must support two full months of delinquent premiums asking to be waived. A single month of delinquent premiums is not considered a hardship as it does not cause Working Healthy coverage to end. Only one hardship waiver may be granted within a 12-month timeframe. Any additional hardship waiver requests must be approved by the KDHE-DHCF Eligibility Policy Team.

2664.6 ONGOING ELIGIBILITY

When Working Healthy coverage ends, medical eligibility must be considered under other Medicaid coverage groups. Persons with accumulated resources may not be eligible for continuing coverage. The following action shall apply:

1. **Working Healthy to Independent Living -** For spenddown cases, the 6-months period begins the month following the month Working Healthy ends.

2. **Working Healthy to HCBS -** HCBS budgeting begins the month HCBS begins. Any applicable HCBS obligation is also determined. Working Healthy premiums paid or owed in the month HCBS begins are allowed against the obligation. If the entire premium obligation cannot be accounted for in the initial month, the bill may be allowed over multiple months until the entire obligation is accounted for.

3. **Working Healthy to LTC -** LTC budgeting begins the month following the month of entrance unless Spousal Impoverishment provisions apply. Any premium amount must be paid in full the month the arrangements begin.

2664.7 EXTENSION OF COVERAGE FOR TEMPORARY UNEMPLOYMENT

Working Healthy recipients who become temporarily unemployed and intend to return to work may remain eligible for a period up to 4 months following the month in which employment ended. Unemployment may be for any reason, but the recipient must provide a clear reason for the unemployment. Continued eligibility during the temporary unemployment period is only provided if the individual is otherwise eligible for Working Healthy. A temporary unemployment period may be granted for an individual who is employed but fails to meet the earned income requirements of 2668.3 (FICA/SECA, minimum wage and earnings tests). This extension is not available to persons whose only employment occurred in a prior medical period per 7330 (2).

1. **Temporary Unemployment Plan**
   The individual must have an active Temporary Unemployment Plan (TUP) in place to receive continued coverage under this provision. Persons who report becoming unemployed shall be referred to the Benefits Specialist for establishment of the TUP and the individual must cooperate with the Benefits Specialist in this process. The purpose of the TUP is to establish a plan to return to work. The Benefits Specialist has much leeway in the establishment of the plan, as the plan shall consider factors such as disability and job skills. Failure to cooperate with establishment of the plan will result in termination of Working Healthy coverage.

2. **Temporary Unemployment Period**
   The 4-month period shall begin the month following the month unemployment began. If the individual is cooperating with the Benefits Specialist and all other eligibility factors are met, coverage may be provided through the last day of the 4-month period. Any required review, either an annual review or a six-month desk review, must be completed at scheduled intervals during the period. Regular reporting requirements also continue to apply. Persons who have not returned to work at the end of the 4-month period are no longer eligible under Working Healthy, but coverage may be considered under other programs (e.g., LMB, QMB, Medically Needy, etc.)

3. **Impact on Premium Obligation**
   Any changes to the premium obligation because of a change in income are made the month following the month of report. Any new or additional income the individual has begun receiving because of unemployment (e.g., disability payments from the employer, Social Security payments, etc.) must be considered in the recalculated premium. However, action to change the premium shall not be delayed in anticipation of a change in income source. The premium will be considered and re-budgeted at the next review, annual or 6-months desk review. The individual must remain current on any premiums during this period.

2665 WORKING HEALTHY MEDICALLY IMPROVED

Home > 2000 General Eligibility > 2600 Requirements Specific to Medicaid and MediKan Programs > 2660 Medical Only Coverage Related to the SSI Program (MS/CI) > 2665 Working Healthy Medically Improved > 2665 Working Healthy Medically Improved

Gainfully employed persons receiving medical coverage under Working Healthy who are determined to no longer meet Social Security disability criteria because of a medical improvement are eligible for extended coverage under the Medically Improved group if the requirements of this section are met. Like standard Working Healthy coverage, authority for this group is provided under TW-WIIA. Coverage begins January 1, 2005.

2665.1 GENERAL REQUIREMENTS/WORKING HEALTHY RECIPIENT

All general eligibility criteria of the Working Healthy program as per 2664.1 must be met. In addition, only those persons receiving coverage under the Working Healthy program at the time the disability terminates may receive extended eligibility. However, persons who were enrolled in another eligibility group as 2664 who were other eligible for Working Healthy, may elect to change eligibility to Working Healthy in the last month of coverage. This is only necessary if it will permit the individual to access ongoing coverage. Annual redeterminations are required (9373).

2665.2 MEDICAL IMPROVEMENT

Loss of disability status must be based on a medically improved disability. Loss of disability status for other reasons will not qualify an individual for extended coverage. Medical improvement must be documented through contact with Social Security or DDS.

2665.3 FINANCIAL ELIGIBILITY/ PREMIUM REQUIREMENT

The financial eligibility criteria of 2664.4 are applicable, including the resource and income limits. The premium requirements of 2664.5 and subsections are also applicable.

2665.4 EMPLOYMENT STATUS

Persons must meet the earned income requirement as per 2664.3 requiring payment for FICA or SECA taxes [see KEESM 2664.3(1) for SECA tax requirements]. In addition, the individual must

be earning at least the federal minimum wage and working a minimum of 40 hours per month. Persons earning below these levels are not eligible for extended coverage. The extended coverage provisions of 2664.7 are also applicable. To find the current minimum wage click this link, https://www.dol.gov/general/topic/wages/minimumwage, then scroll down and click on 'What is the Minimum Wage?

2665.5 MEDICALLY DETERMINABLE SEVERE IMPAIRMENT

Once the individual is determined to have lost disability due to medical improvement, the agency must also document the individual continues to have a medically determinable severe impairment.

This is determined to exist if a medical professional (doctor, nurse practitioner, or psychologist) documents one or more of the following health conditions:

1. The individual's disability continues to substantially limit the ability to work or conduct daily life activities.

2. The individual has a mental or physical health problem that has been stabilized by assistive technology, medication, treatment, monitoring by medical professionals, or a combination of all of these, and loss of medical services may result in a deterioration of the condition.

3. The loss of medical care could result in the individual's not being able to continue in the workforce or the health problems would regress to the point where the individual would meet the SSA definition of disability and become eligible for Social Security Disability Insurance (SSDI) payments. The Benefit Specialist is responsible for establishing the level of impairment is met. The level of impairment is reviewed annually.

2665.6 REFERRAL TO BENEFITS SPECIALIST

Upon discovery of a suspected case involving a medical improvement, the individual must be referred to the local Working Healthy Benefits Specialist. The Benefit Specialist will verify the reason for loss of disability status and inform the eligibility worker. The Benefit Specialist will also determine if the individual meets the necessary level of impairment initially and at annual review.

8113 (NURSING FACILITY / INSTITUTION) LONG TERM VS. TEMPORARY CARE (PLANNED BRIEF STAY)

Home > 8000 Institutional and Home and Community Based Services Living Arrangement > 8100 Institutional Living/Long Term Care > 8113 Long Term vs. Temporary Care (Planned Brief Stay)

Individuals whose stay in a Medicaid approved institution will not exceed the month of entrance and the following two months are in temporary care and eligibility is to be determined under independent living methodologies. The person would be treated as though he or she were still living in the community and be included in either an individual or family group assistance plan as appropriate. However, this provision would not be applicable to the extent that it conflicts with the

requirements of 8143 regarding separate budgeting for institutionalized spouses and 8144.2 regarding application of the spousal impoverishment income provisions.

NOTE: A stay shall be defined as any continuous period of institutionalization, whether in a hospital, nursing facility, other institution, or a combination of one or more.

On the other hand, long term care shall be generally defined as a stay which will exceed the month of entrance and the following two months except when spousal impoverishment provisions apply as indicated below. Long term care policies would be applicable beginning with the month of entrance for children under the age of 18 entering an institutional arrangement or the month following the month of entrance for adults, except that financial eligibility methodologies will vary for individuals in adult care homes based on whether or not the individual meets the monthly liability amount as specified in 8172.

For institutionalized spouses for whom the spousal impoverishment provisions of 8144 and subsections are applicable and for children under the age of 18 as described in 2666 and 8183, long term care shall be defined as a stay which will last at least 30 consecutive days.

If the stay does not exceed this time period, independent living methodologies (including HCBS or PACE) would be applicable as noted above. If the stay is determined to exceed this time period, long term care policies would be applicable beginning with the month following the month of entrance except for those persons in which application of the spousal impoverishment provisions of 8144.2 are more beneficial. In addition, financial eligibility methodologies will vary for individuals in adult care homes based on whether or not the individual meets the monthly liability amount as specified in 8172.

If the individual enters the institution from an HCBS arrangement, the requirements of 8173 apply.

NOTE: If an individual is initially processed as being in temporary care and the stay exceeds those timelines, long term care policies shall then be applied beginning in the third month following the month of entrance.

8400 WORK OPPORTUNITIES REWARD KANSANS (WORK)

Home > 8000 Institutional and Home and Community Based Services Living Arrangement > 8400 Work Opportunities Reward Kansans (WORK) > 8400 Work Opportunities Reward Kansans (WORK)

This section sets forth guidelines for persons who receive services under the *WORK* program. *WORK* provides personal care and other related services to employed persons with disabilities, including assistive services and independent living counseling. *WORK* services are only provided in a community-based setting and are not appropriate for institutional residents.

Although the services a beneficiary receives under *WORK* are like the services provided under an HCBS waiver, *WORK* is not an HCBS waiver. Therefore, program guidelines are not the same. Persons can either be served under an HCBS waiver or *WORK* - a beneficiary cannot have both services in the same time period.

WORK is considered a 'cash and counseling' model of delivering long term care services. Under the cash and counseling model, personal care services provided to *WORK* participants will be made in the form of an allocation paid to the applicant/recipient or designee.

Information regarding functional eligibility criteria and available services can be found in the KDHE-DHCF *WORK* Program Manual.

8400.1 WORKING HEALTHY RECIPIENT STATUS

To enroll in *WORK*, persons must be eligible for and receiving Medicaid coverage through *WH* (see 2668). An individual enrolled in another eligibility group is not eligible for *WORK*. All *WH* criteria must be met, including age and employment status.

Except for individuals eligible as mandatory categorically needy (2611 (1) (a)), persons receiving Medicaid under another program who meet *WH* eligibility criteria, but are not enrolled in *WH*, may elect to change coverage in order to participate in *WORK*. Persons eligible under a mandatory categorically needy program (including SI, MP, and the protected groups) cannot choose to enroll in *WH*.

Although the Medicare Savings Plans are considered mandatory categorically needy plans, because eligibility is restricted to Medicare cost sharing, enrollment in these groups does not prohibit enrollment in *WH*.

Example 1: Bill has 1619(B) status with Social Security and is considered an SSI recipient per 2634. Therefore, Bill is categorically needy and cannot elect to receive *WH* coverage. Bill cannot enroll in *WORK* as he cannot enroll in *WH*.

Example 2: Will has an open Medically Needy case and requests *WORK*. Will may elect to switch from Medically Needy to *WH* to get *WORK* services. If he decided to change, Will may have to pay a *WH* premium.

Persons eligible for *WH* under a Temporary Unemployment period as per **2668.7** may also receive *WORK* services.

8400.2 INTEGRATED EMPLOYMENT

In addition to meeting the *WH* eligibility criteria, all *WORK* participants must be employed in a competitive, integrated work setting. A determination regarding the type of employment

must be made prior to enrolling in *WORK*. The eligibility worker will work with Benefits Specialist to make this determination.

Competitive employment is defined as work performed in the competitive labor market on a full or part time basis for which individuals are compensated at or above minimum wage, but not less than the customary wage and level of benefits paid a non-disabled individual for the same or similar work. To find the current minimum wage click the following link, https://www.dol.gov/general/topic/wages/minimumwage.

Integrated employment is defined as a setting typically found in the community in which individuals with the most severe disabilities interact with non-disabled individuals according to the duties and responsibilities of the position. If the individual's only interaction with a non-disabled person is with a caretaker, the requirement is not meet.

The individual's employment arrangement must meet both criteria. Self-employment enterprises will be evaluated on a case-by-case basis.

8400.3 LEVEL OF CARE

An individual must be determined to need *WORK* services to live and work in the community. All individuals seeking *WORK* services are referred to the *WORK* Program Manager in KDHE-DHCF Central Office. The program manager will then refer the individual to the contracted entity to perform the assessment.

Following the assessment, if the individual chooses *WORK* and meets the necessary level of care, the information is then sent to the Program Manager for final approval. If approved by the Program Manager, notification is sent to the eligibility worker and assigned Benefit Specialist with information regarding the enrollment in *WORK* and the effective date. The individual is also referred to the community organization responsible for providing Independent Living Counseling services.

8400.4 PREMIUM REQUIREMENT

Because all *WORK* participants must enroll in *WH*, all the program requirements must be met, including the premium requirements of 2664.5. Because the *WORK* participant must participate in any premium payment, there is no Client Obligation or patient liability to receive *WORK* services.

8400.5 ENROLLMENT GUIDELINES

WORK enrollment is prospective, meaning the IL Counselor and Program Manager will plan for a transition to *WORK* services to begin in the future. *WORK* begins the first day of the month and ends the last day of the month. *WORK* participation terminates upon entry into a nursing facility or other institution.

Action to approve *WORK* coverage must be taken by medical card deadline to be effective the first day of the next month. If action is taken after the medical card deadline, *WORK* coverage is not effective until the first day of the second month after the month of action. This applies to both new applications and reinstatement after case closure.

WORK recipients are exempt from Medicaid copayments and managed care requirements.

8400.6 ALLOCATION PAYMENTS (SEE 6410)

Personal services will not be paid in the traditional fee-for-service model in the *WORK* program. Instead, a monthly allocation payment will be paid to each *WORK* participant for necessary personal care services. The allocation is directly based on the number of hours of assistance the individual requires each day. The *WORK* participant is responsible for securing attendants and other services to meet his or her needs. The *WORK* participant is also responsible for ensuring service providers are reimbursed for services. All allocation payments will be made at the beginning of the month for which services are rendered in the month of payment.

1. **Allocation Expenditures -** Payments made from the *WORK* allocation must be used to purchase services or goods to support the recipient's ability to live as independently as possible and will develop an individualized budget to reflect the use of *WORK* allocation funds in ways that are related to the service and give the recipient some latitude in expending the *WORK* allocation payment. The allocation may be used for direct attendant pay, including applicable payroll deductions. Alternative payments may also be made, if approved by the Program Manager. The recipient may purchase equipment or devices which could reduce the dependence on individual attendants (for example, a washing machine or microwave oven). The individual is allowed to save for these major purchases over time. Certain payments have been determined inappropriate for payment with an allocation. These include gifts to family, friends, or workers; loans; rent or mortgage payments: utilities; entertainment; televisions, DVD players and similar equipment.

2. **Individual Budget -** With the assistance of the Independent Living Counselor, the *WORK* participant will be required to develop an individual budget detailing the plan for expending the allocation. A monthly allocation report detailing the actual expenditures must be submitted to the Program Manager. A *WORK* participant who fails to comply with terms of the individualized budget or fails to complete the monthly allocation report is subject to termination of *WORK* services, as determined by the Program Manager.

3. ***WORK* Account -** Each program participant is ultimately responsible for the management of their allocation payments. All *WORK* program participants are required to use the Fiscal Management contractor to manage their *WORK* account.

The Fiscal Manager is responsible for receiving the *WORK* allocation, maintaining the account, and payment of all expenses.

8400.7 WORK DISENROLLMENT

Persons shall be terminated from *WORK* when program requirements are no longer met. Persons who become ineligible for *WH* coverage for any reason are immediately terminated. Persons who return to *WH* may be allowed back on *WORK* as determined by the Program Manager.

Persons who fail to comply with the rules regarding payment, distribution and savings of the allocation payment are subject to immediate termination from the program, as determined by the Program Manager. Any suspected abuses or misuse of the allocation are to be immediately reported to the Benefits Specialist for investigation. Funds remaining in the *WORK* account must be returned to KDHE-DHCF upon termination in the *WORK* program. Inappropriate expenditures are subject to recovery action.

8400.8 COMMUNICATION

Communication is required between the *WORK* Program Manager, eligibility staff, and the Benefit Specialist assigned to the case. The *WORK* Program Manager is responsible for notifying eligibility staff and the Benefit Specialist of assignment to the *WORK* program with the effective date. Eligibility staff and the Benefit Specialist are responsible for reporting case changes (including case closure) to each other. In event of case closure, eligibility staff shall also notify the *WORK* Program Manager (in addition to the Benefit Specialist) of the closure.