Work Opportunities Reward Kansans

WORK
Program Manual

Kansas Department of Health and Environment
Division of Health Care Finance
Working Healthy Program
900 SW Kansas, Suite 900N
Topeka, KS 66612

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

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1000 - INTRODUCTION

This manual details the policies and procedures for *Work Opportunities Reward Kansans (WORK)*, the long term care program which provides supports for people who are eligible for *Working Healthy*. Unlike other Medicaid long term care programs, individuals eligible for *Working Healthy* do not receive services through Home and Community Based Services (HCBS) waivers. Instead, they receive a Medicaid State Plan package of services which is called *WORK*. The Kansas Department of Health and Environment (KDHE) is responsible for the oversight of both *Working Healthy* 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 Home and Community Based Services (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: http://www.kdheks.gov/hcf/workinghealthy/work.htm

2000 - WORKING HEALTHY

A. Program Description

Working Healthy 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 in order to reduce long term reliance on public supports, while not jeopardizing their health care.

Working Healthy 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. *Working Healthy* 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.

B. Eligibility

To be eligible for *Working Healthy*, 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

C. Benefits

In addition to eliminating spenddown and substituting a more affordable premium, other *Working Healthy* 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 Opportunities Reward Kansans* (*WORK)*

3000 - WORK OPPORTUNITIES REWARD KANSANS (WORK)

A. Program Description

Work Opportunities Reward Kansans (WORK) is the program through which people enrolled in *Working Healthy* receive personal assistance services (PAS). *Working Healthy* beneficiaries cannot receive Home and Community Based Services (HCBS) waiver services. In addition to PAS, *WORK* services include Supported Employment/Individual Employment Support Services, Assistive Technology and Independent Living Counseling (ILC).

B. Eligibility

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

- be receiving services through one of the following HCBS waivers: the Intellectual/Developmental Disability (I/DD), Physical Disability (PD), or Traumatic Brain Injury (TBI) Waivers, or
- be on the waiting lists to receive services through these **waivers (waiver screenings must have been conducted within the last 12 months or new waiver screenings will be required)**, or
- have functional limitations and need for assistance similar to individuals meeting an institutional level of care. **Members who are not currently receiving HCBS waiver services, or are not on the waiting list for HCBS waiver services, must be screened for I/DD, PD, or TBI waiver eligibility before a WORK assessment can be conducted.**

C. Benefits

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

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

4000 - ENROLLMENT/DISENROLLMENT

A. Enrollment

Members interested in *Working Healthy/WORK* should contact the *Working Healthy* Benefits Specialist serving their region. Benefits Specialists provide an orientation to *Working Healthy/WORK*, and if members appear to be eligible for *Working Healthy* and indicate a need for *WORK* services, Benefits Specialists refer them to the *WORK* Program Manager. This is an informal determination; KDHE eligibility staff are responsible for a formal *Working Healthy* eligibility determination, and an assessor determines eligibility for *WORK* Services.

Once a Benefits Specialist makes a referral, the *WORK* Program Manager determines whether the individual is currently receiving services through an HCBS waiver, or on an HCBS waiver waiting list. If so, the Program Manager will schedule a *WORK* needs assessment. If not, the Program Manager will schedule a screening to determine whether the member is eligible for HCBS waiver services. If the member is determined eligible for waiver services, a *WORK* assessment will be conducted following the screening. 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 because he/she is not eligible for HCBS .

Following the needs assessment, the assessor will send the *WORK* Program Manager the assessment form indicating whether the member requires services. If services are needed, the *WORK* Program Manager will coordinate a start date for *WORK* services with the member, KDHE eligibility staff, the MCO Case Manager, and the *WORK* Independent Living Counselor.

WORK services begin on the first day of the month (there is no retroactive eligibility for *WORK* services). Before *WORK* services can begin, the following must be completed:

- screening to determine HCBS eligibility (if the member is not already receiving HCBS services or on a waiting list for HCBS services)
- an assessment of need and assignment of a monthly allocation
- an Independent Living Counselor selected
- an Individualized Budget developed and submitted to the MCO Case Manager for approval
- all fiscal management paperwork for both the *Working Healthy/WORK* member and the member's personal assistants (PAs) completed, submitted and approved by the Fiscal Management Services (FMS) provider

Once all of the above tasks are accomplished, the *WORK* Program Manager will send either form 3160 or 3161 to KDHE eligibility staff. The form must be received by the 18th of the month in order for the member's case to open the first day of the following month. (See Appendix A – *WORK* Initial Start Workflow)

If the assessment does not indicate a need for *WORK*, the *WORK* Program Manager will refer the member to a Benefits Specialists to discuss options available to him or her, including enrollment in *Working Healthy* without *WORK* services.

B. Disenrollment

Members who become unemployed for any reason, e.g., illness, layoff, termination, etc., are no longer eligible for *Working Healthy*, therefore they are no longer eligible for *WORK* services. KDHE eligibility staff will close their case as *Working Healthy/WORK*, possibly determining eligibility for other Medicaid coverage.

Members previously on HCBS Waivers will have the option of returning to those waivers. Members who were on waiting lists for waivers will have the option of returning to the waiting list in the order they would have achieved had they not left the waiting list. The *WORK* Program Manager and MCO Case Manager will assist members to return to HCBS Waivers or waiting lists. Members may also voluntarily choose to leave *Working Healthy/WORK* at any time, and the above process will still apply.

5000 - LOSS OF EMPLOYMENT/TEMPROARY UNEMPLOYMENT PLAN

A. Loss of Employment

In order to continue to be eligible for *Working Healthy* 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 eligibility staff within ten days of the loss occurring. If a Benefits Specialist, an MCO Case Manager or *WORK* Independent Living Counselor (ILC) becomes aware that a member is no longer working, and the member has not reported this, the Benefits Specialist, MCO Case Manager or the ILC is responsible for informing KDHE eligibility staff. Members who become temporarily unemployed and intend to return to work may be eligible for *Working Healthy/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.

B. Temporary Unemployment Plan

Members who are not currently employed for any reason, including but not limited to illness, injury, layoff, termination, and temporary absence from the state, must have an approved Temporary Unemployment Plan (TUP) in place in order to maintain medical coverage under *Working Healthy* and continue to receive *WORK* services. 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 *Working Healthy* coverage.

The purpose of the TUP is to establish a plan to return to work. *Working Healthy* 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. The Benefits Specialist has 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, limited periods of employment since the last TUP, requesting two or more TUPS in a one year period, etc. Benefits Specialists maintain the right to reject a TUP if they do not believe it will result in employment at the end of the four-month temporary unemployment period

The four-month 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 four-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.

Members who have not returned to work at the end of the four-month period are no longer eligible for *Working Healthy*, but coverage may be provided under other Medicaid programs, such as Medically Needy, if the members continue to be eligible for Medicaid.

6000 - REPRESENATIVES, CONSERVATORS, GUARDIANS, POWER OF ATTORNEY

A. Representatives

Members may select representatives to assist them in managing their services. Representatives are not required to have any type of legal authority in order 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, they are still expected to be involved in all decision making related to *WORK*.

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

1. Limitations/Restrictions

- Representatives cannot be paid to provide any *WORK* services to the members for whom they are representatives, including Personal Assistance Services, Supported Employment/Individual Employment Supports, Assistive Services, Independent Living Counseling and Fiscal Management Services.

- Representatives may not employ members for whom they are representatives in any capacity.
- Independent Living Counselors or MCO Case Managers may not act as a representative for *WORK* members for whom they are providing services.

B. 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.

1. Limitations/Restrictions

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

7000 - SERVICES

A. Personal Assistance Services

1. Description

Personal Assistance Services include:

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

- Members must require assistance with ADLs in order to receive *WORK* services and receive assistance with IADLs.
- Assistance with ADLs and IADLs is not provided for members who are performing similar tasks at their place of employment, e.g., members who are employed as kitchen workers, housekeepers or indoor/outdoor maintenance workers. Members employed in these professions may not receive assistance with meal preparation and clean-up, housekeeping, or lawn care/snow removal at their home.
- Alternative and cost-effective methods of obtaining assistance to the extent that expenditures would otherwise be used for human assistance, e.g., meal or laundry services, or purchase of equipment that decrease the need for human assistance, e.g., microwave oven to heat pre-cooked or frozen meals, medication dispenser, etc. Equipment purchases must demonstrate cost-effectiveness by decreasing their need for human assistance. Examples of equipment that may not be purchased include computers, laptops, tablets, cell phones, home security systems, etc.

2. Limits/Restrictions/Requirements

- **Central Registries, Excluded Lists, Terminated Providers**
  - Members may not use their *WORK* monthly allocation to pay personal assistants listed on the Kansas Adult Abuse, Neglect, Exploitation Central Registry and/or Child Abuse and Neglect Central Registry
  - Members may not use their *WORK* monthly allocation to pay personal assistants, or agencies, listed on the Health and Human Services Office of the Inspector General Office Exclusion List.
  - Members may not use their *WORK* monthly allocation to pay individuals or agencies on the Kansas Medicaid Program Integrity Terminated Provider List.
- **Prohibited Offenses** - 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.
- **40 Hour Per Week Per Personal Assistant Limit**
  - Members may not use their *WORK* monthly allocation to pay PAs for hours above 40 per week. In order to use the *WORK* monthly allocation, members requiring more than 40 hours per week in PA services must hire the number of PAs necessary for each PA to work a maximum of 40 hours of service per week.
- **Age Requirements**
  - PAs must be 18 years of age or older to provide paid support for ADLs.
  - PA's who are 14-18 years of age may provide paid support for IADL's
    - 3 hours on a school day
    - 18 hours in a school week
    - 8 hours on a non-school day

    - 40 hours in a non-school week, and
    - between 7 a.m. and 7 p.m., except from June 1 through Labor Day, when nighttime work hours are extended to 9 p.m.
- **Capable Person(s) Policy**
  - Assistance with IADLs is not provided when a capable family member lives in the same residence as the member, whether or not the residence in which the member resides is the family member's legal address. The capable person policy applies whether capable family members work inside or outside of the home. Capable family members include, but not limited to, spouses, parents, children and siblings age eighteen and above.
  - Assistance with IADLs is not provided when the member lives with a person with whom they have a significant relationship, whether or not the residence in which the member resides is the legal address of the significant other. Significant relationships include boy/girlfriend, fiancé, partner, and divorced spouse.
  - Assistance with IADLs including house cleaning, lawn mowing and snow removal are divided when the member lives with a roommate, even if the residence in which they reside in not the legal home of the roommate. Roommates are responsible for their share of housecleaning, lawn mowing, and snow removal.
- **Conservators, Guardians, POA, Representatives**
  - Members may not use the *WORK* monthly allocation to pay individuals to provide personal assistance services if they are also the member's guardian, conservator, *WORK* representative, or POA.
- **Personal Assistants**
  - PAs may not be conservators, guardians, have POA, or act as representatives of members for whom they provide services.
  - PAs may not employ members either as an employee or in a self-employed capacity. PAs who violate this will no longer be able to provide personal assistance services. Members who violate this will be required to have their services agency directed.
  - PAs may not borrow money from members, lend money to members, or become involved in any contractual arrangements with members, e.g., cell phone contracts. The only monetary interactions allowed between members and PAs are payments by the Fiscal Management Services provider to PAs for personal assistance and employment support services provided by them to members.
  - PAs may not assist members, whether employed by an employer or self-employed, to assist in performing any aspect of their job. PAs may only assist with ADLs at the workplace, and/or provide assistance with the activities described in the section.
  - PAs may not be paid for cuing/prompting an individual by phone. Any cuing/prompting needs to be face to face.

- **Transportation**
  - Transportation is only provided to travel to and from work, and to and from shopping or banking.
  - Non-Emergency Medical Transportation (NEMT) to and from medical appointments must be obtained from the member's MCO. PAs may not be paid to provide medical transportation.
- **Monitoring**
  - *WORK* does not provide assistance to monitor members on the internet, telephone, etc.
- **Provider Operated Homes**
  - Members receiving *WORK* Personal Assistance Services may live in a provider operated home as long as the operator of the home is not providing the member's personal assistance services. Members may not live in a residence operated by a provider agency or organization that also provides their personal assistance service. Members living in provider operated residences must either self-direct their services or choose an outside agency that is not in any way connected with the provider operated residence to direct their personal services on their behalf.
- **Minor Children or Other Family Members**
  - *WORK* personal assistance services do not include care required by minor children or any other family members. Personal assistance services are only provided to members based on their disability and specific needs.
- **Pets**
  - Personal assistance services are only provided for the care of <u>one</u> certified service or therapy pet. Care is limited to feeding, watering and, if appropriate, walking the service pet. Documentation that the animal has been trained and certified as a service pet must be provided.
- **Vehicles**
  - *WORK* services do not include assistance with cleaning, maintain or repairing member's vehicles.

3. Provider Qualifications

Members receiving *WORK* service are free to establish their own qualifications for the PAs they hire, however they must follow the program policies listed under **Limits/Restrictions/Requirements** for Personal Assistance Services.

Members are strongly encouraged to obtain background checks on providers of personal services. Members MCO pays for background checks. Members are also strongly encouraged to obtain references from previous employers, as well as personal references.

4. Documentation

See page B. 4. – "**Documentation,"** on page 16.

5. Payment

See B. 5. – "**Payment,"** on page 16.

B. Supported Employment/Individual Employment Support Services

1. Description

Supported Employment/Individual Employment Support Services are supports for members who, because of their disabilities, need such support to maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce. Supported Employment/Individuals Employment Support Services are individualized.

Supported Employment/Individual Employment Support Services include:

- support to learn new or evolving job responsibilities
- support to increase accuracy and/or speed
- support to exhibit appropriate work behavior
- support to interact appropriately with other employees and the general public
- support to practice safety measures at work
- transportation to and from work
- consultation, and provision of technical assistance, with the employer to deal with employment related issues and/or job related adaptations or modifications

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 on the job. The member's MCO Case Manager will review the need for supported employment quarterly, and reduce the number of hours accordingly.

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.

2. Limits/Restrictions/Requirements

Supported Employment/Individual Employment Support Services does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

- Supported Employment/Individual Employment Support 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.

- Supported Employment/Individual Employment Support Services may be decreased or eliminated based on whether members learn job responsibilities, exhibit appropriate work behavior, interact appropriately with co-workers and the public, and practice safety measures. Supported Employment/Individual Employment Support Services may be re-instated if members require the service again to maintain employment or learn new job responsibilities.

- For those who are self-employed, Supported Employment/Individual Employment Support Services does not include the expenses associated with starting up or operating a business, including but not limited to:

  - assistance with business travel
  - assistance with, or performing, day-to-day operations of the business
  - assistance with, or performing, financial management of the business
  - organizing and/or setting up work areas or work tasks
  - verifying whether work is performed accurately
  - scheduling business related activities and/or meetings
  - obtaining business related materials

3. Provider Qualifications

Qualifications for Supported Employment/Individual Employment Support staff include:

- Community service providers who have trained and certified staff, such as employment specialists, job specialists, job coaches, supported employment specialists, etc., who provide technical assistance to members, co-workers and employers in order to assist in maintaining employment. These individuals are typically paid a higher hourly rate to work with the employer because of their training and certification.

- 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 general public, to practice safety measures at work, and/or to provide transportation to and from work.

4. Documentation

Documentation of the provision of all work services is required. Documentation of Personal Assistance Services and Supported Employment/Individual Employment Supports includes:

- The PA's time sheets with the date, start and end times, whether assistance was provided with ADLs, IADLs or Supported Employment/Individual Support, the PA's signature, and the member's signature verifying that the time was worked by the personal assistant.
- Invoices or receipts for personal assistance services provided in an alternative way.
- Invoices for personal assistance services and/or Supported Employment/Individual Employment Supports provided by an agency.

5. Payment

Members use their monthly allocation, determined at the time of their initial assessment or annual re-assessment, to pay for Personal Assistance Services (PAS) and Supported Employment/Individual Employment Supports. Members develop Individualized Budgets directing how payments are made, and manage these funds, however they do not handle the funds directly. Each MCO contracts with a Fiscal Management Service (FMS) to administer the *WORK* monthly allocations for their *WORK* members.

C. Assistive Services

1. Description

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.

Examples of Assistive Services include:

- 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 service dogs and other service animals;
- 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. Limits/Restrictions/Requirements

Excluded items include, but not limited to:

- food or nutritional supplements
- clothing
- shoes of a non-medical nature
- computers, laptops, IPADs, 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
- 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.
- 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.
- *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.
- *WORK* Assistive Services <u>cannot</u> be authorized retroactively. If complete paperwork is not submitted for approval and prior authorized by the MCO, payment will be denied.
- *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).
- *WORK* Assistive Services does not include technology or modifications necessary for self-employed members to operate their business.
- *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.

- 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.

3. Provider Qualifications

Durable Medical Equipment (DME) vendors, orthotics and prosthetics vendors, Community Developmental Disability Organizations (CDDOs) and affiliates of CDDOs, Centers for Independent Living (CILs), and licensed Home Health Agencies, that are enrolled as a provider of *WORK* Assistive Services. In order to provide and receive payment for Assistive Services, providers must be enrolled in KMAP as a *WORK* service provider **(Provider Type 56)** with a Specialty of Assistive Services **(Provider Specialty 526)**, and use the billing code for Assistive Services **(Billing Code S5165).**

4. Documentation of Assistive Services

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

- KDHE Request for Assistive Services form, or form specified by MCO Case Manager
- 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 Case Manager
- pictures and/or diagrams, if requested by the MCO

Once the MCO Case Manager receives all of the information, it will be reviewed and 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.

a. Medical Necessity

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

b. Alternative Funding Sources for Assistive Services

As Medicaid is the payor of last resort, members receiving services through the *WORK* program must 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.

c. 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 Case Manager has the right to request any documentation necessary to determine the need for assistive services. In some cases photographs and/or diagrams may be requested. 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.

5. 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

D. Independent Living Counseling

1. Description

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 Manager (TCM). 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 Back-up 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.

2. 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:

- be employed by a Center for Independent Living (CIL), Community Developmental Disability Organization (CDDO) or CDDO affiliate, or a licensed Home Health Agency (HHA) that is enrolled as a provider of Independent Living Counseling services; and

- a minimum of six months' experience with a disability as recognized by the Rehabilitation Act of 1973; **or**
- a minimum of one year professional experience providing direct services, including case management (working directly with people with a variety of disabilities); and completed at least twelve hours of standardized training annually; and
- completed a two-hour *WORK* orientation
- completed and passed the KDHE web-based *WORK* Independent Living Counseling examination on KS Train
- participate in all state mandated *WORK* and Independent Living Counseling training to ensure proficiency of the program and services rules, regulations, policies, and procedures set forth by the KDHE.

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

3. 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.

ILC responsibilities include:

1) Conveying *WORK* program policies to members, and ensuring that they understand them

2) Discussing the options listed on the *WORK Member Agreement Form*, and assisting members to complete the *WORK Member Agreement Form*.

3) Assisting members to locate emergency back-up care and emergency assistance, develop viable emergency back-up, natural disaster, and pet care plans, and complete the *Emergency Back-Up Form*

4) 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 *Working Healthy* website, or any other available tool.

5) Assisting members to develop Individualized Budget, including

    a. assisting members/representatives to determine hourly wages for their service providers, taking into account payroll deductions, and that the total amount is within the parameters of their monthly allocation

b. assisting members to locate alternate, cost-effective methods for purchasing services, and determine a reimbursement amount that is within the parameters of their monthly allocation

c. assuring that member's Individualized Budget reflects the services determined necessary during the *WORK* assessment

d. assisting in planning for, and documenting the use of, any excess (carryover) funds remaining from the monthly allocation

e. assuring that members/representatives remain within the parameters of their monthly allocation

f. assisting to revise the Individualized Budget, if necessary

g. assuring members/representatives do not include on their Individualized Budget services of goods that are prohibited by program policy

h. assisting members/representatives to obtain approval of Individualized Budgets and Emergency Back-Up, natural disaster, and pet care plans, from their MCO Case Manager

i. entering Individualized Budgets into web-portals if directed to do so by the MCO Case Manager

6) Assisting members to locate providers of personal assistance services,

7) Assisting members to interview, hire, supervise, and terminate personal assistants.

8) 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.

9) Assisting members to accurately and thoroughly complete and submit required paperwork to fiscal management service (FMS) providers.

10) Assuring that the member understands the importance of verifying time worked by the PA, and the significance of the member's/representative's signature on the time sheet(s).

11) Assisting members to document and submit requests for reimbursements to the FMS provider in a timely manner.

12) Assisting members to coordinate non-emergency medical transportation (NEMT).

13) Assisting members to document the need for assistive services, and locate providers of assistive services.

14) Assisting members to complete and submit annual eligibility and six-month review paperwork.

15) Assist members to send *Working Healthy* premiums to the correct address. (ILCs should not handle or mail premium payments without the member present).

16) Assisting members to connect to other services, such as Vocational Rehabilitation or affordable housing.

17) Communicating any changes in status, needs, problems, etc., to the member's MCO Case Manager.

18) Submitting all required MCO paperwork in a timely fashion.

19) Reporting emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to the MCO Case Manager and the DCF Adult Protective Services (see K.S.A. 39-1430 and K.S.A. 39-1431).

20) Monitoring to ensure that members are receiving the services that they are paying for.

21) Notifying the *WORK* Program Manager and/or the MCO Case Manager when it appears that a member is not capable of self-directing services and requires a representative or agency directed services.

22) Reporting health and safety concerns to the *WORK* Program Manager and/ or the MCO Case Manager when it appears that a member's health and/or safety are in jeopardy.

23) Reporting to the *WORK* Program Manager when individuals/representatives or personal assistants are not following *WORK* program policies and procedures.

24) Assuring that the member's/representative's budget, back-up 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

25) Assisting members to dis-enroll and access either HCBS waivers or waiver waiting lists.

4. Limits/Restrictions/Requirements

- ILCs are expected to provide conflict free Independent Living Counseling at all times, including but not limited to, the following:

- ILCs cannot provide personal assistance services for any *WORK* member.
- 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.
- 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.
- 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.
- 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.

- 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.
- 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. In the event that 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.
- ILCs may not bill for the following:
  - Attending initial, annual or revised assessments
  - Advocacy
  - Assistance with, or testifying at, appeals
  - Travel
  - Anything not specified in the *WORK* Program Manual under Independent Living Counselor Responsibilities.
- 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.

- 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.

5. Documentation Requirements

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:

Member's Name

IL Counselor's Name

IL Counselor's Agency

Date of Service

Beginning Time of Service Provided

Ending Time of Service Provided

Service Type (indicate by number listed to left of ILCs responsibilities in the *WORK* Program Manual)

Description of Service Provided (include a narrative that supports the Service Type listed on the form)

How Service Provided (indicate face-to-face, telephone)

If Other Please Explain (indicate any other method of service provision)

ILCs must have the members/representatives for whom they have provided services sign the documentation form on a monthly basis. The member's/representative's signature verifies that the member has received the documented services. The ILC must also sign the documentation.

<u>ILCs must remain current in their documentation at all times. 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 keep copies of their documentation of</u>

services provided for a minimum of five years or longer based on the contractual requirements of the MCOs.

a. 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 in order to provide this service and receive payment.

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

WORK Independent Living Counseling is to be billed in units of 15 minutes, i.e., One unit = 15 minutes. There is a limitation of 40 units (10 hours) per month per member. A unit is reimbursed at $10.60 per unit. Units should be billed for services actually provided and do not need to equal 40 units per member, but cannot exceed 40 units per member per month.

Exceptions to the 40 units per month limit may be made by the MCO Case Manager on a case-by-case basis. The requesting IL Counselor will have to provide documentation supporting why additional assistance is required.

E. Care Coordination/Care Management

1. Description

Member receiving *WORK* services receive care coordination or care management through their MCO. MCOs assign members receiving *WORK* services a Care Coordinator or Care Manager. MCOs may refer to these services and staff members by different names; however MCOs are responsible for all care coordination/management for members receiving *WORK* services, including:

- 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

2. Limitations/Restrictions/Requirements

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

3. Payment

Care Coordinators/Case Managers work for an MCO and are paid by the MCO.

8000 – MONTHLY ALLOCATION, INDIVIDUALIZED BUDGET, FISCAL MANAGEMENT, AND EMERGENCY BACKUP PLAN

A. Monthly Allocation

Personal Assistance Services are paid by the member using a monthly allocation which is determined during the assessment. Following the *WORK* assessment, assessors determine the total number of hours members need in order to live and work in their communities. Assessors then use a formula established by the State to translate hours of assistance into a monthly allocation which members may then use to purchase their services. Members have the freedom to hire personal assistants, pay for alternative methods to obtain personal services, or select an agency to provide personal assistants for them.

The *WORK* monthly allocation is comprised of federal and state Medicaid dollars specifically to purchase personal assistance service and supported employment/individual support 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 these funds are used to purchase

their 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 *Working Healthy* 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:

h = hours of daytime assistance
$13.25 = daytime hourly rate
8 = maximum hours of night support
$9.00 = night support hourly rate
7 = days in the week
4.33 = average number of weeks per month
3% or 10% = Fiscal Management, Background Checks, and Worker's Compensation Fees

Members Needing Daytime Assistance Only

<u>Self-Directing and Combined Self-Directed/Agency Directing Members</u>

h x $13.25 x 7 x 4.33 – 10% = Monthly Allocation

<u>Agency-Directed Member</u>

h x r x 7 x 4.33 – 3% = **Monthly Allocation**

Members Needing Daytime Assistance and Night Support

<u>Self-Directing and Combined Self-Directed/Agency Directing Members</u>

(h x $13.25) + (8 x $9.00) x 7 x 4.33 – 10% = Monthly Allocation

<u>Agency-Directed Members</u>

(h x $13.25) + (8 x $9.00) x 7 x 4.33 – 3% = Monthly Allocation (Agency-direction members are assessed 3% for fees)

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/individual employment support services. Examples include:

- advertising for PAs
- hourly wages up to 40 hours per week per PA
- all applicable payroll deductions for PAs
- alternative methods of purchasing personal assistance, e.g., meal or laundry service
- supported employment/individual 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

3. Limitations/Restrictions/Requirements

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

- *Working Healthy* premium payments
- Plan for Achieving Self-Support (PASS)
- gifts for workers, families, friends
- loans for workers
- payments to representatives, conservators, guardians, those with POA
- rent or mortgage payments
- vehicles or vehicle repairs
- utility payments (gas, electric, sewage, water)
- cell phones and landlines
- computers, tablets, printers, handheld devices
- clothing
- groceries or nutritional supplements; (supplements)
- lottery tickets
- entertainment
- entertainment devices such as television, DVD players, iPods;
- alcohol or tobacco products; and
- items available through another source, such as employers or Vocational Rehabilitation
- paying PAs in excess of 40 hours per week (It is not permissible to use the WORK allocation to pay for overtime. Time worked over 40 hours a week is

considered overtime and fiscal management vendor is required to pay time-and-a-half for hours worked over the 40 per week. Available hours of assessed support may be significantly reduced when paying time-and-a-half). *

- exceeding the monthly allocation (will result in a denial of payment by the FMS provider)
- paying for services that are not included in the Individualized Budget and have not approved by the MCO Case Manager
- paying for services that have not been provided (*WORK* services may be terminated and this may result in a report to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU)
- paying for more than one PA at a time **
- paying PAs to work in the home during a time the member is not in the home to supervise
- paying PAs during a stay at a hospital, nursing facility, rehabilitation facility, etc.

Members should contact their MCO Case Manager, Independent Living Counselor, or the *WORK* Program Manager if uncertain about the appropriate use of the allocation.

*Exceptions may be made on a case-by-case basis if meeting the following criteria:

- the member lives in a rural area where recruiting and retaining additional PAs may be difficult (agency availability will be taken into consideration before an exception is made)

- the member requires so many hours of assistance that it is difficult to hire the number of PAs, at 40 hours per week per PA, necessary to provide the total amount of assistance needed (agency availability will be taken into consideration before an exception is made)

** Using and paying for more than one PA at a time during the day may be permissible with written justification from the member and approval from the WORK Program Manager. An example of this would be, the member has a PA providing ADL support (bathing) and at the same time has another PA providing IADL support (cleaning and laundry). This overlap with PA's must also be indicated on each timesheet and the tasks of each PA must be documented on each timesheet during the overlap.

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 Case Manager 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 Case Manager 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 Independent Living Counselor must develop a revised Individualized Budget and submit it to the MCO Case Manager for approval.

B. Individualized Budget

1. Description

Once members know the amount of their monthly allocation, they must develop an Individualized Budget indicating how allocated funds will be used to pay for personal and employment services. Independent Living Counselors 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;
- 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 similar to the hourly rate on which the monthly allocation is based. 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 Case Manager before services can begin. The review will include whether the budget includes all of the required elements, meets the needs of the member, and reflects the amount, duration and scope of assistance identified during the *WORK* assessment.

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 Case Manager.

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

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

3. Allowed uses of carryover funds

Carryover funds may be used to purchase the following:

- small items that will result in increased independence and a decreased need for personal assistance, e.g., a microwave oven to heat pre-cooked or frozen meals rather than having an assistant prepare meals, kitchen items (requests should be submitted to the MCO Case Manager explaining how the equipment is related to the disability and increases independence)
- health, safety and emergency equipment such as fire extinguishers, carbon monoxide and smoke detectors
- advertising costs to recruit PA's

- background checks for PA's (except for members with agency-directed services)
- additional personal assistance related to temporary increased need or emergency back-up care
- leave for PAs (limited to the number of hours worked by PA during a one week period and no more than one week per year)
- assistance with PA health insurance premiums

Note: Leave for PAs is based on the availability of carryover funds, and given at the discretion of the member. Leave is limited to one week per PA per year, and can only cover the number of hours typically worked by a PA during a one week period, e.g., a PA 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 PA 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 carryover funds

Carryover funds may not be used to purchase, or to save for, the following items:

- high cost items such as a washer or dryer
- home modifications (these may be covered under Assistive Services)
- items not related to the member's disability
- loans for workers
- payment for someone to be a representative
- rent or mortgage payments
- utility payments
- clothing
- groceries
- lottery tickets
- entertainment
- entertainment devices
- vehicles and vehicle repairs
- alcohol or tobacco products
- items related to the disability that would be available through another funding source

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 Back-Up Plan

Following the development of the Individualized Budget, members will be asked to carefully consider, and to document, their resources in the event of an emergency. Included on the plan must be:

- name(s) and contact information of person(s) that will provide emergency back-up 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 they will be cared for in the event of a hospitalization or emergency

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

9000 - DIRECTING SERVICES AND MEMBER AGREEMENTS

Members may self-direct their services, have an agency direct services on their behalf, or a combination of both.

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 PAs
- interviewing PAs
- performing former employer and personal reference checks for the PAs
- obtaining background checks on PAs
- negotiating and setting hourly wages for PAs within the parameters of their assessed needs and monthly allocation
- hiring PAs
- ensuring that PAs have completed and submitted all required employee paperwork to the FMS provider
- reviewing invoices for services rendered or items purchased, and signing to verify the accuracy, before submitting to the FMS provider
- training PAs
- scheduling PAs
- verifying for the FMS provider that the hours listed on PA time sheets accurately reflects hours worked

- terminating PAs if necessary
- completing the FMS paperwork indicating that a PA is no longer working for them
- providing references for former PAs, as appropriate

Web-based self-direction training is available on the *Working Healthy* website located at the following web address: http://www.kdheks.gov/hcf/workinghealthy/work.htm.

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 PA's, recognizing and receiving good PA services, etc.

B. Agency Direction

Members who do not want to self-direct their services may select an agency to provide services on their behalf. Members who choose agency directed services are not the employer; the agency is the Employer-of-Record, however members still manage their monthly allocation. Members, with the assistance of their IL Counselor if needed, 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 PA(s), the member is responsible for the following:

- scheduling PAs
- explaining personal preferences when receiving assistance
- supervising daily activities
- notifying the agency if problems arise
- verifying that PAs 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 PAs they are self-directing, while the agency is the Employer-of-Record for the PAs who work for 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
- request/not request background checks

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.

10000 - ASSESSMENT OF NEED FOR ASSISTANCE

A. Description

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. During this process, the member's 1) need for personal assistance, 2) risks and safety, 3) layout of the home environment, and for people with intellectual/developmental disabilities, 4) need for supported employment/individual employment support services, will be assessed. Medical documentation of the member's physical condition(s) may be requested by the assessor, MCO and/or KDHE. If so, the documentation must be provided before the assessment is finalized.

A re-assessment is performed in the member's home annually. Members may request a re-assessment at any time if they experience changes in their physical condition. The *WORK*

Program Manager and/or MCO Case Manager may also request a new assessment at any time. (See Appendix B – *WORK* Re-assessment flow chart).

The assessor will use the *WORK* Monthly Allocation Tool to determine the member's need for assistance with the following:

a. Activities of Daily Living (ADLs)

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

- Can the member perform this task independently?
- How much time does it require for the member to perform this task independently?
- 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 need physical assistance to perform the task, and the amount of time this assistance requires?
- Does the member require cuing and prompting to perform the task, and the amount of time this requires?
- Is there a capable person residing in the home?

Members with physical disabilities or traumatic brain injury must demonstrate a need for physical assistance with ADLs in order to receive *WORK* Services. Members with intellectual/developmental disabilities must demonstrate a need for physical assistance, or cuing/prompting, to perform ADLs.

Night Support - 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.

When an assessment indicates that a member requires personal assistance during the night, eight hours per night, seven days per week, will be added to the member's assessment. These hours will be calculated at $9.00/hour. Members residing with family members 18 years and older will not have their monthly allocation increased. Family members are expected to provide night support without payment.

Night support will only be 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.

In the event that a member's family chooses not to provide night support, the member will receive an increase in his/her monthly allocation and may select an agency or non-family member to provide support.

Exception: Members who indicate they cannot find an agency to provide night support may pay family member(s) to provide night support once they provide documentation from Home Health agencies or other providers of personal assistance within a 30 mile radius stating that they are unable to provide night support. This requirement is for both agency and self-directing members. The *WORK* Program Manager will review the documentation and determine whether an exception will be made.

b. Instrumental Activities of Daily Living (IADLs)

Members who demonstrate a need for assistance with ADLs will then be assessed to determine the need for physical assistance, or cuing and prompting, to perform IADLs following the same process listed above. **Members who reside with a capable person, or a person with whom they have a significant relationship, will not receive personal assistance services for IADLs.**

c. Supported Employment/Individual Employment Support Services

Members with intellectual/development disabilities or traumatic brain injury may be assessed to determine their need for Supported Employment/Individual Support Services at their place of employment. During the assessment, the assessor will review the member's need for support to:

- learn new or evolving job responsibilities above and beyond the support an employer would reasonably provide for individuals without disabilities
- increase accuracy and/or speed, exhibit appropriate work behavior, interact appropriately with other employees or the public, in order to maintain the job
- operate safely at work
- travel to and from work

The assessor will also determine whether there is an intermittent need for a supported employment specialist to meet with the member and employer as a consult and provide technical assistance if and when problems arise.

The assessor will not assess the member's need for assistance to perform the job. That may be the responsibility of the member's employer under Title I of the American's with Disabilities Act. If the member is self-employed, assistance to set up the business or perform the day-to-day job operations is the responsibility of the member. Examples of assistance that *WORK* does not provide include, but are not limited to, the following:

- assistance with business travel
- assistance with, or performing, day-to-day operations of the business
- assistance with, or performing, financial management of the business
- organizing and/or setting up work areas or work tasks

- checking, correcting or maintaining business documentation and records
- verifying whether work is performed accurately
- scheduling business related activities and/or meetings
- obtaining business related materials

d. 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
- utilities functioning
- egress safety
- abuse, neglect and/or exploitation issues

11000 - PROVIDER ENROLLMENT

Assistive Services and Independent Living Counseling Provider Enrollment

In order to bill for Assistive Services and Independent Living Counseling providers must be enrolled in 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)** in order to receive payment for providing these services.

Working Healthy/WORK Codes

Population

26 – *Working Healthy* Basic Eligibility

27 – *Working Healthy* Medically Improved

Level of Care

WK - *WORK*

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

Provider Type

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

Provider Specialty

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

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

Procedure Codes

S5165 - Assistive Services

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

12000 - 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 *Working Healthy* 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 Back-Up 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 to be 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 *Working Healthy* cases closed and *WORK* services will end.

- Members are responsible for paying their *Working Healthy* premium monthly by the date specified on their statement. Members who do not pay premiums will have their *Working Healthy* cases closed and *WORK* services will end. Members whose payments are in arrears must pay <u>all premiums in full</u> before their *WORK* services can continue.

- 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.

- 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 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 complete an Emergency Back-Up Plan that ensures adequate coverage in the event that 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 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 complete all of the paperwork required by the FMS provider in a thorough and timely manner to ensure that their PAs and services providers are paid in a timely manner.

- 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 time worked by signing time sheets. Falsification of time sheets, either by the Member or PA 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 Case Manager 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 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 communicate any changes in status, needs, problems, etc. to the appropriate DCF, KDHE, or MCO staff.
- Members have the responsibility to inform their MCO Case Manager or Independent Living Counselor in a timely manner if they wish to return to an HCBS waiver or waiver waiting list.
- Members have the right to report abuse, neglect, and exploitation to DCF, Prevention and Protection Services.

13000 - GRIEVANCES, REVIEWS, APPEALS, JUDICIAL REVIEW

A. MCO Grievance/Appeal Process for WORK Services

Members who disagree with an action taken by their MCO related to their *WORK* services have the right to file a grievance or request an appeal with the MCO.

Grievance - Members must file a grievance within 180 days of the action taken by the MCO. The MCO must acknowledge in writing the grievance was received within 10 business days; 98% of all grievances must be resolved in 30 business days. If the MCO believes an additional 30 business days may be needed to resolve the grievance, this request must be made to KDHE/DHCF two business days in advance of the 30 business day deadline. 100% of grievances must be resolved in 60 business days.

Appeal – Members who have experienced an adverse action with an MCO may appeal the decision and request a fair hearing through the MCO defined process within 30 days, plus 3 calendar days if mailed, of the adverse action. Members may request a fair hearing either orally or in writing. An oral request may be made in person or by telephone. A written request may be made in person, by mail, by fax, or by email. Note: For fair hearing requests submitted after business hours via telephone, fax or email, the date of receipt shall be the next business day.

The MCO must inform the member of the action in a notice. This notice is called a "Notice of Action." The MCO must send a letter to the member within five business days acknowledging receipt of the appeal request. The MCO must resolve the appeal within 30 business days. **Note:** Members may request a State Fair Hearing (SFH) with the Office of Administrative Hearings (OAH) at the same time that they appeal an action taken by their MCO, or wait until after the

MCO makes a final decision and then request an SFH if dissatisfied with the MCO's final decision.

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

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 Review

Members have a right to ask for a review of an action taken by the state related to their *WORK* assessment or closure of their *WORK* services. Members may ask for a review of this decision by the *Working Healthy/WORK* Senior Manager, the Kansas Office of Administrative Hearings, or both.

- If a member wishes to ask for a State Fair Hearing after the *Working Healthy* Senior Manager has reviewed the assessment, the Kansas Office of Administrative Hearings must receive the request for a State Fair Hearing within 33 days after the mailing date of the *WORK* Senior Manager's response letter notifying the member of the outcome of the review. Members may request a fair hearing either orally or in writing.

- If a member wishes to ask for a State Fair Hearing instead of a review by the *Working Healthy* Senior Manager, or at the same time as the *WORK* Senior Manager's review, the Kansas Office of Administrative Hearings must receive the State Fair Hearing request within 33 days of the mailing date of this Notice of Action. Members may request a fair hearing either orally or in writing.

Members may request a review of their assessments by contacting the *Working Healthy/WORK* Senior Manager by telephone, e-mail or letter at the following address. Letters should be mailed to the following address:

Working Healthy/WORK Senior Program Manager
KDHE/DHCF - LSOB, Suite 900 North
900 SW Jackson
Topeka, KS 66612

C. Appeals

Members may request a fair hearing, either orally or in writing, if dissatisfied with an action taken by the MCO or by the state. An oral request may be made in person or by telephone. A written request may be made in person, by mail, by fax, or by email. Note: For fair hearing requests submitted after business hours via telephone, fax or email, the date of receipt shall be the next business day. This can be done at the same time the member is appealing a decision with the MCO or after the MCO makes their decision. The request must be received within 30 days of the notice of the decision, with three additional days added to allow for delivery via mail (33 days). All hearing dates, resolutions, and notifications follow the timelines prescribed by the Office of Administrative Hearings. If neither the member nor the State request that the KDHE State Appeals Committee (SAC) review the decision, the decision becomes final thirty (30) days from the date of the order.

Written requests for a State Fair Hearing should be sent to:

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

1. KDHE State Appeals Committee (SAC)

If members or the state disagree with the decision of the OAH, they may request, within 15 days of the OAH decision, that the KDHE State Appeals Committee (SAC) review the decision. The KDHE SAC reviews the appeal and the OAH Initial Order, and issues a Final Order. Following a SAC review, the decision becomes final thirty (30) days from the date of the order. A party has the option of appealing the decision to District Court. Should a party seek judicial review, then, pursuant to K.S.A. 77-613(b), the request for judicial review must be filed within 30 days from the date of the Final Order.

2. Judicial Review

Members dissatisfied with the decisions of the KDHE SAC have the right to file a petition for a Judicial Review in the appropriate District Court within 30 days of the Final Order being issued.

14000 - 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

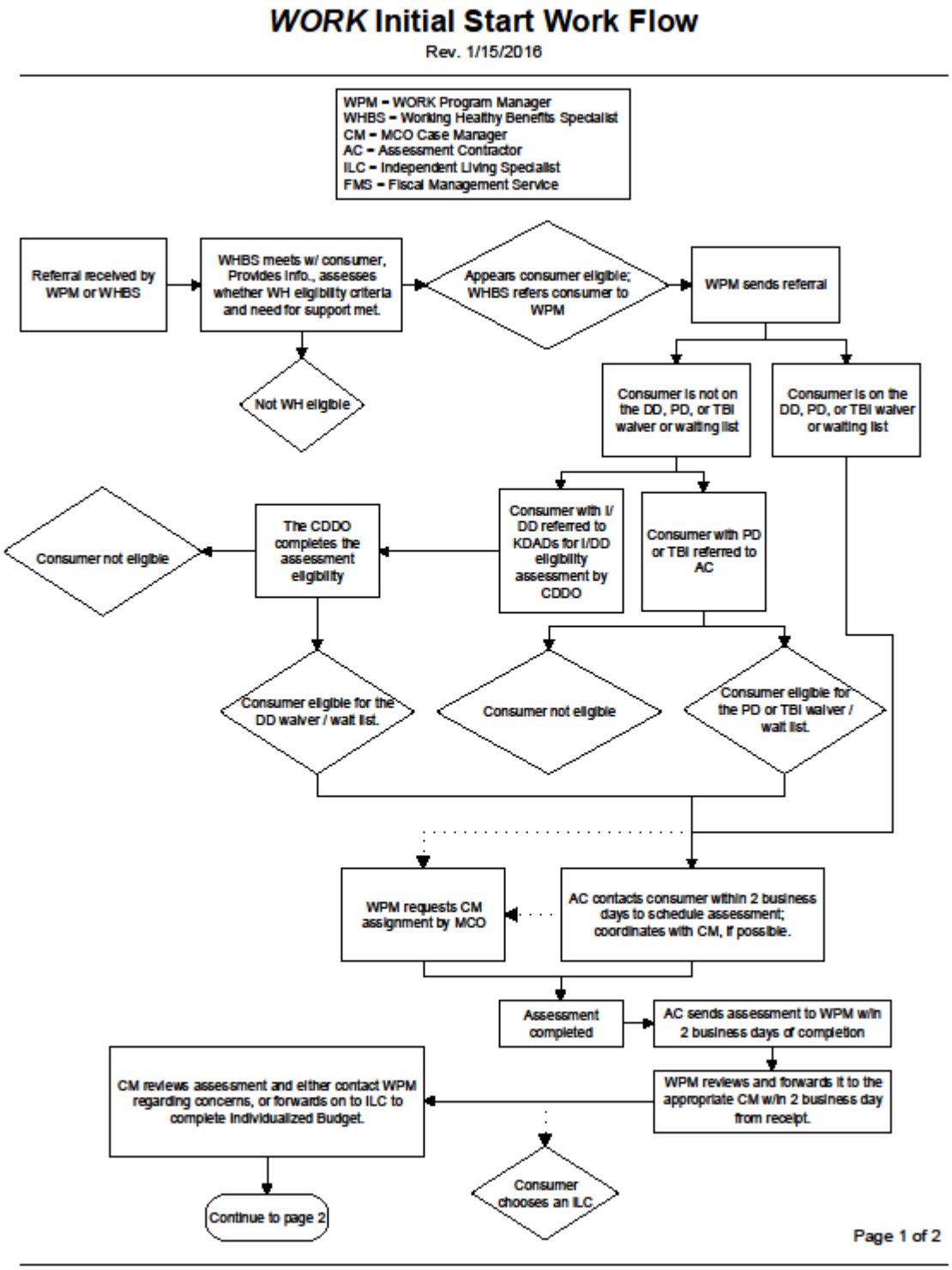
- with service problems when other help is not available directly through an MCO or provider
- understand where to take their problems with KanCare, such as the MCO grievance and appeals process and the State fair hearing process
- obtain answers when they feel their rights have been violated
- contact 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**.

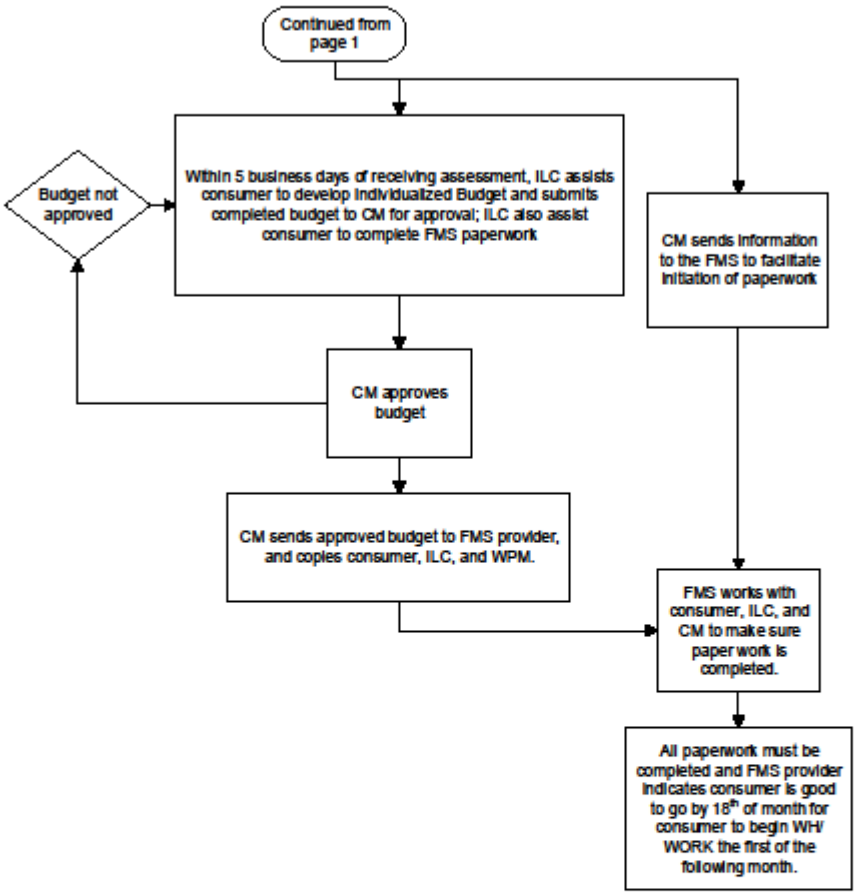
15000 - APPENDIX

WORK Initial Start Work Flow Chart



WORK Initial Start Work Flow

Rev. 1/15/2016



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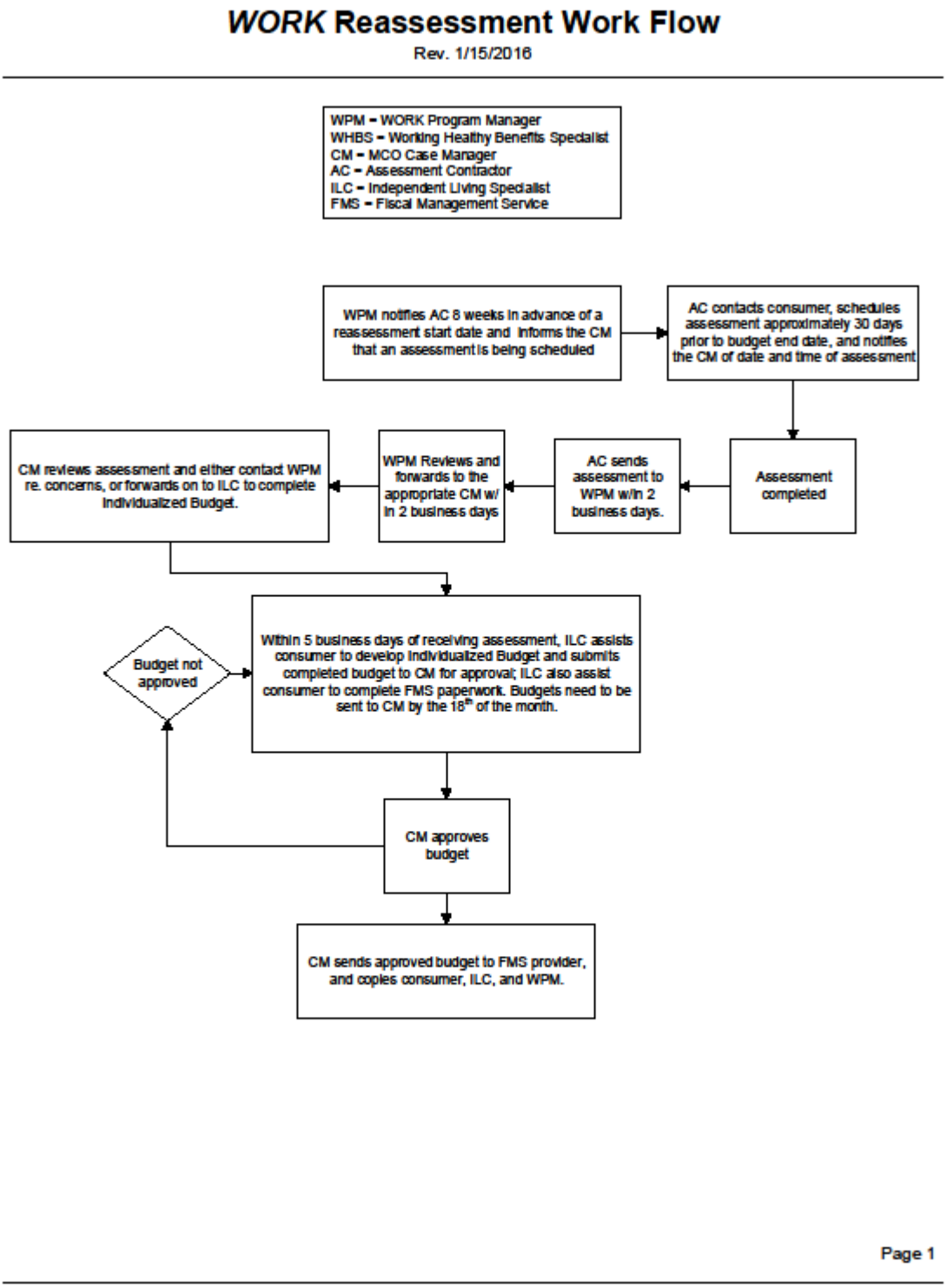
WORK Reassessment Work Flow Chart