State of Kansas Department of Social and Rehabilitation Services
Gary Daniels, Acting Secretary

Integrated Service Delivery - Candy Shively, Deputy Secretary (785) 296-3271
Economic and Employment Support - Bobbi Mariani, Director (785) 296-3349

MEMORANDUM

TO:	EES Program Administrators All Asst. Regional Directors	DATE:	December 15, 2004
FROM:	Bobbi Mariani, Director Economic and Employment Support	RE:	Implementation Instructions KEESM Revision 21 Effective January 1, 2005

This memo provides implementation instructions and information for the following January 1, 2005 KEESM changes:

- Adding New Household Member to a Pending Application - KEESM 7401 (1)
- Potential Employment - KEESM 3540
- KLS Referrals - KEESM 1724 and 2315
- Kansas Early Head Start and SRS Child Care Subsidy - KEESM 10021.1 (8) and 1114
- Food Stamp Work Related Exemptions - KEESM 3230
- Working Healthy - Medically Improved Group - KEESM 2665
- Out of Home Relative Provider Rate Reduction - KEESM 10240
- 215 Hour Cap on Out of Home Relative Provider Child Care Plans - KEESM 7600
- Child Care Provider Purchasing Violation Option - KEESM 10037

• In-Home Child Care Provider Case Files - KEESM 10036.4

I. **MULTIPLE PROGRAMS**

Adding New Household Member to a Pending Application -[See Summary of Changes, Item 1, B. (2) and KEESM Section 7401(1)] Assistance for the new household member is prorated from the date of application when the new person enters a cash or food stamp household after the application has been filed but during the month of application and prior to case approval. If the new household member enters a cash or food stamp household in the month following the month of application, but prior to approval, assistance for the new household member is effective the first day of the month the person entered the home. The clarification will be incorporated into the May KEESM revision.

Examples:

1. Rosa applies for TAF and food stamps on January 20, 2005. On February 4, Rosa reports that another child, Sara, returned to live with Rosa on February 2. Sara had been living with her father. The application is approved on February 11. Assistance is prorated for all household members except Sara from January 20. Sara is added effective February 1, 2005.

2. Fred, Ginger and their two children apply for TAF and FS on January 4, 2005. On January 15, Ginger has a new baby and reports this on January 17. The application is processed and approved on January 24. All five individuals have both TAF and FS assistance prorated from January 4, the date of application.

3. Sally applies for TAF and FS on January 20, 2005. On February 8, Sally reports that she gave birth to twins on February 7. The application is processed and approved on February 10. TAF and FS are approved for just Sally effective January 20. The twins needs are added to both TAF and FS effective February 1, 2005.

4. Ellen applies for TAF and food stamps on January 25, 2005. On February 10, Ellen reports that her husband, Joe, returned to the home on February 2. Joe had earnings during January but lost his job and will not receive any earned income during February. The application is processed on February 14. Assistance is prorated for all household members except Joe from January 25. Joe is not considered a household member in January and his income is not counted. Joe is added to the assistance plan effective February 1, 2005.

5. Same situation as #4 except the application is processed on March 4. The case action is the same. Assistance is prorated for all household members except Joe from January 25. Joe is not considered a household member in January and his income is not counted. Joe is added to the assistance plan effective February 1, 2005.

6. Ellen applies for TAF and food stamps on January 25, 2005. The application is processed on February 14. On February 18, Ellen reports that her husband,

Joe, returned to the home on February 16. Joe had earnings during January but lost his job and will not receive any earned income during February. Joe is added to the assistance plan in March, the month after the change is reported.

Potential Employment - [See Purpose, Background and Reason for Change, third paragraph, last sentence and KEESM Section 3540.] Please note that an individual item for this change was inadvertently omitted from the Multiple Programs, Changes, section of the Summary of Change. This change applies to both food and cash assistance. This revision changes the potential employment provisions to state that the potential employment penalty for reducing hours of employment shall only be applied if the person voluntarily reduces hours of employment from 30 or more per week to less than 30 hours per week AND reduces monthly gross earnings to less than 30 hours a week multiplied by the federal minimum wage (currently $5.15 per hour). For example, under the new policy, a person who without good cause, reduces hours of employment from 40 hours a week to 25, but is paid $8 per hour would not be penalized for reducing hours of employment. This new policy applies to voluntary reductions in hours (without good cause) being evaluated for a penalty or denial of assistance on or after 1/1/05.

II. CASH ASSISTANCE

KLS Referrals - [See Summary of Changes, Item III. A. 1 and KEESM Sections 1724 and 2315] GA applicants are to be referred to KLS for services immediately upon application. This referral will occur prior to approval of the application and prior to receipt of the 3151 in most instances. The purpose of this policy change is to allow for the earliest possible involvement of KLS in the Social Security Disability process. KLS will be responsible for making contact with Social Security on behalf of the consumer and will be responsible for scheduling the initial interview.

III. CHILD CARE ASSISTANCE

Kansas Early Head Start - [See Summary of Changes, Item IV. A. 3 and KEESM Sections 7600 - 7620]This revision change makes it possible for Kansas Early Head Start (KEHS) families to access child care assistance for a limited time and under specific criteria. It is important for KEHS and SRS staff to use the SRS Turnaround Communication Referral Form, Appendix, Item #C-20 when families enter and exit child care assistance. Usual application processing policies and procedures will apply to the KEHS families taking this option. The only exception is that plans should not be set up for more than 10 months if the family is found eligible. Staff will be aware of these families through the Turnaround form presented by the family with the application. A new Reason for Child Care code is being added to KsCares to help with tracking at the Central Office level. The new code is EH for Early Head Start. The EH reason code should be used on CHCP when plans are authorized. If staff have additional questions as this option is utilized, they should be directed to Mary Weathers, Kansas Early Head Start Program Manager.

215 Hour Cap on Out of Home Relative Provider Child Care Plans - [See Summary of Changes, Item IV. A. 3 and KEESM 7600] This revision implements a cap on the number of hours of care SRS will purchase per child from an Out of

Home Relative provider. Child care plans (and payments) should not exceed 215 hours per month per child. There will not be an edit added to KsCares to specifically address this policy change for Out of Home Relative providers. Only the existing 215 hour edit will be in place. A printout will be made available to workers which will indicate any plans with Out of Home Relative providers that exceed 215 hours. These plans will need to be adjusted according to the new policy. While doing the fiscal analysis of this change, it was found that only about 5% of Out of Home Relative provider plans statewide have scheduled hours over 215. The work involved in adjusting plan hours according to this change should be minimal. Providers and clients should be notified of child care plan changes through use of the C401 Change Notice on KsCares. An example is attached to this memo. Child care plan hours will need to be adjusted and updated on CHCP (Pf12 to update) at the same time the C401 is sent. The new plans (Pf5 to print) will then need to be sent to the client and provider. This shall be done by 1/19/05 (adverse action deadline) for plans beginning 2/1/05. Staff are reminded that Policy Memo 04-03-02 Child Care Plan Authorization - Sleep Time for Children remains in effect.

Out of Home Relative Provider Rate Reduction - [See Summary of Changes, Item V. A. 1 and KEESM 10240] Processing will begin January 3, 2005 to implement a rate reduction for Out of Home Relative child care providers. Notifications will begin January 3, 2005, with the new rate effective for the service month of February 2005 which is paid in March 2005. All payments for the February 2005 service month (paid in March) will reflect the lower rate.

Staff are reminded of KsCares system changes made with the October 2004 revision. One of these changes was separating Out of Home Relative provider rates from Registered provider rates on KsCares. Since no rate change for Out of Home Relative providers was implemented with the October 2004 system changes, many staff may not have noticed the changes. These changes could be seen on the PRRA (Provider Rate) screen on KsCares. With the January 2005 revision, SRS will be utilizing these system modifications and implementing a rate reduction for Out of Home Relative child care providers. This rate change will NOT be like the In-Home rate changes that were implemented in October 2004. With the In-Home rate change, KsCares programming was completely changed. There were tables added to KsCares and the way the system paid for In-Home care was completely different. The In-Home transition resulted in all payments keyed after the system migration was completed being impacted (prior months included). This will NOT occur with the Out of Home Relative rate change being implemented with the January 2005 revision. The Out of Home Relative provider rate change will look similar to past provider rate adjustments. The KsCares programming logic will be the same and the rate tables adjusted by Central Office staff will have effective dates. Essentially, once these tables are changed, the system will know what rate to pay for which service month.

Staff should refer to the updated SRS Provider Rate Schedule to see the new rates. As seen on the schedule, counties remain grouped according to current SRS county clusters. This new Out of Home Relative provider rate represents 65% of the Registered provider rate for that county grouping. This is in keeping with the approach taken by other states in regard to payment for this type of care. This new

rate should be considered a standard rate to be paid to any Out of Home Relative provider. There is no need to process the private pay rates indicated by the relative on the ES-1653. The new Out of Home Relative rates should be filled in by SRS staff on the ES-1653 in the SRS rate section. This section tells the provider what rate they will be receiving. There is no need for staff to enter these state rates for relatives on PRRA after implementation of this change. By leaving these fields blank, the system will always pay the state rate that is indicated on the rate table maintained by Central Office. Staff will not need to blank out existing rates on PRRA for existing Out of Home Relative providers. Preliminary analysis indicates that there are only 3 relative providers statewide with a rate on PRRA lower than the new standard rate. These particular relative provider rates will be blanked out by Central Office staff so the provider receives the new standard rate. This will mean that these few providers will see a rate increase. Local staff will be notified when this is done. The reason why existing rates on PRRA do not need to be blanked out across the board on PRRA is because KsCares pays the rate on the table (controlled by Central Office) or the rate on PRRA, whichever is lower. If a provider's rate on PRRA is higher than the new rate, the system will pay the new rate on the table. Since Out of Home Relative providers turn over fairly quickly, open providers with rates entered on PRRA will eventually phase out naturally. It is suggested that provider enrollment staff cross out the section on the ES-1653 which asks for the provider's rate and fill in the SRS rate prior to sending the document to the provider. This may save time in processing the ES-1653. The ES-1653, as well as all other provider enrollment forms, will be revised prior to EBT CC implementation. Drafts will come out shortly after the first of the year.

Workers will not need to update child care plans (CHCP) in the system in order for the new rate to be paid. Correct rates will be paid in accordance with the table changes that will be made on KsCares. (CHCP will need to be updated if the worker is reducing the plan hours to 215 however. This is discussed further in another section of this memo.) Current child care plans will automatically begin using the new rates when payment is made on REPC for the Payment Month of February 2005 (paid in March). Whenever new plans are created, they will use the new rates for that provider. Staff are reminded that wording on the child care plan indicates that rates may change due to changes in SRS maximum reimbursement rates. Out of Home Relative providers will also be notified of the rate change separately as listed in the next paragraph.

A Provider Notice will be available on KsCares. The notice will be P001 SRS Child Care Provider Rate Adjustment. This notice should be sent by local staff to all active Out of Home Relative providers by 1/19/05 (adverse action deadline). This will provide adequate and timely notice of rate reduction for service month of February 2005 (paid in March). Reports are available from Central Office to assist with this task.

If a provider or client wishes to Appeal this rate reduction they may do so. Normal procedures for processing Appeal requests and/or requesting dismissal should be used. See KEESM 10514 or 1615.

Out of Home Relative providers should be informed that becoming a Registered provider through the Health Department is an option. If an Out of Home Relative

provider becomes Registered, they would be eligible for the Registered provider rate. Registered providers are also eligible to participate in the Child and Adult Care Food Program (CACFP) administered by the Department of Education. CACFP can provide reimbursement for food served to children in care and CACFP staff also provide nutrition education to the provider. As a Registered provider, the relative would still have control over who and how many children they "enroll". Essentially, becoming Registered does not obligate the provider to serve additional children.

Child Care Provider Purchasing Violation Option - [See Summary of Changes, Item V. A. 4 and KEESM 10037]Child care provider monitoring staff have expressed the desire to be able to address purchasing violations with more flexibility. An example is a provider who is over capacity with KDHE. Staff would like to address this issue without having to terminate the provider completely. This revision will allow staff the option to prevent new child care plans from being written with a particular provider without having to disrupt current families with provider termination. Staff will be able to write Corrective Action plans with providers. New plans can prevented by putting an "N" in the CC Plan field on PRRA.

In-Home Child Care Provider Case Files - [See Summary of Changes, Item V. A. 3 and KEESM 10036.4] If not already in place, Regions should begin making specific In-Home Child Care Provider files maintained by provider enrollment monitoring staff. It has been indicated that in some Regions, workers maintain all of this information in the client's case file. With the pending implementation of EBT CC, it will be necessary for local staff to put the actual In-Home provider on the KsCares system (now the client is put on KsCares). It is the provider, not the client, who will be sent to eFunds for enrollment under EBT. It will be the provider, not the client, who will need to be able to receive payments through direct deposit into a bank account. Maintaining In-Home provider files centrally will help when this transition comes.

IV. FOOD ASSISTANCE

Food Stamp Work Related Exemptions - [See Summary of Changes, item VI, A. (2) and KEESM Section 3230] With this change in policy, one work related exemption is being modified and four new work related exemptions are applicable to the Food Stamp Program.

The exemption regarding employment is being modified to state that a person employed or self employed and working a minimum of 30 hours weekly OR receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours is exempt. For example, effective 1/1/05, a person working 20 hours a week and earning $10 per hour is exempt from food stamp work related requirements. In another example, a person who is self-employed and who works 30 hours a week, would also be exempt from food stamp work requirements. (Use prudent person in making the decision whether a self-employed person is exempt from work requirements or not.) When determining if the amount of self-employment is equal to or more than 30 hours a week times minimum wage, consider the adjusted gross self-employment income (after income producing costs or flat 25% deduction).

JOPR reason code is EM.

In regard to the four new exemptions, the following are suggested guidelines for determining if the person is exempt from work related requirements. The appropriate JOPR exemption code is also listed below.

- A person subject to and complying with TANF work requirements - This includes persons receiving TANF cash assistance and cooperating with TANF work requirements.

  JOPR reason code is PA.

  NOTE: Although exempt from FS work requirements, the comparable treatment of disqualification policies of 2550 still apply.

  NOTE: The PA reason code should only be used if it is the only applicable exemption reason code for a TAF/FS recipient. For example, if the TAF/FS person has a child under 6, the reason code of CU-EX should be used instead of PA-EX.

- A person receiving unemployment compensation - This includes a person who is receiving unemployment compensation, or who has been approved for unemployment compensation, but has not yet received the first benefit.

  JOPR reason code is UC.

- A regular participant in a drug addiction or alcoholic treatment and rehabilitation program -This includes all outpatient drug or alcoholic treatment; cooperation with RADAC; and cooperation with an individual drug or alcoholic treatment plan. Some documentation of participation in the program is required.

  JOPR reason code is AD.

- A student enrolled at least half-time in any recognized school, training program or institution of higher education - This included on-line, virtual schools (half-time enrollment as verified by the school). Documentation is required.

  JOPR reason code is ST.

  These new work related exemptions shall be applied to all applications received or processed on or after January 1, 2005. For on-going cases, any persons who are currently mandatory, but who should be exempt under the new definitions, shall be converted to exempt as identified, but no later than the time of the next review or IR, whichever comes first.

  NOTE: Until the KAECSES code cards are revised the above reason codes need to be added to the JOPR code card, page 6, under Reason Code as follows:

  AD Alcohol/Drug Treatment (FS only)
  PA Subject to and complying with TANF (FS only)
  ST Student at least ½ time (FS only)
  UC Receiving UC (FS only)

V. MEDICAL ASSISTANCE

Working Healthy-Medically Improved Group - [See Summary of Changes, Item VIII. A. 3 and KEESM Sections 2664.2 and 2665] Coverage under this new eligibility group will be effective Feb 1, 2005. The Medically Improved group is an extension of the current Working Healthy program. Persons covered are those who were covered under the current Working Healthy group but lost eligibility due to a medical improvement which resulted in a loss in disability status with SSA.

Working Healthy Case Closure - The eligibility worker is responsible for notifying the Benefits Specialist upon closure of all Working Healthy cases. When the worker suspects a case has been closed because of medical improvement, a special note shall be made on the referral. Suspect cases can be identified by information on EATSS and should be noted on the referral. When Social Security terminates benefits for an individual a BENDEX or SDX record will be generated. The change in payment status will prompt a change alert to the eligibility worker. For terminations based on medical improvement one of the following codes will be reflected:

- For SSI, a payment status of N07
- For Title II/SSDI, a payment status code of T8

However, the presence of these codes do not always indicate a medical improvement was the basis for closure. Social Security must must verify the closure was based on medical improvement as complete information is not available on EATSS. The eligibility worker will identify suspect cases but the Benefits Specialist will actually contact SSA and confirm the closure reason. The Benefits Specialist will contact the beneficiary and discuss other options as well, including appealing the termination with Social Security. As with all medical assistance cases based on disability, if the individual appeals the Social Security decision within 60 days of action, Medicaid coverage continues as long as the appeal remains active. The Benefits Specialist will work through these issues with the beneficiary and will provide the eligibility worker with Social Security status information.

NOTE: In some cases persons may have been covered under another category, but otherwise meet Working Healthy criteria (e.g., SI under 1619b). When a suspected termination for medical improvement occurs for these individuals, the case is to be staffed with the Benefits Specialist. In some cases, administrative action to move the individual to the Working Healthy group for the sole purpose of establishing coverage under the Medically Improved group may be acceptable

Approval Process - If the individual does not exercise SSA appeal rights or has exhausted them, he may elect to move to the Medically Improved group. The individual must meet all criteria of the Working Healthy program, with the exception of disability criteria. In addition, persons must be employed a minimum of 40 hours per month earning at least minimum wage. The individual must also continue to have a documented severe impairment. A new application is required prior to approving Medically Improved coverage.

Although all individuals must have previously enrolled in the Working Healthy group, Medically Improved coverage may be established following a break in such coverage. For example, Working Healthy closed 05-04 due to a loss in disability status. The Benefits Specialist confirms a medical improvement. Coverage under the new group may be established effective 02-01-05 if all eligibility criteria continue to be met.

All verification requirements of the Working Healthy program apply to the Medically Improved group. In addition, the employment criteria of 40 hours a week at minimum wage level must also be verified prior to approval.

Medically Improved cases are established on the MS program in KAECSES and are specifically denoted by using a PICK code of WM. The WH program subtype must also be used. Premiums are required at the same level as Working Healthy. An individual may enter into a repayment agreement as outlined in KEESM 2664.5 if necessary.

Ongoing Coverage - Changes are managed as in the current Working Healthy program. A desk review shall be completed every 6 months as with Working Healthy. Premiums are to be adjusted at this time. A full redetermination is required annually. Verification that the individual meets the 40 hour per month employment criteria is required for both full reviews and 6 month desk reviews.

Medically Determinable Severe Impairment - The individual must continue to have a documented medically determinable severe impairment. This must be documented annually, at the time of the redetermination. The Benefits Specialist is responsible for this determination. At the same time the annual review is sent to the beneficiary, a request shall be made to the Benefits Specialist for impairment status. The Benefits Specialist will then generate a request for a medical statement to determine the status of the condition. The form, The Statement Of Continuing Eligibility, is attached. The form must be completed by a medical professional familiar with the beneficiary's condition. Other documentation may be requested if necessary. The level of impairment shall be reported to the eligibility worker, prior to completion of the review. Completed forms and other verification used to establish the level of impairment shall be retained in the eligibility case file. If it is established the individual no longer has such an impairment, coverage shall be terminated.

Notices - Several new notices have been developed to support the new program.

N119 - WH - Medically Improved Approval - No Premium
N120 - WH - Medically Improved Approval - With Premium
N145 - WH - Medically Improved Review - No Premium
N146 - WH - Medically Improved Review - With Premium
N426 - WH - Medically Improved Closure - Other Reasons

BM:PG:jmm

Attachments - Statement Of Continuing Eligibility

C401 Change Notice

KEESM Home | Table of Contents| Index | EES Home |
Page Last Updated: 4/1/08 11:22 AM