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Economic and Employment Support - Bobbi Mariani, Director (785) 296-3349
*....Enriching lives today and tomorrow***MEMORANDUM****To:** EES Program Administrators
All Asst. Regional Directors**Date:** September 16, 2005**From:** Bobbi Mariani, Director
Economic and Employment Support**RE:** Implementation Instructions - KEESM
Revision 25 Effective October 1,
2005

This memo provides implementation instructions and information for the following October 1, 2005 policy changes and clarifications in the Kansas Economic and Employment Support Manual (KEESM):

- Exemption of Veteran's Educational Income
- Foster Care Child in Relative's Home
- TAF Participation Rate Requirements
- Special Service Allowance
- MS-2126 Revision

I. MULTIPLE PROGRAMS

Exemption of Veterans Educational Income - See Summary of Changes, Item I, A, 3. and Section 6400(18).

With this revision, Veterans Educational Income is now exempt for persons in post secondary education. This exemption applies to all applications and reviews received or processed on or after October 1, 2005. The exemption is also effective for all ongoing cases starting with the benefit month of October 2005.

To help staff identify affected cases, a report has been prepared that will identify all open FS, GA, TAF, and MS cases with VA OT income coded on the UNIN or UNIE screens. Persons listed have VA OT income, are coded IN, DI or DF, and are between the ages of 16-40. Child care only cases could not be identified as KsCares does not currently have this income code. These cases shall be addressed at the next case review. Statewide only 98 cases were identified using the above criteria. Each case listed on the report must be evaluated to determine if the VA income being counted is educational income. If it is NOT educational income, then it is not exempt. However, if it is VA educational income, then the income should be coded as EE on UNIE or XA on UNIN for the benefit month of October. If necessary, supplemental benefits for October will need to be provided if the change is not made in time to affect the regular monthly issuance. If cases are later discovered (not identified on the printout) with Veterans

Educational income that should have been exempted, restored benefits shall be provided back to the benefit month of October 2005. Notify all households the reason their benefits are increasing. An income code of VE - Veteran's Educational Income (EX) is being added to KsCares to be used with cases processed on or after October 1, 2005.

II. CASH ASSISTANCE

Foster Care Child in a Relative's Home - See Summary of Changes, Item III B, Section 2210 and Policy Memo 05-07-03.

Policy Memo 05-07-03 was issued in July 2005 replacing EES Policy Memo 01-02-02. The purpose of this Policy Memo was to: Provide EES staff with guidelines regarding TAF eligibility for children placed with a relative by a Child Welfare Community Based Service (CWCBS) provider; eliminate duplicate payments to the household; and emphasize the importance of communication between Children and Family Service (CFS) social workers and EES staff. This memo also provided clarification that there can be TAF eligibility during the interim period before the approval of the licensed or approved home unless the CWCBS provider is making payments to the relative during this time.

Section 2210 is modified in Revision 25 to indicate that relatives working with CWCBS providers may receive TAF during the interim period before the relative's home is licensed or approved. This section is also updated to cross reference Policy Memo 05-07-03.

The following example illustrates the modification to Section 2210:

Jane is in the custody of SRS and placed with her aunt by the CWCBS provider. The provider explains to Jane's aunt that the following options are available: Financial support from the CWCBS provider; TAF; or become payee of Jane's SSI/SSA (which is not an available option in this situation). Jane's aunt decides that she would like to receive financial support from the CWCBS provider. The provider encourages Jane's aunt to become a licensed or approved foster home through KDHE. Jane's aunt may either receive TAF payments or financial support from the CWCBS provider until she becomes a licensed or approved foster home. EES and CFS staff need to communicate closely to assure that there is no duplicate payment during this time.

III. MEDICAL ASSISTANCE

MS-2126, Notification of Facility Admission/Discharge - The MS-2126 has been revised and renamed. The primary objective of the revision is to determine payment eligibility of the facility. Additional elements have been added to the document to capture relevant information necessary to make this decision. The previous version of the form required additional follow-up with the facility in many instances. The new version is also designed to facilitate change reporting by the facility, including changes in the level of care. The process is being expanded for use by other facility types as well, including swing beds and Level VI facilities.

A. Process/Highlights

The facility continues to be responsible for initiating the MS-2126, under the conditions specified in KEESM 8184.1. An MS-2126 is required for a new admission requesting Medicaid payment, any change in level of care within the facility, a discharge from the facility or hospital leave in excess of 30 days.

1. **Section I: Resident Information** - This section has been revised to capture the name of any responsible agency (for example, a child welfare contractor) as well as the relationship of the named responsible party to the facility resident.
2. **Section II: Facility Information** - This section has been modified to capture the name of the agency or person who placed the resident (for example, a community based screening team or a court order). All facilities must include CARE or Screening information. For instances where one isn't required (for example, swing bed) the reason must be stated. The provider number was removed from this section as it is no longer relevant to payment approval, as long as the provider is a Medicaid provider.
3. **Section III: Facility Placement/Discharge** - This section has been expanded to capture detailed information on the level of care provided in the facility and prior to admission/payment request. Note that State Hospitals may continue to use forms previously designed for use by the hospital with the permission of the SRS Regional Service Center.
4. **Section IV: Hospital Leave** - This section has been clarified that a new MS-2126 is only needed when the hospitalization exceeds 30 days.

B. Implementation Issues

The form is to be reproduced locally by the facilities as needed. Nursing facilities are to be encouraged to discard older versions of the form. However, older versions of the form may be accepted as long as all critical information is reported in a timely manner in the case situation.

C. Level VI Issues

Earlier this year, Medicaid payment processes were modified to begin evaluating the level of care present on the MMIS, as passed through from KAECSES. To ensure information is communicated effectively and timely, information has been added to the MS-2126 specifically for Level VI facilities. As with other facility types, the Level VI facility is responsible for ensuring any screening requirements are met. However, the eligibility worker is no longer responsible for verifying screening requirements are met for Level VI facilities, as other SRS staff are responsible for this process.

1. Contact Persons

In order to ensure a smooth flow of information between the Level VI facilities and eligibility staff, specific contact persons have been designated to handle

these issues.

i. **Facility Contacts**

Each Level VI facility has been assigned a specific contact person within SRS. This individual will serve as the single contact person and general repository of information for the facility. The facility will send all new MS-2126 payment requests to the designated individual. The designated contact will then coordinate with the assigned eligibility worker to ensure Medicaid eligibility and eligibility for payment are determined. Because a number of Level VI residents may also be foster care recipients, contact with both CFS and JJA staff as well as eligibility staff will be necessary.

The contact points for the facilities are in the [KHPA PTRF Training material](#).

ii. **Regional Contacts**

SRS Region and the HealthWave Eligibility Clearinghouse shall appoint a single contact person for all general Level VI issues within the region. The regional Level VI contact point will coordinate all Level VI issues within the region, including requests from specific facility contact persons.

Regional Level VI contacts are in the [KHPA PTRF Training material](#).

2. **Eligibility Process**

Eligibility staff have requested additional information in order to process Level VI requests. The following policies and processes are not new, but are offered as supplemental material to the new MS-2126.

- i. **Length of Stay** - For youth age 18 and younger, it is necessary to determine the anticipated length of stay in the facility (KEESM 8183 and specified references). If the stay is NOT expected to last at least 30 days, independent living budgeting applies. Generally, the child is included in the assistance plan applicable prior to admission. The CI program is not appropriate for stays which do not exceed 30 days, unless the individual is age 18 or over.

If the stay is expected to last at least 30 days, long term care budgeting applies. Generally, eligibility is determined on the CI program in these situations. Although parental income and resources are not included, the parent is responsible for completing the application and providing any necessary documentation.

- ii. **Current Recipients** - When a current Medicaid recipient enters a facility the first step is to determine if the person will remain covered

under the current program. Youth in foster care (SRS or JJA custody) or adoption support related programs will continue coverage in these categories. Patient liability does not apply to foster care youth. However, for youth in adoption support programs, patient liability is determined and the subsidy is included in the determination. An off-system paper budget is required to determine the patient liability in these cases.

For other current Medicaid recipients under age 18, if the individual enters a Level VI facility for a stay not to exceed 30 days, no changes in the case are necessary. Independent living budgeting applies, and the current program continues. In order to approve facility payment, an MS-2126 is required. LOTC must be completed, with a patient liability of \$0 unless a spenddown exists. For Medically Needy programs, the spenddown amount may be used as a patient liability to meet the spenddown.

NOTE: If the child entering the facility is included on an MA CM or MP case in the HealthWave Clearinghouse, the Clearinghouse is responsible for ensuring LOTC is properly coded for the child. As the child will continue with the current assistance plan, no additional action is necessary. However, for Medically Needy programs the case will be sent to the field for a full determination.

If the stay is anticipated to last 30 days or more, long term care budgeting applies. A new application is required and eligibility shall be redetermined based on LTC rules. The CI program is generally used in these situations. For cases in the HealthWave Clearinghouse, the Clearinghouse is responsible for ending participation on the current case. The field is responsible for establishing ongoing eligibility under the new program, including determination of any patient liability, completing LOTC and notifying the beneficiary/representative and the facility.

If a current HealthWave XXI recipient enters a Level VI facility, a Medicaid determination must be completed, beginning with the date of entrance. Coverage of Level VI placements is not included in the HealthWave XXI plan. Similar to the process outlined for stays exceeding 30 days, the SRS regional office is responsible for completing the Medicaid determination. The Clearinghouse is responsible for terminating HealthWave XXI coverage under the current case number.

3. Level V vs Level VI

Level V facilities are not considered medical treatment facilities. Therefore, long term care budgeting does not apply to residents of Level V facilities. Independent living rules, including the temporary absence provisions, are used to determine eligibility for persons living in a Level V facility. In most

cases, the child will be included in the assistance plan prior to entrance in the Level V facility.

If a spenddown results, the charges of the Level V facility are not allowable against the spenddown. Patient liability does not apply to Level V facilities, as long term care is not applicable. These cases are processed by the SRS regional office or the HealthWave Clearinghouse, depending on where the application is received.

4. Notices

Special notices are currently in development and will be announced through SRSTSC when available.

IV. SUCCESSFUL FAMILIES

A. TAF Participation Rate Requirements - See Summary of Changes, Item IV, B, 1 and Section 3110.

The federal TANF work participation report was modified in June 2005 to consider the following situation as a One-Parent household rather than a Two-Parent household for federal work participation reporting purposes:

Boyfriend/girlfriend (BG Relationship Code) situations where one parent is under age 18 and not emancipated

The definition of a Two-Parent household is modified to reflect this change in Section 3110.

The following example illustrates this definition modification:

Bob (age 21), his girlfriend Ann (age 17) and their mutual child, Ben (age 13 months) receive TAF assistance. Bob works 20 hours per week and Ann is working on her GED 10 hours per week. This case meets the federal work participation requirement for a one-parent household. Prior to the June federal report programming modification this situation would have been considered a two-parent household, and the household would have failed to meet the federal participation requirement.

B. Special Service Allowance - See Summary of Change, item IV, B, 2 and Section 3411.2.

EES staff have a great deal of flexibility in the authorization of work program support services. Clarification is being added to emphasize two possible uses of Special Service Allowance funding to promote the use of work experience and also to provide payment to clients who are participating in a "job try-out" as part of a work assessment. These payments are the Work Experience Reimbursement Allowance and the Work Assessment Reimbursement Allowance.

1. **Work Experience Reimbursement Allowance.** This procedural information about the Work Experience Reimbursement Allowance was originally

contained in the KEESM Revision #14 Implementation Memo (dated April 18, 2003). That information is being repeated in this memo for ease of reference.

EES staff have the flexibility to issue TAF clients participating in work experience EES (profit and nonprofit) a Work Experience Reimbursement Allowance for additional costs associated with work experience participation. The Work Experience Reimbursement Allowance is considered exempt income in the determination of cash and food stamp benefit amounts.

NOTE: TAF clients participating in work experience could be eligible for other support services (i.e., transportation, special services allowance, etc.) in addition to the Work Experience Reimbursement Allowance if there is a documented need.

Calculation of the Work Experience Reimbursement Allowance:

Work Experience clients would routinely be assigned 24 to 40 hours per week. At the end of each month of the work experience assignment, the total number of work experience hours worked in that month based on the work site monthly report are multiplied by the federal minimum wage. The gross amount of the TAF grant and gross amount of the food stamp benefit for the month including any supplemental payments during the month, are added together. If the TAF/FS total is greater than the number of hours worked multiplied by the federal minimum wage, there will be no Reimbursement Allowance. If the hours worked total is greater, the TAF/FS total will be subtracted from the hours worked total and the difference is issued to the client as a Work Experience Reimbursement Allowance.

This Work Experience Reimbursement Allowance payment would be made monthly. Payment Type is SS WP (Special Services) and WP Service for Payment Code, LR Labor Standard Work Experience Reimbursement Allowance, are to be used to identify these payments.

EXAMPLE of Reimbursement Allowance Calculation :

The client has worked 160 hours in work experience in February. $160 \times \$5.15 = \824.00 . Gross amount of February cash (\$300.00) and food stamp benefit (\$ 141.00) total is \$441.00. Since the hours worked at minimum wage is greater than the gross amount of cash and food stamp benefits, the EES Specialist will issue the difference of \$383.00 ($\$824.00 - \$441.00 = \383.00) as a Work Experience Reimbursement Allowance and send the W808, Work Experience Reimbursement Allowance Notice, to notify the client of the payment. A Work Program Activity code, WXP Work Experience With For-Profit Employer, is available and should be utilized when a client is assigned to a for-profit work site assignment.

The calculation of the Work Experience Reimbursement Allowance is based on the information known at the time of the calculation. A Work Experience Reimbursement Allowance would not be considered an incorrect payment if information that would have resulted in a different payment amount is discovered after the calculation and issuance of the allowance. For example,

in the situation above it is later determined in April that the correct benefits for February cash should have been (\$350.00) and the correct food stamp benefits should have been (\$175.00) for a total benefit of \$525.00. The client is issued those additional cash and food stamp benefits for February in April. Based on those benefits, the client would have been eligible for a \$299.00 (\$824.00 - \$525.00 = \$299.00). Work Experience Reimbursement Allowance rather than the \$383.00 payment received. The \$84.00 difference would not be considered an overpayment because the Allowance was based on the information known at the time of the calculation. The supplement issued in April of February cash and food benefits would be used in the calculation of the April Work Experience Reimbursement Allowance.

2. **Work Assessment Reimbursement Allowance.**

EES staff have the flexibility to compensate work program clients for participation on a worksite as part of a work assessment. Following are a couple of examples of when this payment might be utilized:

- EES is piggy-backing on a VR Community Based Work Assessment Pay for Performance Agreement. This agreement provides for compensation to the client for up to 80 hours of participation at a worksite as part of a work assessment. At the completion of the work assessment, the Work Assessment Reimbursement Allowance may be used to compensate the client for up to 80 hours of participation at minimum wage.
- A Contracted Employment Service Provider places EES clients on a worksite as part of the work assessment. The Work Assessment Reimbursement Allowance may be used to compensate the client for up to 80 hours of participation at minimum wage.

Payment Type SS WP (Special Services) and WP Service for Payment Code, WA, Work Assessment Reimbursement Allowance, are to be used to identify these payments.

The Work Assessment Reimbursement Allowance is considered exempt income in the determination of cash and food stamp benefit amounts.

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