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**Economic and Employment Support - Bobbi Mariani, Director (785) 296-3349**  
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**MEMORANDUM**

<b>TO:</b>	EES Program Administrators All Asst. Regional Directors	<b>DATE:</b>	06-19-08
<b>FROM:</b>	Bobbi Mariani, Director Economic and Employment Support	<b>RE:</b>	Implementation Instructions - KEESM Revision 36 Effective July 1, 2008

This memo provides implementation instructions and information for the following July 1, 2008 policy changes in the Kansas Economic and Employment Support Manual (KEESM):

**I. ALL PROGRAMS**

Child Citizenship Act of 2000 – See [Summary of Changes](#), item I, A, 3 and KEESM section [2141.1](#).

KEESM section [2141.1](#) has been revised to add clarification due to numerous questions and to alleviate confusion related to this policy. Automatic citizenship occurs on the date the following criteria have all been met:

- The child has at least one U.S. citizen parent (by birth or naturalization);
- The child is currently residing permanently in the United States in the legal and physical custody of the U.S. citizen parent; and
- The child is a lawful permanent resident

The above criteria do not have to occur in any particular order. Children who obtain this automatic citizenship are not required to obtain their own Certificate of Citizenship. Their citizenship can be verified by verifying each of the separate items outlined above.

**Example:** A mother and her child immigrate to the United States in 2006 as lawful permanent residents. On December 12, 2007, the mother becomes a naturalized citizen. On this date, the child also becomes an automatic citizen based on the following: the child's parent is a citizen, the child is residing in the U.S. with her mother and the child is a lawful permanent resident. Now that this child is a U.S. citizen, she must provide verification of citizenship and identity

to qualify for Medicaid coverage. The child's SAVE verification which outlines she is a lawful permanent resident, along with the mother's naturalization certificate serves as verification of citizenship for this child. A separate document verifying identity for the child must also be provided.

## II. Child Care

### A. Enhanced Rate for Special Care – See [Summary of Changes](#) Item II, A, 1 and section 7600.

1. The Special Purpose and Special Needs child care rates are being eliminated effective 7-1-08, and are being replaced by a single Enhanced Rate for Special Care. This will require that all current plans written using the Enhanced or Special Purpose rate or the Special Needs rate be ended and new plans written using the new Enhanced Rate for Special Care. The new Enhanced Rate will be used for all hours of care authorized, so only one plan will be necessary for any child on a case. All of these changes need to be made on KsCares prior to the issuance of the July monthly CC benefits, which will occur on the night of June 26th.

a. For plans currently coded on KsCares as “EN”:

i. Provider enrollment staff do not need to do anything to the provider data on PRR2.

ii. The worker must create a new Enhanced Rate plan to replace the old Enhanced Rate plan. The new plan should begin in July, 2008. It will have the Enhanced Rate of \$6.00 per hour. The new plan could have more hours each month than the old Enhanced Rate plan because the new Enhanced Rate is not limited to 4 hours per day. Creating a new Enhanced Rate plan, rather than just updating the old Enhanced Rate plan, will ensure that a new family plan, containing the new Enhanced rate, will be automatically printed and mailed to the PI of the case.

iii. In addition to receiving a copy of the new family plan, the PI of the child care case must be notified of the reason for the change in the amount of their monthly benefit. Suggested wording for this change notice might be “This change is due to a statewide policy change in the hourly benefit rate paid for child care for a child with special needs.” The manual

reference is KEESM 7600.

b. For plans currently coded on KsCares as “SP”:

i. Provider enrollment staff must enter a new rate record for that provider on PRR2. The new rate should begin in July 2008. The old rate record should end in June 2008. On the new rate record, enter “Y” in the Enhanced Rate field, and enter the provider’s previous rates in the Regular Rate fields. Note that the Special Purpose rate field will no longer be on PRR2.

ii. After entering the new rate on PRR2, provider enrollment staff notify each worker who has a Special Purpose plan with that provider.

iii. After being contacted by their provider enrollment staff about the provider, the worker then creates a new plan with that provider for each child who has had a Special Purpose Plan with that provider and that plan was scheduled to end after June 2008. This new plan will replace the old Special Purpose plan. The new plan will begin on July 1, 2008, and it must have a “Y” entered in the Enhanced Rate field on CHCP.

iv. Workers must change the expiration date of all current special purpose plans scheduled to end after June 2008 to 6/30/08. KsCares will not issue Special Purpose benefits for any month after June 2008.

v. Workers must notify the casehead of the reason for the change in their monthly benefits. See item 1.a above for suggested wording for this notice.

c. For plans currently coded on KsCares as “SN”:

i. If the provider for the Special Needs plan has not been a Special Purpose provider, but they have been approved for the new Enhanced Rate, provider enrollment staff must create a new rate record for the provider, beginning in July 2008, and enter “Y” in the Enhanced Rate field for that new rate record – the same process as described in 1.a. above for providers with Special Purpose plans. The old rate record should end in June 2008. **If the provider for the Special Needs plan has not**

**been approved for the new Enhanced Rate, nothing needs to be done on PRR2 for that provider.**

- ii. After entering the new rate on PRR2, provider enrollment staff notify each worker who has a Special Needs plan with that provider if the plan has been approved for the new Enhanced Rate. **If the Special Needs Plan has not been approved for the new Enhanced Rate, notify the worker.**
  - iii. After being contacted by their provider enrollment staff about the provider, the worker then creates a new plan with that provider. This new plan will replace the old Special Needs Plan. The new Plan will begin on July 1, 2008, and it must have a “Y” entered in the Enhanced Rate field on CHCP. **If the provider for the Special Needs plan has not been approved for the new Enhanced Rate, the worker does not need to create a new plan using the new rate on CHCP. If the family remains eligible for benefits for that child, a new plan must be created using the regular benefit rate.**
  - iv. Workers must change the expiration date of all current Special Needs plans to end after June 2008 to 6/30/08. KsCares will not issue Special Needs benefits for any month after June 2008.
  - v. If the total monthly benefit for the family has changed, the casehead must be notified of the reason for the change. See item 1a above for suggested wording for that notice.
- d. For new approvals processed after June 1 for June (or earlier) benefits, these must be paid at the old Special Purpose and/or Special Needs rates. Since these rates have been removed from KsCares, it will be necessary for you to create plans entering zero hours, ending June 30, 2008. The worker will then need to calculate an amount of the payment and enter that payment amount on EXPC with a payment type of “UN”. Instructions for calculation of those payments is as follows:
- i. Create a CC plan that starts in June 2008 and ends in June 2008.
  - ii. On CHCP leave the Enhanced Rate field blank and enter zero in the HRS (hours) field for the month of

June.

iii. Calculate the cost of care yourself:

- If the plan is using the old Special Purpose rate, then multiply the number of hours of care by either \$7.05 (if the child is at least 19 months old), or by \$7.37 (if the child is 18 months old or younger). The age for each child is displayed in years and months on CHCM.

- If the plan is using the old Special Needs rate, enter 1 in the HRS field for the month of June on CHCP. Press ENTER, then see what rate is displayed in the RATE field next to the HRS field. Then add \$0.15 to that rate, and multiply the resulting rate by the number of hours needed for June to get the cost. After doing that, remove the 1 in the HRS field and press ENTER – nothing should then appear in the Rate, Cost or SRS Payment fields.

iv. If there is a Family Share Deduction for that plan, subtract the amount of the Family Share Deduction from the cost of care you just calculated. The result is the SRS payment (benefit amount that you will make).

v. From CHCP, go to EXPC and create an UN payment (Underpayment) for the month of June. First, on CHCP press PF10, then on PAMA enter X in the Sel(ect) field next to 06 08 and press PF11. On EXPC, after entering 06 08 in the Payment Month field and UN in the Payment Type field, press ENTER, then in the Payment Amount field enter the amount of the SRS Payment that you calculated previously. After updating EXPC, authorize the payment on PAMA.

2. To clarify a couple of issues regarding the use of the Enhanced Rate for Special Care:

a. The start date for use of the enhanced rate should be the application date for new applications, as long as the necessary information is provided within the initial 30 days of the application date. If the information is not received within the initial 30 days, and it is received later, it would be treated as a change, and acted on for benefits for the month after the information is received. If a

request for the enhanced rate is received for a child with an ongoing child care case, it would be treated the same as any other change. If the necessary information is received timely, the change would take place for benefits for the month following the month of request. If the information is not timely received, the change would take place for the month following the month of receipt.

- b. Reviews for child care cases with children receiving benefits at the new Enhanced Rate will be the same as other child care cases. If the information on the 1627a indicates a condition of a temporary nature, the worker may either set the review date to match the projected end date for the condition, or they may set an alert to request information for a possible revision to the plan.
- c. The need for a new Request for Enhanced Rate for Special Care form 1627a at review will depend on information listed on the current 1627a regarding the duration of the child's condition that requires enhanced care from the child care provider. The caseworker will need to check the 1627a at review, and if the 1627a and supporting documentation indicates that the condition is permanent, it will not be necessary to repeat the form and documentation, unless there is a change in providers.

### III. CHILD CARE AND TAF

**Mandatory Verification That Affects Eligibility for Program Benefits -** See [Summary of Changes](#), item III, A, 1 and KEESM section [1322](#) and [7110](#).

These sections are being revised to require mandatory verifications of non-exempt earned income for the TAF and Child Care programs for new employment, termination of employment, and for on-going employment at application, review or when income changes. This will apply to all new applications and reviews as they are processed. Existing cases will have information verified as changes become known to the agency or at the next review, whichever comes first.

#### **Examples:**

1.) Dorothy is currently employed 10 hours a week at Subway. She is receiving TAF, FS and Child Care. She reports she left that job and took employment at Taco Tico for 13 hours a week. She reports her last check from Subway will be this Friday, and promises to bring in the check stub when she receives it. She brings in verification of her new employment at Taco Tico and the pay stub from Subway. An employment letter is sent to Subway to verify termination of employment. It is returned showing

Dorothy is now working 20 hours a week, and has received a raise. Income from both employers are budgeted for TAF, FS and Child Care.

2.) Father is employed. IR received with reported income. Copy of the last 30 days of income verification attached. An increase in hourly wage is indicated. IR is processed, and TAF or Child Care budget is completed using verified income. An employment letter is mailed to the employer to verify date of increase in income, and request pay verification by pay date since increase received. Upon receipt of employment letter, determine if overpayment has occurred and take appropriate action.

#### IV. MEDICAL

A. **HCBS Protected Income Level** - See KHPA Memo, [Implementation of New HCBS Protected Income Level](#), dated May 19, 2008.

The HCBS protected income level increases by \$11.00 from \$716.00 to \$727.00 beginning July 1, 2008. KEESM section [8260](#), form [ES-3104.5](#) and Appendix item F8 have been updated with this change.

B. **Treatment of Discretionary Third-Party Trusts** - State Statute [K.S.A. 39- 709(e)(3)] concerning the treatment of discretionary third-party trusts has been modified effective July 1, 2008. A trust established with assets of someone other than the applicant/recipient is considered an unavailable resource if the individual funding the trust states a clear intent to be supplemental to public assistance. An existing trust may be amended to meet this requirement, but may also be considered an inappropriate transfer of resources in certain instances.

Prior to this revision, in order for a third-party discretionary trust to be considered an unavailable resource, the trust had to contain specific language indicating that the trust was supplemental to "Medicaid, medical assistance or title XIX of the social security act". If that language was not present, the trust was considered an available resource up to the full extent of the trustee's discretion.

With this statutory change, the specific language is no longer required as long as there is a clear intent for the trust to be supplemental to public assistance. Existing trusts which do not currently meet this criteria may be amended to comply. However, any amended trust must be scrutinized for a potential transfer of property penalty.

Staff shall continue to submit all trusts to KHPA Policy via the Request for Trust/Annuity clearance form (Appendix item [B-6](#)).

KEESM sections [5620\(4\)](#) and [5720](#) have been updated with this revision.

**Example:** A trust funded by a 36 year old applicant's parent gives the trustee full discretion to use the income and principal of the trust for the applicant's support, maintenance and welfare. This trust would be considered an available resource. Under the new statutory authority, the trust may be amended to state that the intent is to be supplemental to public assistance. The trust would then be considered an unavailable resource. However, since the result of this action was to make available resources inaccessible, an inappropriate transfer subject to penalty has likely occurred.

C. **Money Follows the Person (MFP)** - Money Follows the Person (MFP) is a new five year demonstration grant program being implemented beginning July 1, 2008.

1. **Background** - Building on a pilot program began in 2004 serving a very limited number of individuals in the state, Kansas was awarded a five year demonstration grant through the Centers for Medicare and Medicaid Services (CMS). This Money Follows the Person initiative was included in the Deficit Reduction Act of 2005 (DRA) in a nationwide effort to remove barriers to community living for people with disabilities and chronic illness.

The intent of the program is to help shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home and community based services (HCBS) by allowing what would otherwise be nursing home funding to "follow the person" to a community assisted living setting.

2. **Target Population** - MFP will serve individuals transitioning from a nursing facility or ICF-MR to community based services who meet the following criteria:
  - a. **Screening** - MFP is not an HCBS waiver program, but the individual must be otherwise eligible for one of the following HCBS waivers at the time of transition to the community: Frail Elderly (HCBS/FE), Physically Disabled (HCBS/PD), Mentally Retarded/Developmentally Disabled (HCBS/MRDD), or Head Injury (HCBS/HI). Screening and assessments for this program will be conducted by the gateway agencies that currently serve each of the MFP populations: CDDO's for MRDD, ILC's for PD and HI, and AAA's for FE.
  - b. **Institutionalization** - The individual must have been residing in a nursing facility or ICF-MR for at least 6 months prior to approval under this program. The EES

eligibility worker may be contacted by the transition coordinator to verify this requirement has been met.

- c. **Medicaid Eligibility** - The individual must have received Medicaid coverage for at least 30 days prior to approval for the MFP program. There is no retroactive eligibility for MFP. The transition coordinator shall contact the EES eligibility worker to verify the individual's Medicaid status.

It is anticipated that a total of approximately 1,000 individuals will be served by this program over the course of the five year demonstration grant period.

3. **Services** - Coverage under the program will be limited to a total of 365 days. Those days need not be consecutive but must begin prior to the end of the five year demonstration grant period. The MFP Program Manager will be responsible for tracking the 365 days.

In addition to all services specific to the particular HCBS waiver program, the individual will be entitled to enhanced community services to help make a return to the community possible. Those enhanced services would include one-time non-room and board costs up to a maximum of \$2,500. Reasonable expenses to establish a residence would include deposits for rent and/or utilities, dishes, linen, basic furniture as well as life-line and other personal security measures.

Funds for these one-time enhanced services will be issued directly to the individual. This will eventually be accomplished via issuance of a debit card to the individual, but until that system has been put in place, funds will be transmitted to the individual through the gateway agency. These funds are considered a medical reimbursement and are exempt as income and a resource for all programs [KEESM [6410\(45\)\(a\)](#)].

4. **Eligibility Process** - Again, although MFP is not an HCBS waiver program, the eligibility process is very similar to that of the existing waiver programs.
  - a. **Referral** - An individual seeking coverage under the MFP program may be referred for services in a number of ways. The individual can complete a self referral by contacting the gateway agency responsible for administering the specific HCBS waiver program. The EES eligibility worker can complete a formal referral to the gateway agency. A community bridge building team has been created specifically to identify and contact institutionalized individuals who have expressed a desire

to return to the community.

- b. **Assessment** - As discussed earlier, the individual must have been screened for one of the participating HCBS waivers and been determined to be otherwise eligible if not for participation in the MFP program.
- c. **Financial** - Financial eligibility for the individual shall be based on the individual's own income and resources and shall follow the HCBS budgeting methodology. The MFP eligibility start date will normally be the date the individual transitions from the institution to the community.
- d. **LOTC Coding** - Coverage under MFP must be reflected on the LOTC screen to ensure proper funding and payment for services provided.

The Living Arrangement (LA) code for MFP is **MF**. The companion Level of Care (LOC) code is based on the underlying HCBS waiver. MFP based on the Frail Elderly (FE) waiver would be coded on the LOTC screen as MF/FE, Physically Disabled (PD) as MF/PD, Head Injury (HI) as MF/HI and Mental Retardation/Developmentally Disabled (DD) as MF/DD.

The existing temporary care policies apply to a MFP individual entering a long term care facility. Any stay less than the month of entry and the following two months is considered a temporary stay. A special temporary care code of **TM** must be entered in the Living Arrangement (LA) field on the LOTC screen to identify this as a MFP individual.

**NOTE:** Time spent in a temporary stay situation does not count against the 365 day limit under the MFP program.

- e. **Communication** - All communication between the EES eligibility worker and the MFP/HCBS case manager will be via the existing [ES- 3160/ES-3161](#) forms. The forms should be sent by fax to expedite delivery.
- f. **Transition** - There is no waiting period for an individual initially qualifying for MFP who leaves the program and later requests services again. An individual receiving coverage under MFP will be automatically enrolled in an existing HCBS waiver once the MFP coverage has been exhausted (ie: received services for 365 days).

- D. **Transfer of Property** - The average nursing home private pay daily rate in the state has increased from \$136.60 to \$137.65. The new daily rate is effective with all penalty periods with a start date on or after July 1, 2008. The daily rate divisor is used to determine penalty periods for transfers occurring on or after 2-8-2006. The \$4,000 monthly divisor remains in effect for transfers occurring prior to 2-8-2006. The basic rule that the penalty period is determined based on the divisor in effect in the month the penalty begins has not changed.

KEESM section [5724.4\(2\)](#) and Appendix item [W-9](#) (Transfer of Property Worksheet) have been updated with this revision. In addition, the electronic Transfer of Property Worksheet has been updated and re-issued. Previous versions are obsolete and should be discarded.

**Example:** An individual applies for long term care coverage on 6-15-2008 with an inappropriate transfer that occurred on 3-7-2008. If the individual would be otherwise eligible for coverage, the penalty would commence on 6-1-2008 and the old \$136.60 divisor would be used to determine the penalty period. If the individual would be otherwise eligible commencing 7-1-2008 (or later), the new \$137.65 divisor would be used.

A long term care recipient receives an inheritance on 5-5-2008 and then gifts it away on 5-25-2008. Even though the transfer occurred in 5-2008, due to timely notice requirements, the penalty could not be applied until 7-1-2008. The new \$137.65 divisor would be used to determine the penalty period since the penalty would not commence until 7-1-2008. If the transfer occurred on 5-5-2008, the penalty would commence 6-1-2008 and the old \$136.60 divisor would be used.

- E. **Medical Representative** - The definition of medical representative is being changed with this revision to include specific criteria as to who may serve. A new assistive category, Facilitator, has also been added to this section for individuals granted limited authority to help with the application process only.

KEESM section [2111](#) has been re-written and re-formatted with this change. There are now three levels of medical representation for an individual depending on their legal capacity and the scope of authority granted:

1. **Legally Incapacitated** - An adult who has been determined to be legally incapacitated must be represented in the application and eligibility process by a guardian or conservator. This is not a change.

2. **Not Legally Incapacitated** - An adult who has not been determined legally incapacitated may be represented by the spouse, personal representative, a person with a durable power of attorney for financial decisions, or a representative payee for Social Security benefits.

For any other individual to be a medical representative, a signed written authorization from the person for whom they are applying must be obtained. The medical representative authorization section on the [ES-3100.1](#) application form may be used for this purpose and must be signed by the adult and at least one witness.

The medical representative essentially takes the place of the adult. They shall receive copies of all notices and are responsible for completing the review form and reporting changes. It is therefore critical that the medical representative be someone who is trusted and knowledgeable about the adult's needs and circumstances. A good friend or neighbor may be acceptable while an individual with little or no prior experience with the individual would not.

3. **Facilitators** - An adult may grant limited authority to another to assist in the application process. This individual would not be a medical representative but could share and receive information depending on the scope of authority granted. That authority shall be granted via the new Authorization for Release of Protected Health Information form (Appendix, item [P-11](#)).

The role of a facilitator shall be confined to helping the individual with the application process. The naming of a facilitator does not supplant the individual's right to control their own application. A facilitator may not request benefits on behalf of the applicant, including a request for a spenddown or coverage in prior months.

A medical representative shall be listed on the ADDR screen, while a facilitator may be listed on the ADAD screen. A facilitator listed on the ADAD screen must be promptly removed from that screen once the authorization has ended.

- F. **PRTF-CBA HCBS Waiver** - A clarification has been added to this revision to indicate that individuals aged 19-22 under the PRTF-CBA HCBS waiver do not need a disability determination to receive coverage under this program. This policy aligns with the SED HCBS waiver.

## V. SUCCESSFUL FAMILIES

A. **ORIENTATION, ASSESSMENT AND REFERRAL (OARS)** – See [Summary of Changes](#) item V, A, 1 and KEESM section [3330.8](#).

This policy is being revised to change the mandate of joint meetings between the customer, the OARS advocate, and the SRS case manager from a minimum of yearly to a minimum of every six months. If you have not met within the last 6 months, you should schedule an appointment at the next work program review, or by 12/31/08, whichever comes first.

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