Kansas Department of Social and Rehabilitation Services

Gary J. Daniels, Acting Secretary

Health Care Policy / Medical Policy

Scott Brunner, Director

Information: (785) 296-3981 | **Fax Number:** (785) 296-4813

POLICY MEMO:	
To: All SRS Staff	**From:** Kristi Scheve, Senior Manager, Family Medical Eligibility Program Policy
HCP Eligibility Policy No: 2004 -11-17b	**KFMAM:** 2470 & 2501
RE: Retroactive Enrollment	**Program(s):** HealthWave 21

Background

Shortly after the HealthWave program was implemented, it was discovered that there was a need to grant retroactive eligibility to Title XXI beneficiaries in limited circumstances.

This policy memo is being issued as a result of additional questions and the need for further clarification surrounding retroactive enrollment. This memo outlines appropriate circumstances in which HealthWave 21 coverage is retroactively authorized, explains how to establish retroactive coverage, and is intended to replace all previous communication regarding HealthWave 21 retroactive enrollment.

NOTES:

- Originally, the circumstances related to retroactive XXI enrollment were described in a policy memo from EES (policy memo 99-10-12). This memo became obsolete when HCP Eligibility Policy Memo No. 2003-10-10a was issued to provide additional clarification with the implementation of daily Title XXI enrollment. HCP Eligibility Policy Memo No. 2003-10-10a is obsolete with the issuance of this memo.

- Information about creating dual Title XXI and Title XIX or Medically Needy coverage for the same month is not addressed in this memo, but is addressed in HCP Eligibility Policy Memo No. 2003-10-10b and in the recently issued HCP Eligibility Policy Memo No. 2004-11-17a.

I. How Title XXI (HW 21) Enrollment Works

HW 21 is a capitated managed care program and there is no fee-for-service component. With capitated managed care, an eligible beneficiary must first be enrolled with the managed care organization (MCO) and then must either choose or be assigned to a Primary Care Physician (PCP) in the MCO's contracted network. The PCP's responsibility is to manage the care of the beneficiaries assigned to him or her. SRS pays the MCO a per-member/per-month rate to provide services for eligible beneficiaries. This rate is not affected by whether or not the beneficiary uses services or by how many services the beneficiary uses.

A. Daily Enrollment - HW 21 beneficiaries are **not** eligible for coverage until they are

enrolled in a health plan. HW 21 eligibles are enrolled on a daily basis. If you approve coverage today, the beneficiary is enrolled and eligible to access services on the next processing day, which is usually the next business day. The HW 21 enrollment functions are performed by EDS and eligibility/enrollment information can be viewed in the Beneficiary Subsystem of the MMIS.

II. Retroactive HW 21 Coverage

Retroactive assignments are generally not possible in a capitated managed care service delivery model because the insurance coverage is provided "after-the-fact". If a beneficiary received services during a retroactive period, there is no guarantee that they went to a provider who is in the MCO's network. In these situations, the per-member/per-month monthly fee is paid to the MCO. The MCO, however, is not required to pay for the services the beneficiary received from a non-network provider. For this reason and because Title XXI is not an entitlement program, we generally do not allow retroactive HW 21 enrollments. Nonetheless, there are some limited circumstances when retroactive HW 21 enrollment is allowed.

A. Circumstances Staff May Authorize Retroactive Coverage - Staff may approve retroactive HW 21 coverage, without prior authorization from HCP/MP, on the KAECSES system in the following situations (see Section III (A), below, for instructions on how to authorize retroactive HW 21 coverage).

1. Babies born to a mother receiving coverage under HW 21 (mother under the age 19) are deemed eligible for HW 21 from the month of birth through the end of the family's continuous eligibility period. Refer to KFMAM 2500.

2. Timely appeals concerning termination of benefits per KFMAM 1503.

B. Retroactive Coverage Granted Upon Authorization from HCP/MP - In all situations not specified in Section II (A), above, retroactive HW 21 coverage may **only** be approved on the KAECSES system at the direction of the Family Medical Program Policy Managers in HCP/MP (contact information is listed at the bottom of this memo). The KAECSES system allows staff to grant retroactive approval for the past 5 months, however, retroactive HW 21 assignment is not appropriate in all instances. When one of the following situations is discovered, eligibility staff will contact the Family Medical Program Policy Managers. Eligibility staff must be prepared to explain the case situation, approximate the total outstanding medical expenses for the months in question, and furnish the names of the providers for the outstanding medical expenses. The Family Medical Program Policy Managers will evaluate each case and provide instructions to staff on how the retroactive months will be processed. In some cases, the HealthWave 21 Program Manager will send a special notice on the KAECSES system to the consumer regarding expenses incurred in the retroactive time period.

1. Retroactive coverage may be granted upon authorization from HCP/MP Family Medical Program Policy Managers, in limited cases, where an agency error has occurred. This is especially true if the beneficiary was provided written notification of coverage. The agency must honor the written notification. The following are common situations that must be reviewed on a case-by-case basis.

    a. Accidental de-authorizations for a month where the consumer was notified they were covered, but the coverage has stopped due to de-authorization

of the case.

Note to Regional SRS Staff: Accidental de-authorizations may be prevented or reduced by checking the AUTHORIZED column on the CR300 Active Cases Listing report just prior to the monthly medical card run.

b. Incorrect denial of benefits to an individual or family where the agency's eligibility determination (or re-determination) was incorrect and resulted in HW 21 coverage being delayed.

c. Reviews processed untimely by staff when the consumer submitted the review application and subsequent verifications in a timely manner.

Under **no** circumstances should you authorize retroactive enrollment into HW 21 except for the exceptions listed in Section II (A), above. In all other situations, you must first contact the Family Medical Eligibility Program Policy Managers in HCP/MP for authorization prior to approving retroactive coverage on the KAECSES system.

C. Limits To Retroactive Approval - The system will not allow retroactive enrollments for periods greater than five months prior to the current calendar month.

Example: On October 15th, the worker is wanting to retroactively enroll someone in HW 21 for the past 7 months. The system will allow you retroactively enroll for the months of May through October, but will not allow retroactive enrollment for months prior to May.

In situations beyond the five-month system allowed retroactive approval period, where medical expenses are known to exist and an agency error has occurred, contact one of the Family Medical Eligibility Program Policy Managers in HCP/MP for additional guidance. Be prepared to explain the case situation, approximate the total outstanding medical expenses for the months in question, and provide the names of the providers for the outstanding medical expenses. Providing coverage, for more than five retroactive months is beyond the scope of the health plan's contract and is only authorized in rare circumstances after consultation with the HealthWave 21 Program Manager.

III. Authorizing Retroactive HW 21 Enrollment

If you determine that retroactive HW 21 enrollment is appropriate according to the criteria listed in Section II (A), above, or you have been instructed to approve retroactive HW 21 coverage in accordance with Section II (B), above, you will authorize the retroactive HW 21 enrollment on the KAECSES system.

A. How to Authorize Retroactive Coverage - Authorize the program on **PLID** for the specific benefit month. Enter a **'Y'** in the Retro 21 Indicator field on the **PLGD** screen next to each person who is to be retroactively enrolled. Note that the system will not allow a **'Y'** indicator for a Title XIX child, for someone who is not eligible for HW 21, for a future month, or for a month that is greater than five calendar months in the past.

All retroactive HW 21 months that are authorized generate a record that is sent to the

MMIS system with the daily file. Records for paid system months that are authorized without the Retro 21 Indicator are ignored. If the **'Y'** is present in the Retro 21 Indicator field, eligibility for the retro month is updated. **You must be careful to enter a 'Y' in this field only when it is appropriate to do so. Otherwise, incorrect payments for HW 21 coverage will occur.**

Example: On October 15th, you learn that a baby was born to an HW 21 beneficiary on October 3rd. Policy states a newborn born to an HW 21 mother is eligible the month of birth through the family's continuous eligibility period, as long as the birth is reported within three months after the month of birth. (Note: This action does not require authorization from the Family Medical Program Policy Managers per Section II (A) of this memo). Since it is October 15th, and the newborn is a new HW 21 eligible, you authorize coverage for the child. You must enter a **'Y'** into the Retro 21 Indicator field, so that coverage for the newborn will be effective October 1st rather than the next business day.

B. Filling The Gap - The MMIS system has the ability to automatically "fill in the gap" if the HW 21 beneficiary's coverage has lapsed for less than one month.

Example: An HW 21 child loses coverage at the end of October because the review application was not submitted. In November, the review is received and processed. The child is approved for continuing HW 21 coverage. The MMIS will automatically enroll the child in HW 21 effective November 1 instead of the next business day. The eligibility worker does not need to do anything, because the system automatically decides whether to start coverage effective the first of the month or the next business day based on whether the child had HW 21 coverage the month before.

This automatic system feature, however, is based on the calendar date that the actual authorization occurs. If in the example above, the worker authorized the November benefit in December, the November record will not automatically go to the MMIS and the gap will not be automatically filled. If the situation merits, a retroactive enrollment will need to occur. See Section Item II (A & B), above, for appropriate retroactive enrollment situations, as there are times when it is not appropriate to "fill in the gap."

Example: If the child had no eligibility in the previous month (or was eligible for Title XIX in the previous month), the gap in coverage will not be filled. In these situations, the child will enroll as if she or he is a new HW 21 beneficiary, on or around the next business day.

Because HW 21 is a capitated managed care delivery system in which beneficiaries must access services through a primary care network, it is not necessarily beneficial to the beneficiary to fill in this gap. There is no guarantee that having the coverage would pay for any services incurred during the gap period.

IV. Other Retroactive Changes

The HealthWave Change Request form is used to report changes. The processes to make other types of retroactive updates are listed below:

A. Premium Changes – The HealthWave Clearinghouse processes premium payments, so if a premium amount needs to be adjusted, the eligibility worker will need to send an e-mail to HW-Maxhelp@srskansas.org to request the change.

B. Pregnancy – The MMIS system completes all enrollments and issues cap payments. There is no way in KAECSES to automatically notify interChange that an HW 21 beneficiary is pregnant and to communicate the due date. This information is entered into interChange manually. The attached form is used to communicate pregnancy related facts to EDS. This form has been modified to allow only the necessary information for reporting a pregnancy, reporting a change of due dates, or reporting the termination of a pregnancy. It is attached to this memo in Word and WordPerfect formats. Please use the Word document if at all possible, as EDS may not be able to open the WordPerfect document correctly. When complete, the form should be e-mailed to the address on the form.

   If a pregnancy is reported to EDS by an MCO, EDS will enter that due date on interChange and notify the eligibility worker. If the eligibility worker subsequently learned that the pregnancy terminated or the due date has changed, the worker is responsible for reporting this to EDS and may use the new HW 21 Pregnancy Report form to do this.

C. Correcting an Incorrect County Code – County codes on ADDR are one factor in determining someone's managed care assignment for Title XIX. An incorrect county code may create an incorrect managed care assignment. Eligibility workers will be able to correct county codes in the same way that they make address changes appear in the MMIS. The correct county code must be entered on the ADDR screen in KAECSES. Then the eligibility worker must go to the **last paid benefit month** and reauthorize the program. For HW 21, this is done on the PLID screen.

   NOTE: The case location field on ADDR does not affect managed care assignments. However, the same process may be used to update the case location field during the month.

Conclusion

If you have questions about this memo, please send them to Kristi Scheve, Senior Manager, Family Medical Eligibility Program Policy at kaxg@srskansas.org or Patty Rice, Manager, Family Medical Eligibility Program Policy at psys@srskansas.org.

Attachments: HealthWave 21 Pregnancy Report Form and HealthWave Change Request Form (both forms are located in the Miscellaneous Forms Section of the KEESM).