Kansas
Department of Health and Environment
Division of Health Care Finance

To: EES Program Administrators & Staff
HealthWave Clearinghouse Staff

Date: May 10, 2012

From: Russell Nittler

RE: Implementation Instructions –

KFMAM Revision 12, various effective dates

This memo sets forth implementation instructions regarding changes to the KFMAM, Revision 12. The effective dates for the changes are stated in the respective sections of this memo. The memo addresses changes made to the following topics:

- Self-declaration of Income
- Passive MP Reviews

A. Self-declaration of Income

Background

Effective January 1, 2010, a policy was implemented that permitted the use of wage data found on BASI to support earnings reported by the consumer. Wage verification is not required when information found on BASI is consistent with what is reported by the consumer. The information reported by the consumer is what is used to determine financial eligibility.

Following this policy implementation, additional policies have been implemented which expand when self-declared income may be used to determine financial eligibility.

Reviews and Changes in Income

Effective with cases processed on or after September 20, 2010, verification is not required when processing a review or reported income change on an open case. However, when verification has been provided, or information is available in system interfaces, this information shall first be used to verify income. If hard copy income and/or verification from a system interface is not available for all forms of income, the consumer's self-declared income shall be used to determine eligibility.

The self-declaration may be obtained from the review form or through a verbal conversation with the consumer. Self-declared income may be used for all forms of income, both earned and unearned. For cases

with self-employment, a tax return must be requested if the business was not reported the prior year, or when the difference in the self-declared amount from what was used the prior year will potentially change program eligibility.

When the review form includes a request for coverage for a new individual, self-declared income shall also be used to determine current and prior medical coverage for the new individual. Prior medical income must still be determined using the actual income received in each of the prior medical months, although it may be obtained verbally instead of requiring hard copy documentation.

Eligibility staff shall always use their prudent person judgment as outlined in KFMAM 1300 and may require additional documentation when they deem it is necessary. Documentation must be in the case file to explain why eligibility staff felt additional information was needed.

B. MP Passive Reviews

Effective with December 2010 MP reviews; families receiving coverage on the MP program qualify for the 'passive' review process. Families eligible for a Passive Review will have their coverage extended in KAECSES for 12 months. These families will then be mailed a letter which informs them of the extension of coverage and also details the information we know about the family, including household composition, income type and amount, and health insurance. The letter instructs the family to contact the HealthWave Clearinghouse by telephone to report any change in the information displayed. If no changes have occurred, the family is not required to contact the Clearinghouse; coverage will continue for them until the next review.

Much of the passive review process is either automated, or processed with a limited group of staff located at the HealthWave Clearinghouse. The information that follows will provide a general overview of the passive review process.

1. Address Verification – Approximately 60 days before the end of the review period, cases are compared to the United States Postal Service (USPS) database to verify the address. The response received is automatically generated in the caselog with details about the verified or unverified address. If an out of state forwarding address is received, the case is closed for failing to meet residency requirements. If there is no known address, the case is closed for loss of contact. Staff will generate a letter in KAECSES for closed cases. Cases with verified addresses proceed to step 2 in the process.

2. Through the use of a macro, the income screens are updated in KAECSES using information obtained from the subsystems: BARI, BASI, KAECSES-CSE and EATSS.

3. Cases with either zero income (with the exception of relative caretaker cases) and those with a Federal Poverty Level of 201% or higher are pulled from the Passive review process and mailed a review form. The remaining cases proceed to step 4 in the process. Note: A formal review was required for zero income cases effective August 2011 and for FPL of 201% or higher effective with June 2012 reviews.

4. Coverage is extended automatically in KAECSES through the use of a macro. Clearinghouse staff run the macro and manually authorize cases which can't be automatically extended by the macro.

    a. Coverage is extended based on the information entered in KAECSES. Therefore, any updates to the case that have occurred over the last year (changes in household members, change in the type or amount of income, etc) and the income found in the subsystems will be taken into account when reauthorizing coverage. Children may change or lose coverage based on the updates that occurred on the case during the previous continuous eligibility period.

5. HealthWave 21 cases are compared to a premium billing file to identify those that have a delinquent premium account. A notice is mailed to these families giving them 10 days to bring the account current. This notification also instructs the family to report any changes such as income or household changes. If changes are reported, the family is re-evaluated for Title 19 coverage as this does not require

payment of past-due premiums to establish coverage. If no contact is made, the Clearinghouse closes the cases for failing to pay the premium balance and a notice is sent in KAECSES.

6. A Passive Review letter is generated and mailed for each family. The letters are not mailed from KAECSES. The letter identifies household members, those receiving coverage as well as those who do not. It identifies the amount and type of income being received and the existence of other health insurance. The letter also serves as a notice of action as it provides information regarding whose coverage has been extended and for what program. When the case has some individuals approved and some denied, the letter will identify the reason for closure for the denied individuals as well. The verbiage on the letter is not static. The letter changes based on the circumstances of the family. For example, if the family has a premium obligation, additional details about premium payments is provided. If all members are approved for coverage, there is no content related to closure of coverage. See the attachment for an example of the passive review letter.

7. Once the letter is mailed one of the following may occur:

    a. No contact – The consumer is only required to contact the Clearinghouse if they have changes to report. If nothing has changed in the family's circumstances, then no action is required on their part. Therefore, no additional action is needed by eligibility staff. The case will continue to roll until the next scheduled review.

    b. Consumer calls to report changes – When a consumer calls the Clearinghouse at 1-800-792-4884 in regards to their passive review letter staff respond to their inquiry and obtain all reported changes. This staff member responds to their inquiry and obtains all reported changes. Specially trained eligibility staff then process these changes and determine the impact on eligibility. Notices are sent in KAECSES to notify the consumer of any changes made to eligibility based on their phone call.

    c. Mail is returned as undeliverable – Despite the address verification with USPS the mail still may be returned as undeliverable. Clearinghouse staff take action to close the case for loss of contact if another address can't be located for the family.

Another variation of the review process has been established at the Clearinghouse to address cases that were not passively reviewed due to an eligibility or administrative reason. These are called Manual Passive Reviews. Manual Passive Reviews are completed on cases that were closed for failing to pay past-due premiums or cases that were not included on the Clearinghouse passive review file because they were still in the SRS caseload. Cases that remain in the SRS caseload at the time of the MP review cannot be systematically Passive Reviewed because they are not contained on the Clearinghouse Passive Review file. SRS may have already mailed a review form and conducted a medical review for cases that were still in the SRS caseload at the time of review. This manual passive review process does not include cases reviewed by SRS. It is only intended for those cases that did not complete a review, either with SRS or passively.

Manual Passive Reviews are processed by specially trained eligibility staff at the Clearinghouse. Clearinghouse staff attempt to review the case by telephone, obtaining all updated information from the consumer during the call, and redetermining eligibility for the next 12 months of coverage. If the family cannot be reached by phone, coverage is reinstated based on the information on file. A passive review letter is sent to notify the family of coverage extension and requiring contact to report changes.

Note: Policies outlined in KFMAM 2440.01 are to be used to determine when a case closed for failure to pay premiums may be reinstated.

Conclusion

If you have any questions about the material included in this memo, please contact:

Allison Miller
Family Medical Policy Manager
(785) 291-3881
Amiller@kdheks.gov

Questions regarding any KAECSES issues are directed to the SRS Business Help Desk at helpdeskbusiness@srs.ks.gov