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**To:** EES Program Administrators & Staff  
HealthWave Clearinghouse Staff

**Date:** DRAFT - December 16, 2009

**From:** Jeanine Schieferecke

**RE:** Implementation Instructions –

KFMAM Revision 11, Effective January 1, 2010

This memo sets forth implementation instructions regarding changes to the KFMAM effective January 1, 2010. Unless otherwise stated, these requirements are applicable to any decisions made on or after January 1, 2010. The memo addresses changes made to the following topics:

- Citizenship and Identity Requirements for HealthWave 21
- Reasonable Opportunity Period to Provide Verification of Citizenship and Identity
- Premium Billing changes
- Irregular income in the Month of Application
- Census Income
- Budgeting Child Support Income
- Verification of Pregnancy
- MACM Resource and Trust Test
- Wage Verification

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## **A. Citizenship and Identity Requirements for HealthWave 21**

Effective with new applications and reviews processed on or after January 1, 2010, documentation of citizenship and identity is required for HealthWave 21. Policies in place for Medicaid recipients now apply to HealthWave 21 recipients. Exempt populations, acceptable documents, use of electronic records and documentation required in the case file are applied as with Medicaid.

New cases approved after on or after January 1, 2010 must have appropriate documentation. Existing cases must include appropriate documentation no later than the next regularly scheduled review.

KEESM Appendix item A-12 includes the list of acceptable documents. KFMAM 1325.01 and 2045 have been updated.

## **B. Reasonable Opportunity Period to Provide Verification of Citizenship and Identity**

These instructions shall be applied to all applications, reviews and requests for coverage processed on or after January 1, 2010.

A formal Reasonable Opportunity Period is now provided when additional time is needed to provide citizenship and identify verification. The Reasonable Opportunity period allows additional time to provide required documentation if the individual has demonstrated an attempt to provide the information. An individual does not have to specifically request the reasonable opportunity period in order to receive the additional time.

Prior to establishing a Reasonable Opportunity period, electronic systems and the case file must be reviewed to determine if the information is available. If not, additional information shall be requested from the individual. If the individual requests additional time to provide the requested documentation, coverage shall be approved for the reasonable opportunity period. The reasonable opportunity period continues through the month following the month action is taken on the request. The effective date of coverage is established according to existing program rules; Title 19 coverage shall begin the first day of the month of application and Title 21 coverage shall begin the day following approval. Prior medical coverage is provided to eligible individuals as part of the reasonable opportunity period. The level of benefits is established by other factors such as income and resources, and other eligibility requirements must be met (e.g. residency.) Individuals otherwise ineligible (e.g. excess income) are not given coverage.

A due date of the last date of the reasonable opportunity period is included on the approval notice. Following the reasonable opportunity period, if the documentation has not been provided, action is taken to end coverage, providing timely notice.

Reasonable opportunity periods are only applicable if the individual is cooperating. If the individual fails to respond to a request for documentation of citizenship and identity, the reasonable opportunity period does not apply. Use the following guidelines for contact with the applicant/recipient:

- The applicant/recipient is given a minimum of 10 days to respond to an initial request for verification.
- If no response is received, the reasonable opportunity period does not apply. The request for coverage shall be denied.
- If following negative action, the individual provides verification within 45 days of the original application date the application is to be reactivated.
- If following negative action, the individual makes contact within 45 days and expresses a need for additional time to obtain the documentation, the application is to be reactivated and coverage approved for a reasonable opportunity period.

- Example: Applicant provides a copy of a driver's license but indicates he does not have a birth certificate. He was born outside of Kansas and must request a copy of his birth certificate. This would be sufficient information to reactivate the application and approve coverage for the reasonable opportunity period.

Special KAECSES notices have been created and existing notices modified to accommodate this policy change.

- V070 – used as the initial request citizenship and identity
- V071 – used to approve a reasonable opportunity period; a due date is required; the address field is blank to allow the entry of the appropriate office address.
- V073 – used to approve a reasonable opportunity period; a due date is required to be entered; the address and fax number of the Clearinghouse is included.

For Family Medical cases opened with a Reasonable Opportunity period in a SRS field office, the case shall be transferred to the Clearinghouse following initial approval. These applications are not held in the local office during the reasonable opportunity period. SRS staff may use the V073 notice when approving the reasonable opportunity period. This directs the family to send their documents to the Clearinghouse. SRS staff shall also set an alert on KAECSES indicating the due date of the requested verification. This will allow the Clearinghouse to correctly respond to those cases who have not provided their verification within the reasonable opportunity period and must be closed.

### C. Premium Billing changes

- a. **Background** – Effective January 1, 2010, the HealthWave premium billing vendor is changing from Maximus to HP Enterprise Services, formerly known as EDS. To accommodate the transition and to enhance the effectiveness of the program, several changes have been made to the premium requirements.

Premiums continue for some HealthWave 21 beneficiaries. In addition, failure to pay a premium has no effect on HealthWave 19 recipients.

- b. **Premium Requirements** – A monthly premium shall continue to be charged for qualifying families with incomes over 150% of the federal poverty level. Failure to pay required premiums shall result in the loss of coverage as outlined below.
  - i. Delinquency Threshold – Premium payments are due by the end of the month for which they are billed. Any payment that has not been paid on time is considered overdue. The account is considered delinquent when there is more than one month of overdue premiums. To identify delinquent accounts, a Delinquency indicator within the Premium Billing system has been added (see item c. below) to identify accounts that are delinquent. When a payment is made, bringing the account to less than one month overdue, the Delinquency Indicator will be updated. Families in delinquent status will continue to receive monthly statements regarding their premium obligation as long as there is a current premium due.
  - ii. Premium Requirement at Review – Enforcement of the premium requirements will continue to occur only at review for HealthWave 21. However, with the establishment of the Delinquency Threshold, the amount that can be unpaid has been changed. At review, children are ineligible for continued HealthWave 21 coverage when the premium account is

delinquent – or more than one month overdue. Eligibility staff use the Delinquency indicator in the Premium Billing system to identify a delinquent premium account. When a delinquent account is identified at review, a notice is sent to the case, giving them 10 days to make a payment. At the end of that time, if a payment has not been made, action is taken to close coverage. When action is taken prior to the end of the review period, the household must only make a payment which brings the account to a non-delinquent status. See section *vi* below for more information.

- iii. Non-Sufficient Funds Fee – Non-sufficient fund bank fees will be charged to the individual and included as an overdue premium amount. These charges occur when an individual attempts to pay their premium(s) with a bad check. Previously, these fees were absorbed administratively by the program and not charged to the individual.
- iv. Debt Set-Off – Delinquent premium amounts will be referred to state debt set-off when the account is more than 6 months overdue. The collection fee charged to the agency for these debt set-off services will be charged to the individual and included as an overdue premium amount. The fee is currently 17% of the balance. This collection process may occur while the family is still receiving HealthWave 21 coverage, since action to terminate coverage won't occur until the review is completed.
- v. Semi-annual Statements – Families who no longer have a current premium obligation, but have a past due premium balance will receive a statement on a semi-annual basis with mailings occurring in January and July. The first mailing of this semi-annual statement will occur in July 2010. Currently, only families that are active with HealthWave receive a premium statement. These semi-annual statements should assist KHPA in obtaining payments for old unpaid balances for families no longer enrolled.
- vi. Reinstatement – A closed case may be reinstated when the required action to cure the closure is taken by the recipient by the end of the month coverage ceases. Once a HealthWave 21 recipient has been notified of case closure, coverage may not be reinstated until the following conditions occur.
  1. Closure For Non-Payment – A case that has been closed for non-payment of premiums may only be reinstated if sufficient payment is received by the end of the month of closure so that the remaining overdue amount (if any) falls below the delinquency threshold. The customer must notify the eligibility worker that a payment has been made, which would then be verified via access to the premium billing system. Therefore, a partial payment can be made in the closure month and coverage can be reinstated.
  2. Closure For Other Reasons - A case that has been closed for reasons other than non- payment of premiums may be reinstated if the reason for the closure is cured by the end of the month of closure. Payment of overdue premium amounts would not be required for reinstatement, unless the overdue amount meets the 1 month delinquency threshold as described above.
- vii. Reopening – A closed case may be reopened when the required action to cure the closure is taken during the calendar month after coverage ceases. Coverage for an individual on HealthWave 21 that has been closed for any reason may not be reopened after the effective date of closure unless the full amount of overdue premiums (including any non-sufficient funds or debt set-off fees) is paid in full. This applies even where the overdue amount is less

than one month overdue. Therefore, when determining eligibility from a new application, HealthWave 21 coverage cannot be approved until all unpaid premiums are paid. STAFF MUST CHECK THE PREMIUM BILLING SYSTEM PRIOR TO APPROVING HEALTHWAVE 21 COVERAGE.

- c. **Premium Billing System** - As the premium billing vendor, HP Enterprise Services is responsible for billing and collection of HealthWave 21 Premiums. HP will send billing statements, handle all bank activity related to collection and provide customer service functions to support the system. HP will not determine the amount of the premium – eligibility staff shall continue to be responsible for correctly establishing the premium amount and notification of the premium obligation via the KAECSES system. Eligibility staff shall also continue to follow the policy contained in KFMAM 2440 concerning the adjustment of incorrect premium amounts.

The following services will be provided by HP in order to assist eligibility staff in identifying cases which require action.

- i. Premium Billing System – Eligibility staff shall have access to the new premium billing system. Once an account is more than one month overdue, the account will be identified as delinquent. At the time of review or new eligibility determination, the premium billing system should be accessed to confirm the delinquency and account balance.
  - ii. Premium Billing Address – The new premium billing system will allow the monthly premium statements to be mailed to either the program beneficiary, the beneficiary's responsible person, or a third party designated by the beneficiary.
    1. Beneficiary – The premium statements will be mailed to the beneficiary based on the address listed on the KAECSES ADDR screen – unless (b) or (c) below applies.
    2. Responsible Person – If there is a responsible person listed on the KAECSES ADDR screen, the premium statement will default to this individual and be mailed to them – unless (c) below applies. The premium statement will not be mailed to the beneficiary where a responsible person exists. Nor will a duplicate statement be mailed to the beneficiary in these instances.
    3. Third Party – The beneficiary may designate a third party to receive the premium statements by calling HP Member Services with their name and mailing address. Neither the premium statement nor a duplicate statement will be mailed to the beneficiary in these instances. It is expected that this option will be rarely used by HealthWave 21 recipients.
- d. **Reports** – Several management reports have been created for use by supervisory and/or eligibility staff to help manage individual caseloads and cases pertaining to the premium payment requirements. These reports will be available through the KHPA imaging system, ImageNow. The reports and a brief description of each follow. These are monthly reports and are available on the 5<sup>th</sup> of each month.
- i. HealthWave Overdue Premium Report – This report lists cases which have been newly re-opened where an old unpaid premium amount is still outstanding indicating that the case may have been opened in error. These cases should be reviewed to determine if action needs to be taken to terminate coverage and/or establish an overpayment for receipt of

incorrect benefits.

- ii. American Indian / Alaska Native Report – This report identifies all cases with an American Indian / Alaska Native race code entered on KAECSES. It then displays the premium amount charged for the family, even when \$0 has been charged. The race code of A on KAECSES screen ETRC is often selected in error for those recipients that indicate a race of Asian or African-American. When a recipient reports a race of Asian, the correct code on ETRC is S; a race of African-American is entered on ETRC with race code of B. The cases displayed on the report should first reviewed to determine if the correct race code was entered, and then action taken to remove a premium obligation for those cases that include an American Indian / Alaska Native child.
  - iii. Suspect Premium Report – This report identifies cases for which the premium amount is other than expected based on the case’s poverty level. This usually occurs when making a change to a case, such as a new request for coverage or a change in the household composition. The cases displayed on this report must be reviewed to determine if the premium obligation is accurate. Action should be taken to correct the premium when necessary. When the premium amount is correct, staff will ‘Approve’ the premium on the Premium Billing System Premium Details window. This prevents correct premiums from continually being reported, when they’ve been reviewed and determined to be accurate.
- e. **Notices** – No additional KAECSES notices have been created or modified due to these specific policy changes. The existing HealthWave notices should continue to be used.
- These notices do not mention any untimely grace period for making premium payments. The existing notice language instructs the recipient “This must be paid on time for your children to stay covered.” Staff should continue to convey that message to recipients concerning their premium paying responsibilities, specifically emphasizing that any non-payment may potentially result in collections.
- f. **Transition Welcome Letters** – Transition Welcome Letters were sent to all current HealthWave 21 premium paying recipients the week of December 14, 2009 informing them of the premium billing vendor transition from MAXIMUS to HP. The letter includes important facts, addresses, phone numbers, and answers to important questions concerning the transition. A copy of the letter has been attached to this memo for reference.
  - g. **iCMMIS Modifications** – Three new windows have been created in the iCMMIS system to support the new premium billing system - Beneficiary Responsible Person Address and Beneficiary Premium.
    - i. Beneficiary Responsible Person Address – This window will display the responsible person address that is entered on the KAECSES ADDR screen. This address information will be sent to the iCMMIS system and then to the new premium billing system. As explained earlier, the premium statements will be mailed to this individual and address. Therefore, it is very important that this information is correct and that the beneficiary wants the statements to be sent to this individual.

The address information on this new window will be updated in the same manner as the beneficiary address information in iCMMIS. The address must be changed on the KAECSES ADDR screen and the last paid benefit month reauthorized in order to send the updated information to iCMMIS.

The new Beneficiary Responsible Person Address window in iCMMIS will display the current address information and will also store historical information indicating when a change occurred and what the address was on a specific date.

- ii. Beneficiary Premium – This window will display the premium information that was entered on KAECSES and sent to iCMMIS for a specific case. The data displayed on this window is the information that is sent to the premium billing system. The window will display the type of premium, the amount of the premium, the start and end date for the premium amount, and the premium status.

#### **D. Irregular income in the Month Of Application**

New income received in the month of application which is expected to continue in the future, shall be prospected beginning with the month of application. New income is income received from a new source, such as a change in employment. In addition, irregular income, or non-representative income, which is irregular due to a loss in income (such as a job loss), is also prospected beginning with the month of application.

Previously, actual income was used to budget all irregular income received in the month of application. Actual income will continue to be used for irregular income received from the same source. Prospective budgeting applies only to irregular incomes where there has been a change in source in the month of application. Verification is required for all income received in the month. When action is taken prior to the end of the month of application, income must be projected from the best information available.

Verification of terminated income in the month of application which will not be used in the determination is not required.

Example 1: Marcia applies for medical coverage on January 29th for her three children. She is employed, but reports that one of her kids has recently been sick and she missed work for the last 4 weeks. Because of this, her income in January is lower than normal. The eligibility worker identifies this is considered non-representative income in the month of application, because the wages in January are so much lower than other income and do not represent future income. Because the income is from the same employer, actual income is used to determine eligibility in the month of application.

Example 2: Jack applies for medical coverage on December 10<sup>th</sup> for his two children. He was employed at a manufacturing company, but just recently got laid off. His last day at work was on November 18<sup>th</sup>, and he received his last paycheck on December 4<sup>th</sup>. He has applied for unemployment, but is still waiting for a determination. The eligibility worker identifies that this is considered non-representative income in the month of application, because the consumer lost his job and received his last paycheck in the month he applied. Because there has been a change in the source of income, the income is prospected based on the current situation. Because there is no income at this time, the case is budgeted with \$0 income.

#### **E. Census Income**

All income received from the Census Bureau for the 2010 Census is exempt as income. Some of the census related jobs may be through private companies contracted with the Census Bureau. Income received from an outside contractor can NOT be exempted under this provision. If there is any doubt whether or not the income is from a private contractor or the Census Bureau, the income source will need to be verified. Otherwise the income does not need to be verified since it is exempt.

## **F. Budgeting Child Support Income**

When child support income has been reported by the applicant, and verification is not found on KAECSSES-CSE or the Kansas Payment Center, then the amount declared by the applicant is used. If at any time clarification is needed from the applicant regarding the amount of support received, these verbal statements are also acceptable verification.

## **G. Verification of Pregnancy**

Verification of pregnancy is no longer required for MP PW or MA CM. A request for coverage may be approved based on self-declaration of pregnancy.

## **H. MA CM Resource and Trust Test**

Effective with actions taken on or after January 1, 2010, the trust fund requirements for MA CM are eliminated. As trusts were the only countable resource for MA CM, the resource test for MACM has, therefore, also been eliminated. When a trust fund is reported, the applicant shall be contacted to determine if payments are received from the trust. Income from a trust is still countable unearned income.

## **I. Wage Verification**

Documentary evidence of wage verification (e.g. pay check stubs, employer letter) is not required when information found on Benefit Account Status Inquiry (BASI) is consistent with the information reported by the applicant. Information reported by the applicant is used when supported by information from BASI. Additional guidance is presented in training material being made available to eligibility staff.

## **Conclusion**

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

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Questions regarding any KAECSSES issues are directed to the SRS Business Help Desk at [helpdeskbusiness@srs.ks.gov](mailto:helpdeskbusiness@srs.ks.gov)