Premium Billing Exception Support

Process & Procedure Guide

Document Controls

Note

This document will be updated to further clarify and formalize the responsibilities of the call center, the premium processors (specifically the target audience for this document) and DSS.

The document will be updated to formalize the workflows and referrals between the different organizations. This will include referral mechanisms, forms and closed-loop tracking.

Document Purpose

This document provides guidance on the manual support processes for premium billing for the HUSKY programs. Most processes are automated or outsourced to the bank. Even with automation, some payments will error out of the automated posting process for business reasons, e.g., a check has been received, but there is no client account to credit the funds. These anticipated business scenarios are built into the bank process with the bank generating a daily exception file. The manual support processors involve researching systems and associating the received payments to the correct client accounts. Occasionally, an in-depth investigation will identify the need for corrective actions to be taken in the systems; this document describes those scenarios and outlines possible correction actions.

Intended Audience

The expected audience for this document includes:

1. DSS Management
2. Operational trainers
3. Operational contractor staff

Version Control

Version	Date	Author(s)	Change
1.0	9/30/2018	DSS/KPMG	Initial draft following the implementation of the ImpaCT premium module and the sunsetting of the third-part legacy system.

Key Reviewers

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Process Overview

High Level Description

The Department has two HUSKY Health programs that can have associated premium payments:

- HUSKY B – Band 2 plans have a $30 monthly premium for a single child on a plan or a $50 premium for two or more children on the same plan. Eligibility for HUSKY B and the inclusion of children into HUSKY B plans is determined by the HIX/Tier-1 system.

  There are some exceptions to the premium requirement that are handled in the rules, e.g., American Indian / Alaskan Natives (AI/AN) are exempt for any cost sharing and the initial four months for a newborn are waived.

- HUSKY C – Medicaid for Employees with Disabilities, also known as MED-ConneCT, has a means-tested monthly premium, i.e., the amount varies by an individual's financial situation and there is a threshold test that exempts many members from having to pay any premiums. Approximately two-thirds of eligible MED-ConneCT clients have zero premium obligation (no minimum monthly premium) with full HUSKY C coverage. Eligibility and premium calculation for MED-ConneCT is determined by ImpaCT.

This ImpaCT premium module is responsible for sending out bills and tracking payments for both types of premium-based HUSKY coverage.

Clients mail premium payment checks to the State's lockbox account and these are processed by the bank. The bank applies payments and sends the details to the State in a daily file. The State loads the premium information on this file into the ImpaCT premium module.

Any premiums that the bank couldn't process (e.g., could not find an active account) are available through its web portal for review and disposition, i.e., ultimately all payments need to "find a home" and be sent through on the daily file to be reflected in the system

Process Components

There are three systems that are used by the premium support workers in their investigative and corrective action work.

- ImpaCT

- This system has a premium payment module (PPM) which is responsible for premium billing and netting of payments against bills. This module is the core of any investigative review.
- The premium module generates reports that can drive work, e.g., overpayment balances.
- This system determines eligibility and sets the premium amount for MED-ConneCT, just one of the premium payment programs.
- The ImpaCT system generates daily report with transactions posted via bank file and most manual posting.
- ImpaCT receives and "warehouses" the HUSKY B eligibility determinations in order for them to leverage shared medical support functionality, e.g., medical card production, interface with the Medicaid Management Information System (MMIS) claims system, and interface with the medical network Administrative Support Organizations (ASOs). The most pertinent shared functionality for this document is the ImpaCT premium billing functionality.
  - As could be assessed, any enrollment discrepancy or processing delays between the HIX/Tier-1 system and ImpaCT can lead to issues that need resolving.

- HIX/Tier 1
  - HUSKY B determinations are made in HIX/Tier-1 (the system of record for HUSKY B) and sent to ImpaCT.
  - HIX/Tier-1 is the system of record for eligibility determination and enrollment for approximately 88% of HUSKY. It determines HUSKY B and passes the details to ImpaCT.
- Bank Web Portal
  - This is used daily to resolve the issues identified by the bank, e.g., when the bank cannot identify which account to post a check to.

Process Details

Overview

There are three triggers for work execution:

1. Bank triggered investigative tasks:

a. These are available daily for review in the bank web portal and are for checks that could not be posted to an active account.

b. These tasks should be reviewed daily (in the morning) and dispositioned by the end of the day. It is possible to defer final resolution, i.e., interim response at the end of the day and then a resolution the following day.

2. Ad-hoc Client triggered investigative or processing tasks:

    a. Clients may have issues regarding premium payments and balances that the call center representative is unable to handle. There are two main call centers (Access Health CT and DSS Benefits Center) and these have different capabilities with respect to line of sight into the premium module and the ability to reprint invoices, notices, etc.

    b. The task could be logged directly in the tracker database by a call center representative or could be forwarded as an email which is then logged into the tracker. The task should be worked to completion, i.e., contact the client with the resolution. The resolution should be noted as comments in the tracker, in ImpaCT and optionally in the HIX/Tier-1 system for HUSKY B.

3. Client request triggered refund investigations

    a. A client may contact the call center to request a refund. These requests should be logged into a tracker and worked to completion.

    b. Not every overpayment results in a refund. There is a process to investigate and determine the action for an overpayment. For example, a HUSKY B client may have renewed their coverage, but the ImpaCT system has yet to be updated; in this situation the resolution is to have the ImpaCT system updated with the new coverage.

Task Details

Managing Bank Exceptions

Premium payments from clients are collected via the bank's lockbox and the bank sends a daily summary file a secure State server. ImpaCT ingests and processes the file. The system performs a low-level technical validation, e.g., checks for alphanumeric or special characters. If

there are no issues with the file, the system will post the payments to the appropriate accounts and update account balances. If there are any issues detected in the file, the processing stops and payments are not posted.

The exception processors must log into bank's web portal daily and review any payments that the bank excluded from the previous day's file. The bank web portal contains images of checks, money orders, and invoice stubs submitted to the lockbox.

Each item in the web portal is reviewed within the bank web portal. Since the volume is low, the coordination between items (i.e., who is working on which item) can be handled informally by the workers or can be handled by entering the task into a tracker.

Each review item typically begins by executing an investigation step to establish the details of the business scenario:

1. Review the bank images for the following details: Case Number, Client/ Individual id, Logical Plan id, Plan id, Check document name, Check number, Payment amount, Program Indicator, Check date and payment date.
    a. Use ImpaCT and HIX/Tier-1 to confirm the client's program participation in HUSKY B Band II or MED-ConneCT.
2. When the client and account is identified, manually post the details, paying attention to using the set formatting. The check disposition is set to "Submit" in the bank web portal.
3. When processors can't associate payments to a client in the ImpaCT system, the processors should mark it with the "reject" reason code and use the "Sent to PDF" disposition. This action causes the check to be deposited by the bank, removed from the web portal and excluded from any future daily transmission file.

    The "Sent to PDF" action results in the check image being saved manually to the PC drive. The check must be tracked and manually ultimately associated to a client account (in order to balance with the bank receipts).
4. When extra documents are received with the check, the processors will disposition the check accordingly and the extra documents will be marked as "Extra Document Not Needed". The images of these documents will be sent and are saved. The extra documents (do not appear to associate to premium payments) will be returned to the sender with a brief notice.

Client Triggered Investigations

For calls referred from a call center via a referral form:

1. Conduct a household search in ImpaCT
2. If there is no account in ImpaCT, then for HUSKY B clients search the HIX/Tier-1 system for current eligibility
    a. If the most recently submitted application did not grant HUSKY B program eligibility, direct the client to the Access Health CT call center for assistance.
    b. If the most recent application granted HUSKY B eligibility, follow the Escalation Procedure (see below).
3. If there is an account in ImpaCT
    a. Check the eligibility and enrollment for the client.
4. If there is eligibility but no enrollment, research ImpaCT to verify payment was received.
    a. If the payment was received, enroll the children.
    b. If the payment was not received and the client states that their payment was processed/cashed (if it wasn't then the call center representative should have told them to call back after 3 – 5 days to make sure it wasn't cashed), then follow the Escalation Process.
5. If there is current eligibility and enrollment in ImpaCT, check Medicaid InterChange (MMIS) for active eligibility. If not, follow escalation process (see ii below)
    a. If the Medicaid InterChange (MMIS) shows active coverage, advise the client to ensure that the provider is using the correct client ID number; and if that is not the issue, to have the provider call the Provider Assistance Line for further assistance.
    b. If Medicaid InterChange (MMIS) is not showing active coverage, have the case escalated and advise the client that they would follow up with the Benefit Center.

All client driven inquiries about enrollment must be closed with outreach to the client with resolution status. If the process requires multiple steps and days to achieve resolution, then the client must be kept updated on progress.

Processing Refunds

These can be triggered by a direct (ad-hoc) client request or as line items on the over-payment report. In each situation the task and disposition should be added to the tracker database.

Each task typically begins by executing an investigation step to establish the details of the business scenario.

1. Review all systems to verify eligibility and enrollment (ImpaCT and HIX/Tier-1 systems).
2. Confirm whether the client is eligible for a refund.

Credit – Reimbursement Research:

- If the credit amount aligns in ImpaCT and the balance is listed correctly in ImpaCT, the credit can stay on the client's account to be used toward future premiums; the system will automatically apply the credit each month until the credit is exhausted.
- The client can choose to not have the credit applied towards future payments, but instead have it processed as a refund. If the client requests a refund, proceed with executing the reimbursement process via the ImpaCT systems.

Invoice and Notice Reprints

There are two notices sent to HUSKY clients – the Initial Premium Notice and the Reminder Notice. These notices are generated from the ImpaCT application. Invoices show the monthly premium and any overdue balances or credits. Mailed invoices include a return postage-paid envelope with the bank's address and individualized remittance form to be included with a mailed check.

Reprint requests are performed using the ImpaCT system functions. Ideally these requests are handled directly at the call center, but they can be routed as requests to the premium exception processing unit. At the time of writing, the Benefits Center can use ImpaCT to resend premium notices, but the Access Health CT call center does not have access to the ImpaCT system.

HUSKY B Premium Related Enrollment Issue

Premium processors need to ensure that the enrollment effective start date and enrollment end date in Hix/Tier-1 mirror the dates in ImpaCT

Take the following steps to verify enrollment:

1. Review the eligibility determination in HIX/Tier-1 and ImpaCT to make sure they aligned.

2. Check ImpaCT premium module to see if payments were received and posted.
3. When unable to resolve, proceed with escalation process (see below).

Eligibility Determination:

- If the eligibility is not the same in HIX/Tier-1 and ImpaCT, and the HIX/Tier-1 system shows the client with current HUSKY B Band 2 coverage and ImpaCT doesn't reflect this, proceed with the escalation process (see below).
- If the eligibility is the same in HIX and ImpaCT, verify the payments received in the ImpaCT premium module.

HUSKY B Payment Verification:

- If payment has been received but has not been applied to determine the enrollment, the premium exception processor should determine if the payment received was posted under the dummy plan id, "233" (this is a temporary system workaround in order to allow for a check to be posted for someone without a plan and most cases fall under this scenario) or a HIX/Tier-1 plan id that has not been attached to the client's ImpaCT case. Proceed with the Escalation Process (see below).

Escalation Process

After the investigative process is complete and an issue is identified that requires escalation to DSS for triage (e.g., system defect or an unprocessed "HIX-ImpaCT Escalation Task"), record the result on the tracker and forward to the DSS representative for premium support.

The DSS representative may triage an escalation as follows:

1. Forward a request to a DSS eligibility support team to prioritize the disposition of the manual ImpaCT HIX-Eligibility Task (this is a task that is created when the automated interface between the HIX/Tier-1 system and ImpaCT encounters a business conflict/issue), or
2. Refer to the appropriate DSS Technical assistance team for HIX or ImpaCT. This can also include:
    a. Manual processing steps for a known issue.
    b. Submitting a Data Change Request (DCR) for a known issue.
    c. Creating a technical problem ticket ("JIRA") for tracking and future resolution.