IBM Cúram Social Program Management

Cúram Children's Health Insurance Program Guide

Version 6.0.4

Note

Before using this information and the product it supports, read the information in Notices at the back of this guide.

This edition applies to version 6.0.4 of IBM Cúram Social Program Management and all subsequent releases and modifications unless otherwise indicated in new editions.

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Chapter 1

Introduction

1.1 Document Purpose

The purpose of this document is to provide a business level overview of the Cúram Children's Health Insurance Program™ (CHIP) and the implementation of this program within the Cúram Medical Assistance™ product.

This guide does not describe in detail how to use the application; it does, however, provide some application specifics where it is deemed helpful to the reader in understanding the CHIP program.

1.2 Audience

This document is intended for business users who are interested in understanding the Cúram implementation of the Children's Health Insurance Program (CHIP). After reading this document, it is intended that the user would have obtained a business level understanding of the program, the specific evidence recorded in the system, the process for checking program eligibility, and the creation and management of the CHIP Product Delivery.

1.3 Available Documentation

Supporting documentation relating to Medical Assistance and associated programs, including CHIP can be found in the Business Analysts guide titled Cúram Global Medical Assistance Program.

Users may also find the business guides for other Medical Assistance programs useful. For Long Term Care, see Cúram Long Term Care Medical Assistance Guide. For SpendDown, see Cúram Medical Assistance with SpendDown Guide.

Chapter 2

Children's Health Insurance Program Overview

2.1 About Children's Health Insurance Program (CHIP)

In 1997, the balanced budget act established a Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. This program is jointly financed by the federal and state governments and administered by individual states. Within broad Federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures.

The Children's Health Insurance Program (CHIP) is a national program in the United States designed for families who earn too much money to qualify for Medical Assistance, yet cannot afford to buy private insurance for their children. The program was created to address the growing problem of children in the United States without health insurance. CHIP coverage provides eligible children with coverage for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits, emergency room visits and more.

States are allowed to impose premiums and co-payments for some services and for some groups. To receive CHIP coverage, families with eligible children, unless exempt, may be required to pay premiums. The premium payable represents the amount of money required to maintain CHIP coverage. Premiums are calculated based on the total family income and the number of eligible children being covered under CHIP. Co-payments may also be imposed for services. A co-payment is a fixed dollar amount paid by a CHIP enrollee each time certain covered services are received. This amount is paid directly to the provider.

States can provide care through two different ways, managed care or fee-for-service. Managed care offers most medical care through one source: a health plan. A health plan is an organization of licensed insurers, non profit organizations and managed care organizations (MCO's) who are contracted

to provide services to eligible CHIP children. If children are enrolled in a managed care health plan, they go to one person for their medical care called a Primary Care Provider. A Primary Care Provider is the doctor, nurse practitioner, or physician assistant who takes care of the children to make sure they get all of the health care they need. With fee-for-service children do not belong to a health plan. They can go to any doctor, pharmacist, or other provider who will take the children’s medical ID card for payment.

2.2 The Cúram Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) provides medical services to eligible children under the age of 19 who do not have health insurance and do not qualify for Medical Assistance. The Children's Health Insurance Program (CHIP) is part of Cúram Global Medical Assistance. Like other Medical Assistance programs, the information required to determine program eligibility is captured as evidence. This evidence is assessed against a set of business rules to determine whether or not an individual is eligible for CHIP. Eligibility for CHIP is determined as part of the existing cascading eligibility workflow for Medical Assistance programs. The cascading eligibility process determines program eligibility based on a hierarchy. The hierarchy is used to determine the order in which the program rules are executed. The eligibility rule set for the program with the highest priority are executed first, followed by the rules for the program of next highest priority. The rules for the categorically needy programs (including cost sharing programs) are executed first followed by the rules for the medically needy programs. CHIP eligibility is only determined if an individual is ineligible for all the categorically needy/medically needy programs. This hierarchy is configurable within the product to meet the individual requirements of a state.

There are a number of additional features associated with the Children's Health Insurance Program (CHIP). Because of limitations on funding and available slots in the program, applications for CHIP are only accepted during open enrollment periods. Open enrollment is the period of time during which eligible individuals can apply for CHIP. States limit the numbers they enroll according to the funds available for the program. Once this period has passed, unless exempt, for example a newborn, it is not possible to apply for this program. A new processing entity, Enrollment Details, has been added to record time periods when applications can be accepted by the state.

Unlike Low Income Families with Children (LIFC), individuals eligible for CHIP can choose whether or not they wish to receive the program. There are no mandatory assistance unit members; therefore, families can decide what child(ren) in the eligibility result need coverage.

Once the CHIP product delivery is created, a benefit delivery system must be selected for each child. A benefit delivery system must include a Health Plan or a Fee for Service system and a Dental Plan. It can also include a Primary Care Provider.

To receive CHIP coverage, families may be required to pay premiums. This depends on whether or not the state requires premiums for coverage. The application of premiums is controlled by an environment variable to facilitate customization by individual states.

If premiums are applicable, two product deliveries are created during the CHIP product delivery creation process: a benefit product delivery to manage the provision of medical services to the eligible individual(s) and a liability product delivery to manage the billing, collection and allocation of premiums.

2.2.1 Evidence

Evidence is the set of data items captured to determine the household's eligibility for Medical Assistance programs including CHIP. For the most part, CHIP uses the standard Medical Assistance evidence. This includes standard household, income, resource and expense evidence stored at the integrated case level. Updates have been made to existing resource entities and, as well, new resource entities have been created to capture the additional data requirements for CHIP. In addition to the new resource entities, there is also a new evidence entity, Elective CHIP Enrollee, which is maintained at the CHIP product delivery level rather than the integrated case level.

The evidence chapter provides a summary of the changes made for CHIP. Existing standard evidence used by the Children's Health Insurance Program is not specified in the evidence chapter.

2.2.2 Eligibility Determination and Product Delivery Case Creation

Eligibility is determined for the Children's Health Insurance Program according to a predefined set of rules. The eligibility determination section describes the CHIP rules executed during the cascading eligibility workflow process, the eligibility decision including the identification of the possible assistance units within the household and the medical services covered.

The product delivery case creation process describes the selection of assistance unit members, viewing the associated premiums and co-payment limit and creating the CHIP product delivery, including a liability product delivery if applicable. It also describes the selection of a benefit delivery system for each child.

2.2.3 Reassessment and Eligibility Renewal

This chapter describes the reassessment and eligibility renewal process for a CHIP product delivery. Reassessment takes place as part of ongoing eligibility or as a result of a change of circumstances. Eligibility renewal outlines the steps required to renew CHIP coverage.

Chapter 3

Evidence

3.1 Introduction

This chapter describes the resource entities that have been added and updated to support the Children's Health Insurance Program. All resource evidence is stored at the integrated case level and accessible by all programs. This chapter also describes Elective CHIP Enrollee evidence which is product specific and thus maintained at the CHIP product delivery level.

3.2 Resource Evidence

The resource evidence General Insurance, Coverage Type Details and Entitlement are new entities. Medical Insurance and Coverage are existing entities which have been modified to cater for the additional data requirements for CHIP.

3.2.1 General Insurance

General insurance evidence captures the policyholder details, insurance company name and address and information on the general insurance policy itself such as the policy start date, the premium paid and the general insurance type, for example, automobile liability or general liability. Coverage evidence records the household member(s) who are insured under the policy and their relationship to the policyholder.

3.2.2 Coverage Type Details

Coverage Type Details evidence captures details of the type of coverage included under a medical insurance policy, for example, dental, prescription drugs, etc. One or more coverage types may be associated with a medical insurance policy. The type of coverage an individual receives may affect an individual's eligibility for the Children's Health Insurance Program (CHIP).

For example, if the type of medical insurance cover is deemed comprehensive the child is ineligible for CHIP.

3.2.3 Entitlement

Entitlement evidence captures details of the household members who are entitled to coverage under a medical insurance policy, for example, an employer based plan or a group health plan. A household member may be automatically covered under a medical plan but an extra fee is payable to provide coverage for another member of the household. In this case, entitlement to coverage exists for the other household member. In other cases, a waiting period is required before coverage under a health plan can begin, for example, a minimum of six months continuous service with an employer. Entitlement to coverage exists following completion of the waiting period. Entitlement evidence captures details such as the name of the entitled household member, the cost of coverage for the household member, an indication of whether a waiting period applies and the enrollment date when coverage can begin.

3.2.4 Medical Insurance

Medical insurance evidence captures the policyholder details, insurance company name and address and information on the policy itself such as the policy start date, the premium paid and the medical insurance type, for example, group medical insurance plan.

The following changes have been made to Medical Insurance:

- The attributes 'perPersonDeductible' and 'maxDeductible' have been added. A deductible is the amount which must be paid before the insurance company begins to pay medical bills. This is an annual amount per insured person. Typically there will be a maximum amount of deductibles a family will have to pay in a given year. For example, if the "per person" deductible is $500, and there are five people in the household covered under the health insurance, the maximum "family" deductible might be $1500. Once three of the household members pay the full deductible during the year, no more deductibles should be paid by the household for the rest of the year.
- The attribute 'countryWideCoverageInd' has been added. This is an indicator to show that coverage under a medical insurance policy applies in all states country wide and is not restricted to a single state.
- The attribute 'stateOfCoverage' has been added. This attribute stores the State in which coverage under a medical insurance policy applies where coverage under the policy is restricted to one state only. The attributes 'countryWideCoverageInd' and 'stateOfCoverage' are mutually exclusive.

3.2.5 Coverage

Coverage evidence captures details of the household members who are insured under a medical insurance policy. At least one coverage record or one entitlement record must be recorded for a medical insurance evidence record. More than one coverage record can be added when there are many household members covered by a medical insurance policy. Coverage evidence captures details such as the name of the covered household member and the relationship of the household member to the policyholder, or the relationship to the employee covered by an employer group scheme.

The following changes have been made to Coverage:

- The attribute 'coverageExhaustedInd' has been added. This is an indicator to show whether the maximum claimed benefit limit under the medical insurance policy has been reached.
- The attribute 'coverageEndReason' has been added. Coverage end reason records an explanation of why coverage under the medical insurance policy ended for the household member. For example, coverage may end due to termination of coverage by a non custodial parent.

3.3 Product Specific Evidence

Product specific evidence is recorded against the actual product. Elective CHIP Enrollee is a new entity added specifically for CHIP.

3.3.1 Elective CHIP Enrollee

The Elective CHIP Enrollee entity is used to record that a household member has elected to continue receiving CHIP even though the member has been determined eligible for Medical Assistance.

Normally if a child is eligible for regular Medical Assistance, s/he is no longer eligible for CHIP. However, if the reason the child is eligible for regular Medical Assistance is solely because of a decrease in income, the child does not have to move to regular Medical Assistance and can choose to continue receiving CHIP until the end of the current eligibility period.

Chapter 4

Eligibility Determination and Product Delivery Case Creation

4.1 Introduction

This chapter outlines the processes for determining eligibility for the Children's Health Insurance Program (CHIP) and creating the CHIP product delivery.

4.2 Check CHIP Eligibility

The existing Check Medical Assistance Eligibility functionality, which determines eligibility for all Medical Assistance programs based on a hierarchy, has been extended to include CHIP. When checking Medical Assistance eligibility from the integrated case home page, the caseworker now has the option to check eligibility for all Medical Assistance programs or just CHIP.

If the caseworker has selected 'All Medical Assistance Programs', the Medical Assistance Eligibility workflow process checks eligibility for the Categorically Needy and Medically Needy programs for all household members. Eligibility for CHIP will only be carried out if it is determined that a member is not eligible under any categorically needy or medically needy program. In addition, the caseworker may also manually check eligibility for Medically Needy with SpendDown. If eligible under Medically Needy with SpendDown in addition to CHIP, the member must choose which program to receive.

If the caseworker has selected 'Children's Health Insurance Program (CHIP)', the same Medical Assistance Eligibility workflow process is called. The result is filtered to only display children in the household who are eligible for CHIP. The CHIP only option may be used where a family just want to apply for CHIP for the children. If none of the children in the house-

hold are eligible for CHIP, the caseworker has the option to view the full eligibility result as determined by the Medical Assistance Eligibility workflow process. It may be that the children are eligible for other Medical Assistance programs that have a higher priority than CHIP in the cascading hierarchy. For example, a child found eligible for Aged, Blind and Disabled (ABD) during the Medical Assistance Eligibility workflow process will not have CHIP eligibility determined as the program rules for ABD are executed before the program rules for CHIP.

Once an eligibility result set has been determined, a task is created by workflow in the caseworker's inbox. This task links to the relevant Medical Assistance Eligibility Result Page.

4.3 Rules

This section provides a high level overview of the rules executed for CHIP during the Medical Assistance Eligibility workflow process.

4.3.1 Open Enrollment Criteria

The open enrollment rules determine whether or not an application for CHIP has been received during an open enrollment period. An open enrollment period is a specific time period set by the organization in which applications for CHIP can be accepted. Once this period has passed, no applications are accepted. The organization limits the number they enroll according to the funds available for the program. Some exceptions apply, for example, a newborn can be added to an existing CHIP product delivery without waiting for the next open enrollment period. Also a child who loses Medical Assistance coverage and does not qualify for any other Medical Assistance program without paying a SpendDown, may enroll in CHIP without waiting for the next open enrollment period.

4.3.2 Non-Financial Requirements

The child must satisfy the standard non-financial requirements rules for Citizenship, SSN and Residency.

4.3.3 CHIP Specific Eligibility Requirements

There are a number of specific eligibility requirements that must be met in order to receive CHIP. The program is only available to children under 19 who are uninsured, as defined by CHIP rules, and who are ineligible for any categorically needy or medically needy Medical Assistance program. Eligibility for categorically needy/medically needy Medical Assistance programs is determined as part of the cascading eligibility workflow process.

4.3.4 Financial Eligibility Requirements

To be eligible to enroll in CHIP, the household's adjusted gross countable income must not exceed the income limit for the household size. Income limit is defined as a percentage of the federal poverty level (FPL). CHIP uses the income and deduction rules that apply to the family programs (LIFC, Pregnant Woman and Children) to determine what income is countable/excluded and what deductions to apply. CHIP has its own rules to determine the income unit and household size. The income unit is the individuals whose income is counted in determining CHIP eligibility. The number of individuals counted in the household size determines the income limit used when comparing against the household's income.

The household does not have to pass a resource test to be eligible for CHIP.

4.3.5 Household Composition

The eligibility determination process for CHIP identifies the possible assistance units which exist in the current household. Unlike Low Income Families with Children (LIFC), all CHIP eligible household members are seen as 'optional', as they do not have to receive CHIP coverage if they do not want it.

For example, an applicant (aged 18), the applicant’s husband (aged 18), and the applicant’s child (aged 1) are living with the applicant's mother (aged 42) and father (aged 44). The applicant’s cousin (aged 16) and the cousin’s son (aged 1) also live in the household. Assuming all the CHIP eligibility criteria is met, there are a number of different assistance units, based on different combinations, that could apply:

1. Applicant, Applicant's Husband and Applicant's Daughter.
2. Applicant
3. Applicant's Husband
4. Applicant's Daughter
5. Applicant and Applicant's Husband
6. Applicant and Applicant's Daughter
7. Applicant's Husband and Applicant's Daughter
8. Applicant's Cousin and Applicant's Cousin's Son
9. Applicant's Cousin
10. Applicant's Cousin's Son

For CHIP, rather than displaying every possible combination and having validations to ensure a household member cannot receive CHIP in more than one assistance unit, each different result is displayed with one assistance unit containing every member who could potentially receive coverage under the same product delivery. The caseworker chooses which members to proceed with during case creation; these members then become part of

the benefit group. Using the example above, there are 2 results displayed on the eligibility result page:

1. Applicant, Applicant's Husband and Applicant's Daughter
2. Applicant's Cousin and Applicant's Cousin's Son

If the applicant is the only child who wants coverage, the caseworker selects result 1 from the eligibility result page, and at a later stage during the process, the caseworker selects the applicant as the one to proceed with. A product delivery is created for the applicant where she is the only member of the benefit group.

If the applicant's cousin also wants coverage, both result 1 and 2 are selected, and the caseworker chooses who to proceed with for both results. Both the applicant and the cousin will have their own product delivery, as they cannot exist together in the same benefit group based on the household composition rules.

The household composition rules used to determine what individuals can exist together in an assistance unit are as follows:

- Child who satisfies the CHIP eligibility rules*
- Child's siblings, half, adopted and step who also satisfy the CHIP eligibility rules
- Parents and stepparents of any child, if the parents and stepparents satisfy the CHIP eligibility rules
- Children of any child if the children satisfy the CHIP eligibility rules
- The spouse of any child if the spouse satisfies the CHIP eligibility rules

*The CHIP eligibility rules refer to the CHIP Specific Eligibility Requirements and the standard Non-Financial Requirements rules (Citizenship, SSN and Residency).

4.4 Eligibility Result

The output from the eligibility determination process is the eligibility result. It displays a list of Medical Assistance programs including CHIP for which household members are eligible. A tree view of the decision details associated with each program listed can also be viewed. If premiums are applicable on a CHIP program, the decision details will display two objectives, one for the provision of services and a financial objective for premium billing and collection. A list of medical services covered under the CHIP program can also be viewed. Each Medical Assistance program has its own medical services. The services for each program are stored in code tables.

It is also possible to view ineligible decisions to see why household members may not be eligible for certain programs.

The household member can select which program to apply for using the results of the eligibility determination process and by reviewing the medical services provided under each eligible program.

4.5 Create CHIP Product Delivery

The standard create product delivery process has been extended to include additional processing required to create a CHIP program. The caseworker enters the receipt date, which is the date an application for Medical Assistance is received by the organization, and proceeds to select assistance unit members for the CHIP product delivery.

Selection of assistance unit members is a new step specific to the Children's Health Insurance Program (CHIP). Participation in CHIP is optional for eligible individuals. During the eligibility determination process eligible household members are grouped into assistance units according to the household composition rules. Each assistance unit contains one or more eligible household members; however, an eligible household member only belongs to one assistance unit. The individuals within an assistance unit represent the household members that can exist together on a CHIP case. The selection process is required to confirm who is proceeding with CHIP coverage. A CHIP case is created for each assistance unit.

Once the assistance unit members have been selected, the premium processing rules determine the CHIP premium payable and the co-payment maximum limit for the assistance unit. This is a new step specific to CHIP.

The premium payable is based on the household size, household income (expressed as a percentage of the federal poverty guideline) and the number of children applying for CHIP. Premium values and the frequency of premium payment are determined using Rate Tables.

A co-payment is a monetary contribution towards the cost of a service received under CHIP coverage. Enrollees in CHIP are required to pay co-payments, up to a maximum co-payment limit for a family within a specified period of time. The maximum co-payment limit for a family is calculated as a percentage of the family’s gross countable income less the total amount payable in CHIP premiums by the family within a defined period of time. The time period to which the co-payment limit applies is based on the certification dates of the product delivery. In general, this will be 12 months.

The steps to select assistance unit members and view and accept their premium and co-payment details are repeated for each CHIP program selected from the Medical Assistance Eligibility Result.

When all CHIP assistance units have been selected and premiums and co-payment limits have been confirmed, a product delivery is created for each selected program using the standard create product delivery functionality within the product.

4.5.1 Case Creation

Where premium processing rules determine that premiums are payable for CHIP coverage, two product deliveries are created: a CHIP benefit product delivery and a CHIP liability product delivery. The purpose of the liability product delivery is to manage the billing, collection, and allocation of premiums.

The calculated premium amount and the premium frequency information is stored on the premium entity, which is linked to the CHIP benefit product delivery. A copayment record is also created containing the co-payment limit for the household and the period of time the co-payment limit covers.

The premium details are used in the creation of the CHIP liability product delivery to determine the financial components applicable. Financial components represent the billing schedule for premiums for the CHIP liability product delivery. They contain the various elements that constitute a financial schedule within the product, for example, amount, validity period, frequency, processing date, and due date.

To cater for the advance payment of premiums, the liability product is configured to allow for over allocation. This allows for a person to pay an amount greater than the amount that was billed. A case relationship record is created between the CHIP product delivery and the liability product delivery. The system automatically sets the same default values as part of the liability product delivery creation process with the exception of the case groups, premiums and co-payment information.

4.5.2 Effective Date Of Coverage

States vary on the effective date of coverage for CHIP. Four effective date options from which a state can choose are provided:

1. Date when the first month's premium has been received
2. First day of the month following payment of the initial premium
3. First day of the month following an eligibility decision
4. Date of application (or date of application minus number of days Grace Period granted)

The effective date option is set as an environment variable or property.

The effective date of coverage for options 1 and 2 depend on when the first initial premium is received. For options 3 and 4, the effective date of coverage is not dependent on premiums.

Effective Date Options 1 & 2

As effective date options 1 and 2 involve an initial premium payment which determines when the regular premium payments begin, two financial components are required for the liability: one dealing with the initial premium and the second dealing with ongoing premiums. The second financial com-

ponent is created when the first premium has been received. This process is triggered by the CHIP liability rules. The CHIP liability rules are used to trigger the billing procedure for ongoing premiums.

The first financial component is once-off as it only covers the initial premium. The second financial component, created once the initial premium is received, is a recurring component to cater for the collection of ongoing premiums. The next processing date and due date on the financial component are used to determine when to send the bill for premium payment to the customer and the date on which the premium should be paid to the organization.

The Activate CHIP Case workflow is triggered at this point, which sets the effective date, for options 1 and 2, on the CHIP product delivery and the liability product delivery. For option 1, the effective date is the allocation date, the date on which the premium received is allocated to the related bill (liability instruction line item). For option 2, it is the 1st of the month following the allocation date. The certification period is also set using the effective date and the CHIP continuous eligibility period. The CHIP continuous eligibility period is the length of time a person has on CHIP before a renewal is due. It is set at 12 months. This is stored as an environment variable and therefore can be customized depending on individual states' requirements. A case renewal event is also created to take place at the end of the current certification period.

Effective Date Options 3 & 4

Effective date options 3 and 4 do not involve an initial premium payment before regular premium payments begin so only one recurring financial component is required for the liability. The next processing date on the financial component determines when a bill for premium payment is sent to the customer and the due date represents the date on which the premium is due to be paid to the organization.

As the effective date for options 3 and 4 does not depend on when the first premium is received, the effective date for coverage is set at case creation. The certification period is also set at case creation using the effective date plus the CHIP continuous eligibility period. A case renewal event is automatically created at this stage to take place at the end of the current certification period.

4.6 Benefit Delivery System

Once the CHIP product delivery has been created, the caseworker can choose to enter benefit delivery system details for all eligible children in each assistance unit, or each child individually. A benefit delivery system consists of health plans, fee-for-service, dental plans and the primary care provider. A health plan or a fee-for-service system and also a dental plan or a fee-for-service system must be selected for each CHIP child. The caseworker can choose a primary care provider for each plan if desired. A health

plan or dental plan is an organization of licensed insurers, non profit organizations and managed care organizations (MCO's) who are contracted to provide services to eligible CHIP children. A primary care provider (PCP) is a doctor, nurse, dentist or other health professional who is responsible for providing and coordinating the CHIP child's health care. Most CHIP children will receive care through a health plan or dental plan, however if there is no health plan or dental plan available in the area, they can choose fee-for-service. With fee-for-service the child can attend any doctor or other provider who will take the child's medical card for payment.

When selecting a benefit delivery system, the caseworker can search for a health plan/dental plan by state and county or by primary care provider. Fee for service options available are included in the search results for health plan/dental plan by state and county.

When the product delivery is activated, a validation is displayed if the caseworker has not entered benefit delivery system details for every eligible child.

Often a beneficiary is 'locked-into' a health plan and dental plan for 12 months from the date of enrollment, as long as the child remains eligible. However as this varies considerably between states, and often is at the discretion of the caseworker, there is no time limit imposed. These details can be changed at any stage. The facility to impose a time limit for changes exists if needed.

4.7 Product Delivery Home Page (Benefit)

CHIP uses the existing product delivery home page functionality within Cúram. An extra field, effective date, representing the effective date of coverage, is displayed on the product delivery home page for CHIP. There is also a new link to renew eligibility on the home page. The navigation bar has some extra links to view premium details, record and view co-payments and maintain benefit delivery system details.

4.7.1 Premiums

A premium is defined as the amount of money required for coverage under a specific insurance policy for a given period of time. The requirement to pay a premium for CHIP is controlled by an environment variable. If this value is set, families with eligible children (unless exempt) are required to pay a premium to receive CHIP coverage.

The premium details viewable are the premiums payable for CHIP coverage for household members in the assistance unit. Details of premiums received by the organization, retrieved from the related CHIP liability product delivery, are also displayed.

4.7.2 Co-Payments

In order to track whether the maximum co-payment limit has been reached for a household, co-payment receipt details must be recorded. The co-payment limit reached indicator is set when the sum of the values of all receipts received for a case is equal to or greater than the maximum co-payment limit.

4.7.3 Certifications

For CHIP, case certification is controlled by the system and is based on the effective date. The certification period is set to the effective date plus 12 months and can not be changed by the caseworker manually. A certifications list page is provided for every case. For CHIP, on the Certifications page, the caseworker can only view certification details. The functionality relating to adding and modifying certifications has been removed.

4.7.4 Benefit Group

The benefit group refers to the household members who are eligible for medical assistance under a specific program. Like other programs, the benefit group for CHIP is determined after the execution of the medical assistance eligibility rules when the CHIP product delivery is created from the Medical Assistance Eligibility Result. For CHIP, the group members can subsequently be modified by the caseworker. As a result, there are now two types of Benefit Group pages, one for CHIP and one for all other programs.

The benefit group pages for CHIP allow caseworkers to add and remove household members to and from a product delivery. The caseworker can only add members who currently exist on the integrated case and who were determined eligible for CHIP on the most recent decision for the product delivery. This will be any child who decided not to be covered by CHIP even though eligible originally, any child who was previously ineligible but who is now eligible as a result of a change in circumstance or a child who is a recent addition to the household such as a newborn.

4.8 Product Delivery Home Page (Liability)

Each CHIP program within an integrated case has its own benefit product delivery home page. If premiums are applicable, the CHIP program also has its own liability product delivery home page. The liability product delivery is managed entirely by its related CHIP benefit product delivery.

Chapter 5

Reassessment and Eligibility Renewal

5.1 Introduction

This chapter describes the reassessment and eligibility renewal process for a CHIP product delivery.

5.2 Reassessment

A CHIP case can be reassessed at various stages over a given period of time. Reassessment detects whether an individual or group of individuals is still eligible for CHIP and whether there is a change in the premium payable or the co-payment limit. This section details when the reassessment of a case takes place for the Children's Health Insurance Program. This can take place as part of ongoing eligibility or when there has been a change of circumstance.

5.2.1 Ongoing Eligibility

The frequency of ongoing eligibility determination can be configured according to an individual state's requirements. The default value is monthly. As part of ongoing eligibility determination, the child must meet all the CHIP eligibility rules executed during the Medical Assistance Eligibility workflow process with the exception of the open enrollment rules. In addition, premiums must be paid on time for coverage to continue. Premium rules exist to ensure coverage is cancelled when premiums have not been paid for a specified period. The specified period varies between states. Once coverage has been cancelled, there is a waiting period before the child can re-enroll in CHIP. Again, this period of time varies between states, some states do not impose a waiting period at all. If no payments have been allocated toward the liability instruction line item for two consecutive months, the CHIP case and the liability case should be closed at the end of the second month. Premiums not paid in full are treated as non-payments.

Eligibility should also be checked for regular Medical Assistance in case the requirements for another Medical Assistance program become less restrictive, so even though the child's circumstances are unchanged, they may become eligible for regular Medical Assistance.

5.2.2 Change of Circumstance

Change of circumstances processing occurs when there has been an evidence change on the integrated case, when a household member is added or removed from the benefit group, or when a household member is added or removed from the integrated case. The following section outlines the type of changes which trigger the change of circumstance processing.

Evidence Changes on Integrated Case

When evidence changes on the integrated case, reassessment is triggered automatically across all product deliveries and case groups are updated as necessary. This is out of the box functionality. If one of the product deliveries is a CHIP product delivery, a task should be created to inform the case worker to check eligibility across all Medical Assistance programs (in case they are now eligible for a more beneficial program).

If the child is found ineligible for CHIP, it does not necessarily mean the child will lose coverage. Certain changes are essentially ignored until eligibility renewal. The types of changes and what happens is outlined in the sections below.

Changes Causing Ineligibility

If any of the following changes occur, the child loses coverage:

- The child dies.
- The family request that the CHIP coverage be stopped.
- The child no longer meets the age requirements.
- The child no longer meets the residency, citizenship and SSN requirements.
- The child receives other comprehensive medical insurance coverage.
- The child becomes eligible for regular medical assistance (the case worker must manually check eligibility for all other medical assistance programs whenever there is a change of circumstance to determine if the child is now eligible for regular medical assistance).*
- The child takes up residence in a public non medical institution.
- The child takes up residence in a psychiatric facility.

The effective date of disenrollment is the last day of the month the change

occurred unless the child has died, in which case the effective date is the date the child died. A task is created for the caseworker to inform him or her to take the appropriate action. If there was only one child on the case or if the change of circumstance affects all children on the case, the case is closed on the effective date of disenrollment. If only one child is affected by the change, the case remains open and the affected child is removed from the benefit group on the effective date of disenrollment.

*If the reason the child is eligible for regular medical assistance is *solely* because of a decrease in income, the child does not have to move if he or she does not wish to (until the end of the current eligibility period). However if the child is eligible for regular medical assistance because of any other change, the child must be removed from CHIP. This is a manual process which the caseworker must carry out.

Income Changes

When there is a change in income evidence, it must be evaluated to determine if it affects an individual's eligibility.

Income Increase

1. If the reported income change does not adversely affect the case (does not cause ineligibility or an increase in the premium/co-payment limit), eligibility should be renewed for another certification period, from the 1st of the month following the increase in income. A task is created to inform the caseworker to recertify the CHIP and Liability product deliveries for the new period of time. When the certification period is updated for CHIP, the case renewal event should also be updated as this is based on the certification period.

2. If the reported income change does adversely affect the case (causes ineligibility or an increase in premium/co-payment limit), the increase is not acted upon until the end of the current eligibility period when the family is applying for renewal. They remain covered under CHIP with the same premium amount and co-payment limit until the end of the continuous eligibility period.

Income Decrease

1. If the reported income change makes a CHIP enrollee eligible for regular medical assistance (without a SpendDown) and this is the *only* reason on the enrollee is now eligible for regular medical assistance, but the family does not request regular medical assistance, then the reported change is not acted on until the next renewal. They remain covered under CHIP until the end of the continuous eligibility period.

2. In addition to the situation described in 1 above, the income decrease also results in a reduction of the enrollee's premium and co-payment limit), the reported change is not acted on until the next renewal. The enrollee remains covered under CHIP with the same premium amount

and co-payment limit until the end of the continuous eligibility period.

3. If the reported income change results in a reduction of the enrollee's premium and co-payment limit, but does not make him or her eligible for regular medical assistance, then the reported change is acted on immediately and the enrollee(s) are renewed for another certification period, from the 1st of the month following the decrease in income. A task is created to inform the caseworker to re-certify the CHIP and Liability product deliveries for the new period of time. The premium and copayment records should be updated with the new information and the financial component should be updated with the new premium amount (taken from the premium entity). When the certification period is updated for CHIP, the case renewal event should also be updated as this is based on the certification period.

For 1 and 2 above, where the family requests regular Medical Assistance following a reported decrease in income, the child(ren) eligible for Medical Assistance must be removed from the CHIP case and a new case for Medical Assistance is opened. If there are other children on the CHIP case who are not eligible for regular Medical Assistance, the income change is acted on immediately and they are renewed for another certification period, from the 1st of the month following the decrease in income. A task is created to inform the caseworker to re-certify the CHIP and Liability product deliveries for the new period of time and to remove the children who are eligible for and want regular medical assistance, from the benefit group from the last day of the month the decrease in income occurred. This is done manually by the caseworker from the benefit group list page, which in turn triggers a reassessment. Any other children remain on the CHIP Product delivery. When the children are removed, the premium and copayment records should be automatically updated with the new information and the financial component should be updated with the new premium amount (taken from the premium entity). When the certification period is updated for CHIP, the case renewal event should also be updated as this is based on the certification period.

Premium Refunds

When a case is closed during the period of continuous eligibility due to ineligibility or at the time of eligibility renewal, premiums may be refunded after a certain period of time has lapsed (usually 90 days). This can only happen when the premiums were paid in advance by the family and, because the coverage ended prematurely, they ended up paying too much. They are refunded following a change of circumstance resulting in a decrease in premium or immediate case closure.

Modification of the Benefit Group in CHIP

When changes are made to the benefit group in the Children's Health Insurance Program (CHIP), reassessment of CHIP is triggered automatically. The premium and copayment records should be automatically updated with any

new information and the financial component should be updated if there is a new premium amount (taken from the premium entity). When the certification period is updated for CHIP, the case renewal event should also be updated as this is based on the certification period.

1. Adding a household member to the benefit group

   The caseworker can only add household members who currently exist on the integrated case and who were determined eligible for CHIP on the most recent decision for the product delivery. This will be any child who decided not to be covered by CHIP even though eligible originally, any child who was previously ineligible but who is now eligible as a result of a change in circumstance or a child who is a recent addition to the household such as a newborn.

   Once a new member is added to the product delivery, an automatic reassessment of the product delivery is triggered to ensure this person is still eligible. An additional child can be added to CHIP only if it is during an open enrollment period unless the child is a newborn or has just lost coverage to regular medical assistance. This is controlled by the CHIP eligibility rules which have to be run for the 'new' child. If the new child is eligible, the following happens:

   - The child is added to the existing benefit group on today's date and is eligible for the remaining period of certification for the case.
   - The premium amount is determined based on the current premium plan level for the household. While the premium amount may have increased (it costs more for 2 children than for 1 child), the premium level (Plan A, B etc.) remains the same. The premium and co-payment records should be updated with any new information
   - The financial component should be updated with the new premium amount (taken from the premium entity). The next bill is sent in the normal way to the family but it incorporates the new premium.

2. Removing a household member from the member group

   A child can stop CHIP coverage at any stage if desired. When a household member is removed, the member will still receive coverage under CHIP up to and including the last day of the month. A task is created for the caseworker to take the appropriate action. If there was only one child on the case, the case is closed after the last day of coverage. If there are other children on the case, the case remains open and the affected child is removed from the benefit group on the last day of coverage.

   The family may be entitled to a premium refund if they had paid in advance for the 'removed' member. However the refund is only issued when the case is finally closed. A family may also reach their co-payment limit by removing a child. It is up to the family, however, to track their co-payments and notify the department once this happens.

Modification of Household Member Evidence on Integrated Case

1. Adding a member to Integrated Case

   When someone is added to the integrated case, a task is created for the caseworker to check eligibility across all programs. This triggers an automatic assessment across all programs. In the case of CHIP, if it is determined the new household member is part of the income unit and household size, the member is automatically added to the financial group and member group of that product delivery.

   If the new household member is eligible for CHIP (for example, a newborn), a task is created to inform the caseworker to manually add the new household member to the CHIP case if the household member wants CHIP coverage. The new household member is added to the case from today's date, unless a newborn, in which case, the member is added to the benefit group from his or her date of birth. The same procedure as discussed in number 1 above (Modification of the Benefit Group in CHIP) will subsequently take place.

2. Removing a member from Integrated Case

   When a household member is removed from the integrated case, the end date is automatically updated on the case group pages of any active cases on which he or she is a member. Reassessment of any product deliveries the member was part of is automatically triggered.

   If the 'removed' member was part of a CHIP benefit group, he or she remains covered for CHIP up to and including the last day of the month. A task is created for the caseworker to take the appropriate action. If there was only one child on the case, the case is closed after the last day of coverage. If there are other children on the case, the case remains open and the affected child is removed from the benefit group on the last day of coverage.

5.3 Eligibility Renewal

CHIP provides twelve months of continuous coverage to eligible individuals. In order to continue CHIP coverage beyond twelve months, a re-evaluation of the CHIP eligibility rules must be run. If eligibility is re-determined, eligible individuals can continue to receive CHIP for a subsequent twelve-month period without any break in coverage. It is not necessary to be in open enrollment at the time of reassessment. This process is described as eligibility renewal.

The renewal month is the last month an enrollee is eligible to receive CHIP in a twelve-month enrollment period (last month of certification). In the month prior to the renewal month, notification is sent to the enrollee informing him or her that eligibility must be renewed. The notification contains current application details for a household held by the organization for ex-

ample, employer(s), income, household members. The enrollee must review the application information to verify that the information is correct and current. Any changes to the information held must be noted and documented on the renewal notification form. Where applicable, verification of information changes must be provided.

A system task is generated for the caseworker to renew the CHIP product delivery. The renew link on the product delivery home page is only active for a specified time period before and after the renewal month.

5.3.1 Renew CHIP Eligibility

Eligibility renewal is processed similarly to a new application; however, children are only screened for continued CHIP eligibility. During eligibility renewal, only eligibility for CHIP is reassessed. If the household is determined eligible for continued CHIP coverage, the caseworker is prompted to renew eligibility. If a household is determined ineligible for continued CHIP coverage, eligibility for all Medical Assistance programs should be checked. A task is generated for the caseworker to carry out this action.

5.3.2 Renew CHIP Product Delivery

The procedure for renewing a CHIP product delivery is very similar to the create CHIP product delivery in that assistance unit members are selected, premiums and co-payments are determined for selected members and the caseworker confirms the desire to renew the CHIP program(s). The existing CHIP product delivery is re-certified and the following occurs:

- A new certification period is created for the product delivery. The certification period is twelve months beginning on the first day following the end of the current certification period.
- A new premium record is created for the case to store the premium information determined.
- A new copayment record is created for the case to store the co-payment information determined.
- If a product delivery has a related financial liability case, the financial liability product delivery should also be re-certified for twelve months beginning on the first day following the end of the current certification period. A new recurring financial component is generated on the liability product delivery based on the premium details determined.
- The benefit delivery system details are not changed on the product delivery. If a new household member is selected for coverage, this household member inherits the existing benefit delivery system details of the oldest household member on the existing product delivery.

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