Merative Social Program Management 8.1

Cúram Health Care Reform Business Guide

Note

Before using this information and the product it supports, read the information in Notices on page 123

Edition

This edition applies to Merative™ Social Program Management 8.0.0, 8.0.1, 8.0.2, 8.0.3, and 8.1.

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1 Overview of the Income Support for Medical Assistance (Health Care Reform)

An overview of how the solution supports the ACA legislation requirements, with a summary of the ACA legislation as it pertains to the solution.

1.1 Income Support for Medical Assistance (Health Care Reform) summary

A summary of the key solution features and the supported healthcare programs and legislative provisions.

Business Feature Summary

A brief summary of the important business features provided by the Income Support for Medical Assistance (Health Care Reform) (HCR).

- **Citizen Portal**
  Clients can manage their account online, estimate household eligibility, enter applications for a range of insurance affordability programs, view eligibility results, enroll in programs, shop for plans, and view their notifications. They also can enter a change of circumstances, such as a change of address and new household members.
  - The programs include Medicaid, Children's Health Insurance Program (CHIP), Insurance Assistance, and optionally a state basic health program.
  - Using a single entry point and a **Cúram HCR** application script, information capture is limited to information needed for an accurate determination for Modified Adjusted Gross Income (MAGI)-based eligibility, such as applicant, household, and income information.
  - Clients can shop directly for Qualified Health Plans (QHPs) without having to apply for assistance. Individuals are presented with the full range of healthcare programs available. The plan premiums are not adjusted as no financial assistance is available to help with the costs when they purchase insurance.
- **Streamline applications**
  - To ensure a simplified and streamlined application process, only information that is necessary for a determination is collected.
  - Individuals do not need to apply for multiple programs to try to get the best program. Eligibility is determined for all insurance affordability programs.
- **Enrollment periods**
  Enrollment through an exchange is controlled by enrollment periods, annual open enrollment for yearly enrollment, and special enrollment to handle changes that occur to clients. Special enrollment periods ensure that individuals and their families do not wait until they get sick to enroll in coverage, or switch to more comprehensive coverage when in need of an expensive medical procedure.

- **Coordination with the exchange**
  - Through integration with a plan vendor, clients can shop the individual exchange to browse different qualified health plans and enroll in their selected plan.
  - Individuals can use the exchange without seeking financial assistance, although they must be determined eligible to use the exchange.
  - Access to the Federally Facilitated Small Business Health Options Program (FF-SHOP)) - Individuals and households still can apply for assistance and be determined income-ineligible for assistance, but continue to enroll in a QHP if they satisfy the other non-financial criteria. If applicants know that financial assistance is not available, or are willing to look for health coverage without assistance, they can apply to shop directly for QHPs. The system captures non-financial information to purchase QHPs through the exchange.
- **Eligibility rules**
  - Eligibility is based on MAGI income, a simplified income determination in comparison to a traditional Medicaid determination - no resource test, no complex income rules.
  - Calculates advanced premium tax credits and cost-sharing reductions. Also calculates whether an employer-sponsored plan is affordable to the employee.
  - Consistent income rules are used for all programs where MAGI is used to determine eligibility, allowing for a few exceptions for MAGI-based income that is applicable only to Medicaid and CHIP.
  - Rule sets are built by using the Cúram Express Rules (CER) framework.
- **E-verifications**
  Client-attested information is compared to or verified against information about the client that is maintained on other state or federal systems. Electronic verification helps to reduce caseworker workload and speed up eligibility authorizations.
- **Coordination with the federal hub**
  - Information from the federal data hub provides for no-touch eligibility and remote identify proofing and new applications and eligibility determines are received from the hub.
  - Updates to eligibility status that are determined by the Cúram HCR solution are sent to the hub.
  - Periodic polling of external systems and retrieval of the most current client data ensures that Cúram HCR has the most current information available. Caseworkers are kept informed of changes by using the Advisor.
  - Services are available through the hub, which prepopulates information on the application form.
- **Screen for, or apply for, other Human Services Programs**
  HCR integrates with Merative SPM Income Support to allow individuals to screen for or apply for other programs that also might be offered by the agency. Other programs include Cash Assistance, Food Assistance, and traditional Medical assistance.
- **Role-based workspace**
  HCR caters for a number of different user roles that include individuals and employees, navigators who assist a client with an application and caseworkers who process and manage client cases.
- **Supports the three state marketplace models**
  States can choose to operate their own State-based Marketplace (SBM) or a State Partnership Marketplace, in partnership with the Federal Marketplace. A Partnership Marketplace allows states to make key decisions and tailor their marketplaces to local needs and market conditions. The federal government is operating the marketplace in those states that did not establish their own. Such states are called Federally Facilitated Marketplace states (or FFM

states), which is used by clients to apply for assistance through an SBM, FFM, and working in partnership with the Federal Marketplace.

- **Reasonable opportunity period**
  Clients with information that is yet to be verified can receive their benefits for a limited period. This flexibility is supported through eligibility rules, verification configurations, and communications to clients.
- **Annual Renewals**
  Support is provided to allow clients to renew QHPs annually. Annual renewals for QHPs are at the same time each year for all clients. Medicaid and CHIP renewals through the year also are available. During the annual renewal process, Cúram checks federally mandated information by querying external systems and new coverage is created for the following year when applicable.
- **Exemptions**
  Individuals might choose to request an exemption from having health insurance. For example, the individual might have a qualifying religious exemption.

Streamlined Application Process

Merative SPM Income Support for Medical Assistance streamlines the application process by presenting the individual with a single application script for the insurance affordability programs. This makes the process of applying for assistance shorter than would traditionally be the case when screening a client for multiple assistance programs.

Using a single application script and entry point, citizens can be considered for a number of different programs for which they and their households may be potentially eligible.

The Merative SPM Income Support for Medical Assistance application script collects only the information that is necessary to make a determination for insurance affordability. The online application is defined with a Cúram Intelligent Evidence Gathering (IEG) script that guides the citizen through a series of steps that collect the appropriate information for the programs for which the citizen is applying. IEG permits administrators to create and maintain flexible, question-and-answer based scripts to gather information. The Cúram Rules Engine is also used to control the presentation and ordering of questions, and the navigation of question scripts. Screens are dynamically rendered at runtime based on the question scripts defined using the IEG Editor. Question pages are displayed to the individual based on defined preconditions and are dynamically presented based on the answers supplied. The Merative SPM Income Support for Medical Assistance application script is designed to be as simplified and streamlined as possible. There are no resource tests or complex income calculations necessary. A simplified MAGI approach is used to determine a household's income. This is different from the traditional Medicaid application, for which extensive information is captured for household, income, resources, and expenses. Household eligibility is determined for the insurance affordability offerings by using basic information that is supplied by the individual about themselves, their household, and their household income.

Information that is entered by the individual and captured in the application is considered client-attested information, which can be compared to information recorded for the client on other trusted external systems through the federal data hub. The use of technology and electronic validation (or 'e-verification') of identity, household, insurance and financial information from other sources greatly increases the accuracy of the eligibility determination, thus speeding up the decision process for citizen and case worker alike. E-verification negates the need for clients to provide supporting documentation for their application.

'Reasonable compatibility' between information entered on an application and information retrieved from the federal hub provides greater flexibility, allowing the agency to define what constitutes verification. Reasonable compatibility ensures that there does not need to be an exact match for a state to accept data as verified. For example, a client address that differs from the address held on another system can be marked as reasonably compatible, and therefore verified, by a state if both addresses are within the exchange service area. If the income available for a client from trusted data sources determines the client to be eligible for Medicaid but the client attests to a different income amount on the application which also determines the client eligible for Medicaid then this information is considered reasonably compatible and requires no supporting documentation to be provided by the client for verification. This moves towards real-time or near real-time determinations for individuals applying online whose eligibility can be verified, or considered reasonably compatible online.

Any outstanding verifications that could not be electronically verified are collected into a list and presented to the citizen before displaying the application results. These discrepancies are represented to a case worker as 'outstanding verifications' against a piece of evidence attested by the applicant or when such evidences are missing as 'Advisor Issues'. However; presenting the details to the citizen as part of the online application makes them aware of the items that are delaying a complete determination. Any result presented is provisional, dependent upon the client providing supporting documentation to a case worker. As a follow-up action on receiving the supporting documentation a case worker could mark the outstanding verifications as 'Verified', close an Advisor Issue manually by providing appropriate reasons or modify the client attested data to reflect the information available through the trusted data sources to resolve the inconsistency. The provisional determination might permit issuance of benefits depending on the program and the reasonable opportunity period associated with that program.

Eligibility Results

Following completion of the application process, Merative ™ SPM Universal Access is used to provide an eligibility results page for the range of HCR programs that a citizen and household can enroll in. The results of the eligibility determinations are prominently displayed.

The starting point for the integration is in the calculation of the maximum tax credit available to a citizen/family that is necessary in determination for Insurance Assistance. The tax credit calculation requires the appropriate cost to use for the benchmark plan for this coverage family to be known. To do that, the system passes high-level information about the people in the coverage family, their ages and where they live into a web service to be provided by the plan management vendor. In case the enrollment is being assisted by a Navigator, the assister information is also passed on to the plan management system. This returns a monthly premium for the benchmark plan (the second-lowest cost silver plan available in the exchange) along with the cost of essential health benefit as an amount as well as a percentage of the benchmark plan premium. If there is no plan management system in place, default values of $150 per adult and $75 per child are used in the calculation of the benchmark plan.

After eligibility and entitlement are determined, citizens can enroll in different types of plans depending on their eligibility. Enrollment options such as the enrollment group household members and the primary member of the insurance plan are captured before passing the information to the plan management system.

An iFrame is used to display the plan management pages. To load the plan management pages, an enrollmentID is passed through the plan management URL, which the plan management system then uses to call a web service that returns information on each of the people involved in the

enrollment and the assistance they are eligible for, for example, to return the maximum tax credit available the household.

Following completion of enrollment in a plan, the plan management system redirects the iFrame to a URL that is provided by Social Program Management that returns the individual to the results page, which is updated based on the enrollment details. To get these enrollment details, a web service provided by the plan management system is called by using the enrollmentID. Plan enrollment details are then returned, for example, the plan name, premium, tax credit used, or deductible associated with the plan.

ACA Healthcare Programs and Other Provisions

Under the ACA, individuals and their households who can afford it are required to obtain health insurance coverage. Eligibility for financial assistance with this coverage is determined by comparing the household's income to the Federal Poverty Limit (FPL) for that household size.

ACA Healthcare Programs

The ACA addresses four programs: Medicaid, CHIP, State Basic Health Plan, and Insurance Assistance.

- **Medicaid**
  Households whose income is less than 133% of the FPL are eligible for Medicaid, a state-administered healthcare program that normally provides free coverage to low-income families for essential health services. As part of the ACA legislation a streamlined Medicaid (or MAGI Medicaid) program is available, which allows states to determine eligibility and categorize people within those households so that different services can be made available to different members of a family unit. The categories of people that are supported under the ACA include parents and caretakers, children, pregnant women, individuals formerly in receipt of foster care, and adults who do not satisfy the eligibility criteria for other coverage categories. Streamlined Medicaid does not include traditional Medicaid based on disability or age (over 65) and limited other programs.
- **CHIP**
  The Children's Health Insurance Program (CHIP) was streamlined as part of the ACA legislation. CHIP applies to the children of households whose income is too high for the whole family to receive Medicaid, but is still less than 200% of the FPL. A common scenario is when household income is just below 200% FPL, which results in adult members in the household receiving Insurance Assistance and the children being eligible for CHIP.
- **State Basic Health Program**
  States can optionally extend the range of the coverage they provide for families with income of up to 200% of the FPL with a state basic plan under the State Basic Health Program, which provides basic health insurance to families where the insurance plan is chosen and paid for by the state. If states choose not to provide a basic plan, then the upper limit for Medicaid stays at 133% and all adult members in the household between there and 400% are eligible for Insurance Assistance; the amount of assistance that is offered by the government decreases as the household income increases to 400% limit.
- **Insurance Assistance**
  Citizens and households whose income is above the level at which they can get state-sponsored healthcare but below 400% of the FPL are still entitled to financial assistance from the federal government that they can use to offset the cost of private insurance. This 'Insurance Assistance' is issued in the form of advanced premium tax credits or cost-sharing reductions.

Advanced premium tax credits are tax credits that allow a household to reduce their tax bill to offset the monthly cost of an insurance plan. Since tax returns are filed annually, this corresponds to an annual amount and is formally calculated at the time a tax return is filed. Tax credits are calculated on a sliding scale based on income as a percentage of the FPL. For example, someone with an income equivalent to 300% of the FPL gets a lower tax credit than someone with an income of within 200% of the FPL.

Other Provisions

- **Shop Only**
  Citizens and households whose income is above 400% of the FPL are not entitled to any financial assistance from either the federal or state government, but must still comply with the individual mandate to purchase private health insurance in the form of Qualified Health Plans (QHPs). These individuals and households can still apply for assistance and be determined income-ineligible for assistance, but continue to enroll in a QHP if satisfying the other non-financial criteria. Or if safe in the knowledge that financial assistance is not available, or happy to look for health coverage without assistance, they can apply to shop directly for QHPs.
- **Employer Sponsored Plans**
  Employers have an obligation towards their employees to offer assistance with their insurance costs. Like the individual exchange, the SHOP exchange is a competitive marketplace where individuals that are employed by small businesses can buy QHP coverage, which is subsidized by their employer. The premium that an employee must pay for the cheapest plan that is offered by their employer after the contribution is taken away must not exceed 9.5% of the employee's income. If the premium does not exceed this amount, then this coverage is considered affordable and the employee can avail of this employer-sponsored coverage. Additionally, employees can look to their options in the individual exchange; eligibility for employer-sponsored coverage does affect a citizen's eligibility for Insurance Assistance. However, the employee is not precluded from being determined eligible for Medicaid, and that might be a more beneficial coverage option for the employee. If the premium does exceed 9.5% of the employee’s income, the employee is entitled to waive their employer-sponsored coverage and apply for assistance in purchasing insurance coverage. This includes insurance assistance in the form of advanced premium tax credits and cost-sharing reductions.
- **Exemptions**
  Individuals can choose to request an exemption from the individual responsibility requirement in a limited number of circumstances as defined in the ACA, for example, if the individual has a qualifying religious exemption, is a member of a health-sharing ministry, is incarcerated, or is not lawfully present in the United States.

Plan Selection and Enrollment

Merative SPM Income Support for Medical Assistance provides a plan management integration contract allowing individuals to shop for and enroll in Medicaid, CHIP, and Qualified Health Plans as part of the application process through integration with a plan management vendor of the customer's choice.

The starting point for the integration is in the calculation of the maximum tax credit available to a citizen/family that is necessary in determination for Insurance Assistance. The tax credit calculation requires the appropriate cost to use for the benchmark plan for this coverage family to be known. To do that, the system passes high-level information about the people in the coverage family, their ages and where they live into a web service to be provided by the plan management

vendor. In case the enrollment is being assisted by a Navigator, the assister information is also passed on to the plan management system. This returns a monthly premium for the benchmark plan (the second-lowest cost silver plan available in the exchange) along with the cost of essential health benefit as an amount as well as a percentage of the benchmark plan premium. If there is no plan management system in place, default values of $150 per adult and $75 per child are used in the calculation of the benchmark plan.

After eligibility and entitlement are determined, citizens can enroll in different types of plans depending on their eligibility. Enrollment options such as the enrollment group household members and the primary member of the insurance plan are captured before passing the information to the plan management system.

An iFrame is used to display the plan management pages. To load the plan management pages, an enrollmentID is passed through the plan management URL, which the plan management system then uses to call a web service that returns information on each of the people involved in the enrollment and the assistance they are eligible for, for example, to return the maximum tax credit available the household.

The plan selection process differs depending on the programs that the individual and their household has been found eligible for. Medicaid generally has no monthly costs associated with it and as a result there is no need to capture payment details. There might also be no need to select from many plans if the State limits the plans available through Medicaid. In this way, the enrollment process is simplified. CHIP plans do have a monthly cost associated with them. A citizen seeking CHIP coverage must consider the monthly premium for coverage and the annual co-payment limit when choosing a plan. As such, CHIP enrollment requires additional information including payment details to be captured. Insurance Assistance plans also have premiums that must be paid so that household members can be covered and cost-sharing reductions that affect the annual costs a citizen might be expected to pay. The QHP premium for plans selected is also adjusted for essential health benefits/additional benefits. Payment details are captured during Insurance Assistance plan enrollment, and this is further complicated by the premium credits - as they are issued in advance, applicants can decide to forego the entire amount of tax credit and use only a portion of this in helping pay plan premiums. Upon completing enrollment, Social Program Management maintains the household contribution, ensuring the QHP premium is covered (by a combination of tax credits and household contribution). Any subsequent household enrollments can use an adjusted APTC amount; ensuring they can never use more than they have been determined eligible for. If a household has multiple enrollments, and does not use all of their maximum APTC; they can revisit an enrollment and update the amount they have apportioned to ensure they use all of their APTC. Alternatively they can continue without using all of their credit. This is a likely scenario when the individual knows that the financial situation is likely to change. An increase in household income results in a lower actual tax credit being issued, and if they use a higher change amount, then they are obliged to pay back the excess as part of reconciliation.

Following completion of enrollment in a plan, the plan management system redirects the iFrame to a URL provided by Social Program Management that returns the individual to the results page, which is updated based on the enrollment details. To get these enrollment details, a web service provided by the plan management system is called by using the enrollmentID. Plan enrollment details are then returned, for example, the plan name, premium, tax credit used, or deductible associated with the plan.

Application Submission

An application can be submitted through a number of channels. Applications are submitted when the plan selection and enrollment process is completed in the plan management system. Alternatively, submission also occurs when the individual chooses to submit the application from the Merative ™ SPM Income Support for Medical Assistance (Health Care Reform) Eligibility Results page. A caseworker can complete and submit an application on behalf of a client.

In each of these circumstances, the submitted application is processed in the same manner, starting the Intake process so that an application case is created to represent the point-in-time application, and handle the ongoing interactions between the applicant and the agency, through integrated cases and product delivery cases.

Small Employer Exchange

Employers enter summary details of the employees on the exchange in the form or a roster of qualified employees. Employers choose the plans made available to employees and the contribution that they will make towards coverage. Employees can then select the plans offered to satisfy the individual mandate for minimum essential coverage through employer-sponsored insurance.

Shop Only

Citizens can shop directly for QHPs without having to apply for assistance. When shopping directly for a QHP, individuals are presented with the full range of healthcare programs available; plan premiums are not adjusted as no financial assistance is available to help with the costs when they purchase insurance.

However, citizens must still be determined eligible to purchase QHPs through the Exchange. A subset of the information that is needed for the assistance application process is captured and used in this determination.

Rules determine whether the program is affordable to the client. If it is not, rules calculate advanced premium tax credits and cost-sharing reductions.

1.2 Affordable Care Act legislation summary

In March 2010 the Patient Protection and Affordable Care Act (PPACA or ACA for short) was passed by Congress and signed into United States law by President Obama. The law aims to ensure that affordable healthcare is available to all US citizens through a number of shared responsibility measures that are targeted at states, employers, insurance carriers, and citizens themselves.

The individual shared responsibility provision expects all citizens to have essential healthcare coverage (known as minimum essential coverage) for each month, or qualify for an exemption, or face a financial penalty. Minimum essential coverage includes government-sponsored plans like Medicaid, employer-sponsored plans, or plans in the private insurance market with or without assistance.

The individual responsibility requirement applies to individuals of all ages, including children. To help achieve this goal, the law includes the following items:

- Expanding Medicaid eligibility to cover households whose income is up to 133% of the Federal Poverty Limit (FPL)
- An optional state basic health program that can be used to cover households whose income is up to 200% of the FPL
- Financial assistance to households whose income is up to 400% of the FPL and who need to purchase private health insurance
- Regulations for employers as to the contributions they must make towards health insurance for their employees

Considerable flexibility is afforded to states to define the income levels that are used in determining eligibility.

The federal government specifies deadlines to ensure that they are satisfied in a timely and consistent manner. The open enrollment period can vary from year to year. Therefore, states must provide clients with access to each of the previous options through a Health Insurance Exchange. The Health Insurance Exchange is an online marketplace that allows citizens to see options from insurance carriers to make an informed choice on healthcare coverage.

FFM Assessment versus Determination

States with a Federally-facilitated Marketplace can elect to have the FFM make assessments of Medicaid/CHIP eligibility, transferring the account to the Medicaid or CHIP agency for a final determination. These are called FFM Assessment States. The other model is where the eligibility determination made by the FFM is accepted by the state Medicaid agency. These are called FFM Determination States.

For states who have chosen the Federally Facilitated Model or to work in partnership with the Federal Market Place. the Account Transfer interface is key to the user experience.

The Health Insurance Exchange

The ACA mandates that States have an obligation to provide citizens with access to affordable health insurance that offers minimum essential coverage. This obligation is met by the Health Insurance Exchange (or Exchange for short), an online marketplace for insurance plans offered by insurance carriers.

Once a household is determined eligible for assistance within the range of insurance affordability programs, or when not eligible for assistance but still eligible to use the Exchange, then citizens can search for and compare different Qualified Health Plans (QHPs). QHPs are plans that are offered by healthcare providers through the Exchange.

These QHPs are certified by the Department of Insurance and rated based on the actuarial value of the plan (bronze = 60%; silver = 70%; gold = 80%; platinum= 90%). This actuarial value promotes plan competition that is based on a number of cost-sharing factors: premiums, quality, provider network, and customer service. Better coverage is typically available in a platinum-level plan. However, this is also reflected in the premium that is associated with that coverage. Plans offered by different carriers with similar cost-sharing designs have the same actuarial value, allowing citizens to choose among plans of comparable levels of coverage.

The Exchange creates an organized and competitive market, and promotes easy comparison of available plan options that are based on price, benefits, and quality. A citizen looking for healthcare coverage can obtain comprehensive information on the coverage options currently available and make informed health insurance choices. Equality and consistency are ensured by establishing common rules on the offering and pricing of insurance Information is made readily available to help consumers better understand the options available to them.

The Exchange is also responsible for filtering plans on the citizen's eligibility and adjusting the different cost factors of plans according to their entitlement.

For example, Insurance Assistance offers financial assistance to citizens in the form of advanced premium tax credits and cost-sharing reductions. Since cost-sharing reductions are only allowed to be used on silver plans, this fact is reflected in the list of plans that are shown to any citizen eligible for a cost-sharing reduction. Equally, all plan premiums should be adjusted based on the premium tax credit that is available to a citizen or family.

Citizens can shop directly for QHPs without having to apply for assistance. When shopping directly for a QHP, individuals are presented with the full range of healthcare programs available; plan premiums are not adjusted as there is no financial assistance available to help with the costs when they purchase insurance. However, citizens must still be determined eligible to purchase QHPs through the Exchange. A subset of the information that is needed for the assistance application process is captured and used in this determination.

Small Employer Exchange

The ACA also attempts to make healthcare more affordable to citizens by ensuring employers provide contributions towards healthcare for their employees.

Since large employers typically already have agreements in place with insurance carriers, the focus for employer-sponsored insurance (ESI) is on small employers. States are required to provide a small employer exchange as well as the individual exchange. Both exchanges operate in much the same way. The only real differences are the range of plans available to employees, and the assistance they get in paying for the plan premiums.

The law provides tests to ensure compliance - an affordability check verifies that employers are fulfilling their obligation to provide affordable healthcare to their employees and that employees are not having to pay excessive premiums as a result. If the employer-sponsored coverage is considered affordable after considering the financial situation of the employee, then the employee can avail of this ESI. If not affordable, then the employee is entitled to waive their ESI and apply for assistance in purchasing insurance through the individual exchange instead. The employer is subject to a penalty as they have not provided affordable coverage.

Enrollment Periods

Enrollment through an exchange is controlled by enrollment periods; annual open enrollment to permit yearly enrollment as the name suggests, and special enrollment to handle changes that occur to citizens. Annual enrollment periods ensure that individuals and their families do not wait until they get sick to enroll in coverage, or switch to more comprehensive coverage when in need of an expensive medical procedure.

Before annual open enrollment, exchanges must provide a written annual open enrollment notification to each enrollee. Legislation defines this notification must be issued in advance of any period, in the month of September. This notice allows plan carriers to adjust the plans that

they want to make available on the exchange, and gives sufficient notice to enrollees to address their options for the upcoming coverage year.

Clients can enroll on a plan during the open enrollment period and during special enrollments. The dates prescribed are flexible, states may implement coverage dates earlier than those specified if they can prove to HHS that all of the carriers participating in their exchange agree to the shorter time frames.

During the annual open enrollment period, individuals and families that are already enrolled on a QHP can revisit the exchange, redetermine their eligibility and entitlement for the different insurance affordability programs, view details of all the plans available to them in the exchange and change coverage from their existing plan to a new one if they so choose.

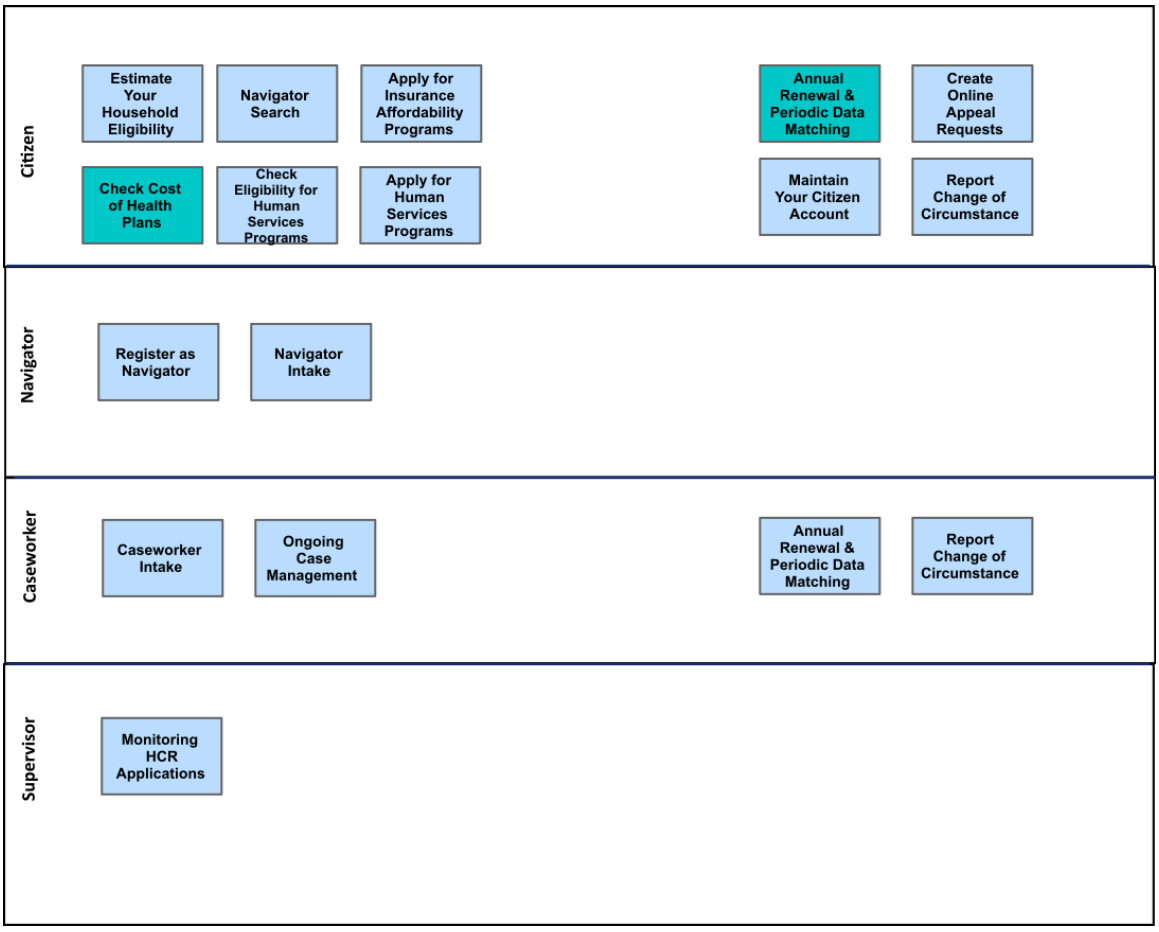
Any plan selections that are made during the open enrollment period take effect on January 1 of the following year. Enrollees can change their plan as often as they like within the open enrollment period. That selection is considered 'final' when the open enrollment period elapses. If a person chooses not to change their plan during an open enrollment period, then the coverage automatically carries over for another year on their existing plan.

Enrollees who qualify for a special enrollment period are allowed to change plans at any time during their coverage year, as long as they select a new plan within 60 days of the event that triggered qualification. In general, if a client selects a new plan between the 1st and 15th day of any month in a special enrollment period, the effective date of coverage of the plan must be the first day of the first following month. If they select a plan between the 16th and the last day of a month, the effective date of coverage must be the first day of the second following month. There are exceptions to this rule, for example, in the case of birth or adoption the exchange must ensure that coverage is effective on the date of birth or date of adoption.

2 Key business flows of the Income Support for Medical Assistance (Health Care Reform)

Key business flow diagrams and detailed business flow descriptions help you to understand the solution functions and features in context. Summaries of the most important configuration and customization options can help you to focus your efforts during a fit gap analysis. These summaries do not cover all configuration and customization options, always refer to the developer documentation for full details.

This swimlane diagram shows the key business flows organized by role. Click a business flow for a detailed business flow description.



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Note: **Check Cost of Health Plans** or **Annual Renewal and Periodic Data Matching** might not be relevant for States who have chosen the Federally Facilitated Model or to work in partnership with the Federal Market Place.

2.1 Estimate Your Household Eligibility

You can choose an option on the home page to run a simplified calculator that provides a simple screening for MAGI-based or insurance affordability programs You need only the number of adults and children in the household and the household income details.

The system runs rules to indicate whether the household potentially qualifies for the insurance affordability programs and an estimate of their eligibility for Medicaid, if any.

What can I configure or customize?

The **Merative SPM Income Support for Medical Assistance** home page provides the organization with a number of options that can be configured, including the calculator. Because eligibility requirements can vary by state, the organization might need to customize the screening rules. The organization can customize the CER rule set to meet the project requirements.

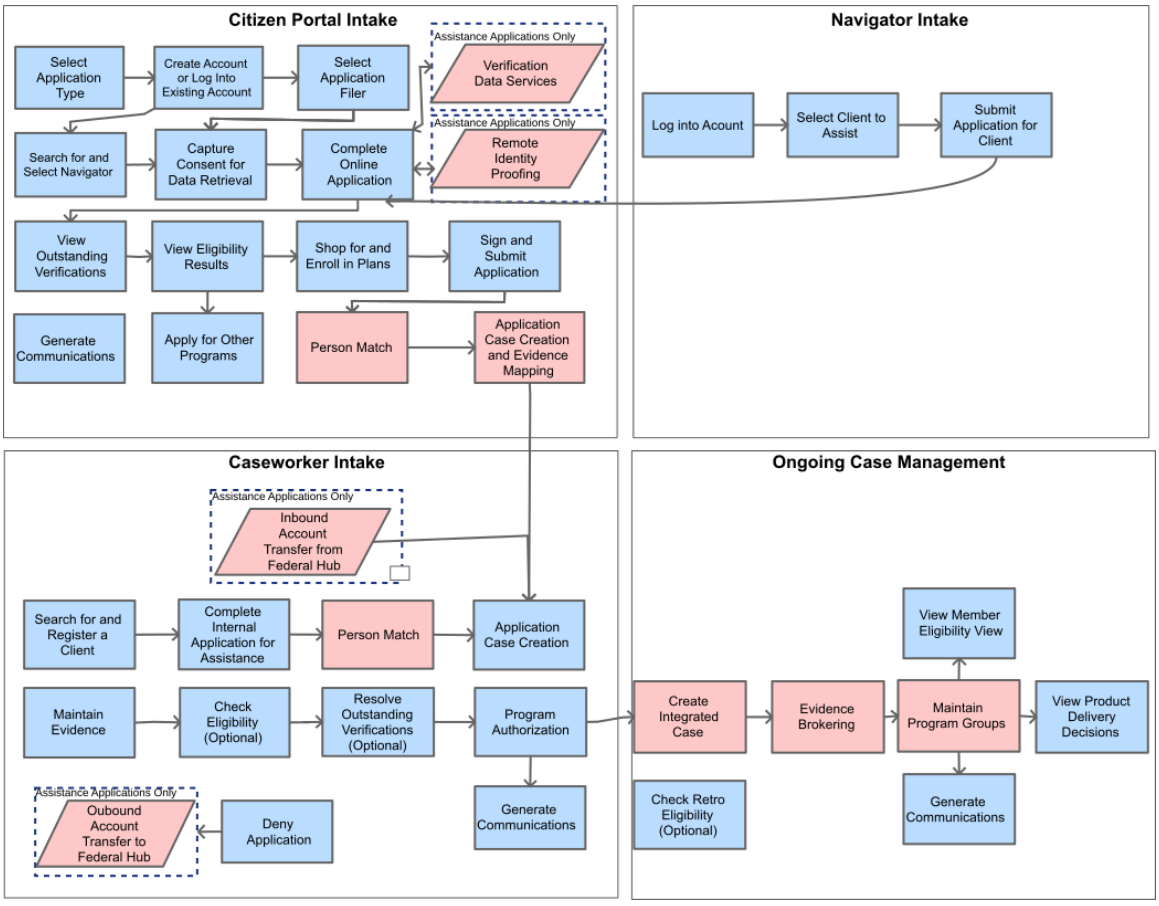
2.2 Apply for Insurance Affordability Programs

Clients can apply for insurance affordability programs directly online, with the assistance of a navigator, or through a caseworker. Submitted applications pass through the ongoing case

management business flow and result in product delivery cases for the insurance affordability programs.

When a client applies online, the Citizen Portal Intake business flow starts. When a navigator registers and applies on behalf of a client, the Navigator Intake business flow starts. When a client applies through a caseworker, the Caseworker Intake business flow starts. Each of the intake business flows results in an application case. Applications cases are authorized to create product delivery cases.

When the application case is created, a PDF document is created. The PDF document contains the information that either the client or the caseworker entered in the application form. The PDF document is stored as an attachment on the application case. For information about how to customize the PDF document, see the *Customizing the generic PDF for processed applications* related link.



1. Select Application Type on page 28

2. Create an Account or Log into an Existing Account on page 31
3. Select Application Filer on page 32
4. Verification Data Services on page 38
5. Search for and Select a Navigator on page 32
6. Capture Consent for Data Retrieval on page 33
7. Complete an Online Application on page 33
8. Remote Identity Proofing on page 37
9. View Outstanding Verifications on page 39
10. View Eligibility Results on page 39
11. Shop for and Enroll in Plans on page 41
12. Sign and Submit Application on page 43
13. Generate Communications on page 45
14. Apply for Other Programs on page 40
15. Person Match on page 44
16. Application Case Creation and Evidence Mapping on page 44
17. Log in to Account on page 48
18. Select Client to Assist on page 48
19. Submit Application for Client on page 48
20. Inbound Account Transfer from Federal Hub on page 50
21. Search For and Register an Individual on page 48
22. Complete Internal Application for Assistance on page 49
23. Person Match on page 44
24. Insurance Affordability Application Case Creation on page 52
25. Maintain Evidence on page 53
26. Check Eligibility on page 53
27. Resolve Outstanding Verifications on page 99
28. Program Authorization on page 54
29. Outbound Account Transfer to Federal Hub on page 57
30. Deny Application on page 57
31. Generate Communications on page 56
32. Viewing Eligibility on page 64
33. **Create Integrated Case** on page 58
34. Evidence Brokering on page 59
35. Run Program Group Logic and Activate Product Delivery Cases on page 61
36. Viewing Product Delivery Decisions on page 65
37. Check Retroactive Eligibility on page 67
38. Generate Communications on page 56

Citizen Account Home Page

The **Citizen Account** home page provides a central location for the client to create a user account, view or update their information, submit applications for insurance affordability programs, and track ongoing applications. When the client logs in, the page displays their options plus the messages and campaign information and Merative SPM Income Support for Medical Assistance (HCR)-specific links.

These links represent the same options that are available from the solution's landing page, where appropriate. The client can access the **Citizen Account** home page only if the client is authenticated by the organization. The client also needs to have a linked account (the client must be registered as a participant and be linked to their Citizen Self-Service Account).

The home page itself has three main sections: **Messages**, **Outreach**, and the **left navigation** pane.

- **Messages** pane - The messages section displays messages that aim to predict why the client is logged in. For example, the Cúram HCR **Citizen Account** home page displays a Health Care Application acknowledgment message that the organization received the client's healthcare application for Insurance Affordability. The message indicates the status of the application along with the application reference number.
- **Outreach** pane – Outreach allows agencies to define targeted campaigns, which can be displayed in the client account. The campaigns are based on information that the agency knows about the client. In addition to the option to view the status of any enrollments, when a client logs in to their Citizen Account, the **Outreach** pane presents details about the next open enrollment period. This feature uses the campaign functions available in Universal Access (UA). The client's account displays dynamic information about open enrollment periods. An entry is made to the **campaign bar** on the right side of the account home page 30 days before the start of an enrollment period. This marker counts down towards the start of the period. After that period starts, messages are displayed stating how long the individual must apply before end of the enrollment period. It is hoped that this message gives the client prior warning of when enrollment is expected, and after it is open, the time limit to enroll in a plan.
- **Left navigation** - From the left navigation pane of the **Citizen Account** home page, the client can view their activities, enrollments, applications, screenings, navigator information, contact information, caseworker contact information, updates, and appeals. More information for each of these items is provided in the information that follows:

Clients or their authorized representatives can see the status of any applications, resume or delete these applications, or continue to enrollment.

Applications for both traditional Medicaid and Modified Adjusted Gross Income (MAGI) Medicaid (as part of an Insurance Affordability application) are available. When enrollment is complete, they can be viewed in the account.

What can I configure or customize?

Cúram HCR implemented a custom version of the **Universal Access Client Account** home page. The **Citizen Account** home page is extended with an extra pane to contain solution-specific links. Support is provided to configure many aspects of the **Citizen Account** home page, which includes the following information:

- The text displayed in the participant messages in the **Messages** pane.
- System messages displayed in the **Messages** pane.
- The display order of the messages displayed in the **Messages** pane.
- The campaigns displayed in the **Outreach** pane.
- The welcome message displayed to a client.

The Citizen Account also provides a framework for organizations to build their own client account pages or to override the existing pages.

Citizen Portal Intake

From the client-facing application, you can create a user account, view or update their information, submit applications for insurance affordability programs, and track submitted applications without having to follow up with multiple agencies and departments.

By default, only the English language is supported in the Merative SPM Income Support for Medical Assistance (HCR) **Citizen Portal**. It is possible for the organization to add the content for other languages to the **Citizen Portal**.

Select Application Type

The first step in the Apply for Assistance business flow is to apply for a type of assistance from the Merative ™ **Health Care Reform** (HCR) solution home page. The home page provides the client with a number of application options:

- Apply for assistance with healthcare
- Apply to purchase healthcare without assistance
- Apply for an exemption from the individual responsibility requirement
- Apply for employer-sponsored coverage

All four of these application types follow the application end-to-end business flow with some exceptions that are noted in the application sections that follow.

The home page is a custom Merative ™ SPM Universal Access home page that is tailored to meet the needs of the Cúram HCR solution. From the home page, you can log in to your account, view informational links, and undertake a number of business processes, such as Apply for assistance with health care.

These business processes are implemented by using motivations. Merative™ Social Program Management uses motivations to allow the user to undertake an action from the home page. A motivation allows a customer to define their own processes and make them easily available from the **Citizen Account**.

What can I configure or customize?

The organization can customize the home page, including the motivations, to meet the project requirements. Each motivation that is displayed on the solution home page is configured in the **Universal Access** section of the Social Program Management Administration application. Each motivation is associated with an Intelligent evidence gathering (IEG) script, a data store schema, and a display rule set.

Related concepts

Apply for Assistance with health care

The Merative SPM Income Support for Medical Assistance application for assistance is a means for a prospective client to apply for assistance and have their eligibility determined across multiple insurance affordability programs in a clear and straightforward manner, capturing and using only the information that is necessary for that determination.

The application script is as simplified and streamlined as possible so that only questions that are relevant to a household's circumstances are displayed. Certain questions must be asked of all applicants. The application flows through the following sections: applicant details, household details, income information for the individuals in the household, program-specific questions, and finally general questions that are asked of all applicants. Section introduction pages provide

applicants with an explanation and details of the information they may need to provide. Section summary pages ensure that all information captured is displayed, also allowing applicants an opportunity to revisit and edit information previously entered. There is also an overall summary for the application script which applicants can use at the end. The application process is dynamic. Questions that are not relevant to the current application about the person and household are not displayed. This filtering ensures that applicants can complete the process as quickly as possible, and will not be presented with questions about information that does not affect their eligibility. For example, male household members are not asked pregnancy-related questions. This is of benefit to an applicant when they can avoid a series of questions, for example, a household member aged 26 and over will not be presented with questions that are necessary to determine eligibility for Medicaid under the former foster care category, because individuals aged 26 and beyond are ineligible for this category of Medicaid. Before beginning the application proper, a consent page is displayed so that applicants can agree to allow their information to be used to retrieve other details from government agencies like the Department of Homeland Security or the Inland Revenue Service. If consent is given, personal information like the citizen's social security number can be used to look up other systems and verify their identity, citizenship and other relevant details. If consent is not granted by the citizen, then any information they enter on an application is still subject to verification by a case worker before eligibility can be determined.

Apply to Purchase Healthcare Without Assistance

Clients can apply to purchase healthcare for themselves and their families without seeking financial assistance. As with other application processes, a citizen account is required in order to purchase healthcare plans directly.

When the user is logged in, an application script captures the necessary information, which is a subset of the information that is required when applying for assistance. To be eligible to purchase a health plan in the exchange, individuals must meet certain non-financial requirements. The applicant and members of their household applying must satisfy state residency, citizenship/ lawful presence requirements and not be incarcerated.

Eligibility is determined for each household member results displayed by using the same Cúram Health Care Reform eligibility results page that is used in the application for assistance. A successful determination allows the applicant to continue to shop for plans in the exchange.

Plan selection, shopping, and enrollment follow the same process in the plan management system to that for a citizen selecting having applied and been found eligible for assistance. Summary demographic and eligibility information is passed to the plan management vendor and is used in plan selection and enrollment. The key difference in this flow is that there is no associated tax credit or cost-sharing reduction information. As a result, the plan management system does not need to adjust any monthly premiums, or ask questions that are related to how much of the tax credit is to be used. Upon completion, enrollment summary information is returned to Cúram and displayed on the solution’s eligibility results page.

Alignment with the application for assistance ensures that ongoing case management is identical. The intake process can begin upon completion of enrollment.

Apply for an Exemption from the Individual Responsibility Requirement

The individual shared responsibility provision calls for each individual to have minimum essential coverage for each month, or qualify for an exemption. A number of exemptions are called out in HCR legislation that is available in the exchange, or can be claimed as part of filing a tax return, or are available in both.

- The religious conscience exemption and the hardship exemption are available only by going to the exchange and applying for an exemption.

- Exemptions for members of Indian tribes, members of healthcare sharing ministries, and incarcerated individuals can be applied for through the exchange OR while filing an annual tax return.
- Exemptions for unaffordable coverage, short coverage gaps, and individuals who are not lawfully present in the US can only be claimed as part of filing a tax return. The exemption for individuals who are under the tax filing threshold is available automatically. No action is required.

The exemptions that are supported by the Merative SPM Income Support for Medical Assistance solution are the ones that can be applied for only through the exchange and the ones that can be applied for either through the exchange or by filing a tax return. The following exemption categories can be applied for:

- Incarcerated Individuals
- Religious Conscience
- Membership in a health sharing ministry
- Membership in a federally recognized Indian tribe

Exemptions are applied for in a similar manner to other application processes. A user account is required to submit an exemption application. Applicants can apply for exemptions under more than one exemption category. Additional information for each exemption category being requested is captured during the application. This ensures that an applicant is only presented with questions that are relevant to the exemption for which they are applying, for example, an exemption due to religious conscience asks only for the religious sect or division which the member is part of, and the date on which membership commenced. Once the application script is completed, rules are run to determine whether the applicants are likely to be eligible for the requested exemptions and the results are displayed on the solution’s eligibility results page.

Unlike the other application processes, there is no plan selection or enrollment. The eligibility result can be processed by submitting the application. This calls the Intake process so that cases can be created to manage the exemption in the same way as it handles any other application submission.

Apply for Employer Sponsored Coverage

A further application process supports employees whose employers are on the Small Employer Exchange (or SHOP), where employees are using the exchange to access to employer-sponsored coverage.

As with the application processes for the individual exchange, the user is required to have an account before starting an application. The employee must either create a new account or log in to an existing one. Having done so, they are taken to the application script, which captures information about the employee and also the members of their household if they are to be considered for enrollment on the employer-sponsored coverage as well.

The application consists of the following sections:

- A section that identifies if the person is applying for just themselves or themselves and their family
- A section covering other family members
- A section to gather information about the employee
- An optional section about the other members of their household

Upon completion of the application, the employee's details, including their SSN, are sent to the plan management system to determine whether this person has been entered on a roster of

qualified employees for any employers in the SHOP and whether the open enrollment period for any of those employers is active. If active, then summary information about the options available to the employee in the SHOP is presented on the Merative SPM Income Support for Medical Assistance eligibility results page. If the employee is eligible, they can continue to enroll on the plan that is subsidized by their employer. Otherwise, they are informed that they cannot be found in the roster of qualified employees for employers in the SHOP. If found on the roster and the enrollment period is not active, this too is communicated to the employee. As well as the determination for employer-sponsored coverage, employees are also presented with the option to apply for assistance in the individual exchange, as they might be eligible for a program within the insurance affordability programs.

The employee affordability check is done as part of the individual application flow. If employer-sponsored coverage is not considered affordable, then the employee might be entitled to advanced premium tax credits and cost-sharing reductions they would otherwise be ineligible for. The information that is necessary for this affordability determination is about the employee, the household, and those with income in that household. Many of the same questions are asked as part of the individual application process. The affordability check is necessary in the individual application because it is a prerequisite for an eligibility determination for Insurance Assistance. If a person is eligible for employer sponsored insurance that is unaffordable, then they can proceed to check their eligibility for Insurance Assistance. If eligible for employer sponsored insurance that is affordable, then the employee cannot be determined eligible for Insurance Assistance. However, eligibility for affordable coverage does not preclude eligibility for Medicaid. It is in the best interests of the employee to look for the best coverage options and Medicaid might be suitable; meaning the employee goes without coverage under the QHP subsidized by the employer.

Continuing to enroll on a plan that is offered by their employer follows the same pattern to plan selection and enrollment as in the individual exchange. The employee selects the household members for coverage, before being taken into the plan management screens for the Small Employer exchange. Eligible plans are displayed with premiums minus the amount that is subsidized by their employer contribution, as well as the date from which the coverage is offered. As with applications for the other insurance affordability programs, conditional verifications are used on the application case to check that information that is entered on the application is consistent with information available through the federal data hub. For employees, this is their social security number and state residency status. Client attested information that has not been verified or considered reasonably compatible is displayed to the employee on completion of the application. Client-reported information that cannot be verified or considered reasonably compatible requires case worker intervention in order for the application case to be authorized.

Create an Account or Log into an Existing Account

When the client selects to apply for assistance from the home page, the system displays the Universal Access **Getting Started** page with two options: create an account or log into your an existing account.

As part of an application for assistance, client are required to create a citizen account. This is the same when applying for insurance affordability assistance, applying to use the exchange to purchase a QHP (commonly known as Straight to Shop), applying for employer-sponsored coverage, or applying for an exemption from the individual mandate.

After the client logs into their account and authenticates, the client is taken to the first page of the application script, where she can begin to fill out the information required for the application. Authenticated individuals can save and exit an in-progress application. Saved applications can be

resumed for completion at a later date. Once completed and submitted, a client can log in to their account to check the status of their applications.

What can I configure or customize?

The Getting Started page is implemented in Universal Access. It is a Page Player page. Certain elements of the page can be configured by the organization.

When the client creates their user account, their data is secured under this account. Multifactor authentication can also be configured to allow for additional authentication when a citizen attempts to log in to the system. From the Universal Access section of the Admin application, select the Authentication Factors link to configure the factors.

Related information

Select Application Filer

The **Getting Started** page is the first page of the Cúram Health Care Reform (HRC) intelligent evidence gathering (IEG) script. It allows the user to select the category of applicant who is completing the application. From here, three options for application filer type are offered:

- You can complete an application for yourself and the members of your family.
- A navigator can complete an application as an individual acting responsibly on behalf of someone else. Individuals who are not comfortable applying online without assistance can designate a navigator, such as a community organization representative, to complete the application on their behalf, or assist them in its completion. The navigator must enter their own details.
- An authorized representative can log in to the portal with their credentials and apply for you on your behalf. This option allows the user to choose another family member, or trusted person with legal authority to apply on your behalf. Some additional details are captured for the authorized representative, such as name, address, and authorization information. The authorized representative is recorded as the application filer for the application. Authorized representatives can submit applications for multiple clients. They also can access those applications from the **My Information** page of the Citizen Account, where they can resume and complete an existing application on behalf of a client.

What can I configure or customize?

From the **Intelligent Evidence Gathering** section of the Social Program Management **Administration** application, the organization can customize the solution's default IEG scripts. Since the state application script requirements vary, it is likely the organization needs to customize the scripts to meet project requirements. IEG scripts have a defined structure and a set of supported operations for IEG expressions. The entire script can be customized.

Search for and Select a Navigator

From the Citizen Portal, the client can select a navigator either by searching on a map or by reference number. After the client creates an account and logs in to the system, the client can request assistance from a navigator by selecting the **Search for a Navigator** option in the Merative ™ SPM Income Support for Medical Assistance (Health Care Reform) portal. A navigator is a person who can apply for an insurance affordability program on the client's behalf.

After the client uses the map search to find a navigator, the system displays a map that shows any registered navigators in the local area. The search is based on the address entered in the search

box. The client can select a map entry that presents a **more information** link about the navigator to the user. The client can choose to send an email referral or get directions to the navigator.

Alternatively, if the client already knows which navigator they want to assist them and have their reference number, the client can use the **Select the Navigator Assisting You** option to find the navigator.

What can I configure or customize?

The organization can register a navigator and configure their services offerings by using Merative ™ SPM Provider Management. To enable the retrieval and storage of `geocodes` for addresses, set the property `curam.miscapp.geocode.enabled` to true. Setting this property to true ensures that `geocodes` for a Navigator's address are stored when the address is created. This property allows the navigator's location to be displayed on the map in Universal Access (UA).

The organization also can set the default latitude and longitude values to determine the center of the map display. From the **Universal Access** section of the **Admin** application, it is possible to configure the geocoding bias area that dictates the boundaries of the map within which the providers are displayed.

Related concepts

Capture Consent for Data Retrieval

Before beginning the application, a consent page is displayed so that applicants can agree to allow their information to be used to retrieve other details from government agencies such as the Department of Homeland Security or the Internal Revenue Service. This consent is referred to as the e-verification process.

If consent is given, personal information such as the citizen's social security number can be used to look up other systems and verify their identity, citizenship and other relevant details. If consent is not granted by the citizen, then any information they enter on an application must be verified by a caseworker before eligibility can be determined.

The consent page is part of the solution's IEG script.

What can I configure or customize?

The default IEG script, that includes the consent page, is provided in the Admin application. The elements of the consent page (such as text) can be customized via the IEG script.

Complete an Online Application

After the user has logged into the application and provided their consent, the application proper is displayed. The Merative SPM Income Support for Medical Assistance application for assistance is a means for a prospective client to apply for assistance and have their eligibility determined across multiple insurance affordability programs in a clear and straightforward manner, capturing and using only the information that is necessary for that determination.

The assistance application flows through the following sections: applicant details, household details, income information for the individuals in the household, program-specific questions, and finally general questions that are asked of all applicants. Note, the sections in the other application scripts differ.

Section introduction pages provide applicants with an explanation and details of the information they may need to provide.

Section summary pages ensure that all information captured is displayed, also allowing applicants an opportunity to revisit and edit information previously entered. There is also an overall summary for the application script which applicants can use at the end.

The application process is dynamic. Questions that are not relevant to the current application about the person and household are not displayed. This filtering ensures that applicants can complete the process as quickly as possible, and will not be presented with questions about information that does not affect their eligibility. Unnecessary questions are not presented.

Special enrollment rules are not part of the online application script.

What can I configure or customize?

Since the state application script requirements vary by state, the organization will likely need to customize the scripts to meet the project requirements. From the Intelligent Evidence Gathering section of the Social Program Management Administration application, it is possible to customize the default Merative SPM Income Support for Medical Assistance IEG scripts. Intelligent Evidence Gathering scripts have a defined structure and a set of supported operations for IEG expressions. The entire script can be customized.

Applicant Details Section

The application begins with questions to capture information about the individuals in the household. This process includes basic identifying information about the individual that is required for eligibility determination. This information is referred to as nonfinancial information. The requested information varies based on whether the individual is applying for assistance. For example, because citizenship status is required to be recorded only for applicants, this question is not asked of non-applicants. The information includes a validation that the primary contact must be an adult.

Household Details Section

The **Household Details** section captures non-financial information about other members of a client's household, and other important information that can affect the eligibility and entitlement of the household. For example, household members' relationships to the applicant and tax relationships.

This information is gathered by capturing basic demographic and contact information. Questions determine whether the household member is an applicant. Based on entered information, the system can gather everything that is required of an applicant, or the subset of information required of non-applicants.

Each time a household member is added, the current picture of the household hat is being built up is displayed, and more people can be added as required. A question is displayed to ask what other people need to be included so that the individual is presented with all the information they need to decide whether more people need to be added. The aim is to ensure that the correct household is captured before it is moved on to capture household relationships, tax status, and tax relationships for each individual in the household.

The tax filing questions are asked of a household in a logical sequence:

- Identify which members in the household are planning to file taxes
- Identify any married couples in the household. At least one of the spouses is chosen as a tax filer, then a question is asked if the married couples are filing taxes jointly.
- Identify any members that are claimed as a tax dependent by another tax filer on the application; otherwise, they are non-filers.

- Tax filers that claim dependents and spouses who are filing joint returns cannot be claimed as dependents. Tax filers that do not claim any dependents are looped through to determine whether anyone else claims them. This check is to support scenarios where a tax dependent also is required to file taxes.

Throughout the Household Details section, questions are displayed dynamically. For example, student questions are not asked of household members above age 21, which is the age limit for individuals for Medicaid household composition rules.

Income Information Section

To streamline the application process for the citizen before you enter income for the household, the application uses income data from existing state and federal sources.

If an applicant filed taxes previously, the applicant is given an option to attest that the annual income available in the tax return is an accurate representation of their income for the coverage year. If the tax income is not representative of their current financial situation, the applicant has the opportunity to enter a different annual income. If tax return information is not available (or if any of the following checks fail), then information about current income is retrieved from state systems and presented to the applicant. A number of conditions are run as part of a check to determine whether it is worthwhile to give an option for the applicant to attest to the IRS income.

The check includes the following conditions.

- Running household composition rules to determine whether there is more than one financial household within the overall household
- Checking whether any household members are American Indian/Alaska Native (AI/AN)
- Checking whether the household income that is shown in the tax returns is under the Medicaid/CHIP threshold for any of the applicants in the household

The application script for income loops through each member of the household to determine:

1. If tax return information is available, there is only one financial unit required and the estimated household income is above the Medicaid/CHIP income levels for all applicants, and there is no AI/AN individual, then the applicant is provided the option to confirm if the income for the coverage year is the same as that of the annual income on the tax return. To ensure compliance with Federal law, and to reduce the amount of identity proofing during the application process, the federal tax return income, and title II benefits from SSA are not displayed. The 'expedited' income approach is still supported; an applicant can still confirm that the income for the upcoming coverage year is the same as that of the federal tax return income, but no income value is displayed. Tax return income and title II benefits continue to be used for verifications and determining eligibility.
2. If the applicant has tax return income but indicates the returned information is not accurate, or if they have no tax return income, then the current income service is polled to see if there are any records for the applicant. If there are, they are presented to the applicant and the applicant can remove them if desired, or add new income manually.If neither the tax return page nor the current income page has been presented to the user, they are asked whether they have any income and given a chance to add any if they do.
3. If the member has income other than what is on their tax return, they are asked whether they have any adjustments they need to make to it and given an option to provide the details.
4. If the member has income other than their tax return, they are presented with an estimated summary of their projected annual income for the following year, and given a chance to enter a new amount if they expect it to be something different.

Next, the manual income capture step allows the applicant to enter wages and other income information for household members that has not been retrieved from tax return income, or from income via the current income service. The benefits of using these information sources means that these income records are verified. If an applicant modifies information that has been retrieved from other systems, or enters income manually, this might require verification by a case worker.

Tax return income is returned as a MAGI amount. If the income is entered manually it must be built up to a MAGI income total per individual.

For each member, income is summed to a Gross Income (GI) total. The client can enter allowable deductions to determine an Adjusted Gross Income (AGI) total for each member.

The MAGI calculation involves adding in the tax-exempt income portions for interest, foreign earnings, and social security income. However, there are varying types of interest, some of which are entirely exempt from tax, such as municipal bonds, and some of which are taxable. As a result, the interest income type is captured as either taxable Interest or tax-exempt interest. Both are counted in the MAGI determination, but only the taxable interest type is counted initially in gross income calculations.

For all the three income types, the user can enter the tax exempt amount. When either income type is entered, the caseworker identifies how much of that amount is tax-exempt. Again, the tax exempt amount is excluded from the GI total but included in the MAGI total for a citizen. These are not listed as distinct income types (as they are for the interest type) as their tax-exempt portions are identified above a certain threshold for the same income type. A detailed breakdown of GI, AGI, and MAGI is provided that is available on the program display rules for a case worker. This is also representative of how citizens report their income on their annual tax returns.

The MAGI income for a citizen is what is used when adding up the household income that is necessary for eligibility determination for Insurance Assistance. However, for Medicaid or CHIP determinations, the rules must determine eligibility using a MAGI-based income total. Essentially there are a few income types that are counted as part of a MAGI income determination but are excluded as part of a MAGI-based income determination. Certain types of American Indian/ Alaska Native income, and income from scholarships or awards that are used for education purposes are not counted in MAGI-based income. Similarly, lump sum income is only counted in the month it is received for MAGI-based income, otherwise it is not counted. It is important therefore that these income types are identified as part of the application process, for example, if an AI/AN individual has income that is derived from distributions or ownership interests, then this income is not counted in their eligibility determination for Medicaid.

What can I configure or customize?

The eligibility rules that determine the display of retrieved income from the IRS can be customized to meet your project requirements.

Related tasks

Program Specific Questions and Additional Questions

Following income information capture, the system captures the remaining information in order to complete an application. This is either program-specific questions that are presented only where applicable, or questions asked of all applicants as the information is required to help screen for non-MAGI Medicaid.

To present program-specific questions at the start of this section, the system runs Cúram Express Rules rule sets (for each applicant in the household to determine whether they are eligible for Medicaid/CHIP (assuming any outstanding verifications are resolved) or potentially eligible

for insurance assistance. If any of the applicants are eligible for Medicaid/CHIP, then a page is displayed which asks questions of those applicants which are specific to those programs. This page displays questions about the applicant's medical bills for the last 3 months and whether they are eligible or enrolled on Indian Health Benefits, if they are selected to be of American Indian/Alaska Native origin. If there are any applicants who are potentially eligible for insurance assistance, then other pages which ask questions specific to that program are asked of those applicants, for example, incarceration and access to employer-sponsored coverage. The answers to these follow-up questions will be used by the rules which are run at the end of the script to determine actual eligibility for Insurance Assistance.

For individuals eligible for Medicaid, avoiding the Insurance Assistance questions is beneficial. A citizen potentially eligible for Insurance Assistance is asked for details about their access to employer-sponsored insurance. If they have employer-sponsored insurance, they are further asked about the cost of that insurance and the contribution that is made by the employer. This information is necessary for the affordability test, which checks whether the cost of the insurance that is offered to the employee after taking into account the available contribution; represents greater than 9.5% of the individual's household income. If it does, then the coverage is not considered affordable and therefore that employee might be eligible for advanced premium tax credits and cost-sharing reductions that they would otherwise be ineligible for. If they are already enrolled in employer-sponsored coverage, then, it is by implication considered affordable. All of this information is of no relevance to those who are eligible for Medicaid, and therefore is not displayed unless relevant for the applicant or a member of his tax household.

Applicants who are not eligible for any financial assistance but are applying to purchase QHPs in the exchange are presented with questions to determine tobacco usage and incarceration. Tobacco usage is a contributing factor to plan premiums for QHPs made available in the exchange, and incarceration is a condition of eligibility for enrollment in a QHP.

After program-specific questions are captured, a page is displayed at the end of the script, which asks questions about each applicant in the household regardless of what program they might be eligible for, the answers to which are used to screen for non-MAGI Medicaid on the application results page. These questions identify whether anyone is blind, disabled, or in need of assistance with their daily needs. The ACA mandates that these MAGI-excepted individuals must follow the traditional Medicaid application process - a link to that traditional Medicaid application process is available from the Curam Health Care Reform eligibility results page.

What can I configure or customize?

The organization can customize the default eligibility rules that determine which specific questions are asked based on eligibility for Medicaid, CHIP, or Insurance Assistance.

Related tasks

Remote Identity Proofing

At certain points during the application process, the information that is entered on the assistance application can be electronically checked for accuracy against external systems by using the federal hub. Data that must be verified with external systems is compared with the specified external data sources and marked either as e-verified or verification outstanding. The verification process is a required step for only assistance application and not for other application types (for example, applying for an exemption, employer-sponsored coverage).

There are two levels of verification – remote identity proofing of the application filer and verifying information provided on the application that is used to determine eligibility. Health Care

Reform provides support for integrating with external systems such as state systems or third-party commercial applications that are identified by states as data sources.

The first level of verification is to verify the identity application filer by using the Remote Identity Proofing (RIDP) process. RIDP is only used when the client applies for themselves or their family. It is not used when the client applies as an individual acting on behalf as someone else or as an authorized representative.

In this process, the application filer's identifying information, such as Name and Date of Birth, is sent to an external service that generates and sends back a set of questions for the filer to answer. These questions are based on the filer's personal information, such as the last 4 digits of the SSN or Bank Account Number. The filer's responses are then evaluated by the external service, and a decision is returned. If the filer's identify proofing is successful, then the filer can continue to complete the application. If the identity proofing fails,the filer is directed to get in touch with the external service for follow-up. When the filer resumes the application process, the system validates that the application filer successfully completed identity verification with the external service.

What can I configure or customize?

Curam Health Care Reform provides interfaces and corresponding implementations for integrating with the remote identify proofing services provided by the Federal Hub. Organizations can provide their own implementations for these integration points.

Related concepts

Verification Data Services

The second level of verification is on the information that is provided in the application that is used to determine the household eligibility. This electronic verification processing is conditional upon the individual having earlier consented to having their information used in this manner.

If consent is given, the system can use verification services by passing personal identifying information, such as the client's Social Security number (SSN), to look up other systems and verify their identity, citizenship, and other relevant details. The SSN for the primary applicant is verified early in the application process, just after the basic identifying information is recorded. The SSN is verified early because a valid SSN is a prerequisite for later services such as verification of annual tax return income.

In general, the supplied personal information is used to verify financial and non-financial information that the client attests to. Any client-attested information that matches information that is retrieved from other systems is considered e-verified because it was provided to Social Program Management from the federal hub.

This system of electronic verification (e-verification) provides flexibility for states with a 'reasonable compatibility' requirement between information recorded on the application and information retrieved from the federal hub. States can define what they consider reasonably compatible for the purposes of verification. Information can be accepted as verified even if not an exact match. E-verification and reasonable compatibility introduce the possibility of real-time determinations, meaning a reduced workload for caseworkers because they have no need to follow up with clients for outstanding verifications. E-verification also provides the applicant with a quicker decision.

What can I configure or customize?

By default, Health Care Reform (HCR) provides processing for electronic verification of data such as citizenship, residency, or SSN. The framework for electronic verification supports adding implementations for custom verification processing for data elements that are either not covered by default processing or those data elements that are added as part of the custom implementation. Also, it is possible to override the default verification processing, if needed.

Income has a verification rule set that looks at reasonable compatibility rules. The requirements for reasonable compatibility vary by state. The rule set can be customized to meet the project requirements. The other verifications rules can be customized with java code.

Related concepts

View Outstanding Verifications

At the end of the Cúram Heath Care Reform intelligent evidence gathering (IEG) script, any verifications that were not electronically verified by the federal hub are shown to the client before the application results are displayed. By showing the details to the client, they are aware of the items that are delaying a complete determination. Any result that is presented is provisional, and depends on whether the client provides supporting documentation to a caseworker.

What can I configure or customize?

The display of the outstanding verifications at the end of the Merative SPM Income Support for Medical Assistance IEG script is based on custom code.

View Eligibility Results

Following completion of the application process, the system determines eligibility for assistance. Universal Access is used to display an eligibility results page for the range of Merative SPM Income Support for Medical Assistance (HCR) programs that a client and household can enroll in. The results of the eligibility determinations are displayed prominently in an easy-to-use interface.

Online help is available to explain terminology so that the individual can make the best decisions to address the needs of the household.

The Cúram HCR eligibility is divided into several discrete sections. The **top pane** displays the applicants in the household and provides summary information about the programs for which they are eligible and their enrollment status. **My items** retains details of the enrollments that already are processed.

The main page content consists of three main sections.

- **Health Care Options**
  The healthcare options are displayed front and center on the **eligibility results** page as they relate directly to the reason the individual is here - to get healthcare coverage whether through state-administered Medicaid or the Children's Health Insurance Program (CHIP) or by using the federal assistance for health insurance. The options available to a client depend on the results of the eligibility determination for insurance affordability programs. The client can choose to view details about the eligibility result. However, the opportunity to continue by shopping for and selecting plans for enrollment are presented, plan selection and enrollment is handled by a plan management system. Upon completion of enrollment, a client is returned to the eligibility results page and can view summary enrollment details.

- **Other Government Services**
  Screening results that the client can select are displayed after the healthcare options. Individuals can use the screening results to apply for any other government services that are offered in-state and configured to be made available as part of the HCR solution. For example, a low-income single mother might be determined to be eligible for Food Assistance or Cash Assistance, but she can continue to apply for one or all of these programs. This approach is the 'no wrong door' approach provided by the solution.
- **Other Community Services**
  Other community services are highlighted in a map for services that are within reach of the individual. These services are shown as a result of triage, that is, the first interaction the client has with an agency that quickly identifies the client's needs. For example, a client might have an immediate need for food and shelter for the family. Triage identifies these requirements and provides a triage map so that the client easily can identify the locations of the services that are being provided. The **Other Community Services** section is empty in the initial installation, so customers can complete the page as required.

Clients who do not enroll in a plan directly can submit their applications to be further processed by caseworkers. On submission, an application reference number is provided to the applicant. Completion of enrollment in a Qualified Health Plan (QHP), or submission of the application starts the intake process in the back-end case management system. Information that is gathered in the application is mapped to evidence on an application case, which is used to represent the information captured at the time of application.

What can I configure or customize?

The eligibility results page can be configured through a combination of display rules and application configurations found in the **Universal Access** section of the **Administration** application. The Cúram Express Rules (CER) rule sets used in determining eligibility are customizable. The display of the eligibility results page is configured through a combination of display rules and configurations. Through these mechanisms, the organization can customize the three main content sections, plus actions, links, tooltips, My Items, icons, and help text.

Two types of rule sets are available, Citizen Portal or online rules and caseworker rules. Since the eligibility results page is the portal, the online rules run here.

Apply for Other Programs

There is close integration between the application process and ongoing case management for the HCR insurance affordability programs and the traditional Medicaid coverage types as provided by Income Support. From the eligibility results page, the client can choose to apply for other human services programs that are not part of the Merative SPM Income Support for Medical Assistance process; for example, food assistance and cash assistance. Screening for these other programs is done as part of the eligibility determination for HCR. The screening rules are run against the data captured on the assistance application. The eligibility results are displayed in the **You might be eligible for the following benefits** section of the results page. The client can choose to start an application for a screened program by selecting the **Apply Online** action.

Applying online begins the application process for one of the Income Support programs. The client is brought to the program selection screens as part of the Universal Access intake process, the difference is that this is done within the eligibility results page. When the Income Support application intake process is finished, the user is returned to the solution’s eligibility results page with the status of the relevant programs updated.

When a user chooses to apply for one of Income Support programs, mapping functionality is used to transfer information from the data store that is used by the Merative SPM Income Support for Medical Assistance application script to the one used by the Income Support application script. A generic mapper transfers data items with the same name and type.

What can I configure or customize?

From the Universal Access section of the Admin application, the organization can configure the programs displayed in the **You might be eligible for the following benefits** section of the eligibility results page. This is achieved through the display rule set configured for the specific Universal Access motivation.

The existing system provides an API which prepopulates the Income Support datastore with the Cúram Health Care Reform. The organization can extend this API for a more complete prepopulation based on their own specific datastore customizations.

Related concepts

Shop for and Enroll in Plans

If there is no plan management system in place, default values for the adult and child are used in the calculation of the benchmark plan. From the eligibility results page, the client can shop for and enroll in Medicaid, Children's Health Insurance Program (CHIP), and Qualified Health Plans (QHP) through integration with a plan management vendor of the customer's choice. The integration with the plan management vendor allows the client to enroll on a plan on the plan management vendor's system with the eligibility information that is determined on the Social Program Management side. Also, Social Program Management can query the plan management vendor's web services to read and store any plans in which a client enrolls.

The starting point for the integration is in the calculation of the maximum tax credit amount available to an individual or household for Insurance Assistance. The second-lowest priced silver plan available within a state health insurance exchange in a geographical region is called the benchmark plan. Tax credit amounts are derived based on the cost of this benchmark plan and are then adjusted according to an enrollee’s annual income.

To calculate the tax credit amount, the system passes high-level information about the people in the tax household, their ages and where they live into a web service provided by the plan management vendor. If the enrollment is being assisted by a navigator, the assister information is also passed on to the plan management system. Then, the system returns a monthly premium for the benchmark plan, the cost of essential health benefit as an amount, and the percentage of the benchmark plan premium. The default implementation has values of $75 for children and $150 for adults.

The eligibility results page also displays a Monthly Premium Cost to Household on the page. By default, it is always displayed as `zero`. The amount is intended to be used to keep a total of how much the household has to pay for their coverage - the contribution that remains after they have used (a portion or all) of their tax credits against the QHP premiums. There is information returned in the plan management web service for enrollment information to identify how much of the Advance Payments of the Premium Tax. Credit (APTC) was used, and how much the actual QHP coverage costs, which can be used by agencies to calculate how much the household is responsible to pay for coverage. By default, it is always displayed as zero.

After eligibility and entitlement are determined, clients can enroll in different types of plans depending on their eligibility. Enrollment options, such as the enrollment group household

members and the primary member of the insurance plan, are captured before passing the information to the plan management system. An inline frame is used to display the plan management pages. To load the plan management pages, an `enrollmentID` is passed through the plan management URL, which the plan management system then uses to call a Social Program Management web service that returns information on each of the people involved in the enrollment (that may also include an assister) and the assistance they are eligible for, for example, to return the maximum tax credit available the household.

The plan selection process differs depending on the programs that the individual and their household are eligible for. Therefore, medicaid generally has no associated monthly costs and no need to capture payment details. The applicant might not need to select from many plans if the State limits the plans that are available through Medicaid. In this way, the enrollment process is simplified.

A monthly cost is associated with CHIP plans. A client that is seeking CHIP coverage must consider the monthly premium for coverage and the annual co-payment limit when they choose a plan. CHIP enrollment requires additional information, which includes payment details.

Insurance Assistance plans also have premiums that must be paid so that household members can be covered and cost-sharing reductions that affect the annual costs that a client might be expected to pay. The QHP premium is also adjusted for essential health benefits/additional benefits. Payment details that are captured during Insurance Assistance plan enrollment are complicated by the premium credits. Premium credits are issued in advance so that applicants can decide to forego the entire amount of tax credit and use only a portion of the credits to pay plan premiums. When the client completes enrollment, Social Program Management maintains the household contribution, ensuring that the QHP premium is covered (by a combination of tax credits and household contribution). Any subsequent household enrollments can use an adjusted APTC amount to ensure that they can never use more credits than they are eligible for. If a household has multiple enrollments, and does not use all of their maximum APTC, they can revisit an enrollment and update the amount that they apportioned to ensure that they use all of their APTC. Alternatively they can continue without using all of their credit if the individual knows that the financial situation is likely to change. An increase in household income results in a lower actual tax credit, and if they use a higher change amount, then they are obliged to pay back the excess as part of reconciliation.

Following completion of enrollment in a plan, the plan management system redirects the iFrame to a URL provided by Social Program Management that returns the individual to the results page, which is updated based on the enrollment details. To get these enrollment details, a web service provided by the plan management system is called by using the `enrollmentID`. Plan enrollment details are then returned, for example, the plan name, premium, tax credit used, or deductible associated with the plan.

What can I configure or customize?

- **Plan management**

  Income Support for Medical Assistance (Health Care Reform) provides a plan management application programming interface (API) interface that supports integration with a plan management vendor. Income Support for Medical Assistance (Health Care Reform) implements a vendor-agnostic approach to plan management integration and does not include a specific implementation of the plan management API interface in the product. Each project is responsible for implementing their own integration between the Social Program Management system and the plan management system of choice.

Plan management integration is accomplished with a combination of both user interface and web services integration. A plan management vendor's user interface is shown in an inline frame on a solution page.

- **Eligibility results**

  From the **Universal Action** section of the **Administration** application, the client can configure the results page actions that allows the user to shop and enroll from the eligibility results page.

  One of the customizations that an organization might want make is to calculate Monthly Premium Cost to Household on the page. The default implementation contains values of children and adults for calculating the Benchmark Plan Monthly Premium used in the Maximum Tax Credit calculation. Customers must provide their own implementation of the web service API to call their Plan Management vendor. The API that contains the default implementation is `curam.planmanagement.adapter.impl.PlanManagementAdapter.getBenchmarkPlan` The custom API implementation will replace the default implementation.
- **Web services**

  Customization is required to implement the web services.

Related concepts

Sign and Submit Application

The Sign and Submit application process involves obtaining an e-signature, capturing acceptance and attestations, and submitting the application. After the client submits the application, it cannot be changed through the portal.

Applications are submitted when the plan selection and enrollment process is completed in the plan management system. Alternatively, submission also occurs when the individual chooses to submit the application from the solution's eligibility results page.

In each of these circumstances, the submitted application is processed in the same manner, starting the Intake process so that an application case is created to represent the point-in-time application. The process also handles the ongoing interactions between the applicant and the agency, through integrated cases and product delivery cases.

On submission of the application, the authorized representative is added as an **Application Filer** case participant type. If the authorized representative can receive correspondence on behalf of the application, the authorized representative is also a **Correspondent** case participant type.

As part of the submission process, the e-signature of the application filer can be recorded. The e-signature page has sections that capture the acceptance of the application filer for cooperation on medical support information collection, eligibility renewals, reporting change in circumstances, and attestation that the information provided is true. The e-signature page is displayed when the user submits the application. A validation is conducted to check that the signature matches the logged in user details. Another validation ensures that the application was signed by the client or the assister.

After the application is submitted, the system also creates the Citizen Account.

What can I configure or customize?

The application submission process can be configured by the organization. The e-signature is captured by using the **Sign & Submit** link on the results page. This link itself is a **Universal**

Access Category action, and a new page can be specified if it is required. Category actions can be configured through Results Categories in **Universal Access** in Curam **Admin**. The data that is entered during the online application is copied to a generic generated form.

It also is possible to configure a PDF for the application. The organization agency can design their own PDF to be used with the intake application. The data that is entered during the online application is copied to a PDF form based on the program that is applied for that include associated mapping configurations. If a mapping configuration is not associated with a program, the information that is entered during the online application for that program is not copied to the PDF form.

Person Match

You can configure and customize a person match process to work in much the same manner as the online application. Person match can attempt to match applicants automatically to registered Social Program Management participants. These registered persons with existing client records can then be used in a newly created application case.

If the primary applicant was selected based on finding an already registered person through a search, person match can be skipped (since the person is known). Social Program Management provides capabilities to proceed to create the application case and add the existing registered person as the primary participant on the case. Other persons recorded on the application can be matched in the same way. If applicants cannot be automatically matched, the system can proceed to create the application case and add the applicants as prospects or fully registered persons, depending on the results of the person match search.

After the household members that are listed on an application are matched to existing clients or recorded as new participants, an application case can be created automatically. Information that is gathered in the internal application can then be mapped to evidence on the application case.

What can I configure or customize?

The default implementation of the PersonMatch API returns an empty list. Customers can provide their own implementation of the PersonMatch API if they so wish.

Common Intake allows users to configure the person match process. Person match search is configurable by using an application property. A weight can be assigned to each of the available search criteria. The weight is used to determine how important the criterion is to the matched outcome. The sum of the weights from a search result is compared against configured threshold values, which determine whether a result is an exact match, a possible match, or not a match. The sample criteria weights the reference or Social Security Number (SSN) highest, along with date of birth, given name, and surname. The upper and lower score threshold values are set as system properties. The properties are available in the **Application – Person Match Settings** category.

Related concepts

Application Case Creation and Evidence Mapping

After the household members that are listed on an application are matched to existing clients or recorded as new participants, an application case is created automatically.

In Merative ™ SPM Income Support for Medical Assistance (HCR), application cases are used to manage any of the options that a client or employee can apply for, including applications for insurance affordability assistance, application for exemptions from the mandate to purchase health insurance, applications for individuals who proceed to shop directly for insurance without financial assistance, and employees who are applying for employer-sponsored coverage.

Each of these application processes is separated out from the insurance affordability application onto their own case types. These application processes mean that they are configured with the specific evidence types and verifications required only by those applications. For example, an application to shop in the exchange without assistance does not require the capturing of any income information, nor any verification requirements that relate to income. The application captures non-financial information such as state residency and citizenship so that applicants can be determined eligible to purchase Qualified Health Plans (QHPs) through the exchange. The application case types that are available are:

- Insurance affordability
- Employer-sponsored coverage
- Shop in exchange without assistance
- Exemption

Information that is gathered in the online application is mapped to evidence on the application case as active evidence.

- **Straight Through Processing Workflow**
  A submitted application does not require caseworker intervention when all client-attested information is electronically verified (e-verified). The case is routed to the Straight Through Processing workflow. In straight-through processing, the caseworker is notified about the application case when it is authorized, but does not need to be involved. The applications are authorized automatically.
- **Manual Processing**
  Any evidence items that are not verified by an external system as part of the application process or accepted based on client self-attestation, require manual verification by a caseworker. Straight-through processing is halted and a caseworker is assigned the task of resolving the outstanding evidence verifications with the client. Federal requirements for reasonable opportunity or inconsistency periods allow states to continue with the delivery of a program during this period. In addition when any evidence validations have failed, straight-through processing is also halted. The evidence is created in an in-edit status and the caseworker is assigned the task of resolving the outstanding evidence validation issues. When straight through processing is not used an application case is created and the caseworker manually authorizes the application.
- **Process Instance Errors View**
  After an application is submitted, some errors cannot be corrected by the caseworker and are sent to the Process Instance Error Queue. The errors can be seen from the **Process Monitoring** section of the **Admin** application.

What can I configure or customize?

From the **Universal Access** section of the **Admin** application, the customer can configure the application case. Information that is gathered in the online application is mapped to evidence on the application case. This mapping is achieved through a Cúram Data Mapping Engine configuration. The mapping configuration can be customized by the organization.

Related concepts

Related tasks

Generate Communications

Merative SPM Income Support for Medical Assistance (HCR) provides for a basic set of communications, primarily to notify the applicant or current enrollee of an eligibility

determination. The notification for eligibility determination varies depending on whether any outstanding verifications that are associated with the application exist.

For the straight-through application process where client-attested information is verified, the eligibility determination and associated communication notify the applicant of the household's eligibility. The notification is combined for the household members across the insurance affordability, employer-sponsored coverage, and exemption programs. The notice informs the household of their individual eligibility for Medicaid, Children's Health Insurance Program (CHIP), state basic health plan, employer-sponsored insurance, or exemptions.

When outstanding verifications exist, the communication notifies the applicant of household eligibility on a temporary basis. This notification is necessary to support the inconsistency period for an application, during which eligibility must be determined by using the client-attested information. Therefore, this notification includes details of the client-attested information that are not verified yet, and require follow-up with a caseworker. Each notification includes details about the possible appeal for any decision that is associated with an eligibility determination, with instructions about how to file that appeal.

Two notifications are available.

Table 1: Merative SPM Income Support for Medical Assistance client notifications

Notification	Description
Health Care Application Acknowledgment	After submission, an online notification is shown to the client that the application was received and the status is pending. It lists the application reference number. After the application is authorized, the status changes to disposed.
Notice of Provisional Eligibility Determination	After the client submits an eligible application from the portal, a communication displays for the caseworker with subject `Preliminary Eligibility Determination Notification`. This notice is a pro forma communication.

What can I configure or customize?

Communications can be customized by the organization.

Navigators

A navigator is a person who can be assigned to help a client to apply for an insurance affordability program.

For those individuals who are not comfortable applying online without assistance, they can designate a navigator, such as a community organization representative, to complete the application on their behalf, or assist them in its completion.

Search Navigator

The **Navigator** tab in the Citizen Account allows the client to search for a navigator. From here, the client can start a search to find a navigator that assists them with the application process. The search process displays the navigator on a map

What can I configure or customize?

The organization can register a navigator and configure their services offerings by using Provider Management. To enable the retrieval and storage of `geocodes` for addresses, set the `property curam.miscapp.geocode.enabled` to true. Setting this property to true ensures that `geocodes` for a navigator's address are stored when the address is created. This designation allows the navigator's location to be displayed on the map in **Universal Access** (UA).

The organization can also set the default latitude and longitude values to determine the center of the map display. From the **Universal Access** section of the **Admin** application, it is possible to configure the geocoding bias area that dictates the boundaries of the map within which the providers are displayed.

Related concepts

Navigator Registration and Intake

Registered navigators can help clients with their applications.

Register as Navigator

Using Provider Management, a client or external agency can register as a navigator from the **Navigator** portal. When the person or agency requests to register as a navigator, a number of details are recorded, and the request is submitted.

Navigator requests are processed by resource managers. A task is created and assigned to a default workflow. Resource managers can accept the task, review the request, and when they are satisfied that the person or agency meet the requirements for being a navigator, the request can be processed to register the provider as a participant on the system. Registered Navigator Providers can have the services that they offer to clients recorded for their profiles.

When a submitted navigator request is approved, an email is sent to the email address that is recorded for the navigator. The email contains login credentials for the **Navigator** portal. Navigators then can begin assisting individuals with their applications by accessing the **Navigator** portal.

What can I configure or customize?

The **Register as a Navigator** page is a standard Social Program Management page that can be customized to meet your project needs. You can customize the external inquiry workflow to meet your project needs.

Related concepts

Navigator Intake

Navigators can help a client look for health coverage options through the marketplace, including completing and submitting the Insurance Assistance application.

Log in to Account

After navigators are registered successfully and approved by the agency, they can log in to the Navigator Portal by using their login details.

What can I configure or customize?

Universal Access provides support to customize the login page and the links and messages that are displayed there.

Select Client to Assist

The navigator can choose a client to assist from a list of clients who requested assistance.

What can I configure or customize?

The **View** page is a standard Cúram list page and can be customized to meet your project needs.

Submit Application for Client

The navigator can help a client by completing and submitting an application for Insurance Assistance on behalf of the client. The navigator can also resume saved applications.

When a navigator submits an application for a client, a record of the navigator who assisted the client is created. A record of all the clients who were assisted by the navigator also is kept and is available in the Navigator Portal.

The client's application is also available for the client to view in the client account. The client can choose to resume an application started by the navigator.

What can I configure or customize?

The **View** page is a standard Social Program Management list page and can be customized to meet the project needs.

Caseworker intake

The internal application process allows a caseworker to complete and submit an application on behalf of the client. An internal application is configured in the system that allows caseworkers to create and submit applications for their clients by using Intake. Use the information in the following section to understand how to complete the internal application process that uses Intake.

The internal application process allows a caseworker to complete and submit an application on behalf of the client. An internal application is configured in the system that allows caseworkers to create and submit applications for their clients by using Intake.

Search For and Register an Individual

The worker initiates the intake process by searching for the individual in the system. Use this information to understand how the process works for searching for an individual, initiating the intake process, and registering that person into the system.

The first step in the caseworker intake process is to search for and register the individual. Use this information to understand how to start the intake process and search and register an individual in the Merative SPM Income Support for Medical Assistance application.

The worker initiates the intake process by searching for the individual in the system. The Health Care Reform (HCR) application uses the person search function to allow the caseworker to search across all the persons and prospect persons who are registered on the system. From the search results, the worker can decide whether the details of anyone who already is registered in the system match the individual. If a match is identified, the worker can select the individual from the search results, and begin the intake process. If no matches are found, the worker can register a new individual as a person or as a prospect person participant and then can create a new application form for that individual.

The worker might not have all the necessary information that is required for full person registration, so the worker can register the individual as a prospect person with minimal data. A full registration can be completed later when all of the required information is available.

Most often, an individual is registered as a prospect until the individual files an application for a program, at which time the individual is registered fully as a person.

Complete Internal Application for Assistance

After the caseworker completes the person search match process, the caseworker can create and submit an application for the client. The caseworker application form is an Intelligent Evidence Gathering (IEG) script that contains the necessary set of guided questions for the insurance affordability application.

After the caseworker completes the person search match process, the caseworker can create and submit an application for the client.

The caseworker application form is an Intelligent Evidence Gathering (IEG) script that contains the necessary set of guided questions for the insurance affordability application.

The first page of the script displays text that the caseworker must read to the client about how their information is used by the agency and the privacy act statement. The client must agree to allow their information to be used for the application. The caseworker is required to confirm that the text is communicated to the individual applying for the program and that the client provides their consent before the caseworker can continue.

After the consent page, basic information that was captured when the caseworker registers the person is prepopulated in the script, including person name, date of birth, gender, and Social Security Number (SSN).

In essence, the script captures the same information as the online application. Differences exist that make it more appropriate for a caseworker. For example, all of the staging pages that explain what is coming in the next section and most of the informational text at the top of application pages is removed. The pages are Help text or preparatory details that guide a citizen through the application process and are not deemed relevant for a caseworker.

The last page of the script includes rights and responsibilities text. The text appears in the application before the caseworker submits the application script. The caseworker is required to confirm that the text is communicated to the individual applying for the program before the caseworker continues the application process.

When the caseworker completes the script, the caseworker submits the application and the application case is created. A PDF document is created and stored as an attachment on the application case. The PDF document contains the information that the caseworker entered on the application form. When caseworkers are working on the client’s case, caseworkers can view the PDF document.

What can I configure or customize?

Caseworkers can customize the PDF document that contains the information that the caseworker entered on the application form. For more information about how to customize the PDF document, see the *Customizing the generic PDF for processed applications* related link.

The default Health Care Reform IEG application script is provided in the Admin application. Since the application script requirements vary by state, you likely need to customize the scripts on your project. IEG scripts have a defined structure and a set of supported operations for IEG expressions. The presentation of pages in a script is configurable.

The text on the consent page and the rights and responsibilities text page is configurable.

Related concepts

Related information

Person Match

You can configure and customize a person match process to work in much the same manner as the online application. Person match can attempt to match applicants automatically to registered Social Program Management participants. These registered persons with existing client records can then be used in a newly created application case.

If the primary applicant was selected based on finding an already registered person through a search, person match can be skipped (since the person is known). Social Program Management provides capabilities to proceed to create the application case and add the existing registered person as the primary participant on the case. Other persons recorded on the application can be matched in the same way. If applicants cannot be automatically matched, the system can proceed to create the application case and add the applicants as prospects or fully registered persons, depending on the results of the person match search.

After the household members that are listed on an application are matched to existing clients or recorded as new participants, an application case can be created automatically. Information that is gathered in the internal application can then be mapped to evidence on the application case.

What can I configure or customize?

The default implementation of the PersonMatch API returns an empty list. Customers can provide their own implementation of the PersonMatch API if they so wish.

Common Intake allows users to configure the person match process. Person match search is configurable by using an application property. A weight can be assigned to each of the available search criteria. The weight is used to determine how important the criterion is to the matched outcome. The sum of the weights from a search result is compared against configured threshold values, which determine whether a result is an exact match, a possible match, or not a match. The sample criteria weights the reference or Social Security Number (SSN) highest, along with date of birth, given name, and surname. The upper and lower score threshold values are set as system properties. The properties are available in the **Application – Person Match Settings** category.

Related concepts

Inbound Account Transfer from Federal Hub

For states that chose the Federally Facilitated Model (FFM) or to work in partnership with the Federal Marketplace, the Account Transfer Interface is key to the user experience. The fundamental goal of the Account Transfer Interface is to ensure that individuals that use state and

federal systems do not have to rekey their information and that information remains consistent across the two systems. This process involves the transfer of information in a format defined by the Account Transfer Interface at specific trigger points defined by the Account Transfer Interface.

Information that is sent from the FFM to the State Medicaid Agency (SMA) or Children's Health Insurance Program (CHIP) is sent over what is referred to as an Inbound Account Transfer. If a client is determined potentially eligible for Medicaid or CHIP by the FFM, the FFM transfers the account to the SMASocial Program Management system. In an assessment state, the SMA makes the final determination. In a determination state, the FFM makes the final determination and the SMA enrolls the person when they are told to do so. This process is an Inbound Account Transfer and is treated as an initial application.

For an account that was previously transferred to Social Program Management from the FFM, a subsequent account transfer for a change reported in the FFM comes in as an inbound payload to Social Program Management. This payload is treated as an inbound Change of Circumstance payload and the existing ongoing case for the household must be updated with the received changes. If a client has Medicaid or CHIP coverage for a period but is later found to be ineligible, their account can be transferred from Social Program Management to the FFM to be assessed for Insurance Assistance. This transfer is an outbound transfer from Social Program Management to the FFM.

To understand the trigger points behind the Inbound Account Transfer Interface, it is necessary to understand the basic flow of the interface. This flow is best illustrated through an example of an initial application:

1. An individual applies for a benefit in the FFM.
2. The FFM assesses or determines (dependent on the state model chosen) that they are potentially eligible or ineligible for Medicaid or CHIP.
3. The individual elects to submit their application to the SMA
4. The FFM now sends an Inbound Account Transfer to the SMA.

What can I change or customize?

The Account Transfer process contains application programming interfaces (APIs) that map Inbound Account Transfers to Social Program Management data structures: for example, to cases and evidence.

> **Note:** These APIs might not completely map all data fields from Inbound Account Transfers and cannot take into account customizations made by the organization. It is the responsibility of the organization to ensure that a fit gap analysis was undertaken to ensure that all Account Transfer data fields map to the organization's case and evidence structures.

The mapping APIs are customizable through extension points that were provided for each entity mapped to Social Program Management from the Account Transfer payload. This process enables organizations to add their own custom data mappings to support their particular requirements. To further enable organizations to complete these tasks, the source code for the Account Transfer process is delivered with Merative™ Social Program Management Data Extractor.

Note: You can use the source code to build any customizations that are required for the Account Transfer process. The location of the Account Transfer source code is `EJBServer/components/FederalExchange/sample/src.zip`. For more information about the source code for the Account Transfer process and the release of the sample implementation, see the *CMS Account Transfer Business Services Description (BSD)* related link.

Related concepts

Related information

CMS Account Transfer Business Services Description (BSD)

Insurance Affordability Application Case Creation

After the caseworker submits the Insurance Assistance application, a new Insurance Affordability application case is created for the person. By default, the application cases that are created internally are assigned directly to the user, the HCR caseworker, who created the application. The application is displayed in the user's **My Applications** list.

When the caseworker creates and submits an application form for the client, a PDF document is created and stored as an attachment on the application case. The PDF document contains the information that the caseworker entered on the application form. When caseworkers are working on the client's case, caseworkers can view the PDF document.

In Merative SPM Income Support for Medical Assistance, application cases are used to manage any of the options that a client or employee can apply for, including applications for insurance affordability assistance, application for exemptions from the mandate to purchase health insurance, applications for individuals who proceed to shop directly for insurance without financial assistance, and employees who are applying for employer-sponsored coverage.

Each of these application processes has been separated out from the insurance affordability application onto their own case types meaning they are configured with the specific evidence types and verifications required only by those applications. For example, an application to shop in the exchange without assistance does not require the capturing of any income information, nor any verification requirements relating to income. The application is specifically designed to capture non-financial information such as state residency and citizenship so that applicants can be determined eligible to purchase Qualified Health Plans (QHPs) through the exchange. The application case types that are available are:

- Insurance Affordability
- Employer-sponsored insurance
- Unassisted insurance
- Exemptions
- Account transfer change of circumstance

What can I change or customize?

Caseworkers can customize the PDF document that contains the information that the caseworker entered on the application form. For more information about how to customize the PDF document, see the *Customizing the generic PDF for processed applications* related link.

From the **Universal Access** section of the **Admin** application, you can configure the application case. Information that is gathered in the online application is mapped to evidence on the application case. This mapping is achieved through a Data Mapping Engine configuration. The mapping configuration can be customized by the organization.

The solution uses Cúram Intake functionality to provide caseworkers with the tools they need to process and manage applications by providing the link between the application and case management. A case type of Application Case was defined to specifically meet the requirements for processing applications.

The organization can configure the ownership strategy for the internal application case. By default, application cases that are created internally are assigned directly to the user the caseworker, who created the application. The organization can configure the application case to be assigned to a user or a work queue, among other options.

Related concepts

Related tasks

Related information

Maintain Evidence

From the Insurance Affordability application case, the caseworker can maintain evidence. The Merative SPM Income Support for Medical Assistance application includes a number of dynamic evidence types that are associated with the Insurance Affordability application case. Evidence can be maintained by using the **Evidence** tab on the application case. There are also two static evidence types (Annual Tax Return and Absence).

What can I configure or customize?

Organizations must copy the Merative SPM Income Support for Medical Assistance dynamic evidence configurations, even if no customizations are required. Organizations can configure new dynamic evidence configurations

Related concepts

Check Eligibility

The Insurance Affordability application case type is configured to include an option for a caseworker to run an eligibility check by using the evidence that is `In-Edit` on the case. The caseworker can check the client's eligibility for the programs on the application case as of the current business date.

The **Check Eligibility** step does not need to be done before a caseworker authorizes the application. Each time an eligibility check is done, a new row is added to the **Eligibility Checks** page. The page can be expanded to show which members of the household are eligible for each program.

The rule set outputs the eligibility decision for the programs that are checked on the application case, and, if relevant, the entitlement for that program.

What can I configure or customize?

The **Check Eligibility** feature is configurable. Rulesets can be customized in CER. The rule set outputs the eligibility decision for the programs that are checked on the application case. If an Eligibility Check rule set is specified, an Eligibility Check Strategy also must be defined from the application case in the Admin application.

> **Note:** There are two types of rule sets: citizen portal (on-line) and caseworker. Because this is the caseworker side, the caseworker rules run here.

Resolve Outstanding Verifications

From the application case, the caseworker can resolve any outstanding verifications. Use this information to understand how to resolve outstanding verification issues.

Any evidence items that are not verified by an external system as part of the application process or accepted based on client self-attestation, require manual verification by a caseworker. Straight-through processing is halted and a caseworker is assigned the task of resolving the outstanding evidence verifications with a client. Federal requirements for reasonable opportunity or inconsistency periods allow states to continue with the delivery of a program during this period. To support this requirement, verifications are configured to be optional for the application case.

What can I configure or customize?

Merative SPM Income Support for Medical Assistance (HCR) application cases and integrated cases are configured to use the verification framework. From the **Verifications** section of the administration application, you can configure the Merative SPM Income Support for Medical Assistance Verifications. You also can customize conditional verification rule sets in the same way as other rule sets.

Related concepts

Program Authorization

Use this information to understand authorization of each program on an application case.

After the caseworker resolves any outstanding verifications that are associated with the application case, the worker can start the program authorization process. Authorization of each program on an application case is required to process the application case to completion. By default in Merative SPM Income Support for Medical Assistance, the authorization strategy is set at the program level. After all the programs are authorized, the application case status is set to Closed.

Ongoing case management requires both an integrated case and a product delivery to complete the delivery of services and benefits to clients. Integrated cases are not necessarily created for every program authorization, however. An existing integrated case can be used to host newly created product delivery cases. For Merative SPM Income Support for Medical Assistance, if integrated cases exist of the appropriate type for which any of the application case clients is a member, the case worker is presented with the option to use one of these cases or to create a new integrated case.

What can I configure or customize?

Program authorization can be configured at either the application level or at the program level to meet your project requirements. From the **Universal Access** section of the **Admin** application, you can configure the program authorization processing for the application case.

Application Level Authorization Strategy

When the application level authorization strategy is selected, you must define the authorization Cúram express rules (CER) ruleset. You also must decide whether a new or existing integrated case is appropriate to be used when the program authorization is successful. The integrated case is used to host any product deliveries that are created as a result of the authorization. If a new integrated case is created, all of the application case clients are added as case participants to the integrated case. If an existing integrated case is used, any additional clients on the application

case are added as case participants to the integrated case. Any evidence that is captured on the application case that also is required on the integrated case is copied to the integrated case upon successful authorization.

Program Level Authorization Strategy

You can choose to authorize the application at the program level when the application case has one or more program types that are associated to it. Separate integrated cases are used to manage the product deliveries that are created as a result of authorization. If you decide to authorize at the program level, then each program must be authorized separately. You can choose to create a new integrated case for each program that is authorized. Alternatively, you can choose to use an existing integrated case or allow the caseworker to select one or the other. You must also define the type of integrated case that is created as a result of authorizing the program. Program Group Logic functionality is used to create and maintain product deliveries. The program group rules are executed in order to determine which clients are eligible for which products. Then the Program Group Logic creates the corresponding products.

Reasonable Opportunity Period/Inconsistency Period

Use this information to understand the federal requirements for resolving inconsistent information that is provided in an application and how to manage the reasonable opportunity and inconsistency periods for handling these issues.

Federal rules require that states allow a period of 90 days to resolve inconsistencies between the information an applicant provides and information available from other trusted sources. During this period, the applicant still can receive benefits based on the information they provided. The inconsistency period starts on the date that the potential eligibility notification is sent. If the notification is not sent, the date is the case start date. To support the reasonable opportunity requirement, the verification requirements are configured to be optional for the application case, allowing the program to be authorized with outstanding verifications. The verifications are mandatory for the integrated case. To activate the product delivery cases to ensure benefit delivery during the inconsistency period, the system automatically bypasses any mandatory outstanding verification by creating Verification Waivers. The waiver period is set to the duration of the inconsistency period from the date the notification was sent. This process allows activation of evidence and product delivery cases with outstanding verifications, allowing applicants to have access to benefits during this period.

If the inconsistencies are not resolved by the end of the reasonable opportunity period, follow-up actions such as redetermination of eligibility that uses information available are required. To trigger these actions, Case Milestones are created, with the expected start and end dates set to be the same as the inconsistency period. The actual start date of the milestone is set to the date the notification was sent and the 90-day period countdown begins. When the business date passes the 90-day period, the milestone overdue event is raised which can be used to complete the follow-up actions.

What can I configure or customize?

The default inconsistency period processing infrastructure consists of a batch process, a workflow, and the inconsistency period processing application programming interfaces (APIs). By default in the Merative SPM Income Support for Medical Assistance application, an inconsistency period is created only once for the lifetime of a case. This can be customized by the organization. The inconsistency period starts from the date the potential eligibility notification is sent, this can be customized.

Related tasks

Generate Communications

Merative SPM Income Support for Medical Assistance provides for a basic set of communications, primarily to notify the applicant or current enrollee of an eligibility determination. The notification for eligibility determination varies depending on whether outstanding verifications remain that are associated with the application.

For the straight-through application process where client-attested information is verified successfully, the eligibility determination and associated communication notify the applicant of the household's eligibility. This determination is a combined notice for the household members across the insurance affordability, employer-sponsored coverage, and exemption programs, which notifies the household of their individual eligibility for Medicaid, Children's Health Insurance Program (CHIP), state basic health plan, employer-sponsored insurance, or exemption.

Where outstanding verifications exist, the communication notifies the applicant of household eligibility on a temporary basis. This notification is necessary to support the inconsistency period for an application, during which eligibility must be determined by using the client-attested information. This notification includes details of the client-attested information that as yet is verified, and requires follow-up with a caseworker. Each notice includes details on the possible appeal for any decision that is associated with an eligibility determination along with instructions on how to file that appeal. Four notifications are available:

Table 2: Merative SPM Income Support for Medical Assistance client notifications

Notification	Description
Eligibility decision for an application	If authorization of an application succeeds, then this notification is generated informing the household of the decision. It is stored as a communication with the integrated case for the primary client.
Eligibility decision as the result of evidence change	If evidence was added to the integrated case and applied successfully, then this notification is generated informing the household of the decision. It is stored as a communication with the integrated case for the primary client.
Preliminary eligibility determination with evidence inconsistencies	This determination is generated for an application case and the primary client when it is first created if the application has outstanding evidence that needs to be resolved.
Preliminary eligibility determination with evidence inconsistencies for a change reported through evidence	This determination is generated for an integrated case when new evidence is introduced to the case.

What can I configure or customize?

Support is provided for two types of templates: Extensible Stylesheet Language (XSL) templates and Microsoft Word templates. XSL templates are stylesheets that are used for generating pro forma communications; Microsoft Word templates are used to create Microsoft Word communications. These templates are managed differently on the system.

Related concepts

Deny Application

Use this information to understand under what circumstances a caseworker can choose to deny the Insurance Affordability application.

From the application case, the caseworker can choose to deny each program with a valid denial reason. The worker selects a denial reason and any additional comments in relation to the denial. The worker can select to deny a program at any point in the application case lifecycle prior to case closure. No products are created for a denied program.

Outbound Account Transfer to Federal Hub

Information that is sent from the State Medicaid Agency (SMA) to the Federally Facilitated Marketplace (FFM) is sent over what is referred to as the Outbound Account Transfer. The same physical interface schema is used to support both outbound and inbound transfer. However, the nature and constraints on the data that must be passed over that interface depends on whether it is an inbound or an outbound call.

This process is complicated further in terms of the trigger points by what is referred to as the Deferred Response. This process is illustrated best by two examples that relate to initial applications.

Example 1

1. An individual applies for a benefit in the FFM.
2. The FFM assesses or determines (dependent on the state model chosen) that they are potentially eligible or eligible for Medicaid, Children's Health Insurance Program (CHIP) or both.
3. The individual elects to submit their application to the SMA
4. The FFM now sends an Inbound Account Transfer to the SMA.
5. The SMA immediately must send a synchronous response that indicates receipt (the FFM automatically will stop sending future requests – until discussion with the state occurs – if it detects these responses are not sent).
6. The SMA later must send a Deferred Response to the FFM indicating the eligibility and enrollment of the individual. (In a determination state, the state does not get to determine eligibility as that determination already is established.) This Deferred Response is an Outbound Account Transfer.

Example 2

1. An individual applies for a benefit in the SMA.
2. The SMA determines that the individual (or anyone in the household) is not eligible for Minimum Essential Coverage (MEC) under the Modified Adjusted Gross Income (MAGI) rules.
3. The SMA now must send an Outbound Account Transfer to the FFM. As no original Inbound Transfer exists from the FFM, this transfer is not a Deferred Response.

The exact trigger points for when an Outbound Account Transfer must be sent depend on whether it is a Deferred Response, not on it being an Outbound Account Transfer. For example, in the first scenario above an Outbound Account Transfer must be sent by the SMA if an individual is found not to be eligible because they did not provide necessary verification requirements that take into account Reasonable Opportunity). In the second scenario, an Outbound Account Transfer is not be sent if the individual is found not to be eligible for MEC because they did not provide necessary verification requirements.

An outbound account transfer to the FFM also can be triggered when:

- The caseworker denies the application with a reason other than Procedural Denial.
- The individual or household is ineligible for Streamlined Medicaid/CHIP, unless the ineligible decision is an unlawfully present applicant (because they would not be eligible for any other coverage).

What can I configure or customize?

The Account Transfer process contains APIs that map the Social Program Management data structures to an Outbound Account Transfer. Note that these APIs might not completely map all data fields from the case structures to the Outbound Account Transfer and cannot take into account customizations made by the organization. It is the responsibility of the organization to ensure that a fit gap analysis has been undertaken to ensure that all of the organization's case and evidence structures map to the Account Transfer data fields. The mapping APIs are customizable through extension points that have been provided for each entity mapped from Social Program Management to the Account Transfer payload. This enables organizations to add their own custom data mappings to support their particular requirements. To further enable organizations to perform these tasks, the source code for the Account Transfer process is delivered with Social Program Management.

Note: You can use the source code to build any customizations that are required for the Account Transfer process. The location of the Account Transfer source code is `EJBServer/components/FederalExchange/sample/src.zip`. For more information about the source code for the Account Transfer process and the release of the sample implementation, see the *CMS Account Transfer Business Services Description (BSD)* related link.

Related concepts

Related information

CMS Account Transfer Business Services Description (BSD)

Ongoing Case Management

Applications require both an integrated case and a product delivery to complete the delivery of services and benefits to clients.

Create Integrated Case

Following the authorization of programs on an application case, an Insurance Affordability integrated case is created.

Integrated cases allow for the typical case management tasks of resolving verifications and capturing updates to evidence for ongoing eligibility. Integrated cases can be used to manage any number of application cases that exist for the members in a family. For example, an employee application for employer-sponsored coverage results in an application case for that employee. If other household members were to apply for assistance in the individual exchange, this possibility would result in an insurance affordability application case. When verifications are resolved and the programs that are associated with these applications are authorized, they result in one integrated case for the household.

What can I configure or customize?

In Common Intake, you can configure the ongoing case that is associated with the application case. From the Universal Access section of the Admin application, select the Application Cases link. By default, the Insurance Affordability Application Case is configured to include the Insurance Affordability program.

From the Insurance Affordability program home tab, you can select the **Ongoing integrated case type**. By default, the Insurance Affordability integrated case is configured.

From the **Case** section of the Admin application, you can configure the Insurance Affordability integrated case.

Related concepts

Integration with Person Evidence

Much of the data that is stored for a person or prospect persons meets the Social Program Management definition of evidence. It is used in eligibility and entitlement calculation, and often it is information that is retrieved from a citizen or household as part of an application or intake process. Maintaining this data as evidence allows it to be used for eligibility and entitlement in a way that allows users to choose when data changes need to be applied and take effect.

Configuring person evidence types onto other cases (such as an integrated case where other case evidence is maintained), allows users to maintain the information along with other case evidence. This process provides a better way of managing all evidence for a person or prospect person.

If a change is made to person evidence from outside of the Insurance Affordability integrated case, the evidence can be shared with the case and a user is notified that there is incoming evidence to be reviewed.

What can I configure or customize?

The types of person evidence that can be added and maintained on a particular case type can be configured by the organization. It can be configured whether updates are shared to other cases. The evidence broker plays a central role because sharing needs to occur between the intake application, ongoing cases (integrated cases or product deliveries), and the person.

PDC mode is set to on by default. Setting PDC to off is not supported.

Evidence Brokering

Following the creation of an Insurance Affordability integrated case, the application case evidence is automatically shared to the integrated case if evidence is configured to be shared.

When evidence is configured to be shared with the Participant Manager, logic is included with the Participant Manager evidence types to ensure that logical duplicates are not brokered. For example, where a new gender record is created on an application case and the gender is not different from what already is recorded against that person, the broker discards the new record when it brokers the evidence from the application case to the Participant Manager.

Integration with Income Support is available through the person record. It takes two main forms:

- The **Person** tab for any of the people who are involved displays a list of all cases related to that person.
- Person evidence from both the Insurance Affordability and Income Support integrated cases is shared with the person evidence area of the Participant Manager.

In addition to the possibility of being brokered from cases to person evidence, evidence also can be brokered from person evidence to any open cases for the person. If the evidence change originated on a case, when it is brokered as person evidence it is sent only to other cases and not the case on which the change originated. So, if a caseworker adds phone number evidence for a person on an Income Support integrated case, this information is brokered to that person's evidence in the Participant Manager and then on to the Insurance Affordability integrated case if one exists for that person.

The table that follows includes a list of the evidence sharing configurations that are provided to share evidence between the Insurance Affordability application and integrated cases, the Participant Manager, and Income Support:

Table 3: Evidence sharing configurations

Source	Target	Configuration
Application Case (All Merative™ Social Program Management Health Care Reform application types that exclude Account Transfer CoC application)	Integrated Case – Insurance Affordability	All evidence types are Trusted Source=Yes
Integrated Case – Insurance Affordability	Participant Manager – Person Record	All evidence types are Trusted Source=Yes (standard behavior for Participant Manager evidence)
Participant Manager – Person Record	Application Case (All Merative SPM Income Support for Medical Assistance application types that exclude Account Transfer CoC application)	All evidence types are Trusted Source=Yes
Participant Manager – Person Record	Integrated Case – Insurance Affordability	All evidence types are Trusted Source=Yes
Participant Manager – Person Record	Integrated Case – Income Support	All evidence types are Trusted Source=Yes
Participant Manager – Prospect Record	Integrated Case – Income Support	All evidence types are Trusted Source=Yes
Integrated Case – Income Support	Participant Manager – Person Record	All evidence types are Trusted Source=Yes
Integrated Case – Income Support	Participant Manager – Prospect Record	All evidence types are Trusted Source=Yes
Integrated Case – Insurance Affordability	Integrated Case – Insurance Affordability	All evidence types are Trusted Source=Yes
Logically equivalent evidence sharing		
Integrated Case – Insurance Affordability	Participant Manager – Person Record	Source evidence is SSN Details, target evidence is Identifications, Trusted Source=Yes, Share Verifications – Always, sharing rules XML file contains the attribute mapping rules

Source	Target	Configuration
Participant Manager – Person Record	Insurance Affordability Application Case	Source evidence is Identifications, target evidence is SSN Details, Trusted Source=Yes, Share Verifications – Always, sharing rules XML file contains the attribute mapping rules
Participant Manager – Prospect Person Record	Insurance Affordability Application Case	Source evidence is Identifications, target evidence is SSN Details, Trusted Source=Yes, Share Verifications – Always, sharing rules XML file contains the attribute mapping rules
Participant Manager – Person Record	Insurance Affordability Integrated Case	Source evidence is Identifications, target evidence is SSN Details, Trusted Source=Yes, Share Verifications – Always, sharing rules XML file contains the attribute mapping rules

What can I configure or customize?

From the **Case** section in the administrative application, you can choose which evidence types to share and then to enable or disable each evidence type for sharing on each case type. For example, an integrated case type might have several evidence types and only a few of the evidence types might be suitable for sharing. Therefore, only the suitable types are enabled. In order for sharing evidence to work at the case level, in addition to enabling evidence sharing on evidence types, agencies must be licensed for the Merative™ Social Program Management *Evidence Broker* function.

From the **Rules and Evidence** section of the administrative application, you can configure the evidence sharing settings. You can also configure evidence to be shared between Insurance Affordability integrated cases and Income Support integrated cases by using logically equivalent evidence sharing rules. For more information about configuring evidence sharing, see the related link.

Related concepts

Run Program Group Logic and Activate Product Delivery Cases

Following successful program authorization and creation (or reuse) of an integrated case, program group logic is run on the integrated case to determine the set of eligible programs and the citizens who receive these programs

Rules logic determines whether to create a new product delivery case, or reuse an existing product delivery case, and determine the post processing that is required in various situations. This logic applies only within an Insurance Affordability integrated case, and not across other integrated cases. Product delivery cases are created, one for each of the eligible Insurance Affordability programs for which a household is eligible.

For the Insurance Assistance (IA) and Unassisted Qualified Health Plan (UQHP) product delivery cases (including State Basic Health Plan and Employer Sponsor coverage), the rules are different based on whether the application date is in the open enrollment period or not. If the application date is in an open enrollment period, the certification period is set to start on the first day of the coverage period for the first open enrollment period that is configured in the system (for example,

Jan. 1, 2014) and ends on the last day of that coverage period (Dec. 31, 2014). Eligibility is determined for the calendar year. The product delivery case start date is set to the certification start date. Individuals that apply after the coverage period start state are found to be ineligible from the certification period start date until the day before they are eligible.

If the application date is not in the open enrollment period, the certification period is set to after the coverage period state date and ends on the last day of that coverage period (for example Dec. 31, 2014). Eligibility is determined for remainder the calendar year. The product delivery case start date is set to the certification start date. Individuals that apply after coverage period start date are found to be ineligible from the certification period start date until the day before they are eligible.

For the Streamlined Medicaid and Children's Health Insurance Program (CHIP) product delivery cases, the certification period is set to start on the first day of the application month where the individual is eligible in the application month. For example, if the individual applies for benefits in June 5, 2015, and is determined eligible at that time, then the coverage period is would begin on June 1, 2015, and end May 30, 2016. The product delivery start date is set to the certification start date. An exception applies where the Streamlined Medicaid product delivery includes a child eligible for the Deemed Newborn category and the child’s date of birth is before the application date. The child is eligible from the child's date of birth. The certification period is 12 months starting on the first day of the month in which the date of birth occurs.

For exemptions, the exemption period starts from the month the applicant has a valid exemption reason or the first of the calendar year, whichever is later. The end date is when the exemption reason is no longer satisfied or the end of the calendar year, whichever is earlier.

The eligibility rules take in to account the certification period. Therefore, decisions within the product delivery case that depict the eligibility duration that starts from the product delivery case creation date until the end of the certification period are created. Typically when the individual applies before the enrollment period starts, two decisions are available. One ineligible decision from the case start date until the start of the certification period and another eligible decision that covers the duration of the certification period. For IA and UQHP, for applications both in and outside of open enrollment, there is a 15 day eligibility rule. If the application date is between the first and 15th of the month, eligibility start date is the first of the following month. If the application date is after the 15th of the month, eligibility start date is the first day of the second month following the month of application.

Based on the client-attested data, if the household is eligible for Streamlined Medicaid starting Jan. 1, 2014, until March 31, 2014, and thereafter eligible for Insurance Assistance, both the products would be created during program authorization with the decisions within the product that reflect the eligibility period of coverage on the products.

For Merative SPM Income Support for Medical Assistance, the following product delivery cases are created:

- Streamlined Medicaid
- CHIP
- Insurance Assistance product deliveries, one product delivery for each tax household determined eligible
- State Basic Health Plan
- Unassisted Qualified Health Plan
- Exemptions
- Employer-Sponsored Insurance

When a new product delivery case is being created, a check is done to determine whether a product delivery of that type exists on the integrated case. If existing product delivery exists that is suitable for reuse, it is reused. Otherwise, a new product delivery is created.

If the existing product delivery case is closed, the closure reason is checked to see whether the case can be reopened. Cases with a closure reason of 'Created in Error' are never reopened. The indicator 'Reassess Closed Cases' for a product delivery case type is bypassed if the case is closed with a closure reason of 'Created in Error'. If the case cannot be reopened, then a new product delivery case is created. The closure reasons that prevent a product delivery case from being reopened can be configured.

What can I configure or customize?

You can customize the program group logic rules to meet your project requirements. The list of closure reasons for which a case will never be reopened can be configured through an application property.

The `BulkICReassessment` batch process allows a bulk run of program group logic for all cases on the system. Support is provided to customize this batch process.

Related concepts

Generate Communications

Merative SPM Income Support for Medical Assistance provides for a basic set of communications, primarily to notify the applicant or current enrollee of an eligibility determination. The notification for eligibility determination varies depending on whether outstanding verifications remain that are associated with the application.

For the straight-through application process where client-attested information is verified successfully, the eligibility determination and associated communication notify the applicant of the household's eligibility. This determination is a combined notice for the household members across the insurance affordability, employer-sponsored coverage, and exemption programs, which notifies the household of their individual eligibility for Medicaid, Children's Health Insurance Program (CHIP), state basic health plan, employer-sponsored insurance, or exemption.

Where outstanding verifications exist, the communication notifies the applicant of household eligibility on a temporary basis. This notification is necessary to support the inconsistency period for an application, during which eligibility must be determined by using the client-attested information. This notification includes details of the client-attested information that as yet is verified, and requires follow-up with a caseworker. Each notice includes details on the possible appeal for any decision that is associated with an eligibility determination along with instructions on how to file that appeal. Four notifications are available:

Table 4: Merative SPM Income Support for Medical Assistance client notifications

Notification	Description
Eligibility decision for an application	If authorization of an application succeeds, then this notification is generated informing the household of the decision. It is stored as a communication with the integrated case for the primary client.

Notification	Description
Eligibility decision as the result of evidence change	If evidence was added to the integrated case and applied successfully, then this notification is generated informing the household of the decision. It is stored as a communication with the integrated case for the primary client.
Preliminary eligibility determination with evidence inconsistencies	This determination is generated for an application case and the primary client when it is first created if the application has outstanding evidence that needs to be resolved.
Preliminary eligibility determination with evidence inconsistencies for a change reported through evidence	This determination is generated for an integrated case when new evidence is introduced to the case.

What can I configure or customize?

Support is provided for two types of templates: Extensible Stylesheet Language (XSL) templates and Microsoft Word templates. XSL templates are stylesheets that are used for generating pro forma communications; Microsoft Word templates are used to create Microsoft Word communications. These templates are managed differently on the system.

Related concepts

Viewing Eligibility

After the program group logic is run and the product delivery cases are active, you can view eligibility details by using the Eligibility Viewer (EV) on both the Integrated Case and Person or through the product delivery case decisions.

Over time, individuals might be eligible for different programs. The Eligibility Viewer (EV) provides a holistic view of eligibility at the Integrated Case and Person level. At the Integrated Case level, the EV provides the caseworker with a single consolidated timeline view of program eligibility for all members of the Integrated Case. At the Person level, the EV provides the caseworker with a single timeline view of a person’s eligibility across Integrated Cases.

Eligibility is displayed for the current calendar year with the current month highlighted. The caseworker can use **Back** and **Forward** buttons to view eligibility for either an earlier or later year. For each member, eligibility for a program is represented by an eligibility bar on the timeline, where members are ordered first by Integrated Case primary client, and then by age. The caseworker can also view the eligibility information in a list format. The caseworker can click an eligibility bar and see the start and end dates of eligibility. A split is displayed on the eligibility bar where there is a change in either eligibility or entitlement for the program. For example, a split is displayed if the Annual Premium Tax Credit (APTC) amount that the tax filer is eligible for changes from $50 per month to $75 per month.

For each program type that a client is eligible for, the caseworker can click the eligibility bar and view extra information in addition to the coverage start and end dates. The extra information provides the caseworker with details that contribute to the eligibility calculation to help answer customer queries about eligibility. For example, the following extra information is displayed:

- **Insurance assistance and SBHP programs**
  - Tax household
  - Assistance unit
  - Monthly premium tax credit

  - Household income
  - Cost sharing reduction
  - Percentage of federal poverty limit (FPL)
- **Children's health insurance program (CHIP)**
  - Financial unit
  - Assistance unit
  - Monthly premiums
  - Maximum co-payments
- **Streamlined Medicaid**
  The period of retroactive coverage is highlighted in the bar.

Key events

If one or more key events occur in a month, where a key event is either an evidence change or a rule change, an icon is displayed next to the month. The caseworker can click the icon to view a list of changes. For each change, the list indicates the date of the change, a brief description of the change, and the person that the change applies to, as shown in the following example:

```
mm/dd/yyyy - Income increase - Case participant name (age)
```

Examples of evidence changes include a change in income or age, or the addition of a new member to a case.

The following sample rules that can be used to determine changes in a case are provided with the default installation:

- In receipt of Streamlined Medicaid - child individual's19th birthday occurs during the month
- In receipt of Streamlined Medicaid - adult individual's 65th birthday occurs during the month
- In receipt of Streamlined Medicaid - former foster care and 26th birthday occurs during the month
- In receipt of Emergency Medicaid and date of entry is 5 years before the current date

What can I configure or customize?

The display of the eligibility viewer can be customized. New product types can be configured to display in the eligibility viewer. Also, an administrator can customize the rules that determine evidence changes.

Viewing Product Delivery Decisions

Decision screens are available that display the results of an eligibility decision for each insurance affordability program. These screens provide a detailed overview of the eligibility decision for each household member in a product delivery case.

Cúram Express Rules (CER) are used to define the display rules that determine what is displayed based on whether rules or rule groups are satisfied or not. Eligibility for each program is assessed against a common set of factors, and these factors are grouped accordingly on the decision screen. The decision details provide the caseworker with high-level summary of eligibility or ineligibility for a program, in addition to the ability to drill down to view member eligibility or ineligibility and reasons for that determination.

A standard set of decision screens are available for each of the insurance affordability programs - overall summary, non-financial summary, and an income summary.

Table 5: Decision screens for each of the insurance affordability programs

Category summary	Information presented
Eligibility summary	Pass/fail for income and non-financial information.
Program-specific summary for Streamlined Medicaid	Eligible members and the coverage category for which they are eligible, for example, parent/ caretaker, child, pregnant woman, adult, former foster care recipient.
Program-specific summary for CHIP	Coverage cost, including the monthly premium and the maximum co-payment limit.
Program-specific summary for Insurance Assistance	Benefit unit and assistance details; including the premium tax credit and cost sharing reduction.
Excluded members	Household members that are excluded from the determination of program eligibility are displayed along with the exclusion reason. For example, members that are eligible for Medicaid coverage are displayed as excluded members in the CHIP program, with the exclusion reason: Eligible for Medicaid.
Exempted members	Members of American Indian/Alaskan Native origin are exempted from the CHIP coverage cost.

The non-financial summary includes a high-level eligibility summary per member for each of the areas assessed within the non-financial rules for that program:

- Social Security Number (SSN), Residency and Citizenship are displayed for Medicaid and Children's Health Insurance Program (CHIP).
- Residency, Citizenship, and Incarceration are displayed for Insurance Assistance.

An income summary is also presented which reflects the income requirements of each program. For Medicaid, CHIP and Insurance Assistance, the income summaries include the following types of information:

- Financial Units summary (for Medicaid, financial units are formed for each member of the case. For CHIP, financial units are formed around each child) including whose income in the unit is counted or not counted
- For CHIP, financial units are formed around each child) including whose income in the unit is counted or not counted.
- Tax Household summary (for Insurance Assistance) lists the members in the tax household.

  The Income Summary provides a summary of the income and calculations used in the eligibility determination. These vary according to the source of income used in the calculations. Income eligibility provides a summary per member including the household income, the household size, the FPL for that household size, and the income as a percentage of the FPL.

What can I configure or customize?

From the Cases section in the Admin application, the organization can configure the product delivery case decision categories to explain how eligibility and entitlement results are determined.

Support is provided to customize the associated CER display rules.

Related tasks

Check Retroactive Eligibility

Use this information to understand how to run an eligibility check for Retroactive Medicaid that uses the evidence that is active on an Insurance Affordability integrated case.

Cúram supports Retroactive Medicaid for Modified Adjusted Gross Income (MAGI). The Insurance Affordability integrated case type is configured to include an option for a caseworker to run an eligibility check for Retroactive Medicaid that uses the evidence that is active on the case. If found eligible for Retroactive Medicaid and a Streamlined Medicaid product delivery case exists for the client, the certification start date is moved back to accommodate eligibility during the retroactive period (the past three months). If a Streamlined Medicaid PD does not exist for the client, a product delivery case is created for the retroactive period. The **Determinations** tab on the PDC displays only eligible/ineligible decisions for retro and SM period. The determinations tab on the product delivery case displays a decision of Yes for Retroactive Medicaid for the coverage period.

You can be eligible for Medicaid for three months before the month of application. When you have medical expenses during any of the three months immediately before the month you apply for Medicaid, you might be able to receive Medicaid for some or all of that time if you met the eligibility requirements in those months. Income and resources (if applicable) are calculated separately for each month of retroactive coverage. In case of policy changes during the retroactive period, the policy and income limits for each retroactive month apply.

You do not have to be eligible for the month of application to be eligible for any of the retroactive months.

The basic flow for Merative SPM Income Support for Medical Assistance when it determines Retroactive Medicaid is as follows:

1. Clients can request for retroactive Medicaid eligibility determination by answering `Yes` to the question 'Does anyone in the household need help paying for medical bills from the last 3 months?' on the solution's **Find Assistance** application.
2. On Application authorization, a task is generated to the caseworker that indicates the clients request for retroactive Medicaid eligibility.
3. A caseworker then is expected to add the required evidence data for the past 3 months and use the **Check Retroactive Medicaid Eligibility** link that is introduced on the Integrated case to trigger the retroactive Medicaid eligibility determination process.

To be eligible for retroactive Medicaid eligibility, a client must pass the existing Streamlined Medicaid rules for the retroactive months and have medical bills for the retroactive months.

What can I configure or customize?

Retroactive rules can be customized in CER.

Generate Communications

Merative SPM Income Support for Medical Assistance provides for a basic set of communications, primarily to notify the applicant or current enrollee of an eligibility determination. The notification for eligibility determination varies depending on whether outstanding verifications remain that are associated with the application.

For the straight-through application process where client-attested information is verified successfully, the eligibility determination and associated communication notify the applicant of the household's eligibility. This determination is a combined notice for the household members across the insurance affordability, employer-sponsored coverage, and exemption programs, which

notifies the household of their individual eligibility for Medicaid, Children's Health Insurance Program (CHIP), state basic health plan, employer-sponsored insurance, or exemption.

Where outstanding verifications exist, the communication notifies the applicant of household eligibility on a temporary basis. This notification is necessary to support the inconsistency period for an application, during which eligibility must be determined by using the client-attested information. This notification includes details of the client-attested information that as yet is verified, and requires follow-up with a caseworker. Each notice includes details on the possible appeal for any decision that is associated with an eligibility determination along with instructions on how to file that appeal. Four notifications are available:

Table 6: Merative SPM Income Support for Medical Assistance client notifications

Notification	Description
Eligibility decision for an application	If authorization of an application succeeds, then this notification is generated informing the household of the decision. It is stored as a communication with the integrated case for the primary client.
Eligibility decision as the result of evidence change	If evidence was added to the integrated case and applied successfully, then this notification is generated informing the household of the decision. It is stored as a communication with the integrated case for the primary client.
Preliminary eligibility determination with evidence inconsistencies	This determination is generated for an application case and the primary client when it is first created if the application has outstanding evidence that needs to be resolved.
Preliminary eligibility determination with evidence inconsistencies for a change reported through evidence	This determination is generated for an integrated case when new evidence is introduced to the case.

What can I configure or customize?

Support is provided for two types of templates: Extensible Stylesheet Language (XSL) templates and Microsoft Word templates. XSL templates are stylesheets that are used for generating pro forma communications; Microsoft Word templates are used to create Microsoft Word communications. These templates are managed differently on the system.

Related concepts

Income Support Caseworker Role

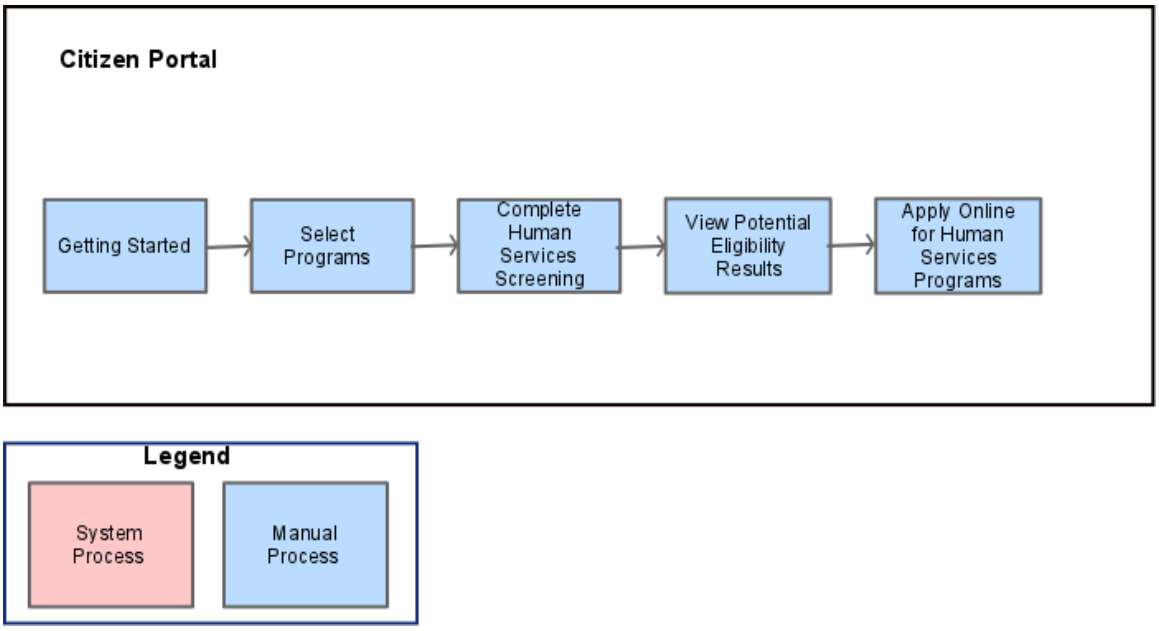
A case worker might need to manage applications and cases that combine Insurance Affordability and traditional Medicaid, Food Assistance, or Cash Assistance programs. While Cúram Health Care Reform and Income Support have distinct business processes, a caseworker can manage all applications and cases through a single workspace with the IS Case Worker role. The IS Case Worker role combines the HCR Case Worker and IS Eligibility Worker roles. By using the IS Case Worker role, a caseworker can work on applications and cases that previously needed to be done separately by the two roles.

What can I configure or customize?

The workspace can be configured and customized to meet the business needs of the agency for this particular role. For example, the home page, pods, the application view, and pages within the view.

2.3 Check Eligibility for Human Services Programs

The interactive business flow diagram outlines the process for checking eligibility for Human Services programs. Click a process to view information about the process in a separate topic.



1. Getting Started on page 70
2. Select Programs on page 70
3. Complete Human Services Screening on page 72
4. View Potential Eligibility Results on page 72
5. Apply Online for Human Services Programs on page 73

Getting Started

When the client selects to check if they are eligible for other programs from the home page, the system displays the Getting Started page with three options: create an account, log into an existing account, or start screening without creating an account.

What can I configure or customize?

The Getting Started page is implemented in Universal Access. It is a Page Player page. The Page Player is a Universal Access framework that displays non-UIM pages on the Universal Access citizen portal.

Certain elements of the page can be configured by the organization. When the client creates their user account, their data is secured under this account. Multifactor authentication can also be configured to allow for additional authentication when a client attempts to log in to the system. From the Universal Access section of the Admin application, select the Authentication Factors link to configure the factors.

Related information

Select Programs

After the client either logs in to their account and authenticates or selects to start screening without creating an account, the client is taken to a page where they can select a screening type. From the Select Screening page, the client can select to complete a human services screening by providing only basic information about the household. The system uses the basic information to determine what benefits and services might be available to the client. Alternatively, the client can select to run a screening by providing more detailed information about the household to get a more accurate result.

Human services programs provide financial and medical assistance and supportive services to vulnerable clients of all ages to help them achieve and maintain independence and optimum health and improve their lives. Services and benefits include temporary and emergency cash assistance, work and training opportunities, health care, food and nutrition benefits, housing and home energy assistance, and child development programs.

Human Services Screening provides eligibility determination for the programs and services listed below.

Programs	Description
Cash Assistance	This program provides temporary cash assistance, supportive services, and work opportunities to needy families. The program's goal is to help people get employment and become self-sufficient through job training, education, and work activities.
Child Care Assistance	The Child Care Program provides assistance to low-income families who need child care so they can work or participate in a work-related training or education activity. The purpose of the program is to ensure that children are well cared for in a safe, healthy, and educational environment by trained, qualified child care providers while parents are working or attending training.

Programs	Description
Early Head Start	The Early Head Start program (for pregnant women, infants and toddlers) provides educational, health, nutritional, and social services for low-income families.
Emergency Assistance	This program provides short-term cash assistance to citizens in emergency situations. Examples of emergencies include homeless, need to make a rent payment to prevent eviction, need to make a mortgage payment to prevent foreclosure, need money for legal services to avoid eviction, or the need to make a utility payment to prevent shutoff.
Food Assistance	The Food Assistance Program helps low-income people and families buy the food they need for good health. This benefit may be issued in the form of vouchers or credit on an Electronic Benefits Card (EBTcard) which can be used in place of cash to purchase food in participating stores.
Head Start	The Head Start program (for children ages 3-5) promotes school readiness for children in low-income families by providing comprehensive educational, health, nutritional, and social services. The program focuses on helping preschoolers develop the early reading and math skills they need to be successful in school.
Low Income Home Energy Assistance Program (LIHEAP)	The Low Income Home Energy Assistance Program (LIHEAP) assists eligible low income households pay home heating costs. Households may also be eligible for cooling assistance and emergency heating assistance.
Medical Assistance	The Medical Assistance program provides health care and health related services to certain low income individuals and families, including families with dependent children, pregnant women, children to age 21, individuals age 65 and older, or individuals determined blind or permanently disabled.
School meals	School Meals (National School Lunch program and School Breakfast program) provides free, nutritious meals and snacks to children in low income areas.
Summer meals	The Summer Food Service Program provides free, nutritious meals and snacks to children in low-income areas. The program helps children get the nutrition they need to learn, play, and grow, throughout the summer months and during other long periods when they are out of school.
Women, Infants and Children (WIC)	The purpose of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is to promote and maintain the health and well-being of nutritionally at risk pregnant, breastfeeding and postpartum women, infants and children. The WIC program provides supplemental nutritious foods, nutrition and breastfeeding information, and referral to other health and nutrition services.

What can I configure or customize?

The types of programs and screenings that are available can be configured by an organization.

The help text in the IEG script can be customized.

Complete Human Services Screening

Human services screening enables the client to check their potential eligibility for a range of programs and services. It also provides the client with the necessary information to make an informed decision about whether to pursue benefit assistance. The human services screening script guides the client through a set of questions that relate to the client, the home, benefits, income, expenses, and resources.

Clients are not required to enter detailed information. However, the accuracy of the screening eligibility determination depends on the level and accuracy of information entered by the client. Clients can complete the screening anonymously.

The client can screen for multiple clients in a household. More clients can be added at any stage during the screening process.

Following completion of the screening process, the system determines potential eligibility for assistance. The screening eligibility determination rules are then run against the recorded data to determine the potential eligibility.

What can I configure or customize?

You can configure screening types and related programs in the Universal Access section of the administration application.

Human services screening is implemented through the Merative ™ SPM Universal Access components. From the Intelligent Evidence Gathering section of the Social Program Management administration application, the customer can customize the scripts. Because the state screening script requirements vary by state, the customer might need to customize the scripts to meet project requirements. Intelligent Evidence Gathering scripts have a defined structure and a set of supported operations for IEG expressions. The entire script can be customized.

View Potential Eligibility Results

Universal Access is used to display the eligibility results page for the range of human service programs and services. A list of potentially eligible programs and a list of programs for which eligibility might not be determined are displayed to the client.

A client can select a link on any of the programs that are displayed in the results pages, and depending upon configuration this action results in the client to be taken to any of the following program-specific options:

- Online Application for the selected programs
- An external website to view further program information for example SNAP or TANF

Online help is available for terminology that is of significance to the individual to make the decisions that best address the needs of the household.

What can I configure or customize?

This page contains the screening results including the display rules written for the specific program. It also contains a **More Info** link that can go to an external website, for example a Food and Nutrition Service (FNS) website for Supplemental Nutrition Assistance Program (SNAP). The Cúram Express Rules (CERs) screening rule sets can be customized to support custom display rules on the **screening results** page.

Apply Online for Human Services Programs

After the client views the potential eligibility results, the client can select to apply for human services programs either online or by printing and mailing in the application form. From the 'Your Next Step' page of the screening script, the client can see a list of programs that can be applied for online. As a result of integration with Income Support, the **Apply Online** function is enabled for Food Assistance, Medical Assistance, and Cash Assistance.

Applying online begins the application process for the selected Income Support programs - a client is taken into the program selection screen, Human Services Application Form, as part of the Universal Access intake process.

The Income Support intelligent evidence gathering (IEG) application script is displayed. Mapping functions were added which transfers information from the data store that is used by the Income Support screening script to the one used by the Income Support application script when a user chooses to apply for one of the Income Support programs from the screening results page. A generic mapper transfers data items with the same name.

When the application intake process is finished, the user is returned to the client's home page with the status of the relevant applications updated.

Authenticated individuals can save and exit an in-progress application. Saved applications can be resumed for completion later.

What can I configure or customize?

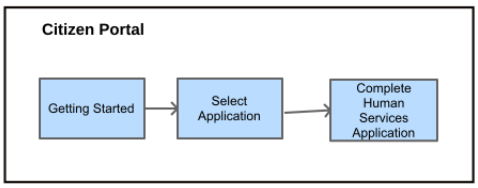
Screening types and related programs can be configured in the Universal Access section of the administration application.

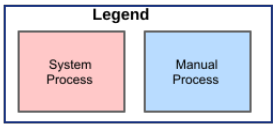
Since the state application script requirements vary by state, the organization might need to customize the scripts to meet the project requirements. From the IEG section of the Social Program Management Administration application, it is possible to customize the default Income Support IEG scripts. Intelligent Evidence Gathering scripts have a defined structure and a set of supported operations for IEG expressions. The entire script can be customized. The organization can configure whether they require prepopulation of the screening script to occur.

2.4 Apply for Human Services Programs

If your organization delivers Merative ™ SPM Income Support programs, your organization can benefit from integration with application processes or ongoing case management, depending on

your system. From the **Merative SPM Income Support for Medical Assistance** home page, a client can create a user account and apply online for select programs.





1. Getting Started on page 70
2. Select Application on page 76
3. Complete Human Services Application on page 77

The solution is delivered as part of the Merative SPM Income Support solution product. Cúram Income Support functionality supports applications and ongoing case management for Food Assistance, Cash Assistance, and traditional Medicaid coverage types. There is close integration between the application process and ongoing case management for the Merative SPM Income Support for Medical Assistance insurance affordability programs and the equivalent processes for traditional Medicaid coverage types as provided by Merative SPM Income Support.

The section provides a detailed description of the Apply for Other Programs feature that is available from the solution's home page.

What can I configure or customize?

For Merative SPM Income Support for Medical Assistance only organization's (that do not use the Income Support solution), the organization should customize the HCR landing page to remove the Apply for Other Programs link.

Getting Started

When the client selects to check if they are eligible for other programs from the home page, the system displays the Getting Started page with three options: create an account, log into an existing account, or start screening without creating an account.

What can I configure or customize?

The Getting Started page is implemented in Universal Access. It is a Page Player page. The Page Player is a Universal Access framework that displays non-UIM pages on the Universal Access citizen portal.

Certain elements of the page can be configured by the organization. When the client creates their user account, their data is secured under this account. Multifactor authentication can also be configured to allow for additional authentication when a client attempts to log in to the system. From the Universal Access section of the Admin application, select the Authentication Factors link to configure the factors.

Related information

Select Application

After the client either logs into their account and authenticates or selects to start the application process without creating an account, the client is taken to the first page of the application script.

From the Select Application page, the client can select to complete the human services application form.

What can I configure or customize?

Applications and programs can be configured in the Universal Access section of the administration application.

Complete Human Services Application

The client can select to apply for other human services programs either online or by printing out and mailing in the application form. From the 'Human Services Application Form' page of the script, the client can see a list of programs that can be applied for online. This begins the application process for the selected Income Support programs, such as Food Assistance, Cash Assistance, or traditional Medical Assistance.

The Income Support IEG application script is displayed.

When the application intake process is finished, the user is returned to the client's home page with the status of the relevant applications updated.

Authenticated individuals can save and exit an in-progress application. Saved applications can be resumed for completion at a later date.

Submitted applications can be withdrawn by selecting a Reason and entering other details if the reason is other. The citizen electronically signs the application by checking the signature box and signing with the same name used on the application.

What can I configure or customize?

Applications and programs can be configured in the Universal Access section of the Social Program Management Administration application.

Since the state application script requirements vary by state, the organization will likely need to customize the scripts to meet the project requirements. From the Intelligent Evidence Gathering section of the Administration application, it is possible to customize the default Income Support IEG scripts. Intelligent Evidence Gathering scripts have a defined structure and a set of supported operations for IEG expressions. The entire script can be customized.

Integration with Income Support Intake

If a citizen submits their Merative SPM Income Support for Medical Assistance application from the **Health Care Reform** results page and then submits an application for another Income Support program, the two applications are processed separately. The respective intake processes for these two applications are quite different from each other.

Merative SPM Income Support for Medical Assistance uses Cúram Intake application case functionality. Income Support makes uses a type of application case that is a facade that is built on top of an integrated case.

Where the two applications can overlap is through how the two different intake processes can match applicants against people who are already registered in the system. In the Health Care Reform solution, this is an automated process, facilitated by Person Match processing. In Income Support, this is a manual process facilitated by Client Merge processing.

For example, if a citizen submits a Merative SPM Income Support for Medical Assistance application when there had previously been no record of them in the system; as part of the process of creating an application case and mapping information to it, the Person Match algorithm is run for each of the people on the application. Since no matches are found, the individuals are automatically registered as new participants on the system. As part of registering these people, person evidence is created for evidence items such as their name, date of birth, SSN. The standard straight-through process then takes effect for this application to decide whether manual

intervention is required before authorizing the program and creating an insurance-affordability integrated case with the necessary product delivery cases created within it.

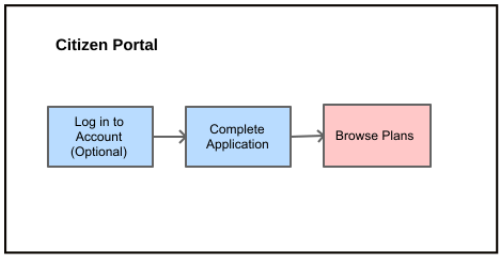
When the Income Support application is submitted, each of the people on the application (which would typically, but not always, be the same people submitted on the Merative SPM Income Support for Medical Assistance application) are initially created as prospect persons and the intake worker is responsible for registering them. To do this, they search for people that are already registered in the system with similar details and if they find someone they are happy is a match, the intake worker can then 'merge' the prospect with the actual person on the system, ensuring that any evidence entered as part of this application is associated with that person. Depending on the Evidence Broker configuration, evidence can also be shared from the Income Support application case to the Cúram Health Care Reform application case (if it is still open) or the solution’s integrated case. This can happen through the person evidence; and directly between the cases (evidence brokering happens automatically if the configuration is in place).

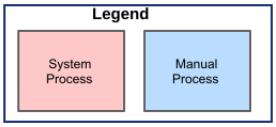
If a Merative SPM Income Support for Medical Assistance application is submitted when people on the application are already registered via an Income Support application, then the process of matching the new applicants with the existing people is automatic so long as either a conclusive match or no match at all is found. Where multiple potential matches exist, a task is created for a case worker to decide whether any of those potential matches should be used or a new person registered

Related concepts

2.5 Check Cost of Health Plans

For organizations that have implemented a plan management system for a state-based exchange, citizens can browse the details and cost of the plans offered by the exchange. A user account is not required because there is no eligibility determination at this stage. Social Program Management provides an API that supports integration with a plan management vendor. Customers must provide their own implementation of the API to communicate with the plan management vendor.





1. Getting Started on page 70
2. Browse Plans on page 80
3. Submit Application for Client on page 48

Getting Started

When the client selects to check if they are eligible for other programs from the home page, the system displays the Getting Started page with three options: create an account, log into an existing account, or start screening without creating an account.

What can I configure or customize?

The Getting Started page is implemented in Universal Access. It is a Page Player page. The Page Player is a Universal Access framework that displays non-UIM pages on the Universal Access citizen portal.

Certain elements of the page can be configured by the organization. When the client creates their user account, their data is secured under this account. Multifactor authentication can also be configured to allow for additional authentication when a client attempts to log in to the system. From the Universal Access section of the Admin application, select the Authentication Factors link to configure the factors.

Related information

Complete Application

An integrated development environment (IDE) script is used to ask clients for some basic information that can affect the quote for a monthly premium for plans, such as date of birth, tobacco usage, and the postal code for the household. Plan providers can vary plan premiums only for households in the exchange based on four factors: age, tobacco usage, family size, and geographical area. Legislation prohibits the use of other rating factors such as current health status or medical history. The available plans are displayed based on the data returned from the plan management system.

What can I configure or customize?

The organization can customize the home page to include the motivations to meet the project requirements. Each motivation that is displayed on the solution home page is configured in Universal Access section of the Social Program Management Administration application. The motivation is associated with an IEG script, a data store schema, and a display rule set. The IEG script can be customized.

Browse Plans

From the eligibility results page, the client can select to **Browse for Plans** to see a list of plans they are eligible for and decide on a plan that best suits their needs. Information about plans

is taken from the plan management system - the plans are displayed along with the monthly premium that was calculated.

Clients cannot select and enroll in plans within the plan management system. After the client reviews the available plans, if a client decides they want to apply for a plan, they must apply for assistance as described in the Citizen Portal Intake process

What can I configure or customize?

The display of the eligibility results page is configured through a combination of display rules and configurations in the **Universal Access** section of the **administration** application.

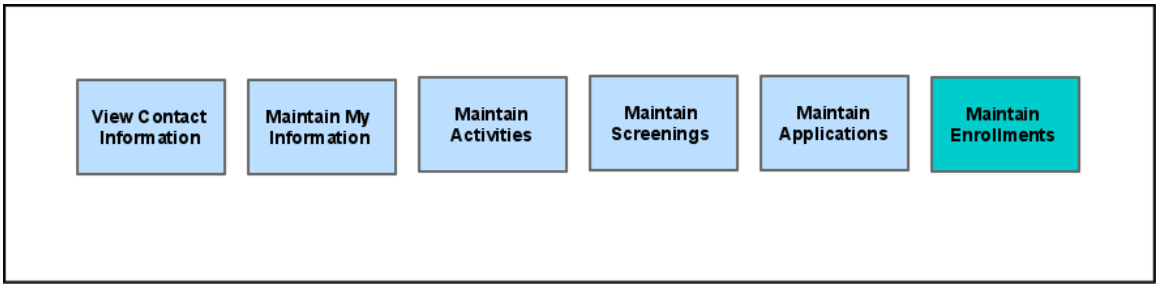
Plan management integration is accomplished with a combination of both user interface and web services integration. A plan management vendor's user interface is shown in an inline frame on a Social Program Management page.

A plan management vendor must call Social Program Management web services to be able to populate their screens for this scenario. An organization can replace the default Social Program Management web services with their own custom web services if required.

Social Program Management provides a plan management application programming interface (API) interface that supports integration with a plan management vendor. Social Program Management implements a vendor-agnostic approach to plan management integration and does not include a specific implementation of the plan management API interface in the product. Each project is responsible for implementing their own integration between the Social Program Management system and the plan management system of choice.

2.6 Maintain Your Citizen Account

Clients can view and maintain their personal and account information with the options on the **Citizen Account** home page.



1. View Contact Information on page 83
2. Maintain My Information on page 83
3. Maintain Activities on page 83

4. Maintain Screenings on page 84
5. Maintain Applications on page 84
6. Maintain Enrollments on page 84

Note: **Maintain Enrollments** might not be relevant for states that have chosen the Federally Facilitated Model or to work in partnership with the Federal Market Place.

Citizen Account Home Page

The **Citizen Account** home page provides a central location for the client to create a user account, view or update their information, submit applications for insurance affordability programs, and track ongoing applications. When the client logs in, the page displays their options plus the messages and campaign information and Merative SPM Income Support for Medical Assistance (HCR)-specific links.

These links represent the same options that are available from the solution's landing page, where appropriate. The client can access the **Citizen Account** home page only if the client is authenticated by the organization. The client also needs to have a linked account (the client must be registered as a participant and be linked to their Citizen Self-Service Account).

The home page itself has three main sections: **Messages**, **Outreach**, and the **left navigation** pane.

- **Messages** pane - The messages section displays messages that aim to predict why the client is logged in. For example, the Cúram HCR **Citizen Account** home page displays a Health Care Application acknowledgment message that the organization received the client's healthcare application for Insurance Affordability. The message indicates the status of the application along with the application reference number.
- **Outreach** pane – Outreach allows agencies to define targeted campaigns, which can be displayed in the client account. The campaigns are based on information that the agency knows about the client. In addition to the option to view the status of any enrollments, when a client logs in to their Citizen Account, the **Outreach** pane presents details about the next open enrollment period. This feature uses the campaign functions available in Universal Access (UA). The client's account displays dynamic information about open enrollment periods. An entry is made to the **campaign bar** on the right side of the account home page 30 days before the start of an enrollment period. This marker counts down towards the start of the period. After that period starts, messages are displayed stating how long the individual must apply before end of the enrollment period. It is hoped that this message gives the client prior warning of when enrollment is expected, and after it is open, the time limit to enroll in a plan.
- **Left navigation** - From the left navigation pane of the **Citizen Account** home page, the client can view their activities, enrollments, applications, screenings, navigator information, contact information, caseworker contact information, updates, and appeals. More information for each of these items is provided in the information that follows:

Clients or their authorized representatives can see the status of any applications, resume or delete these applications, or continue to enrollment.

Applications for both traditional Medicaid and Modified Adjusted Gross Income (MAGI) Medicaid (as part of an Insurance Affordability application) are available. When enrollment is complete, they can be viewed in the account.

What can I configure or customize?

Cúram HCR implemented a custom version of the **Universal Access Client Account** home page. The **Citizen Account** home page is extended with an extra pane to contain solution-specific links. Support is provided to configure many aspects of the **Citizen Account** home page, which includes the following information:

- The text displayed in the participant messages in the **Messages** pane.
- System messages displayed in the **Messages** pane.
- The display order of the messages displayed in the **Messages** pane.
- The campaigns displayed in the **Outreach** pane.
- The welcome message displayed to a client.

The Citizen Account also provides a framework for organizations to build their own client account pages or to override the existing pages.

View Contact Information

The **Contact Information** tab in the Citizen Account lists the caseworker contact details. The system displays phone numbers, addresses, and email addresses for the caseworker.

What can I configure or customize?

The Universal Access **Contact Information** page can be configured through a number of application properties. An organization might want to display more contact information; for example, Twitter handle, for a caseworker. To do this, an organization should implement the necessary interface that allows the addition of extra caseworker contact details to the Contact Information screen in the Citizen Account. Both the properties and interface information are provided through the links that follow.

Maintain My Information

The My Information tab in the Citizen Account displays a high level summary of the household information. By default, the household member details, living arrangement details, and tax filing status are displayed. A client can report a change of circumstance to the organization by selecting the **Update My Information** link on the page. This process is documented in the Reporting Change of Circumstance by Client process.

What can I configure or customize?

The My Information page can be replaced with a custom page.

Maintain Activities

The My Activities tab in the Citizen Account displays all activities that are scheduled for the client. Displaying activities helps to ensure that a citizen attends all scheduled activities. Activities include actions, services, and referrals that are scheduled for a client in Social Program Management. Services, referrals and actions are normally scheduled for a client in an outcome plan that aims to help a client achieve a particular goal, for example, self-sufficiency.

What can I configure or customize?

The **My Activities** page can be replaced with a custom page.

Maintain Screenings

The My Screening tab in the Citizen Account displays in progress screenings and completed screenings for the client. The client can choose to continue with an in progress screening or delete it. From the page, the client can choose to start a new eligibility screening. The page displays a list of completed screenings. From there, the client can delete a screening or review the screening information and results.

What can I configure or customize?

Screenings can be configured in Universal Access.

Maintain Applications

The My Applications tab in the Citizen Account lists existing applications that are either in progress (not yet submitted to the agency) or submitted. The client or their authorized representative can access this page only from the citizen account if the client was authenticated by the organization and has a linked account (the client must be registered as a participant and be linked to their Citizen Self Service Account).

The client is presented with several options that depend on the state of a particular application. The client might choose to resume or delete an incomplete application, withdraw an application that was submitted, or start a new application.

If an application is rejected by the organization, it gets reflected on the account so that the client can be aware of the changes.

The client can also review the information that was entered on the application. A PDF document can be generated by the client that contains all of the information entered by the citizen on the application. This application then can be brought or posted to the organization and also acts as a copy for the client’s records of the information that was entered on the application.

What can I configure or customize

The **My Applications** page can be replaced with a custom page.

Applications themselves can be configured through the Admin application. The reasons for withdrawing the program application can be configured for the intake application in Universal Access (UA) administration.

Maintain Enrollments

The My Enrollments tab in the Citizen Account lists the programs that the members of the household are enrolled in. Details about the plan they are enrolled in (including program name, enrolled members, coverage start date, and coverage end date) are visible from the page. By default, the enrolled plans include QHP, CHIP, or Streamlined Medicaid programs supported by

the organization. Enrollment functionality and the data that is displayed here, is unique to this solution and not provided by the Citizen Self-Service in its initial installation.

For States that chose the Federally Facilitated Model (FFM) or to work in partnership with the Federal Market Place (FMP), this process would not be applicable to them.

What can I configure or customize?

The **Maintain Enrollments** page can be replaced with a custom page.

The number of open enrollment periods and their start and end dates can be configured by an administrator.

Merative SPM Income Support for Medical Assistance implements a vendor-agnostic approach to plan management integration and does not include an implementation of the plan management adapter in the product. Each project is responsible for implementing their own integration between the Social Program Management system and the plan management system of choice.

Related concepts

2.7 Create Online Appeal Requests

A citizen might want to appeal a decision that was made about their application, for example, a citizen who applied for a benefit and was deemed ineligible, or whose benefit payments were reduced might choose to appeal the decision. An appeal can be requested online from the citizen's account, if the citizen is a participant on a Social Program Management application or case.

From the **My Appeals** tab of the Citizen Account, the client can request an appeal. When an appeal request is initiated, an IEG script is used to collect the following information:

- The purpose of the appeal
- The name of the person that initiated the appeal
- A capture of the electronic signature.

On submission of the request, a task is created and assigned to an appeal request work queue. A PDF is generated from the Intelligent Evidence Gathering script and is stored for caseworker reference as a communication against the appellant in the caseworker application. A caseworker can then take action on the request and either acknowledge the request and continue with the appeal process or reject the request. An acknowledgment or rejection message is displayed in the account of all citizens that are included in the appeal request. A list of submitted appeal requests is provided in the citizen's account and provides a view of the status of the request.

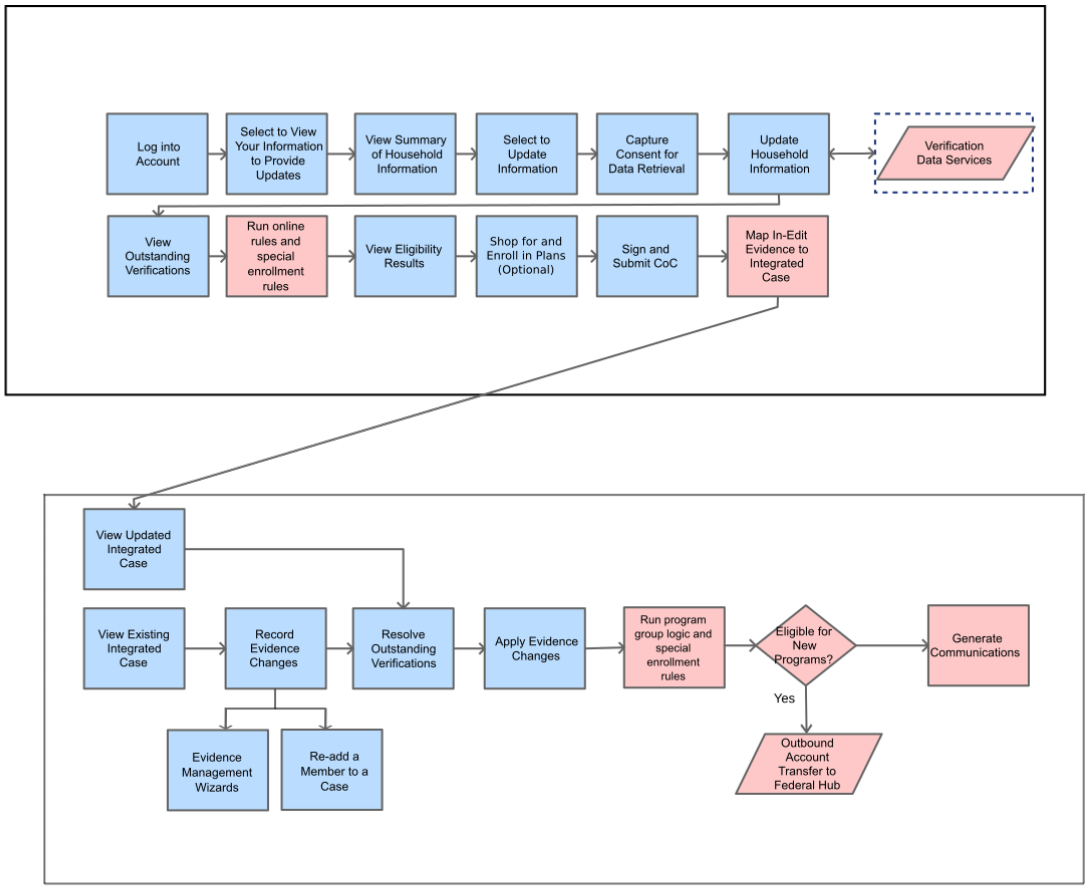
What can I configure or customize?

The default online appeal script is provided in the Admin application. Because appeal script requirements vary by state, the organization will likely need to customize the scripts to meet project requirements. IEG scripts have a defined structure and a set of supported operations for IEG expressions. The presentation of pages in a script is configurable. By default, a PDF that summarizes the information that is entered by a citizen during an appeal request is created when a citizen submits an appeal. The XSL template of this PDF can be configured to meet the project requirements.

Related information

2.8 Changes In Circumstance Reporting

A client's circumstances typically change over time. These everyday changes can affect previously determined eligibility decisions. Clients can report changes through their online account or notify a case worker. Eligibility is redetermined when a citizen submits changes online, or when a case worker adds or updates evidence on the integrated case and applies the changes.



1. Log in to Citizen Account and Select to Record a Change of Circumstance on page 89
2. Log in to Citizen Account and Select to Record a Change of Circumstance on page 89
3. Log in to Citizen Account and Select to Record a Change of Circumstance on page 89
4. Log in to Citizen Account and Select to Record a Change of Circumstance on page 89
5. Capture Consent for Data Retrieval on page 33
6. Update Household Information on page 91
7. Verification Data Services on page 91
8. View Outstanding Verifications on page 92
9. Run Online Rules and Special Enrollment Rules on page 92
10. View Eligibility Results on page 93
11. Shop For and Enroll in Plans on page 94
12. Sign and Submit Change of Circumstance on page 95
13. Map In-Edit Evidence to Integrated Case on page 95
14. Reporting Change Circumstance by Caseworker on page 96
15. View Existing Integrated Case on page 96
16. Record Evidence Changes on page 96
17. Evidence Management Wizards on page 96
18. Re-adding a member to a case on page 98
19. Resolve Outstanding Verifications on page 99
20. Apply Evidence Changes on page 100
21. Run Program Group Logic and Activate Product Cases if Required on page 100
22. Outbound Account Transfer to Federal Hub on page 101
23. Generate Communications on page 102
24. Run Program Group Logic and Activate Product Cases if Required on page 100

Changes in circumstances can cause product delivery cases to be reassessed, which can result in one of the following outcomes:

- A complete or partial change in the product deliveries and eligible case members
- A change to the eligible members of a product delivery
- No change in product delivery or eligible members, but changes to entitlement
- No change in product delivery or eligible members or entitlement

Where a change of circumstance results in an individual moving to a less beneficial product delivery or Medicaid category, adverse action is used to determine when coverage under the existing product delivery or Medicaid category ends. It ensures that an individual who is in receipt of a product delivery or Medicaid category is given timely notice of proposed action to end their eligibility.

Moving to a less beneficial product delivery might occur in one of the following circumstances:

- When an individual moves from Streamlined Medicaid to a Qualified Health Plan.
- When an individual moves from Streamlined Medicaid to CHIP.
- When an individual moves from CHIP to a Qualified Health Plan.

Moving to a less beneficial Medicaid category might occur when an individual moves from one category to another category that is lower down the Medicaid hierarchy, for example, moving from Parent/Caretaker to Adult.

Coverage under the existing product delivery or Medicaid category aligns to the end of the month in which eligibility ends. An extended decision is used where there are 10 days or less before the

end of the month. An extended decision provides an extra month of coverage under the existing product delivery or Medicaid category, to ensure that the individual is given timely notice of the proposed change.

The coverage start for the new product delivery or Medicaid category is triggered by the ending of either the existing product delivery or the existing Medicaid category. Eligibility for the new product delivery or Medicaid category starts on the first of the month following the month in which coverage ends on either the existing product delivery or the existing Medicaid category. This approach ensures that no gaps or overlaps exist in product deliveries or Medicaid categories when moving from one to another.

Reporting Change of Circumstance by Client

Some changes of circumstance can be reported directly through an online citizen account. A citizen with an existing application that has been disposed can report a change of circumstances through their online citizen account. There must be an integrated case but there does not have to be an active product delivery on it. The application must have been authorized. They must report any other changes of circumstance to a caseworker. Correction to information already provided is not considered as a CoC and hence the online CoC reporting does not cover that.

Log in to Citizen Account and Select to Record a Change of Circumstance

From the **Health Care Reform** (HCR) home page, the client can log in to their Citizen Account to report a change of circumstance. The client can log in their account directly from the home page if they already have credentials.

Authentication completes a number of verifications against the log-in credentials. Default authentication involves verifying the user name and password specified during login against the stored values. All log-in information in this case is maintained by the Social Program Management application. Provided all verifications are successful, the user is considered to be authenticated by the application.

After the client logs in to their account and are authenticated, the system displays the Merative ™ SPM Universal Access Citizen Account home page. From the home page, the client can select either the **View your information to provide updates** link or the **My Information** menu option to see a read-only summary of their evidence (such as date of birth, social security number, citizenship, address, and tax filing details).

After the client selects to update their household information, the system displays the **My Information** page. The read-only data that is shown on the **My Information** page is the most current information for each evidence type, specifically the most recent active evidence. If the client recently created an in-edit version of evidence by a previous change of circumstance, that in-edit version is displayed instead.

From the **My Information** page, the client can select to report a change of circumstance by selecting the **Update My Information** link.

> **Note:** This link is displayed only if no change of circumstances are outstanding.

When the client chooses to provide updates to their information, the client is presented first with a list of items about which they cannot submit changes online. If the client indicates that they want

to update one of these items, an informational message is displayed with further contact details. The client is then returned to the main **My Information** page.

A change of circumstance is marked as complete when updates that the client submits through the portal are added as evidence to the case and activated. Some issues can slow that process down. For example, evidence fails to map to the case, client evidence is left as in-edit on the case, or evidence has verifications and can't be automatically activated. After the evidence is activated, the client can then submit another change of circumstance. While a change of circumstance is in progress, the **Update My Information** link is disabled and the client sees an informational message.

What can I configure or customize?

When the client creates their user account, the client's data is secured under this account. Multifactor authentication can also be configured in UA to allow for extra authentication when a client attempts logs in to the system.

Since the state application script requirements vary by state, you likely need to customize the scripts on your project. From the **Intelligent Evidence Gathering** (IEG) section of the Social Program Management Administration application, you can customize the default change of circumstances IEG script. IEG scripts have a defined structure and a set of supported operations for IEG expressions. The entire script can be customized, and multiple scripts can be created from the one. It is the organization’s responsibility to customize the **My Information** User Interface Metadata (UIM) page. For more information, see the **Maintain My Information** page.

It is assumed that only one integrated case (IC). If the organization expects multiple ICs, this process must be customized. The process includes a customization point for organizations to decide which IC to use.

Related concepts

Related tasks

Related information

Capture Consent for Data Retrieval and Verification

Before beginning the change of circumstance script proper, a consent page is displayed so that applicants can agree to allow their information to be used to verify their identity or to retrieve other details from government agencies like the Department of Homeland Security, Social Security Administration, or the Internal Revenue Service. This is referred to as the e-verification process.

If consent is given, personal information like the citizen's social security number can be used to look up other systems and verify their identity, citizenship and other relevant details. If consent is not granted by the citizen, then any information they enter on an application must be verified by a case worker before eligibility can be determined.

The consent page is part of the Merative SPM Income Support for Medical Assistance HCR change of circumstance IEG script.

What can I configure or customize?

The default change of circumstances IEG script, that includes the consent page, is provided in the Admin application. Since the consent page requirements vary by state, the organization will likely need to customize the page requirements via the script to meet project requirements. It is possible

to customize the look and feel of the page including the text, hyperlinks, and actions displayed on the page using the IEG script.

Related tasks

Update Household Information

After consent for data retrieval is provided, the system displays a summary of the household information that can be updated online. The system retrieves the evidence from the ongoing Insurance Affordability integrated case and displays a pre-populated summary screen that allows the client to add, modify, or end date data.

The data that is shown on the IEG script is the most up-to-date information for each evidence type. The evidence is either the most recent active evidence or the in-edit evidence, in cases where the citizen recently created an in-edit version through a change of circumstance. The client can then update any of the information that is displayed in the script.

The questionnaire dynamically prompts the user for information that is related to specific changes. For example, the addition of a new household member takes the client through most of the questionnaire to collect all the related pieces of evidence, including relationships with existing household members, income. This approach ensures the capture of all required information to redetermine the household's eligibility.

What can I configure or customize?

From the Intelligent Evidence Gathering section of the Social Program Management Administration application, the organization can customize the household summary information that is displayed on the default change of circumstance IEG script and data store schema. Since the script requirements vary by state, the organization likely needs to customize the scripts to meet project requirements.

It is assumed that only one integrated case exists. If the organization expects multiple ICs, the scripts must be customized. A customization point is provided for organizations to select the IC to use.

Related tasks

Verification Data Services

If the client consents to allow the organization to use their information for verification purposes, the updated information is verified with external systems. Personal identifying information, such as a social security number, is used by the federal hub to verify the client's identity, citizenship, and retrieve other relevant details. Any data that cannot be electronically verified or that was not previously manually verified is flagged for manual verification.

What can I configure or customize?

It is possible to override the default verification processing, if needed. It is the organization's responsibility to customize the system to integrate with other systems to perform e-verification. Cúram provides integration points which allow an organization to communicate with external systems in order to retrieve verification information.

Related concepts

View Outstanding Verifications

At the end of the change of circumstance script, any outstanding verifications that could not be electronically verified by the federal hub are collected into a list and presented to the citizen before the application results are displayed. Presenting the details to the client as part of the change of circumstance questionnaire makes them aware of the items that are delaying a complete determination.

What can I configure or customize?

The display of the outstanding verifications at the end of the change of circumstance IEG script is based on a rule set and custom code. The system compares the data received from the federal hub to the data entered by the organization. There is a default rule set for reasonable compatibility. The rest of the rules can be customized through Java code.

The **Outstanding Verifications** page is part of the change of circumstance IEG script that can be customized by the organization if needed.

Income has a verification rule set that looks at reasonable compatibility rules. The requirements for reasonable compatibility vary by state. The rule set can be customized to meet the project requirements. The other verifications rules can be customized with java code.

Run Online Rules and Special Enrollment Rules

Rules are run to generate a results page for the client. For the Citizen Portal, this is eligibility rules and special enrollment rules. Any result that is presented is provisional, dependent on the client providing supporting documentation to a caseworker.

Clients can enroll on a qualified health plan (IA and UQHP) outside the configured open enrollment period only if they meet the special enrollment criteria. A set of special enrollment rules are run to determine whether the reported change qualifies an individual for special enrollment. A results page with the outcome of those rules is displayed to the client. Depending on the results, the client can proceed to enrollment.

Adverse action applies to Streamlined Medicaid and CHIP and refers to when an individual is negatively impacted by a change in circumstance; for example, if an individual loses coverage under Streamlined Medicaid or CHIP, or if an individual moves to a lesser coverage under Streamlined Medicaid. Change is adverse when a change of circumstance that is recorded causes an individual to move between one of the following sets of categories:

- Streamlined Medicaid to Qualified Health Plan
- Streamlined Medicaid to CHIP OR
- CHIP to Qualified Health Plan OR
- Between Medicaid categories

Moving to a less beneficial Medicaid category occurs when an individual moves to a lower category in the Medicaid hierarchy; for example, moving from Parent/Caretaker to Adult.

Where a change of circumstance results in an individual moving to a less beneficial product delivery or Medicaid category, adverse action is used to determine when coverage under the existing product delivery or Medicaid category ends. It ensures that an individual who is in receipt of a product delivery or Medicaid category is given timely notice of proposed action to end their eligibility.

Coverage under the existing product delivery or Medicaid category aligns to the end of the month in which eligibility ends. An extended decision is used where there are 10 days or less before the

end of the month. An extended decision provides an extra month of coverage under the existing product delivery or Medicaid category, to ensure that the individual is given timely notice of the proposed change.

The coverage start for the new product delivery or Medicaid category is triggered by the ending of either the existing product delivery or the existing Medicaid category. Eligibility for the new product delivery or Medicaid category starts on the first of the month following the month in which coverage ends on either the existing product delivery or the existing Medicaid category. This approach ensures that no gaps or overlaps exist in product deliveries or Medicaid categories when moving from one to another.

Special Enrollment Rules

Default special enrollment rules have been implemented for change of circumstance processing. These rules determine if an individual is eligible to shop and enroll in plans outside of the open enrollment period.

The changes that qualify an individual for special enrollment shopping are:

- The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care.
- The qualified individual, or his or her dependent, who was not previously a citizen, national, or lawfully present individual gains such status.
- The newly qualified individual is eligible or ineligible for advance payments of the premium tax credit, or has a change in eligibility for cost-sharing reductions.
- The enrollee is determined newly eligible or newly ineligible for advance payments of the premium tax credit, or has a change in eligibility for cost-sharing reductions.
- The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move.
- The qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, enrolls in a QHP or changes from one QHP to another one time per month.

What can I configure or customize?

The organization can customize the online rules and special enrollment rules to meet the project requirements.

Related tasks

View Eligibility Results

Universal Access is used to display an eligibility results page for the range of HCR programs that a client and household can enroll in. The results of the eligibility determinations are prominently displayed.

Online help is available for terminology that is of significance to the individual in making decisions that best address the needs of the household.

The Merative SPM Income Support for Medical Assistance HCR eligibility results page is logically broken up into a number of discrete sections. The top panel displays the applicants in the household and provides summary information on the programs they are eligible for, and the enrollment status. **My items** retains details of the enrollments that were processed.

The results page content consists of three main content sections:

Health Care Options - The health care options are displayed on the eligibility results page as they relate directly to the reason the individual is here - to get health care coverage whether through state-administered Medicaid/Children's Health Insurance Program (CHIP) or through the exchange. The options available to a client depend on the results of the eligibility determination for insurance affordability programs. The client can choose to view details about the eligibility result. The opportunity to continue by shopping for and selecting plans for enrollment are presented. However, plan selection and enrollment is handled by a plan management system. Upon completion of enrollment, a client is returned to the eligibility results page and can view summary enrollment details.

Other Government Services - Screening results that a client can avail of are displayed below the health care options. Individuals can use the screening results to apply for other government services if offered in-state and configured to be made available as part of the Health Care Reform solution. For example, a low-income single mother might be determined potentially eligible for Food Assistance or Cash Assistance. She can continue to apply for one or both these programs; the 'no wrong door' approach provided by Merative SPM Income Support for Medical Assistance HCR.

Other community services can be highlighted in a map for services within reach of the individual. These services are shown as a result of triage, generally the first interaction a client has with an agency that quickly identifies a client's needs. For example, a client might have an immediate need for food and shelter for the family. Triage quickly identifies these needs and provides details of suitable services on the triage map so that a client can easily identify the locations of the services being provided. The **Other Community Services** section is empty in a default installation.

What can I configure or customize?

The eligibility results page can be configured through a combination of display rules and application configurations found in the Universal Access section of the Administration application. The CER rule sets used in determining eligibility are customizable. The display of this page is configured through a combination of display rules and configurations. Through these mechanisms, the organization can customize the three main content sections, plus actions, links, tooltips, my items, icons, and help text.

Two types of rule sets are available, client portal or online rules and caseworker rules. Since this is the portal, the online rules run here.

Related concepts

Shop For and Enroll in Plans

If eligible for a qualified health plan – Insurance Assistance (IA) and Unassisted Qualified Health Plan (UQHP), clients can proceed to shop and enroll in plans from the results page provided they satisfy special enrollment criteria and no pending verifications need to be completed.

If outstanding verifications exist on the change of circumstance, the client is prevented from shopping and enrolling in plans. The client can submit the reported changes to the agency and resume the shopping process later when the data is manually verified by a caseworker.

What can I configure or customize?

Income Support for Medical Assistance (Health Care Reform) provides a plan management API interface that supports integration with a plan management vendor. Income Support for Medical Assistance (Health Care Reform) implements a vendor-agnostic approach to plan management

integration and does not include a specific implementation of the plan management API interface in the product. Each project is responsible for implementing their own integration between the Social Program Management system and the plan management system of choice.

Plan management integration is accomplished with a combination of both user interface and web services integration. A plan management vendor's user interface is shown in an inline frame on a solution page.

Related concepts

Sign and Submit Change of Circumstance

The client can submit the change in circumstance by signing and submitting the content to the agency. A Sign and Submit modal page is displayed which serves as an e-signature attesting that the information entered by the client is correct to the best of their knowledge. The client can also change or specify the period for which the agency can automatically renew the coverage. An option is also provided to opt out of automatic eligibility renewal for help in paying for health insurance.

The information is submitted to the integrated case and becomes available as in-edit evidence. The evidence is then automatically or manually verified, depending on the project. An attempt to activate evidence will only be made if the curam.healthcare.coc.auto.activate.evidence application property has been set to true AND there are no outstanding verifications. If any outstanding verifications exist, the evidence does not progress to activation. A task is created for a caseworker to make the necessary modifications to the evidence. When the evidence is modified, the caseworker selects the Evaluate Verification Requirements option to retry the evidence verification. This validates the evidence set for the change of circumstance and closes the case worker task. Verifications for the evidence set are then evaluated. Successful verifications results in the evidence being activated on the case. If evaluation of the verifications fails, the evidence verifications remain un-evaluated. The case worker can resolve this by requesting a system administrator to retry the process.

When a citizen submits a change of circumstance and is found eligible for Insurance Assistance, they have up to 60 days to complete plan enrollment. Following the change of circumstance submission, the citizen can log into their citizen account on a later date and resume the plan enrollment process.

What can I configure or customize?

Similar to the sign and submit page on initial intake, the sign and submit link on the results page is customizable through Universal Access motivations.

Related tasks

Map In-Edit Evidence to Integrated Case

By default, the evidence changes that are captured on the change of circumstance intelligent evidence gathering (IEG) script are mapped to the integrated case as in-edit evidence.

The change of circumstances process uses the Life Event infrastructure as the mechanism for updating the ongoing Insurance Affordability case with the new or modified data that is supplied by the client. When the life event associated with the change of circumstances is submitted, the following processing is triggered:

1. The state of the life event is updated to pending. The **Update My Information** link is disabled to prevent the client from triggering a second change of circumstances while there is still one in progress.
2. The change of circumstances workflow is started.

A change of circumstance is marked as complete when updates that the client submits through the portal are added as evidence to the case and activated. Some issues can slow that process down. For example, evidence fails to map to the case, client evidence is left as in-edit on the case, or evidence has verifications and can't be activated automatically. After the evidence is activated, the client can then submit another change of circumstance. While a change of circumstance is in progress, the **Update My Information** link is disabled and the client sees an informational message.

What can I configure or customize?

Support is provided to customize the change of circumstances workflow. An application property can be used to configure the change of circumstance submission workflow. The property allows the change of circumstance evidence to be automatically activated on the associated integrated case, provided no verifications are outstanding. When the workflow is configured for manual review, the caseworker must activate the evidence manually to redetermine or reassess the eligibility for the household on the product delivery cases. The caseworker is notified when a change of circumstance is submitted and the automatic activation of evidence is turned off.

The data that is entered by the user in the script is mapped to evidence on the ongoing case by mapping application programming interfaces (APIs). These APIs are customizable by the organization.

Related tasks

Reporting Change Circumstance by Caseworker

A client can also report a change of circumstances to a case worker, who can then update the citizen’s evidence on their Insurance Affordability integrated case.

View Existing Integrated Case

The first step in the caseworker change of circumstance reporting process is for the caseworker to navigate to the client’s Insurance Affordability integrated case where the caseworker can record the change of circumstance via the Evidence tab.

Record Evidence Changes

From the integrated case home page, the case worker can record evidence changes by either updating existing evidence or adding new evidence to the case.

Evidence Management Wizards

Organizations can simplify the process of recording changes by configuring a wizard that guides them through the required updates. In addition to being able to manually record a change on the various evidence screens, the caseworker can manage changes of circumstances through a guided process, reducing the time that is needed to identify which evidence to enter and in what order.

The Evidence Management wizard feature involves a User Interface Metadata (UIM) wizard plus additional implementation to highlight any missing evidences. The **Add a Member** wizard is provided as an example of this solution approach.

Note: The **Add a Member** guided wizard is not intended for use in a scenario where either of the following apply:

- The participant to be added is an active household member.
- The participant to be added is returning to the household and is to be re-added to an ongoing case.

In either scenario, a validation prevents participants from being selected in the **Add a Member** guided change wizard on the case participant page. To re-add a member to an ongoing case, caseworkers can use **Re-add a Member**. For more information about how to re-add a member to a case, see the *Re-add a member to a case* related link.

1. The **Add a Member** wizard supports scenarios in which a new member is added to the application case or to the ongoing case after the initial application is submitted. Access the **Add a Member** wizard from either the application or ongoing case from the following locations.
    1. The **Guided Changes** link in the **Tab Action** menu.
    2. The **Guided Changes** page group navigation bar within the Evidence tab.
2. Select the **Add a Member** change type, and start the wizard. The wizard guides the user through steps that ensure that the minimum information is captured. After the user completes the wizard, the user might have to enter more evidences. The wizard consists of the following steps:
    1. Participant Details: Allows the user to enter information that relates to the person that is being added to the household, including whether the person is registered on the system or not, their Address information and Application Details, and whether they are applying for assistance.
    2. Personal Information: Captures information related to the newly added person. The information that is collected differs depending on whether the person added is an applicant or non-applicant. For example, if the person is a non-applicant, information such as Race and Ethnicity and SSN information is captured. Additional information, which includes Citizenship information, is captured for an Applicant. The user can also indicate whether the person has a primary caretaker, other than a parent, who is an existing household member.
    3. Relationships: Allows the user to select the most appropriate description of the relationship between the person that is being added and each individual in the household, including whether the existing household member is a primary caretaker. If the user indicates on the **Personal Information** page that the person the user is adding has a primary caretaker, other than a parent, who is an existing household member, the user can indicate the existing household member who is the primary caretaker.
    4. Tax Information: Captures the tax information of the person that is being added to the household.
    5. Income: Captures the income of the person that is being added to the household. If the person receives income from more than one source, the user can select **Add New Income** to enter extra income records.
    6. Summary: Displays a summary of all the information that is captured through the wizard that the user must review before the information is submitted.

3. On submission of the wizard, a set of rules are run and the **Guided Changes** page is presented to the user. The **Add a Member** change type is created with a status of submitted. The **Action Required** list displays a list of evidence that informs the user what information is required to successfully complete the change of circumstance process. The list of evidence includes eligibility and program-specific evidence that is used to determine the person's eligibility. The **Previously Completed** list displays a list of evidence that the user added after they submitted the wizard.
4. To add the required evidence, the user can select the **Add** link. When this evidence is saved, it is removed from the **Action Required** list, and added to the **Previously Completed** list.
5. The user marks the change of circumstance as complete to ensure that they provided all the information that is related to the change of circumstance and the change is ready for reassessment. If the change is not marked as completed, a message informs the user that a submitted guided change exists. The message is displayed when the evidence changes are applied.

What can I configure or customize?

One OOTB wizard, named **Add Member**, exists to allow the user to add new members to the case. The wizard can be customized. The set of rules that are run for Guided Changes for this wizard can also be customized (a combination of coding and CER rather than CER only).

Related concepts

Re-adding a member to a case on page 98

By using the evidence screens, caseworkers can manually re-add a household member to a case. However, to reduce the time that is required to identify the evidence, caseworkers can also re-add a household member to a case by using a guided process.

Re-adding a member to a case

By using the evidence screens, caseworkers can manually re-add a household member to a case. However, to reduce the time that is required to identify the evidence, caseworkers can also re-add a household member to a case by using a guided process.

The **Re-add a Member** function uses a User Interface Metadata (UIM) wizard. The function automatically creates the Application Details evidence type that determines whether a member is active on the case. The **Re-add a Member** function is provided as an example of this solution approach. The **Re-add a Member** function can be customized.

1. The **Re-add a Member** function supports scenario in which a member returns to the household and the member is re-added to an ongoing case. Users can access the **Re-add a Member** function from the ongoing case from either of the following locations:
   - The **Guided Changes** link in the **Tab Action** menu.
   - The **Guided Changes** page group navigation bar within the **Evidence** tab.
2. Users select the **Re-add a Member** function. The function prompts the user to select the case participant who is re-entering the household and the date the case participant is to be re-added. Only case participants who meet the following two criteria are displayed:
   - No active Application Details evidence.
   - The motivation type is Insurance Affordability.
3. Users are prompted to confirm the selection that the user made. After the user completes the process, the user is prompted to review the existing evidence for the re-added participant. The function consists of the following two steps:

- 1. Select **Participant**. Users select the participants to re-add to the household. Users must enter the date that the user re-entered the household.
  2. Confirmation. When users select **Finish**, a confirmation message is displayed to the user that indicates to the user to review the participant's evidence. Users can also select to save and re-add another participant. When users select to save and re-add another participant, the re-add process, after the selected participant is re-added, is restarted.

4. When the submission is complete, the system automatically creates the Application Details evidence. The status of the Application Details evidence moves to **In-Edit**. The user is directed to the **Active Evidence** list page to review the participant's evidence.
5. When the system automatically creates the Application Details evidence, the evidence details are populated as shown in the proceeding table.

Property	Value
Received Date	Defaults to today's date
Case Participant	Set to the case participant that is selected in the first step of the wizard
Application ID	Set to the value stored in the most recent end-dated Application Details evidence record with a **Motivation Type** of Insurance Affordability
Primary Applicant	Defaults to **No**
End Date	Defaults to blank
Motivation Type	Defaults to Insurance Affordability
Reason person added	Defaults to returning to household
Applicant	Defaults to **Yes**
Application Date	Set to the date of re-entry into the household entered in the first step of the wizard
End Reason	Defaults to blank
Primary Contact	Defaults to **No**
Lives with Parent external to household	Set to the value stored in the most recent end-dated Application Details evidence record with a **Motivation Type** of Insurance Affordability

What can I configure or customize?

The **Re-add a Member** function can be customized in the following two ways:

- Additional processing can be implemented to occur after the member is re-added to the case.
- Different default values can be provided for the Application Details attributes.

Resolve Outstanding Verifications

From the integrated case, the caseworker can resolve any outstanding verifications. Use this information to understand how to resolve outstanding verification issues.

Any evidence items that are not verified by an external system as part of the application process or accepted based on client self-attestation, require manual verification by a caseworker. Straight-through processing is halted and a caseworker is assigned the task of resolving the outstanding evidence verifications with a client. Federal requirements for reasonable opportunity or inconsistency periods allow states to continue with the delivery of a program during this period. To support this requirement, verifications are configured to be optional for the integrated case.

What can I configure or customize?

Merative SPM Income Support for Medical Assistance (HCR) application cases and integrated cases are configured to use the verification framework. From the **Verifications** section of the administration application, you can configure the Merative SPM Income Support for Medical Assistance Verifications. You also can customize conditional verification rule sets in the same way as other rule sets.

Apply Evidence Changes

After the caseworker records the evidence addition or change, the evidence changes must be applied from the Insurance Affordability integrated case home page and evidence tab The apply evidence changes process serves two purposes: one is to activate new and updated evidence, the other is to remove active evidence which has been flagged as pending removal. When the worker removes active evidence it is not final until it is activated.

For example, a client who is made redundant by their employer and who was previously eligible for Insurance Assistance informs a case worker of their change in income. The case worker updates the income evidence that is related to that employment and activates the evidence. This results in the client now being eligible for Medicaid as the loss of employment means the household income is below the Medicaid limit.

What can I configure or customize?

Custom processes can be added in before and after evidence is applied on the case.

Run Program Group Logic and Activate Product Cases if Required

Program group logic is triggered when evidence changes are activated on the Insurance Affordability integrated case. Activating the evidence initiates a reassessment, which redetermines the household’s eligibility and results in the determination of a new set of eligibility decisions for the case.

Rules logic determines whether to create a new product delivery case, or reuse an existing product delivery case, and determine the post processing that is required in various situations. This logic applies only within an Insurance Affordability integrated case, and not across other integrated cases. Product delivery cases are created, one for each of the eligible Insurance Affordability programs for which a household is eligible.

When a new product delivery case is being created, a check is done to determine whether a product delivery of that type exists on the integrated case. If an existing product delivery is suitable for reuse, it is reused. Otherwise, a new product delivery is created.

If the existing product delivery case is closed, the closure reason is checked to see whether the case can be reopened. Cases with a closure reason of 'Created in Error' are never reopened. The indicator 'Reassess Closed Cases' for a product delivery case type is bypassed if the case is closed with a closure reason of 'Created in Error'. If the case cannot be reopened, then a new product delivery case is created. The closure reasons that prevent a product delivery case from being reopened can be configured.

What can I configure or customize?

The organization can customize the program group logic rules to meet the project requirements.

You can configure a set of closure reasons for program group logic. Product delivery cases that close with one of these closure reasons are not automatically reopened by program group logic.

How the effective date of a change of circumstance is used in determining the coverage period start date can be configured. The configuration determines whether the coverage period start dates is based on the effective date or received date of evidence. The configuration is the same for all programs.

Related tasks

Special Enrollments

For Advanced Premium Tax Credit (APTC) programs only, changes in circumstances can result in a client who becomes eligible for a program outside the open enrollment periods. Special enrollment rules are run to identify if a client is eligible for special enrollment, and if so, an enrollment link is enabled on the results page.

At reassessment, special enrollment rules are not run. When a client needs to shop for a plan and it is not an open enrollment period, the caseworker can manually enable special enrollment shopping for the client. The caseworker enables special enrollment shopping from an IC menu item.

The enrollment link is enabled for 60 days from the effective date of the event that qualified the client for special enrollment. For example, if an individual reports an increase in income that qualifies them for special enrollment and this change is effective from the March 1, 2016, the special enrollment link is enabled until the April 29, 2016.

What can I configure or customize?

The list of special enrollment reasons that the caseworker selects can be customized.

Outbound Account Transfer to Federal Hub

For FFM states only, you must use the Account Transfer Interface when reporting changes either to the FFM or to the organization. A distinct set of trigger points exist when this must be done.

If the application originated with FFM and a change of circumstance on the case is associated with that application, then the details are sent back to the FFM in an outbound account transfer. This account transfer occurs whether there is a change in eligibility program or not. By default, no outbound transfers are sent if everyone in the household continues to be eligible only for Streamlined Medicaid or CHIP. An exception is when any previously eligible persons are now eligible for Non-Magi Medicaid or are eligible for a non-Minimum Essential Coverage program. For example, the Pregnant Woman coverage category.

At a later stage, the client reports a change to the FFM and as a result of the change the FFM now reassesses their eligibility for Medicaid and CHIP and determines them potentially eligible. An Inbound Account Transfer is sent to the organization again. The FFM treats this account transfer as a “Change of Circumstances” style of account transfer but the organization must treat it as a new application.

What can I configure or customize?

The Account Transfer process contains APIs that map the Cúram data structures to an Outbound Account Transfer. It should be noted that these APIs may not completely map all data fields from the case structures to the Outbound Account Transfer and cannot take into account customizations made by the organization. It is the responsibility of the organization to ensure that a fit gap analysis has been undertaken to ensure that all of the organization's case and evidence structures map to the Account Transfer data fields. The mapping APIs are customizable through extension points that have been provided for each entity mapped from Social Program Management to the

Account Transfer payload. This enables organizations to add their own custom data mappings to support their particular requirements. To further enable organizations to perform these tasks, the source code for the Account Transfer process is delivered with Social Program Management.

Note: You can use the source code to build any customizations that are required for the Account Transfer process. The location of the Account Transfer source code is `EJBServer/components/FederalExchange/sample/src.zip`. For more information about the source code for the Account Transfer process and the release of the sample implementation, see the *CMS Account Transfer Business Services Description (BSD)* related link.

Related information

CMS Account Transfer Business Services Description (BSD)

Generate Communications

Merative SPM Income Support for Medical Assistance provides for a basic set of communications for Change of Circumstance processing, primarily to notify the applicant or current enrollee of an eligibility determination due to an evidence change.

Two notifications are available.

Table 7: Change of circumstance client notifications

Notification	Description
Eligibility decision as the result of evidence change	If evidence was added to the integrated case and applied successfully, then this notification is generated informing the household of the decision. It is stored as a communication with the integrated case for the primary client.
Preliminary eligibility determination with evidence inconsistencies for a change reported through evidence	This notification is generated for an integrated case when new evidence is introduced to the case.

What can I configure or customize?

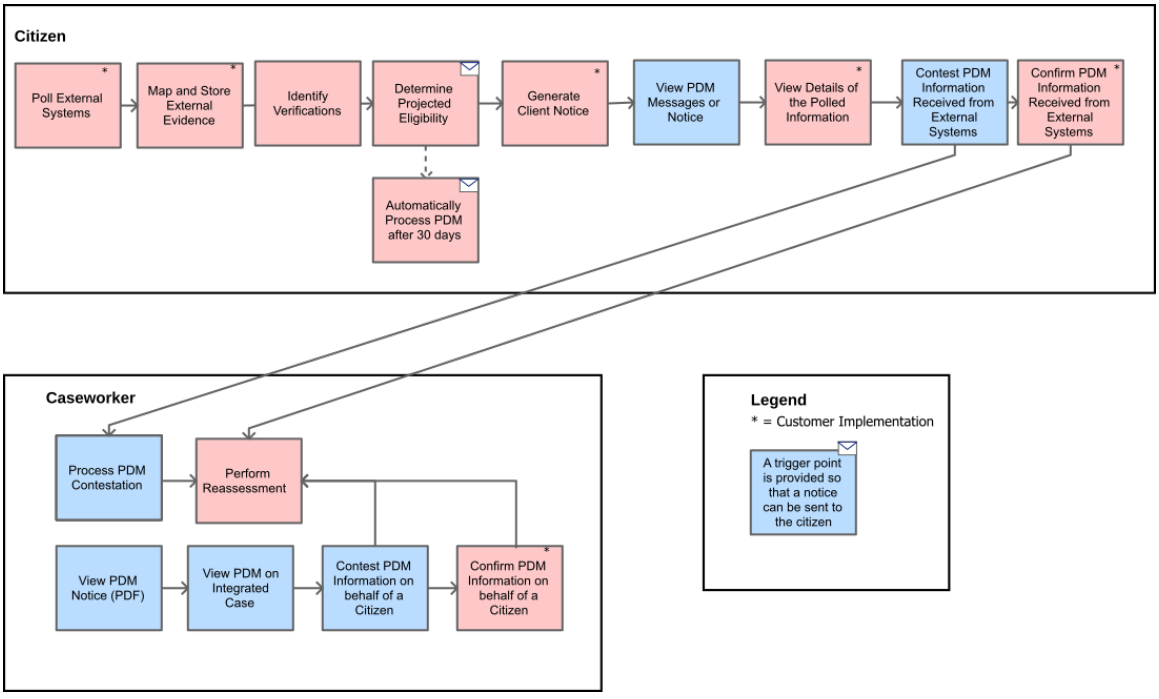
Communications can be customized by the organization.

2.9 Annual renewals and periodic data matching

Annual renewals and periodic data matching (PDM) both focus on the management of information that is retrieved after polling external sources on a regularly scheduled basis. Organizations are responsible for polling the external services and managing the information when it is returned. Social Program Management provides organizations with a mechanism that allows them to populate the polled information into Social Program Management evidence. The business processing for annual renewals and periodic data matching starts from the point that the polled information is inserted as evidence. The shared technical infrastructure that is provided for periodic data matching and annual renewals contains the required configuration, customization, and extension points to implement a custom solution.

Periodic Data Matching

Periodic data matching examines external data sources to determine whether an individual's eligibility changed due to a change in evidence. Cúram supports mandatory polling of minimum essential coverage (MEC) evidence and death evidence according to federal regulations. MEC checks for Medicaid/CHIP for applicants enrolled on QHP programs. If the client is enrolled in both, Cúram notifies the client through their Client Account that the updated information from the external data source might impact their projected eligibility.



1. Poll External Systems (PDM) on page 104
2. Map and Store External Evidence on page 105

3. Identify Verifications on page 105
4. Determining Projected Eligibility on page 105
5. Generate Notice on page 106
6. View PDM Messages and Updates from Polled Data on page 107
7. View PDM Messages and Updates from Polled Data on page 107
8. Contest and Confirm PDM Information Received from External Sources on page 107
9. Contest and Confirm PDM Information Received from External Sources on page 107
10. Automatically Process PDM after 30 Days on page 106
11. Process PDM Contestation by Caseworker on page 108
12. Perform reassessment on page 109
13. View PDM notice by caseworker on page 108
14. View PDM on integrated case on page 109
15. Contest and Confirm PDM Information on behalf of a citizen on page 109
16. Contest and Confirm PDM Information on behalf of a citizen on page 109

Poll External Systems (PDM)

The periodic data matching (PDM) process starts when information that is polled from external sources is returned to Social Program Management. The organization must identify the timing, cases, and clients for which external systems are polled for data and ensure that client authorization is available for accessing their data. Polled information is stored as incoming evidence on the Insurance Affordability integrated case and categorized as ‘External System’ read-only, in-edit evidence.

The system identifies what triggered the population of the external evidence, that is, a result of a periodic data match and the match run it relates to.

What can I configure or customize?

It is the responsibility of the organization to retrieve the external evidence required for Period Data Matching. Social Program Management does not provide a solution to communicate with external systems in bulk, but Social Program Management does provide an API to add the retrieved evidence to cases. Because this API writes to the process control tables in the background to mark cases for processing, it is mandatory that the API is used for PDM. By default, the Minimum Essential Coverage, Death Status, Income, and Annual Tax Return evidence types that are used in projected eligibility for PDM are modeled and ready to accept evidence that is returned from external systems. The organization can configure new external evidence types. By convention, the existing external evidence types are not used in rules processing. New external evidence types that are used in PDM should follow this convention and should not be brokered from the integrated case.

Related concepts

Related tasks

Map and Store External Evidence

The incoming data for minimum essential coverage and Death Status evidence is processed by the default external evidence handlers, then mapped to Social Program Management external evidence types and added as external evidence to the correct cases.

What can I configure or customize?

It is the organization's responsibility to map the evidence from the external systems to the evidence tables in Social Program Management. An integration point (API) is provided to map this evidence.

Identify Verifications

External evidence can be associated with verifications that ensure that the values are compatible with client-attested values. For example, client-reported yearly income must be reasonably compatible with the external **Annual Tax Return** evidence type, otherwise the client must provide proof that the evidence from the trusted data source is incorrect.The client reported yearly income will live on the "Income" dynamic evidence. - The income that is retrieved from external sources, such as the Federal Hub, will live on the **Annual Tax Return** and **Income Details** evidence. Conditional verification rules will look at both client attested and external evidences in order to determine if the figures are reasonably compatible or not.

> **Note:** External evidence must not be directly referenced by eligibility and entitlement rule sets because it causes case redeterminations every time that external evidence is added to a case. Redetermining cases as part of evidence polling might lead to performance issues, and removes the ability to generate eligibility projections that use the external data.

What can I configure or customize?

It is the organization's responsibility to customize the reasonable compatibility verification rules to meet the project requirements.

Determining Projected Eligibility

The periodic data matching regulations require that a projection of eligibility is made by using the external evidence. Essentially, this projection is simulating the effect of applying the external evidence to the internal evidence. To facilitate the concept of projecting eligibility, the rules are run by using the external evidence from the federal hub instead of the active client-attested evidence on the integrated case.

Based on the information that is received from polling, the system determines the projected eligibility from the external evidence. The system uses the most current evidence polled specific to the periodic data match run and active client-attested evidence to project eligibility. It ignores any client-attested evidence types that reflect the external system equivalent. For example, death details are captured in the client-attested evidence field, Application Details. Projected eligibility ignores this evidence and instead uses the new Death Status evidence type. This process projects a determination of eligibility and ultimately if the system needs to apply the evidence for an actual predetermination. The eligibility rules need a date of death to determine when it takes effect.

Note: Only a Death Status is received from the external service (not the actual date of death). The date that is provided for death is based on the received data that is populated on the external system Death Status evidence type.

When the eligibility projection is done, the system notifies the client through their Citizen Account of their projected eligibility. The system records the results on the Citizen Portal and on the insurance affordability case.

What can I change or customize?

The organization can customize the default projected eligibility implementation to include extra external evidence types. Projected eligibility evidence handlers enable Merative SPM Income Support for Medical Assistance (HCR) rules to use external data in eligibility projections. These evidence handlers convert external data into rule objects that are used when the rules run. The data that was drawn from external sources and added as evidence to the case then can be used to determine eligibility and entitlement in the case.

You can replace or disable the default evidence handlers. You also can add custom evidence handlers for external evidence types that are not supported by default.

Note: This process can be a complex task that depends on the evidence types and the structure of the rules. It involves detailed analysis, relatively complex coding requirements, and rigorous testing to ensure that the organization's implementation is correct to ensure that it creates the correct projected eligibility decision.

Related tasks

Automatically Process PDM after 30 Days

The client is given time to respond to the notice. After this time expires, all remaining cases where the client took no action will be automatically processed to redetermine the client's eligibility. The organization can run the automatic completion batch process for periodic data-matching at a defined interval after they run projected eligibility. By default, the defined interval is 30 days. External evidence converters convert external evidence to evidence on the case that is used by the eligibility and entitlement rules. The updates can be seen on the evidence on the case.

What can I configure or customize?

It is the responsibility of the organization to create a custom implementation to process the cases that cannot be automatically processed.

Generate Notice

A notice is used to inform the citizen of the PDM process. The organization must implement a process to create client notices as this is required by regulation.

What can I configure or customize?

It is the organization's responsibility to implement a notice (also referred to as a communication). Social Program Management does not provide a default notice. The batch processing for a case will not complete successfully without a notice being successfully generated.

The documentation does provide sample code to illustrate how to write a notice. By using the provided APIs for generating the notice they will be generated and stored by the batch process on the Attachments table. The storage is no different to the existing strategy for storing communications and can be accessed in the same manner.

Related tasks

View PDM Messages and Updates from Polled Data

When the eligibility projection is done, the client is given 30 days to contest the information received from the external sources. A notification is triggered to the client and a message is available in the Citizen Account. A notification is triggered even if the information polled is the same as the client-attested information held on record. For a specified period, any updates are made available for confirmation by the client or a caseworker. On the expiration of that period, the updates are applied permanently to the client's integrated case.

The client can log in to their **Citizen Account** home page to view a message that new information about the individual and their household was received and might affect their eligibility. From the home page, a primary message and a secondary message are displayed to align with other Citizen Account messaging. Both messages provide navigation to the existing **My Updates** page.

The **My Updates** page displays any **Updates to the Review** section. The update information was received as a result of the data match, which includes the type of evidence, the date received, and client name. A message informs the client how long they have to contest the information and what happens if they do not take any action. From the **My Updates** page, the client can choose to contest the information received from periodic data matching (PDM).

The client also can view a projected eligibility notice that is available in the Citizen Account in PDF format. Data matching notifications are displayed only until the data match is resolved.

What can I change or customize?

The organization can modify the default set of messages that are displayed on the **Citizen Account** home page and on the **My Updates** page.

Support is provided to implement custom project eligibility notices and run the appropriate batch processes for PDM.

If the organization requires new external evidence types, the **Citizen Portal** does not display the new evidence types automatically on the PDM screens. Customization is required to modify the client screens for any new evidence types that are added to PDM processing.

Related tasks

Contest and Confirm PDM Information Received from External Sources

When the projected eligibility is complete, the client can contest the information received from the external sources. From the **My Updates** page of the Citizen Account, the client can contest the information. A modal is then presented asking the client to confirm that they contest and to provide a reason why they believe that the information is incorrect. After they confirm that they contest, a workflow process generates a task for the caseworker and ends the data-match time period to contest. When a change is contested, it is removed from the list of updates that are displayed.

If the client does not contest the PDM information received from the external system within 30 days of the polling date, the system automatically applies the evidence to the integrated case. No

process allows the client or caseworker to accept the data-match information before the data-match time period ends.

What can I configure or customize?

It is the organization's responsibility to customize the evidence types that clients can contest and implement a process that allows the client to confirm the PDM information. Use the `curam.healthcare.pdm.contestable.evidence` application property to define the contestable evidence types. Some development effort is necessary (Java, UIM Client page updates) to define new contestable evidence types.

Related tasks

Process PDM Contestation by Caseworker

When a client contests a change, a task is created for the caseworker who must then resolve any outstanding verifications and advance the case. The task includes the reason that the client entered for contesting the PDM data. The caseworker then updates the relevant evidence based on what the client is contesting. For example, if the client is contesting the date of death, the caseworker must update the application details evidence to 'end' the client details and record the reason of deceased.

What can I configure or customize?

Social Program Management UIM pages can define the content of an application page such as fields, action controls, clusters, lists, and other elements. User Interface Metadata (UIM) provides enough control to present the page content in ways that meet most presentation requirements. It is the customer's responsibility to customize the UIM to meet the project requirements. If necessary, the task that is created can also be customized to allow for a different flow.

View PDM notice by caseworker

From the **Communications** section of the integrated case, caseworkers can see notices that were sent to the client, which includes their projected eligibility and the evidence changes that were retrieved from external systems.

What can I configure or customize?

It is the organization's responsibility to implement a notice (also referred to as a communication). Cúram does not provide a default notice. The batch processing for a case does not finish successfully if no notice is successfully generated.

The documentation provides sample code to illustrate how to write a notice. The batch process uses the provided APIs to generate the notice and store it on the Attachments table. The storage is no different than the existing strategy for storing communications and can be accessed in the same manner.

Related tasks

View PDM on integrated case

Caseworkers can see whether a data-match was done on an Insurance Affordability case under Recent Transactions on the Insurance Affordability homepage.

What can I configure or customize?

Cúram User Interface Metadata (UIM) pages can define the content of an application page in terms of fields, action controls, clusters, lists, and other elements. UIM provides enough control to present the page content in ways that meet most presentation requirements. It is the customer's responsibility to customize the Insurance Affordability UIM to meet the project requirements.

Contest and Confirm PDM Information on behalf of a citizen

The caseworker can also contest on behalf of a client. From the Data Matches section of the Insurance Affordability integrated case, the caseworker can contest the PDM information and record or edit the reason for contesting. The status of the record is then changed to **Caseworker contested**. Changes that are contested by a caseworker instead of by the client are marked as such and the comments do not appear on the client's citizen account.

What can I configure or customize?

Cúram User Interface Metadata (UIM) pages can define the content of an application page in terms of fields, action controls, clusters, lists, and other elements. UIM provides enough control to present the page content in ways that meet most presentation requirements. It is the customer's responsibility to customize the Insurance Affordability UIM to meet the project requirements.

Perform reassessment

After the evidence is activated by the caseworker, the system uses existing reassessment processing to create a new determination. Program group logic is triggered when evidence changes are activated on the Insurance Affordability integrated case. Activating the evidence initiates a reassessment, which redetermines the household's eligibility and results in the determination of a new set of eligibility decisions for the case.

Related concepts

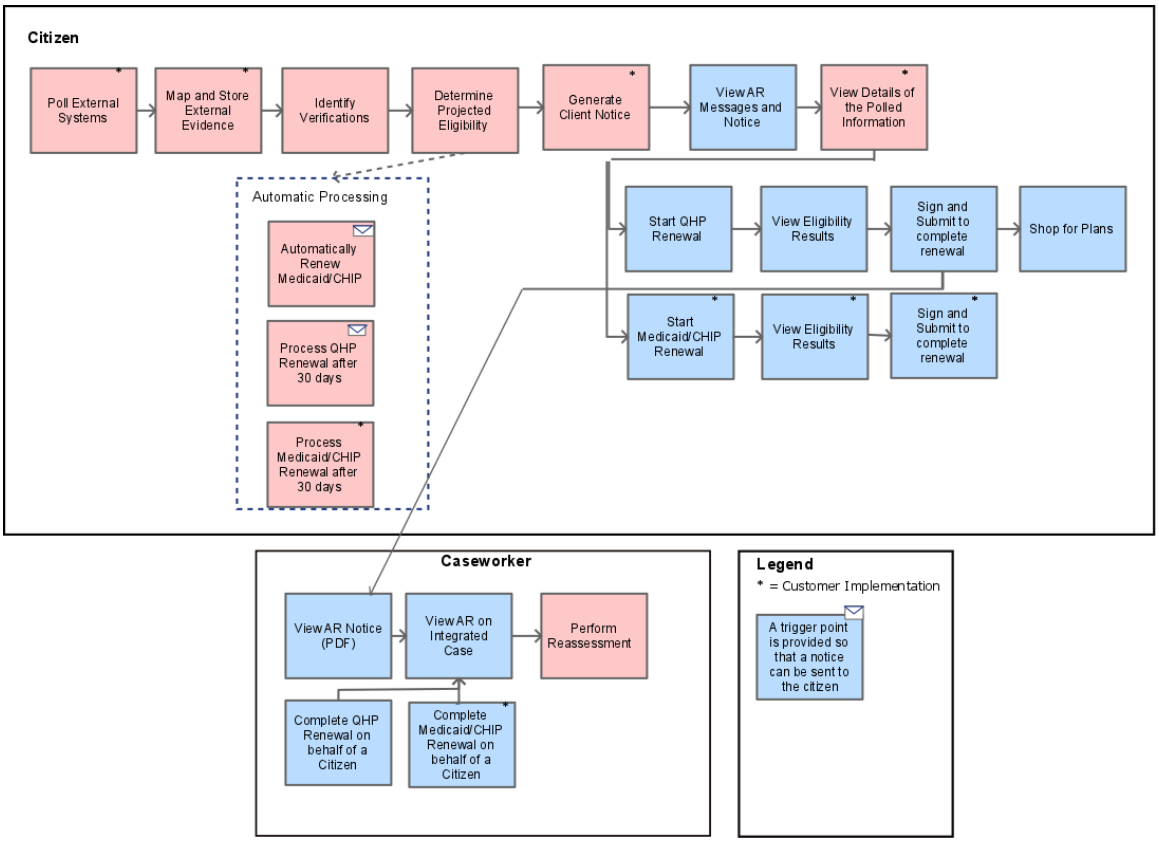
Run Program Group Logic and Activate Product Delivery Cases on page 61

Following successful program authorization and creation (or reuse) of an integrated case, program group logic is run on the integrated case to determine the set of eligible programs and the citizens who receive these programs

Annual Renewals

Annual renewal processing occurs when a Qualified Health Plan (QHP) reaches the end of the certification period, external data sources are checked to see whether the evidence on the case is still considered reasonably compatible with the data sources. Organizations must support the mandatory Affordable Care Act (ACA) requirement that individuals renew their QHPs annually. Support is also provided to implement a Medicaid and Children's Health Insurance Program (CHIP) annual renewal process.

Note: Employee sponsored coverage does not have a renewal process in the product. Employers complete the renewals.



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Annual renewals for Qualified Health Plans

Support is provided to allow clients to renew Qualified Health Plans (QHPs) annually. Annual renewals for QHPs are at the same time each year for all clients. During the annual renewal process, Social Program Management checks federally mandated information by querying external systems. The projected eligibility for QHP Annual Renewal is determined with coverage effective from the first day of the following year. Upon completion of the annual renewal processing for a case, a new product delivery case is created to cover the next year. The certification period for the new case is determined by the program group rules and automatically created.

Poll External Systems (AR)

The annual renewal (AR) process starts when information that is polled from external sources is returned to Social Program Management. The organization must identify the timing, cases, and clients for which external systems are polled for data and ensure that client authorization is available for accessing their data.

It is the organization's responsibility to retrieve the external evidence required for Annual Renewals. By default, Social Program Management polls only the mandatory annual renewal information: IRS and Current Income. Annual Tax Return evidence is used to store IRS income and Income Details evidence is used to store Current Income and Social Security Benefit Income. Polled information is stored as evidence categorized as incoming evidence on the Insurance Affordability integrated case and categorized as 'External System' read-only evidence.

Just like PDM, the system identifies what triggered the population of the external evidence – that is, a result of an IA renewal and the polling run it relates to. The system uses the external evidence that is polled to perform an eligibility projection. It uses the latest evidence polled

specific to the annual renewal data match run and active client attested evidence to project eligibility. It ignores any client attested evidence types that reflect the external system equivalent.

What can I configure or customize?

It is the responsibility of the organization to retrieve the external evidence required for Annual Renewals. Social Program Management does not provide a solution to communicate with external systems in bulk. However, Social Program Management does provide an API to add the retrieved evidence to cases. This API writes to the process control tables in the background to mark cases for processing so it is mandatory to use the API for both PDM and AR. By default, the Minimum Essential Coverage, Death Status, Income, and the Annual Tax Return evidence type that is used in projected eligibility for annual renewals is modeled and ready to accept evidence return from external systems.

Related concepts

Related tasks

Map and Store External Evidence

The incoming data for Annual Tax Return evidence is processed by the default external evidence handlers, mapped to Social Program Management external evidence types, and is added as external evidence to the correct cases.

What can I configure or customize?

The organization’s responsibility is to map the evidence from the external systems to the evidence tables in Social Program Management.

Related tasks

Identify Verifications

External evidence can be associated with verifications that ensure that the values are compatible with client-attested values. For example, client-reported yearly income must be reasonably compatible with the external **Annual Tax Return** evidence type, otherwise the client must provide proof that the evidence from the trusted data source is incorrect.The client reported yearly income will live on the “Income” dynamic evidence. - The income that is retrieved from external sources, such as the Federal Hub, will live on the **Annual Tax Return** and **Income Details** evidence. Conditional verification rules will look at both client attested and external evidences in order to determine if the figures are reasonably compatible or not.

> **Note:** External evidence must not be directly referenced by eligibility and entitlement rule sets because it causes case redeterminations every time that external evidence is added to a case. Redetermining cases as part of evidence polling might lead to performance issues, and removes the ability to generate eligibility projections that use the external data.

What can I configure or customize?

It is the organization’s responsibility to customize the reasonable compatibility verification rules to meet the project requirements.

Determining Projected Eligibility (AR)

Projected eligibility is the process where the Merative SPM Income Support for Medical Assistance program group rules are run in a mode that uses the active data on the case,

supplemented by data that is obtained from external sources, to determine and inform a client of the effect that the external data would have if it was applied to their case. Depending on the project type, the projection can be for the current period or for an eligibility period in the future, such as the next enrollment period.

The projected eligibility for QHP Annual Renewal is determined with coverage effective from the first day of the following year. Based on the information that is received from polling, the system determines the projected eligibility from the external evidence. The system uses the latest evidence polled specific to the periodic data match run and active client attested evidence to project eligibility. It ignores any client attested evidence types that reflect the external system equivalent.

What can I configure or customize?

The organization can customize the default projected eligibility implementation to include extra external evidence types. Projected eligibility evidence handlers enable Merative SPM Income Support for Medical Assistance rules to use external data in eligibility projections. These evidence handlers convert external data into rule objects that are used when the rules run. Then, the data that was sourced from external sources and added as evidence to the case can be used to determine eligibility and entitlement in the case. You can replace or disable the default evidence handlers. You can also add custom evidence handlers for external evidence types that are not supported by default. However, this task can be complex, depending on the evidence types and the structure of the rules. It involves detailed analysis, relatively complex coding requirements, and rigorous testing to ensure that the organization's implementation is correct, that is, it creates the correct projected eligibility decision.

Related tasks

Automatically renew Medicaid or CHIP cases

Annual renewals for Medicaid or CHIP are automatically completed if all the current benefit unit members remain eligible.

What can I configure or customize?

It is the organization's responsibility to create a custom implementation to process the cases that cannot be renewed automatically

Automatic Processing After Defined Interval

After the time period expires for the client to respond, all remaining cases where no action was taken by the client will be processed automatically to redetermine the client's eligibility, for this year, and for the next in the case of annual renewals. The organization must run the automatic completion batch process for periodic data matching (PDM) at a defined interval after projected eligibility is run, by default 30 days. External evidence converters convert external evidence to internal evidence on the case. Internal evidence can be referenced by eligibility and entitlement rules.

Clients have a defined interval in which to sign and submit their annual renewal, by default 30 days. If they do not respond in this period, the system automatically applies polled evidence for the Qualified Health Plan (QHP).

What can I configure or customize?

Support is provided to modify the number of days that are allowed for clients to respond to changes that result from PDM. It is the organization's responsibility to create a custom implementation to process the cases that cannot be processed automatically.

Related tasks

Generate notice

It is the organization's responsibility to send citizens a custom renewal notice that informs the client of their eligibility projection and the updated information that is used to determine the projected eligibility. The custom notice also informs the citizen that they have 30 days to sign and submit their renewal to the organization. The organization must implement a process to create client notices as this is required by regulation.

What can I configure or customize?

It is the organization's responsibility to implement a notice (also referred to as a communication). Cúram does not provide a default notice. The batch processing for a case will not complete successfully without a notice being successfully generated.

The documentation does provide sample code to illustrate how to write a notice. By using the provided APIs for generating the notice they will be generated and stored by the batch process on the Attachments table. The storage is no different to the existing strategy for storing communications and can be accessed in the same manner.

Related tasks

View updates from polled data and annual renewal messages

When the eligibility projection is done, the system notifies the client of their projected eligibility and records the results on the Citizen Portal and on the insurance affordability case.

From the Citizen Account, the client can view a message that the annual renewal is due and select to renew online. For Insurance Assistance (IA) renewals, a primary message and a secondary message are displayed to align with other Citizen Account messaging. Both messages provide navigation to the existing **My Updates** page.

The **My Updates** page displays a renewal section with the information that was received as a result of the data match. For annual tax return income, the system just displays that information exists for annual tax return but does not display the amount according to regulations.

Citizens are also sent a projected eligibility notice that is available from the **My Updates** page. This projected eligibility notice is available in their Citizen Account in PDF format.

What can I configure or customize?

Support is provided to customize the default set of messages that can be displayed on the annual renewals home page. It is also possible to customize the default annual renewal **My Updates** page to add new evidence types or to add new columns on the page. If new external evidence types are added, the Citizen Portal does not present the new evidence types automatically on the AR screens. The organization must customize the client screens for any new evidence types that are added to annual renewal (AR) processing.

Support is provided to implement custom project eligibility notices and run the appropriate batch processes for AR.

Related tasks

Complete annual renewal for QHP

From the Universal Access**Citizen Account home** page, the client can start the annual renewal, complete the script, and review the information for accuracy. The eligibility results are displayed indicating whether the client is potentially eligible for benefits during the next renewal year.

The way the citizen can contest the information that is retrieved from external systems is different between PDM and AR. For PDM, the **Contest** button is explicitly available. But for AR, the citizen must complete the renewal script online and they can provide updated income information, which if different from information that is retrieved from the external system is considered to be a contest.

After the client completes the annual renewal script, they can sign and submit their annual renewal. This stops the timer for the interval to return their annual renewal, by default 30 days. The recorded information is mapped to the insurance affordability case, and if possible automatically renews Medicaid/Children's Health Insurance Program (CHIP), and raises tasks for the caseworker where required.

After the annual renewal is signed and submitted, the client can shop for plans during the open enrollment period.

What can I configure or customize?

The number of days that are allowed for citizens to respond to changes that result from annual renewals are set out by legislation and are subject to change. The organization can modify the default expiry intervals to meet the project requirements.

To complete the end to end Qualified Health Plan (QHP) annual renewal process in batch, the organization must implement a number of custom batch jobs that work with the provided `QHPProjectedEligibility` and `QHPProcessAutoCompletions` batch jobs.

A trigger point is provided to so that a notice can be sent to the client after the client signs and submits the renewal.

Related concepts

Related tasks

Process annual renewals by caseworker

Caseworkers can act on behalf of a client by manually completing a renewal. They can also resolve any verifications and manage evidence updates to ensure that the renewal information has been reflected accurately.

View AR notice

From the **Communications** section of the Insurance Affordability integrated case, caseworkers can see notices that were sent to the client, which includes their projected eligibility and the evidence changes that were retrieved from external systems. No sample notices are provided.

What can I configure or customize?

The caseworker workspace that contains the **Communication** section and page can be replaced with a custom page.

Organizations must develop any required notices.

Related concepts

View AR on integrated case
Caseworkers can view recent transactions on the Insurance Affordability integrated case to see whether the annual renewal process started on a case, or whether external data was received for the case.

What can I configure or customize?

The **case** home page can be replaced with a custom page.

Complete QHP renewal on behalf of a client
Caseworkers can sign and submit an annual renewal on behalf of a client in the caseworker application. When the caseworker is acting on behalf of the citizen, a caseworker is required to update any evidence as reported by the citizen. They also need to ensure that necessary verifications are resolved. The caseworker selects the **Sign and Submit Insurance Assistance Renewal** action from the integrated case home to submit the annual renewal process. A modal is displayed for the caseworker to confirm that the client has signed and submitted their annual renewal. This action stops the timer.

A caseworker might be awaiting final verifications or information updates after signing and submitting the renewal. The caseworker must process the outstanding verifications before selecting to **Complete Insurance Assistance Renewal** action on the client's behalf. The complete renewal step allows the caseworker to signify that the renewal is complete and therefore an actual redetermination can be generated.

What can I configure or customize?

The **Sign and Submit Insurance Assistance Renewal** can be customized.

The verifications that are required on the case can be configured.

Informing a caseworker when client-attested annual renewal evidence needs reverification
The advisor is used to inform caseworkers that annual renewal income evidence that is updated when the caseworker signs and submits an annual renewal needs to be reviewed for reverification.

When evidence is created as a result of polling the external system for an annual renewal and the client does not update their information on the annual renewal (effectively saying that their existing verified information still holds true), a mismatch might exist in evidence where no verification is raised against it.

The advisor compares client attested income and income evidence that was added as a result of polling the external system. When evidence items are not reasonably compatible with each other, advice is displayed on the **Integrated Case** home page and **Evidence Dashboard** page. When a caseworker completes an annual renewal, they are asked to confirm that the client-attested evidence on the case is reviewed and verified as necessary. When the caseworker confirms that the evidence is reviewed and verified, the advice is no longer displayed.

What can I configure or customize?

A sample advisor rule set is provided which can be used to advise a caseworker when client attested income evidence that is part of an annual renewal that is submitted by the caseworker

needs to be reviewed for reverification. The organization can implement advice for other evidence types by using advisor rule sets.

Related concepts

Annual Renewals for Medicaid and CHIP

Support is provided to allow the organization to create an implementation to renew Medicaid and Children's Health Insurance Program (CHIP) benefits annually.

For Medicaid and CHIP, the following applies:

- Annual renewal for a product delivery case, or in other words a program type, occurs 12 months from the eligibility start date on that PD case.
- Upon completion of the annual renewal processing for a case, a new product delivery of the same type is automatically created to cover the next 12 month period. The certification period for the new product delivery is determined by the program group rules and automatically created.
- Renewals should occur before completing any ongoing case actions, such as reporting change of circumstance. When any ongoing case action is performed after the certification ends, the case is reassessed; however, if the case is not renewed before the certification ends, then no new product delivery of any type is created, nor are the decisions extended. In other words, if there is a change of circumstance which results in the client being eligible for another program, then a new product delivery is not created.

Support is provided to allow the organization to create a custom implementation to poll external evidence for Medicaid or CHIP cases, determine projected eligibility and automatically renew the cases for the next 12 months.

Clients have a defined interval in which to sign and submit their annual renewal, by default 30 days. If they do not respond in this period, the system automatically applies polled evidence for Medicaid and CHIP.

Projected eligibility is run for cases that are identified as existing Medicaid and CHIP cases based on the polled information. If potential eligibility has not changed from the current program, then the case is renewed automatically. A notification is generated and a message is displayed in the client account, informing the client that their Medicaid and CHIP case has been renewed.

If potential eligibility has changed, for example, if the client is no longer eligible for Medicaid as a result of the polled information, then the case is not automatically renewed. The `PDMRunCaseControlManager` API can be used to identify the cases that cannot automatically be renewed.

What can I configure or customize?

It is the organization’s responsibility to create a custom implementation to process the cases that cannot be automatically renewed as the same product delivery type. To complete the end-to-end Medicaid annual renewal process in batch, the organization must implement a number of custom batch jobs that work with the provided `MedicaidProcessAnnualRenewals` batch job. For example, if the case is not renewed before the certification ends, then no new product delivery case is created. For example, if the case is not renewed before the certification ends, then no new product delivery case is created.

Related concepts

Related tasks

2.10 (deprecated) Monitoring Merative SPM Income Support for Medical Assistance Applications

The Administration user can generate Merative SPM Income Support for Medical Assistance application intake reports for managers that provide a business view of all the Merative SPM Income Support for Medical Assistance applications that are being processed by the system, from initiation through to an eligibility decision. The reports provide a count of applications in each state and highlight applications that require intervention to progress.

Warning: Refreshing these reports generates significant load on the system and can prevent intake applications from being processed. Before you refresh the reports, ensure that no ongoing intake applications or other system activities are affected.

Intake Reports display the status of applications and programs as follows:

Incoming Applications

The total number of applications that are started is shown, divided into the number of applications that are started and pending submission, and the number of applications that were submitted. The applications are categorized by the source of the application:

- **Account Transfer**
  Applications that are submitted from external systems through account transfer.
- **Caseworker**
  Applications that are submitted from the Cúram application by a caseworker.
- **Online**
  Applications that are submitted from an online citizen account by a citizen or navigator..

Applications Received

The total number of applications that are received by the agency is shown and generally this number matches the total number of applications that are submitted as represented in Incoming Applications.

The applications are categorized by their status:

- **In Progress**
  Applications that currently are in progress.
- **Closed**
  Applications that progressed to the completion of the intake process and for which an eligibility decision is available.
- **Withdrawn**
  Applications that a citizen withdrew after they submitted them.

Intervention Required

The number of in-progress applications that could not be processed automatically and that require intervention to progress them further. The applications are categorized by the type of intervention that is needed.

- **Outstanding Registrations**
  Applications where person registration is incomplete, that is, which are associated with one or more prospect persons. All applications with outstanding registrations are assigned to this category, irrespective of any other interventions that they might require.
- **Outstanding Verifications**
  Applications that have evidence that requires verification, excluding applications with outstanding registrations.
- **Failed Validations**
  Applications that are in the Awaiting Resolution state, due to invalid evidence.
- **Failed to Determine Eligibility**
  Integrated cases where an eligibility decision could not be made, typically because of incoming or inedit evidence.
- **Failed to Broker Evidence**
  Application cases in the Authorization Failed state, where evidence could not be brokered from the application case onto other cases.

Eligible programs

The number of currently active Merative SPM Income Support for Medical Assistance programs that were created since the specified date, which are categorized by type. The programs can be generated as a result of the Merative SPM Income Support for Medical Assistance Intake process, in addition to other application processes, such as Change of Circumstances.

Table 8: Default Programs and abbreviations

Abbreviation	Program
CHIP	Children's Health Insurance Program
EMA	Emergency Medicaid
ESI	Employer Sponsored Insurance
Exem	Exemption
IA	Insurance Assistance
MA	Streamlined Medicaid
SBHP	State Basic Health Plan
UQHP	Unassisted Qualified Health Plan

What can I configure or customize?

Note: application property that was introduced in Social Program Management 6.0.5.5. Reports are not intended for use with applications that pre-date this release. The application process is considered complete once an eligibility decision is made on the application. The report tracks applications up to that point. It does not track subsequent inconsistency period processing that may arise for some applications.

Reports depend on the `curam.intake.use.resilience` application. Customization of these reports is not recommended. These reports rely on underlying functions that have the potential to change in future releases.

3 Program information

Use Health Care Reform (HCR) rate tables to maintain rates that are effective during set time periods.

3.1 HCR rate tables

Rates are values that can vary over time. Use rate tables to maintain these rates. Since rate tables can be created and maintained independently, you can use a more flexible approach to rates that apply to products. Use rate tables for values that are effective during set time periods.

Table 1 contains the HCR rate tables.

Table 9: HCR rate tables

Rate table name	Description
CER Annual Federal Poverty Levels for Qualified Health Plan	Configures income limits based on household size. These limits are used by Qualified Health Plans.
CER Annual Federal Poverty Levels for Streamlined Medicaid and CHIP	Configures income limits based on household size. These limits are used by Streamlined Medicaid and CHIP only.
CER Tax Filing Thresholds for Dependents	Configures individual threshold rates for unearned and earned income across different categories of age and marital status.
CER Tax Filing Thresholds for Dependents rate table for Gross Income	Configures individual threshold rates across categories that are used in gross income-related rules.

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