IBM Cúram Social Program Management
Version 6.0.5

Cúram Health Care Reform Business Guide

Note
Before using this information and the product it supports, read the information in "Notices" on page 39

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This edition applies to IBM Cúram Social Program Management v6.0.5 and to all subsequent releases unless otherwise indicated in new editions.

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Cúram Health Care Reform Business Guide

IBM Cúram Health Care Reform helps citizens to access health care options and helps agencies to manage health care applications for their clients. IBM Cúram Health Care Reform is part of Cúram Income Support and Cúram Income Support for Medical Assistance.

Introduction

The purpose of this guide is to provide an overview of the IBM Cúram for Health Care Reform (HCR) solution which is available as part of Cúram Income Support, and also as part of Cúram Income Support for Medical Assistance. After reading this guide, the reader should have a clear understanding of the IBM Cúram Health Care Reform solution, the ways in which it allows citizens to access health care options and helps agencies to manage health care applications for their clients.

Audience

This guide is intended for business analysts working within a social enterprise organization. It is assumed that this audience is familiar with the basic concepts of Social Enterprise Management (SEM) and has a strong knowledge of IBM Cúram and the organization's business requirements.

Further Reading

IBM Cúram for Health Care Reform builds upon and extends a number of key areas of the IBM Cúram application. In order to fully understand the concepts discussed in this guide, it is suggested that the reader has read and has an understanding of the concepts covered in the following documents.

Table 1. IBM Cúram for Health Care Reform recommended reading

Business Guide	Description
Cúram Universal Access Guide	IBM Cúram Universal Access allows citizens to interact with an agency over the Internet. Universal Access is a fully-configurable, citizen-facing application that enables agencies to provide a user-friendly and intuitive web self-service solution.
Cúram Universal Access Configuration Guide	This guide describes the configuration options available for IBM Cúram Universal Access, including the ability to configure the Universal Access home page and motivations that are available to a citizen from the home page.

Table 1. IBM Cúram for Health Care Reform recommended reading (continued)

Business Guide	Description
Cúram Intake Guide	Cúram Intake provides a means for the workers in an agency to carry out the functions required as part of the intake process in a cohesive and usable manner. It facilitates agencies in providing a collaborative, 'No Wrong Door' approach to the intake process for clients applying for benefits. This reduces the number of contacts a client has to make in order to access benefits and/or services across multiple agencies, by providing workers with the facility to carry out the intake process across multiple programs.
Cúram Integrated Case Management Guide	Cúram Integrated Case Management works in conjunction with Cúram Outcome Management to provide a holistic approach to assessing the needs of families and meeting these needs through the delivery of programs, services and achieving positive outcomes for clients.
Cúram Participant Guide	The business of a social enterprise organization involves many individuals and bodies. These are 'participants' in Cúram terms. This guide defines the basic concepts of participants and participant types. After reading this guide, the reader should understand the roles the different participant types play, the importance of participant registration, and what information can be maintained for the different participant types.
Cúram Evidence Guide	The Cúram evidence framework allows evidence to be maintained at the application, person/prospect person, and case level.
Cúram Dynamic Evidence Configuration Guide	Cúram supports evidence definition and maintenance as an administrative exercise; no longer a development-time activity.
Cúram Evidence Broker Guide	The Cúram Evidence Broker enables a flexible approach to evidence sharing. Social Enterprise Management agencies can configure how evidence is shared and received.
Cúram Verification Guide	Cúram Verification validates information that has been submitted by a client and compares it to other information that the system has access to. Customization of many aspects of verification functionality is possible, for example: limited access to verifiable data, specialized processing triggered by changes to verified evidence, and determining whether or not a verification is mandatory.

Table 1. IBM Cúram for Health Care Reform recommended reading (continued)

Business Guide	Description
Cúram Appeals Guide	When an application, product delivery case, or issue case is appealed, an appeal case is created to manage the appeal. This starts a chain of events which includes collating statements, scheduling hearings, deciding whether or not to overturn the application, product delivery or issue decisions, and implementing the appeal decision accordingly.
Cúram Provider Management Guide	Cúram Provider Management (CPM) is concerned with the management of the provider lifecycle, and information relating to that provider. CPM also allows for the management of the delivery of services by a provider.
Cúram Medical Assistance Program Guide	Medical Assistance is a program that pays the medical bills (and in some cases the cost of institutional care) of people who have low income and cannot afford medical care. It is a means-tested program, available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. The Medical Assistance program provides eligibility determination for households based on financial and non-financial factors.
Cúram CHIP Program Guide	Cúram Children's Health Insurance Program (CHIP) is an implementation of the CHIP program within the Cúram Medical Assistance product. Cúram Children's Health Insurance Program provides eligibility determination for children of eligible households based on financial and non-financial factors.
Cúram Income Support Food Assistance Program Guide	The Food Assistance program is an assistance program that provides food to low and no income households. Benefits are distributed using cards or coupons which can be used to purchase food. Cúram Income Support Food Assistance provides eligibility determination for households based on financial and non-financial factors. The information required to determine program eligibility is captured as evidence. This evidence is assessed against a set of business rules to determine whether or not the household is eligible for Food Assistance.

Table 1. IBM Cúram for Health Care Reform recommended reading (continued)

Business Guide	Description
Cúram Income Support Cash Assistance Program Guide	The Cash Assistance program is a program that provides cash assistance to needy families with dependent children. Under the program individuals are entitled to a maximum of 60 months of benefits within their lifetime and there is a component requiring clients to attempt to find employment. The program aims to get people off the temporary assistance, primarily by getting them into jobs. Cúram Income Support Cash Assistance provides eligibility determination for households based on financial and non-financial factors. The information required to determine program eligibility is captured as evidence. This evidence is assessed against a set of business rules to determine whether or not the household is eligible for Cash Assistance.

IBM Cúram for Health Care Reform Overview

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, commonly referred to as Health Care Reform (HCR) aims to ensure that affordable health care is available to all US citizens through a number of shared responsibility measures targeted at states, employers, insurance carriers, and citizens themselves. The individual shared responsibility provision expects all citizens to have essential health care 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, the law includes the following:

- Expanding Medicaid eligibility to cover households whose income is up to 133% of the Federal Poverty Limit (FPL)
- An optional state basic health program which 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 used in determining eligibility.

The federal government has also provided deadlines to ensure they are satisfied in a timely and consistent manner. Enrollment opens October 2013 for coverage beginning January 2014, therefore states must provide citizens with access to each of the options above through a Health Insurance Exchange, an online marketplace that allows citizens to see options from insurance carriers to make an informed choice on health care coverage.

Provisions of the Affordable Care Act

ACA legislation consists of several interconnected provisions, such as eligibility and entitlement determination and access to an exchange to ensure citizens are offered continuous and affordable coverage. IBM Cúram for Health Care Reform satisfies these provisions by providing a single point of entry through which citizens can shop for the full range of 'insurance affordability' programs - a collective term which includes Medicaid, CHIP, state basic health program and Insurance Assistance in the form of premium tax credits and cost-sharing reductions. Applicants can apply for assistance and if determined eligible, can enroll in the appropriate program.

To ensure a simplified and streamlined application process, information gathering is shorter than has traditionally been the case; only information that is necessary for a determination is collected. This is done by capturing details about the primary applicant, the household and the household income. Services are available through the federal data services hub (or federal hub) which pre-populates information on the application form, for example, income information retrieved from state and federal systems. An applicant has the option to use these pre-populated details rather than having to enter details themselves thus making the application process easier and quicker. Further consumer-friendly provisions are satisfied by providing assistance to individuals in a variety of ways, either through navigators who provide fair and impartial help, or through outreach assistance services.

The HCR application determines eligibility across all of the available insurance affordability programs using the same simplified eligibility rules for Medicaid, CHIP, State Basic Health Plan and premium tax credits. Consistent income rules are used for all programs where Modified Adjusted Gross Income (MAGI) is used to determine eligibility, allowing for a few exceptions for 'MAGI-based' income which is applicable only to Medicaid and CHIP. Individuals do not have the option to apply for a single program alone; determination is performed for all available health programs. This coordinated approach ensures individuals do not have to apply for multiple programs, nor do they have to apply for one program after another if they initially apply for a program for which they are not ultimately eligible. This ensures there is "no wrong door" into health coverage.

Another key provision of the ACA is to increase efficiency to help reduce agency worker workload. The federal hub can be used wherever possible to ensure client-attested information is compared to, or verified against information about the client that is maintained on other state and federal systems. This near real-time verification of client information when successful negates the need for case workers to follow up with the client for supporting documentation, allowing individuals to receive an eligibility determination and enroll in a plan in a single visit. The timely determination benefits the client, worker, and agency.

The Health Insurance Exchange

The ACA mandates that States have an obligation to provide citizens with access to affordable health insurance offering 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 has been determined eligible for some kind of assistance within the range of insurance affordability programs, or even when not eligible for assistance but still determined eligible to use the Exchange, then citizens can search for and compare different Qualified Health Plans (QHPs) - the name given to plans that are offered by health care providers through the Exchange.

These QHPs are certified by the Department of Insurance and given a rating based on the actuarial value of the plan (bronze = 60%; silver = 70%; gold = 80%;platinum= 90%). This actuarial value promotes plan competition 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 will also be reflected in the premium associated with that coverage. Plans offered by different carriers with similar cost-sharing designs will have the same actuarial value, thereby 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 based on price, benefits, and quality so that an individual seeking health care 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, and information is made readily available to help consumers better understand the options available to them.

The Exchange is also responsible for filtering plans based on the citizen's eligibility and adjusting the different cost factors of plans based on their entitlement. For example, Insurance Assistance offers financial assistance to citizens in the form of premium tax credits and cost-sharing reductions. Since cost-sharing reductions are only allowed to be used on silver plans, this should be reflected in the list of plans 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.

As mentioned above, 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 health care programs available; plan premiums are not adjusted as there is no financial assistance available to help with the costs when purchasing insurance. However, Citizens must still be determined eligible to purchase QHPs through the Exchange; a subset of the information needed for the assistance application process is captured and used in this determination.

Small Employer Exchange

In addition to the different types of assistance provided by the government within the insurance affordability programs, another way in which the ACA attempts to make health care more affordable to citizens is by ensuring employers provide contributions towards health care for their employees. Since large employers typically already have agreements in place with insurance carriers, the focus in terms of providing this employer-sponsored insurance (ESI) has been on small employers, hence the requirement for states to provide a small employer exchange as well as the individual exchange described above. Both exchanges operate in much the same way, with the only real difference being the range of plans available to employees, and the assistance they can avail of in paying for premiums associated with those plans.

Employers enter summary details of the employees on the exchange in the form of a roster of qualified employees, and choose a contribution to make towards their coverage as well as the plan(s) made available to them for selection. Employees can then select the plan(s) offered to satisfy the individual mandate for minimum essential coverage through employer-sponsored insurance.

The law provides tests to ensure compliance - an affordability check verifies that employers are fulfilling their obligation to provide affordable health care to their

employees and that employees aren't 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 in this circumstance 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 don't wait until they get sick to enroll in coverage, or switch to more comprehensive coverage when in need of an expensive medical procedure. Prior to annual open enrollment, exchanges must provide a written annual open enrollment notification to each enrollee. Legislation defines this must be issued in advance of any period, in the month of September; this allows plan carriers to have made any adjustments to the plans they wish to make available on the exchange, and gives sufficient notice to enrollees to address their options for the upcoming coverage year.

For coverage in the first year, 2014, the ACA has defined an extended initial annual enrollment period between October 1, 2013 and March 31, 2014 where qualified individuals can enroll in a QHP through the exchange. For subsequent coverage in years 2015 and beyond the annual open enrollment period for the individual exchange begins on October 15th and ends on December 7th. During this period, individuals and families already enrolled on a QHP can re-visit 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 made during the open enrollment period take effect on January 1st of the following year. Enrollees can change their plan as often as they like within the open enrollment period. That selection is considered 'final' once the open enrollment period has elapsed. 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 coverage is effective on the date of birth or date of adoption.

Note that the dates from which an enrollee is covered are slightly different for the initial annual enrollment period. Up to and including December 15 2013, any enrollment behaves exactly the same as during a normal annual enrollment period, except that none of the qualified individuals will already be enrolled on a QHP on the exchange; coverage takes effect on January 1, 2014. For the remainder of the initial open enrollment (i.e. December 16, 2013 to March 31, 2014) this period behaves the same as special enrollment periods in terms of plan selection and

effective dates; coverage from the first of the first following month when enrolled in first half of the month, and coverage from the first of the second following month when enrollment occurs in the latter half of the month. The qualification for being able to select a plan in this period would be based on whether you have selected a plan already. If you have not already selected a plan, you can select one during this period without any qualifying event – if you have already enrolled on a plan, then you need to qualify for special enrollment.

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 timeframes.

Finding the Right Health Care Options

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.

Households whose income is less than 133% of the FPL are eligible for Medicaid, a state-administered health care program which 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 supported under the ACA includes parents and caretakers, children, pregnant women, individuals formerly in receipt of foster care, and adults who don't satisfy the eligibility criteria for other coverage categories.

The Children's Health Insurance Program (CHIP) has been 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, therefore, when household income is just below 200% FPL is for adult members in the household to receive Insurance Assistance and children to be eligible for CHIP.

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 offered by the government decreases as the household income increases to that limit.

Citizens and households whose income is above the level at which they can get state-sponsored health care but below 400% of the FPL are still entitled to financial assistance from the federal government which they can use to offset the cost of private insurance. This is 'Insurance Assistance' and is issued in the form of premium tax credits and/or cost sharing reductions. 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 will get a lower tax credit than someone with an income of within 200% of the FPL.

Citizens and households whose income is above 400% of the FPL aren't 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 simply apply to shop directly for QHPs; essentially non-financial information is captured without the need for income information and eligibility determined to purchase QHPs through the exchange.

Employers have a duty towards their employees to offer assistance with their insurance costs. Like the individual exchange, the SHOP exchange is a competitive marketplace where individuals employed by small businesses can buy QHP coverage, subsidized by their employer. The premium that an employee has to pay for the cheapest plan offered by their employer after the contribution has been taken away should not exceed 9.5% of the employee's income. If the premium doesn't exceed this amount, then this coverage is considered affordable and the employee can avail of this employer-sponsored coverage. Additionally, the employee can look to his options in the individual exchange; eligibility for employer-sponsored coverage does impact an individual's eligibility for Insurance Assistance, however the employee is not precluded from being determined eligible for Medicaid, and that may be a more beneficial coverage option for the employee. If the premium does exceed 9.5% of the employees 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 premium tax credits and cost-sharing reductions.

Individuals may 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.

IBM Cúram for Health Care Reform meets each of these by allowing citizens and employees to peruse a range of health care options, determine their potential eligibility for assistance, shop for plans, and apply directly to health care providers, or apply for an exemption.

Streamlined Application Process

HCR 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 significantly 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 HCR 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 HCR 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 in order 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 using basic information supplied by the individual about themselves, their household, and their household income.

Information 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 via 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 via 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 may 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 via 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 caseworker 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 caseworker.As a follow up action on receiving the supporting documentation a caseworker 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 may or may not permit issuance of benefits depending on the program and the reasonable opportunity or inconsistency requirements associated with that program.

Eligibility Results

Following completion of the application process, Cúram 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 in an easy-to-use interface. 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 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, as well as the enrollment status. 'My items' retains details of the enrollments that have been processed. The main page content consists of three main sections:

- Health Care Options

  The health care options are displayed front and center 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/CHIP or using the federal assistance for health insurance. The options available to an individual obviously depend on the results of the eligibility determination for insurance affordability programs. The citizen 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, this is explained in more detail later. Upon completion of enrollment, an individual is returned to the eligibility results page and can view summary enrollment details.
- Other Government Services

  Screening results that a citizen may avail of are displayed below the health care options. Individuals have the ability to 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 could be determined potentially eligible for Food Assistance or Cash Assistance; the mother can continue to apply for one or all of these programs; this functionality reiterates the 'no wrong door' approach provided within HCR.
- Other Community Services

  Other community services are 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 citizen has with an agency which quickly identifies an individual's needs. For example a client may have an immediate need for food and shelter for the family. Triage will quickly identify these needs and provide details of suitable services on the triage map so that a citizen can easily identify the locations of the services being provided. Note that the 'Other Community Services' section is empty in a default installation, customers can fill out the page as required.

Citizens that do not directly enroll on a plan can submit their applications to be further processed by case workers. Upon submission, an application reference number is provided to the applicant. Completion of enrollment in a QHP, or submission of the application invokes the intake process in the back-end case management system. Information gathered in the application is mapped to evidence on an application case, which is the vehicle used to represent the information captured at the time of application. Additional details are available in the Working with Client Applications chapter.

Plan Selection and Enrollment

HCR 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. In order 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.

Once eligibility and entitlement have been determined, citizens have the option to 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. In order to load the plan management pages, an enrollmentID is passed via the plan management URL, which the plan management system then uses to call a Cúram web service which 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 may also be no need to select from a large number of 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. An individual 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 an individual may 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, IBM Cúram maintains the household contribution thereby 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 have the ability to 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 will result in a lower actual tax credit being issued, and if they have used an amount higher than this then they are obliged to pay back the excess as part of reconciliation.

Following completion of enrollment in a plan, the plan management system re-directs the iFrame to a URL provided by Cúram which returns the individual to the results page, which is updated based on the enrollment details. In order to get these enrollment details, a web service provided by the plan management system is called via 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 via a number of channels. Applications are submitted once 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 HCR eligibility results page. Case worker can complete and submit an application on behalf of a citizen. In each of these circumstances, the submitted application is processed in exactly the same manner, invoking 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. The intake process is explained in more detail in the 'Working with Client Applications' chapter.

E-signature

The e-signature of the application filer can be recorded. The e-signature page has sections which capture the acceptance of the application filer for cooperation on medical support information collection, eligibility renewals, change in circumstances reporting, and attestation that the information provided is true. These pages are displayed when the user selects to submit the application.

HCR for the Individual and Household

IBM Cúram for Health Care Reform builds upon the functionality provided by Cúram Universal Access to provide citizens with a 'no wrong door' solution to their health care needs. Cúram Universal Access is a fully-configurable, citizen-facing application that enables agencies to provide a user-friendly and intuitive self-service web based solution to the public. It provides easy access to citizens to create a user account, view or update their information, submit applications for insurance affordability programs, and track ongoing applications without having to follow up with multiple agencies and departments.

The HCR landing page is a custom Universal Access home page tailored to meet the needs of HCR with a look-and-feel compatible with the rest of Universal Access. The main functional elements of the screen are the links in the top right-hand corner, the calculator at the bottom of the page which lets citizens quickly estimate what they might be eligible for and the citizen account log in panel. Informational links, frequently asked questions and other citizen help tools are also presented on the landing page.

Individuals can do the following on the HCR landing page:

- Apply for assistance with health care
- Apply to purchase health care without financial assistance (shop for plans)
- Browse for health insurance - check the cost of health plans
- Apply for an exemption from the individual responsibility requirement
- Apply for employer sponsored health coverage

- Log in to a secured citizen account (where account creation occurs as part of application processes)
- Check potential eligibility for the range of other programs that are offered by the agency
- Apply for other programs that are offered by the agency

Creating a Citizen Account

As part of an application for assistance, individuals 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. When creating an account, citizens register by providing key details about themselves which are necessary to access the citizen's account in the future. Having selected to start an application process, the individual is required to either log in to an existing account or create a new one. Once this is successful, they are taken to the first page of the application script, where they 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, an individual can log in to their account to check the status of their application(s).

Agencies may have various security processes to validate that a citizen account user is the same person that is registered on the system. HCR supports this by allowing agencies to link citizen accounts to participants registered on their system. This allows the agency to maintain information about the individual relating to their applications as participant evidence in an integrated case.

Applying for Assistance

The HCR 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 designed to be as simplified and streamlined as possible so that only questions that are relevant to a household's circumstances are displayed. There are certain questions which 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 anything entered. There is also an overall summary for the application script which applicants can use at the end.

The application process is dynamic. This means that questions which are not relevant to the current application about the person and household are not displayed. This ensures that applicants can complete the process as quickly as possible, and won't be presented with questions about information that doesn't affect their eligibility. A simple example is that 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 caseworker before eligibility can be determined.

Information About the Individual

The application starts with questions to capture information about the individuals in the household. This includes basic identifying information about the individual that is required for eligibility determination, normally referred to as non-financial information. The requested information varies based on whether the individual is applying for assistance or not. For example, citizenship status is required to be recorded only for applicants, this question is not asked of non-applicants.

Information that is entered in the application can be verified electronically, through external systems via the federal hub. There are two levels of verification - the first level is the identity proofing of the application filer, through the Remote Identity Proofing (RIDP) process which is used to verify that the application filer is who he says he is. In this process, the application filer's identifying information such as Name and Date of Birth are sent to an external service that generates and sends back a set of questions for the application filer to answer. These questions are called as Precise Identity Questions, which are based on the personal information of the application filer, such as the last four digits of the SSN or Bank Account Number. The application filer's responses are then evaluated by the external service, and a decision returned. If the application filer's identify proofing is successful, then he can continue to complete the application. In case the identity proofing fails, the application filer is directed to get in touch with the external service for follow-up. When resuming the application process, the system validates that the application filer has successfully completed identity verification with the external service. The second level of verification is on the information 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 like the citizen's social security number to look up other systems and verify their identity, citizenship and other relevant details. The social security number (SSN) for the primary applicant is verified early in the application process, just after the basic identifying information is recorded. This is because a valid SSN is a prerequisite for later services such as verification of annual tax return income.

In general, the personal information entered is used to verify financial and non-financial information that the client attests to. Any client attested information that matches information retrieved from other systems is considered e-verified as it will have been provided to Cúram via the federal verification hub.

This system of 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 to be 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 as they have no need to follow up with clients for outstanding verifications. This is also beneficial for the applicant as it provides them with a quicker decision.

Information About the Household

The Household Information section captures non-financial information about other members of an individual's household, and other important information which may affect the eligibility and entitlement of the household, for example, household members' relationships to the applicant and tax relationships.

Similar to the primary applicant details, this information is gathered by capturing basic demographic and contact information. Questions determine whether the household member is an applicant or not. 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 being built up is displayed, and more people can be added as required. A reminder is displayed of what other people should be included, so that the individual is presented with all the information they need to decide whether more people should be added or not. The aim is to ensure that the correct household is captured before moving on to capture household relationships, tax status, and tax relationships for each individual in the household.

The set of questions asked to determine tax filing status for household members is clear and intuitive. The tax filing questions are asked of a household in a logical sequence:

1. Identify which members in the household are planning to file taxes
2. If there are any married couples in the household and 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.
3. Identify any members claimed as a tax dependent by another tax filer; otherwise they are non-filers.
4. Tax filers that claim dependents and spouses filing joint returns cannot be claimed as dependents. Tax filers that do not claim any dependents are looped through to determine if anyone else claims them. This is to support scenarios where a tax dependent also has a requirement to file taxes.

Throughout this section questions are displayed dynamically, as in keeping with the rest of the application. For example, student questions will not be asked of household members above age 21, as this is the age limit for individuals necessary for Medicaid household composition rules.

Information About Household Income

To help streamline the application process for the citizen prior to having to enter income for the household, the application attempts to use income data from existing state and federal sources. If an applicant has 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 his or her income for the coverage year as well; the applicant has the opportunity to enter a different annual income if the tax income is no longer representative of their current financial picture. If tax return information is not available (or if any of the below checks fail) then information on current income is retrieved from state systems and presented to the applicant. A

number of conditions are executed as part of a check to determine if it is worthwhile to give an option for the applicant to attest to the IRS income. The check involves:

- running household composition rules to see whether there is more than one financial household within the overall household
- checking whether there are any American Indian/Alaska Native (AI/AN) individuals in the household
- checking whether the household income indicated by the tax returns is below 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. Note that 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.
3. If neither the tax return page nor the current income page have been presented to the user, they will be asked whether they have any income and given a chance to add any if they do.
4. 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.
5. 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 may 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, and a page is displayed to capture a few 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. The implementation for social security benefits and foreign earnings is unchanged. When either income type is entered, the system 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 an individual. These aren't 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. This approach differs from the Centers for Medicare and Medicaid Services (CMS) model application which doesn't identify tax-exempt portions. 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 an individual is what is used when adding up the household income which is necessary for eligibility determination for Insurance Assistance. However, for Medicaid/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 derived from distributions or ownership interests, then this income is not counted in their eligibility determination for Medicaid.

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, it is necessary to run rules 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 Medicaid-eligible individuals, avoiding the Insurance Assistance questions is very beneficial. An individual potentially eligible for Insurance Assistance will be 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 made by the employer. This information is

necessary for the affordability test which checks whether the cost of the insurance 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 may be eligible for 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 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 have been 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 HCR eligibility results page.

Apply to Purchase Health Care without Assistance

Citizens can apply to purchase health care for themselves and their families without seeking financial assistance. As with other application processes, a citizen account is required in order to purchase health care plans directly. Once the user is logged in, an application script captures the necessary information which is a subset of the information 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 using the same HCR 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 follows the same process in the plan management system to that for an individual 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 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 HCR 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.

Employee Applications

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 into 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:

- 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 employer(s) in the SHOP and whether the open enrollment period for any of those employers is currently active. If active, then summary information about the options available to the employee in the SHOP will be presented on the HCR eligibility results page. If the employee is eligible, they can continue to enroll on the plan subsidized by their employer. Otherwise, they are informed that they can't 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 may be eligible for a program within the insurance affordability programs.

The employee affordability check is performed as part of the individual application flow. As previously mentioned, if employer-sponsored coverage is not considered affordable, then the employee may be entitled to 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. A lot 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 un-affordable; then they can proceed to check their eligibility for Insurance Assistance. If eligible for employer sponsored insurance which 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 may be suitable; meaning the employee goes without coverage under the QHP subsidized by the employer.

Continuing to enroll on a plan 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 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 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.

Exemptions

As documented in the Overview, 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 are 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 health care 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 U.S. can only be claimed as part of filing a tax return. The exemption for those who are under the tax filing threshold is available automatically - there is no action required.

The exemptions supported by the HCR solution are those which can only be applied for through the exchange and the ones which 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

Hardship exemptions are not supported.

Exemptions are applied for in a similar manner to other application processes. A user account is required in order 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 course of the application. This ensures that an applicant is only presented with questions that are relevant to the exemption for which he or she is applying, for example, an exemption due to religious conscience will ask 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 HCR 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 invokes the Intake process so that cases can be created to manage the exemption in the same way as it handles any other application submission.

Browse Plans

HCR allows citizens to browse the QHPs offered in the exchange. This process, (unlike the application processes) does not require the creation of a user account because there is no eligibility determination - the citizen is simply looking at the plans available in the exchange. The information which is asked is restricted to only that which can affect the quote for a monthly premium for plans offered by carriers. For each member, this is their date of birth, tobacco usage, and the zip code for the household. Plan providers can only vary plan premiums for households in the exchange based on four factors: age, tobacco usage, family size, and geography. Legislation prohibits the use of other rating factors such as current health status or medical history.

The application script to capture this minimal set of information is very short, and the HCR eligibility results page is presented to the individual consistent with the other applications available in the HCR solution. And as with those other processes, plans are displayed in a plan management system - the plans are displayed along with the monthly premium that has been calculated.

Citizens cannot select and enroll in plans within the plan management system. Having browsed the available plans, if an individual decides they want to apply for a plan, they must complete the application process in full, which requires them to return to the HCR landing page and create a user account, and start an application in order to determine eligibility.

Working with Client Applications

HCR makes use of Cúram Intake (CI) functionality to provide case workers with the tools they need to effectively process and manage applications in a swift and expedient manner by providing the link between the application and case management. For further information on Cúram Intake, please consult the Cúram Intake guide. The HCR solution takes advantage of the flexibility afforded in Cúram Intake.

A case type of Application Case has been defined to specifically meet the requirements for processing applications. As evidence changes over time it becomes impossible to differentiate between application evidence and any other evidence updates on an integrated case. The application case type addresses these and other issues.

For HCR, application cases are used to manage any of the options that an individual 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 have 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 QHPs through the exchange. All of these application types map onto a single Insurance Affordability integrated case type for the household. The application case types that are available are:

- insurance affordability
- employer-sponsored coverage
- shop in exchange without assistance
- exemption

Matching Clients and Creating an Application Case

All applications that are submitted by individuals from the HCR eligibility results page are processed as application cases. This also applies to applications that are submitted as part of plan enrollment.

Upon submission of applications and prior to the creation of an application case, Person match functionality attempts to automatically match applicants to registered Cúram participants. These registered persons with existing client records can then be used on a newly-created application case. If the primary applicant can be automatically matched to an existing Cúram person participant, the system proceeds to create the application case and adds this existing registered person as the primary participant on the case. Other persons recorded on the application are matched in the same way. If applicants cannot be automatically matched, the system proceeds to create the application case and adds the applicants as prospects or fully registered persons, depending on the results of the person match search.

Person match search is configurable via an application property which can be set in the administration application. 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 at all. The sample criteria weights the reference or SSN highest, along with date of birth, first name, and last name. The upper and lower score threshold values are set as system properties. The properties are available in the 'Application – Person Match Settings' category.

Once the household members listed on an application have been matched to existing clients or recorded as new participants, an application case is created automatically. It is not necessary for case workers to manually create application cases and add members and evidence to them. Information gathered in the online application can then be mapped to evidence on the application case.

Checking Eligibility

The Insurance Affordability application case type is configured to include an option for a case worker to run an eligibility check using the evidence that is currently 'in edit' on the case. Each time an eligibility check is performed a new row is added to the 'Eligibility Checks' page which can be expanded to show which members of the household are eligible for each program.

Program Authorization

Authorization of each program on an application case is required in order to process the application case to completion. The authorization process varies

depending on the nature of the programs that are being applied for. An authorization strategy can be configured for an application case. For HCR, this is a strategy of type 'Application' meaning that a rule set can be associated with an application case which determines the set of eligible programs and the clients entitled to receive the programs.

A submitted application does not require caseworker intervention when all client-attested information has been e-verified. In that scenario, straight-through processing ensures that the case worker is notified about the application case when it is authorized, however as the name suggests, there is no need for the caseworker to get involved.

Any evidence items which haven't been verified by an external system as part of the application process or accepted based on client self-attestation, require manual verification by a case worker. Straight-through processing is halted and a caseworker is assigned the task of resolving the outstanding evidence verifications with a client. Evidence with outstanding verifications is mapped to the application case in an 'in edit' state. Federal requirements for reasonable opportunity or inconsistency periods allow states to continue with the delivery of a program during this period. This is detailed below.

Following the authorization of program(s) on an application case, an integrated case is created and the application case evidence is brokered onto the integrated case. 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 which may exist for the members in a family. For example, an employee application for employer-sponsored coverage will result in an application case for that employee. If other household members were to apply for assistance in the individual exchange this would result in an insurance affordability application case. When verifications are resolved and the programs associated with these applications are authorized, they will result in one integrated case for the household. The Evidence Broker configuration used in HCR allows evidence to be automatically accepted and activated on the integrated case.

Ongoing case management requires both an integrated case and a product delivery in order 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. This is controlled via a configuration setting for application cases. For HCR, 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.

Reasonable Opportunity Period/Inconsistency Period

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 which the applicant can still receive benefits based on the information they have provided. The inconsistency period starts five days from the date the potential eligibility notification is sent. In order to support the reasonable opportunity requirement, the verification requirements have been configured to be optional for the application case, allowing the program to be authorized with outstanding verifications. The verifications are mandatory for the IC. But in order to activate the PD 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 plus the 5 days from the date the notification was sent. This would allow activation of evidences and product delivery cases with outstanding verifications thereby 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 using information available are required. In order 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 95-day period countdown begins. When the business date passes the 95-day period, the milestone overdue event is raised which can be used to perform the follow-up actions.

Product Delivery Creation

Following successful program authorization and creation (or reuse) of an integrated case, program group logic is used on the integrated case to determine the set of eligible programs and the clients who will be in receipt of these programs. Rules logic determines whether to create a new product delivery case, or reuse an existing product delivery case, as well as determine the post processing required in various situations. This logic only applies within an insurance affordability integrated case, and not across other integrated cases of this type.

Product delivery cases, one for each of the eligible Insurance Affordability programs that a household is eligible for are created. For each of the PD case, the certification period is set to start on the first day of the coverage period for the first open enrollment period configured in the system (for example,1/1/2014) and ends on the last day of that coverage period (12/31/2014). The product delivery start date is set to the date the case is created and the certification period is set as defined above. The eligibility rules take in to account the certification period and hence decisions within the product delivery case depicting the eligibility duration starting from the PD case creation date, till the end of the certification period are created. So there will typically be two decisions available - one ineligible decision from the case start date till the start of the certification period and another eligible decision covering the duration of the certification period.

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

Program group logic allows for product deliveries of the following types to be created:

- Streamlined Medicaid
- CHIP
- Insurance Assistance product deliveries; one for each tax household determined eligible
- State basic plan
- Unassisted qualified health plan
- Exemptions
- Employer-Sponsored Insurance

When creating a new product delivery case, a check is performed to determine whether a product delivery of that type already exists on the integrated case. If there is, the existing product delivery can be reused; if not, then a new product delivery is created. If a member is eligible on a product delivery but was previously an eligible member on a different product delivery type, then additional updates must be made to the product delivery case that the member is leaving, before being added as a member on the new product delivery. As the number of Insurance Assistance product deliveries is dependent on the number of tax households within the overall household, this further complicates program group logic.

Changes in circumstances will cause the existing product deliveries to be reassessed. Cases may no longer be relevant for ongoing case management. Federal guidance uses the term 'churn' to describe a situation where household income fluctuates. For example, a Medicaid-eligible household has an increase in income that exceeds the Medicaid standard. The household then qualifies for Insurance Assistance. The HCR solution caters for this churn whereby an Insurance Assistance product delivery would be created. Note that in this scenario the original Medicaid product delivery would not be closed. A future decrease in household income could result in the household being determined eligible for Medicaid again. This may necessitate a separate case closure process which would check for cases where certification periods for all members has ended and automatically closing such cases or notifying a case worker to close them.

Viewing Product Delivery Decisions

Decision screens are available which display the results of an eligibility decision for each insurance affordability program. These 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 which 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 case worker with high level summary of eligibility or ineligibility for a program, as well as 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 2. 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, e.g., 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

Table 2. Decision screens for each of the insurance affordability programs (continued)

Category	Summary Information Presented
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:

- SSN, Residency and Citizenship are displayed for Medicaid and 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
- Tax Household summary (for Insurance Assistance) lists the members in the tax household

The Income summary provides a summary of the income and the income 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.

Client Notifications

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 or not there are still outstanding verifications associated with the application.

For the straight-through application process where client-attested information has been successfully verified, the eligibility determination and associated communication notify the applicant of the household's eligibility. This is a combined notice across the insurance affordability, employer-sponsored coverage, and exemption programs for the household members which notifies the household of their individual eligibility for Medicaid, 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 is necessary in order to support the inconsistency period for an application, during which eligibility must be

determined using the client-attested information. This notification includes details of the client-attested information which have not yet been verified, and therefore requires follow-up with a caseworker.

Each notice includes details on the possible appeal for any decision associated with an eligibility determination along with instructions on how to file that appeal. There are four notifications available for HCR:

Table 3. HCR 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 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	This is generated for an integrated case when new evidence is introduced to the case.

Caseworker Submitted Applications

An application case is created automatically when an application is submitted online by a citizen, or created manually by a case worker. An internal application has been configured in the system that allows case workers to create and submit applications for citizens. When a case worker creates an application case, he or she must first search for or register the client for whom the application case is being created. Further details on the configurable options available within the application creation process are detailed in the Cúram Intake business guide.

For HCR, the case worker registers either a person or a prospect person in the system and can then create a new application form for that client. The application form is an IEG script containing the necessary set of guided questions for the insurance affordability application. Basic information that has been captured when registering the person will be pre-populated in the script, including person name, date of birth, gender and SSN. In essence, the script captures the same information as in online application. There are some differences which make it more appropriate for a case worker. For example, all of the 'staging' pages which explain what is coming in the next section and most of the informational text at the top of application pages have been removed. These are help text or preparatory details that guide a citizen through the application process and are not deemed relevant for a case worker.

When the case worker has finished the application, a new application case is created for the person in the same manner as that followed for the online

application, except that person match functionality does not need to be run using the person's details. The newly-created application case is then available within the person's list of application cases.

HCR Case Appeals Configuration

Customers who are licensed for the Cúram Appeals module can install Cúram Appeals to sit alongside HCR. When installed, the following configuration should be applied:

- Set the 'appealable' indicator to true on all of the HCR case types.
- Create a new Appeals process to match what is described in the latest federal rules. It is recommended to set up the appeals process as follows:
  1. Stage 1 = 'Any'
     - The HCR Evidentiary Hearing, which is normally the first stage in the process, maps to the Cúram Hearing type. However, it is possible that the HHS Appeal (which maps to a Hearing Review) can happen first, so to support this, the type for stage 1 should be 'Any'.
  2. Stage 2 = 'Hearing Review'
     - As above, this maps to the HHS Appeal as described in the federal rules
  3. Stage 3 = 'Judicial Review'
     - A match for the Judicial Review as described in the federal rules

Once these settings have been applied, caseworkers can appeal any denied application or product delivery case, regardless of its status. For more details on the functionality available for Cúram Appeals, please read the Cúram Appeals Guide.

Reporting Changes in Circumstances

The details of a client's circumstances change over time as various factors come into play during the course of everyday life. These everyday changes can affect previously determined eligibility decisions and can be reported via evidence updated by the case worker.

Case workers can record changes by updating existing evidence and activating these changes, invoking reassessment which results in a new set of eligibility and entitlement decisions being determined for the case. For example, a client who is made redundant by their employer and who was previously eligible for Insurance Assistance informs a caseworker who can update the income evidence related to that employment. Activating this evidence change results in the client being found eligible for Medicaid - the loss of employment resulted in a reduced household income below the Medicaid limit.

To summarize, changes in circumstances can cause product deliveries cases to be reassessed, which can mean the following:

- 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

Open Enrollment Periods

HCR makes use of an enhanced Universal Access so that when a citizen logs in, the Citizen Account home page displays messages and campaign information. This

is extended with an extra panel inserted to contain HCR-specific links – these links represent the same options that are available from the HCR landing page, where appropriate. The links are dynamic – for example, if an individual has an in-progress application (which includes one with outstanding enrollments to complete) the 'resume' option is provided.

In addition to the functionality being used directly as part of the configuration of Universal Access a number of other features are now available in the underlying infrastructure which are available for use. More information on those features are provided in the Universal Access configuration guide. Citizens have the ability to see the status of any applications or enrollments they may have

When an individual logs into their citizen account, as well as having the option to view the status of any enrollments, they are also presented with details about the next open enrollment period - this uses the campaign functionality available in Universal Access. The citizen's account displays dynamic information about open enrollment periods. The number of open enrollment periods and their start and end dates can be configured by an administrator. From 30 days prior to the start of an enrollment period, an entry is made to the campaign bar on the right-hand side of the account home page which counts down towards the start of the period. Once that period has started, messages are displayed stating how long the individual has to apply before end of the enrollment period. It is hoped that this gives the citizen prior warning of when enrollment is expected, and once open, how long they have to actually enroll in a plan.

Navigators

The role of the navigator is to assist a citizen in making an application 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.

Navigator Registration

Before a navigator can work with clients on behalf of the agency, they must first be registered on the system. HCR makes use of Cúram Provider Management to provide this functionality. When an individual or external agency requests to be registered as an navigator via the navigator portal, a number of details are recorded, and the request is submitted. Navigator enquiry requests are processed by resource managers. Resource managers can review the request and once 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 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 can then begin assisting individuals with their applications by accessing the Navigator Portal.

The Navigator Portal

Navigators can access the navigator portal using the login details they are provided with once they are successfully registered and approved by the agency. The list of clients that requested for assistance are displayed in the portal. The navigator can choose to assist a client from this list, such as filling up and

submitting applications for Insurance Assistance on behalf of the client. The navigator can also resume saved applications.

On submission, a record of the navigator who assisted the client is created. A record of all the clients who have been assisted by the navigator is also kept and is available in the navigator portal. The applications are also available for the client to view in the citizen account. The client can choose to resume an application started by the navigator.

Navigator-assisted Applications

A citizen can request assistance from a navigator by selecting the 'Search for a Navigator' option on the HCR Universal Access Landing page. The citizen is then presented with a map which shows any registered navigators in the local area, based on the address entered in the search box. Clicking on a map entry presents a 'more information' link about the navigator to the user. The individual can choose to send an email referral or get directions to the navigator.

The list of clients that requested for navigator assistance through the referral function, are displayed in the navigator portal. The navigator can choose to assist the clients by launching new applications or resuming application from the navigator portal. On resumed applications, the information entered by the client before requesting for navigator assistance are prepopulated.

Navigator assisted applications are recorded with the details of the navigator who assisted with the application, the date the assistance was provided and the name of the authorizing applicant. A record is kept of all citizens that a navigator has assisted. The navigator information is also available for the caseworker, in relation to the application that was submitted.

Applications that the Navigator submitted are also listed in the citizen account. Additional information on the selected navigator can also be viewed by the client. The client can also choose to change their current navigator and select a different one for assistance.

Integration with Income Support

The HCR solution is delivered as part of Cúram Income Support. Cúram Income Support functionality supports applications and ongoing case management for Food Assistance, Cash Assistance, and pre-ACA Medical Assistance coverage types. More information on what is available in support of these programs can be found in the following guides:

- Cúram Income Support Food Assistance Program Guide
- Cúram Income Support Cash Assistance Program Guide
- Cúram Medical Assistance Program Guide
- Cúram Children's Health Insurance Program Guide
- Cúram Medical Assistance with Spend Down Guide

There is close integration between the application process and ongoing case management for the HCR insurance affordability programs and the equivalent processes for traditional Medicaid coverage types as provided by Cúram Income Support.

Universal Access

The starting point for this integration is in Universal Access, where the sample HCR landing page includes extra links to standard Universal Access screening (the 'Check if I am eligible for other programs' link) and standard Universal Access intake (the 'Apply for other programs' link). Screening and Intake functionality have been configured to include the Cúram Income Support.

After logging into an account the individual can select the type of screening to perform and then proceed into the Income Support script for screening. Upon completion, the individual is presented with a simple screening results page which displays the results of the Income Support screening. The MAGI-based or insurance affordability programs are not included in this screening results page. The simplified calculator on the HCR landing page provides a much simpler screening for MAGI-based programs, requiring only the number of adults and children in the household along with the household income details.

Intake for the Cúram Income Support programs is available from a number of different places:

- Directly from the landing page, using the 'Apply for other programs' link
- From the screening results page
- From the screening results available on the HCR eligibility results page (as a result of a HCR application)

HCR Eligibility Results

Screening for other programs is performed as part of the eligibility determination for HCR, and displayed in the 'Other Government Services' section of the results page. As a result of integration, the 'Apply Online' functionality has been enabled for some of the programs; for example, food assistance and cash assistance.

Applying Online begins the application process for one of the Income Support programs - an individual is taken into 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 application intake process is finished, the user is returned to the HCR eligibility results page with the status of the relevant programs updated.

Mapping functionality has been added which transfers information from the datastore used by the HCR application 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 HCR results page. A generic mapper transfers data items with the same name.

Intake

If a citizen submits their HCR application from the 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. HCR uses Cúram Intake application case functionality. Income Support makes uses a type of application case which is really a facade built on top of an integrated case.

Where the two applications can overlap is through the way in which the two different intake processes can match applicants against people who are already

registered in the system. In HCR, this is an automated process, facilitated by Person Match processing. In Income Support, this is a manual process facilitated by Client Merge processing.

To take an example, if a citizen submits a HCR 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, etc. The standard straight-through process then kicks in 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 HCR application) are initially created as prospect persons and the intake worker is responsible for registering them. To do this, they search for people 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, thereby 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 HCR application case (if it is still open) or the HCR integrated case. This can happen through the person evidence; and directly between the cases (evidence brokering will happen automatically if the configuration is in place).

If a HCR 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.

Case Management

HCR applications are ultimately turned into insurance affordability integrated cases. Income Support applications ultimately turn into Income Support integrated cases. Each case has its own evidence set to represent what has been entered as part of the application/intake process. This integration is available through the person record. It takes two main forms:

1. The Person tab for any of the people involved displays a list of the all cases related to that person.
2. Person evidence from both integrated cases is shared with the person evidence area of the participant manager. Person evidence can be seen by clicking on the Evidence tab within the Person tab.

Person evidence does not have the Cúram concept of 'in edit' or incoming states for evidence. This means that all evidence brokered from cases as person evidence is automatically accepted.

As well as the possibility of being brokered from cases to person evidence, evidence can also 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 only sent to other cases and not the case on which the change

originated. So, for example, if a caseworker adds phone number evidence for a given person on an Income Support integrated case, this 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. When the evidence is brokered on to the integrated case, it appears as incoming evidence so that a caseworker can choose whether to accept it or not.

Integration with Person Evidence

A lot of the data stored for a person or prospect persons meets the Cúram definition of evidence. It is used in eligibility and entitlement calculation, and often it is information retrieved from an individual or household as part of an application or intake process. The per-existing Cúram evidence structure is limited as it prevents data deemed to be evidence being maintainable on a case even though it may be used in eligibility and entitlement. This results in a poor usability experience because the user is forced to work outside of a case to maintain data for a person. It also does not provide a full audit trail of changes made over time. Maintained as static data, it is not configurable. If there is a requirement to change an attribute or add further attributes, then this requires a customization effort. Additionally, any data changes at the participant level can cause a reassessment on the case without the user ever being aware of it.

Using Person Evidence

Evidence can only reside inside a case, therefore this participant evidence is modeled as a special case type to allow configuration of dynamic evidence at the Person/Prospect level - known as Person Evidence or Participant Manager Evidence. Updates to the existing platform code has created a number of dynamic evidence types modeled on the existing legacy tables:

- Names
- Birth and Death Details
- Gender
- Identifications
- Bank Accounts
- Email Addresses
- Addresses
- Phone Numbers
- Contact Preferences
- Relationships

These dynamic evidence types that are provided by default include a write back of the data to the corresponding participant manager legacy table, so for example when a user maintains name information in evidence, updates are made to the 'AlternateName' table. This is necessary because system processing relies on the data being present in the legacy entity. For example, 'AlternateName' data is accessed in search processes.

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 should be applied and take effect. This evidence can remain 'in edit' until such time as a user decides to apply it to the case. Also, configuring these new dynamic 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 provides a much more user-friendly way of managing all evidence for a person or prospect person.

There are a number of other participant data tables that fall into the 'evidence' category. However; this data is not used in system processing and therefore is not converted into dynamic evidence. Items that fall into this category include:

- Demographic data (such as race and ethnicity)
- Citizenships
- Foreign Residencies
- Education
- Employment/Employment Working Hours

The pages that allow users to maintain this data is configured to be not visible in the default application views. Custom dynamic evidence types can be configured with custom attributes and validations.

It is worth noting that the 'case' for a participant is just an architecture. The end user will still continue to see the evidence for a person inside the Participant Manager 'Person/Prospect Person' tab. Person registration is the function which creates the case and the necessary dynamic evidence records the background. Person evidence is automatically activated and evidence processing logic determines how information brokered from other cases is applied.

PDC Configuration

Whether person evidence is used or not is configurable. There is a PDC 'off' mode which means the existing screens and updates can be made in the pre-existing manner. This PDC mode is set to 'on' by default.

HCR Integration with Person Evidence

Person evidence can be configured at the case level. It can be configured whether updates should be shared to other cases and vice versa. The evidence broker plays a central role in this because sharing needs to occur between the intake application, ongoing cases (integrated cases or product deliveries) and the participant manager. The HCR solution has implemented the following and rules have been updated to reference these new evidence entities where applicable.

- Email Address
- Birth and Death Information
- Phone Number
- Gender
- Contact Preferences
- Identification - maps from PDC Identification evidence to HCR SSNDetails evidence

Evidence Broker Configurations

The Evidence Broker is fundamental to the use of person evidence. As it is necessary to transfer evidence from person records in the participant manager to the insurance affordability application case, configurations have been added so that the full configuration is now as follows for each of the evidence types shared by HCR cases and the participant manager:

- From application case to integrated case: all types auto accepted and auto-activated
- From application case to participant manager: all types implicitly auto accepted and auto-activated (standard behavior for participant manager evidence)
- From integrated case to participant manager: all types implicitly auto accepted and auto-activated (standard behavior for participant manager evidence)
- From participant manager to application case: no types auto accepted or auto-activated (will appear as incoming evidence)
- From participant manager to integrated case: no types auto accepted or auto-activated (will appear as incoming evidence)

In addition, 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 no different from what is already recorded against that person, the broker will discard the new record when brokering the evidence from the application case to the participant manager.

Conclusion

The following is a summary of the main concepts covered in this guide:

Summary

- IBM Cúram for Health Care Reform allows citizens to avail of a range of health care options, determine their eligibility for assistance, shop for plans without assistance, or simply browse plans made available by plan providers in the Exchange.
- Using a single entry point and HCR application script, citizens can apply for the range of insurance affordability programs for which they and their household may be eligible.
- Insurance affordability programs that applicants can be determined eligible for include Medicaid, CHIP, Insurance Assistance, and optionally a state basic health program.
- The Exchange is an online market for insurance plans offered by private insurance carriers that are presented to individuals for plan selection and enrollment. The Exchange provides a means for citizens to search for and compare different qualified health plans.
- Individuals can use the exchange without seeking financial assistance, although they must be determined eligible to use the exchange
- Information capture is limited to information needed for an accurate determination for MAGI-based eligibility - essentially applicant, household and household income information.
- Eligibility is based on MAGI income, a simplified income determination in comparison to a traditional Medicaid determination - no resource test, no complex income rules.
- Electronic verification or e-verification ensures a near real-time eligibility determination
- HCR integrates with Cúram Income Support to allow individuals to screen for or apply for other programs that may also be offered by the agency.
- HCR makes use of the redesigned Cúram Universal Access to provide a landing page and citizen account functionality for the range of HCR services a citizen can access.

- Eligibility rules for insurance affordability are based on the legislative requirements as defined in the Affordable Care Act. The insurance affordability rule sets are built using the Cúram Express Rules framework.
- HCR caters for a number of different user roles including individuals and employees, navigators who assist a citizen in making an application, and case workers who process and manage client cases.

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