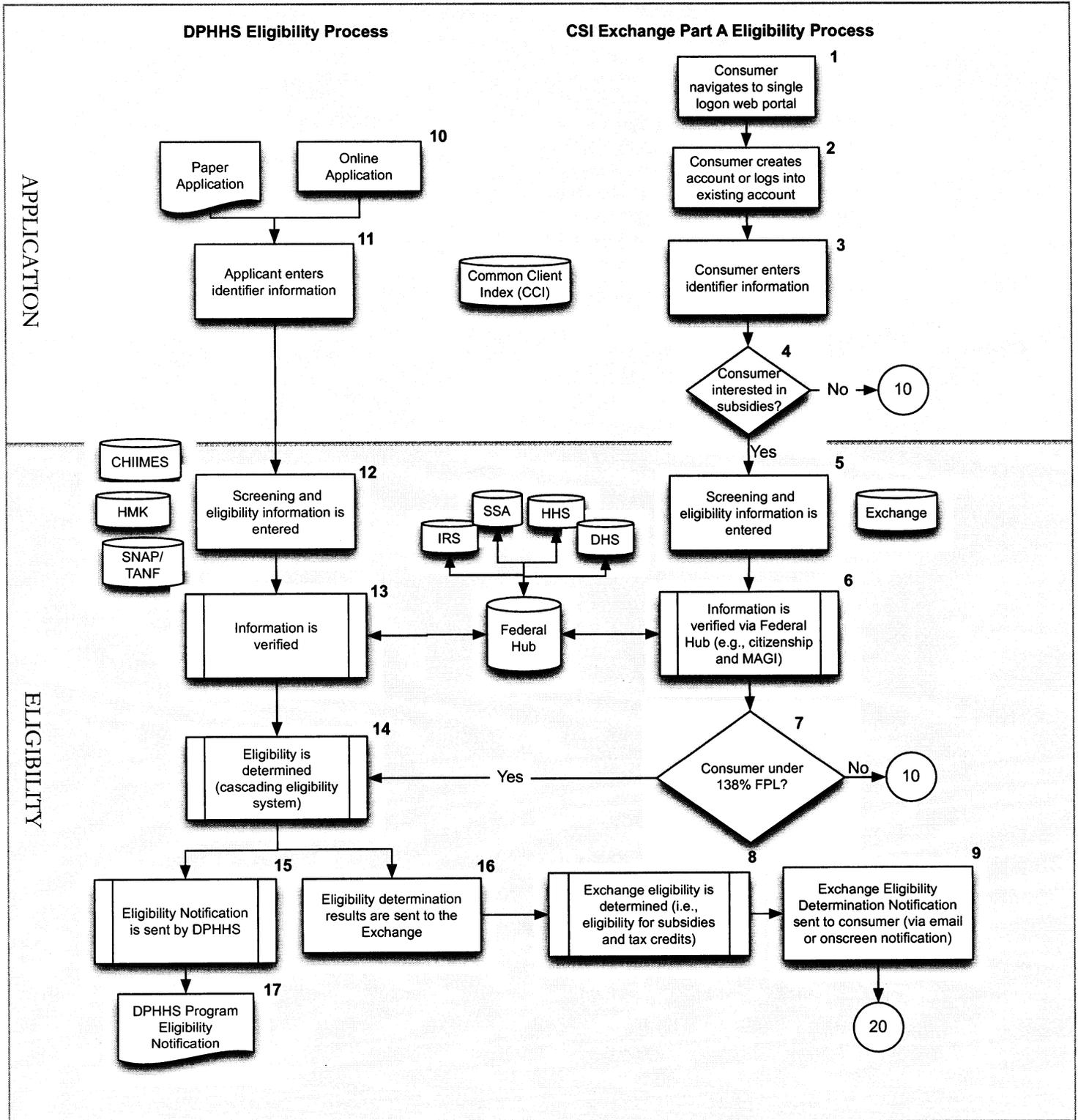
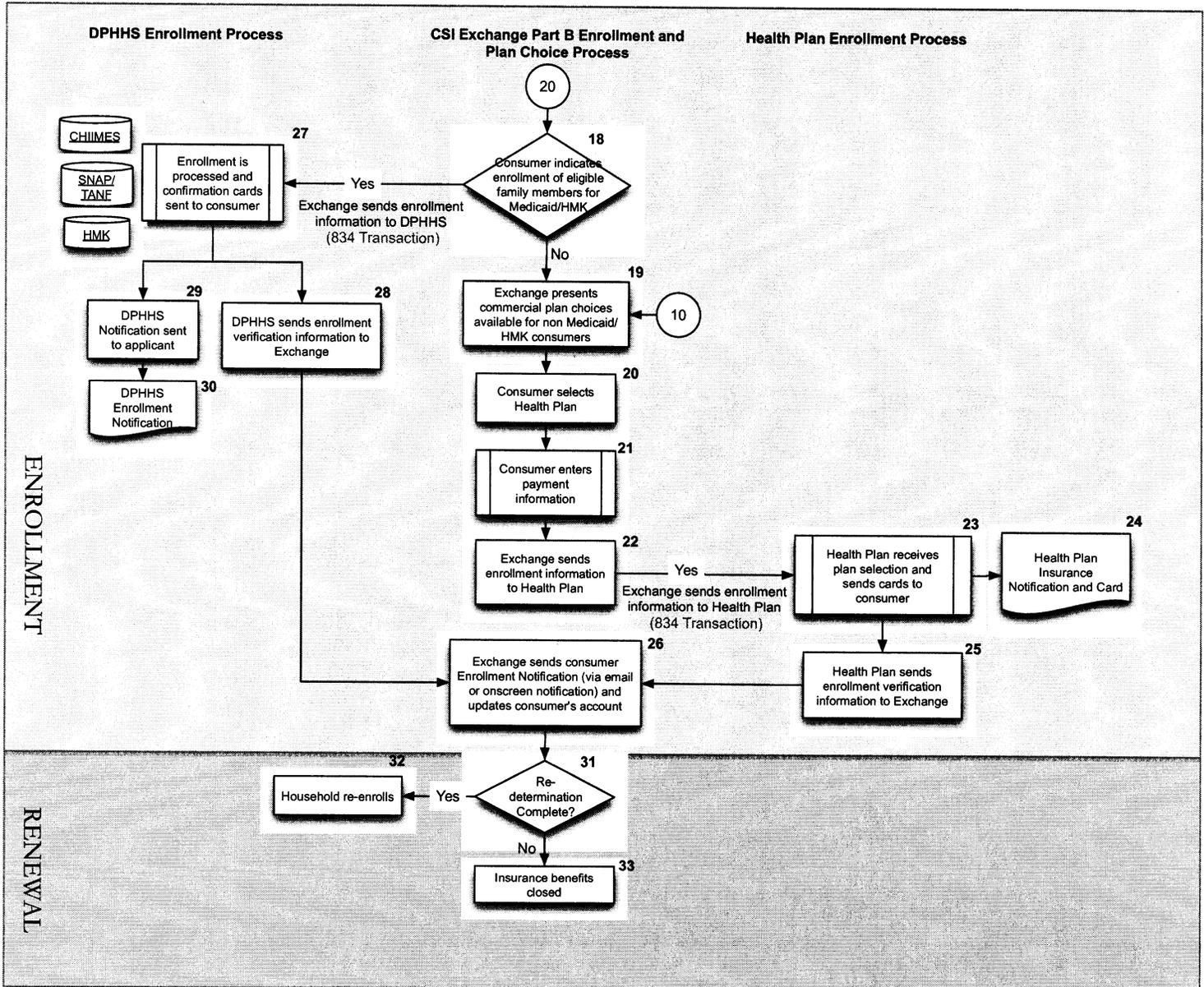


Exchange/CHIMES In





Process Narrative

The following narrative provides additional detail for the process map on the previous page.

Steps 1 – 9 identify the application acceptance and eligibility determination steps for the “CSI Exchange Part A” which is depicted in the right half of the first page of the process flow diagram.

1. Consumers searching for health plan options and/or assistance will navigate to a single logon web portal. [Note: the shared portal is a single unified process for individuals to apply, receive determinations and renew enrollment for DPHHS and CSI programs.]
2. First time consumers will create a user account, and returning consumers will log into their account. Consumers will be able to start an application, return to an existing application, report changes in their information, access account information, and otherwise interact with the site using their account. For example, DPHHS applicants/clients will be able to access Medicaid and Children’s Health Insurance Program (CHIP) information using their user accounts.
3. Consumers will enter and/or update person identifier information. The Exchange will create and utilize a common client index (CCI) so it can interact with the DPHHS programs (e.g., CHIMES, CHIP, SNAP/TANF). As a result, DPHHS applicants
 - The state needs to research social security number involvement in the common client index (CCI), which DPHHS is implementing as a part of the CHIMES-SNAP/TANF project.
 - The Exchange personal identifier requirements will impact how DPHHS defines the CCI in the CHIMES implementation project.
4. The consumer will indicate whether he/she is interested in subsidies.
5. In the event a consumer is interested in subsidies, he/she will enter the information required for eligibility determination.
 - It is unclear whether filing unit functionality needs to be created in the Exchange. The IRS household definition is very different from Medicaid household rules. Some of the household definition issues that will arise include:
 - Mixed status families – Citizen children with non-citizen parents will need to be considered.
 - Legal immigrants – There are time limits and minimum waiting periods for legal immigrants to receive Medicaid benefits. Department of Homeland Security (DHS) will interface with this hub.

- Dual eligibles – Medicare and Medicaid dual eligibility – currently there can be one caretaker relative who is not a parent who can be a dual eligible. This will change.
 - Non-custodial parents – If eligibility is based on tax forms, it may not be the custodial parents who will be considered in the same household as the children. Federal rules will have to provide more details.
 - Consumers will complete an application so the Exchange can send designated information to DPHHS for program eligibility determinations. DPHHS and CSI will align the application questions with the paper and online medical benefits application as much as possible. The Exchange will include a question about whether families would like to apply for other benefits (e.g. Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) and Temporary Assistance for Needy Families (TANF).
6. The Exchange will verify the consumer's information (e.g., citizenship and modified adjusted gross income (MAGI) via a Federal Hub, which interfaces with a number of Federal agencies (e.g., IRS, SSA, HHS, and DHS).
- The level of simplicity for verifications depends on how the Federal government puts together point in time verification.
 - The Federal government needs to provide additional information about household definition, modified adjusted gross income (MAGI), and verification requirements.
 - The Exchange application questions will need to ask questions about circumstances changing from income tax information, which means consumers, will be self-declaring information. The Federal government will need to provide guidance on how this should work.
 - Montana has a large population of Medicaid clients who do not file income taxes.
 - The Federal government needs to provide guidance on how Exchanges should process self-employment income.
 - The Exchange should match applicants with existing insurance.
 - When there is a discrepancy between information received through verification, it is up to the state to determine what to do.
7. In the event the consumer is below 138% of the Federal Poverty Level (FPL) and gives permission to check for Medicaid and Healthy Montana Kids (HMK) eligibility, the Exchange

will send the eligibility information as well as the information verification results to CHIMES. The Exchange will send the client's information to DPHHS (i.e. CHIMES) so applicants can be determined eligible based on existing Program's (e.g., Medicaid, CHIP) eligibility rules. This transfer of information will occur seamlessly using DPHHS enterprise architecture/shared services; and CHIMES will determine eligibility using its existing cascading eligibility determination process.

- Eligibility finalization does not currently occur real-time in the offices of public assistance (OPAs). It can take up to 45 days to process a Medicaid application under existing rules. Depending on how the final Medicaid rules are written, CHIMES may be able to make real time determinations of eligibility. The level of simplicity depends on the verification requirements.
 - OPA workers will have to potentially get additional information from applicants. This process will depend on how finely tuned the Federal eligibility hub will be, which depends on final Federal rules.
8. In the event the consumer is not below 138% of the Federal Poverty Level (FPL), the Exchange will determine whether the consumer (and household members) are eligible for insurance subsidies. If the consumer does not give permission to check for Medicaid and Health Montana Kids (HMK) eligibility, then the consumer cannot be considered for insurance subsidies.
9. The Exchange notifies the consumer of the eligibility determination (via email or an onscreen notification).

Steps 10 – 17 identify the application acceptance and eligibility determination steps for DPHHS, which is depicted in the left half of the first page of the process flow diagram.

10. Individuals can also apply for services through traditional medical assistance routes (county OPAs, hospitals, Indian Health Services (IHS), tribal health, libraries, and other community partners). Applicant can utilize a paper application or submit an application online. OPA workers would enter the information into CHIMES. OPA workers will not work in the Exchange directly.
- Generally people who want Medicaid also want other assistance. Individuals often apply for Medicaid, TANF, and SNAP at once.

- The states that are building Medicaid/CHIP eligibility directly into the Exchange have legacy systems or web wrappers around a legacy system. CHIMES is able to determine cascading eligibility using business rules.
11. Applicants will enter and/or update person identifier information. CHIMES will create and utilize a common client index (CCI) so it can interact with the Exchange.
- The state needs to research social security number involvement in the common client index (CCI), which DPHHS is implementing as a part of the CHIMES-SNAP/TANF project.
 - The Exchange personal identifier requirements will impact how DPHHS defines the CCI in the CHIMES implementation project.
12. The applicant will enter the information required for eligibility determination.
13. CHIMES will verify the applicant's information.
- The Federal government will have to clarify which verifications are required for simplified family Medicaid.
 - CHIMES will continue to use Federal interfaces verifying whether participants receive benefits from Federal program – e.g. Public Assistance Reporting Information System (PARIS). If CHIMES discovers these benefits and makes applicants ineligible for Medicaid/CHIP because of income, this may also impact the Exchange because applicants may be eligible for subsidies.
14. CHIMES-Medicaid will determine eligibility using its cascading process.
- Eligibility finalization is immediate if all data required is present at application registration and information entry. The process can take up to 45 days if additional information or verification is needed. Real-time determinations of eligibility from an on-line application submission may be possible under current rules once the auto-populate feature is in place for CHIMES (estimated at November 2012) and under ACA, depending on the level of simplicity present in the verification requirements.
 - OPA workers will have to potentially get additional information from applicants. This process will depend on how finely tuned the Federal eligibility hub will be, which depends on final Federal rules.
15. DPHHS will send the eligibility notification to the client

16. CHIMES will send application and eligibility determination information to the Exchange so an applicant/consumer can access the Exchange at a later time, log into his/her account, and look up information about their application/case. [Note: CHIMES will identify both eligible and ineligible household members for Medicaid and/or CHIP.]
- OPA workers will be able to access the results of the Exchange eligibility determination directly from the Exchange, using single sign on (SSO) from their desktops. The OPA workers will access Medicaid and CHIP eligibility results from CHIMES. Applicants and consumers can also access their eligibility results for Medicaid, CHIP, and insurance subsidies through the Exchange.
 - It should be a seamless referral from OPAs to the Exchange if individuals are determined ineligible for Medicaid because they are over income. Applicants will not have to answer questions again for the Exchange.
 - While they will not be navigators, county OPA workers will have to be trained about the insurance subsidies and the Exchange functionality.
17. The application receives the DPHHS eligibility notification in the mail (i.e., it is a paper notification).

Steps 18 – 25 identify the enrollment steps for the “CSI Exchange Part B” and the Health Plans which is depicted in the right half of the second page of the process flow diagram.

18. If the consumer was eligible for Medicaid and/or HMK, the consumer indicates whether he/she would like to enroll in the assistance programs.
- Households can have more than individual members receiving benefits through both the Exchange and HMK. How this will work will depend on how filing units are defined.
 - Families have the option of requesting that everyone receives insurance even when one member is eligible for Medicaid.
19. If the consumer does not want to enroll in Medicaid and HMK, the Exchange presents commercial health plan choices without subsidy for the non-Medicaid and non-HMK consumers.
20. The consumer selects a health plan.
21. The consumer enters payment information.

22. The Exchange sends the enrollment information to the Health Plan of choice.
23. The Health Plan receives the enrollment information from the Exchange.
24. The Health Plan sends the insurance notification and card to the consumer.
25. The Health Plan sends enrollment verification information to the Exchange.
26. The Exchange receives the enrollment verification information from the Health Plan, notifies the consumer via an email and/or on-screen notification and updates the consumers account with the enrollment information.

Steps 27 - 30 identify the enrollment steps for DPHHS which is depicted in the left half of the second page of the process flow diagram.

27. After the Exchange sends DPHHS the required enrollment information, DPHHS enrolls the applicant into Medicaid, CHIP, and/or HMK.
28. DPHHS sends the enrollment notification to the applicant.
29. DPHHS sends the enrollment verification information to the Exchange.
30. The client receives the paper enrollment notification from DPHHS for Medicaid, CHIP and/or HMK.
 - Applicants will receive notices and insurance cards from either insurance companies through the Exchange or from DPHHS via CHIMES. The Exchange will not duplicate the existing notification process from CHIMES.
 - Medicaid household members may be eligible for many types of Medicaid.
 - The state wants to show clients the status of their eligibility and enrollment process to clients in notification. The state would like for this to occur online, but is not sure if the state is set up for this.

Steps 31 - 33 identify the renewal steps for the “CSI Exchange Part B” which is depicted in the bottom portion of the second page of the process flow diagram.

31. Households will need to re-determine eligibility every twelve months or when a change occurs.
 - The Exchange will need to support online re-determination. As with the initial application process, households can also work directly with the OPA to re-determine eligibility.
 - Medicaid is required to check eligibility a minimum of once every 12 months. In practice, Medicaid is determined month-to-month. Healthy Montana Kids/CHIP has continuous 12-months of eligibility. All other medical assistance programs have month-to-month eligibility.
 - Medicaid sends forms to clients a month in advance of re-determination with current information, which asks if anything has changed.
 - The state wants to align all household members with the same renewal timeframe regardless of the type of benefit they receive wherever possible.
 - The state also wants to limit coverage gaps. Medicaid may change Federal rules to allow Medicaid benefits to continue for a month to prevent gaps as individuals move to insurance subsidies.
32. Clients who complete the redetermination process re-enroll for Medicaid, CHIP, insurance subsidies, and/or insurance coverage for another year.
33. What are consequences if individuals do not respond? Medicaid currently closes these cases. Individuals are informed of their redetermination a month before the information is due, and receive a ten-day notice before closing. Closures occur at the end of the month.
 - Insurance subsidies will also have to close for non-payment.
 - Unclear how this aligns with the mandate.