Cúram 8.1.2

Income Support for Medical Assistance Children's Health Insurance Program Guide

Note

Before using this information and the product it supports, read the information in Notices on page 23

Edition

This edition applies to Cúram 8.1, 8.1.1, and 8.1.2.

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The Children's Health Insurance Program is part of Medical Assistance. It is designed for families who earn too much money to qualify for medical assistance, but cannot afford to buy private insurance for their children. Captured evidence is assessed against a set of business rules to determine whether an individual is eligible for assistance.

1.1 Introduction

Document Purpose

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

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

Audience

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

Available Documentation

Supporting documentation relating to Medical Assistance and associated programs, including CHIP can be found in the Business Analysts guide titled *`Income Support for Medical Assistance Program`*.

Users may also find the business guides for other Medical Assistance programs useful. For Long Term Care, see *`Income Support for Medical Assistance Long Term Care Guide`*. For Spend Down, see *`Income Support for Medical Assistance Spend Down Guide`*.

1.2 Children's Health Insurance Program Overview

About Children's Health Insurance Program (CHIP)

In 1997, the balanced budget act established a Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. This program is jointly financed by the federal and state governments and administered by individual states. Within broad Federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Children's Health Insurance Program Reauthorization Act of 2009 later reauthorized CHIP.

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

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

States can provide care through two different ways, managed care or fee-for-service. Managed care offers most medical care through one source: a health plan. A health plan is an organization of licensed insurers, non profit organizations and managed care organizations (MCO's) who are contracted to provide services to eligible CHIP children. If children are enrolled in a managed care health plan, they go to one person for their medical care called a Primary Care Provider. A Primary Care Provider is the doctor, nurse practitioner, or physician assistant who takes care of the children to make sure they get all of the health care they need. With fee-for-service children do not belong to a health plan. They can go to any doctor, pharmacist, or other provider who will take the children's medical ID card for payment.

The Cúram Children's Health Insurance Program

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

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

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

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

If premiums are applicable, the billing, collection and allocation of premiums is managed by an external vendor.

Eligibility Determination and Product Delivery Case Creation

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

The product delivery case creation process describes the selection of assistance unit members, viewing the associated premiums and co-payment limit and creating the CHIP product delivery.

Reassessment

This chapter describes the reassessment process for a CHIP product delivery. Reassessment takes place as part of ongoing eligibility or as a result of a change of circumstances.

1.3 Eligibility Determination and Product Delivery Case Creation

Introduction

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

Check CHIP Eligibility

The check medical assistance eligibility functionality which determines eligibility for all Medical Assistance coverage types based on a hierarchy also includes CHIP. When checking Medical Assistance eligibility on application or on the integrated case home page, the caseworker has the option to check eligibility for all Medical Assistance coverage types or just CHIP.

If the caseworker has selected 'All Medical Assistance Programs', the Medical Assistance rules check eligibility for the Categorically Needy and Medically Needy coverage types for

all household members. Eligibility for CHIP will only be carried out if it is determined that a member is not eligible under any categorically needy or medically needy coverage type. If eligible under Medically Needy with SpendDown in addition to CHIP, the member must choose which coverage type to receive.

If the caseworker has selected 'Children's Health Insurance Program (CHIP)', the same Medical Assistance rules are called. The result is filtered to only display children in the household who are eligible for CHIP. The CHIP only option may be used where a family just want to apply for CHIP for the children. If none of the children in the household are eligible for CHIP, the caseworker has the option to view the full eligibility result as determined by the Medical Assistance eligibility rules. It may be that the children are eligible for other Medical Assistance coverage types that have a higher priority than CHIP in the cascading hierarchy. For example, a child found eligible for Aged, Blind and Disabled (ABD) during the Medical Assistance eligibility rules will not have CHIP eligibility determined as the coverage type rules for ABD are executed before the rules for CHIP.

Rules

This section provides a high level overview of the rules executed for CHIP.

To be eligible for CHIP:

- The child must satisfy the open enrollment rules AND
- The child must satisfy the non financial requirements AND
- The child must satisfy the CHIP specific eligibility requirements AND
- The household must satisfy the financial eligibility rules AND
- The household must satisfy the household composition rules

Open Enrollment Rules

The open enrollment rules determine whether or not an application for CHIP has been received during an open enrollment period. An open enrollment period is a specific time period set by the organization in which applications for CHIP can be accepted. Once this period has passed, no applications are accepted. The organization limits the number they enroll according to the funds available for the program.

The following exceptions apply:

- A family, who has a child enrolled in CHIP, may enroll a new child born to or adopted by a household member without waiting for the next open enrollment period.
- A family, who has a child enrolled in CHIP, may enroll an additional child who loses Medical Assistance coverage and does not qualify for any other Medical Assistance coverage type without paying a spend down, without waiting for the next open enrollment period.
- A child who loses Medical Assistance coverage and does not qualify for any other Medical Assistance coverage type without paying a spend down, may enroll in CHIP without waiting for the next open enrollment period

Non Financial Requirements

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

See Non Financial Requirements in the Common Rules - Non Financial Requirements chapter.

Eligibility Requirements

There are a number of specific eligibility requirements that must be met in order to receive CHIP:

- The child must be under age 19 or if in receipt of CHIP the child is eligible up to the last day of the month in which the child's 19th birthday occurs AND
- The child must be ineligible for any categorically needy or medically needy Medical Assistance coverage type (This is determined as part of cascading eligibility) AND
- The child must not have other comprehensive health insurance coverage AND
- The child must be uninsured for at least 90 days unless they meet one of the Good Cause for Loss of Health Insurance reasons AND
- The child must not involuntarily reside in a public, non-medical institution AND
- The child must not be in an inpatient psychiatric facility AND
- The child has not been disenrolled from CHIP for failure to pay premiums within the last 3 calendar months unless the child has been on Medical Assistance in the interim

Comprehensive Health Insurance

Comprehensive coverage is defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as coverage under any of the following:

- Group health insurance plans
- Medicare Part A or Part B
- Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- Public Health Plan
- Health Care for Peace Corps Volunteers
- Insurance policies (private)
- Employer based plans
- Health insurance coverage on the basis of a family member's active permanent employment by a state, county, or city government agency
- Entitlement to coverage under employer/group plan
    - When a child is 'entitled' to coverage under an employer based plan or a group health insurance plan and the cost would be less than 10% of the household's gross income, the child is seen as having comprehensive medical insurance unless a waiting period applies
    - If the child has to wait for a period of time before they can enroll in the employer based plan, they are eligible for CHIP until they are allowed to enroll in the insurance

Good Cause for Loss of Health Insurance reasons

No waiting period will be imposed if health insurance was discontinued for any of the following reasons:

- Insurance was lost because the individual providing coverage died
- Insurance was lost because the family member who carried insurance changed jobs or stopped employment due to a layoff, reduction-in-force, or the closure of a business
- The employer stopped contributing to the cost of family coverage

- The child's coverage was discontinued by an insurance company for reasons of uninsurability
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) policy
- Voluntary termination of coverage by a non custodial parent.
- The previous health insurance coverage exceeds 10% of the family's gross monthly income, or exceeds 10% of the family's gross monthly income at the time the insurance was dropped

Financial Eligibility Requirements

To be eligible to enroll in CHIP, the household must pass an income test. CHIP uses the income and deduction rules that apply to the family coverage types to determine what income is countable/excluded and what deductions to apply. CHIP has its own rules to determine the financial unit and household size.

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

Financial Unit

The financial unit is the individuals whose income is counted in determining CHIP eligibility. The following household members are included in the financial unit:

- The child who meets the CHIP eligibility rules
- The child's siblings, half-siblings, adopted-siblings and step-siblings if they are under age 19
- Parents and step-parents of any child counted in the financial unit.
- Only one non-parent caretaker relative where both of the child's parents are absent from the caretaker relative's home
- Children of any children counted in the financial unit
- The spouse of any child who is included in the financial unit
- Unborn children of anyone included in the financial unit

Financial Unit Exception

Do not include the following household members in the financial unit:

- SSI recipients

Household Size

The number of individuals counted in the household size determines the income limit used when comparing against the household's income. The household size is the same as the financial unit.

Income Rules

Income rules are used to determine the unearned, earned and self employment income that are countable/non countable for the household. Income is classified as either countable or non-countable. Only countable income is included in the income eligibility determination.

The household's adjusted gross countable income must be equal to or less than 200% of the federal poverty level for the household size.

See the Family - Common Income Rules chapter for the steps to calculate the household's total countable income.

Household Composition Rules

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

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

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

For CHIP, rather than displaying every possible combination and having validations to ensure a household member cannot receive CHIP in more than one assistance unit, each different result is displayed with one assistance unit containing every member who could potentially receive coverage under the same product delivery. The caseworker chooses which members to proceed with during case creation; these members then become part of the benefit group. Using the example above, there are 2 results displayed on the eligibility result page:

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

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

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

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

- Child who satisfies the CHIP eligibility rules*
- Child's siblings, half, adopted and step who also satisfy the CHIP eligibility rules

- Parents and stepparents of any child, if the parents and stepparents satisfy the CHIP eligibility rules
- Children of any child if the children satisfy the CHIP eligibility rules
- The spouse of any child if the spouse satisfies the CHIP eligibility rules

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

Eligibility Result

The output from the eligibility determination process is the eligibility result. It displays a list of Medical Assistance coverage types including CHIP for which household members are eligible.

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

The household member can select which coverage type to apply for using the results of the eligibility determination process.

Create CHIP Product Delivery

The standard create product delivery process includes additional processing required to create a CHIP product delivery.

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

Once the assistance unit members have been selected, the premium processing rules determine the CHIP premium payable and the co-payment maximum limit for the assistance unit.

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

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

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

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

Case Creation

Where premium processing rules determine that premiums are payable for CHIP coverage, the calculated premium amount and the premium frequency information is stored on the premium entity which is linked to the CHIP product delivery. A copayment record is also created containing the co-payment limit for the household and the period of time the co-payment limit covers.

The billing, collection and allocation of premiums is handled by an external vendor.

Effective Date Of Coverage

The effective date of coverage for CHIP is the date of application (or date of application minus number of days Grace Period granted). When an emergency or some other circumstance beyond the control of the applicant prevents them from filing a CHIP application, a grace period beginning no earlier than a defined number of days prior to the date an applicant submits a completed and signed application is allowed.

- Date of application (or date of application minus number of days Grace Period granted)

The effective date for coverage is set at case creation. The certification period is also set at case creation using the effective date plus the CHIP continuous eligibility period.

Product Delivery Home Page

CHIP uses the existing product delivery home page functionality within Cúram. The navigation bar has some extra links view premium details and record/view co-payments.

Premiums

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

The premium details viewable are the premiums payable for CHIP coverage for household members in the assistance unit. The billing, collection and allocation of these premiums is handled by an external vendor.

Co-Payments

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

Certifications

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

Benefit Group

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

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

1.4 Reassessment

Introduction

This chapter describes the reassessment for a CHIP product delivery.

Reassessment

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

Ongoing Eligibility

The frequency of ongoing eligibility determination can be configured according to an individual state's requirements. The default value is monthly. As part of ongoing eligibility determination, the child must meet all the CHIP eligibility rules executed during the Medical Assistance eligibility determination with the exception of the open enrollment rules. In addition, premiums must be paid on time for coverage to continue. Premium rules exist to ensure coverage is cancelled when premiums have not been paid for a specified period. The specified period varies between states. Once coverage has been cancelled, there is a waiting period before the child can re-enroll in CHIP. Again, this period of time varies between states, some states do not impose a waiting period at all. If no payments have been made for two consecutive months, the CHIP case should be closed at the end of the second month. Premium payment and processing is handled by an external vendor. An eligibility rule exists to check are premiums paid for the specified period. The external vendor will provide this information to the Cúram Children's Health Insurance Program.

The caseworker can check eligibility for regular Medical Assistance in case the requirements for another Medical Assistance coverage type become less restrictive, so even though the child's circumstances are unchanged, they may become eligible for regular Medical Assistance.

Change of Circumstance

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

Evidence Changes on Integrated Case

When evidence changes on the integrated case, reassessment is triggered automatically across all product deliveries and case groups are updated as necessary. This is out of the box functionality. If one of the product deliveries is a CHIP product delivery, the caseworker is notified to check eligibility across all Medical Assistance coverage types (in case they are now eligible for a more beneficial coverage type).

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

Changes Causing Ineligibility

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

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

The effective date of disenrollment is the last day of the month the change occurred unless the child has died, in which case the effective date is the date the child died. The caseworker is notified to take the appropriate action. If there was only one child on the case or if the change of circumstance affects all children on the case, the case is closed on the effective date of disenrollment. If only one child is affected by the change, the case remains open and the affected child is removed from the benefit group on the effective date of disenrollment.

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

Income Changes

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

Income Increase

A reported income increase (adversely affecting the case or not) is not acted upon until the end of the current eligibility period when the family is applying for renewal. They remain covered under CHIP with the same premium amount and co-payment limit until the end of the continuous eligibility period.

Income Decrease

A reported income decrease is not acted upon until the end of the current eligibility period when the family is applying for renewal. They remain covered under CHIP with the same premium amount and co-payment limit until the end of the continuous eligibility period (i.e. current certification).

Modification of the Benefit Group in CHIP

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

1. Adding a household member to the benefit group

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

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

   - The child is added to the existing benefit group on today's date and is eligible for the remaining period of certification for the case.
   - The premium amount is determined based on the current premium plan level for the household. While the premium amount may have increased (it costs more for 2 children than for 1 child), the premium level (Plan A, B etc.) remains the same. The premium and copayment records should be updated with any new information
2. Removing a household member from the member group

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

   A family may reach their co-payment limit by removing a child. It is up to the family, however, to track their co-payments and notify the department once this happens.

Modification of Household Member Evidence on Integrated Case

1. Adding a member to Integrated Case

When someone is added to the integrated case, the caseworker checks eligibility across all coverage types. This triggers an automatic assessment across all coverage types. In the case of CHIP, if it is determined the new household member is part of the financial unit and household size, the member is automatically added to the financial group and member group of that product delivery.

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

2. Removing a member from Integrated Case

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

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

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