County Medical Services Program Guide (CMSPG) Letter #08

January 18, 2012

Subject **COUNTY MEDICAL SERVICES (CMS) CHRONIC CONDITION AUTOMATIC EXTENSION PROCESS**

Effective Date Upon Receipt

Reference County Policy

Purpose The purpose of this letter is to inform staff of the automatic extension process when a beneficiary is identified by Administrative Services Organization (ASO) as having a CMS chronic condition.

Background The standard certification period for applicants is for up to six months. Beneficiaries who have been identified by the ASO as having a chronic medical condition have a "CHRONIC" indicator entered on the IDX Eligibility Enrollment Summary Screen. At recertification or reapplication, the worker must look for the "CHRONIC" indicator to assist them in determining the appropriate certification period. CMS beneficiaries with the "CHRONIC" indicator, who recertify or reapply, may be certified for up to 12 months if they continue meet all eligibility requirements and there are no foreseeable changes in circumstances that affect eligibility during the certification period.

Changes Individuals who have been certified CMS with the standard certification period of up to six months, and have been identified later during their certification as having a chronic condition by the ASO based on established criteria, will be evaluated to have their certification periods automatically extended up to an additional 6 months. The total certification period shall not exceed 12 months.

ASO Process The ASO shall send a list of beneficiaries who have been identified as having a chronic condition on a monthly basis, to the Health Coverage Access (HCA) designated eligibility staff. HCA will evaluate ongoing

eligibility and extend CMS certifications, as appropriate.

Required Actions

Once a case has been identified on the list from the ASO as being Chronic, the worker will:

Step	Action
1	Verify that the chronic indicator has been placed on IDX.
2	Evaluate the case for ongoing eligibility.
3	Extend the CMS benefits (by selecting *Auto Extension* from the dropdown window in the General Indicator section in AuthMED) for up to an additional 6 months or as appropriate for a maximum total of up to 12, not exceeding 12 months.
4	Send Automatic Extension Notice of Action (NOA) CMS 41/CMS-41 (SP)

Forms Impact

The CMS-41 (Eng/Span) (Attachments A&B) has been created to notify beneficiaries of the auto-extension of their CMS benefits. These forms have been uploaded to the CMS IT system.

Automation Impact

An Auto Extension indicator flag has been added to the CMS IT system under general indicators to identify cases which have been automatically extended.

Appeals Impact

None

ACCESS Impact

None

Quality Assurance Impact

Effective with the February 2012 review month, Quality Assurance will cite with the appropriate error any case that does not comply with the requirements outlined in this letter.

Summary of Changes

The table below shows the changes made to the CMSPG.

Section	Changes
08.01	Addition of the automatic extension process.
08.03	Added reference to automatic extension.

Managers Approval

Janya Bowman, Assistant Deputy Director
Health Care Policy Administration
Strategic Planning and Operational Support

SB

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

Date: _____

To _____

_____

_____

Member ID#: _____

CMS Representative: _____

Phone: _____

Location: _____

Address: _____

_____

_____

You are receiving this notice because County records show that you applied for County Medical Services (CMS) and are now determined to have a chronic medical condition. Due to your chronic medical condition, you are eligible for a longer certification period. All other requirements remain unchanged.

Your CMS benefits have been extended and you are now eligible for CMS through:

____/___/____.

Comments: _____

Your Medical Home/Primary Care Clinic (PCC) is listed on your CMS card. Your primary care provider coordinates your medical care, as appropriate. Except for emergencies, always contact your primary care provider for your care.

Share of Cost is the amount you must pay or be obligated to pay toward the cost of your CMS covered health care services each month. In any month you receive CMS services, you will be billed by the County for your share of cost or the amount of CMS services, whichever is less. You will not be billed for any months in which you did not receive CMS services.

If you are eligible to CMS with a monthly Share of Cost and your spouse is eligible to Medi-Cal with a Share of Cost, the money spent to meet the Medi-Cal spouse's SOC may be applied to reduce the CMS SOC amount using CMS rates, as long as the services are within CMS scope of services. To be eligible for a CMS SOC deduction, you must send the itemized statement for services received by the Medi-Cal spouse, proof of the amount paid towards the Medi-Cal SOC amount and billing statement when sending your CMS SOC payment to the County.

CMS provides medical services for serious health problems. This approval does not imply that all services are covered by CMS. A medical determination for each health care service you receive will be made each time you visit the CMS health care provider.

To continue your CMS coverage past your certification period you must call the CMS Eligibility Appointment Line (800) 587-8118 before your CMS expiration month to request a recertification appointment.

To report changes in your address, income, or any other circumstance, call 1-888-553-5552.

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling:

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION – GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 days shall only be considered if you present good cause for missing the deadline.

The Consumer Center for Health Education and Advocacy may be able to offer you free advice on how to handle your appeal. For more information call 1-877-734-3258.

CMSPG Regulations: 8.01

COUNTY MEDICAL SERVICES
AVISO DE ACCION

Fecha:_____ No. de Miembro:_____

Representante de CMS:_____

Para:_____ Teléfono:_____

_____ Ubicación:_____

_____ Domicilio:_____

_____

Usted recibe este aviso porque los archivos del Condado indican que usted solicitó el programa County Medical Services (CMS, por sus siglas en inglés) y se ha determinado que tiene una condición médica crónica. Debido a su condición médica crónica, usted es elegible para un período de certificación más largo. Todo otro requisito permanecerá sin cambiar.

Sus beneficios de CMS se han extendido y usted es elegible ahora para el programa CMS hasta el día: ____/___/____.

Comentario: _____

Su Centro Médico/Clínica de Cuidado Primario (PCC) está anotado en su tarjeta de CMS. Su proveedor de cuidado primario coordinará su cuidado médico, como sea apropiado. Siempre llame a su proveedor de cuidado primario para su cuidado, excepto en caso de emergencia.

Parte de Costo es la cantidad que usted debe pagar u obligarse a pagar cada mes hacia el costo de sus servicios médicos que cubre CMS. Cualquier mes que usted reciba servicios médicos del programa CMS, el Condado le cobrará la cantidad de su parte de costo o la cantidad de sus servicios médicos, la cantidad que sea menor. Usted no recibirá un cobro por ningún mes en el cual usted no recibió servicios médicos de CMS.

Si es elegible para CMS con parte de costo y su cónyuge es elegible para Medi-Cal con parte de costo, puede ser que la cantidad que se gastó para satisfacer la Parte de Costo del cónyuge elegible a Medi-Cal se aplique para reducir la Parte de Costo de CMS usando la cantidad del precio que usa CMS, siempre y cuando los servicios médicos recibidos son parte del criterio de cobertura del programa CMS. Para ser elegible a la deducción de Parte de Costo de CMS, debe de enviar el estado detallado de los servicios recibidos por su cónyuge elegible a Medi-Cal, prueba de la cantidad pagada hacia la Parte de Costo de Medi-Cal y el estado de cuenta cuando envíe su pago al Condado.

CMS provee servicios médicos para problemas serios de salud. Esta aprobación no implica que todos los servicios serán cubiertos por CMS. Se hará una determinación médica por cada servicio de cuidado médico que usted reciba cada vez que usted visite al proveedor de salud de CMS.

Para continuar su cobertura para el programa CMS usted debe de llamar a la Línea para Citas de Elegibilidad (800) 587-8118 antes de que su elegibilidad este programada a terminar para solicitar una cita para renovar el programa CMS.

Para reportar cambios de domicilio, ingresos o cualquier otra circunstancia, llame al 1-888-553-5552.

Si usted no está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a:

COUNTY MEDICAL SERVICES
AVISO DE ACCION

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
TELEFONO: (858) 514-6887

Peticiones recibidas después de 14 días consecutivos serán consideradas solamente si usted presenta una buena causa que le impidió hacerlo a tiempo.

El Centro del Consumidor Para Educación Sobre La Salud y Defensa de Sus Derechos puede darle información gratuita de cómo llevar acabo su apelación. Para más información, llame al 1-877-734-3258.

CMS Regulations: 8.01

Article 8 Section 01 Certification

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CMSPG LTR #08 (1/12)

08.01.01 Certification

08.01.01A General

This section contains guidelines for determining certification periods for CMS applications processed via a County worker at a CMS eligibility site or by a HOS worker for patients **admitted** to the hospital through the emergency room.

08.01.01B Beginning Month

The applicant must meet all eligibility criteria before certification. The first month of the certification period depends upon when the applicant has met all eligibility criteria.

If all criteria are...	Then the certification period begins...
met for the application month,	that month.
not met until the following month,	the month following the application month.

(**Note**: In the case of erroneous certification, refer to 08.02)

EXAMPLE 1:	The applicant is admitted to the hospital on July 28 and discharged on August 5. His net non-exempt income for July exceeds the CMS income limit, and his estimated net non-exempt income for August is below the CMS income limit. The beginning month of the certification period is August.
EXAMPLE 2:	The applicant is admitted to the hospital on June 15 and discharged on June 20. In June, her net

	non-exempt property exceeds the CMS property limit. She has thirty days from the denial notice of action to spend the excess property down to within the limit. On July 10, she provides proof that she spent the property appropriately. The beginning month of the certification period is June.
EXAMPLE 3:	The applicant received treatment at a Primary Care Clinic or Hospital Emergency Room on June 15. They had no current CMS eligibility at the time the treatment was provided but are now requesting CMS coverage for that uncertified visit. If within 30 days from the date of the uncertified visit, the patient contacts the ASO to schedule the CMS intake interview, and if all other eligibility factors are met, the beginning month of the certification period is June. If the phone call was made more than 30 days from the date of the uncertified visit, or if patient does not meet all other eligibility factors for the month of the uncertified visit, the beginning month of eligibility is the month of July. Refer to 02.01 for additional information.

08.01.01C Ending Month

The standard certification period for applicants is six months. When a foreseeable change in circumstances that affects eligibility is expected during the certification period, the certification period may be less than six months. The last month of the certification period is the last month when all eligibility criteria are met.

When the certification period is less than six months, the worker must state the reason in the case record comments and on the NOA that certifies CMS.

EXAMPLE 1:	The applicant's net non-exempt income is below the income limit in the month of application, but is expected to exceed the income limit the following month. The certification period is one month.
EXAMPLE 2:	The applicant's INS document expires in three months. The certification period is three months.
EXAMPLE 3:	The applicant needs to see a doctor or fill a prescription within 72 hours and is unable to get a bank statement. The worker can call the bank to verify the account balance and certify one month. Upon receipt of the bank statement, the worker may extend the certification period.
EXAMPLE 4:	The applicant applies in the month of May and is

	receiving bi-weekly gross earned income of $595. Based on the paydays, the applicant will receive two paychecks per month for the period of May through August and will get a third paycheck in September. The gross income totals $1,289.36 when converted to a monthly amount using the 2.167 factor. The net non-exempt income is $1,199.36 after deducting the $90 standard work expense, which puts the applicant over the CMS MNL. The worker will re-compute eligibility using the actual income of $595 x 2 paydays in the month. This equals a net countable income of $1,100 after deducting the $90. The worker will certify for the months of May through August.

MPG Letter #699 (2/09)

08.01.01D Automatic Extension

Individuals who have been certified CMS with the standard certification period of up to six months, and have been identified later during their certification as having a chronic condition by the ASO based on established criteria, will be evaluated to have their certification periods automatically extended up to an additional 6 months. The total certification period shall not exceed 12 months.

The ASO shall send a list of beneficiaries who have been identified as having a chronic condition on a monthly basis to the Health Coverage Access (HCA) designated eligibility staff. HCA will evaluate ongoing eligibility and extend CMS certifications, as appropriate.

Step	Action
1	Clear the list and identify beneficiaries eligible for extension and verify that the chronic indicator has been placed in IDX.
2	Extend the identified CMS benefits for up to an additional 6 months or as appropriate for a maximum total of up to 12 months; making sure to select *Auto Extension* indicator in AuthMED.
3	Sends Automatic Extension NOA CMS-41/CMS-41(SP)

CMSPG LTR #08 (1/12)

Article 8 Section 03 Recertification

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08.03.01 Recertification

08.03.01A General

Recertification is a determination that a beneficiary continues to meet the CMS eligibility criteria and has not had a break in aid of more than one (1) month. CMS has two standards for recertification: standard and chronic. Recertification information shall be recorded in the case narrative.

08.03.01B Non-Chronics

Non-chronics may be recertified for up to six months.

MPG LTR #713 (11/10)

08.03.01C Chronics

Chronics are those beneficiaries who have been identified by the ASO as having a chronic medical condition by entering a "**CHRONIC**" indicator on the IDX Eligibility Enrollment Summary Screen. Before recertifying, the worker **must** look for the "**CHRONIC**" indicator. CMS beneficiaries with the "**CHRONIC**" indicator, who recertify or reapply, may be certified for up to 12 months if they continue meet all eligibility requirements and there are no foreseeable changes in circumstances that affect eligibility during the certification period as described in 08.03.01D below. If the beneficiary has been identified as chronic before their certification period ends, the case may be eligible for an automatic extension. (refer to 08.01)

CMSPG LTR #08 (1/12)

08.03.01D Exceptions

CMS beneficiaries, both chronic and non-chronic, are to be recertified for up to the allowable period with the following exceptions:

When a beneficiary has a foreseeable change in circumstances that affects eligibility during the recertification period, the recertification period may be less than the allowable period. When the recertification period is less than the allowable, the worker must state the reason in the comment section of the CMS IT automated NOA that certifies CMS and in the case narrative.

EXAMPLE 1:	A CMS beneficiary with the "CHRONIC" indicator on IDX will turn 65 years old in nine months. The worker will recertify for eight months and note "Turns 65 month/year" in the comment section of the enrollment form. In this example, if the beneficiary is a non-chronic, the worker will recertify for six months and note "Turns 65 month/year" in the case narrative.