County Medical Services Program Guide (CMSPG) Letter #14

July 17, 2013

Subject **COUNTY MEDICAL SERVICES (CMS) ELIGIBILITY DISCONTINUANCE POLICY**

Effective Date Upon receipt.

Reference County Policy

Purpose To inform and provide staff with instructions regarding the implementation of a discontinuance policy for CMS.

Background CMS does not have a policy for discontinuing benefits when a beneficiary:

- No longer meets CMS eligibility criteria;
- Fails to comply with CMS eligibility requirements; or
- Is in receipt of Medi-Cal or LIHP benefits.

At this time, CMS can be discontinued only if the beneficiary was erroneously approved.

Highlighted Change

Discontinuance

The CMS discontinuance policy has been established to:

- Discontinue benefits for individuals who are not eligible for or who wish to discontinue their CMS benefits; and
- Provide correct CMS eligibility information on the Provider Online Verification (POV) website.

HHSA: CMS-131 Discontinuance Notice of Action (NOA) (Eng/Span)

This NOA was created to inform the beneficiary of the reason their case is being discontinued and the effective date of the discontinuance (Attachments A & B).

Timeframe for Discontinuing Benefits

CMS benefits may be discontinued before the end of the certification

Continued on next page

Highlighted Change (continued)

period with timely notice as defined in CMSPG 15.01. Exceptions to the timely notice requirement are listed in CMSPG 15.01.

Aid Paid Pending (APP)

A CMS beneficiary's benefits may be continued if all APP requirements are met as outlined in CMSPG 12.02.

APP will not be given when the:

- Issue is an application denial; or
- Request for hearing occurs after the 10-calendar day timeframe described in CMSPG 12.02, unless good cause has been determined.

Required Action

Discontinuing Benefits

Upon receipt of information that causes a beneficiary to become ineligible for CMS, the worker is responsible for discontinuing the case with timely notice, as appropriate. Refer to CMSPG 15.01 for discontinuance reason(s) and exceptions to the timely notice requirement.

Rescission of CMS Discontinuance

Upon receipt of information that requires the reinstatement of CMS benefits, the worker must reinstate the benefits and inform the beneficiary via rescission NOA CMS-110R (Attachment C & D) as outlined in CMSPG 15.03.

Aid Paid Pending (APP)

Issue APP if all APP requirements are met as outlined in CMSPG 12.02. APP benefits must not exceed the timeframes outlined in CMSPG 12.02.

Forms Impact

This table below shows the forms issued with this letter.

Number	Title	Change	Attachment
CMS-131 (Eng/Span)	Discontinuance NOA	New	A & B
CMS-110R (Eng/Span)	Rescind NOA	Revised	C & D

Continued on next page

Forms Impact
(continued)

Number	Title	Change	Attachment
CMS-34 (Eng/Span)	Informing Letter	Revised	E & F

The new and revised forms have been uploaded into the CMS IT system (AuthMed).

CMS IT System (AuthMed) Impact

AuthMed has been enhanced to:
- Process CMS discontinuances; and
- Update the Providers On-line Verification (POV) website.

Appeals Impact

Appeals shall follow the process as stated in this letter.

ACCESS Impact

ACCESS Customer Service Agents must be aware of the CMS discontinuance policy when taking calls from CMS beneficiaries whose benefits have discontinued. Agents will refer a caller who wishes to file a County Administrative Hearing to the Appeals Section at (619) 237-8534 or to the CMS Eligibility Appointment Line at 1-800-587-8118 to re-apply.

Quality Control (QC) Impact

Effective with the August 2013 review month, QC may cite the appropriate error on 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:

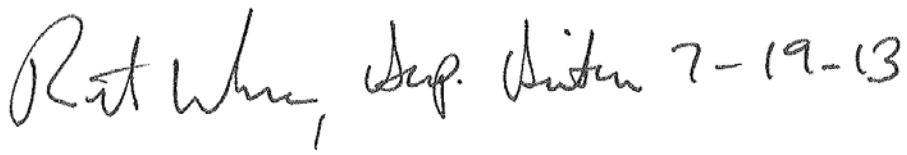
Section	Changes
Table of Contents	Added discontinuance section.
Article 01, Section 05.01	Added new acronyms.

Continued on next page

Summary of Changes
(continued)

Section	Changes
Article 02, Section 05.02	Added discontinuance requirement when Medi-Cal linkage is established.
Article 08, Section 04.01	Added discontinuance requirement for GR/CMS recipients.
Article 08, Section 09.01	Added discontinuance requirement for changes reported.
Article 12, Section 01.01	Updated eligibility determination outcome to appeal.
Article 12, Section 02.01	Added discontinuance and Aid Paid Pending (APP) information.
Article15	Added discontinuance section.

Approval for Release



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County Medical Services Program Guide

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Summary

A.15 Details

ARTICLE 15 DISCONTINUANCE	
TITLE	**PG CITE**
Discontinuance	15.01

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01.05.01 Acronym Definitions

01.05.01 Definitions

The following table lists definition of acronyms used throughout the program guide.

Acronym	Definition
ABD	Aged, Blind or Disabled
APP	Aid Paid Pending
ASO	Administrative Services Organization
CFBU	Case Family Budget Unit
CMS	County Medical Services
DDSD	Disability Determination Service Division
DHCS	Department of Health Care Services
EO	Eligibility Operations
FPL	Federal Poverty Level
FRC	Family Resource Center
GR	General Relief
HCA	Health Coverage Access
HOS	Hospital Outstationed Services
IDX	Computer system used by the ASO
IEVS	Income and Eligibility Verification System
LIHP	Low Income Health Program (LIHP)
MEDS	Medi-Cal Eligibility Data System (State)
MFBU	Medi-Cal Family Budget Unit
MIA	Medically Indigent Adult
MNL	Maintenance Need Level
MPG	Medi-Cal Program Guide
NOA	Notice Of Action
OHC	Other Health Coverage
ORR	Office of Revenue & Recovery
PAFD	Public Assistance Fraud Division
PS	Program Specialist

QC	Quality Control
SAVE	Systematic Alien Verification for Entitlements
SDX	State Data Exchange
SSI/SSP	Social Security Supplemental Security Income/State Supplemental Program
SOC	Share of Cost
TPL	Third Party Liability

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02.05.02 Medi-Cal Disability Linkage Established

02.05.02A Medi-Cal Linkage Established

A CMS beneficiary determined to be disabled by State or Federal DDSD is not eligible for CMS. A CMS beneficiary who has applied for Medi-Cal has the responsibility to complete the entire full scope Medi-Cal application process. If s/he has been determined disabled but fails to finish the entire full scope Medi-Cal eligibility determination process, s/he cannot return to CMS.

Upon receipt of the DDSD decision, CMS Recovery staff will:
- Add the disability information in AuthMed; and
- Sends an informing letter advising the beneficiary to complete the Medi-Cal application process.

CMS eligibility shall be discontinued when the beneficiary is in receipt of Medi-Cal benefits (Refer to CMSPG 15.01).

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08.04.01 General Relief (GR) Recipients

08.04.01A General

GR recipients are automatically eligible to CMS without having to complete a CMS application; however, they are not automatically enrolled into the CMS IT System (AuthMed) and IDX. (Refer to the GR Program Guide for details.)

When a GR case closes prior to the GR eligibility period ending, CMS eligibility continues until the end of the certification period unless the

reason for the GR case discontinuing is one of the reasons listed in CMSPG 15.01.01A.

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08.09.01 Changes and Information Reported During the Certification Period

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08.09.01A General

CMS eligibility continues until the end of the certification period unless the beneficiary has been determined no longer eligible for CMS prior to the certification end date. (Refer to CMSPG 15.01.01A for discontinuance reasons.)

Exception: Erroneous certifications (Refer to CMSPG 08.02 for additional information)

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08.09.01B Information Received

When the worker receives information or becomes aware of a change that may affect CMS eligibility, the worker shall:

Step	Action
1	Review the case and determine whether clarifying information is needed.
2	Send informing letter HHSA: CMS-34 to the beneficiary if additional information is required. The CMS-34: 1 – Explains how the information may affect CMS eligibility and the beneficiary may need to make other payment arrangements with health care providers before the certification period ends. 2 – Informs the beneficiary of any additional verification that must be provided and the specific due date for the requested verification.
3	Upon receipt of verifications, update the CMS case with the new information. **If beneficiary…** / **Then…** remains eligible, / CMS case remains active. is found to be ineligible, / discontinue CMS case according to

		CMSPG 15.01.

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08.09.01C Fraud Referral

If information is received after a case is granted that would have made the applicant ineligible to CMS at the initial application, the worker shall follow the instructions for fraud referrals in CMSPG 11.01 and discontinues the CMS case as appropriate (Refer to CMSPG 15.01).

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12.01.01 Policy

12.01.01C Eligibility Determination

Applicants/beneficiaries have the right to request an administrative hearing.

1. Individuals, who disagree with the eligibility determination of CMS, have the right to appeal the decision by filing a County Administrative Hearing.
2. If dissatisfied with the County Hearing Officer's decision, the individual may file an appeal with the San Diego County Superior Court.

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Article 12 Section 02 County Administrative Hearings

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Hearing Decisions	**12.02.01G**
Authorized Representative (AR) at the Hearing	**12.02.01H**
Interpreters at the Hearing	**12.02.01I**
Aid Paid Pending (APP)	**12.02.01J**

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12.02.01D Reporting the Request

GR/CMS Calendar Clerk:

- Notifies the CMS eligibility location via email within one work day of the appeal request; and
- Provides the CMS eligibility location with the applicant's/beneficiary's name, social security number (SSN) or member ID number, address, telephone number, CMS application date and scheduled hearing date.

CMS Eligibility Location:

Notifies the CMS Supervisor of the appeal request within one work day from the date the request was reported by the GR/CMS Calendar Clerk.

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12.02.01E Conducting the Review

The table below shows the actions that must be taken when conducting a review of a case record:

<table>
<tr><th>Step</th><th>Who</th><th>Action</th></tr>
<tr><td>1</td><td>CMS Supervisor</td><td>Conducts a Supervisor Review of the case record within three work days of the CMS/GR Calendar Clerk notification to ensure the worker followed proper program procedures.
<table>
<tr><th>If the CMS Supervisor determines there is…</th><th>Then the Supervisor narrates in case comments the results of the Supervisor Review and…</th></tr>
<tr><td>no County error,</td><td>case proceeds to a County Administrative Hearing. No further action is required.</td></tr>
<tr><td>a County error,</td><td>returns the case to the last worker to resolve the issue before the County Administrative Hearing.</td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td>2</td>
<td>CMS Worker</td>
<td>
<table>
<tr><th>Subject</th><th>Action</th></tr>
<tr>
<td>Denial</td>
<td>
<table>
<tr><td>1</td><td>Rescinds the previous denial. This will put the case into a PENDING status.</td></tr>
<tr><td>2</td><td>Sends the CMS-110R to inform the applicant of the following:
Previous denial NOA has been rescinded;
A new NOA will be sent regarding the new eligibility determination; and
To contact Appeals if they choose to cancel their request for an Administrative Hearing.</td></tr>
<tr><td>3</td><td>Proceeds to Step 3.</td></tr>
</table>
</td>
</tr>
<tr>
<td>Discontinuance</td>
<td>
<table>
<tr><td>1</td><td>Rescinds the previous discontinuance. This will put the case into an PENDING status.</td></tr>
<tr><td>2</td><td>Sends the CMS-110R to inform the beneficiary of the following:
Discontinuance action has been rescinded;
A new NOA will be sent regarding the new eligibility determination; and</td></tr>
</table>
</td>
</tr>
</table>
</td>
</tr>
</table>

		<table><tr><td></td><td>• To contact Appeals if they choose to cancel their request for an Administrative Hearing.</td></tr><tr><td>3</td><td>Proceeds to Step 3.</td></tr></table>
3		Contacts the applicant/beneficiary to correct the error and/or request in writing any additional required verification(s).
4		Re-evaluates CMS eligibility: <table><tr><th>If…</th><th>Then…</th></tr><tr><td>approving the previously denied/discontinued application,</td><td>issue CMS-39A NOA.</td></tr><tr><td>re-denying the previous application,</td><td>issue CMS-39D NOA.</td></tr><tr><td>discontinuing a previous discontinued application,</td><td>issue CMS-131 NOA.</td></tr></table>

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12.02.01G Hearing Decisions

The County Hearing Officer conducts the hearing and within 15 work days from the date the record closes renders a written decision and notifies the applicant/beneficiary. All hearing decisions are emailed to the Manager for the CMS eligibility location and CMS Program Manager.

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12.02.01J Aid Paid Pending (APP)

A CMS beneficiary's benefits will be continued (APP) (Refer to CMSPG 15.01.03 for instructions on how to continue benefits) if the:

- Negative action was a discontinuance;
- Beneficiary timely files an appeal (within 10-calendar days of the date of the Discontinuance NOA) or if the beneficiary untimely files an appeal, where good cause has been determined;
- Certification period covered by the original authorization has not expired; and
- Beneficiary requests their benefits to be extended before the

effective date of the Discontinuance NOA.

APP benefits will continue:
- Until the CMS Hearing decision is rendered;
- For the duration of the original certification period; or
- Until the enrollee withdraws the hearing request, whichever is earlier.

APP will not be given when the:
- Issue is an application denial; or
- Request for hearing occurs after the 10-calendar day timeframe described above, unless good cause has been determined.

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Article 15 Section 01 Discontinuance

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Resources

RESOURCES	TITLE
How To's	#1003 Discontinue/Rescind Benefits for CMS Beneficiaries in AuthMed (CMS IT System)

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15.01.01 Discontinuance Requirements

15.01.01A Reasons

CMS benefits shall be discontinued for any of the following reasons:

The beneficiary:

- Requests their CMS benefits be discontinued.
- Is in receipt of Medi-Cal or LIHP benefits.
- Lives/moved outside San Diego County.
- Has income and/or property which exceeds CMS program limits.
- Has been confirmed as deceased.
- Failed to provide requested and required verifications that are otherwise unavailable to HHSA staff (Refer to CMSPG 02.06.03).

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15.01.02 Discontinuance Process

15.01.02A General

Upon receipt of information that causes a beneficiary to become ineligible for CMS or the beneficiary requests their benefits be discontinued, the following procedures apply:

- Obtain supporting documentation as appropriate;
- Discontinue the case as outline in How To #1003 by updating the CMS IT system with the discontinuance information;
- Narrate in case comments the circumstance supporting the case discontinuance. Information should include, but is not limited to the reason(s) for discontinuance and the effective date of discontinuance; and
- Ensure the beneficiary is given timely notice, as appropriate, of the discontinuance. (Refer to 15.01.02D). The CMS Discontinuance NOA will be provided to the beneficiary informing them of the date and reason the case is being discontinued.

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15.01.02B Discontinuance Request

A beneficiary may request discontinuance of CMS benefits at any time by:

- Submitting a signed statement indicating the request for discontinuance; or
- Making a verbal request for discontinuance.

When the request is…	Then the worker will…
written,	• discontinue the case; and

	• send CMS-131 NOA to the beneficiary.
verbal,	• ask that the request be made in writing; • document in case comments of the oral request and that written confirmation has been requested; • discontinue the case; and • send CMS-131 NOA. **Note:** It is not necessary to wait for the written request before the case is discontinued.

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15.01.02C Discontinuance Not Required

The worker must check the CMS IT System (AuthMed) to verify the existing certification period end date. If the certification period is due to end at the same time the discontinuance NOA would be effective, the case does not need to be discontinued. However, the worker must enter information related to the reason(s) for ineligibility in case comments.

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15.01.02D Timely and Adequate Notice Requirement

Timely Notice

A written notice that is mailed to the beneficiary at least 10 calendar days prior to the effective date of the action.

Adequate Notice

A written notice informing the beneficiary of:
- the action the County intends to take;
- the reasons for the intended action;
- the specific regulations supporting such action;
- an explanation of the claimant's right to request a county appeal hearing; and
- the circumstances under which aid will be continued if a hearing is requested.

Unless an exception applies, beneficiaries must be given at a minimum 10 calendar day notice prior to the end of the month in which their CMS certification is to end.

The CMS Discontinuance NOA (CMS-131) must be sent to the beneficiary by NOA deadline (Refer to 15.01.02E).

Exceptions to the timely notice requirement are below. However, in each of the below circumstances, an adequate notice must be issued:

The beneficiary:

- Has provided written/verbal request to discontinue their benefits.
- Is in receipt of Medi-Cal or LIHP benefits.
- Has been confirmed as deceased.
- Has lost San Diego County residence.

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15.01.02E Discontinuance NOA Cut –off Date

The deadline for mailing the CMS discontinuance (CMS-131) NOA is the following:

Calendar Day	Month
18th	All months; except February
16th	February
Note: If the deadline falls on a holiday or weekend, the NOA must be mailed and dated the workday prior to the deadline date.	

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15.01.02F Applicant Contact

The following actions are to be taken when the applicant contacts the County after a discontinuance action:

When contact is made…	Then the worker shall…
prior to the date of discontinuance,	rescind the discontinuance.
after the date of discontinuance,	advise the beneficiary of the option to submit an appeal to dispute the action and/or reapply. However, the worker may rescind the discontinuance if good cause is determined.

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15.01.03 Rescission of Discontinuance

15.01.03A Rescission of Discontinuance

Upon receipt of information that requires the reinstatement of benefits, the worker must:

Step	Action
1	Rescind the discontinuance as outlined in How To #1003.
2	Notify the beneficiary by sending the Rescind Notice (CMS-110R) when any of the following conditions apply: • A County Administrative Hearing decision orders a reevaluation of CMS benefits; • Beneficiary contacts the County prior to, or after the discontinuance date on the NOA and good cause is found; • The beneficiary is eligible to APP; or • It has been determined that the discontinuance was in error.
3	Re-evaluate the case based on CMS eligibility criteria.

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