County Medi-Cal Services (CMS) Program Guide (PG) Letter #18

June 27, 2012

Subject **ARTICLE A - LOW INCOME HEALTH PROGRAM (LIHP) POLICIES**

Effective Date Upon receipt.

Reference County Policy

Purpose To inform staff that the Low Income Health Program (LIHP) policies shall follow Medi-Cal regulations, with specific exceptions as listed in Article A of the County Medical Services (CMS) Program Guide (PG).

Background LIHP follows CMS program regulations with specific exceptions; the exceptions are listed in Article A of the CMSPG. LIHP provides access to health care coverage to San Diego County residents and creates efficiencies in the delivery of health care services which supports the County "Live Well, San Diego!" initiative.

Changes LIHP follows Medi-Cal regulations with specific exceptions. These exceptions are detailed in CMSPG Article A.

CMSPG
CMSPG language and hyperlinks to Medi-Cal Program Guide (MPG) sections have been added to CMSPG Article A as appropriate.

MPG
A work request has been submitted to move the LIHP policies from the CMSPG to the MPG. Until such time that the policies are moved to the MPG, MPG Article A shall contain a hyperlink to CMSPG Article A.

Required Actions Workers are to familiarize themselves with the LIHP policies detailed in CMSPG Article A. To view CMSPG Article A click here.

Forms Impact No impact.

Continued on next page

Quality Assurance

Effective with the July 2012 review month, Quality Assurance staff will cite the MPG and CMSPG Article A as the source of LIHP program regulations.

ACCESS Impact

No impact.

Appeals Impact

Eligibility staff will review and determine LIHP eligibility based on the policies contained in the MPG and CMSPG Article A.

CMS IT System

The CMS IT system has been updated with the new program guide citations.

Summary of Changes

The table below shows the changes made to Article A of the CMSPG.

Section	Change
Article A	• CMSPG language previously referenced in Article A has been added. • Hyperlinks to appropriate MPG sections have been added.

Approval For Release

JP/SB

Low Income Health Program (LIHP) Policies

Table of Contents

Summary

A.01 Details

A.02 Details

Application Process	A.02.03

A.03 Details

SECTION 03 CERTIFICATION AND RECERTIFICATION	
TITLE	**PG CITE**
Certification	A.03.01
Recertification	A.03.02

A.04 Details

SECTION 04 CITIZENSHIP/IDENTITY/ALIEN STATUS	
TITLE	PG CITE
U.S. Citizenship and Identity	A.04.01
Alien Status	A.04.02

A.05 Details

SECTION 05 INCOME	
TITLE	**PG CITE**
Income	A.05.01

A.06 Details

SECTION 06 DISCONTINUANCE	
TITLE	**PG CITE**
Discontinuance Requirements	A.06.01
Discontinuance Process	A.06.02

A.07 Details

SECTION 07 AUTOMATION	
TITLE	**PG CITE**
CMS IT System	A.07.01
IDX System	A.07.02

A.08 Details

SECTION 08 GRIEVANCE AND APPEALS	
TITLE	**PG CITE**
Grievance and Appeals	A.08.01
County Level Grievance and Appeal Requirements and Process	A.08.02

State Fair Hearing	A.08.03
Aid Paid Pending (APP)	A.08.04
Timeframe and Content of Notice for Resolution of Grievances and Appeals	A.08.05
Monitoring Reporting	A.08.06

A.09 Details

SECTION 09 QUALITY ASSURANCE	
TITLE	**PG CITE**
Policy	A.09.01
Case Sample Selection	A.09.02
Case Review Process	A.09.03
Results and Required Responses	A.09.04
Challenge Procedure	A.09.05
Report of Findings	A.09.06

Back to the top

Article A Section 01.01 Program Overview

Table of Contents

A.01.02 Program Overview

A.01.01A Policies

Article A of the CMSPG contains the policies and procedures for the Low Income Health Program (LIHP). Generally, LIHP follows Medi-Cal regulations with specific exceptions. These exceptions are detailed in CMSPG Article A. **For LIHP Policies Table of Contents** click here.

CMSPG LTR 18 (06/12)

A.01.01B Description

The Coverage Initiative (CI) program was San Diego's 1115 Medicaid-waiver program through 06/30/11. Upon implementation of the new 1115 Medicaid-waiver program, Low Income Health Program (LIHP) on 07/01/11, the CI program expired and new regulations went into effect for LIHP.

LIHP helps uninsured adult county residents to get medical care and limited mental health services. LIHP uses a network of community health centers, private physicians, public and private mental health clinics, and local hospitals to provide the services.

LIHP consists of 2 components, the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI).

- MCE – covers individuals with income up to and including 133% of the Federal Poverty Level (FPL).
- HCCI – covers individuals with income above 133%, up to and including 200% FPL.

San Diego's LIHP will offer new enrollment to the MCE portion of LIHP. Enrollment into HCCI will be limited to those individuals already enrolled in Coverage Initiative who have income within the HCCI range, and who continue to meet eligibility criteria and requirements.

There is no cost sharing (monthly premiums or share of cost (SOC)) or co-payments required in LIHP.

Article A Section 01.02 Scope of Services

Table of Contents

A.01.02 Scope of Services

A.01.02A General

The following link Enrollee Handbook provides information of the scope of services provided under LIHP.

CMSPG LTR 01 (08/11)

Article A Section 01.03 Access to Eligibility

Table of Contents

A.01.03 Access to Eligibility

A.01.03A Standard Eligibility Application

Adults can apply at any one of the LIHP Eligibility locations where Non-HOS workers are located by calling 1-800-587-8118 to schedule an eligibility appointment.

A.01.03B Hospitalization Application

Adults admitted through the emergency room can apply while in the hospital if the hospital chooses to refer the patient to the on-sight Hospital Outstation Services (HOS) worker. The referral may be handled by the HOS worker or decentralized via procedures outlined in the HOS Policy and Procedures Manual (PPM).

A.01.03C County Operated and Contracted Mental Health Clinic Application

Adults can apply at any one of the county operated mental health and contracted mental health clinic locations where a Non-HOS and County Mental Health Uniform Method of Determining Ability to Pay (UMDAP) workers are located.

Article A Section 01.04 Administrative Responsibilities

Table of Contents

A.01.04 Administrative Responsibilities

A.01.04A Health Coverage Access (HCA)

This section within HHSA contains a manager overseeing eligibility staff located at hospitals, public health centers, community clinics and Family Resource Centers. HCA is responsible for:

1. Evaluating eligibility for Medi-Cal and LIHP;
2. Helping applicants through the eligibility process;
3. Teaching enrollees how to receive covered services and how to resolve access to health care problems;
4. Referring applicants/enrollees to other resources, e.g., Medi-Cal, State Disability, General Relief, community-based organizations, etc.; and
5. Providing LIHP applicants/enrollees with other program information that is appropriate to their circumstances at the time eligibility to LIHP is established or denied.

CMSPG LTR 01 (08/11)

A.01.04B LIHP Program

This section within HHSA is the Program/Recovery section. Program/Recovery maintains LIHP policies and procedures in Article A, initiate Disability Determination Service Division (DDSD) applications, and process various types of recovery for LIHP.

A.01.04C Administrative Services Organization (ASO)

San Diego County contracts with an ASO to:

1. Schedule eligibility appointments;
2. Manage patient care;
3. Authorize treatment based upon established guidelines;
4. Process provider claims;
5. Bill Medi-Cal for reimbursement; and
6. Manage a scope of service grievance or appeal process.

Article A Section 01.05 Definitions of Acronyms and Terms

Table of Contents

A.01.05 Definition of Acronyms and Terms

A.01.05A Acronyms

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

Acronym	Definition
ASO	Administrative Services Organization
CAS	Corrective Action Supervisor
CI	Coverage Initiative Program
COBRA	Consolidated Omnibus Budget Reconciliation Act
FBU	Family Budget Unit
GR	General Relief
HCA	Health Coverage Access
HOS	Hospital Outstation Services
IDX	Computer system used by the ASO
LIHP	Low Income Health Program
LPR	Legal Permanent Resident
MCE	Medicaid Coverage Expansion
MNL	Maintenance Need Level
QA	Quality Assurance
STCs	Special Terms and Conditions between the State of California and the Centers for Medicare and Medicaid Services.
UMDAP	Uniform Method of Determining Ability to Pay

A.01.05B Terms

The following table lists definition of terms used throughout the program guide. They are intended to serve as a resource to staff, not to provide regulations.

Term	Definition
Administrative Services Organization (ASO)	A firm that performs administrative management functions and provides

	day-to-day administration of specific services related to LIHP.
Adult	A person age 19 through 64. Adult status begins the month following the 19th birthday and ends the last day of the month before their 65th birthday.
Adverse Action	An action taken which discontinues LIHP eligibility.
Approval Of Eligibility	An applicant who has met several conditions of eligibility and their application is approved for LIHP based on an eligibility determination.
Case Management	Services which assist LIHP eligible individuals in gaining access to needed medical services.
County Medical Services (CMS)	A county funded program for adults 21 to 64 years of age who do not meet the eligibility criteria for Medi-Cal or LIHP.
Disability	As determined by Social Security Administration or Medi-Cal/DDSD process.
Effective Date Of Eligibility	The first of the month when the person is eligible to LIHP benefits.
Eligibility Criteria	The criteria relating to the initial and continuing determination of a person's LIHP eligibility.
Enrollee	The individual who has been found eligible for LIHP.
Hospital Outstation Services (HOS)	Staff located in hospitals contracted with the Hospital Association of San Diego & Imperial Counties responsible for processing LIHP, Medi-Cal and CMS applications.
IDX	The computer corporation the County contracts with to provide software systems for the ASO to record LIHP eligibility, and process claims and treatment authorizations.
Medical Home (Clinic)	The County approved provider or facility where an enrollee receives all primary medical care.
Reapplication	An application submitted after a one (1) month break in certification.
Recertification	A redetermination that an enrollee continues to meet the LIHP eligibility criteria without a one (1) month break in

	certification.

Article A Section 01.06 Listings of Contracted Hospitals, Clinics and Pharmacies

Table of Contents

A.01.06 Listing of Contracted Hospitals, Clinics and Pharmacies

A.01.06A Listing

The following link Enrollee Handbook provides a listing of LIHP contracted hospitals, mental health hospitals, primary care clinics, mental health clinics, and pharmacies.

CMSPG LTR 01 (08/11)

Article A Section 01.07 Case Record Retention

Table of Contents

A.01.07 Case Record Retention

A.01.07A Policy

1. Hard Copy Cases
   Both active and inactive patient case records created prior to implementation of the CMS IT System are kept at Records Library and are retained for the period outlined in the HHSA Retention Schedule.

2. Electronic Cases
   Cases created in the CMS IT System will remain on the electronic system until it is purged by the vendor. Purging of electronic cases will be done accordance with the requirements outlined to the vendor.

CMSPG LTR 01 (08/11)

Article A Section 02.01 Eligibility

Table of Contents

A.02.01 Eligibility

A.02.01A General

New MCE applicants who apply and current HCCI enrollees who recertify for LIHP are required to meet several conditions of eligibility and comply with all eligibility/verification requirements before their application can be approved.

Eligibility workers use the MC-210 Statement of Facts (SOF) located in the CMS IT System plus appropriate supplemental forms to determine LIHP eligibility. Until it has been determined that the applicant/enrollee meets the LIHP eligibility criteria, the worker will process the LIHP and CMS applications concurrently. If the applicant/enrollee does not meet LIHP criteria, he/she will be evaluated for CMS benefits.

Exception: The County Mental Health UMDAP worker will **only** evaluate for LIHP.

When a LIHP case is established using the CMS IT system, all documentation and verifications, including forms completed by the applicant and eligibility staff used to determine eligibility to and level of

coverage within LIHP, must be imaged and saved into the CMS IT system.

CIPG LTR 11 (Errata) (06/11)

A.02.01B Eligibility Factors

The eligibility factors to be evaluated include:

- Medi-Cal linkage
- Residency
- Age
- Citizenship/Alien Status
- Identity
- Income
- Other Health Coverage (Applies only to HCCI)

CIPG LTR 11 (06/11)

A.02.01C Resources

LIHP is an asset waiver program. Property information is **not** required.

A.02.01D Cost Sharing

LIHP does **not** have monthly Share of Cost (SOC) or require co-payments.

CIPG LTR 11 (06/11)

A.02.01E Long Term Care

Individuals who reside in a Long Term Care (LTC) facility may be eligible to LIHP. Refer to A.02.02C

CMSPG LTR 17 (06/12)

A.02.01F Presumptive Eligibility

LIHP does **not** offer presumptive eligibility.

A.02.01G Retroactive Eligibility

MCE Program

The MCE program offers retroactive coverage for one month. MCE applicants may request retroactive coverage for the month prior to the month of application for services that are a benefit under MCE. **Note:** Retroactive coverage cannot be approved for any month prior to LIHP implementation, July 1, 2011.

When the applicant requests retroactive coverage only, the applicant

completes the MC 210 for the retroactive month.

Upon receipt of the request for retroactive coverage, the worker will:

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Have the applicant complete form LIHP-210A Supplement to Statement of Facts, for the retroactive month.</td></tr>
<tr><td>2</td><td>Verify county residency and Legal Permanent Residency (LPR) status for the retroactive month, as appropriate.</td></tr>
<tr><td>3</td><td>
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>“No change” in income reported,</td><td>• Use income verification provided to determine current monthly eligibility for the retroactive month.
• Proceed to Step 4.</td></tr>
<tr><td>“Change” in income is reported,</td><td>• Request income verification for the retroactive month.
• The standard ten-ten (10/10) timeline for providing the verification will apply.
• Proceed to Step 4</td></tr>
</table>
</td></tr>
<tr><td>4</td><td>Approve or deny MCE benefits and issue NOA, as appropriate.</td></tr>
</table>

A.02.01H Notification

The CMS IT System will generate and mail to the applicant the appropriate Notice of Action when denying, certifying, recertifying or discontinuing LIHP eligibility. Exceptions to the automatic mailing are listed in A.07.01.

The CMS IT System will upload to the ASO at the end of the business day, notifying the IDX System when LIHP eligibility is approved or denied. Providers are able to view the status of an applicant’s/enrollee’s eligibility using the CMS IT Systems Provider Online Verification (POV) site (https://www.sdcmspov.com).

Workers must also send form HHSA: CMS-4 to the ASO at 0557B to record in IDX COMMENTS any information that needs an explanation or clarification or changes that impact the applicant’s/enrollee’s

eligibility.

A.02.01I Notice of Privacy Practices

Workers shall give the "Notice of Privacy Practices" to all enrollees who are certified or re-certified for LIHP. This is a federal requirement under the Health Insurance Portability and Accountability Act (HIPAA).

All enrollees shall sign the "Notice of Privacy Practices" notice or the CMS-107 in lieu of the receipt acknowledging that they have received the notice. The County will make a good faith effort to obtain the signed acknowledgement that the enrollee received the notice. If the signed acknowledgement is not received from the enrollee, County staff will sign the acknowledgement and document in the case record the efforts taken and the reason why the acknowledgement was not obtained.

NOTE: The enrollee is not required to sign the acknowledgement of receipt as condition of eligibility; therefore, the worker will not deny case if the signed acknowledgement is not received.

A.02.01J Member Card and Enrollee Handbook

Upon approval of LIHP benefits, the CMS IT System will generate and mail the enrollee the LIHP Enrollee Handbook along with the Approval NOA and LIHP card within three (3) working days.

A.02.01K Rights and Responsibilities

As part of the application for or receipt of LIHP benefits, all applicants/enrollees who meet the eligibility criteria for LIHP must be informed of their rights and responsibilities. The worker must give the applicant the LIHP-15, "Rights and Responsibilities of Applicants", at initial application, reapplication and recertification.

Applicants/enrollees shall sign the Rights and Responsibilities form (LIHP-15) acknowledging that they have reviewed the information and they understand their rights and responsibilities. The applicant may sign the CMS-107 in lieu of the LIHP-15.

A.02.01L Coverage Information

Applicants/enrollees must sign the Coverage Information form (LIHP-23) acknowledging that they have reviewed the information and they understand the limitations of LIHP coverage.

A.02.01M Image

The Image Verification Checklist form (CMS-107) eliminates the scanning need of specific forms. Workers scan limited forms into the

Verification Checklist	CMS IT System when using the Image Verification Checklist. The checklist must list the correct effective/revision date for each form given.

Article A Section 02.02 Eligibility Criteria

Table of Contents

A.02.02 Eligibility Criteria

A.02.02A General

Eligible applicants/enrollees must meet **all** LIHP eligibility criteria and requirements for enrollment in the program.

CIPG LTR 11 (06/11)

A.02.02B Potential Linkage to Medi-Cal

1. Linked to CalWORKS or Medi-Cal

   Parents of minor children, who are disabled, incapacitated, or unemployed, must be referred to CalWORKS or Medi-Cal. Workers evaluate linkage based upon the definition in MPG 05.01 & MPG 05.02.

   - HOS workers shall process the Medi-Cal and LIHP applications concurrently.

- Non-HOS workers shall refer the parent to apply for Medi-Cal and deny LIHP.

LIHP applicants and enrollees with a disabling condition that may potentially link them to Medi-Cal must apply for and if eligible, accept full scope Medi-Cal coverage. They must apply for disability linked Medi-Cal through Disability Determination Services Division (DDSD). If they refuse to apply for or accept full scope Medi-Cal, they are not eligible to LIHP.

2. Pending SSA/SSI Disability

A LIHP applicant/enrollee with a pending SSA or SSI Disability application or a pending appeal decision should have applied for Medi-Cal at the time they applied for SSA/SSI. If they did not apply for Medi-Cal, in order to protect the Medi-Cal filing date, the applicant must apply for and complete the Medi-Cal application process for full scope benefits.

Medi-Cal applicants appealing an SSA/SSI denial issued within the last 12 months for not having a disabling condition may be denied Medi-Cal on the basis of no disability in CalWIN. This denial action protects the Medi-Cal filing date so that if the final appeal decision is favorable to the LIHP enrollee, the Recovery staff will initiate a corrective action memo to rescind the Medi-Cal denial and receive reimbursement from Medi-Cal.

Refer to A.02.02.Q for information related to Medi-Cal excess property denials.

A.02.02C Previous Medi-Cal Application Denial

1) Returning Applicant/Enrollee

If the LIHP applicant/enrollee is denied disability linked Medi-Cal (DDSD) because he or she is not linked and returns to apply for LIHP within ninety (90) calendar days of the Medi-Cal denial, the worker must:

Step	Action		
1	Review the denial reason.		
2			
	If the…	**Then…**	
	denial reason is correct and is not due to no show, failure to provide or failure to cooperate,	1	Certify for up to the allowable period, if otherwise eligible.
		2	Document the Medi-Cal denial reason in the case record comments.

	denial reason is questionable, (e.g. SSI denied for reasons other than no disability; 250% Working Disabled Program not evaluated for working individual, etc.),	1	Refer the applicant/ enrollee to appeal.
		2	If otherwise eligible, LIHP may be approved for the allowable period once the individual has complied with Med-Cal DDSD appeals process. **Note:** LIHP cannot be recertified until the individual has fully completed the Medi-Cal DDSD appeals process.
	90 calendar day appeal Medi-Cal appeal timeframe has expired,	1	Re-refer the applicant/ enrollee to apply for Medi-Cal DDSD using form CMS-5. Specify the beginning month for the Medi-Cal application and retroactive months, as needed.
		2	If otherwise eligible, LIHP may be approved for the allowable period **after** it is verified in CalWN that the individual has fully complied in completing the Medi-Cal application process, has met **all** Medi-Cal eligibility and verification requirements, and the DDSD packet has been scanned into DoReS. **Note:** The DDSD decision is not required prior to approving LIHP benefits.

2) <u>New Applicant</u>

When a new LIHP applicant was denied disability linked Medi-Cal (DDSD) because he or she is not linked and continues to declare a disabling condition, the worker will:

Step	Action
1	Evaluate if the denial is within the Medi-Cal ninety (90) calendar day appeal timeframe.

If…	Then…	
it is within the appeal timeframe,	1	Refer the applicant to appeal the denial.
	2	If otherwise eligible, LIHP may be approved for the allowable period once the individual has complied with Medi-Cal DDSD appeals process. **Note:** LIHP cannot be recertified until the individual has fully completed the Medi-Cal DDSD appeals process.
the appeal timeframe has expired,	1	Re-refer the applicant to apply for Medi-Cal DDSD using form CMS-5.
	2	If otherwise eligible, LIHP may be approved for the allowable period **after** it is verified in CalWN that the individual has fully complied in completing the Medi-Cal application process, has met **all** Medi-Cal eligibility and verification requirements, and the DDSD packet has been scaned into DoReS. **Note:** The DDSD decision is not required prior to approving LIHP benefits.

3) Unrelated to Disability

If the Medi-Cal application is denied for a reason unrelated to disability such as no show, failure to provide, or failure to cooperate, then the applicant is not eligible to LIHP until they

comply.

Refer to A.02.02.Q for information related to Medi-Cal excess property denials.

A.02.02D
No Linkage to Medi-Cal Denial

When the parent is denied CalWORKS or Medi-Cal because he/she is not linked and returns to re-apply for LIHP, the worker must review the denial reason.

If the denial reason is...	Then the worker...
correct,	will certify LIHP for up to the allowable period. The worker may, upon request of the parent, rescind the LIHP denial to the original application date by processing the application through the CMS IT System.
questionable,	must refer the parent to appeal the CalWORKS/Medi-Cal denial and may certify for up to the allowable period once the parent has complied with the CalWORKS/Medi-Cal appeals process. **Note:** LIHP cannot be recertified until the parent has fully completed the CalWORKS/Medi-Cal appeals process.

Refer to A.02.02.Q for information related to Medi-Cal excess property denials.

A.02.02E
SSI Advocate Referred

LIHP requires some applicants to apply for disability linked Medi-Cal through Disability Determination Services Division (DDSD) as a condition for eligibility for LIHP and generally follows Medi-Cal regulations regarding applying for unconditionally available income. Medi-Cal does not consider SSI unconditionally available income because it is viewed as Public Assistance.

An LIHP applicant who has been identified as potentially eligible to Medi-Cal or SSI may be referred to the Legal Aid SSI Advocate for assistance in applying for or reapplying for SSI benefits or assisting with the process of filing an SSDI/SSI appeal. Worker will :

- either mail or fax form HHSA:CMS-2 to the SSI Advocate; and
- notes in the case comment section of the CMS IT system, “SSI Advocacy Services referred.”

A.02.02F Deceased Person

LIHP not consider applications made on the behalf of a deceased person. LIHP denies all provider claims for services given to a LIHP applicant/beneficiary who dies while in the hospital. Deceased applicants/beneficiaries are linked to Medi-Cal because Medi-Cal defines disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death."

A.02.02G Cash Assistance Program for Immigrants (CAPI) Applicants

CAPI is a cash program for certain immigrants who are ineligible to SSI/SSP solely due to their immigration status. An LIHP applicant who has a pending CAPI application must also apply for Medi-Cal DDSD and may be approved LIHP while the DDSD decision is pending. The DDSD process for CAPI is the same as Medi-Cal; however a separate Medi-Cal application has to be requested by the applicant. An LIHP applicant who has an active CAPI case is linked to Medi-Cal and is not eligible to LIHP.

A.02.02H Medi-Cal Linkage Established

Full Scope Medi-Cal Coverage

LIHP enrollees determined to be disabled by State or Federal DDSD are **not** eligible for LIHP. Upon receipt of the DDSD decision, Recovery staff enters the disability information into IDX and Recovery staff sends an informing letter advising enrollees to complete the Medi-Cal application process. LIHP enrollees who have applied for Medi-Cal have the responsibility to complete the entire full scope Medi-Cal application process. If they have been determined disabled but fail to finish the full scope Medi-Cal eligibility determination process, they cannot remain on, or return to LIHP.

Refer to A.02.02.Q for information related to Medi-Cal excess property denials.

Limited Scope State Funded Medi-Cal Coverage

An individual eligible to limited coverage State funded Medi-Cal program such as the Medically Indigent Adult Long Term Care (LTC) program [Aid code 53] or the Tuberculosis (TB) program [Aid code 7H] may also be eligible for LIHP.

Refer to A.02.02.Q for information related to Medi-Cal excess property denials

CMSPG LTR 17 (06/12/)

A.02.02I

Applicants/enrollees must reside and maintain their principal residence

Residency in San Diego County.

A. Definition

1) Principal residence is not restricted to a building, boat, car, mobile home, etc. It includes the place where the applicant normally lives even if it is in a park, public restroom, airport lounge, or under a bridge. A fixed address is not required.

2) County residence shall be established by either of the following as long as verification requirements are met:
   a) The applicant/enrollee is physically present and is living in the County with the intention to remain permanently or for an indefinite period; or
   b) The applicant/enrollee is physically present and is living in the County at the time of application, not receiving medical assistance from another county, state, or country, and having entered the County with a job commitment or to seek employment, whether or not currently employed.

3) County residence continues until residence is established in another county. Unless there is evidence to the contrary, County residence ends when a enrollee leaves the County and does any of the following:
   a) Purchases, leases or rents a residence.
   b) Becomes employed.

B. Temporary Absence from San Diego County

1) Residence is not affected by temporary absence from the County of 60 days or less. An absence of 60 days or less is presumed to be a temporary absence unless there is evidence to the contrary.

2) Absence from the County for more than 60 days is presumptive evidence of the enrollee's intent to change residence unless the enrollee declares in writing an intent to return to San Diego County but is unable to do so because of illness or emergency circumstances.

C. Verification

Any one of the items below are acceptable residency verifications for LIHP:

1) A current and valid driver’s license or identification card issued by the California Department of Motor Vehicles in the applicant's name listing a San Diego County address.
2) A current and valid California vehicle registration in the

applicant's name listing a San Diego County address.

3) Evidence that the applicant has enrolled his or her children in a school in San Diego County.
4) Voter Registration document.
5) A current San Diego County rent/mortgage receipt or utility bill in the applicant's name.
6) Residency of an applicant living with his/her spouse may be verified using documents which identify the spouse whether or not the spouse is applying for CMS.
7) If the applicant is unable to provide one of the above specified documents, the worker can consider "other evidence." Other evidence includes, but not limited to, evidence provided by an agency located in San Diego County that supports finding that the applicant is a resident of San Diego (i.e. affidavit from a homeless shelter or court documents).

Note: A sworn statement from the applicant or any other person is NOT acceptable verification of residency.

D. Use of P O Box or Alternative Address

Applicants/enrollees are required to meet residency requirements to be eligible to LIHP. The worker will follow established procedures for verifying residency for all applicants/enrollees, including those who choose to designate an alternate mailing address. Applicants/enrollees may choose to designate a mailing address to receive client correspondence at any of the following:

- Their place of residence;
- A PO Box, including Commercial-Mail Receiving Agencies (CMRAs);
- The Family Resource Center (FRC) PO Box (Homeless applicants); or
- Another address of their choosing.

A.02.02J Age

The individual must be between the age of 19 and 64.

NOTE: Individuals between the age of 19 and 20 **must** have applied for Medi-Cal and determined not eligible for reasons other than not meeting the Medi-Cal eligibility criteria/requirements in order to be evaluated for LIHP.

Refer to A.02.02.Q for information related to Medi-Cal excess property denials.

A.02.02K Citizenship/

The applicant/enrollee must be a U.S. citizen, legal permanent resident

Alien Status

or qualified alien as listed on A.04.01 and A.04.02. However, legal permanent residents and qualified aliens must meet the five-year residency requirement (with some exceptions).

A.02.02L Identity

LIHP shall follow Medi-Cal rules for verifying Identity. Refer to MPG 07.02.

A.02.02M Social Security Number (SSN)

LIHP shall follow Medi-Cal rules for providing a SSN. Refer to MPG 04.11.

A.02.02N Income

HCCI Program – Individuals enrolled in HCCI before 02/14/11:

The income limit under the HCCI program is up to and including 200% of the Federal Poverty Level (FPL). Refer to A.05.01 for computation guidelines.

MCE Program

The income limit under the MCE program is up to and including 133% of the Federal Poverty Level (FPL). Refer to A.05.01 for computation guidelines.

A.02.02O Other Coverage

A. Health Insurance Coverage (Applies only to HCCI)

Applicants with income that falls between 134% FPL and 200% FPL must not have access to health insurance coverage within the last three months, unless the individual had employer-sponsored health insurance and one of the following has occurred within the last three months prior to applying for HCCI:

1. Loss of job.
2. A move to a zip code area or region that is not covered by the employer-sponsored health insurance.
3. Loss of health insurance because the employer stopped providing health insurance for all employees.
4. Divorced or legally separated from the individual whose employer provides health insurance.
5. Loss of benefits due to death of primary insurance subscriber.
6. Consolidated Omnibus Budget Reconciliation Act (COBRA) policy ended.

B. Third Party Liability

A LIHP enrollee may reimburse LIHP from any settlement received

(including a settlement from the enrollee's own insurance) for health care services provided by LIHP, for which another party may be responsible (e.g., vehicle accident, job injuries, injuries caused by a third party's action).

The applicant must fill out the Third Party Liability Report (CMS-7Mares) report as fully as possible. If the applicant refuses to complete and sign it, the worker denies the application for refusal to comply with program requirements and narrates the details surrounding the refusal in case comments.

The CMS-7 is used to ensure that all necessary information is reported and that applicants acknowledge their responsibility to reimburse LIHP.

Workers should review the completed report to ensure that it contains all information and is legible. It is not necessary to complete a report if the applicant received a settlement before applying for benefits, has spent the money and now qualifies for LIHP.

The worker notifies LIHP of the third party by sending the report to the LIHP/CMS TPL Program Specialist at MS 0557-A. The CMS-7 is part of the permanent case record.

A.02.02P Clinic Selection

Applicants/enrollees must select a LIHP clinic as their medical home.

A.02.02Q Property

LIHP is an asset waiver program. No property verification is required unless it is necessary to verify that the only reason the applicant is ineligible to Medi-Cal is due to excess resources.

NOTE: An applicant who is determined to be ineligible for Medi-Cal for the sole reason of excess property, will be evaluated for LIHP, and shall not be required to complete a Medi-Cal property spend down as an eligibility requirement for LIHP.

Table of Contents

A.02.03 Application Process

A.02.03A Good Cause

Refer to MPG 04.13.

CMSPG LTR 18 (06/12)

A.02.03B Statement of Facts

The MC-210 Statement of Facts (SOF) located in the CMS IT System will be used to determine LIHP eligibility. Refer to MPG 04.04 for instructions on who may complete and sign the SOF.

CMSPG LTR 18 (06/12)

A.02.03C Application Date

Once the applicant has met all of the eligibility requirements, the effective date of enrollment for LIHP is the first day of the month in which the application was received by the county.

Should an applicant submit any forms as part of the application process signed and dated prior to their interview, the applicant must sign and date the forms again with the date of the intake interview to establish the date of application.

CMSPG LTR 01 (08/11)

A.02.03D Failed to

Referrals decentralized from HOS which do not meet the HOS Policy

Attend Appointment

and Procedures Manual (PPM) criteria are scheduled an eligibility appointment with a Non-HOS worker. If the applicant fails to show to their scheduled Intake appointment, the worker will deny the application for failure to attend appointment, if good cause is not determined.

A.02.03E Applicant Responsibility

LIHP applicants or authorized representatives are responsible for providing essential verifications and reporting certain changes in a timely manner. They are required to:

- Complete all forms required in the application and recertification process.
- Provide all necessary verifications requested by the eligibility worker to determine eligibility.
- Report any changes in income and living situations within 10 calendar days.

A.02.03F Case Handling

Workers enter applicant information directly into the CMS IT System. The CMS IT System assigns case numbers to each applicant. The applicant retains this case number throughout the lifetime of their LIHP case.

HOS is unique in that workers may be dealing with both an electronic CMS IT system case, as well as a Medi-Cal case, automated through CalWIN. Case handling is different depending on the status of the applicant's Medi-Cal eligibility.

When the applicant is an ineligible member of a Medi-Cal case, the HOS worker creates a separate LIHP case electronically in the CMS IT system. The FBU will consist of the LIHP applicant, his/her spouse and **all** natural or adoptive minor children living in the home.

A.02.03G Clinic Assignment

<u>Enrollee Selection</u>

Upon approval, the worker asks the enrollee to pick one of the primary care clinics (PCC) that contract with LIHP as their medical home. The worker enters the PCC site in the CMS IT System which will be transferred to the LIHP card and mailed to the enrollee.

<u>Patient Unable/Unavailable to Select</u>

If the enrollee is not able or available to select a PCC site, the worker will designate the PCC site based on the following factors:

1. PCC site closest to beneficiary's address;
2. PCC site previously designated in IDX, or
3. Select the site based on information known to the worker as to

where follow-up care would be given.

Native Americans

When the worker is aware that the enrollee is a Native American, the worker enters the information into the CMS IT System and gives the beneficiary the "Health Services Information for Native Americans" form (CMS-120). The CMS-120 informs Native Americans that they may choose to receive their primary health care through the LIHP Primary Care Clinic they selected as part of the LIHP enrollment process and/or a participating Indian Health Clinic.

Changing Clinics

When enrollees want to change their primary care clinic because they have moved or prefer a clinic closer to their home or work, they must call the ASO at (800) 587-8118. The ASO will evaluate what is causing the dissatisfaction and will change the clinic, if appropriate.

Discharged From a Clinic

When an enrollee has been discharged from a clinic because of problems or conflicts with the clinic staff that cannot be resolved, the worker will direct the enrollee to select another clinic. The worker will write in the comment section of the CMS IT System "discharged from (clinic name and date)" and sends a CMS 4 to the ASO. This information will become an alert in IDX that this enrollee cannot select this particular clinic as their medical home. The enrollee will receive written notification from the clinic stating that he or she can no longer get services there.

A.02.03H Authorized Representative (AR)

Refer to MPG 04.02

CMSPG LTR 18 (06/12

Article A Section 03.01 Certification

Table of Contents

A.03.01 Certification

A.03.01A General

The applicant must meet all eligibility criteria before approval of LIHP benefits.

A.03.01B Certification Period

The standard certification period is for up to twelve (12) months. When a foreseeable change in circumstances is expected to affect eligibility during the certification period, the certification period may be less than the allowable twelve (12) months.

Refer to A.04.01 for certification periods related to U.S. citizenship/identity reasonable opportunity period.

Article A Section 03.02 Recertification

Table of Contents

A.03.02 Recertification

A.03.02A General

All LIHP enrollees must have their eligibility for LIHP redetermined every twelve (12) months.

Recertification is a determination that an enrollee continues to meet the LIHP eligibility criteria and has not had a break in aid for more than one (1) month.

Annual recertifications cannot be more restrictive during the recertification period than those that were in effect during the period of the enrollee's initial eligibility determination.

CIPG LTR 11 (06/11)

A.03.02B Certification Period

LIHP enrollees who recertify may be certified for up to 12 months, if they continue to meet all eligibility criteria and requirements and there are no foreseeable changes in circumstances that affect eligibility during the certification period.

EXAMPLE:	The enrollee will turn 65 years old in nine (9) months. The worker will recertify for eight (8) months and state the reason for the 8 month certification in case comments.

CIPG LTR 11 (06/11)

A.03.02C **Annual Recertification**

As part of the recertification process, the enrollee will be required to complete a new MC210, Statement of Facts (SOF).

Exception: Once U.S. CIT/ID has been verified, it does not have to be verified again.

CIPG LTR 11 (06/11)

A.03.02D Evaluation Process

County staff will:

- Review the SOF and supporting documentation provided by the enrollee;
- Evaluate for potential eligibility to Medi-Cal; and
- Notify the enrollee of the results of the eligibility determination.

CIPG LTR 11 (06/11)

Article A Section 04.01 U.S. Citizenship and Identity

Table of Contents

A.04.01 U.S. Citizenship and Identity

A.04.01A General

LIHP follows Medicaid regulations, except where expressly waived or identified as not applicable in the Special Terms and Conditions between the State of California and the Centers for Medicare and Medicaid Services.

An otherwise eligible LIHP applicant who declares to be a U.S. citizen and has not completed the DRA verification requirements of citizenship and identity shall be approved benefits during their Reasonable Opportunity Period (ROP) while they are attempting to gather the required DRA documents of citizenship/identity. The applicant shall be approved for a period not to exceed the ROP.

CIPG LTR 11 (06/11)

A.04.01B U.S. Citizenship or National Status

Refer to MPG 07.02

CMSPG LTR 18 (06/12)

A.04.01C US Citizenship Verification requirements

Refer to MPG 07.02

CMSPG LTR 18 (06/12)

A.04.01D

Refer to MPG 07.02

Automated State-Run SSA CIT/ID Match

CMSPG LTR 18 (06/12)

A.04.01E Identity

Refer to MPG 07.02

CMSPG LTR 18 (06/12)

Article A Section 04.02 Alien Status

Table of Contents

A.04.02 Alien Status

A.04.02A General

Only individuals who are Legal Permanent Residents (LPR) or Qualified Aliens are eligible to receive LIHP benefits. A copy of the documentation viewed by the Federally Qualified Health Center (FQHC) staff, Disproportionate Share Hospital (DHS) staff, or COS/HOS worker is needed in the case file.

Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), provides that certain immigrants who entered the U.S. on or after August 22, 1996 are not eligible to receive federally-funded benefits, including CI, for five (5) years from the date they entered the country with a status as a "qualified alien."

CIPG LTR 11 (06/11)

A.04.02B Documentation

The applicant must provide documentary evidence of his/her lawful immigration status.

A.04.02C Aliens Subject to the 5 year LPR Requirement

The following qualified aliens are subject to the five-year residency requirement **unless** the immigrant qualifies for one of the exemptions listed below:

- Legal Permanent Resident (LPR), usually verified with form I-551, I-151 or I-90;
- Aliens granted parole for at least one year; or

- Battered aliens.

A.04.02D Aliens Exempt from the 5 year LPR Requirement

The following qualified aliens are exempt from the five-year residency requirement:

- Refugees;
- Asylees;
- Cuban and Haitian Entrants;
- Victims of a severe form of trafficking;
- Aliens whose deportation is being withheld;
- Qualified aliens who also are an honorably discharged veteran, or the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran of the U.S. military;
- Aliens admitted to the country as an Amerasian immigrant;
- Legal permanent residents (LPR) who first entered the country under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or alien whose deportation was being withheld) and who later converted to LPR status;
- Members of a Federally-recognized Indian tribe, as defined in 25 U.S.C. 450b(e); and
- American Indians born in Canada to whom §289 of the Immigration and Nationality Act.

A.04.02E Expired LPR Card

LIHP shall follow Medi-Cal policy when an applicant/enrollee presents an expired LPR card. A current SAVE from the Medi-Cal case can also be used. Refer to MPG 07.03

CMSPG LTR 18 (06/12)

A.04.02F Prucol

PRUCOL immigrants are **NOT** eligible to apply for LIHP.

Article A Section 05.01 Income

Table of Contents

A.05.01 Income

A.05.01A General

The CI program, up until 02/14/11, the date the County Low Income Health Program (LIHP) application was submitted to the State, had an income limit of up to and including 200% of the Federal Poverty Level (FPL). The Medicaid Coverage Expansion (MCE) program has an income limit of up to and including 133% FPL. Individuals, who are over this limit, are not eligible. Income must be verified at application, annual recertification or whenever a change in income has been reported.

In order to make a correct budget computation, several factors need to be taken into consideration: Type of income, frequency, allowable deductions, and family size. Gross income is used as a starting point.

To apply the correct income deductions or exemptions, it is necessary to determine whether the reported income is earned or unearned, and if the household composition includes an aged, blind or disabled (ABD) individual.

CIPG LTR 05 (02/11)

A.05.01B Earned Income

Refer to MPG 10.02.

CMSPG LTR 18 (06/12)

A.05.01C Unearned Income

Refer to MPG 10.02.

CMSPG LTR 18 (06/12)

A.05.01D Deductions

Work Related Expenses
Refer to MPG 10.06.

Child Care
Refer to MPG 10.06.

Child Support/ Alimony Received
Refer to MPG 10.06.

Child Support/Alimony Paid
Refer to MPG 10.06.

Self-employment Expenses
Refer to MPG 10.06.

Households with an ABD individual/spouse
Refer to MPG 10.06.

Households WITHOUT an ABD individual/spouse
Refer to MPG 10.06.

CMSPG LTR 18 (06/12)

A.05.01E Income Verification

Refer to MPG 04.07.

CMSPG LTR 18 (06/12)

A.05.01F Budget Computation

Actual Income/Apportioned Income
Refer to MPG 10.04.

When an applicant's income exceeds either the HCCI or MCE limit as a result of converting the weekly or bi-weekly gross income to a monthly amount, the worker will re-compute eligibility based upon actual income received in the month. If the applicant is eligible, the worker will certify eligibility with a certification period ending the month before the extra payday month.

In-kind Income
Refer to MPG 10.04.

CMSPG LTR 18 (06/12)

A.05.01G
Unconditionally Available Income

Refer to MPG 04.12 & MPG 10.04.

CMSPG LTR 18 (06/12)

Appendix 05.01A Federal Poverty Level Chart

Maintenance Need Level (MNL) Chart

Effective 4/1/2012		
Person	**MCE 133% Monthly FPL**	**HCCI 200% Monthly FPL** (Enrolled before 2/14/11)
1	$1,239	$1,862
2	$1,677	$2,522
3	$2,116	$3,182
4	$2,555	$3,842
5	$2,994	$4,502
6	$3,433	$5,162
7	$3,871	$5,822
8	$4,310	$6,482
9	$4,595	$6,910
10	$5,019	$7,548
Add for additional members	+424	+638

CMSPG LTR 15 (04/12)

Article A Section 06.01 Discontinuance Requirements

Table of Contents

A.06.01 Discontinuance Requirements

A.06.01A General

This section establishes procedures to be followed when LIHP benefits are to be discontinued. The policy of discontinuing LIHP cases is to avoid LIHP expenditures on those persons who are not eligible to LIHP because the enrollee failed to comply with eligibility procedures, or no longer meets LIHP program requirements.

CIPG LTR 11 (06/11)

A.06.01B Reasons for Discontinuance

LIHP benefits will be discontinued if the enrollee:

- Voluntary requests to disenroll from the program;
- Has income that exceeds the program limit;
- No longer resides in San Diego County;
- Has attained the age of 65;
- Has established linkage to, or are in receipt of Medi-Cal benefits;
- Becomes incarcerated or is institutionalized in an Institution of Mental Disease (IMD);
- Is no longer living;
- Obtains other health care coverage (applies to HCCI only); or
- Upon receipt of any other information by County staff that causes the enrollee to become ineligible to LIHP.

CIPG LTR 11 (06/11)

A.06.01C Sources that Identify Ineligibility to LIHP

This list of sources may identify information that causes an enrollee to become ineligible to LIHP. This list is not all inclusive:

- Enrollee reports changes which make them ineligible for LIHP.
- Enrollee requests their case to close.
- The Administrative Services Organization (ASO) identifies the

enrollee as an active Medi-Cal recipient.
- Obituary listing.

CIPG LTR 11 (06/11)

A.06.01D Worker Responsibility

Upon receipt of information that causes the enrollee to become ineligible to LIHP, the worker is responsible for:
- Obtaining the supporting information, as appropriate;
- Discontinuing the LIHP case before the end of the certification period; and
- Ensuring the enrollee is given timely notice of the discontinuance, as appropriate.

CIPG LTR 11 (06/11)

Article A Section 06.02 Discontinuance Process

Table of Contents

A.06.02 Discontinuance Process

A.06.02A General

Refer to MPG 04.13 for the procedures whenever an enrollee requests discontinuance of LIHP benefits.

CMSPG LTR# 18 (06/12)

A.06.02B Processing Request

Refer to MPG 04.13

CMSPG LTR# 18 (06/12)

A.06.02C Timely Notice Requirement

Refer to MPG 04.13

CMSPG LTR# 18 (06/12)

A.06.02D Timely and Adequate Notification Requirement

The LIHP Discontinuance Notice of Action (NOA) (LIHP-14) will be sent to the enrollee when discontinuing LIHP benefits. The notice must inform the enrollee of the specific reason(s) for the discontinuance and include the appropriate program guide citations. For most discontinuances, enrollees must be given at minimum a 10 day notice prior to the end of the month in which their LIHP certification is to end.

Exceptions to the timely notice requirement are as follows:

- The enrollee has provided written request to discontinue their benefits.
- The enrollee is already in receipt of Medi-Cal benefits.

- The enrollee's death has been confirmed.

CIPG LTR 11 (06/11)

A.06.02E Discontinuance Effective Date

The LIHP Discontinuance NOA is effective at the end of the month in which the timely NOA is issued. The effective date for notices sent after the NOA deadline is the last date of the following month.

The worker will:

- Designate the discontinuance date, reason(s) for the discontinuance on the NOA; and
- Enter comments and/or verifications related to the discontinuance into the CMS IT System.

CIPG LTR 11 (06/11)

Article A Section 07.01 CMS IT System

Table of Contents

A.07.01 CMS IT SYSTEM

A.07.01A General

The CMS IT System is a web-based eligibility system (sdcmsapps.com). This system affords contracted providers the ability to access the Provider Online Verification (POV) website (www.sdcmspov.com) to view case status.

Workers must clear all LIHP applications on the CMS IT System, CalWIN, MEDS, and IDX System before approving LIHP benefits.

A.07.01B Applications and Verifications

LIHP applications are processed and maintained on the system. All case documentation and verifications will be stored on the system.

A.07.01C Notices of Action (NOAs)

A. NOAs Requiring Manual Mailing

Homeless

The CMS IT System will create various NOAs and Informing Notices for homeless applicants/enrollees but will not automatically mail the notices. The notices will be stored in the applicant's/ enrollee's record in the CMS IT system.

If the applicant/enrollee requests a copy of their NOA or Informing Notice, the worker will be able to access the notice and print it on site for the applicant/enrollee. The worker shall make a narrative entry indicating the date the notice was provided and shall specify

which notice was provided.

B. NOAs which will be automatically mailed

1) Approval NOAs

The certification period will be automatically filled-in prior to the NOA being mailed.

2) Denial NOAs

Workers shall enter all case specific information applicable to the denial into the CMS IT system at the time the denial action is taken (i.e. what specific items the applicant/enrollee failed to provide). The case specific information will be automatically filled-in prior to the NOA being mailed.

A.07.01D Approvals

Based on the applicant's/enrollee's information entered, the CMS IT System will recommend if the individual is approved for CMS benefits. The worker makes the final determination of eligibility.

All approval actions taken by the worker will remain in a "pending approval" status for a minimum of one (1) night. Each night the CMS IT System randomly selects from the pending approvals, which approvals are to be review by a supervisor, which pending approvals can be approved without a supervisor review.

A.07.01E Denials

Based on the applicant's/enrollees information entered, the worker will determine the appropriate denial action, and the CMS IT System will generate a denial NOA and automatically mail it to applicant, as appropriate. Some denial actions require manual NOA mailing.

A.07.01F CalWIN Interface

The CMS IT system can communicate with CalWIN to:

- Initiate citizenship verification through a MEDS SSA match; and
- Add the applicant's demographics to MEDS.

After viewing MEDS and no citizenship/identity codes are present, the worker will:

Step	Action
1	Select the "*CalWIN Interface*" button in the CMS IT system on the main status screen.
2	Select "Create" and confirm that you wish to create the request.
3	Register the Citizenship Online Verification (COV) application in CalWIN. (Refer to "How To #428")

4	

If citizenship is …	Then…
verified,	input the verification type on the document source screen in the CalWIN IT system.
not verified,	request verification documents and cancel COV application in CalWIN.

The worker can view CalWIN or MEDS for the response within five to seven business days. When viewing MEDS and citizenship/identity codes are verified, process case using the appropriate codes. Refer to MPG 07.02 for appropriate codes.

Return to top

Article A Section 07.02 IDX System

Table of Contents

A.07.02 IDX Computer System

A.07.02A General

Below are instructions for recording case activity, including some of the different types of alerts, comment entries and status codes entered on the IDX system to assist staff with the processing of LIHP cases.

Workers must check the IDX comment and status lines for these alerts and entries and take appropriate action before issuing benefits. All cases must have an IDX screen-print of both the Eligibility Summary Screen and the Comment Screen on file and documentation of the actions taken by the worker. *(Refer to Appendix 7A of this section for instructions on how to access the Comment Screen for complete information.)*

A.07.02B Recording of Case Activity

A. Disposition

The disposition of every LIHP application and recertification is automatically communicated from the CMS IT System to IDX each night.

B. IDX Comment entries

Workers must send form HHSA: CMS-4 to the ASO at 0557B to record in IDX COMMENTS any information that needs an explanation/clarification or changes that affect eligibility.

A.07.02C IDX Entries

IDX entries or alerts are entered into the comment section of the current eligibility screen and are carried forward to each subsequent eligibility screen until it is removed by county staff. The alert will also appear as a treatment referral containing the following:

1. Reason for referral;
2. Name of person origination the referral; and
3. Date of referral

A new alert referral is created for each subsequent County or ASO alert referral.

A.07.02D Threatening or Abusive Alerts

This alert is an IDX communication tool designed to notify staff that have face-to-face contact with an applicant/enrollee to exercise caution. The alert may be initiated by either County staff or ASO, and is reviewed at each new application. The information contained in the alert is for staff only, and is <u>not</u> to be shared with the applicant/ enrollee.

This type of alert includes, but is not limited to, the following situations:

1. Applicant/ enrollee identified as a drug seeker.
2. Applicant/ enrollee made threats directed at clinic, County, or ASO staff.
3. Applicant/ enrollee was verbally abusive and/or disruptive at their last appointment.

<u>Referral Procedure</u>

When applicants/ enrollee meet the alert criteria, the worker:

1. Emails their supervisor explaining the situation. The email must contain the applicant/enrollee's name, Social Security number and the clinic or office which the incident occurred.
2. Scan a copy of the email to the case record.
3. The supervisor will advise the ASO to place the alert on IDX.

The above procedure is followed each time the need for a subsequent Alert is identified.

<u>Mandatory Supervisor Reviews</u>

The supervisor reviews all alert referrals for completeness and to insure that it is an appropriate referral. When the referral is appropriate, both the email and the alert referral are forwarded to the ASO. When the referral is inappropriate, the supervisor notifies the originating worker.

A.07.02E Program Alert

These alerts/entries identify applicants/ enrollees who are no longer eligible to be recertified for LIHP or if there are issues that must be

Types

resolved before recertifying LIHP.

Do Not Recert

The **"Do Not Recert"** alert is used when an applicant/ enrollee is determined not eligible for LIHP or the applicant/ enrollee must comply with a program requirement.

(For example: "Do Not Recert" - Pt failed to attend DDSD consultative exam.")

The "Do Not Recert" alerts include the reason for the alert. The date and IDX user ID at the end of the entry identifies the person who placed the alert. Workers are **not** to recertify any case with a "Do Not Recert" alert.

Call Before Recert

The "Call before Recert" alert includes the reason for the alert, the date and the Program/Recovery staff member to be contacted regarding the alert.

After the issues have been resolved, the person who placed the alert will remove it from IDX and will notify staff advising that alert as been lifted.

Workers must not recertify an applicant/ enrollee without first contacting Program/Recovery for instructions on what actions the applicant/ enrollee must take before issuance of benefits. Workers must ensure that all issues are resolved and documented in the case before certifying/recertifying.

Below are some examples when these alerts are used:

1. Fraud
   When the enrollee does not cooperate with the investigation into allegations of fraud, LIHP Program staff will place an alert to prevent recertification until the enrollee cooperates or the investigation is complete.

2. Overpayment Collections
   When the enrollee does not cooperate in reimbursing LIHP for overpayment of benefits, Program staff will place the alert to prevent recertification until the enrollee contacts LIHP Program to discuss payment arrangements.

3. LIHP Program
   Program staff uses the **"Call (initials) Before Recert"** alert when there is a need to speak to the applicant/ enrollee to resolve certain issues and has not been able to contact the applicant/enrollee.

A.07.02F Medi-Cal Status Codes

LIHP uses status codes to track the progress of Medi-Cal referrals and applications. When enrollee are approved Medi-Cal retroactively, LIHP bills Medi-Cal for reimbursement and notifies the hospitals and clinics that they need to bill Medi-Cal for services rendered.

A.07.02G Medi-Cal Pending (A-P)

This status code identifies enrollees who have applied for Medi-Cal and have a case pending in CalWIN, or when enrollees have a SSI application or SSI appeal pending. The worker writes the Medi-Cal application date, or the date of the SSI application or the filing date, and level of the SSI appeal on the case comments. When the enrollee has a record on MEDS, the SSI appeal information is on the MEDS QP screen. Workers must document that they asked the enrollee for an updated status of their Medi-Cal, Social Security application or appeal at every interview. If there is a change, the entry must be made in the case narrative.

If the enrollee is approved for Medi-Cal, Social Security disability benefits or SSI, the worker must immediately forward this information to LIHP Recovery at 0557A, by e-mail, or fax. If the award letter is available, a copy of the letter should be attached to the email or faxed. If the award letter is not available, the worker must ask the enrollee to provide a copy of the award letter and forward it to LIHP Recovery when received.

NOTE: Workers must not approve LIHP benefits for an enrollee that has been determined disabled who has a pending Medi-Cal case, pending SSI/Social Security Disability application, or has an appeal pending at SSA Hearing level.

A.07.02H Medi-Cal Approved (N-A)

This status code identifies enrollees whose Medi-Cal eligibility has been **verified** on MEDS.

Appendix 7A - IDX Comments Screen

APPENDIX A

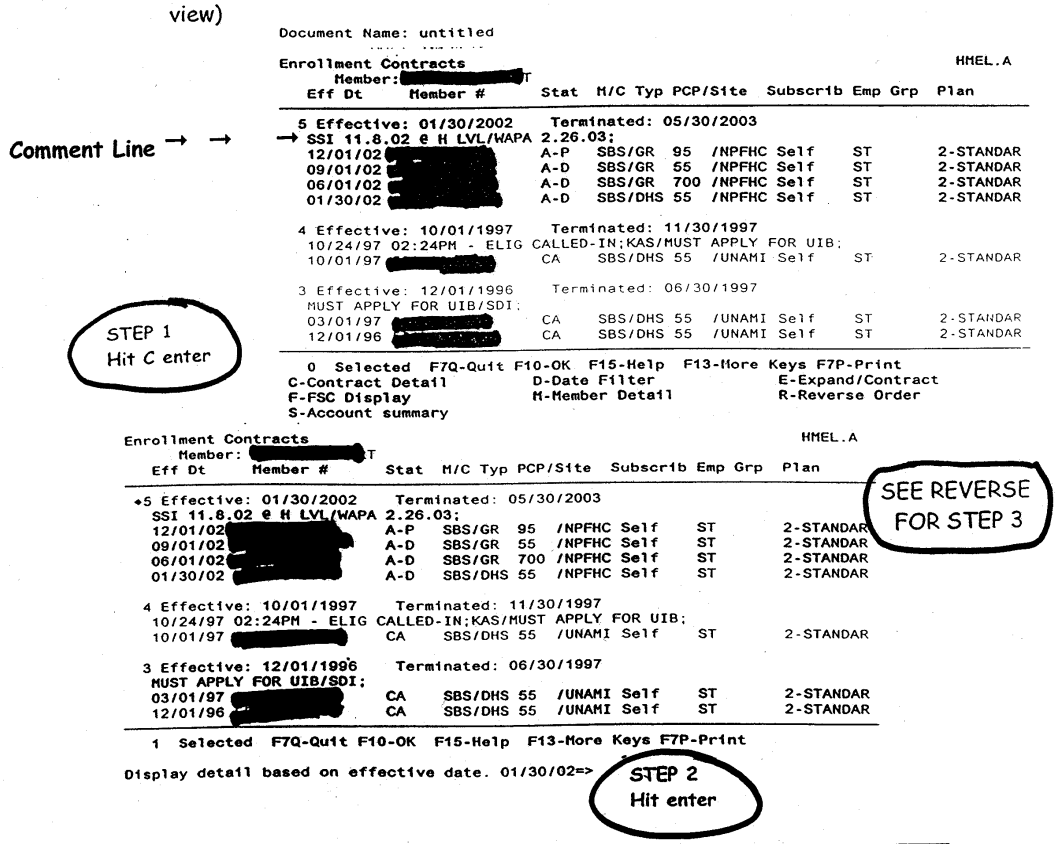
IDX Comment Screen

These are the instructions for accessing complete information in the comment section for each contract number. In this example observe how the IDX enrollment screen only shows part of the comments, but once you get to the comment screen there is more.

(1) Enrollment Screen, Have cursor on contract your working with.
Hit: C enter (contract detail)

(2) Hit: enter (displays oldest date of contract your working with)

(3) Enter: com and then hit enter (Jump to page: selecting what you want to view)



APPENDIX A

Continued: IDX Comment Screen

Document Name: untitled

[redacted]8 Screen dates 01/30/02 to 05/31/02 UMEC.

Ini: Subscrib: [redacted]
Contract: 5) [redacted]
Eff Dt Change: 01/30/200
End Date:

Subscriber Information

AKA Name:
MRN: [redacted]
Sex: M
DOB: 12/01[redacted]
Addr1: [redacted]N STREET
Addr2: APT [redacted]
Zip: [redacted]
City,ST: SAN DIEGO,CA
Phone: 619[redacted]

Ethnicity: CAUCASIA
Alien Ver: N
DSS#:
OHC: NO
Chronic Cond: NO
Family Size: 1
Monthly Income: 0
Empl: A
Type of Empl: E

FSC: CMS
R 1:
R 2:
R 3:
ID:
FS:
Den2:
Den3:

Contract Information

Eff: 01/30/2002 Grp: CMS
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Jump to page:

Article A Section 08.01 Grievance and Appeals

Table of Contents

A.08.01 Grievance and Appeals

A.08.01A General

All LIHP applicants must be given form "Your Grievance and Appeal Rights" (LIHP-19) to inform applicants of their right to file a County-level grievance or appeal and the procedures for exercising this right. Information is also included regarding the right to appeal an action to a State Fair Hearing upon exhaustion of the internal process.

Notice of grievance, appeal and fair hearing procedures and timeframes will be provided to all enrollees at the same time that a Notice of Action is issued (as required in 08.01.01E below).

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A.08.01B Appeal

An "appeal" is defined as a request for review of an action. An "action" is:

1. A denial, termination or reduction of eligibility for Medicaid Coverage Expansion (MCE) or Health Care Coverage Initiative (HCCI).
2. A denial or limited authorization of a requested LIHP service, including the type or level of service.
3. A reduction, suspension, or termination of a previously authorized service.
4. A failure to provide services in a timely manner pursuant to the Special Terms and Conditions of the California Bridge to Reform

Demonstration for the LIHP.

5. A failure of the County or the State to act within the timeframes for grievances and appeals as outlined herein.

In LIHP there are two types or levels of appeal: a County-level appeal and a State Fair Hearing. An appeal does not change policy or regulation; it can only ensure that policy or regulation has been followed or applied correctly.

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A.08.01C Grievance

A "grievance" is an expression of dissatisfaction about any matter other than an action, as "action" is defined above.

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A.08.01D Matters Outside the Scope of the Grievance and Appeal Process

Matters outside the scope of the grievance and appeal process, including the right to a State Fair Hearing are as follows:

1. The sole issue is one of Federal or State law or policy, LIHP protocols approved by DHCS.
2. The establishment of and any adjustments to the upper income limit made by the County.
3. The establishment by the County of enrollment caps for LIHP.

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A.08.01E Notice of Action (NOA)

1. Format - the NOA will be in writing and available in threshold languages.
2. Notice to Applicants – notice will be provided upon completion of an eligibility determination.
3. Timing of Notice for Enrollees – a NOA will be mailed to enrollees at least 10 calendar days before the date of the action.
   a. The requirement for advance notice may be shortened to 5 calendar days in case of probable fraud by enrollees where the agency has facts indicating probable fraud and those facts have been verified, if possible, through secondary sources.
4. Content of Notice
   a. the intended action;
   b. the reasons for the action (including statutory and regulatory references, if applicable);
   c. the effective date of the action;
   d. the program requirements that support the action;
   e. the enrollee's right to file an appeal;
   f. the procedures for exercising these appeal rights;

g. the circumstances under which expedited resolution is available and how to request it, and the circumstances under which benefits are continued and how to request it.

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A.08.01F Scope of Services and Payment Issues

LIHP enrollees have the right to make a complaint or file an appeal with the Administrative Services Organization (ASO) when they do not agree with the County's actions concerning access to medical or mental health services, quality of care, scope of services, or payment of claims. These procedures are in the ASO Complaint and Appeal Policy and Procedures Manual.

Note: An appeal related to scope of services, access to medical or mental health services, quality of care, or payment of claims are handled through the ASO and are not within the jurisdiction of the County HHSA Appeals office.

CMSPG LTR 05 (10/11)

A.08.01G Grievance and Appeals Process

1. For those individuals whose LIHP eligibility is determined by the State, the State assumes the responsibility and accountability for the resolution process.
2. For those individuals whose LIHP eligibility is determined by the County, the State delegates to the County responsibility for the resolution process.
3. Exhaustion of the County- level appeal process will be required of an applicant or enrollee prior to filing a request for a State Fair Hearing to appeal an action.
4. If dissatisfied with the County- level appeal decision, the applicant may file for a State Fair Hearing.
5. Grievances are not appealable to a State Fair Hearing.

CMSPG LTR 05 (10/11)

A.08.01H Authorized Representatives (AR)

1. **General:** Applicants/enrollees may designate an Authorized Representative (AR) for appeal purposes. Such designation must be made in writing and the designation must be signed and dated by the applicant or enrollee on or after the date of the action or inaction with which the applicant is dissatisfied.

2. **AR Assisting:** If the applicant/enrollee wants to designate an AR to accompany and assist with all aspects of the appeal process, the applicant or enrollee and AR must sign and date

the Appointment of Representative form MC 306/MC 306(SP) or any other written statement which contains the same information as the MC306 on or after the date of action or inaction with which the applicant/enrollee is dissatisfied.

3. **AR Acting on Behalf:** If the applicant/enrollee is or is not present at the hearing and wants to designate an AR (person or organization) to act on their behalf with all aspects of the appeal process, they must sign and date the Authorized Representative form DPA19/DPA19 (SP) or any other written statement containing the same information as the DPA19 on or after the date of the action or inaction with which the applicant/enrollee is dissatisfied. If a DPA19/DPA19 (SP) is secured, an MC306 is not needed for the same AR. A DPA19/DPA19 (SP) or any other written statement designating an AR to act on the behalf of an applicant/enrollee will only be recognized during the appeals process and thru the end of the compliance with that appealed action.

A.08.01I Interpreters

1. **General:** If it is determined the applicant/enrollee cannot effectively communicate in English because it is not his/her native language, and his/her native language is not a threshold language, the County will provide an interpreter.

2. **Interpreters provided:** In order to assist the applicant during the grievance/appeal process, the County will provide or secure:
   - either a bilingual interpreter who has passed the technical portion of the County's bilingual proficiency evaluation; or
   - an interpreter who is certified by the state, federal government or by the California Department of Social Services (CDSS).

   County bilingual employees will not serve as an interpreter who are:
   - the applicant's/enrollee's relatives, friends, or an authorized representative;
   - County staff who participated in making the decision complained of; or
   - County staff who are conducting the review.

Article A Section 08.02 County Level Grievance/Appeal Requirements and Process

Table of Contents

A.08.02 County Level Grievance and Appeal Requirements and Process

A.08.02A Requirements

1. For both grievances and County- level appeals:
   a. The County will provide any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability for all stages of the grievance and appeal processes, at no cost to applicants or enrollees.
   b. Applicants/enrollees must file a County-level grievance within 60 calendar days of the incident giving rise to the grievance.
   c. Applicants/enrollees must file a County-level appeal of action within 60 calendar days of the date of the Notice of Action (NOA).
   d. The County will acknowledge receipt in writing of each grievance and appeal.
   e. The decision maker must not be involved in any previous level of review or decision making.
2. Requirements for filing appeal requests of actions:
   a. Oral inquiries seeking to appeal an action will be treated as an appeal request and confirmed in writing by the County unless the applicant, enrollee or provider requests expedited resolution. The request for expedited resolution may be made orally or in writing.
   b. Applicants, enrollees and their representatives will have the opportunity, before and during the appeals process to:
      i. Examine the LIHP's position statement related to the reason services are delayed, denied or withdrawn by the LIHP or the State with advance notice to the County;
      ii. Examine the enrollee's case file, including medical records, and any other documents under consideration in the appeal with advance notice to the county; and
      iii. Confront and cross-examine adverse witnesses.

c. Applicants, enrollees and their representatives will be provided a reasonable opportunity to present evidence and allegations of fact or law, and cross examine witnesses, in person, in writing, or by telephone if requested by the individual, keeping within the timeframes for resolution.

d. In regard to the option for applicants, enrollees and their representatives to present evidence via the telephone, hearings can be conducted by telephone or video conference in lieu of an in-person hearing. Such hearings conducted in this manner must meet the following criteria:

   i. Telephonic hearings may be requested by the individual, at any stage of the appeals process, free of charge.

   ii. The individual must receive a written notice that a hearing can be conducted by telephone or video conference in lieu of an in-person hearing. Such notice must contain information about the process for an individual to review the records, submit evidence, and receive reimbursement for costs in accordance with (iii) through (vii) of this section.

   iii. Applicants, enrollees and their representatives must have the opportunity, before, and during the appeals process, to examine the LIHP's position statement and the enrollee's case file with advance notice to the county, including medical records, and any other documents under consideration in the appeal.

   iv. Applicants, enrollees and their representatives must be able to submit evidence and any other documents for consideration during the appeal within the required timeframes.

   v. The record must be kept open for 15 calendar days to permit applicants, enrollees and their representatives to submit evidence and any other documents for consideration in the appeal after the hearing has concluded, and the County given time to review and respond to documents submitted.

   vi. Applicants, enrollees and their representatives must be able to obtain reimbursement of costs in order to attend an in-person hearing, i.e. transportation.

   vii. Change in Process

      - At any point prior to or during a telephone or video conference hearing, at the request of either party, applicant/enrollee, representative or decision maker, an in-person hearing can be ordered.
      - If an individual has an in-person hearing scheduled, he or she may request a telephonic hearing 24 hours prior to the hearing date.

A.08.02B Process

1. All applicants/enrollees are directed to call the County HHSA Appeals office to request a grievance review or County-level appeal.
2. The County HHSA Appeals office shall send written acknowledgement of the grievance/appeal request as required by A.08.02A above.
3. A face-to-face review is not scheduled unless requested by the applicant/enrollee or their AR.
4. The County HHSA Appeals office notifies the appropriate HHSA office within 1 workday of the grievance/appeal request and provides the applicant's/enrollee's identifying information (name, member ID number, address, telephone number, application date and scheduled hearing date).
5. For Appeals: The appropriate HHSA eligibility staff reviews the case within 3 work days of the HHSA Appeals office notification to determine whether the worker properly followed program policies.
   a. If yes:
      i. The appropriate HHSA office completes the electronic Pre-Hearing Supervisor Review Checklist & LIHP Summary, including recommended finding and supporting program citations.
      ii. The appropriate HHSA office forwards the case and e-mails the Pre-Hearing Supervisor Review Checklist and LIHP Summary form to the HHSA Appeals section within 3 work days.
      iii. HHSA Appeals completes a final review.
         - If HHSA Appeals upholds the appropriate HHSA office's recommended finding, Appeals finalizes the Notice of Appeals Resolution and mails it to the claimant within the designated timeframe (Refer to A.08.05).
         - If HHSA Appeals does not uphold the appropriate HHSA office's recommended finding, Appeals contacts the Manager for the appropriate HHSA office to discuss the resolution.
   b. If no, the appropriate HHSA office:
      i. Rescinds the action being appealed and re-evaluates eligibility;
      ii. Must send notice LIHP-110R to inform the claimant that their case is being re-evaluated; and
      iii. Sends a new NOA to reflect the updated eligibility determination.
6. For Grievances: Grievances received by HHSA Appeals will be

forwarded by Appeals to the appropriate HHSA office. The appropriate HHSA eligibility staff investigates the incident giving rise to the grievance.

a. The appropriate HHSA office writes the Disposition of Grievance and mails it to the claimant within the designated timeframe listed in A.08.05.

Article A Section 08.03 State Fair Hearing

Table of Contents

A.08.03 State Fair Hearing

A.08.03A General

1. A State Fair Hearing may be requested within 90 calendar days of the date of the Notice of Resolution of the County-level appeal of an action.
2. The State will take final administrative action.
3. The County will be a party to the State Fair Hearing.

CMSPG LTR 05 (10/11)

Article A Section 08.04 Aid Paid Pending (APP)

Table of Contents

A.08.04 Aid Paid Pending (APP)

A.08.04A General

Aid Paid Pending (APP) is a continuation of benefits during a County-level appeal of action or a State Fair Hearing.

1. The enrollee's benefits must be continued if:
   a. An enrollee's eligibility is terminated or reduced;
   b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
   c. The original period covered by the original authorization has not expired;
   d. The enrollee or provider (on behalf of the enrollee) files an appeal timely; and
   e. The enrollee requests extension of benefits.
2. "Timely filing" as used in this section means filing on or before the later of either:
   a. Ten (10) calendar days from the mailing of the NOA.
   b. The intended effective date of the proposed action.
   c. In the case of a State Fair Hearing, 10 calendar days from the date of the County-level appeal decision is issued.
3. APP benefits that are continued under this section shall be discontinued/terminated when:
   a. The enrollee withdraws the appeal;
   b. Ten (10) calendar days pass after the mailing of a notice resolving the County-level appeal adverse to the enrollee, unless the enrollee requests a State Fair Hearing with continuation of benefits within 10 calendar days of the issuance of the County-level appeal decision;
   c. A State Fair Hearing decision adverse to the enrollee is issued;
   d. As ordered by the Administrative Law Judge at the State Fair Hearing, in limited permissible circumstances; or
   e. The time period or service limits of a previously authorized service has been met or expired.
4. If the final resolution of the County-level appeal or the State Fair Hearing is adverse to the enrollee, the County may recover from the provider the cost of the services furnished to the enrollee while the appeal is pending, to the extent they were furnished solely

because of the requirements of this section of the procedures.

5. If services were not furnished pending the County-level appeal or the State Fair Hearing, and the resolution of the appeal reverses an action to deny, limit, or delay services, the County must provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
6. If the enrollee received disputed services while the County-level appeal or the State Fair Hearing was pending, and the resolution reverses a denial of services, the County must cover such services.

Article A Section 08.05 Timeframe and Content of Notice for Resolution of Grievances and Appeals

Table of Contents

A.08.05 Timeframe and Content of Notice for Resolution of Grievances and Appeals

A.08.05A Timeframe

1. Standard disposition of grievances – Oral notice must be given or written notice must be mailed within 60 calendar days of receipt of the grievance.
2. Standard resolution of request for appeals – County must mail written notice within 45 calendar days of receipt of the appeal request.
3. Expedited resolution of appeals – County must mail written notice within 3 working days of receipt of the appeal request. In addition, reasonable efforts to provide oral notice will be made.
4. Timeframes on the above may be extended by up to 14 calendar days if either the enrollee requests it, or the County can show (to the satisfaction of the State DHCS upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.
5. Written notice of the reason for the delay under (4.), above, must be provided, unless waived by the enrollee.
6. If a request for expedited resolution of an appeal is denied, the appeal must be treated under the standard resolution timeframe. In addition, reasonable efforts to give prompt oral notice of the denial must be made, and follow up with written notice within 2 calendar days must be provided.

CMSPG LTR 05 (10/11)

A.08.05B Content of Notice

1. Written notice of the resolution must include:
   a. The results of the resolution process and the date it was completed.
   b. Be available in threshold languages.
   c. For appeals not resolved wholly in favor of the applicant or enrollee:

i. The right to request a State Fair Hearing and how to do so and the date by which the request of a State Fair Hearing must be made to be considered timely;
ii. If applicable, the right to request to receive benefits while the hearing is pending, and how to make the request; and
iii. That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the LIHP action.

Article A Section 08.06 Monitoring Reporting

Table of Contents

A.08.06 Monitoring Reporting

A.08.06A General

The County shall maintain a health information system that collects, analyzes and integrates the data necessary to implement the grievance and appeals process. The data listed below shall be provided to DHCS as required by regulation.

1. Time period(s) covered.
2. Average number of LIHP enrollees in the time period.
3. Total number of appeals and the total number of grievance cases received by the County in the period.
4. Rate of appeals and the rate of grievances per 1000 enrollees.
5. Number and percent of cases resolved internally and through the fair hearing process, and outcomes of cases in the period inclusive of:
   a. Number and percent decided in full favor of the enrollee.
   b. Number and percent decided partially in favor of the enrollee.
   c. Number and percent not decided in favor of the enrollee.
   d. Number and percent withdrawn by the enrollee.
   e. Number and percent of cases resolved through the fair hearing process, using telephonic procedures.
      i) Number and percent decided in fully favor of the enrollee using telephonic procedures.
      ii) Number and percent decided partially in favor of the enrollee using telephonic procedures.
      iii) Number and percent not decided in favor of the enrollee using telephonic procedures.
      iv) Number and percent withdrawn by the enrollee using telephonic procedures.
6. Issues involved in all cases.
7. Time it takes to resolve the cases (upper and lower limits, median/mean).
   a. Number and percent of these cases involving expedited processing; and
8. Quality Improvement activities related to issues identified through the County's LIHP.

Article A Section 09.01 Policy

Table of Contents

A.09.01 Policy

A.09.01A General

This section provides information regarding the QA requirements and procedures.

CMSPG LTR 13 (03/12)

A.09.01B Policy

QA reviews are only conducted as desk reviews. The primary purpose of the review is to evaluate worker accuracy, detect error trends and training needs.

CMSPG LTR 13 (03/12)

A.09.01C Review Sample Timeframe

Cases are selected for review by QA workers from a random sample of the total case population on a monthly basis.

CMSPG LTR 13 (03/12)

A.09.01D Specific Review Areas

Specific areas of review include, but not limited to:

1) Application processing timeframes;
2) Income treatment and budget computation;
3) Correct determination of Medi-Cal linkage factors;
4) Correct determination of financial and non-financial eligibility factors such as residency and alien status, etc.; and
5) Acceptable and adequate verification and documentation.

CMSPG LTR 13 (03/12)

Article A Section 09.02 Case Sample Selection

Table of Contents

A.09.02 Case Sample Selection

A.09.02A General

The sample month is defined as any granting action taken in the month regardless of the application date. The sample is drawn from approved applications listed in the CMS IT System.

CMSPG LTR 13 (03/12)

A.09.02B Case Selection

Case selection shall be determined based on eligibility setting:

A. HCA and FRC CMS/LIHP POD Case Reviews
QA will review 2 cases per worker each month. If they are combo workers, QA will review one case for each program (ex: 1 LIHP and 1 CMS).

B. FRC LIHP Case Reviews
QA will review 5% of all LIHP cases that are dispositioned at FRCs each month.

CMSPG LTR 13 (03/12)

Article A Section 09.03 Case Review Process

Table of Contents

A.09.03 Case Review Process

A.09.03A General

QA has access to view the entire case electronically, therefore paper case folders are no longer requested for review.

CMSPG LTR 13 (03/12)

A.09.03B Conducting the Review

The QA worker records all case review data in the Rushmore Case Review System and completes the Print Case Review form. The Print Case Review form contains pertinent data cited in the desk review.

CMSPG LTR 13 (03/12)

A.09.03C Review Findings

Benefit/Eligibility Error

All benefit/eligibility errors are to be reviewed by the QA supervisor. Upon completion of the QA supervisor review, the Print Case Review form shall be sent to the appropriate CAS for review and corrective action.

Procedural Error

Procedural errors are to be reviewed by the QA supervisor. Upon completion of the QA supervisor review, the Print Case Review form is sent to the appropriate CAS for review and corrective action.

No Error

No errors cases are to be reviewed by the QA supervisor. Upon completion of the QA supervisor review, the QA worker records in the Rushmore Case Review System that case had no errors. QA provides the CAS with a complete list of all no error cases reviewed.

CMSPG LTR 13 (03/12)

Article A Section 09.04 Results and Required Responses

Table of Contents

A.09.04 Results and Required Responses

A.09.04A General

The appropriate HHSA office must review all QA error citations, make all necessary corrective actions, and respond to QA providing any necessary documentation along with response.

CMSPG LTR 13 (03/12)

A.09.04B Corrective Action

The worker must take the necessary actions to correct all Benefit/Eligibility and Procedural errors cited. Corrective actions must be taken by the response due date noted on the Print Case Review form.

The worker will **not** change a certified case to a denied case when QA discovers that eligibility was certified erroneously. Certification periods shall be terminated as outlined in program material.

CMSPG LTR 13 (03/12)

A.09.04C Due Date Extension

Extensions will be considered if the request is received prior to the response due date noted on the Print Case Review form. The CAS must contact the QA Supervisor to request an extension.

CMSPG LTR 13 (03/12)

A.09.04D Required Response

The appropriate HHSA office shall provide the QA response by the designated due date. The QA response should include supporting documentation to indicate the error has been corrected.

CMSPG LTR 13 (03/12)

Article A Section 09.05 Challenge Procedure

Table of Contents

A.09.05 Challenge Procedure

A.09.05A General

Challenges to a QA citation will be considered only when QA receives the challenge by the response due date noted on the Print Case Review form. Challenges received by QA after the response due date are returned to the appropriate CAS with no action taken by QA.

CMSPG LTR 13 (03/12)

A.09.05B Citation Challenges

When a citation is challenged, the following information must be provided in the "Comments/Disagree" section of the Print Case Review form:

- Specific error citation being challenged;
- Reason for the disagreement;
- Case documentation supporting position; and
- Relevant MPG citations.

The Print Case Review form and the “Correction/Challenge Route Slip” are sent to QA. The QA Supervisor will re-evaluate the error citation and respond to the challenge within 12 business days.

If the CAS disagrees with the response to the challenge within 12 business days, the CAS will consult with the Corrective Action Coordinator to reach a joint agreement on the challenge.

CMSPG LTR 18 (06/12)

Article A Section 09.06 Report of Findings

Table of Contents

A.09.06 Report of Findings

A.09.06A General

A statistical report of findings for each review month will be made available to management by QA. This report is to be used by management to identify error trends and training needs. The manager and CAS have access to the report of findings and are responsible for monitoring various QA reports stored in the Rushmore Case Review System.

CMSPG LTR 13 (03/12)

A.09.06B Report of Findings

The report contains the following information:

1) Error Listing by Unit identifies the number and type of errors listed by worker.
2) Summary of Error Elements identify the number of errors cited in each program area.
3) Causal Factor Summary identifies the program area where an error occurred and the probable cause of the error.

CMSPG LTR 13 (03/12)