County of San Diego, Health and Human Services Agency (HHSA)
Medi-Cal Program Guide (MPG) Letter

Termination of the Low Income Health Program	**Number**	**Page**
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Issue date:
12/23/2014

Effective date:
July 1, 2014

Purpose:
To inform staff of the following:

- Termination of the Low Income Health Program (LIHP)
- Removal of LIHP policies and procedures contained in Article A of the MPG
- Removal of all reference to LIHP from the MPG and Eligibility Desk Guides (EDGs)
- Retirement of LIHP EDGs, Desk Aids, Processing Guides, How To's, and BEnDS
- Obsoleted LIHP Notices of Action (NOAs) and forms

Background:
San Diego's LIHP was a federally funded Medicaid waiver program for eligible individuals with income at or below 133% FPL. LIHP was established as the bridge to health care reform and expired on December 31, 2013.

Policy Change:
Applicants will no longer be evaluated for the LIHP program.

The LIHP policy and procedures contained in Article A of the MPG and all references to LIHP contained in the MPG have been removed.

Summary of Changes:
04.02.10C: Removed all references to LIHP
05.04.08A: Updated CMS Recovery Mail Stop
05.04.08C: Removed all references to LIHP
Article A: Retired LIHP policies and procedures
Article B: Retired LIHP Desk Aids 2, 3, 4, 12, 18, & 27
Article C: Retired LIHP Processing Guide 5 & 8

Changes to the MPG are noted with highlighted text within each Article/Section.

Impact:
NOAs/Forms/EDGs/Desk Aids/Processing Guides
All LIHP NOAs and forms are obsolete and have been removed from AuthMed. All LIHP How To's, EDGs, Desk Aids and BEnDS, and Processing Guides contained in Article B and C of the MPG are retired.

Automation
CalWIN: LIHP has been removed from CalWIN.
AuthMed: AuthMed will no longer process LIHP applications.

Program Affected:
No impact to other program(s)

Quality Control:
QC will cite the appropriate error on any case that does not comply with the requirements outlined in this letter.

References:
Centers for Medicare & Medicaid Services Special Terms and Conditions 11-W-00193/9

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Approval for Release:

12-23-14

Rick Wanne, Director
Eligibility Operations

Background:

An applicant/beneficiary (including a minor consent applicant) may request retroactive Medi-Cal for any of the three months preceding the month of application. If not requested at application, the request for retroactive Medi-Cal coverage must be made within one year of the month for which retroactive coverage is requested. Medicare Savings Program (MSP) applicants/recipients are **not** eligible to retroactive Medi-Cal.

Policy/Procedure:

04.02.10A Requesting for Retroactive Medi-Cal

The request for retroactive Medi-Cal may be made:

- On the application form;
- On the SOF; or
- By submitting a written request.

Upon receipt of the request, request that the applicant complete the Supplement to Statement of Facts for Retroactive Coverage/Restoration (MC 210 A) form. When the applicant requests retroactive Medi-Cal only, request that the applicant complete the MC 210 for the earliest retroactive month and the MC 210 A for each additional retroactive month.

04.02.10B Retroactive Medi-Cal for Presumptive Eligibility (PE) Recipients

The PE program allows qualified providers to grant immediate temporary Medi-Cal coverage, which is limited to prenatal care, to low-income pregnant patients pending their formal Medi-Cal application. Because of the limited scope of benefits that PE covers, most PE recipients will require retroactive Medi-Cal to cover some services received during their PE eligibility period.

When you become aware that an applicant is a PE recipient, you must provide the applicant with information on how to apply for Medi-Cal and the timeframes for applying for retroactive Medi-Cal coverage. PE recipients shall be informed that they may apply for retroactive Medi-Cal coverage within one year of the month for which retroactive coverage is needed. Additionally, they do not have to apply for or be approved for on-going Medi-Cal in order to apply for retroactive coverage.

04.02.10C Retroactive Medi-Cal for CMS Recipients

An application for retroactive Medi-Cal must be completed for an applicant who is identified as having CMS coverage during any month in the retroactive period. You will need to review the applicant's statement on the 16-2A HHSA and MC 210 to see if the applicant declares CMS coverage and also check for CMS eligibility on an IDX screen print (see Desk Aid 39) for cases originating from HOS to see whether the applicant was in receipt of CMS in the retroactive period.

Since the County can be reimbursed for medical expenses covered by CMS, a CMS recipient who may have a disabling condition that potentially links him/her to Medi-Cal must apply for and cooperate in completing an application for disability linked Medi-Cal. These applications must be referred to DDSD (Refer to Article 5, Section 4). The CMS recipient should be encouraged and assisted as needed to complete the application. If the CMS recipient fails to cooperate in completing the Medi-Cal application, you must narrate the reason why the retroactive application was not completed. If a CMS Medi-Cal Referral (HHSA: CMS-5) form was provided, complete the form and forward to CMS as indicated on the form distribution.

04.02.10D Retroactive Medi-Cal for SSI Recipients

Title 22, California Code of Regulations, Section 50148 states that a request for retroactive Medi-Cal may be made "in conjunction with, or after, application for public assistance or Medi-Cal". An application for "public assistance" includes an application for SSI/SSP benefits. A request for retroactive coverage must be made within one year of the month the eligible expenses were incurred.

Based on this regulation the month of application is established along with the SSI/SSP application, for retroactive Medi-Cal purposes, even if aid (in this case, SSI/SSP) is never approved for the application month. The approval of SSI/SSP benefits is not necessary for the determination of the three month retroactive Medi-Cal eligibility, as in any Medi-Cal only application.

Below are three forms of retroactive Medi-Cal application that may be processed:

1) Retroactive to SSI Approval Month

An SSI recipient who requests Medi-Cal coverage back to the month of SSI approval which may be several months prior to the request. This kind of request should be made within six months of the decision or four months from the date of the first SDX update.

Since the State cannot establish eligibility in MEDS for SSI recipients prior to their initial approval action:

- obtain verification from SSA indicating the person's SSI/SSP date of eligibility and a request for Medi-Cal coverage for that period of time
- attach the SSA verification to a 14-28 HHSA with the appropriate section completed and submit them to the FRC MEDS operator to establish eligibility for that period
- issue an immediate need paper card IF the BIC has not been received by the beneficiary and an immediate need situation occurs
- issue an MC 180 LOA if the retro period is over one year. Refer to Article 14, Section 3 for details on issuing a LOA

2) Retroactive to SSI Application Month

An individual who is approved SSI with an effective date after the date of SSI application. This occurs when the individual was not financially eligible for SSI during these months. The SSI award letter or other verification of entitlement may show a disability onset date prior to the SSI effective date. If the individual is determined disabled or there is other linkage in the retro period, the individual shall be evaluated for Medi-Cal, if otherwise eligible.

3) Month(s) Prior to SSI Application Month

An individual who requests Medi-Cal for the normal three month retro period. This type of request may require that you submit a disability referral to DDSD if no other Medi-Cal linkage exists. If an individual is approved (or denied) SSI and requests Medi-Cal for the three months immediately preceding the month of SSI application:

- mail an MC 210A if one has not been completed by the applicant for the retroactive months(s)
- obtain verification of the SSI application date. Such verification may be an award/denial letter from SSA indicating the date of application and date of approval/denial, or a copy of the individual's original SSI application form, etc.

Before requesting an SSI/SSP Award Letter from the applicant, you must first attempt to obtain the SSI/SSP information from the SDX report located on the ISDX1 through ISDX5 screens in MEDS. If information is unavailable, request from the SSI/SSP recipient a copy of the SSI/SSP Award Letter along with any additional information needed to make an eligibility determination.

Note: Do not ask an applicant for information that is already available to the County from the SDX report or that is unnecessary for a Medi-Cal determination.

The ISDX screens can be accessed in MEDS by clearing the screen, then typing ISDX, and entering the SSN of the individual. The following provides a description of the data included in the screens:

SDX Screens	Description
SDX1-CLIENT DATA	Contains MEDS identification (ID) number, person's name, client index number, health insurance claim number, BIC issue date, birth date, language spoken/written and birthplace
SDX2-ADDRESS DATA	Contains MEDS ID number, person's name, address, and telephone number
SDX3-CLIENT INFORMATION	Contains MEDS ID number, person's name, Title II Claim number, SSI application date, CA residency date, and disability on-set date
SDX4-CLIENT INCOME STATUS DATA	Contains MEDS ID number, person's name, unearned income, and eligibility determination data
SDX5-CLIENT INCOME/STATUS DATA	Contains MEDS ID number, person's name, eligible spouse SSN, ineligible spouse/parent data, spouse/parent earned income, and unearned income

SSI/SSP recipients eligible under the A&D FPL Program are eligible for Medi-Cal in the month of application or in the month of the first day in which their SSI/SSP eligibility criteria were met. MEDS has been programmed to provide eligibility on this basis for the month of application.

04.02.10E Determining Retroactive Medi-Cal Eligibility for SSI/SSP Applicants Pending SSA Disability Determination

Screen the SSI/SSP applicant to any other Medi-Cal program while the SSDI application is pending at SSA.

If it is determined that the SSI/SSP applicant…	Then...
is eligible for retroactive Medi-Cal under any other Medi-Cal program,	the effective date for Medi-Cal eligibility is the first day of the SSA application month and retroactive Medi-Cal eligibility, if found eligible, applies to any/all of the three month(s) prior to the application month.
is not eligible for retroactive Medi-Cal under any other Medi-Cal program,	send a disability packet to DDSD for a disability determination. The disability packet shall include an evaluation request for the retroactive month(s). Refer to Article 5, Section 4.9 for more information on processing disability cases.

Beneficiary Reimbursement Process
Provide information to SSI/SSP applicants who have paid out-of-pocket expenses for Medi-Cal covered services about the availability of the Beneficiary Reimbursement Process (BRP).
Information about the BRP should be given to SSI/SSP applicants who have paid out-of-pocket expenses that occurred in the following time periods:

Time Period	Description
Retroactive Period	The 3-month period prior to the month of application to the Medi-Cal Program
Evaluation Period	From the date of application for the Medi-Cal Program until the date eligibility is established
Post-approval Period	The time period after eligibility is established

SSI/SSP applicants, who have such paid expenses as noted above, should immediately contact the Beneficiary Service Center at (916) 403-2007 or visit the website at this link: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx

04.02.10F Processing Requests Received at Intake
All requests for retroactive Medi-Cal are assigned according to FRC policy. Requests for retroactive Medi-Cal received at application shall be processed as follows:

Step	Action
1	Obtain a completed MC 210 A from the applicant for the retroactive months. If only retroactive Medi-Cal is requested, a MC 210 is completed for the earliest retroactive month and a MC 210 A for each additional retroactive month.
2	For income verification: **If…** / **Then…** "No change" is indicated on the MC 210 A, → utilize income verification that is used to determine current month eligibility on the signed and dated MC 210 for each of the retroactive months. This would also apply to self-employment income provided it adequately reflects actual monthly income. change in income is reported, → request income verification for each retroactive month where a change in income is reported on the MC 210 A.
3	Determine eligibility and SOC.
4	Generate and mail appropriate notices.

Reminder: Only one pay stub is required to verify income, as long as it adequately reflects the actual retroactive month(s) income. You may request further income verification if income reported is inconsistent with the income verification provided.

04.02.10G Processing Requests from Medi-Cal Beneficiaries
When a beneficiary requests retroactive Medi-Cal after a case has been granted:
- have the beneficiary complete an MC 210A for the retroactive month(s)
- attach the MC 210A to the active case file
- refer the case to Intake via your supervisor

04.02.10H Processing Previous Denied Month(s)
The application for retroactive Medi-Cal will be denied when the applicant was previously denied for the requested month(s), unless the application was denied due to:

- An erroneous denial
- The applicant's failure to cooperate was due to circumstances beyond the control of the applicant

Impact:
No impact to other program(s).

Reference(s):
MEPM LTR 274
ACWDL 08-27E
ACWDL 11-31
ACWDL 02-43
County Policy

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Policy/Procedure:

05.04.08A Receipt of Disability Determination Service Division (DDSD) Responses

All DDSD responses must be processed as follows within **five** days of receipt:

- DPC is responsible for:
  - Capture imaging Disability Decisions received from DDSD
  - Validating the Disability Decision as NFM SP2 DDSD 221R
  - Forwarding Disability Decision hardcopies to CMS Recovery at MS W 414 within three business days
- FRC staff is responsible for:
  - Reviewing the Daily DPC Report (DDSD tab)
  - Assigning the disability decisions imaged to appropriate task for processing
  - Ensuring accurate processing of disability decision within **two** business days

05.04.08B Disability Not Approved

The DDSD analyst will return the MC 221 with the disability determination attached explaining the basis of their determination when the applicant does **not** meet the MN disability criteria based on DDSD's vocational and medical evaluation.

The DDSD analyst will attach a notice explaining the basis for their determination (See DDSD Report Codes Desk Aid). If the DDSD rationale notice does **not** explain the basis for the determination, you must request the information from DDSD.

Presumptive Disability (PD)

If PD has…	And	Then…
been granted,	DDSD subsequently adopts SSA's disability denial and the beneficiary files an appeal with SSA,	benefits will continue through the appeal process. **Note:** DDSD will indicate Code "Z53" on the MC 221 if SSA's denial is adopted.
not been granted or the PD individual has not requested SSA's denial,	N/A	evaluate eligibility under any other Medi-Cal linkage.

If disability is the applicant's **only** linkage to Medi-Cal:

- deny or discontinue the case
- attach the DDSD rationale which explains the basis of the determination to the denial or discontinuance NOA and mail it to the applicant **(Do not send a copy of form MC 221to the applicant)**
- send form 14-10 HHSA to notify the hospital of the Medi-Cal denial if the applicant was certified CMS pending the disability evaluation
- enter denial information into case comments
- enter the DDSD determination in Display Disability/Medical Conditions Summary screens in CalWIN

05.04.08C Disability Approved

The DDSD analyst will attach the disability decision to the MC 221. The applicant will be considered disabled under the MN criteria. The onset date provided will take into consideration any request for up to three months retroactive coverage prior to the date of application as long as retro onset is requested on form MC 221. Refer to MPG Article 4, Section 15 for guidelines on annual redetermination for DDSD cases.

When the disability decision is received:

Step	Action
1	Enter the DDSD decision in the *Display Disability/Medical Conditions Summary* screens in CalWIN. **If the case is in… / Then…** pending status, → approve the applicant as disabled. granted status, → reclassify the beneficiary as disabled MN. The effective date will be determined as follows: **When the application date falls… / The effective date will be the…** prior to the disability onset date, → disability onset date. after the disability onset date, → application date.
2	Set a case alert for referral 30 days prior to the re-exam date if one is indicated on form MC 221.
3	Enter approval information into case comments, including onset and re-exam date.
4	Clear the applicant/beneficiary in AuthMed. **If there is… / Then…** an active CMS application, → discontinue CMS in AuthMed as outlined in CMSPG 15.01. not an active CMS application, → no action is necessary.
5	Send form 14-10 HHSA to notify the hospital of the Medi-Cal approval if the applicant was certified CMS pending the disability evaluation by an HOS worker.

05.04.08D DDSD Adopts SSA Allowance

When the applicant applies for SSA benefits, SSA evaluates the applicant's disability before evaluating for any other eligibility factors. If the SSI/SSP application is denied because the applicant does not meet the federal disability criteria, DDSD will "adopt" the SSA's determination.

If SSA has determined the applicant is **not** disabled, the DDSD analyst will return form MC 221 with an attachment indicating the applicant is **not** disabled per SSA. Deny the application following procedures outlined in 05.04.08B above.

If SSA has determined the applicant **is** disabled, the DDSD analyst will return form MC 221 with an attachment indicating the applicant **is** disabled per SSA and will give the onset date. Approve the application following procedures outlined in 05.04.08C above.
A disability determination does not mean the applicant is receiving or will receive SSI/SSP benefits. After SSA determines disability, SSA reviews for other eligibility factors. This review may take several months and the applicant may be determined ineligible to SSI/SSP.

In situations where an applicant/beneficiary is granted SSI/SSP benefits, clear the INQX screen in MEDS:

If the SSI/SSP effective date…	Then…
covers all months including retro months,	deny/discontinue the Medi-Cal case and complete Step 4 of 05.04.08C above.
does not cover all the months including retro months requested,	grant the Medi-Cal for any months covered by the onset date prior to SSI/SSP eligibility following the procedures outlined in 05.04.08C above.

If the DDSD decision indicates that DDSD adopted a SSA allowance and the applicant is **not** currently receiving SSA Disability benefits, check MEDS to determine whether the disability continues. When MEDS indicates that the applicant is no longer disabled, then complete form MC 221 and submit to DDSD for a reevaluation. Benefits shall **not** be discontinued unless a DDSD decision is received indicating that the beneficiary ceases to be disabled.

05.04.08E DDSD Disability Cannot Be Determined
The DDSD analyst may return form MC 221 indicating that s/he was unable to make a determination. The analyst will state the reason(s) for the no determination on the MC 221 and will often request your help in locating the applicant or in obtaining the applicant's cooperation in attending a consultative exam.

If the applicant…	Then…
failed to respond or s/her whereabouts is unknown,	• complete an *ex parte* review for the current address and notify DDSD via form MC 221 • deny or discontinue if the case file does not have a more current address for loss of contact
requests withdrawal of the Medi-Cal application,	deny the application and send an NOA to the applicant.
failed to complete the evaluation process,	• determine Medi-Cal eligibility under any other program • discontinue or deny
submits a referral which lacks sufficient information or the MC223 section 6, 7-10, 15-17 are incomplete,	attempt to obtain needed information and resubmit the packet to DDSD.
fails to cooperate,	determine if there is good cause for non-cooperation. If good cause exists, resubmit the packet to DDSD after gaining the applicant's cooperation. If good cause does not exist, deny or discontinue the case.

Note: DDSD can medically defer a case referral for up to three months when future evidence is needed to assess duration and severity of impairment. Medical deferment is an exception to the rule. Common reasons are strokes or heart surgery. Unless you receive form MC 221 requesting your help, there is no action required.

Impact:
No impact to other program(s).

Reference(s):
ACWDL 00-46
ACWDL 11-23
MEM Proc 22C-9.2
DHCS Clarification
County Policy

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.