

Medi-Cal Program Guide Letter #660

June 1, 2009

Subject **ARTICLE A—2009/2010 COUNTY MEDICAL SERVICES (CMS) MAINTENANCE NEED LEVELS (MNL) AND CMS HARDSHIP MAXIMUM ALLOWABLE EXPENSES**

Effective Date July 1, 2009

Reference County Policy

Purpose This letter is to provide staff with the new CMS and CMS Hardship MNL's and the CMS Hardship Maximum Allowable Expenses amounts effective July 1, 2009.

Background Under direction of the Board of Supervisors, the CMS MNL, CMS Hardship MNL, and CMS Hardship Maximum Allowable Expenses are adjusted annually, effective July 1st.

Changes The CMS Standard MNL is increased to \$1,490 for a single adult and \$2,005 for a married couple. The CMS Hardship MNL for a single adult is \$3,161 and \$4,253 for a married couple. The Allowable Expenses have also increased to accommodate the MNL adjustments.

Required Actions Workers are to use the new MNL's and new CMS Hardship Maximum Allowable Expense amounts effective July 1, 2009 and ongoing.

Forms Impact The forms below have been revised to reflect the 2009 MNL and CMS Hardship Maximum Allowable Expenses.

Form Number	Title	Attachment
HHSA: CMS-38H	CMS Hardship Evaluation Worksheet	A
HHSA: CMS-101A	Mail-In Re-Certification Cover Letter	B
HHSA: CMS-101A (SP)	Mail-In Re-Certification Cover Letter	C

All of the above forms have been uploaded to iWay and are available to be ordered.

Quality Assurance Impact

Effective with the August 2009 review month, Quality Assurance will cite with the appropriate error any case that does not comply with the requirements outlined in this letter.

Automation Impact

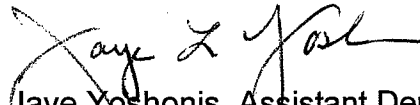
The CMS IT system has been programmed to calculate the budget using the appropriate MNL dollar amount for the designated months.

Summary of Changes

The table below shows the changes made to the MPG.

Article/Section	Changes
Article A, Appendix 5C	MNL charts updated
Article A, Appendix 13A	Allowable Expenses updated

Manager Approval



Jaye Yoshonis, Assistant Deputy Director
Self-Sufficiency Programs
Strategic Planning and Operational Support Division

SB

Patient Name		Budget Month/Year	
Patient Case #		Date	
Worker #		Worker Name	

CMS Budget Worksheet

1.	Number of people in family unit _____	Complete these columns to determine income eligibility	
2.	Name of adult family members with income		
	A.	A	B
	B.	Earned Income	
3.	Gross Earnings/Earned In-kind (before deductions)	\$	\$
4.	State Disability Insurance (SDI)		
5.	Subtotal earned (add lines 3 and 4)	=	=
6a.	Work Expenses (\$90 for each person with earned income)	-90.00	-90.00
6b.	ABD Deduction (\$65 + ½ of the remainder for each person with earned income)	-65.00+\$	-65.00+\$
7.	Total Earned Income (subtract line 6 from line 5)	\$	\$
		Unearned Income	
8.	In-Kind Income	\$	\$
9.	Other Unearned Income (UIB, VA, SSA, etc.)		
10.	Total Unearned Income (Add lines 8 and 9)		
11.	Total Income (add lines 7 and 10)	\$	\$
12.	Health Insurance Premium <input type="checkbox"/> yes <input type="checkbox"/> no	-	-
13.	Verified Court Ordered Child Support/Alimony		
14.	Total Monthly Net Non-Exempt Income (subtract 12 and 13 from 11)	\$	\$
15.	Total CFBU Monthly Net Non-Exempt Income (add individual rounded totals for columns 14 A & B)		\$
16.	CMS MNL for CFBU Size		\$
17.	Subtract line 15 from line 16. If 15 is greater than 16, the applicant is over income. Offer Applicant CMS Hardship Application.		\$

If applicant is being denied for the sole reason of excess income, and is otherwise eligible, calculate CMS Hardship Evaluation budget.

CMS Hardship Evaluation

STEP 1	<p>Determine if the Applicant's monthly net non-exempt income is at or below 350% FPL. Refer to Article A, Section 5, Appendix C for CMS Maintenance Need Levels (MNL)</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <td style="width: 60%; padding: 2px;">Applicant's monthly net non-exempt income</td> <td style="width: 40%;"></td> </tr> <tr> <td style="padding: 2px;">350% FPL</td> <td></td> </tr> </table> <p>If Applicant's monthly net non-exempt income is at or less than 350%, go to Step 2.</p>	Applicant's monthly net non-exempt income		350% FPL																																															
Applicant's monthly net non-exempt income																																																			
350% FPL																																																			
STEP 2	<p>Determine Total Monthly Allowable Non-Discretionary Expenses (using chart below)</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th style="width: 30%;">Non-Discretionary Expenses</th> <th style="width: 20%;">(A) Applicant's Actual Non-Discretionary Expenses</th> <th colspan="2" style="width: 30%;">(B) Maximum Allowable Expense (eff 7/1/09) for 1 or for 2</th> <th style="width: 20%;">Applicant's Allowable Expenses (Lesser of A or B)</th> </tr> </thead> <tbody> <tr> <td>Housing/Utilities</td> <td></td> <td style="text-align: center;">\$792</td> <td style="text-align: center;">\$1,066</td> <td></td> </tr> <tr> <td>Transportation</td> <td></td> <td style="text-align: center;">\$424</td> <td style="text-align: center;">\$570</td> <td></td> </tr> <tr> <td>Food</td> <td></td> <td style="text-align: center;">\$230</td> <td style="text-align: center;">\$310</td> <td></td> </tr> <tr> <td>Miscellaneous (includes clothing, personal)</td> <td></td> <td style="text-align: center;">\$102</td> <td style="text-align: center;">\$137</td> <td></td> </tr> <tr> <td>Allowable Out-of-Pocket Health Care Expense Allowance</td> <td style="background-color: black;"></td> <td style="text-align: center;">\$162</td> <td style="text-align: center;">\$218</td> <td></td> </tr> <tr> <td>Taxes (state and federal taxes deducted from the applicant's earnings, SDI, Social Security, and Medicare.)</td> <td></td> <td colspan="2" style="text-align: center;">Actual</td> <td></td> </tr> <tr> <td>Court Ordered Payments (e.g., current child support and alimony)</td> <td></td> <td colspan="2" style="text-align: center;">Actual</td> <td></td> </tr> <tr> <td>Payments on Prior Medical Debt</td> <td></td> <td colspan="2" style="text-align: center;">Actual</td> <td></td> </tr> <tr style="background-color: #cccccc;"> <td colspan="5" style="text-align: center;">Applicant's Total Monthly Allowable Non-Discretionary Expenses Enter amount in item B below.</td> </tr> </tbody> </table>	Non-Discretionary Expenses	(A) Applicant's Actual Non-Discretionary Expenses	(B) Maximum Allowable Expense (eff 7/1/09) for 1 or for 2		Applicant's Allowable Expenses (Lesser of A or B)	Housing/Utilities		\$792	\$1,066		Transportation		\$424	\$570		Food		\$230	\$310		Miscellaneous (includes clothing, personal)		\$102	\$137		Allowable Out-of-Pocket Health Care Expense Allowance		\$162	\$218		Taxes (state and federal taxes deducted from the applicant's earnings, SDI, Social Security, and Medicare.)		Actual			Court Ordered Payments (e.g., current child support and alimony)		Actual			Payments on Prior Medical Debt		Actual			Applicant's Total Monthly Allowable Non-Discretionary Expenses Enter amount in item B below.				
Non-Discretionary Expenses	(A) Applicant's Actual Non-Discretionary Expenses	(B) Maximum Allowable Expense (eff 7/1/09) for 1 or for 2		Applicant's Allowable Expenses (Lesser of A or B)																																															
Housing/Utilities		\$792	\$1,066																																																
Transportation		\$424	\$570																																																
Food		\$230	\$310																																																
Miscellaneous (includes clothing, personal)		\$102	\$137																																																
Allowable Out-of-Pocket Health Care Expense Allowance		\$162	\$218																																																
Taxes (state and federal taxes deducted from the applicant's earnings, SDI, Social Security, and Medicare.)		Actual																																																	
Court Ordered Payments (e.g., current child support and alimony)		Actual																																																	
Payments on Prior Medical Debt		Actual																																																	
Applicant's Total Monthly Allowable Non-Discretionary Expenses Enter amount in item B below.																																																			
STEP 3	<table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr style="background-color: black; color: white;"> <th colspan="2" style="text-align: center;">Calculation of Total Monthly Discretionary Income</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">A. Total Gross Monthly Income</td> <td style="width: 10%;"></td> </tr> <tr> <td style="padding: 2px;">- B. Total Monthly Allowable Non-Discretionary Expenses</td> <td style="text-align: center;">-</td> </tr> <tr> <td style="padding: 2px;">= C. Total Monthly Available Income</td> <td style="text-align: center;">=</td> </tr> </tbody> </table> <p>Subtract Line B (applicant's Total Monthly Allowable Non-Discretionary Expenses) from Line A (applicant's Total Gross Monthly Income). The remaining amount (Line C) shall be considered the applicant's Total Monthly Available Income.</p>	Calculation of Total Monthly Discretionary Income		A. Total Gross Monthly Income		- B. Total Monthly Allowable Non-Discretionary Expenses	-	= C. Total Monthly Available Income	=																																										
Calculation of Total Monthly Discretionary Income																																																			
A. Total Gross Monthly Income																																																			
- B. Total Monthly Allowable Non-Discretionary Expenses	-																																																		
= C. Total Monthly Available Income	=																																																		
STEP 4	<p>Determine Applicant's Monthly Share of Cost The Applicant's Total Monthly Available Income (Line C above) is the Applicant's Monthly Share of Cost.</p>																																																		



**COUNTY MEDICAL SERVICES
CMS RECERTIFICATION COVER LETTER**

Date: _____

To: _____

CMS Mail-In Recertification Unit
PO Box 85222 MS: O557E
San Diego, CA 92186-5222

You are receiving this letter because you requested a recertification of your CMS eligibility. Enclosed with this letter are the following forms we need from you to process your recertification to CMS:

- HHSА:СMS-101 County Medical Services (CMS) Mail-In Recertification Form
- HHSА:СMS-107 County Medical Services (CMS) Image Verification Checklist
- HHSА:СMS-99 County Medical Services (CMS) Credit Check Authorization
- HHSА:СMS-106 County Medical Services (CMS) Reimbursement Agreement**
- HHSА:СMS-01 County Medical Services (CMS) Hardship Application **
- HHSА:HСPА 14-187 Authorization for Release of Information
- Postage-paid Return Envelope

** CMS Hardship Application (CMS-01) and the Reimbursement Agreement (CMS-106) forms will need to be completed and submitted to apply for CMS Hardship only in the event that your net countable monthly income is between 165% and 350% of Federal Poverty Income Level (effective July 1, 2009: \$1490 to \$3161 per month for 1 person). Applying for a CMS Hardship evaluation is strictly voluntary. If you wish to apply, we may ask for more information from you at a later time to complete this evaluation. If you do not wish to apply for CMS Hardship, no further action is required.

NOTE: The HHSА:СMS-15 Rights and Responsibilities for Applicants, HHSА:СMS-23 Coverage Information and HHSА:СMS-007 CMS General Property Limitations do not have to be returned to CMS just signed off on the HHSА:СMS-107 acknowledging these forms were received, reviewed and understood. The HHSА: СMS-109 Informational Notice: The County's Legal Right and Limitations on Repayment and CMS Health Plan NPP-002 CMS Notice of Privacy Practices are being provided as information only and do not have to be returned to CMS.

You must complete and return the above forms along with any required verifications and/or documentation **within 15 days** of the date listed at the top of the Mail-in Recertification Form to be evaluated for ongoing CMS coverage. A postage-paid return envelope is enclosed for your convenience. If the Mail-in Recertification Form is not received by the 15-day deadline, you will need to call the CMS Eligibility Appointment Line at 1-800-587-8118 to schedule a face-to-face eligibility interview.

A Notice of Action informing you of your approval or denial for ongoing CMS coverage will be mailed to you.

If you have any questions, please call the CMS Mail-In Recertification Unit at (858) 492-2200.



COUNTY MEDICAL SERVICES

CARTA EXPLICATORIA PARA RENOVAR EL PROGRAMA CMS

Fecha: _____

Para: _____

CMS Mail-In Recertification Unit
PO Box 85222 MS: O557E
San Diego CA 92186-5222

Usted recibe esta carta porque desea renovar su elegibilidad para el programa CMS. Junto con esta carta están las siguientes formas que necesitamos para procesar la nueva certificación al programa CMS:

- HHSA:CMS-101 Formulario Para Renovar Por Correo Los Beneficios County Medical Services (CMS)
- HHSA:CMS-107 County Medical Services (CMS) Lista de Verificación de Imagen
- HHSA:CMS-99 County Medical Services (CMS) Autorización Para Examinar Crédito
- HHSA:CMS-106 County Medical Services Acuerdo de Reembolsar el Condado de San Diego**
- HHSA:CMS-01 County Medical Services Solicitud por Circunstancia Extrema de CMS**
- HHSA:HCPA 14-187(SP) Autorización Para Proporcionar Información
- Sobre de Porte Pagado

**La solicitud por Circunstancia Extrema de CMS (CMS-01) y la forma del Acuerdo de Reembolsar el Condado de San Diego (CMS-106) tendrán que ser completadas y regresadas para solicitar la evaluación por Circunstancia Extrema del Programa CMS solamente en caso que su ingreso neto mensual es entre 165% y 350% del Nivel de Pobreza Federal (FPL) de ingreso (efectivo 1 de Julio 2009: \$1490 a \$3161 por mes para una persona). La solicitud por Circunstancia Extrema del Programa CMS es estrictamente voluntaria. Si desea solicitarla, puede ser que después se le pida información adicional para completar esta evaluación.

Si no desea solicitarla, no se requiere ninguna acción de su parte.

NOTA: Formas HHSA:CMS-15 Derechos y Responsabilidades del Solicitante, HHSA:CMS-23 Información de Cobertura y HHSA:CMS-007 Limitaciones Generales de Propiedad del Programa CMS no tienen que ser regresadas al programa CMS solo se pide que reconozca que las formas fueron recibidas, examinadas y entendidas firmando/iniciando forma CMS-107. Forma HHSA:CMS-109 Aviso Informativo: Derechos Legales del Condado y Limitaciones del Reembolso y CMS Health Plan NPP-002 Aviso Sobre Practicas de Privacidad de CMS se proporcionan para información solamente y no tienen que regresarse al programa CMS.

Usted debe de completar y regresar las formas junto con cualquier verificación y/o documentación requerida **dentro de 15 días** de la fecha anotada arriba del Formulario Para Renovar Los Beneficios County Medical Services para evaluar su cobertura al programa CMS. Un sobre de porte pagado está incluido para su conveniencia. Si el Formulario Para Renovar Los Beneficios County Medical Services no se recibe dentro del plazo de 15 días, va a necesitar llamar a la Línea para Cita de Elegibilidad al 1-800-587-8118 para programar su cita.

Se le enviará por correo un Aviso de Acción donde se le informa que fue aprobado(a) o si se le negó su cobertura para continuar si elegibilidad al programa CMS.

Si usted tiene alguna pregunta, favor de comunicarse con la Unidad Para Renovar los Beneficios del Programa CMS al (858) 492-2200.

APPENDIX 5C

County Medical Services (CMS) Maintenance Need and Property Limit Chart

**1.
CMS
Maintenance
Need Level
(MNL)**

CFBU SIZE	CMS 165% FPL (Eff 07/01/09)	CMS HARDSHIP 350% FPL (Eff 07/01/09)
1	1,490	3,161
2	2,005	4,253
3	2,518	5,341
4	3,033	6,433
5	3,546	7,522
6	4,061	8,614
7	4,575	9,706
8	5,089	10,794
9	5,603	11,886
10	6,118	12,978
Add for additional members	515	1,092

MPG Letter #660 (6/09)

**2.
CMS
Property
Limits**

PROPERTY LIMITS	
CFBU SIZE	LIMIT
1	\$ 2,000
2	3,000
3	3,150
4	3,300
5	3,450
6	3,600
7	3,750
8	3,900
9	4,050
10	4,200

**3.
CMS In-kind
Values**

INCOME IN-KIND VALUES				
EFFECTIVE 7/1/89				
HH SIZE	HOUSING	UTILITIES	FOOD	CLOTHING
1	153	33	86	27
2	206	38	182	49
3	225	40	232	75
4	236	41	286	100

5	236	41	346	126
6	236	41	401	149
7	236	41	447	178
8	236	41	490	199
9	236	41	537	227
10	236	41	582	249

APPENDIX 13A

CMS Hardship Evaluation

The following instructions are to be utilized to process CMS Hardship applications

STEP 1	Determine if the Applicant's monthly net non-exempt income is at or below 350% FPL. Refer to Article A, Section 5, Appendix C for CMS Maintenance Need Levels (MNL)				
	Applicant's monthly net non-exempt income				
	350% FPL				
If Applicant's monthly net non-exempt income is at or less than 350%, go to Step 2.					
STEP 2	Determine Total Monthly Allowable Non-Discretionary Expenses (using chart below)				
		(A) Applicant's Actual Non- Discretionary Expenses	(B) Maximum Allowable Expense (eff 7/1/09)		Applicant's Allowable Expenses (Lesser of A or B)
			for 1	or for 2	
	Housing/Utilities		\$792	\$1,066	
	Transportation		\$424	\$570	
	Food		\$230	\$310	
	Miscellaneous (includes clothing, personal)		\$102	\$137	
	Allowable Out-of -Pocket Health Care Expense Allowance		\$162	\$218	
	Taxes (state and federal taxes deducted from the applicant's earnings, SDI, Social Security, and Medicare.)		Actual		
	Court Ordered Payments (e.g., current child support and alimony)		Actual		
	Payments on Prior Medical Debt		Actual		
	Applicant's Total Monthly Allowable Non-Discretionary Expenses Enter amount in item B below.				

STEP 3	Calculation of Total Monthly Discretionary Income	
	A. Total Gross Monthly Income	
	- B. Total Monthly Allowable Non-Discretionary Expenses	-
	= C. Total Monthly Available Income	=
	<p>Subtract Line B (applicant's Total Monthly Allowable Non-Discretionary Expenses) from Line A (applicant's Total Gross Monthly Income).</p> <p>The remaining amount (Line C) shall be considered the applicant's Total Monthly Available Income.</p>	
STEP 4	<p>Determine Applicant's Monthly Share of Cost</p> <p>The Applicant's Total Monthly Available Income (Line C above) is the Applicant's Monthly Share of Cost.</p>	

MPG Letter #660 (05/09)
