

Medi-Cal Program Guide Letter #662

February 10, 2009

Subject **ARTICLE A — UPDATES TO COUNTY MEDICAL SERVICES (CMS) SHARE OF COST (SOC) PROCESS**

Effective Date Upon Receipt

Reference County Policy

Purpose The purpose of this letter is to provide staff with instructions for:

- Changing a CMS SOC during the certification period; and
- Married couples with a SOC.

Background Effective July 1, 2008, individuals eligible to CMS whose monthly net countable income is above 165% of the Federal Poverty Level (FPL), up to and including 350% FPL may apply for a CMS Hardship and may have a monthly SOC to pay towards their medical/dental care.

Share of Cost Increase When a change in income or other circumstances is reported **before** the 15th of the month which results in an increase to the SOC, the worker will follow the actions in the table below.

Step	Action
1	Request all verifications needed by sending the Informing Letter (CMS-34).
2	Recompute the CMS budget and the CMS Hardship budget when all verifications are received.
3	Increase the SOC effective the following month that the change was reported and send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.
4	Notify the Administrative Services Organization (ASO) of SOC change via Registration Information form (CMS-4). The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and must be scanned into the CMS IT system.
5	Note in the case comments the new SOC amount and the

	effective date.
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When a change in income or other circumstances is reported **after** the 15th of the month which results in an increase to the SOC, the worker will follow the actions in the table below.

Step	Action
1	Request all verifications needed by sending the Informing Letter (CMS-34).
2	Recompute the CMS budget and the CMS Hardship budget when all verifications are received.
3	Increase the SOC for the second month following the month in which the change was reported and send the CMS-39S/CMS-39S(SPAN) notifying the individual of the change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.
4	Notify the ASO of SOC change via CMS-4. The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and must be scanned into the CMS IT system.
5	Note in the case comments the new SOC amount and the effective date.

NOTE: Increases to the SOC require a Notice of Action to be mailed at least 10 days before the increase takes affect.

Share of Cost Decrease

When a change in income or other circumstances is reported which results in a decrease to the SOC and the change was reported within 30 calendar days of the change, the worker will follow the actions in the table below and change the SOC as follows:

Step	Action
1	Request all verifications needed using the CMS-34 Informing Letter.
2	Recompute the CMS budget and the CMS Hardship budget when all verifications are received.
3	Decrease the SOC for the month that the change was occurred and send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.
4	Notify the Administrative Services Organization (ASO) of SOC change via Registration Information form (CMS-4). The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and

	must be scanned into the CMS IT system.
5	Note in the comment section the new SOC amount and the effective date.

If the change is not reported within 30 calendar days of the change, the worker will follow the actions in the table below.

Step	Action
1	Request all verifications needed to recomputed the CMS budget by sending the CMS-34 Informing Letter.
2	Recompute the CMS budget and the CMS Hardship budget when all verifications are received.
3	Decrease the SOC for the month following the month in which the change was reported and send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.
4	Do not change the SOC amount for the month reported unless the beneficiary had good cause for failure to report within 30 calendar days of the change.
5	Notify ASO of change via CMS-4. The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and must be scanned into the CMS IT system.
6	Note in the comment section the reason for not changing the SOC in the current month and the new SOC amount and the effective date.

NOTE: Changes to the budget which cause a decrease to the monthly SOC will change the SOC in the current month if the change is reported within 30 calendar days of the change. The worker must send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change.

Verifications not received

When verifications are not received within the first 10 days the worker sends another CMS-34 giving the beneficiary an additional 10 days to comply. If the verifications are not received after the extended 10 days, there are no changes to the CMS budget. The worker must note in case comments no verifications received, no changes made and the SOC remains the same.

**Married
Couples with
a SOC**

A. BOTH SPOUSES ARE ON CMS WITH A SOC:

- Both spouses must read and sign the SOC Process Information Sheet (CMS-111) which informs them of their SOC payment responsibilities.
- The SOC amount shall be applied to the couple.

The worker must take the following steps to link and apply the SOC amount to the married couple in IDX.

Step	Action
1	Complete Registration Information form (CMS-4) and state the SOC amount for the CFBU. Note on the "Comment Line" that a married couple both on CMS with a SOC has been identified and both spouses Social Security Numbers. <u>Example 1:</u> Married Couple both on CMS w/SOC Identified; SSN xxx-xx-xxxx and SSN xxx-xx-xxxx.
2	Scan CMS-4 into both spouses' case records in the CMS IT System.
3	Send the completed CMS-4 to AmeriChoice at mail stop 0557-B.

B. ONE SPOUSE IS ON CMS WITH A SOC AND THE OTHER SPOUSE IS ON MEDI-CAL WITH A SOC:

- Both spouses must read and sign the SOC Process Information Sheet (CMS-111) which informs them of their SOC payment responsibilities and gives the County authorization to add the Medi-Cal spouse's information to IDX for billing purposes.
- The entire CMS SOC amount shall be applied to the CMS spouse.
- The CMS individual shall be advised that monies spent to meet the Medi-Cal spouse's SOC may be applied to reduce the CMS SOC amount using CMS rates, as long as the services are within the CMS scope of services.
- It is the CMS patient's responsibility to provide the County with an itemized statement and proof of the amount paid towards the MC SOC amount along with their CMS SOC payment statement.
- The ASO has been instructed to forward all statements received with Medi-Cal SOC payments to CMS Program Specialist (PS) at MS 0557A. PS will review MEDS for verification that the Medi-Cal SOC has been met and send the statement back to ASO for processing.

The worker **must** take the following steps to identify that this is a married couple, one on CMS with a SOC and the other on Medi-Cal with a SOC, in order for the paid Medi-Cal SOC amount to be applied to the CMS spouse in IDX.

Step	Action
1	Verify that the SOC Process Information Sheet (CMS-111) has been signed by the applicant and the spouse.
2	Complete Registration Information form (CMS-4) and state the SOC amount for the CFBU. Note on the Comment Line "Married couple with CMS and Medi-Cal SOC". Example 1: Married Couple w/CMS & Medi-Cal SOC identified; Spouse is on Medi-Cal.
3	Scan CMS-4 into the CMS IT System.
4	Send the completed CMS-4 to AmeriChoice at mail stop 0557-B.

Forms Impact The table below shows the forms affected by this letter which have been added to iWay.

Title	Change	Attachment
CMS Notice of Action (CMS 39A)	Revised	A
CMS Notice of Action (CMS 39A)Spanish	Revised	B
CMS Notice of Action (CMS 39S)	New	C
CMS Notice of Action (CMS 39S)Spanish	New	D
CMS Share of Cost Process Information Sheet (CMS-111)	New	E
CMS Share of Cost Process Information Sheet (CMS-111)Spanish	New	F

Quality Assurance Impact

Effective with the March 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

None

Summary of Changes

The table below shows the changes made to the Medi-Cal Program Guide (MPG).

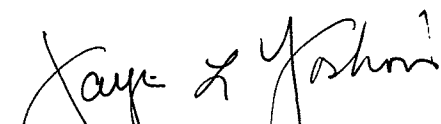
Section	Changes
Article A, Section 5	Add instructions for a decrease to SOC.
Article A, Section 9	New forms CMS-39S/CMS-39S (SPAN) and CMS-111/CMS-111 (SPAN) have been added.

Article A, Section 13	Update and add procedures when a change in SOC occurs and there are spouses with SOCs.
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Important Note

The MPG is available in its entirety on the Internet and can be reached by accessing <http://hhsa-pg.sdcounty.ca.gov>.

Manager Approval


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

SB/JP



COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____

Member #: _____

CMS Representative: _____

To _____

Phone: _____

Location: _____

Address: _____

The following action has been taken on your application for CMS:

- Your application has been approved from _____ through _____ with no Monthly Share of Cost.
- Your application for CMS Hardship has been approved. You are eligible to CMS with the Monthly Share of Cost listed below from _____ through _____.

Your Monthly Share of Cost is: \$ _____.

Comments: _____

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

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

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

- You are potentially linked to disability based Medi-Cal. CMS rules require that you apply for and fully complete the Medi-Cal disability application process for full scope Medi-Cal by applying at the **Family Resource Center** in your area. **You must do this within 10 days from the date of this notice.** Failure to do so may result in future ineligibility to the CMS Program. If you need information on how to apply for Medi-Cal, call the Public Assistance Information (PAI) at (858) 514-6885 or toll free at (866) 262-9881.

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

TO CONTINUE YOUR CMS COVERAGE PAST YOUR CERTIFICATION PERIOD YOU MUST: (1) have an ongoing medical/dental need, (2) have your physician complete the CMS Medical/Dental Need Form (HHSA: CMS-127) that was provided to you today, (3) mail or fax the completed CMS Medical/Dental Need form to: CMS Program Customer Service Supervisor, PO Box 939016, San Diego, CA 92193; (858) 495-1399 before your CMS certification is due to expire, and (4) **call the CMS Eligibility Appointment Line 1-800-587-8118 by the 10th of the month following your CMS expiration month to request a CMS recertification appointment.** You may be eligible to complete your recertification by mail. If you call after the 10th of the month following your CMS expiration month, you will be required to attend a face-to-face-interview.

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

If you disagree with this action, you have the right to request a First Level Supervisory Review. You must do this within fourteen (14) calendar days after the date of this notice in writing or by phone:

You may write to: **OR**
CMS Program (O557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

You may call:
CMS CALENDAR CLERK
(858) 492-2200

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

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

CMS Regulations: _____



COUNTY MEDICAL SERVICES

AVISO DE ACCION

Fecha: _____

Número de Miembro: _____

Para: _____

Representante de CMS: _____

Teléfono: _____

Ubicación: _____

Domicilio: _____

La siguiente acción se ha tomado sobre su solicitud para elegibilidad de CMS:

- Su solicitud ha sido aprobada a partir del _____ hasta el _____ sin Parte de Costo Mensual.
- Su solicitud para la Circunstancia Extrema del Programa CMS ha sido aprobada. Usted es elegible a CMS con Parte de Costo Mensual anotado abajo a partir del _____ hasta el _____.

Su Parte de Costo Mensual es: \$ _____.

Comentario: _____

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

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

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

- Es posible que usted sea elegible a beneficios basados de Medi-Cal por incapacidad. Los reglamentos de CMS requieren que usted solicite y complete totalmente el proceso de la solicitud para beneficios de Medi-Cal por incapacidad. Esta solicitud de Medi-Cal se debe solicitar en el **Centro Familiar de Recursos** en su área. **Usted debe hacer esto dentro de los siguientes diez (10) días de la fecha de esta notificación.** Si no cumple, puede resultar en no ser elegible al Programa de CMS en el futuro. Si necesita información acerca de cómo solicitar Medi-Cal, llame a Información de Asistencia Pública (PAI) al (858) 514-6885 o número sin costo (866) 262-9881.

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

PARA CONTINUAR SU COBERTURA DEL PROGRAMA CMS USTED DEBE DE: (1) tener una necesidad médica/dental continua, (2) pídale a su médico llene el Formulario de Necesidad Médica/Dental Para el Programa CMS (HHSA: CMS-127) que se le ha proporcionado hoy, (3) envíe por correo o mande por fax el Formulario de Necesidad Médica/Dental completo a: CMS Program Customer Service Supervisor, PO BOX 939016, San Diego, A 92193; (858) 495-1399 antes de que su periodo de elegibilidad este programado a terminar, y (4) **llame al la Línea para Cita de Elegibilidad al 1-800-587-8118 para solicitar una cita para renovar el CMS antes del día 10 del mes siguiente que su elegibilidad este programado a terminar.** Tal vez sea elegible para renovar el programa CMS por correo. Si llama después del día 10 del mes siguiente que su elegibilidad este programado a terminar, tendrá que asistir a la entrevista en persona.

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

Si usted no esta de acuerdo con esta acción, usted tiene el derecho de pedir una Revisión de Primer Nivel por un Supervisor. Debe solicitar la revisión dentro de catorce (14) días consecutivos después de la fecha de este aviso escribiendo o llamando a:

Puede escribir a:
CMS Program (0557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

Puede llamar a:
CMS CALENDAR CLERK
(858) 492-2200

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

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

Reglamentos de CMS: _____



COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____

Case # _____

CMS Representative: _____

To _____

Phone: _____

Location: _____

Address: _____

The following action has been taken on your application for CMS:

- Your Monthly Share of Cost has been reduced to \$ _____ from ____ / ____ / ____ through ____ / ____ / ____.
- Your Monthly Share of Cost has been increased to \$ _____ from ____ / ____ / ____ through ____ / ____ / ____.

Here's why: _____

Your Share of Cost was calculated as follows:

Gross Income:	\$ _____
Allowable Expenses:	\$ _____
CMS Net Income:	\$ _____
350% FPL:	\$ _____
Excess Income/SOC:	\$ _____

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

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

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

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

TO CONTINUE YOUR CMS COVERAGE PAST YOUR CERTIFICATION PERIOD YOU MUST: (1) have an ongoing medical/dental need, (2) have your physician complete the CMS Medical/Dental Need Form (HHS: CMS-127) that was provided to you, (3) mail or fax the completed CMS Medical/Dental Need form to: CMS Program Customer Service Supervisor, PO Box 939016, San Diego, CA 92193; (858) 495-1399 before your CMS certification is due to expire, and (4) **call the CMS Eligibility Appointment Line 1-800-587-8118 by the 10th of the month following your CMS expiration month to request a CMS recertification appointment.** You may be eligible to complete your recertification by mail. If you call after the 10th of the month following your CMS expiration month, you will be required to attend a face-to-face-interview.

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

If you disagree with this action, you have the right to request a First Level Supervisory Review. You must do this within fourteen (14) calendar days after the date of this notice in writing or by phone:

You may write to:	OR	You may call:
CMS Program (O557E)		CMS CALENDAR CLERK
FIRST LEVEL SUPERVISORY REVIEW		(858) 492-2200
P.O. BOX 85222		
SAN DIEGO, CA 92186-5222		

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

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

CMS Regulations: _____



COUNTY MEDICAL SERVICES

AVISO DE ACCION

Fecha: _____ Número de Caso: _____

Representante de CMS : _____

Para: _____

Teléfono : _____

Ubicación: _____

Domicilio: _____

La siguiente acción se ha tomado sobre su solicitud para elegibilidad al programa CMS:

Su Parte de Costo se ha reducido a la cantidad de \$ _____ a partir del ___ / ___ /
hasta el ___ / ___ / _____.

Su Parte de Costo se ha aumentado a la cantidad de \$ _____ a partir del ___ / ___ /
hasta el ___ / ___ / _____.

La razón es: _____

La manera cómo se calculó su Parte de Costo es la siguiente:

Ingreso Bruto:	_____
Gastos Permitidos:	_____
Ingreso Neto Para CMS:	_____
350% FPL:	_____
Exceso de Ingreso/Parte de Costo:	_____

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

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

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

recibidos por su cónyuge elegible a Medi-Cal, prueba de la cantidad pagada hacia la Parte de Costo de Medi-Cal y el estado de cuenta cuando envíe su pago al Condado.

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

PARA CONTINUAR SU COBERTURA DEL PROGRAMA CMS USTED DEBE DE: (1) tener una necesidad médica/dental continua, (2) pídale a su médico llene el Formulario de Necesidad Médica/Dental Para el Programa CMS (HHS: CMS-127) que se le ha proporcionado, (3) envíe por correo o mande por fax el Formulario de Necesidad Médica/Dental completo a: CMS Program Customer Service Supervisor, PO BOX 939016, San Diego, CA 92193; (858) 495-1399 antes de que su periodo de elegibilidad este programado a terminar, y (4) **llame al la Línea para Cita de Elegibilidad al 1-800-587-8118 para solicitar una cita para renovar el CMS antes del día 10 del mes siguiente que su elegibilidad este programado a terminar.** Tal vez sea elegible para renovar el programa CMS por correo. Si llama después del día 10 del mes siguiente que su elegibilidad este programado a terminar, tendrá que asistir a la entrevista en persona.

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

Si usted no esta de acuerdo con esta acción, usted tiene el derecho de pedir una Revisión de Primer Nivel por un Supervisor. Debe solicitar la revisión dentro de catorce (14) días consecutivos después de la fecha de este aviso escribiendo o llamando a:

Puede escribir a:
CMS Program (O557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

Puede llamar a:
CMS CALENDAR CLERK
(858) 492-2200

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

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

Reglamentos de CMS: _____

**COUNTY MEDICAL SERVICES (CMS)
SHARE OF COST (SOC) PROCESS INFORMATION SHEET**

This information notice provides a general overview of CMS SOC requirements for all married CMS applicants and beneficiaries who have CMS with a SOC.

Share of Cost (SOC) is defined as: The amount you must pay or be obligated to pay toward the cost of your CMS covered health care services (including CMS approved prescriptions) each month you receive CMS services. You will be billed by the County for your share of cost or the amount of CMS services, whichever is less. You will not be billed for any months in which you did not receive CMS services.

IF BOTH SPOUSES ARE ON CMS WITH A SOC:

- The total SOC amount shall be applied to the married couple.
- You will be billed the amount of your SOC or the amount of CMS services, whichever is less.

You must send your SOC payment along with the billing statement to:

AmeriChoice
County Medical Services (CMS) Program
Attn: Share of Cost Coordinator
P.O. Box 939016
San Diego, CA 92193
Mail Stop: 0557B

IF YOU ARE ON CMS WITH A SOC AND YOUR SPOUSE IS ON MEDI-CAL WITH A SOC:

- The entire CMS SOC amount shall be applied to the CMS spouse.
- Money spent to meet the Medi-Cal spouse's SOC may be applied to reduce the CMS SOC amount using CMS rates, as long as the services are within CMS scope of services.
- It is the CMS patient's responsibility to provide CMS with an itemized statement for services received by the Medi-Cal spouse and proof of the amount paid towards the Medi-Cal SOC amount.
- Medi-Cal spouse's information will be added to the CMS case record for billing purposes.

To be eligible for a CMS SOC deduction, you must send the itemize statement for services received by the Medi-Cal spouse along with your SOC payment and billing statement within 30 days from the date you were notified to:

AmeriChoice
County Medical Services (CMS) Program
Attn: Share of Cost Coordinator
P.O. Box 939016
San Diego, CA 92193
Mail Stop: 0557B

Applicant or Representative Signature

Date

Spouse or Representative Signature

Date

**COUNTY MEDICAL SERVICES (CMS)
INFORMACION SOBRE EL PROCESO DE LA PARTE DE COSTO (SOC)**

Esta hoja de información proporciona una descripción general del requisito de la Parte de Costo del programa CMS para todo solicitante y beneficiario casado elegible a CMS con parte de costo. Parte de Costo (SOC) es definida como: La cantidad que usted debe pagar u obligarse a pagar hacia el costo de sus servicios médicos que cubre CMS (incluyendo medicamentos bajo receta médica aprobadas por el programa CMS) por cada mes que reciba servicios médicos del programa CMS. El Condado le cobrará la cantidad de su parte de costo o la cantidad de sus servicios médicos, la cantidad que sea menor. Usted no recibirá un cobro por ningún mes en el cual usted no recibió servicios médicos de CMS.

SI AMBOS CONYUGES SON ELEGIBLES A CMS CON PARTE DE COSTO:

- La cantidad total de la Parte de Costo será aplicada a la pareja casada.
- Se le cobrará la cantidad de la parte de costo o la cantidad de sus servicios médicos, la cantidad que sea menor.

Envíe el pago de su Parte de Costo junto con el estado de cuenta a la dirección anotada:

AmeriChoice
County Medical Services (CMS) Program
Attn: Share of Cost Coordinator
P.O. Box 939016
San Diego, CA 92193
Mail Stop: 0557B

SI ES ELEGIBLE A CMS CON PARTE DE COSTO Y SU CONYUGE ES ELEGIBLE A MEDI-CAL CON PARTE DE COSTO:

- La cantidad entera de la Parte de Costo de CMS será aplicada al cónyuge elegible a CMS.
- Puede ser que la cantidad que se gastó para satisfacer la Parte de Costo del cónyuge elegible a Medi-Cal se aplique para reducir la Parte de Costo de CMS usando la cantidad del precio que usa CMS, siempre y cuando los servicios médicos recibidos son parte del criterio de cobertura del programa CMS.
- Es la responsabilidad del paciente CMS proporcionarle al programa CMS un estado detallado de los servicios recibidos por su cónyuge elegible a Medi-Cal y prueba de la cantidad pagada hacia la Parte de Costo de Medi-Cal.
- La información del cónyuge elegible a Medi-Cal será incluida en el caso de CMS para la facturación.

Para ser elegible a la deducción de Parte de Costo de CMS, debe de enviar el estado detallado de los servicios recibidos por su cónyuge elegible a Medi-Cal junto con el pago de su Parte de Costo de CMS y estado de cuenta dentro de 30 días de la fecha en que fue notificado a:

AmeriChoice
County Medical Services (CMS) Program
Attn: Share of Cost Coordinator
P.O. Box 939016
San Diego, CA 92193
Mail Stop: 0557B

Firma del Solicitante o Representante

Fecha

Firma del Cónyuge o Representante

Fecha

A.5.1

Income

E. Anticipating Income

Refer to MPG Article A, Section 13.4 if the change in income will result in a decrease to the Share of Cost (SOC).

EXAMPLE: The applicant is unable to work because of an illness or injury. In the month of the application, the applicant's earnings exceed the CMS Hardship MNL; however, in the following month anticipated disability benefits are below the CMS Hardship MNL. The worker certifies CMS SOC beginning with the month following the month of application.

EXAMPLE: The applicant is unable to work because of an illness or injury. In the month of the application, net countable income equals 170% of the FPL. The applicant is eligible to CMS Hardship eligibility and may have a SOC in month one; however, the following month, anticipated disability income is below 165% of the FPL. The applicant shall be certified for CMS Hardship for the month of application and standard CMS beginning in month two and continuing through the end of the normal certification period. Both approvals shall be recorded on the approval notice of action.

b) Increase

When monthly net non-exempt income is equal to or less than 350% of the FPL in the month of application, but the applicant expects the income to exceed the maximum 350% FPL in the following month, the worker certifies CMS for the month of application only.

Refer to MPG Article A, Section 13.4 if the change in income will result in a increase to the Share of Cost (SOC).

A.13.4

Changes to CMS Share of Cost (SOC)

General

Changes in income may require an adjustment to the monthly SOC. The SOC may need to be increased or decreased according to income level. See MPG Article 12, Section 1.3.4

A. Share of Cost Increase

When a change in income or other circumstances is reported **before** the 15th of the month which results in an increase to the SOC, the worker will follow the actions in the table below.

Step	Action
1	Request all verifications needed to accurately calculate the change by sending the Informing Letter (CMS-34).
2	Recompute the CMS budget and the CMS Hardship budget once all verifications are received.
3	Increase the SOC effective the following month that the change was reported and send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.
4	Notify the Administrative Services Organization (ASO) of SOC change via Registration Information form (CMS-4). The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and must be scanned into the CMS IT system.
5	Note in the case comments the new SOC amount and the effective date.

When a change in income or other circumstances is reported **after** the 15th of the month which results in an increase to the SOC, the worker will follow the actions in the table below.

Step	Action
1	Request all verifications needed by sending the Informing Letter (CMS-34).
2	Recompute the CMS budget and the CMS Hardship budget when all verifications are received.
3	Increase the SOC for the second month following the month in which the change was reported and send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.

4	Notify the ASO of SOC change via CMS-4. The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and must be scanned into the CMS IT system.
5	Note in the case comments the new SOC amount and the effective date.

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**B.
Share of Cost
Decrease**

When a change in income or other circumstances is reported which results in a decrease to the SOC and the change was reported within 30 calendar days of the change, the worker will follow the actions in the table below and change the SOC as follows:

Step	Action
1	Request all verifications needed using the CMS-34 Informing Letter.
2	Recompute the CMS budget and the CMS Hardship budget when all verifications are received.
3	Decrease the SOC for the month that the change was occurred and send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.
4	Notify the Administrative Services Organization (ASO) of SOC change via Registration Information form (CMS-4). The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and must be scanned into the CMS IT system.
5	Note in the comment section the new SOC amount and the effective date.

If the change is not reported within 30 calendar days of the change, the worker will follow the actions in the table below.

Step	Action
1	Request all verifications needed to recomputed the CMS budget by sending the CMS-34 Informing Letter.
2	Recompute the CMS budget and the CMS Hardship budget when all verifications are received.
3	Decrease the SOC for the month following the month in which the change was reported and send the CMS-39S/CMS-39S (SPAN) notifying the individual of the

	change. The CMS-39S NOA is part of the case record and must be scanned into the CMS IT system.
4	Do not change the SOC amount for the month reported unless the beneficiary had good cause for failure to report within 30 calendar days of the change.
5	Notify ASO of change via CMS-4. The CMS-4 must include the new SOC amount and the effective date. The CMS-4 is part of the case record and must be scanned into the CMS IT system.
6	Note in the comment section the reason for not changing the SOC in the current month and the new SOC amount and the effective date.

NOTE: Changes to the budget which cause a decrease to the monthly SOC will change the SOC in the current month if the change is reported within 30 calendar days of the change. The worker must send the CMS-39S/CMS-39S (SPAN) notifying the individual of the change.

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**C.
Married
Couples with
a SOC**

A. BOTH SPOUSES ARE ON CMS WITH A SOC:

- Both spouses must read and sign the SOC Process Information Sheet (CMS-111) which informs them of their SOC payment responsibilities.
- The SOC amount shall be applied to the couple.

The worker must take the following steps to link and apply the SOC amount to the married couple in IDX.

Step	Action
1	Complete Registration Information form (CMS-4) and state the SOC amount for the CFBU. Note on the "Comment Line" that this is a married couple with a SOC and both spouses Social Security Numbers. <u>Example 1:</u> Married Couple both on CMS w/SOC Identified; SSN xxx-xx-xxxx and SSN xxx-xx-xxxx;
2	Scan CMS-4 into both spouses' case records in the CMS IT System.
3	Send the completed CMS-4 to AmeriChoice at mail stop 0557-B.

B. ONE SPOUSE IS ON CMS WITH A SOC AND THE OTHER SPOUSE IS ON MEDI-CAL WITH A SOC:

- Both spouses must read and sign the SOC Process Information Sheet (CMS-111) which informs them of their SOC payment responsibilities and gives the County authorization to add the Medi-Cal spouse's information to IDX for billing if needed.
- The entire CMS SOC amount shall be applied to the CMS spouse.
- The CMS individual shall be advised that monies spent to meet the Medi-Cal spouse's SOC may be applied to reduce the CMS SOC amount using CMS rates, as long as the services are within CMS scope of services.
- It is the CMS patient's responsibility to provide the County (ASO) with an itemized statement and proof of the amount paid towards the MC SOC amount along with their CMS SOC payment statement.
- The ASO has been instructed to forward all statements received with Medi-Cal SOC payments to the CMS Program Specialist (PS) at MS 0557A. The PS will review MEDS for verification of Medi-Cal SOC met and send the statement back to ASO for processing.

The worker **must** take the following steps to identify that this is a married couple, one on CMS a with a SOC and the other on Medi-Cal with a SOC, in order for the paid Medi-Cal SOC amount to be applied to the CMS spouse in IDX.

Step	Action
1	Verify that the Share of Cost Process Information Sheet (CMS-111) has been signed by the applicant and the spouse.
2	Complete Registration Information form (CMS-4) and state the SOC amount for the CFBU. Note on the comment Line "married couple with a CMS and Medi-Cal SOC". <u>Example:</u> Married Couple w/ CMS & Medi-Cal SOC identified; Spouse on Medi-Cal.
3	Scan CMS-4 into the CMS IT System.
4	Send the completed CMS-4 to AmeriChoice at mail stop 0557-B.

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D. Verifications

When verifications are not received within the first 10 days the worker sends another CMS-34 giving the beneficiary an additional 10 days to

not received

comply. If the verifications are not received after the extended 10 days, there are no changes to the CMS budget. The worker must note in case comments no verifications received, no changes made and the SOC remains the same.

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