Medi-Cal Program Guide Letter #674

May 20, 2009

Subject **ARTICLE A – SNEEDE V. KIZER AND GAMMA V. BELSHE PROCEDURES FOR COUNTY MEDICAL SERVICES (CMS)**

Effective Date Upon receipt

Reference County Policy

Purpose The purpose of this letter is to inform staff of a program change to the Sneede v. Kizer and Gamma v. Belshe procedures.

Background CMS follows Medi-Cal court order regulations for Sneede v. Kizer and Gamma v. Belshe. The court order does not impact any existing Medi-Cal regulations on linkage. Workers will continue to determine the Medi-Cal Family Budget Unit (MFBU) composition and Medi-Cal linkage as specified under existing Medi-Cal regulations. These procedures must be applied to cases which have a stepparent, child with own income or property, unmarried couple with mutual children, or caretaker relative who is an eligible member of the same MFBU with the children for whom care is provided, AND there is a share of cost or ineligibility due to excess property under the existing regulations.

Change Since CMS was not a party to the lawsuit, CMS will partially adopt the Sneede v. Kizer and Gamma v. Belshe court order regulations set forth in Medi-Cal. These procedures/rules will **only apply** to CMS/ Medi-Cal combination cases where the applicant has applied for both CMS and Medi-Cal and the Medi-Cal eligibility determination requires the use of these regulations. These procedures are not applicable and must not be used in CMS only cases where the applicant has only applied for CMS.

A. CMS/Medi-Cal Combination Cases:

- All income and/or property allocated to a CMS applicant and to his/her spouse, if applicable, from a Sneede and Gamma calculation will be considered countable income and/or property for CMS.
- The number of persons in the CMS FBU will consist of **only** the CMS applicant and his/her spouse, if applicable.

B. CMS Only Cases

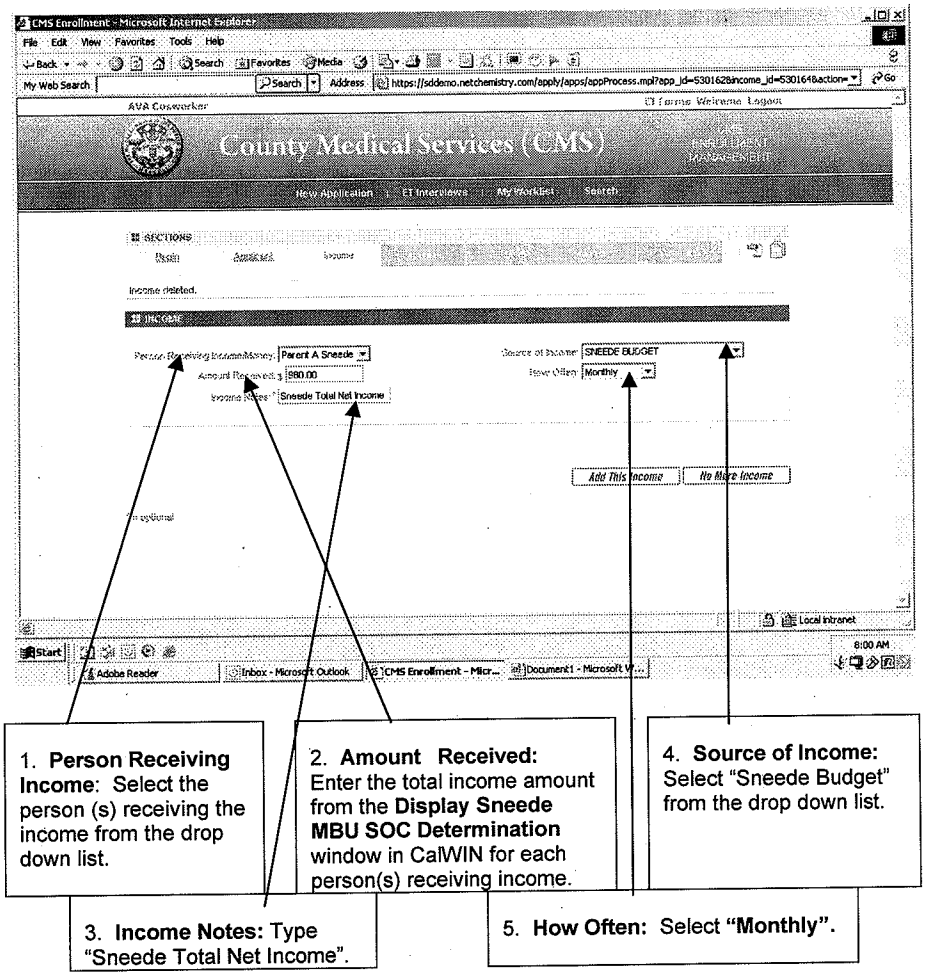
- There is no allocation of income and property between spouses and from parent to child.
- **Only** the CMS applicant's income and/or property and the income and/or property of his/her spouse, if applicable, will be considered countable income and/or property for CMS.
- The number of persons in the CMS FBU will consist of the CMS applicant, his/her spouse, if applicable, and **all** natural or adoptive minor children living in the home.

CMS IT System Impact

The total income amount allocated from a Sneede v. Kizer calculation in CalWIN will be counted as income for the CMS applicant and/or spouse, if applicable, in AuthMed.

Workers must make the following modifications to their usual AuthMed entries to correctly enter income information collected from the **Display Sneede MBU SOC Determination** window in CalWIN.

A. From the **Income** window in AuthMed, enter the following information:



** Enter information and click "Add This Income". Based on this action, AuthMed will automatically calculate the budget. Once you have noticed that the income has been added for all applicable CFBU members, you can click on "No More Income".

Forms Impact

None.

Quality Assurance Impact

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

Summary of Changes

The table below shows the changes made to the Program Guide.

Article	Changes
Article A, Section 2, Item 2	Removed reference to Sneede and Gamma rules.
Article A, Section 3, Item 5	Sneede and Gamma procedure update.

Manager Approval

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

JP

A.3.5

Sneede and Gamma FBU

General

Since CMS was not a party to the lawsuit, CMS will partially adopt the Sneede v. Kizer and Gamma v. Belshe court order regulations set forth in Medi-Cal. The procedures will **only apply** to CMS/Medi-Cal combination cases where the applicant has applied for CMS and Medi-Cal and the Medi-Cal eligibility determination requires the use of these regulations. These procedures are not applicable and must not be used in CMS only cases where the applicant has only applied for CMS.

CMS/Medi-Cal Combination Cases:

Answer the Sneede income screening questions on form MC 175-I to determine when to use Sneede regulations. Procedures for determining income and/or property according to Sneede and Gamma rules are located in MPG Article 5, Section 14.

- All income and/or property allocated to a CMS applicant and to his/her spouse, if applicable, from a Sneede and Gamma calculation will be considered countable income and/or property for CMS.
- The number of persons in the CMS FBU will consist of **only** the CMS applicant and his/her spouse, if applicable.

CMS only Cases:

- There is no allocation of income and property between spouses and from parent to child.
- **Only** the CMS applicant's income and/or property and the income and/or property of his/her spouse, if applicable, will be considered countable income and/or property for CMS.
- The number of persons in the CMS FBU will consist of the CMS applicant, his/her spouse, if applicable, and **all** natural or adoptive minor children living in the home.

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A.2.2

Hospital Outstationed Services (HOS)

E. Case Handling

1) Case Folder

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 patient's Medi-Cal eligibility.

a) CMS only FBU

When the FBU contains only adults, the HOS worker creates an electronic case in the CMS IT system. The manual non-automated CMS case folder will be requested from Record Library (RL) for review only and then returned to RL for storage.

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

c) If there is an existing non-automated case file at another eligibility site, the worker may request the case folder to retrieve previously received verifications. There should not be a new case folder created.

d) Prior to March 2007, CMS only cases were tracked using the case name only. As of March 2007, in order to prepare for the eventual storage of all CMS cases at the County Record Library, case folders shall be manually created and a case number shall be assigned. Workers shall manually create or convert new and existing case folders to a 6-digit case number.

e) As of July 1, 2008, CMS eligibility determinations are automated. Workers will enter applicant information directly into the CMS IT System, AuthMED, there is no paper case file created. The CMS IT System will assign case numbers to each applicant. The applicant will retain this case number throughout the lifetime of the CMS case.

2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in Article 4, Section 13 of the MPG. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 4-13-3B (1), the worker prints the automated #936 from the CMS IT System, to inform CMS applicants that they have an additional 10 days to provide the verifications that were not provided during the initial 10-day period.

3) Denial – Excess Income

Income is a CMS eligibility factor. The worker inputs the applicant information directly into the CMS IT System, and the system will determine whether or not the CFBU is within the CMS income limits and to which CMS eligibility category (CMS or CMS Hardship) the patient may be certified for. When the patient is not eligible to CMS due to excess income (more than 165% FPL up to and including 350% FPL) and is otherwise eligible, the patient may apply for a CMS Hardship Evaluation. Refer to Article A, Section 13 for additional information. The worker shall not deny the case, but will continue to evaluate whether the patient is eligible for a CMS Hardship evaluation. The worker shall advise the patient of the repayment agreement and the 10 day deadline in which to provide any pending verifications.

When denying the application for excess income (more than 350% FPL), it is imperative that the correct CFBU size as well as both the total gross and the net countable income used in the determination are reflected. NOA HHSA: CMS-39D is provided to the CMS applicant, indicating reason for denial and the budget used in the determination.

4) CMS Approved – No Medi-Cal Disability Evaluation (DDSD Pending

Workers enter the applicant information directly into the CMS IT System to certify CMS applications. The Notice of Action CMS-39A is used to inform the applicant of the approval and the eligibility category to which they have been approved.

5) CMS Approved – Medi-Cal Disability Evaluation (DDSD) Pending

The worker opens an automated Medi-Cal case on CalWIN and

places it in a pending status. The worker must also evaluate for retroactive Medi-Cal when the applicant/ beneficiary has had CMS coverage in the retroactive period. The HOS worker shall assist applicants, as needed, with the Medi-Cal application process including helping them complete the Statement of Facts and DDSD packet (see Medi-Cal Linkage in Article A, Section 2, Item 5 for more instructions). **(The HOS worker CANNOT approve CMS until the Medi-Cal application and DDSD packet are received fully completed and all eligibility and verification requirements for both Medi-Cal and CMS have been met.)** In addition, CMS should not be certified if there is a pending fraud investigation on the Medi-Cal application. The date the DDSD packet was sent must be recorded on the CalWIN Disability screen within 30 days from the date of application.

Reminder: Per MPG 5-4.2, DDSD's must be submitted within 10 days of receipt of the Statement of Facts.

Note: If CalWIN Disability Screen input is not completed within 30 days from the date of application, all CalWIN entries will fail. The worker records the CMS certification period and the date the DDSD packet was sent in the case comments of the CMS and Medi-Cal case. Example: CMS 5/05-10/05, MC P (xx/xx application date) DDSD sent 6/12/05. This entry alerts the DDSD Recovery Specialist that there is potential reimbursement from Medi-Cal to CMS. The HOS worker then sends the Medi-Cal case to the DDSD workers at the Family Resource Centers (FRC). IDX screen prints reflecting CMS eligibility and IDX comments must be in the case file as referenced in MPG Article 4, Section 2.7(C). Upon approval or denial of Medi-Cal, the DDSD FRC worker sends form 14-10 HHSA to the ASO at O-557B. The CMS case is sent to HQ for filing in the Record Library.