Medi-Cal Program Guide Letter #711

September 21, 2010

Subject	**ARTICLE A- HEALTH CARE COVERAGE INTIATIVE (CI) OPEN ENROLLMENT**
Effective Date	Upon receipt
Reference	County Policy
Purpose	To inform staff of CMS eligibility requirement changes as a result of CI open enrollment.
Background	CI is a federally funded program for individuals meeting CI eligibility criteria, and is dependent on funding and enrollment limits. CMS workers screen, evaluate, and enroll individuals into the CI program only during the open enrollment period. Open enrollment for the CI program ended January 31, 2009.
CI Open Enrollment	Open enrollment for the CI program begins in September 2010.
Change	Upon notification from CI that enrollment has been opened, workers are to apply these CMS eligibility requirement changes to applications with an application date on or after the issue date of the CI Program Guide open enrollment letter. During CI open enrollment, applicants or CMS beneficiaries meeting the CI eligibility criteria and who choose one of the CI clinics as their primary care clinic (PCC) will not be eligible for CMS and must comply with all CI eligibility requirements to be determined eligible. An applicant or CMS beneficiary who does <u>not</u> meet the CI eligibility criteria can select a CI or CMS clinic as their PCC. An applicant or CMS beneficiary who does not select a CI clinic as their PCC can only be evaluated for CMS.

CI eligibility criteria includes a monthly net non-exempt family income at or below 200% of the Federal Poverty Level (FPL). Refer to the CI Program Guide for a complete listing of eligibility criteria.

Exemptions:
If any of the following conditions apply, an applicant or CMS beneficiary does not meet the CI criteria and shall be evaluated for CMS:

- Monthly net non-exempt family income is above 200%.
- Legal Permanent Resident (LPR) status does not meet the five year resident requirement. Exceptions to the 5 year residency requirement are listed in the CI Program Guide.
- Monthly net non-exempt family income is between 101-200% FPL and has access to health insurance coverage within the last three months.
- Any other exemption as indicated in the CI Program Guide

HHSA: CMS-39D (Eng/Span) Eligibility Denial Notice of Action
The CMS eligibility denial NOA has been revised to include the CI linkage denial reason information (Attachment A/B).

Required Action

Once CI open enrollment has started, eligibility workers must:

- Process the CI and CMS applications concurrently.
- Determine if the applicant or CMS beneficiary meets the CI eligibility criteria.

If...	Then evaluate eligibility for...
yes,	CI only, and approve or deny as appropriate.
no,	CMS only, and approve or deny as appropriate

Forms Impact

The table below shows the revised notice affected by this letter.

Form #	Title	Action	Attachment
CMS-39D (Eng/Span)	Eligibility Denial Notice	Revised	A & B

The revised notice has been uploaded into iWay and is available to be ordered.

CMS IT System

The revised CMS-39D NOA has been uploaded into the CMS IT System.

Quality Assurance

Effective with the November 2010 sample month, Quality Assurance will cite with the appropriate error any case that does not follow the requirements of this letter.

ACCESS Impact

When ACCESS staff receives a call regarding CMS/CI they are to refer the customer to call 1-800-587-8118 for assistance.

Summary of Changes

The table below shows the changes to Article A of the MPG.

Section	Change
Article A, Section 2, Item 2	• Reference to CI Case Processing added.
Article A, Section 2, Item 3	• Reference to CI Case Processing added.
Article A, Section 2, Item 6	• Item renumbered. • CI program process updated.

Manager Approval

for J. Bowman

Janya Bowman, Assistant Deputy Director
Health Care Policy Administration
Strategic Planning and Operational Support Division

JP

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

Date: _____ Member ID#: _____

CMS Representative: _____

CMS Representative #: _____

To: _____ Phone: _____

_____ Location: _____

_____ Address: _____

_____

_____

Your application for County Medical Services (CMS) dated ___/___/___ is denied for the following reason(s):

- ☐ Not a Citizen/Eligible Alien
- ☐ Not a County Resident
- ☐ Lien Forms Not Completed
- ☐ Failed to Attend Recertification Appointment
- ☐ Recertification Mail-in Packet Not Received Timely
- ☐ Coverage Initiative (CI) Linkage
- ☐ Application Withdrawn
- ☐ Medi-Cal Linkage
- ☐ Whereabouts Unknown
- ☐ Failed to Complete Medi-Cal Process
- ☐ Credit Report Form Not Completed
- ☐ Your CMS net income is more than 350% of the Federal Poverty Level (FPL)

Source of Income:	_____
Gross Income:	$ _____
Deductions:	$ _____
CMS Net Income:	$ _____
Maintenance Need (CMS):	$ _____
Excess Income:	$ _____

- ☐ You failed to provide _____

_____

SEE IMPORTANT NOTE ON REVERSE

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

☐ Excess Property

Nonexempt Property Items	Net Market Value
_____	$_____
_____	$_____
_____	$_____
_____	$_____

Total Nonexempt Property	$_____
Property Limit	-$_____
Excess Property	=$_____

To become eligible for CMS, you must spend the amount of your excess property by paying for health care that you received. The health care must be within the CMS scope of services. You may also spend it on current month rent or mortgage and current month utilities excluding cable TV. Talk to the CMS Representative listed above if you want to request this allowance. You must give proof of spending the amount of _____for the month of _____ to the CMS Representative listed above within **30 days** of the date of this notice.

IF YOUR SITUATION CHANGES, YOU MAY REAPPLY FOR CMS AT ANY TIME

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

OR

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: _____

Para: _____

_____

_____

No. de Miembro: _____

Representante de CMS: _____

No. del Representante de CMS: _____

Teléfono: _____

Ubicación: _____

Domicilio: _____

_____

_____

Su solicitud para County Medical Services (CMS) con fecha ___/___/___ ha sido negada por la(s) siguiente(s) razón(es):

- ☐ No es Ciudadano/Extranjero Elegible
- ☐ No es Residente del Condado
- ☐ Faltó de Completar las Formas de Gravamen
- ☐ No Se Presentó a la Entrevista Para Renovar los Beneficios de CMS
- ☐ El Paquete Para Renovar el Programa CMS No Se Recibió a Tiempo
- ☐ Está unido a Coverage Initiative
- ☐ Solicitud Retirada
- ☐ Está unido a Medi-Cal
- ☐ Se Desconoce Donde Se Encuentra
- ☐ No Completó el Proceso del Programa Medi-Cal
- ☐ No Completó La Forma del Reporte de Crédito
- ☐ Su ingreso neto para el Programa CMS es más de 350% del Nivel de Pobreza Federal (FPL).

Fuente de Ingresos:	_____
Ingreso Bruto:	$ _____
Deducciones:	- $ _____
Ingreso Neto:	$ _____
Necesidad Para Mantenimiento (CMS):	- $ _____
Exceso de Ingreso:	$ _____

- ☐ Falto de proporcionar _____

FAVOR DE VER LA INFORMACION IMPORTANTE AL REVERSO

COUNTY MEDICAL SERVICES
AVISO DE ACCION

☐ Exceso de Propiedad

Artículos de Propiedad no Exentos	Valor Neto de Mercado
_____	$_____
_____	$_____
_____	$_____
_____	$_____

Propiedad/recursos no exentos en Total $_____
Limite de propiedad/recursos -$_____
Propiedad/recursos excedente =$_____

Para poder ser elegible al programa CMS, debe de gastar la cantidad en exceso de su propiedad/ recursos pagando por servicios médicos que haya recibido. Los servicios médicos deben ser parte del criterio de cobertura del programa CMS. También puede gastar la cantidad pagando su renta/ abono de casa o pagando los servicios públicos, excluyendo pago de televisión por cable, para el mes actual. Debe comprobar cómo gastó la cantidad de $_____para el mes de _____al Representante de CMS anotado arriba dentro de **30 días** a partir de la fecha de esta notificación.

SI SU SITUACIÓN CAMBIA, USTED PUEDE VOLVER A SOLICITAR EL CMS EN CUALQUIER MOMENTO.

Si usted no está 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 éste aviso escribiendo o llamando a:

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

O

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.

CMS Regulations:

A.2.2 Hospital Outstationed Services (HOS)

E. Case Processing

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, 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 MPG 04.13 of the MPG. If required verifications have not been provided after the

initial 10 days have passed as outlined in MPG 04.13.02, the worker prints a second Verification Checklist 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. If the requested information is not returned within the standard ten-ten (10/10) timeline and good cause is not determined, the worker will deny the application for failure to provide.

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 A.13.0 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) Coverage Initiative (CI) Eligibility

Refer to A.2.6.

5) 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.

6) 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.2.5 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.** CMS should not be certified if there is a pending fraud investigation on the Medi-Cal 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 04.02.10D . Upon approval or denial of Medi-Cal, the DDSD FRC worker sends form 14-10 HHSA to the ASO at 0557B. The CMS case is sent to HQ for filing in the Record Library.

MPG LTR #711 (09/10)

A.2.3 Primary Care Clinics and Public Health Centers

D. Case Processing

1) Case Folder

Workers create an electronic case in the same manner as HOS. Refer to A.2.2E1a) and A.2.2E1c).

2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in MPG 04.13. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 04.13.02, the worker prints the CMS automated letter from the CMS IT System, Reminder Request for Verifications. This letter must be sent as a reminder notice to CMS applicants to inform them that they have an additional 10 days to provide verifications that were not provided during the initial 10-day period. If the requested information is not returned within the standard ten-ten (10/10) timeline and good cause is not determined, the worker will deny the application for failure to provide.

3) Denial – Excess Income

Workers are to follow the same process as HOS. Refer to A.2.2.E3).

4) Coverage Initiative (CI) Eligibility

Refer to A.2.6.

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

Workers at Primary Care Clinics and Public Health Centers may certify CMS eligibility for up to three months after directing an applicant/beneficiary to apply for Medi-Cal. The worker will print the MC-210 from the CMS IT System and give it to the applicant. The worker must specify on the MC-210 the beginning month for the Medi-Cal DDSD application and retroactive months as needed. Retroactive Medi-Cal is needed when the applicant/beneficiary has had CMS coverage in the retroactive period. Workers shall assist those who need help completing the Statement of Facts (MC 210) and Supplemental Statement of Facts (MC 223), etc. The worker must inform the applicant verbally and on the Notice of Action that CMS will not be recertified until they fully complete the Medi-Cal application process. After the three-month period, CMS cannot be approved until the worker verifies the applicant/beneficiary has fully complied in completing the Medi-Cal application process; met all Medi-Cal eligibility and verification requirements; and the Medi-Cal application is pending on CalWIN with the date the DDSD packet was sent. (See Medi-Cal Linkage in A.2.5 for more instructions).

A.2.6 Linkage to Coverage Initiative (CI)

General

CI is a federally funded program for individuals meeting CI eligibility criteria and is dependent on funding and enrollment limits. Refer to the CI Program Guide for a complete listing of eligibility criteria.

Upon processing of applications during CI open enrollment:

If the applicant or CMS beneficiary...	And if they...	Then they…
meets the CI eligibility criteria,	choose one of the CI clinics as their primary care clinic (PCC),	will not be eligible to CMS and must comply with all CI eligibility requirements.
	do NOT choose one of the CI clinics as their PCC,	cannot be enrolled in CI and must comply with all CMS eligibility requirements.
Does NOT meet the CI eligibility criteria,	choose or do not choose one of the CI clinics as their PCC,	

MPG LTR #711 (09/10)

A.
CI Linkage

The worker must take the following actions to determine whether or not the applicant or CMS beneficiary is linked to the CI program and must comply with all CI eligibility requirements.

Step	Action
1	Determine if applicant or CMS beneficiary meets the CI eligibility criteria as specified in Section 2 of the CI Program Guide.

If...	Then...
yes,	evaluate for CI only .
no,	evaluate for CMS only.

2	Determine if there is any other exemption category that would make the individual not eligible to CI as specified in Section 2 of the CI Program Guide. **If...** / **Then...** yes, / evaluate for CMS only. no, / proceed to step 3.
3	Deny CMS in the CMS IT System for CI linkage. Approve or deny CI as appropriate.

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B. Verification Requirements

Until it has been determined that the applicant or CMS beneficiary meets CI criteria, the worker will process the CI and the CMS applications concurrently. The worker is to provide the pending verifications checklist to the applicant informing them of the 10 day requirement to provide verifications needed for both CI and CMS. The worker may refer the applicant to the Certified Applicant Assistor (CAA) for assistance in getting verifications needed for CI.

The 10/10 process will apply for all pending verifications for both programs.

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C. Case Processing

Workers must determine whether the applicant or CMS beneficiary meets the CI eligibility criteria.

If...	Then the worker will...
yes,	• Evaluate eligibility for CI only. • Approve or deny CI as appropriate. • Deny CMS in the CMS IT system for CI Linkage.
no,	• Evaluate eligibility for CMS only. • Approve and deny as appropriate.

MPG LTR #711(09/10)

D. Coverage Initiative (CI) Open Enrollment

The CI program is dependent on funding and enrollment limits. Enrollment will occur only during open enrollment periods. Open enrollment periods are defined via CI Special Notices. CMS eligibility workers will screen, evaluate and enroll individuals into the CI program only during the open enrollment

period.