Medi-Cal Program Guide (MPG) Letter #760

October 29, 2012

Subject	ARTICLE A – LOW INCOME HEALTH PROGRAM (LIHP) RIGHTS AND RESPONSIBILITIES OF APPLICANTS
Effective Date	Upon receipt.
Reference	County Policy
Purpose	To inform staff of a change in policy regarding the applicant's/enrollee's requirement to sign the LIHP-15 Low Income Health Program (LIHP) Rights and Responsibilities of Applicants form.
Background	Currently, as a condition of eligibility, all LIHP applicants/enrollees must sign the LIHP-15 form at initial application, recertification and reapplication acknowledging that they have reviewed and understand their rights and responsibilities under LIHP.
Highlighted Changes	In an effort to align with Medi-Cal policy, the LIHP applicant/enrollee is not required to sign or return the LIHP-15 as a condition of eligibility; therefore, the worker shall not deny case if the LIHP-15 is not signed or returned to the County. The LIHP-15 (Eng/Span) (Attachments A/B) has been revised to: • indicate in the signature line that a signature is optional; • include a "County Use Section" for worker to complete; and • change the revision date of the form to: (09/12) The CMS-107 (Eng/Span) (Attachment B/C) has been revised to: • Change the revision date for the LIHP-15 listed on the form to (09/12); and • Change the revision date of the form to: (09/12)

County Use Section and scanning the LIHP-15 in the case file prior to providing the LIHP-15 to the applicant/enrollee.

ACCESS Impact

No impact.

CMS IT System Impact

The revised LIHP-15 and CMS-107 have been uploaded into the CMS IT System (AuthMed) for printing.

Forms Impact

The revised LIHP-15 and CMS-107 are available in Xerox Print Services for ordering.

Quality Assurance Impact

Effective with the November 2012 review month, Quality Assurance will cite with the appropriate error any case that does not follow the requirements of this letter.

Summary of Changes

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

Article	Changes
A.01.03A	Update to the R&R signature requirement.
A.02.01K	Update to the R&R signature requirement.

Approval for Release

[signature], Dep. Director 10-31-12

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LOW INCOME HEALTH PROGRAM

RIGHTS AND RESPONSIBILITIES OF APPLICANTS

I am applying for the Low Income Health Program (LIHP) from the County of San Diego for myself or for ____.

I fully understand I have the following Rights and Responsibilities as part of my application for, and receipt of LIHP.

RIGHTS - I HAVE THE RIGHT TO:

1. Apply for LIHP and to be told **IN WRITING** whether or not I qualify.
2. Be notified of an action taken to discontinue my LIHP eligibility at least ten days prior to the first of the month in which the action becomes effective.
3. Request an appeal if I do not agree with the LIHP eligibility decision(s), or LIHP denial of health services. I must request the review within the timeframe stated on my notice.
4. File a grievance if I am dissatisfied about other matters, as described in the LIHP "Your Grievance and Appeal Rights" document. I must request the grievance within the timeframe stated on the LIHP "Your Grievance and Appeal Rights" document.
5. Talk to LIHP staff that can help me with my questions, problems, complaints, and or file a grievance.
6. Be treated fairly and equally whatever my race, color, religion, national origin, sex, age or political beliefs.
7. Free language, visual and hearing impairment assistance.
8. Privacy and to have all information that I give to the LIHP kept in confidence, except as required or allowed by law.
9. Choose my medical provider and Primary Care Physician within the limits of the program.
10. Reasonable access to health care services through the LIHP.
11. Be treated with courtesy and respect, to receive clear explanations of my health problems and to participate in decisions about treatment of my health problems.
12. Request or refuse medical treatment.
13. Request a second opinion if I do not agree with the medical care or the treatment plan prescribed for me by my medical care provider.
14. Information about the right to have an Advance Health Care Directive. If I already have one and wish to bring a copy, my provider will add it in my medical record.

RESPONSIBILITIES - I HAVE THE RESPONSIBILITY TO:

1. Give accurate information to the LIHP Representative.
2. Report to the LIHP Representative any changes that occur within 10 days of the change by calling 1-888-553-5552. These changes include, but are not limited to, the following:
   - ✓ My income or a family member's income from any source changes, or our employment situation changes.
   - ✓ I plan to move or change my mailing address.
   - ✓ A family member moves in or out of my home.
   - ✓ I receive, transfer, give away or sell any item of real or personal property.
   - ✓ I or a member of my family become pregnant or become so physically or mentally ill that we cannot work.
   - ✓ I or a member of my family apply for or become eligible to financial benefits from a State, County or Federal Program. Examples include, but not limited to, Social Security benefits, Veterans Administration benefits, CalWORKs, or Disability Compensation.
   - ✓ I have filed an appeal with the Social Security Administration relating to the denial of my disability benefits.
3. Report to the LIHP Representative and use any health care coverage, including insurance, I carry or am entitled to use.
4. Report to the LIHP Representative when LIHP has provided or will provide health care services for an accident or injury which may be covered by 1) my own insurance company or 2) from a third party when I file a lawsuit or

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lawsuit is filed on my behalf, and the action results in a judgment awarded to me.

5. Repay LIHP from third party recovery, including lawsuits.
6. Calling my primary care provider for medical advice FIRST, except in an emergency.
7. Arriving on time for my scheduled appointments.
8. Letting my medical care providers know if I do not understand my treatment plan or what is expected of me, and if I agree to the treatment recommendations, following my medical care providers' instructions.
9. Giving accurate and complete information about my present condition and past illnesses to my medical care providers.
10. Treating providers and LIHP staff with respect and dignity.
11. Cooperate with doctors and nurses in receiving LIHP health services. This includes receiving all health services through the LIHP authorized medical provider, keeping doctor's appointments, and following all treatment plans and instructions given to me by my health care provider.

UNDERSTAND - I FULLY UNDERSTAND THAT:

1. Enrollment discrimination and disenrollment discrimination is prohibited.
2. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which I make the request.
3. If I am potentially eligible for Medi-Cal, I must apply for and fully cooperate with the Medi-Cal process for full scope coverage, and accept coverage if eligible. Failure to do so may result in loss of current or future LIHP eligibility.
4. Failure to provide necessary information, report changes promptly, or deliberately giving false information can result in denial or overpayment of LIHP benefits and I may be prosecuted for fraud. I may also be responsible to repay LIHP for benefits I received for which I was not eligible.
5. The facts I give may be checked against facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
6. Although every effort is made to make all eligibility determinations error free, on occasion, a subsequent quality review of an eligibility determination will reveal that an error was made in granting LIHP benefits. I understand that there is no right to retain LIHP benefits granted in error. Upon notification by County, LIHP benefits granted in error must be returned to the County.

I hereby state that I have reviewed the information on this form and that I fully understand my RIGHTS AND RESPONSIBILITIES under the LIHP and agree to comply with LIHP requirements.

Applicant/Representative (*optional*) Date

County Use Section

I have provided this form to the applicant/beneficiary: (check one) ☐ In Person ☐ By Mail

County Staff Signature Date

County Staff Name (Print)

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LOW INCOME HEALTH PROGRAM

DERECHOS Y RESPONSABILIDADES DEL SOLICITANTE

Estoy solicitando el programa Low Income Health Program (LIHP, por sus siglas en inglés) del Condado de San Diego para mí o para ________________________________.

Entiendo perfectamente que tengo los siguientes derechos y debo de cumplir con las siguientes responsabilidades como parte de mi solicitud para y en recibo del programa LIHP.

DERECHOS - TENGO EL DERECHO DE:

1. Solicitar el programa LIHP y de ser notificado(a) **POR ESCRITO** si califico o no califico.
2. Ser notificado de cualquier acción tomada para descontinuar mi elegibilidad de LIHP al menos 10 (diez) días antes del primer mes en que la acción entraría en efecto.
3. Solicitar una apelación si no estoy de acuerdo con la(s) decisión(es) tomada(s) acerca de mi elegibilidad de LIHP, o con la negación de servicios médicos por parte de LIHP. Debo solicitar una revisión dentro del tiempo indicado en mi aviso de acción.
4. Poner una queja si no estoy satisfecho con otros asuntos, como se describen en el documento de LIHP llamado “Sus Derechos de Quejas y Apelaciones”. Debo presentar la queja dentro de los límites de tiempo establecidos en el documento de LIHP llamado “Sus Derechos de Quejas y Apelaciones”.
5. Hablar con el personal de LIHP que pueda ayudarme con preguntas, problemas, reclamos, y/o a presentar una queja.
6. Que se me trate justamente y con igualdad sin importar mi raza, color, religión, nacionalidad, sexo, edad o creencias políticas.
7. Asistencia gratuita de idioma, y/o para personas con discapacidades de la vista o del oído.
8. Tener privacidad y de que toda la información que yo dé al programa LIHP se mantenga confidencial, excepto como lo requiera o permita la ley.
9. Escoger mi proveedor médico y mi médico de atención primaria dentro de los límites del programa.
10. Tener acceso razonable a servicios médicos a través del programa LIHP.
11. Que se me trate con cortesía y respeto, que me expliquen claramente mis problemas de salud y de participar en las decisiones acerca del tratamiento de mis problemas de salud.
12. Pedir o rehusar tratamientos médicos.
13. Pedir una segunda opinión si no estoy de acuerdo con el cuidado médico o plan de tratamiento que me recete mi proveedor de cuidado médico.
14. Información sobre el derecho de obtener una Directiva Anticipada para la Atención Médica. Si ya tengo una y deseo traer una copia, mi proveedor la agregará a mi expediente médico.

RESPONSABILIDADES - TENGO LA RESPONSABILIDAD DE:

1. Dar información correcta al Representante de LIHP.
2. Reportar cambios al Representante de LIHP dentro de 10 días de que ocurra el cambio llamando al 1-888-553-5552. Estos cambios incluyen pero no se limitan a lo siguiente:
   - ✓ Si mi ingreso o el ingreso de un miembro de mi familia cambia, o si nuestra situación de empleo cambia.
   - ✓ Planeo mudarme de casa o cambiar mi dirección postal.
   - ✓ Un pariente se viene a vivir a mi casa o se muda de mi casa.
   - ✓ Recibo, transfiero, regalo, o vendo cualquier artículo de propiedad personal o bienes raíces.
   - ✓ Yo o algún miembro de mi familia esté embarazada o se enferme físicamente o mentalmente de tal manera que no podremos trabajar.
   - ✓ Yo o un miembro de mi familia solicito/a y soy/es elegible a los beneficios monetarios de un programa del Estado, Condado o Gobierno Federal. Ejemplos incluyen, pero no se limitan a, beneficios del Seguro Social (SSA), beneficios de la Administración de Veteranos, CalWORKS o Compensación por Incapacidad.
   - ✓ Reportar si he presentado una apelación con la Administración del Seguro Social por haberme negado beneficios por incapacidad.
3. Reportar al Representante de LIHP y usar cualquier cobertura médica, incluyendo seguro médico, que yo tenga o que tengo derecho de utilizar.

4. Reportar al Representante de LIHP cuando LIHP haya proporcionado o vaya a proporcionar servicios de cuidado médico para un accidente o lesión que pueda cubrirse 1) con mi propia compañía de seguros o 2) de

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parte de una tercera persona cuando presente una demanda o una demanda se presente de mi parte, y la acción resulte en una orden judicial a mi favor.

5. Reembolsar al programa LIHP de un cobro recibido de parte de una tercera persona, incluyendo demandas.
6. Llamar a mi médico de atención primaria para una consulta médica PRIMERO, excepto en caso de emergencia.
7. Llegar a tiempo a mis citas programadas.
8. Avisar a mis proveedores de cuidado médico si no entiendo mi plan de tratamiento o que se espera de mí, y si estoy de acuerdo con las recomendaciones de mi tratamiento, seguir las instrucciones de mis proveedores de cuidado médico.
9. Dar información correcta y completa a mis proveedores médicos sobre mi condición actual y previas enfermedades.
10. Tratar a los proveedores y al personal de LIHP con respeto y dignidad.
11. Cooperar con los médicos y enfermeras al recibir los servicios de salud del programa LIHP. Esto incluye el recibir todos los servicios de salud por medio de proveedores médicos autorizados por LIHP, presentarme a las citas con el doctor y seguir todo plan de tratamiento e instrucciones que me dé mi proveedor médico.

ENTENDIMIENTO- ENTIENDO COMPLETAMENTE QUE:

1. Se prohíbe la discriminación de inscripción y la discriminación de darse de baja.
2. La fecha de vigencia para la aprobada descontinuación no debe ser más tarde que el primer día del segundo mes después del mes en el cual hago la petición.
3. Si hay posibilidad de que sea elegible para Medi-Cal, tengo que solicitar y cooperar completamente con el proceso para beneficios completos de Medi-Cal y aceptar la cobertura si soy elegible. No cumplir con este requisito puede resultar en la pérdida de mi elegibilidad actual o en el futuro al programa LIHP.
4. Si no proporciono la información necesaria, no reporto cambios inmediatamente, o doy información falsa a propósito, puede que se me nieguen los beneficios de LIHP o que LIHP me pague en exceso, y puedo ser enjuiciado por fraude. También puedo ser responsable de reembolsar al programa LIHP por beneficios recibidos para los cuales yo no era elegible.
5. La información que doy puede ser comprobada contra los hechos dados por patrones, bancos, SSA, Devolución de Impuestos, asistencia pública, y otras agencias. Tendré el derecho de comprobar y corregir cualquier información que esté incorrecta.
6. Aunque se hace todo lo posible para determinar elegibilidad sin errores, en ocasión, un repaso subsecuente de elegibilidad puede revelar que un error se cometió al aprobar beneficios de LIHP. Entiendo que no tengo derecho a quedarme con beneficios de LIHP aprobados por error. Al recibir notificación del Condado, los beneficios de LIHP aprobados en error tienen que ser regresados al Condado.

Yo declaro que he revisado la información mencionada arriba y entiendo perfectamente mis DERECHOS Y RESPONSABILIDADES bajo el programa LIHP y estoy de acuerdo con cumplir con los requisitos del LIHP.

Solicitante/Representante (*opcional*)   Fecha

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County Use Section

I have provided this form to the applicant/beneficiary: (check one) ☐ In Person ☐ By Mail

County Staff Signature   Date

County Staff Name (Print)

LOW INCOME HEALTH PROGRAM/COUNTY MEDICAL SERVICES PROGRAM
IMAGE VERIFICATION CHECKLIST

Name: ________________________________

Member ID #:___________________________

Worker Name: _________________________

Read all forms then place your initials next to the forms which you have received.

You Initial Here	Spouse Initials Here	
		CMS-15 CMS Rights and Responsibilities of Applicants (07/11)
		CMS-23 LIHP/CMS Coverage Information (09/11)
		CMS-007 CMS General Property Limitations (03/11)
		CMS-123 CMS Lien Information (2/11)**
		CMS-123A CMS Lien Acknowledge Statement (1/08)**
		LIHP/CMS Health Plan NPP-002 Notice of Privacy Practices (07/11)
		LIHP-15 LIHP Rights and Responsibilities of Applicants (09/12)

****NOTE:** Forms CMS-123 and CMS-123A are NOT included in the recertification mail-in packet.

I/we hereby state that I/we have received all forms listed. I/we acknowledge that I/we have reviewed and fully understand the forms.

______________________________ ______________________________
Signature of Applicant Date

______________________________ ______________________________
Signature of Spouse Date

______________________________ ______________________________
Signature of Authorized Representative Date

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LOW INCOME HEALTH PROGRAM/COUNTY MEDICAL SERVICES PROGRAM
LISTA DE VERIFICACION DE IMAGEN

Nombre: ______________________________

No. de Miembro: ________________________

Nombre del/la Trabajador/a: ______________

Lea todas las formas y ponga sus iniciales junto a las formas que ha recibido.

Sus Iniciales	Iniciales de su Cónyuge	
		CMS-15 CMS Derechos y Responsabilidades del Solicitante (07/11)
		CMS-23 LIHP/CMS Información de Cobertura (09/11)
		CMS-007 Limitaciones Generales de Propiedad del Programa CMS (03/11)
		CMS-123 Información de Gravamen (CMS) (2/11)**
		CMS-123A (SP) Declaración de Reconocimiento de Gravamen de CMS (1/08)**
		LIHP/CMS Health Plan NPP-002 (SP) Aviso Sobre Practicas de Privacidad (07/11)
		LIHP-15 LIHP Derechos y Responsabilidades del Solicitante (09/12)

****NOTA:** Forma CMS-123 y CMS-123A (SP) **NO** se incluyen en el paquete para renovar por correo el programa CMS.

Yo/nosotros declaramos por medio de la presente que he/hemos recibido todas las formas en la lista. Yo/nosotros reconozco/reconocemos que he/hemos revisado y entendido perfectamente las formas.

Firma del Solicitante	Fecha
Firma del Esposo(a)	Fecha
Firma del Representante Autorizado	Fecha

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A.01.03 Access to Eligibility

A.01.03A Standard Eligibility Application

There are several ways in which adults can apply for LIHP. Examples include:

1. Applying on-line at: www.benefitscalwin.org and selecting the "Medi-Cal" option
2. Mailing a Medi-Cal application to the County
3. Walking into any of the HHSA Family Resource Centers (FRCs) (except Metro)

Any application accepted for Medi-Cal eligibility shall be an acceptable application for LIHP. Required LIHP forms must be provided to the applicant. Required LIHP forms are:

- LIHP-15 (Rights and Responsibilities)
- LIHP-23 (Coverage Information)
- LIHP-19 (Grievance and Appeal Rights)
- LIHP Health Plan NPP-002 (Notice of Privacy Practices)

The LIHP-23 requires the applicant's signature. This form must be completed by the applicant and returned to the County as a condition of eligibility.

The LIHP-15 does not require the applicant's signature or to be returned to the County as a condition of eligibility. Refer to A.02.01K.

The LIHP Health Plan NPP-002 does not require the applicant's signature; however, in lieu of the applicant's signature, the worker must sign the LIHP Health Plan NPP-002 as outlined in A.02.01I.

MPG LTR 760 (10/12)

A.02.01 Eligibility

A.02.01K Rights and Responsibilities

As part of the application for or receipt of LIHP benefits, all applicants/enrollees must be informed of their rights and responsibilities. The worker must provide the applicant the LIHP-15 Rights and Responsibilities of Applicants, at initial application, reapplication and recertification. The LIHP-15 does not have to be returned by the applicant; therefore, the worker shall document in the case record that the LIHP-15 was provided to the applicant/enrollee either with a narrative entry or by completing the County Use Section and scanning the LIHP-15 in the case file prior providing the LIHP-15

to the applicant/enrollee.

Applicants/enrollees may sign the LIHP-15 acknowledging that they have reviewed the information and they understand their rights and responsibilities. The applicant may sign the CMS-107 in lieu of the LIHP-15.

MPG LTR 760 (10/12)