CAMA

Chronic and Acute Medical Assistance Eligibility Manual

Second Edition
November 2002

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MEMORANDUM

DATE: September 14, 2007

TO: ALL CAMA MANUAL HOLDERS

FROM: Carolyn Spalding, Chief
Policy & Program Development

SUBJECT: CAMA Manual Change #2

This manual change introduces a new method for CAMA reapplication. Beginning September, 2007, CAMA recipients will receive the X025 – Review Application notice when it is time to reapply. Recipients can complete this notice and return it as their application. The Gen 50B, Application for Services will also be accepted.

This change also clarifies that a physician assistant may complete the Certification of Medical Status (MED 11) form.

If you have any questions about this manual change, please contact the Policy and Program Development Team at 465-3347 or email dpapolicy@alaska.gov.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

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MEMORANDUM

DATE: September 9, 2003

TO: ALL CAMA MANUAL HOLDERS

FROM: Ellie Fitzjarrald, Chief
Program & Policy Develpment

SUBJECT: CAMA Manual Change #1

This manual change includes policy clarifications and substantial coverage changes due to large reductions in the CAMA appropriations. Effective September 20, 2003, CAMA no longer covers ***any*** inpatient hospitalization, nursing home services, or transportation expenses. Effective October 1, 2003, prescription drug coverage is restricted to three approved prescriptions per recipient within a calendar month. Medical supplies will only be reimbursed if they are related to the administration of a drug product needed to treat one of the covered conditions and may not exceed a 30 day supply.

If you have any questions about this manual change, please contact the Policy and Program Development Team at 465-3347 or email dpa_policy@health.state.ak.us.

OVERVIEW OF CHANGES

900 – Introduction and General Provisions
Removes coverage for inpatient hospitalization, nursing home care and transportation.

910 - 1 – Applying for CAMA
Removes language about using the Med 4 application form for nursing home coverage.

910-3 – Verification and Documentation
Removes the physician assistant signature from being accepted on the Med 11 form, and removes the need for Division of Health Care Services (formerly DMA) approval for nursing home admission.

910-4 – MED 11 Processing Instructions
Removes language about the client signing the release of information in the Patient Identification section. The Med 11 form has been revised with HIPAA approved language.

940-1 – CAMA Household
Clarifies a legally responsible relative must be both categorically and financially eligible as a "potential" cash assistance program recipient to exclude their needs, income, or resources from counting for the applicant's CAMA eligibility - example added.

940-4 – Determining Month Net Income
Fixes a misplaced paragraph that was adding confusion on when to apply a standard 20% deduction from gross income.

950 – Covered Medical Services
Removes coverage for major medical care, impatient physician services, transportation, nursing home services, and laboratory and X-ray services.

950 -2 - Major Medical Care, 950-3 - Transportation, and 950-4 - Nursing Home Care
These subsections are removed.

960 –1 – Period of Eligibility
Removes paragraph regarding eligibility for nursing home cases.

960-2 - Reviews
Updates policy that a new Med 11 form must be completed by the recipient's physician or advanced nurse practitioner for verification that the recipient still has a qualifying chronic condition, cancer, or terminal illness.

970 - The CAMA Authorization (COUPON)
Removes the paragraph about approval needed from Qualis Health for inpatient services.

FILING INSTRUCTIONS

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Pages 13 – 22	Pages 12 -22
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900 INTRODUCTION AND GENERAL PROVISIONS

The Chronic and Acute Medical Assistance (CAMA) program began July 1, 1999. CAMA is available only after a financially qualified applicant has exhausted all other available resources. It was originally designed to pay health care providers who serve the needy individuals suffering from acute and certain chronic medical conditions who are not eligible for Medicaid. CAMA is entirely state funded. The number of individuals covered and the medical services provided by CAMA are dependent on the level of funding available each year.

Beginning November 1, 2002, due to a significant reduction in state funding, CAMA was reduced to primarily a maintenance prescription drug program. The first month of eligibility for CAMA changed to the month after application, instead of the month of application. Inpatient hospitalization coverage was eliminated except for the persons identified below. Retroactive coverage was also eliminated.

Effective September 20, 2003, CAMA no longer pays for inpatient hospital care, nursing home care, and transportation services. Prescription drugs are limited to three approved prescriptions within a calendar month per recipient and Medical supplies will only be reimbursed if they are related to the administration of a drug product needed to treat one of the covered conditions listed below.

To be eligible for CAMA, a person must be terminally ill, have cancer requiring chemotherapy, or have one of the following chronic conditions: (1) diabetes and diabetes insipidus; (2) seizure disorders; (3) mental illness; and (4) hypertension.

CAMA pays for:

- prescribed drugs and medical supplies;
- physician visits;
- chemotherapy and radiation treatment on an outpatient basis; and
- outpatient laboratory and x-ray services

900-1 CONFIDENTIALITY

It is against the law to use or disclose information obtained from an applicant or recipient unless it is to a person directly connected with the administration or enforcement of the CAMA program or other public assistance program. Refer to Section 100-3 of the Administrative Procedures Manual.

900-2 FRAUD

The misrepresentation of fact or omission of information with the intent of illegally obtaining service, payment, or other gain constitutes Medical Assistance fraud. Medical Assistance Fraud exists when a recipient intentionally fails to report income, resources, household composition or other factors that may affect CAMA eligibility.

Persons knowingly and willingly aiding a recipient or provider in committing Medical Assistance fraud are considered to be aiding in the commission of the act and may be held responsible. This is in accordance with AS 47.05.210. Refer to Section 112 of the Administrative Procedures Manual.

910 APPLYING FOR CAMA

910-1 APPLICATION

An application for CAMA must be made on the GEN 50B form. Any person acting on the applicant's behalf (authorized representative), may apply for assistance under the CAMA program by submitting a complete "identifiable application" (see Glossary). An applicant should be instructed to enter "N/A" in sections of the application that do not pertain to the applicant's particular situation.

An application is considered filed when received in a DPA office. A faxed application will be accepted to protect the filing date for the application month, but must be followed up by the original application before benefits can be issued.

910-2 INTERVIEW

The caseworker must interview the applicant before determining eligibility unless the caseworker determines that an interview is impossible or inadvisable because of illness, distance, or other cause. The purpose of the interview is to establish to the satisfaction of the caseworker that the facts of the case are consistent with the statements made on the application and remind the applicant that coverage does not begin until the month after the month of application. When an interview is not possible, the application along with collateral statements from responsible individuals who have knowledge of the applicant's need or circumstances will suffice.

The caseworker must explain the responsibilities of a CAMA recipient and instruct the applicant to report any changes that might affect his or her eligibility. This includes changes in the nature of the medical need, living arrangement, income, or resources. The recipient or the recipient's authorized representative must report changes to the nearest DPA district office within 10 days of the change.

910-3 VERIFICATION AND DOCUMENTATION

An applicant must provide adequate evidence to demonstrate his or her eligibility and financial need. The caseworker must verify the factors of eligibility and document this in the EIS online case notes.

The caseworker may verify factors of eligibility through the best means available to the applicant. For example, verification of income and expenses (i.e. business costs for self-employed applicants) may be accomplished through copies of pay stubs, the applicant's 1040 federal income tax forms, fish tickets, or a letter from the IRS verifying the applicant did not pay taxes.

In villages serviced by a fee agent, verification requirements (with the exception of medical verification) may be satisfied by a statement signed by the fee agent attesting to the validity of information given on the application.

Before initial eligibility can be determined, the caseworker must have a completed MED 11 (see Appendix-A) as verification of the applicant's covered medical need. The MED 11 must be completed by a physician or advanced nurse practitioner verifying that the applicant is terminally ill, is a cancer patient in need of chemotherapy, or has one of the four chronic conditions listed in Section 920-6.

A MED 11 form is valid for 90 days from the date it is signed by the health care provider. If an applicant has a completed MED 11 form, but is denied eligibility for another reason, the applicant may reapply for CAMA using the same MED 11 if the time between the date the provider signed the MED 11 and the date of the new application does not exceed 90 days. Once eligibility is established, the recipient's medical status is presumed to continue until the next review.

A new MED 11 form is required when a former recipient reapplies for CAMA after any month of ineligibility.

910-4 MED 11 PROCESSING INSTRUCTIONS

The caseworker completes the ***PATIENT IDENTIFICATION*** and the ***RETURN TO CASEWORKER*** sections of the MED 11 form. The form should be given to each applicant to take to his or her health care provider. If the applicant has already seen a health care provider, the caseworker may fax the MED 11 directly to that provider. If an applicant has also applied for Interim Assistance and has been issued a DE-25 coupon, the provider may use the DE-25 coupon to complete the MED 11 as part of the IA disability assessment.

The Medical provider completes the MED 11 form and returns it directly to the DPA caseworker identified at the bottom of the form. The applicant is responsible for ensuring the provider completes and returns the MED 11 to the

DPA caseworker in a timely manner. If a MED 11 form is received directly from the applicant, it must be sealed in a provider's envelope to be valid.

The caseworker completes the eligibility determination upon receipt of the MED 11 and verification of all other factors of eligibility. If the medical provider does not find medical evidence to support the application, the caseworker must deny the application with adequate notice. An applicant may choose to get a second opinion, in which case the caseworker may provide another MED 11 to the applicant, but may **not** issue another DE-25 coupon.

Example #1: *Application received 10/15/02. The MED 11 returned 10/25/02. Eligibility issued for November.*

Example #2: *Application received 10/24/02. The MED 11 returned 11/04/02. Eligibility issued for November.*

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920 ELIGIBILITY FACTORS

Eligibility for Chronic and Acute Medical Assistance is based upon

(1) **age**;
(2) Alaska **residency** at the time of application;
(3) U.S. **citizenship** or status as a legal alien;
(4) lack of **third party resources**;
(5) **financial need**; and
(6) **covered medical need.**

920-1 AGE

To be eligible for CAMA, an individual must be age 18 or older.

EXCEPTION: *An individual may be eligible for CAMA regardless of age if that individual is a legal immigrant who is not eligible for Medicaid/Denali KidCare because he or she is not a "qualified" alien or because the individual is subject to the five year bar on receiving Medicaid benefits.*

Most applicants under the age of 21 who meet the financial eligibility requirements for CAMA will be eligible for Denali KidCare or other Medicaid category. Likewise, most applicants age 65 and older who meet the financial eligibility requirements for CAMA will be eligible for APA-related Medicaid. The caseworker must advise the applicant of this fact so that eligibility in another Medicaid category may be determined.

920-2 ALASKA RESIDENCY

To be eligible for CAMA, an individual must be an Alaska resident at the time of application. Being a resident means that the applicant must be present in the state with an intent to reside. Verification in the form of statements from landlords or other appropriate sources may be required.

An individual is not eligible for CAMA if he or she resides in a Pioneer Home, a public institution, or a correctional facility.

920-3 U.S. CITIZEN OR LEGAL ALIEN

To be eligible for CAMA, an individual must be a U.S. citizen or legal alien. Unlike Medicaid/Denali KidCare, CAMA recognizes an individual who is "permanently residing under the color of law" (PRUCOL) as a legal alien. A legal alien who has been in the U.S. for less than five years and who is currently subject to the five year bar from Medicaid may be eligible for CAMA if the applicant meets all other CAMA requirements.

920-4 LACK OF THIRD PARTY RESOURCES

To be eligible for CAMA, an individual must have insufficient third party resources, as described in Section 930.

920-5 FINANCIAL NEED

To be eligible for CAMA, an individual must be in financial need as described in Section 940.

920-6 COVERED MEDICAL NEED

To be eligible for CAMA, an individual must have one of the following conditions as documented by the MED 11:

(1) a terminal illness;
(2) cancer requiring chemotherapy; or
(3) one of the following chronic conditions:

- diabetes and diabetes insipidus;
- seizure disorders;
- chronic mental illness;
- hypertension.

See section 950 for covered medical services.

930 THIRD PARTY RESOURCES

An applicant or recipient for CAMA must help DMA identify any health insurance coverage or other third party who may have a responsibility to pay for the applicant or recipient's health care. The applicant must pursue all third party resources for coverage of medical costs as well as identify any potential sources of payment.

CAMA may not be approved if the applicant has a resource available to meet the medical need or is living with a legally responsible relative able to provide financial support (see section 940-1).

930-1 AVAILABLE THIRD PARTY RESOURCES

An applicant must apply for any benefits for which the division believes may be available to meet the individual's medical need. The caseworker must send written notice to an applicant describing any benefits for which the applicant must apply. An applicant who, without good cause, fails to apply, or pursue a claim within 30 days of mailing of the written notice is not eligible for CAMA.

Third party resources available to meet the individual's medical need include the following:

(1) Coverage by a private medical or hospital insurance policy that will pay 100 percent of the cost of medical care. If the insurance coverage will not pay for the entire cost of medical care, CAMA eligibility may be found but payment is limited to the amount not covered by the insurance policy and that is otherwise covered under CAMA;

(2) Eligibility to receive medical assistance or coverage, including assistance or coverage from the Veteran's Administration, TRICARE, U.S. Seaman's Act Program, Handicapped Children's Program, Office of Vocational Rehabilitation, Division of Mental Health and Developmental Disabilities, Medicaid, and Medicare;

(3) Availability of medical assistance from the Salvation Army, Red Cross, Lion's International, and other charitable organizations that meets the individual's medical need;

(4) Payment for medical bills or medical insurance coverage available through a liable party, including payment for medical claims;

(5) Payment for medical bills or medical insurance coverage available through an absent parent; and

(6) A cash contribution received in a previous month from an individual or organization intended to defray medical costs, including medically related transportation, which the applicant has access to and is sufficient to cover the entire cost of medical care received. If the total contribution will not pay for the entire cost of medical care, CAMA eligibility may be found but payment is limited to the amount not covered by the contribution that is otherwise covered under CAMA. A charitable cash contribution intended to defray medical costs is not considered a countable resource.

IHS Beneficiaries: Eligibility to receive assistance from the U. S. Public Health Service through the Indian Health Service (IHS) is not considered an available resource for the purposes of determining eligibility for CAMA. This means that an individual who is an IHS beneficiary and is also eligible for CAMA has the freedom to choose which health care provider to use. CAMA will pay for services provided to an IHS beneficiary by a non-IHS provider, but will NOT pay an IHS facility for services that the facility renders to an individual who is also eligible for CAMA. When discussing CAMA coverage for recipients who are eligible to receive services at an IHS facility, it is important to explain to the applicant that CAMA coverage differs substantially from IHS coverage. In choosing to receive services from a CAMA provider, the recipient may become liable for services that otherwise would have been provided by an IHS facility at no charge.

930-2 LEGALLY RESPONSIBLE RELATIVES

Under Alaska state law, the relatives of needy individuals are liable for their support while they are living and for their burial upon death. Individuals liable for support in the following order are the spouse, children, parents, grandparents, grandchildren, or siblings of the needy individual who are financially able to provide support. ***Note:*** *This does NOT include a stepparent, stepchild, in-law, cousin, or companion not legally married to the applicant*. However, the determination of a recipient's eligibility must not be

delayed in an attempt to contact such relatives, nor should assistance be denied because of knowledge of their existence or whereabouts.
The statute requires that the legally responsible relative reimburse the state with interest for any relief granted in the event that the relative fails or refuses to support and care for the recipient. If the caseworker becomes aware of the whereabouts of a recipient's relatives and their probable ability to provide support, the caseworker must inform the applicant of this program provision, note the information in the EIS on-line case notes and email DMA third-party liability for follow-up at DMA_TPL@health.state.ak.us.

The total amount of CAMA benefits paid to a recipient constitutes a claim by the state against a recipient's estate and can be awarded to the state upon the recipient's death.

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940 FINANCIAL ELIGIBILITY

940-1 CAMA HOUSEHOLD

The following individuals are included in the household and must have their needs, income, and resources considered in determining financial eligibility for CAMA:

(1) The **applicant**;

(2) A legally responsible **relative** (see Section 930-2) who, at the time of application, has continuously resided with the applicant for a period of 30 days, and who does not maintain a separate residence from the applicant, and is financially able to provide support.

NOTE: *A legally responsible relative who is receiving a cash assistance grant from the Alaska Temporary Assistance Program, Adult Public Assistance (including Interim Assistance), or Supplemental Security Income will not have their needs, income or resources considered in determining financial eligibility or household size.*

Likewise, A legally responsible relative who is both categorically and financially eligible as a "potential" cash assistance program is considered unable to provide financial support and will not have their needs, income, or resources considered in determining financial eligibility or household size.

For example: *the legally responsible relative must have a child under the age of 18 to " potentially" be a TA recipient, and if so, the income and resources of the TA program would be used. To be considered a "potential" APA recipient, the individual would need either to have been determined disabled, or age 65 and older, and if so, the income and resources of the APA program would be used.*

940-2 COUNTABLE RESOURCES

Before eligibility can be determined, the caseworker must verify that countable resources (liquid, property, or a combination of the two) do not or are not expected to exceed $500 on the first moment of the benefit month. If necessary, the caseworker may pend an application for verification of resources before making an eligibility determination.

Example 1: *Application received 11/05. The bank account has $900 and the client indicates this money is going to be used to pay off a debt and that it will not be available next month. Caseworker pends the case for verification. Bank statement received on 11/15 shows a balance of $200. The caseworker has no reason to expect other resources will be available on the first moment of December (benefit month) and approves the application for December benefits.*

Example 2: *Application received 11/25. The bank account has $800 and the client indicates this money will not be available next month. Caseworker pends the case for verification. Bank statement received on 12/3 shows a balance of $400 on 12/1. The caseworker approves the application for December benefits.*

Example 3: *Application received 11/05. The bank account has $300 and the caseworker has no reason to expect other resources will be available on the first moment of benefit month (December). Caseworker approves application for December benefits.*

Example 4: *Application received 11/24. The bank account has $1,500 and the client indicates this money will not be available next month. Caseworker pends the case for verification. Bank statement received on 12/04 shows the balance is over $500 on 12/01. Eligibility for December is denied.*

Note: *An applicant who is denied eligibility because of excess resources may reapply in the same month if the applicant's financial situation changes.*

Countable resources include the following:

(1) **Liquid assets** such as cash, savings, stocks and bonds. Some people have investments that mature over a specific time and have financial penalties for withdrawing any amounts prior to the maturity date. For resources that fit within this description, the value of the resource is the amount of the original investment, less the amount of penalty for early withdrawal.

(2) Real or personal **property** with equity value.

Real or personal property does NOT include:

(A) the home in which the applicant resides and the land on which it stands unless the land has been surveyed for subdivision; if the land has been surveyed for subdivision, only the lot on which the home stands is excluded;

(B) property actively marketed for sale at fair market value or less;

(C) property that is producing "reasonable income";

(D) property that is essential to employment;

(E) either one automobile or motorcycle regardless of value, plus a boat, snowmobile, or all-terrain vehicle (ATV) if the applicant lives in an area where local transportation needs require an alternative.

(3) **Limited Entry Fishing Permit** that was not used during the most recent season for reasons other than:

(A) loss of essential fishing equipment prior to or during the most recent season;

(B) serious illness of the applicant or a household member for the period prior to and including the most recent season; or

(C) lease of the Limited Entry Fishing Permit at fair market value to produce income for the applicant's household.

(4) Credit sufficient to meet the covered need.

940-3 DEFINITIONS RELATED TO COUNTABLE RESOURCES

Fair Market Value: Fair market value is the probable value of the resource if it were to be sold. A caseworker can determine fair market value by checking with real estate agents, classified advertisement listings, the tax assessor's office, stockbrokers, or insurance agents. If the fair market value of a particular resource cannot be determined, the caseworker may establish fair market value by determining the value of comparable property in the vicinity that is being offered for sale or has recently sold.

Reasonable Income: Reasonable income is determined by checking with real estate agents, rental agencies, classified advertisement listings, etc. to determine whether the income produced is comparable to that being produced by similar properties in the vicinity. Producing income does not necessarily imply making a profit. Property may be producing income comparable to that normally produced by other property in the same area and yet it may be losing

money after deductions for expenses are allowed. Any profit gained from income-producing property must be considered income to the applicant or recipient. However, the property itself is an exempt resource.

940-4 DETERMINING MONTHLY NET INCOME

Eligibility for Chronic and Acute Medical Assistance exists only if the household's prospective income for the benefit month does not exceed the need standard in the following table:

NEED STANDARD TABLE

Number of Persons	Maximum Monthly Need Standard
1	$300
2	$400
3	$500
4	$600
5	$700
$100 is added for each additional person.	

To determine monthly net income:

(1) **COUNT** all prospective earned, unearned, or in-kind income expected to be received from any source in the calendar month after which application is made, and all income reasonably expected to be received in time to meet the specific needs. ***Note:*** *income received weekly is multiplied by 4.3, that received every two weeks by 2.15, that received twice monthly by 2, and that received monthly by 1.*

(2) **SUBTRACT** from gross earned income all payroll deductions required by the employer, including federal income tax, FICA, unemployment insurance, union dues, insurance premiums, and retirement from gross earned income. If some, but not all, of the above deductions were made, subtract only those deductions actually made, incurred, or due. If none of these deductions has been made, apply a standard 20% deduction from gross income; and

SUBTRACT from earned and unearned income, all voluntary health insurance premiums which are paid for persons included in the household; and

SUBTRACT from unearned income, all mandatory deductions (e.g. taxes and child support garnishments from UIB).

(3) **DO NOT COUNT** income received in the month of application. Consider this income a resource if retained.

Eligibility for CAMA is determined using the GMAS screen on EIS. A manual determination can also be made using the CAMA Budget Worksheet. See Appendix B.

940-5 DEFINTIONS RELATED TO INCOME

Income: Money and benefits received by an individual, usually on a regular basis, which must be considered when making an eligibility determination.

Earned Income: Income earned through the receipt of wages, salaries, commissions, profits from self-employment or obtained as an employee.

In-Kind Income: Income received by barter for subsistence needs, including housing in exchange for building management.

Unearned Income: Income received (but is not limited to) unsecured loans, Social Security benefits, child support, alimony, dividends (including native corporation distributions), unemployment benefits, BIA benefits if paid directly to the client, strike benefits, and tax refunds.

940-6 SPECIAL INCOME PROVISIONS

The following items are not counted as income for CAMA purposes:

PFD: An Alaska Permanent Fund Dividend.

Vendor Payments: A vendor payment is any payment made directly to a vendor (i.e., landlord, utility company, grocery store) from a third party that does not pass through the hands of the CAMA recipient.

Loans: Loans used to obtain necessary medical services, including medically related transportation and accommodations. Any portion of the loan in excess of the amount used to pay for medical services is considered income in the month received. Any portion of the loan not spent in the month received is considered a resource in following months.

Alaska Student Loans: The use of Alaska student loans is guided by state statute, which indicates that the funds cannot be used to pay for medical services. Since these loans are not intended to be used to pay for medical bills, any portion of the loan not spent when application is made will not be considered available to the applicant and is not considered income or a resource to the applicant.

Other Student Loans and Grants: If a student loan (i.e., Stafford loan) or student grant (i.e., Pell Grant) is paid directly to the school, it is considered a vendor payment. If monies are sent directly to the applicant from the student loan or grant and those monies are left over, or if the entire student loan or grant was sent to the applicant and has not been spent on school as it was intended, that amount is considered income in the month received or a resource if retained the month after receipt. If the applicant can document that the conditions of the loan or grant prohibit spending the money for a non-educational purpose or require that the student document the purchase of tuition, books, etc., the caseworker should use "prudent person judgment" (PPJ) to exclude that amount from income and/or resources.

Contributions: A cash contribution received from an individual or organization intended to defray medical costs, including medically related transportation. Any portion of that contribution not spent in the month of receipt is considered a resource in the following months. Cash contributions must be clearly identifiable from the applicant's other income and resources and its intended use must be verified.

Foster Care Payments: A foster care payment or guardian subsidy that is used for the welfare or support of a child living in the home. Any additional compensation for the time and effort of caring for a child (i.e., a payment that is not for the food, clothing, or shelter costs for a foster child) that is not used for the direct welfare and support for the child is counted as income. This does not apply to subsidized adoption payments, which are counted as income for CAMA purposes.

950 COVERED MEDICAL SERVICES

The Chronic and Acute Medical Assistance program pays for the following services only:

(1) prescription **drugs** and medical supplies;
(2) **physician visits**;
(3) outpatient **hospital radiation and chemotherapy services** rendered to a recipient in need of chemotherapy treatment for cancer; and
(4) outpatient **laboratory and X-ray services**.

950-1 PRESCRIPTION DRUGS, MEDICAL SUPPLIES, AND PHYSICIAN VISITS

CAMA may pay for prescription drugs, medical supplies, and physician visits that are medically necessary for treatment.

A recipient may receive no more than a 30-day supply of any drug. The only non-prescription drug that can be reimbursed without obtaining prior authorization from the Division of Health Care Services (DHCS) is insulin.

A recipient who is eligible for prescription drug coverage at a military medical facility must obtain the prescription from that source unless the drug is unavailable at that military medical facility. If the drug is unavailable, the recipient must obtain a written statement from the military medical facility and present the statement to the civilian pharmacist who fills the prescription. The pharmacist must submit the statement with the claim. If the recipient fails to obtain such a statement, the civilian pharmacist may call the military medical facility pharmacist to determine whether the drug is available. If it is not, the civilian pharmacist should make a record of the telephone contact on the claim submitted to First Health Services Corporation.

950-2 REMOVED BY MANUAL CHANGE #1

950-3 REMOVED BY MANUAL CHANGE #1

950-4 REMOVED BY MANUAL CHANGE #1

950-5 NONCOVERED MEDICAL SERVICES

CAMA will not pay for any of the following expenses:

(1) Major medical care;

(2) Nursing home care;

(3) Drugs, medical supplies, radiation, or chemotherapy not properly prescribed or determined necessary by an appropriate health care provider;

(4) Medical care for a person in the care and custody of a correctional facility, including a juvenile in a detention facility;

(5) An elective procedure (see glossary);

(6) Services provided by an Indian Health Service (IHS) or IHS funded facility that is provided to an IHS beneficiary and for which there is no charge to the individual;

(7) Drugs or medical supplies not directly related to the treatment of a covered medical condition;

(8) Drugs or Medical supplies after the first three prescriptions are filled within a calendar month;

(9) Transportation expenses; and

(10) Physician services if the physician service is provided in an inpatient hospital or in a nursing facility.

Note: *Individuals in need of inpatient psychiatric hospital services should be referred to the local regional mental health coordinator for the Division of Senior and Disabilities Services. These individuals are listed in the Alaska Directory of State Officials published by the Legislative Affairs Agency.*

950-6 RECIPIENT CHARGES

The recipient is responsible for paying:

(1) all charges incurred if no coupon is presented;

(2) charges incurred before and after the eligibility period; and

(3) a $1 co-payment on each prescribed drug or medical supply.

960 CASE MAINTENANCE

This section provides information on situations and changes that the caseworker must act on to determine ongoing eligibility.

960-1 PERIOD OF ELIGIBILITY

CAMA eligibility is issued one month at a time, but may be authorized for up to six months. CAMA eligibility is not available for the month of application.

960-2 REVIEWS

To continue eligibility, the recipient must reapply by submitting a complete CAMA X025 - Review Application notice or a GEN 50B application. Either application will be accepted. In addition, an interview will be conducted at least every six months. Verification of both financial and medical eligibility factors is required.

A new Certification of Medical Status (MED 11) form must be completed by a physician, physician assistant, or advanced nurse practitioner certifying that the recipient still has a qualifying chronic condition, cancer, or terminal illness.

If a review application is received late (i.e. any date after eligibility has lapsed), the applicant is not eligible in the month that the review application is received.

960-3 REPORT OF CHANGE

Any change must be documented in the EIS online case notes and acted upon promptly by the caseworker and, if necessary, eligibility redetermined.

960-4 PRIMARY CARE "LOCK-IN"

The Division of Health Care Services (DHCS) may restrict a recipient's choice of providers if they find that the recipient has used an item or service at a frequency or in an amount that is not medically necessary. When this restriction is imposed on recipients, they are placed into the DHCS's Primary Care Program (also called Lock-In).

960-5 NOTICES

The division must render an eligibility decision for each identifiable application and send a written notice of finding to the applicant within 30 days from the date of the receipt of the application in the District Office.

The caseworker is required to provide adequate notice of any action taken on an application for assistance including a finding of eligibility and a denial of assistance.

Adequate notice means the notice must be in writing and include the reasons for the action, specific manual sections supporting the action, and an explanation of the individual's right to request a hearing.

960-6 FAIR HEARINGS

Any individual whose application is not acted upon within 30 days after its receipt in the DPA district office, or whose application is denied or assistance is discontinued, will, upon presentation of an oral or written request to any employee of the division, be granted the opportunity for a fair hearing before a representative of the Department of Health and Social Services. This hearing will be conducted under the procedure established in the *Administrative Procedures Manual Section 117*.

The hearing authority may deny a hearing request if

- the sole issue is a change in state law or regulations requiring automatic adjustment in eligibility or coverage affecting groups of recipients or all recipients and the issue is not one of incorrect benefit determination; or

- eligibility or coverage was denied because the applicant has requested a service that is not covered.

An individual who is waiting for a hearing or a hearing decision related to a CAMA application or benefit may apply for CAMA in a subsequent month.

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970 THE CAMA AUTHORIZATION (COUPON)

The recipient must guard his or her medical authorization (coupon) with reasonable care to prevent its use by unauthorized individuals.

The CAMA coupon is proof that a recipient is eligible to receive CAMA services as specified on the coupon in a given month. See **Appendix C** for an example of a CAMA coupon.

When securing medical treatment, the recipient is to present the coupon and give it to the provider. The recipient should be prepared to provide identification if required by the provider. The coupon is good only for those services covered by the CAMA program and available from enrolled providers.

The coupon contains the recipient's name, ID number, date of birth, month and year of eligibility, eligibility code, subtype, and up to three resource codes for each individual listed.

970-1 PURPOSE OF THE AUTHORIZATION

Each CAMA coupon serves the following purpose:

(1) verifies a recipient's eligibility, which protects the provider against possible misrepresentation;

(2) informs the provider what services the recipient is eligible to receive; and

(3) expedites payment to the provider for services rendered.

Note**:** *CAMA does not reimburse a recipient for any payments already made to a provider.*

970-2 ELIGIBILITY CODE AND MEDICAL SUBTYPE

The CAMA program uses one primary medical (med) subtype and eligibility code entered in EIS to designate the specific services that the recipient is eligible. The med subtype drives the statement of service limitations that is printed on the coupon. Once the caseworker enters the eligibility code and med subtype on the MERE screen, the service restrictions will be printed on the coupon.

> ***EIS Guide:*** *CAMA med subtypes and their corresponding service limits are:*
>
> GJ Authorization limited to physician services, prior-authorized outpatient hospital radiation and chemotherapy, 3 prescriptions per month, and limited medical supplies.
>
> GP Primary Care "lock-in."
>
> Eligibility code 21 is used with the med subtypes.

970-3 DISTRIBUTION OF CAMA AUTHORIZATIONS

CAMA authorizations (coupons) may be issued either by the EIS computer system or manually from a local DPA office.

A. SYSTEM GENERATED COUPONS

> ***EIS GUIDE:*** *CAMA coupons will be issued from DPA's System Operations according to their EIS production schedule, usually three times a week. An issuance is requested by caseworker authorization of a benefit with either an "I" or "R" issuance indicator. Benefits authorized with an "I" indicator are issued with the next scheduled (immediate) issuance job. Those with an "R" are issued with the next monthly (regular) issuance.*

B. MANUALLY ISSUED COUPONS

Once a CAMA benefit has been authorized by a caseworker, a coupon can be printed on the special coupon stock located in the local DPA

office. This type of coupon is generally issued when the individual needs additional coupons for multiple providers.

EIS GUIDE: Issue manual coupons from EIS as follows:

*(1) Advance to the GMIH or GMBH screen and select the month for which the coupon is requested by placing an "X" next to the month and pressing <ENTER>. **NOTE**: A benefit that has not been previously issued will not appear on the GMIH.*

(2) The Medicaid Manual Coupon Issuance (MEMC) screen will be displayed for the month selected with the service limitation statement according to the med subtype on the case.

(3) Type "F" in the issuance indicator field and press <ENTER>. MEMC redisplays with the issuance indicator hard-coded and document ID field completed.

IMPORTANT: Do not <PF9> out of the MEMC screen unless you want to cancel the issuance. You must always press <ENTER> from the MEMC to record the issuance so the recipient's medical claims will be paid.

(4) One MEMC screen per full 8-1/2" x 11" page may be printed as many times as necessary.

(5) Each coupon must be signed (no initials) before it is released to the recipient.

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GLOSSARY

Applicant	Any individual who completes an application for assistance with the Division of Medical Assistance.
APA	Adult Public Assistance. This is a state program that provides cash payments to help low-income people who are blind, have a disability, or are age 65 or older. This program provides a monthly supplement to the SSI program and is available to many who have too much income to qualify for SSI. (See the APA Manual.)
Authorized Representative	An authorized representative is a person who the beneficiary or the beneficiary's specified relative (i.e. parent) has appointed to act on their behalf. Anyone who is 18 years of age or over may be appointed as an authorized representative.
Budget	The EIS screen or document used to measure an applicant's income (less certain cost and mandatory deductions) against an assistance program's need standard. The budget is used to determine eligibility.
CAMA	Chronic and Acute Medical Assistance
Collateral Statement	An oral or written statement of an individual other than the applicant who has knowledge of the applicant's financial need or of other aspects of the applicant's circumstances that relate to eligibility.
DMA	Division of Medical Assistance
DPA	Division of Public Assistance
Disabled/Disability	The inability to engage in substantial gainful activity due to medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.
District Office	One of the local offices of the Division of Public Assistance, which accepts and processes applications for medical assistance.
Division	The Division of Medical Assistance (DMA); a part of the Department of Health and Social Services.

Elective Procedure	A procedure that is subject to the choice or decision of the patient or physician regarding medical services that are advantageous to the patient but not necessary to prevent death or disability of the patient.
Fee Agent	An agent in a rural community who is on contract with DPA to assist applicants with the completion of forms.
First Health	First Health Services Corporation is the division's fiscal agent who is responsible for reviewing, processing, and paying provider claims on behalf of DMA for the Medicaid and Chronic and Acute Medical Assistance programs.
IA	Interim Assistance; a program that provides temporary cash assistance to APA applicants who are waiting for a final decision on their application for federal Supplemental Security Income (SSI) benefits.
Identifiable Application	An application form that contains at least the applicant's name, mailing address, and signature or witnessed mark.
Authorized Representative	The individual designated to act on the needy individual's behalf in the event of his or her mental or physical incapacity.
Major Medical Care	Non-elective inpatient hospital services that cannot be performed on an outpatient basis and are certified as necessary by the professional review organization under contract with the Division of Medical Assistance.
Medicaid	A needs based program that pays for medical care provided to individuals who are categorically and financially eligible. General eligibility categories include pregnant women; dependent children; individuals needing an institutional level of care; and aged, blind, and disabled individuals.
Countable Resource	Personal property owned by an individual that is actually available to meet the individual's financial need because it can be converted to cash.
Pre-authorization	Request made by a provider to First Health, DMA, or Qualis Health to approve medical or medically-related services for reimbursement if the patient is determined to be eligible for CAMA or Medicaid.

Prescribed Drug	A simple or compound substance, or mixtures of substances, prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that is prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined and limited by federal and state law, and is dispensed by a licensed pharmacist on a valid prescription that is recorded and maintained in the pharmacist's records; "prescribed drugs" also includes chemotherapy provided on an outpatient basis.
Third Party Resource	Assistance that is available through a program other than GR or CAMA. Also called a prior resource.
Prosthetic Device	Artificial limb; leg brace, etc. (does not include dentures).
Provider	Any doctor or health facility which has agreed to provide medical services to recipients under the medical assistance program.
Qualis Health	The professional provider review organization on contract with the Division of Medical Assistance.
Recipient	An individual who is financially eligible for CAMA and who may receive a covered medical service if determined to be eligible to receive the service.
Resource	Something owned by or available to an individual that may provide a means of financial support, and which must be considered when determining eligibility.
SSI	Supplemental Security Income; a federal program providing monthly income for persons who are aged, blind, or disabled. The state normally sends an additional APA check to adult SSI recipients to supplement the federal payment.
Terminally Ill	An individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

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CERTIFICATION OF MEDICAL STATUS

Chronic and Acute Medical Assistance (CAMA)

PURPOSE: This form documents the current and ongoing medical status of the patient identified below for the purpose of qualifying for CAMA benefits. It does not constitute as a finding of disability. It must be completed by the patient's physician or nurse practitioner who has diagnosed the patient and sent directly to the Division of Public Assistance (DPA) caseworker shown below.

PATIENT IDENTIFICATION: SSN: _____-_____-_____ Date of Birth: _____

Last Name (print): _____ First: _____ Middle: _____

PROVIDER CERTIFICATION: (Must be completed by a physician or advanced nurse practitioner)

_____ Based upon my medical evaluation, I have diagnosed the patient listed above with the chronic medical condition(s) indicated below and I certify that the patient is in need of ongoing treatment including prescription drugs, chemotherapy or radiation for this condition(s):

____ Cancer patient requiring chemotherapy
____ Terminally ill (see definition on reverse side)
Diagnosis_____
____ Chronic diabetes or diabetes insipidus
____ Chronic seizure disorder
____ Chronic mental illness (see definition on reverse side)
____ Chronic hypertension

_____ I certify that I have examined the patient named above and this patient does NOT require prescription drugs, chemotherapy or radiation for their chronic condition or illness.

Provider Name: (print) _____

Title: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Please mail or fax this form to the DPA caseworker indicated below. DPA will not accept this form directly from the patient unless it is sealed in the medical provider's business envelope. Completed form is valid for 90 days.

NOTE TO HEALTH CARE PROVIDERS ABOUT DISCLOSURES OF PROTECTED HEALTH INFORMATION TO THE DIVISION OF PUBLIC ASSISTANCE:

The Division of Public Assistance encourages the use of patient authorization to release protected health information and will attempt to provide a HIPAA-compliant authorization signed by the patient to accompany this request for information. However, please be aware that if an authorization to release information does not accompany this request for information, or if you are unable to obtain an authorization from your patient, HIPAA regulation - 45 CFR §164.512(d) specifically permits disclosures of protected health information to government benefit programs for which health information is relevant to beneficiary eligibility without the patient's authorization.

If you have questions concerning disclosures of protected health information, please contact the Department of Health and Social Services Privacy Official at (907) 465-2150.

RETURN COMPLETED FORM TO THE FOLLOWING DPA CASEWORKER:

Name: _____

Division of Public Assistance

_____

_____

Phone: _____ Fax: _____

MED 11 06-3890 (09/03)
HIPAA Compliant

DEFINITIONS
Chronic and Acute Medical Assistance (CAMA)

The following definitions are offered as guidance in making a medical determination of whether the individual listed on the reverse side of this form presents "chronic mental illness" or is "terminally ill." These definitions are only guidelines and are not intended to replace your professional medical judgment in a specific case. These definitions do generally reflect the conditions for which the CAMA program is intended:

Chronic Mental Illness: An individual with "chronic mental illness" suffers from a very serious mental illness and exhibits significant deficiencies in functioning. A chronic mental illness is more than a severe emotional disturbance, and is marked by the presence of (1) a psychosis of some kind, (2) a mental disorder that is marked by a loss of contact with reality, and (3) by a deterioration in personality and social functioning. A determination of chronic mental illness means that the individual shows involvement generally consistent with the following Medicaid definition of "chronically mentally ill adult" in 7 AAC 43.1990(10):

"chronically mentally ill adult" means an individual 21* years of age or older
(1) who has been diagnosed as having a schizophrenic, major affective, or paranoid disorder, or other severe mental disorder with a documented history of persistent psychotic symptoms not caused by substance abuse; **and**
(2) whose role functioning is impaired in at least two of the following three ways:
  (A) inability to function independently in the role of worker, student, or homemaker;
  (B) inability to engage independently in personal care or community living activities; or
  (C) inability to exhibit appropriate social behavior, resulting in intervention by the mental health system or judicial system.

**For the purposes of CAMA, this definition may also be used for 19 and 20 year olds.*

Terminally Ill: Reference Medicare and Medicaid definition used for hospice care: "terminally ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (42 C.F.R. 418.3)

PRIOR AUTHORIZATION: This form does not constitute prior authorization of benefits.
Outpatient Chemotherapy/Radiation Therapy: If the patient listed on this form is in need of outpatient chemotherapy/radiation therapy, prior authorization must be secured from the First Health Services Corporation. See the Alaska Medical Claims Payment System Provider Billing Manual for instructions.

MED 11 06-3890 (09/03)
HIPAA Compliant

Department of Health and Social Services
Division of Public Assistance

CAMA Budget Worksheet

Case Name	Case Number

I	**I. Income**		
	Gross Earned Income	$	
	Mandatory Deductions (or 20%)	-	
	Net Earned Income	=	
	Unearned Income	+	
	Total Net Income	=	
II	**II. Need Standard**		
	Number of Individuals		
	Need Standard	$	

Financial eligibility exists only if the Need Standard Total exceeds Average Monthly Income

III. Finding of Eligibility

Yes? _____
No? _____

Notes

Eligibility Worker	Date

SAMPLE CAMA COUPON

RECIPIENT IDENTIFICATION CARD — STATE OF ALASKA — MEDICAL ASSISTANCE PROGRAM

NAME OF ELIGIBLE PERSON(S)	CLIENT I.D. NO.	ELIG. MONTH	DOB	SUBTYPE	E.C.	RESOURCES	MEDICARE
DOE JOHN	0600000586	1102	0461	GJ	21	** ** **	********
**********	**********		****	**	**	** ** **	********
**********	**********		****	**	**	** ** **	********
**********	**********		****	**	**	** ** **	********

**** AUTHORIZATION STATEMENT ****

AUTHORIZATION LIMITED TO PHYSICAN SERVICES, PRIOR-AUTHORIZED OUTPATIENT HOSPITAL RADIATION AND CHEMOTHERAPY, 3 PRESCIPTIONS PER MONTH, AND LIMITED MEDICAL SUPPLIES.

HEALTH CARE PROVIDER INSTRUCTIONS: THIS CARD IDENTIFIES THE PERSON LISTED ABOVE AS A CAMA RECIPIENT WHO IS ELIGBLE TO RECEIVE MEDICAL ASSISTANCE FROM HEALTH CARE PROVIDERS ENROLLED TO USE THE ALASKA MEDICAL PAYMENT SYSTEM. PROVIDERS MUST VERIFY THAT THE BEARER OF THIS CARD IS THE NAMED PERSON AND WRITE THE CLIENT I.D. NUMBER ON OR ATTACH THE IDENTIFICATION CARD TO EACH CLAIM.

NOTE: Cooperation with third party resources includes supplying your provider with medical insurance coverage information such as detailed information. Providers must accept payment from all resources prior to billing CAMA.

83 00007572 N0000035

DOE JOHN
111 LONG AND WINDING ROAD
ANCHORAGE, AK 99501