

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



February 14, 2002

ALL-COUNTY LETTER: 02-18

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: REQUIREMENTS FOR COUNTY COMPLETION OF THE CONVERSION OF INCOME ELIGIBLE IN-HOME SUPPORTIVE SERVICES RECIPIENTS TO THE PERSONAL CARE SERVICES PROGRAM FOR THE PERIOD FROM APRIL 1, 1999 THROUGH DECEMBER 31, 2000

REFERENCE:

- (1) California Department of Social Services (CDSS) All-County Letter (ACL) No. 10-01 dated January 24, 2001
- (2) CDSS ACL No. 99-25 dated April 19, 1999
- (3) CDSS Electronic Bulletin Board (EBB) 99004 dated February 26, 1999
- (4) CDSS All-County Information Notice (ACIN) I-24-01 dated March 28, 2001
- (5) Manual of Policy and Procedures (MPP) 30-768.41
- (6) Assembly Bill (AB) 2779, (Chapter 329, Statutes of 1998), effective April 1, 1999
- (7) Department of Health Services (DHS) All-County Welfare Directors Letter (ACWDL) 99-77 (December 27, 1999)

The purpose of this letter is to provide instructions to the county welfare departments on the final required steps of the conversion of Income Eligible (IE) In-Home Supportive Services (IHSS) residual program recipients to the Personal Care Services Program (PCSP).

The following specific instructions provide the information needed by counties to determine and apply the lower of a recipient's IHSS and Medi-Cal share-of-cost (SOC). These instructions apply to cases that were eligible for PCSP from April 1, 1999, through December 31, 2000 and subsequently became eligible for the Aged & Disabled Federal Poverty Level (A&D FPL) program on January 1, 2001.

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order or Settlement Agreement
- Clarification Requested by One or More Counties
- Initiated by CDSS

OVERVIEW

AB 2779 made IE IHSS recipients eligible for Medi-Cal coverage of their IHSS program services under the Medi-Cal PCSP. This change allowed the State to obtain matching federal Medicaid funds for services that previously were funded only with State and county funds.

In order not to inadvertently harm recipients who became eligible for PCSP under AB 2779 by increasing their SOC, the calculation of both an IHSS and Medi-Cal SOC and the application of the lower of the two to a PCSP recipient's case are required elements of AB 2779.

AB 2779 added §12305.1 to and amended §14132.95 of the Welfare & Institutions Code. The change in law required that a payment ("buy out") be made to the federal government from the State General Fund when a converted medically needy PCSP recipient's lower IHSS residual SOC (hereinafter IHSS SOC) is lower than the SOC that Medi-Cal would apply if AB 2779 were not applicable.

FEDERAL "BUY OUT" PAYMENTS WHEN IHSS SOC IS LOWER

The "buy out" payment returns federal financial participation (FFP) claimed by the State for the portion of a recipient's PCSP costs that the recipient would have paid had their applicable Medi-Cal SOC been applied instead of the lower IHSS SOC. The "buy out" recipient continues paying the lower IHSS SOC. FFP continues to be available for the balance of the recipient's PCSP costs.

Recipient "Reimbursement" Payments when the Medi-Cal SOC is Lower

Under the Medi-Cal program, medically needy recipients with income above a statutory amount are required to pay their "excess" income towards their own medical expenses each month before Medi-Cal will pay for their remaining health care services in the month. This is referred to as the Medi-Cal SOC. The methodology and rules for determining the Medi-Cal SOC computation are *not* the same as the methodology and rules for determining the IHSS SOC. Due to the differences in the SOC computation rules, there may be some recipients with a Medi-Cal SOC that is lower than their IHSS SOC.

Recipients with a Medi-Cal SOC that is lower than their IHSS SOC are "reimbursement" recipients. From most recipients' perspective, AB 2779 enables them to pay their IHSS SOC, which is usually lower than their Medi-Cal SOC. In those rare instances when the IHSS SOC is greater than the Medi-Cal SOC, the recipient is entitled to retroactive reimbursement for the difference for those months in which the higher IHSS SOC was applied. In these cases the difference is considered as if it were an underpayment governed by MPP 30-768.41. In this manner, "reimbursement" recipients pay the lower Medi-Cal SOC and receive the same treatment that "buy out" recipients receive under AB 2779 (i.e., the recipient pays the lowest applicable share of cost).

SOC COMPARISON

Each county must use both county IHSS and Medi-Cal eligibility records to calculate the two SOC's for each recipient. One SOC must be calculated using IHSS program rules. The second SOC must be calculated using Medi-Cal rules. Each county should create its own process for communication between the IHSS social workers and county staff who determine IHSS and/or Medi-Cal financial eligibility. Similarly, coordination of the exchange of information between county social workers is a county responsibility.

Calculation of two SOC's is only required when eligibility for both IHSS and Medi-Cal PCSP coverage is established. The rules governing Medi-Cal eligibility and the Medi-Cal SOC determination remain a DHS responsibility. If a recipient is not eligible for PCSP coverage the AB 2779 SOC comparison is not necessary.

ACL No. 99-25 and EBB 99004 informed counties of the requirement to key the PCSP provider eligibility flag on the PELG screen in the Case Management, Information and Payrolling System, (CMIPS). ACIN No. I-24-01 also advised that an entry of "Y" in the PCSP field on line "ZZ" of the RELC screen and an entry of "Y" in the "PCSP" field at line H2 of the PELG screen is necessary to identify a PCSP recipient receiving services from a PCSP provider. FFP has already been claimed for services provided to recipients who were identified in this manner.

DHS noted in ACWDL 99-77 (December 27, 1999), that counties were expected to benefit in the amount of \$18.5 million per year in county matching funds reductions due to increased FFP. The required SOC computations and comparisons necessary to determine the "buy out" amount owed the federal government must now be performed by the counties. County costs incurred in performing this activity are funded through the DHS Medi-Cal budget. Accordingly, counties must claim these costs on their Medi-Cal cost reports submitted to DHS.

SPECIAL TRANSACTIONS ARE REQUIRED

The Medi-Cal SOC information for IHSS records that have PCSP eligibility can be provided by MEDS. However, an interface between the CMIPS and the Medi-Cal Eligibility Data System (MEDS) will not be available in the foreseeable future. Because of current budget concerns, funding is not available to provide CMIPS with an accounting package or spreadsheet function to automate the SOC comparison. Between April 1, 1999 and December 31, 2000 (inclusive), counties must report the required SOC comparisons using special transactions.

MEDS TAPE MATCH

CDSS will provide DHS with a tape containing a monthly list of all IE recipients along with their IHSS SOC. This will be in addition to the list mailed to counties during the week of March 1, 1999. (Refer to ACL No. 99-25.) DHS will search for these recipients in MEDS and return a list of the MEDS information including the Medi-Cal SOC for each recipient found in the MEDS database. The list will be sorted by county, district office, social worker, case number, name, social security number, aid and link codes, and month of eligibility. DHS will also provide an exception list identifying the recipients not found in the MEDS database. Medi-Cal eligibility determinations will be required for the IHSS IE recipients from April 1, 1999 forward. Individuals on the exception list must be referred to Medi-Cal for a Medi-Cal eligibility

determination and a Medi-Cal SOC determination. Each county must develop a protocol for the return of the Medi-Cal SOC to the county IHSS office for each recipient on the exception list.

MINIMIZING THE NEED FOR ADDITIONAL INFORMATION FROM RECIPIENTS

Shifting of the cases from IHSS residual to PCSP can usually be accomplished without further information from the beneficiary if the Medi-Cal eligibility worker is able to make a determination with the information provided from the IHSS case file. Information contained in the IHSS Statement of Facts (SOC 310) and from the application (SOC 295) or any form the county may choose may be acceptable, as long as the information the Medi-Cal caseworker requires is provided. If further information is necessary, the Medi-Cal caseworker should first attempt to get the information from an alternative source, such as the Income Eligibility Verification System (IEVS). Thereafter, the county may request that a beneficiary provide additional information necessary for this determination.

SOC DETERMINATION - EXAMPLES

Example 1:

The SOC comparison for an individual is relatively straightforward. Assume that the individual has paid a monthly IHSS SOC of \$200 from April 1, 1999. Also, assume that this person's monthly Medi-Cal SOC throughout this period is \$312. County personnel subtract the \$200 IHSS SOC from the \$312 Medi-Cal SOC. From April 1, 1999, when AB 2779 was to have been implemented, a "buy out" results because a lower SOC was used (\$200 in this example) than Medi-Cal would ordinarily be required to apply. If we assume the federal financial participation rate is 51%, we will reimburse the federal government \$57.12 (51% of \$112).

(See below, "SPEC Federal Government Buy-Out", for more information.)

Assume instead that, from April 1, 1999, a PCSP eligible individual's monthly IHSS SOC is \$200 with a monthly Medi-Cal SOC of \$150. The Medi-Cal SOC is determined using Medi-Cal's rules and the IHSS SOC is determined under the usual IHSS rules. In this situation, the recipient need only pay the Medi-Cal SOC of \$150 per month, from April 1, 1999. A "retroactive reimbursement" in the amount of \$50 per month is to be paid to the recipient from State General Funds from April 1, 1999.

(See below, "SPEC Retroactive Reimbursement to Recipient", for more information.)

The audit trail will be retained in the county case files, not on CMIPS. Sufficient detail will need to be present in the county case file to enable an auditor to verify the IHSS SOC determination and the source of the Medi-Cal SOC determination.

Example 2:

This further example considers the treatment of an IHSS SOC in relation to the Medi-Cal Family Budget Unit (FBU) SOC. Assume that a PCSP eligible husband and wife both receive IHSS. CMIPS cannot fully relate family members. Nevertheless, a 2 in the I2 Link

field of the SOC 293 indicates spousal linkage. For those recipients having spouses, and for minors, counties will need to verify whether other family members have an IHSS SOC. Such relationships will need to be clearly noted in each of the linked family member's case files.

Further assume that, from April 1, 1999, the couple's combined, unequally allocated, monthly IHSS SOC is \$100, and their monthly Medi-Cal FBU SOC is \$212. The entire monthly Medi-Cal FBU SOC is compared to the family's total monthly IHSS SOC. A State General Fund "buy out" is owed to the federal government from April 1, 1999.

Alternately, in this example, assume that the couple's monthly IHSS SOC is \$150, and that they have a monthly Medi-Cal FBU SOC of \$100. A retroactive "reimbursement" from April 1, 1999 of \$50 per month is to be paid to the recipients from the State's General Fund. The \$50 per month reimbursement payment must be allocated between the husband and wife and the county social worker must allocate the reimbursement amount in proportion to their individual IHSS SOC's.

The example would not be any different if the IHSS recipients were two children or a parent and child within the same family budget unit. The IHSS SOC is combined and compared to the Medi-Cal FBU SOC.

Example 3:

Assume that a family consists of a PCSP eligible husband with a monthly IHSS SOC of \$100, a wife and 2 children. Also, assume that the family has a \$212 monthly Medi-Cal FBU SOC and that Medi-Cal, after applying all relevant deductions, indicates that this Medi-Cal FBU SOC has remained the same from April 1, 1999. The entire monthly \$212 Medi-Cal FBU SOC is compared to the family's monthly IHSS SOC of \$100. For illustration purposes, if we assume that the FFP rate during the entire period was 51%, a "buy out" from the State General Fund in the amount of \$57.12 per month is owed to the federal government from April 1, 1999.

Assume instead that, from April 1, 1999, the husband's monthly IHSS SOC is \$150, and that the family has a monthly Medi-Cal FBU SOC of \$100. The entire Medi-Cal FBU SOC is compared to the family's IHSS SOC. A retroactive "reimbursement" from April 1, 1999 of \$50 per month is to be paid to the recipient from the State's General Fund.

IHSS RESIDUAL CASES

Protective supervision is a separate IHSS entitlement from PCSP and is not affected by a concurrent entitlement to PCSP established under AB 2779. Other cases where FFP is not available for the services, such as with spouse/parent providers, advance pay status, or IHSS-residual only recipients, do not require the AB 2779 SOC comparison.

APRIL 1, 1999 THROUGH DECEMBER 31, 2000 CMIPS PROCESSING INSTRUCTIONS

Two CMIPS special transactions (SPEC) are being created to process the "buy out" and "reimbursement" determinations between April 1, 1999 and December 31, 2000. Specific

instructions on entering data into the SPECs will follow.

SPEC - Federal Government “Buy Out”

This SPEC provides counties with the tool they must use to report the “buy out” SOC amount(s) when the IHSS SOC is less than the Medi-Cal SOC. The “buy out” SPEC requires county entry of the recipient’s name, CMIPS case number, the “From and To Dates” for the entry, and the amount of difference between the higher Medi-Cal SOC and the IHSS SOC during that time period.

State funding is budgeted to cover the estimated FFP that must be returned to the federal government due to the forgiven SOC amounts. Counties may enter the amount of the difference between a recipient’s SOC for each individual month or as a total for a block of months as long as all of the months within the block are from the same fiscal year. A block of months must all be from the same fiscal year in order for the State to determine that applicable FFP sharing rate to be applied in calculating the repayments.

Through this SPEC, the counties report the “buy out” information to CDSS. This will allow payment to the federal government from the information provided in the “buy out” SPEC report. No NOAs are required with regard to the “buy out” SPEC and this portion of the transaction may be concluded without any further notification to the recipient.

SPEC - Retroactive Reimbursement To Recipients

Counties will use this SPEC to report the information required issuing retroactive reimbursement to recipients where the IHSS SOC was greater than the Medi-Cal SOC. The Retroactive Reimbursement SPEC requires county entry of the recipient’s name, CMIPS case number, the “From and To Dates” for the entry, and the amount of difference between the higher IHSS SOC and the Medi-Cal SOC during that time period. Unlike the “buy out,” reimbursement recipients are receiving a payment and Notice of Action (NOA) is required.

As described above, the SOC comparison amounts can be entered monthly or for a period of months providing the months are all within the same fiscal year.

NOTICE OF ACTION REQUIRED IN RETROACTIVE REIMBURSEMENT CASES

As previously discussed, when a recipient’s Medi-Cal SOC is less than the IHSS SOC, a lump sum “reimbursement” of overpaid SOC amounts must be made to the recipient. The recipient is only obligated to pay the lower Medi-Cal SOC. The funds received by a recipient as a result of the reimbursement payment must be spent or the funds may be counted toward the maximum allowable property/resources. Retaining the reimbursement may affect Medi-Cal eligibility including loss of eligibility. The required NOA language in these cases is as follows:

Because of a change in law, that required your services to shift from IHSS to PCSP on April 1, 1999, you are receiving \$_____ . This is the difference between your PCSP Medi-Cal share of cost and your former IHSS share of cost. Receipt of this payment could affect you, or your family members, continued Medi-Cal eligibility. You should immediately contact your Medi-Cal eligibility worker to see if it does.

Counties will be required to manually enter the warrant amount in the NOA. Further directions for issuing the warrants will follow when CMIPS programming changes are complete.

THREE MONTH RETROACTIVE MEDI-CAL ELIGIBILITY

Medi-Cal program rules allow applicants to request Medi-Cal coverage for the three months prior to the month of application, if the applicant incurred a cost for a covered health care service in that retroactive month.

For Medi-Cal covered services other than PCSP, if the applicant is determined to be eligible, the applicant is to inform their Medi-Cal provider of their Medi-Cal coverage. The Medi-Cal provider then bills the Medi-Cal Program for the service under current Medi-Cal procedures. Processing claims for Medi-Cal services other than for PCSP is a Medi-Cal responsibility. When the provider is reimbursed by Medi-Cal, he/she would then reimburse the applicant, if the applicant had paid for the service. If a Medi-Cal provider contacts an IHSS worker about non-PCSP claims, the provider should be told to contact the Medi-Cal fiscal intermediary.

For purposes of PCSP services received by newly eligible recipient within three months prior to the application date for IHSS, these PCSP services may be reimbursed by Medi-Cal for otherwise eligible Medi-Cal recipients if the recipient incurred out-of-pocket costs. One of the requirements of Medi-Cal's three-month retroactivity provisions [22 CCR §50197, §50148] is that the recipient actually receives health care services in the retroactive month. This requirement means the services must have been actually received. An unmet need supported by a subsequent assessment would not qualify for Medi-Cal reimbursement. In addition, because the PCSP reimburses recipients directly for services received and paid for, proof of payment must be provided in the form of cancelled checks or such similar proof as DHS may require.

The application date is provided in field P1 of SOC Form 293. Retroactive Medi-Cal payments will not be granted for any months prior to April 1, 1999. Thus, individuals applying for IHSS services on April 1, 1999 would not be eligible for this Medi-Cal coverage of services received during the three-month period before the month of application for IHSS. A medically needy individual that applied for IHSS/PCSP services in June 1999 could apply for two months of retroactive PCSP payments incurred within April and May.

DHS will be issuing instructions to Medi-Cal workers regarding the use of Form SOC 310. Question 18 of Form SOC 310 asks whether the recipient, spouse, or parents had medical expenses within the 3 months preceding application and desire Medi-Cal for those expenses. County IHSS personnel are expected to work closely with county Medi-Cal workers in processing three-month retroactive eligibility periods. Out-of-pocket IHSS residual services that are not covered by Medi-Cal (such as for protective supervision) are not eligible for retroactive reimbursement.

PCSP tracking aid codes of 1F, 2F, and 6F have been established to identify PCSP coverage on MEDS. DHS is expected to issue instructions to counties that tracking codes are to be provided for each month prior to application for which reimbursement is requested. If the health services received in the retroactive month do not include personal care services, the

PCSP aid codes, 1F, 2F, and 6F, would not be reported by the IHSS worker for that month.

County IHSS workers will presume that personal care services for which retroactive Medi-Cal coverage is requested are reimbursable if the services are supported by the IHSS worker's service need assessment of the recipient and the personal care service provided is a covered PCSP service. For example, if the December assessment following a November application indicates the recipient is entitled to 86 hours of PCSP services, then the maximum number of hours for which the recipient may be reimbursed for services in October is also 86 hours, if all other conditions are met.

The number of PCSP hours needed and their cost for each month of retroactive coverage must be retained in the file. No reimbursement will be made unless the recipient provides a statement of necessity from a medical provider that the county IHSS worker must retain in the file for the service reimbursement requested.

ACL 99-25, dated April 19, 1999, informed counties of the need to obtain recipient signatures on the Provider Enrollment Agreement (Form SOC 426) for every eligible provider. In order for a recipient to receive retroactive reimbursement for PCSP services an eligible PCSP provider must have provided the services, e.g., if the provider was a parent of a minor child or the recipient's spouse the services would not qualify for retroactive reimbursement. A SOC comparison will not be required for any period of eligibility prior to the month of application for services. DHS will instruct Medi-Cal workers to verify that the assessed cost of the PCSP hours for the retroactive month exceeds the beneficiary's Medi-Cal SOC.

The following NOA informs the recipients of their ability to request payment for Medi-Cal/PCSP services purchased within three months of conversion to PCSP:

The recipient, spouse, or recipient's parents may be able to request reimbursement for Medi-Cal services, including PCSP services, that were provided and paid for within three months before application for PCSP on ##/##/##. This reimbursement is a Medi-Cal decision.

Individuals that have answered "yes" or "no" to question 18 on Form SOC 310 will not need to be re-notified of their right to reimbursement for medical expenses prior to application.

This NOA will not be issued to every individual on the tape match. IHSS workers will need to manually verify whether each file contains an updated SOC Form 310. If no updated SOC Form 310 appears in the file, the IHSS worker will need to manually issue the NOA.

PRESUMPTIVE ELIGIBILITY FOR IHSS RESIDUAL PROGRAM RECIPIENTS

There is an eligibility distinction between the IHSS residual program and PCSP. Pending a final disability determination, a person may be considered blind or disabled for purposes of IHSS residual program eligibility if the county social worker believes the person (1) has a mental or physical impairment that will last for at least one year or end in death, or (2) meets the program's requirements for blindness. (See MPP 30-759.3.) This presumptive eligibility determination is not allowed under the PCSP. An individual with a disability determination pending should not be converted to PCSP eligibility through the IE to PCSP conversion until the final disability determination has been made. ACL 99-25, dated April 19, 1999, also

informed counties of the need to validate the disability status of the recipients.

A disability determination is not an issue with respect to persons made eligible on the basis of age. A blind or disabled person having interim status has an "I" status code on the CMIPS RELA screen at Field F1. This information also appears on the RHSA screen at Field F1 with an "I" status code. However, the RHSA information is purged over three years and may not be available prior to August 1999.

Once the individual receives a disability determination, Field F1 will show eligibility through an "E" on the F1 field in this screen. PCSP may be granted from this disability onset date, if all other conditions for PCSP eligibility are met for each month.

In the event that the disability status has not been previously validated, the county IHSS worker will need to review the IHSS Assessment (Form SOC 293) forms on file. The worker will need to verify that the recipient does not have an "I" status at Field F1 for any month in which PCSP services are requested. As was discussed above, once the IHSS residual eligibility date has been established in this manner, the individual may be eligible for Medi-Cal including coverage of PCSP services for three months prior to the month of application as long as disability has been established in each of those months for which Medi-Cal is retroactively requested, but not prior to April 1, 1999.

DHS MANAGED CARE

Counties previously identified a potential problem relating to aid code changes for IE recipients enrolled in Medi-Cal managed care plans. There was concern that changes in aid codes resulting from the IE to PCSP conversion could cause involuntary managed care plan disenrollment. This issue has been discussed with the DHS Medi-Cal Managed Care Division and they have made system changes that address this concern.

ADULT & DISABLED FEDERAL POVERTY LEVEL PROGRAM

Individual recipients who were eligible for services with a SOC of \$234 or less received eligibility without a SOC through the A&D FPL Program as of January 1, 2001. In this manner, A&D FPL subsumed most of the IE to PCSP population. A recent estimate indicates that there are 4,380 recipients that remain with a SOC; 3,333 of this population are individuals.

Even though recipients already made eligible for the A&D FPL have no SOC as of January 1, 2001, counties were asked, in ACIN 1-24-01 to maintain their records to determine the respective monthly "buy-out" or reimbursement amounts from April 1, 1999 through the month the recipient was converted with no SOC to the A&D FPL program. The ACIN further instructed that the SOC records for recipients not qualifying for the A&D FPL program, but eligible for services through the IHSS IE to PCSP shift, must continue to be maintained even after January 1, 2001.

Further instructions will be provided concerning the processing of the remaining IE to PCSP population after December 31, 2000. Again, Counties are instructed to rely upon the Medi-Cal eligibility worker's determination of the Medi-Cal SOC for the most advantageous Medi-Cal program, including the A&D FPL program beginning January 1, 2001.

Questions regarding this letter can be directed to your IHSS/PCSP Bureau, Operations and Technical Assistance Unit at (916) 229-4000.

Sincerely,

***Original Document
Signed By***

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division