
ACWDL 01-25 explains that the QSR is still required for the first year of TMC. The first year of TMC is a federal program and federal law requires a status report for TMC persons. This ACWDL also provides other questions and answers regarding the elimination of the QSR.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - March 23, 2001*

Item 01-3-1A

Differences Between the In-Home Supportive Services Residual Program and the Personal Care Services Program

Prior to April 1, 1993, aged, blind and disabled persons who would be unable to remain safely in their homes without assistance could apply for In Home Supportive Services (IHSS). IHSS is an alternative to out-of-home care. The IHSS program is authorized under Welfare and Institutions Code (W&IC) Section 12300 et seq. It is 65% state funded and 35% county funded.

Effective April 1, 1993, the Personal Care Services Program (PCSP) was implemented under the Medi-Cal program to cover essentially the same services authorized under IHSS. PCSP is authorized under W&IC Section 14132.95. As a Medi-Cal program, it is 50% federally funded. In some situations, the IHSS program assesses an IHSS share of cost. Recipients of IHSS receive no-cost Medi-Cal as if they were on public assistance, i.e., they have no Medi-Cal share of cost for their "regular" Medi-Cal services.

As viewed by the CDSS and CDHS, there is one program called IHSS which is divided into IHSS residual and PCSP. IHSS residual covers the needs of any persons that are not covered under PCSP.

While both IHSS residual and PCSP come under the broad heading of IHSS, it is important to properly identify whether the issue at hearing involves IHSS or PCSP. IHSS is a social services program and PCSP is a Medi-Cal program. Persons eligible for personal care or ancillary services under PCSP are not eligible for those services under IHSS. (See MPP §30-757.1; W&IC §12300(f))

Prior to April 1, 1999, a case was a PCSP (rather than an IHSS residual) case if the individual:

- Was a recipient of a categorical aid payment, (Title 22 CCR §51350(b));
- Had a disability expected to last 12 months or end in death (Title 22 CCR §51350(b));
- Had a need for at least one personal care service or paramedical service (Title 22 CCR §§51350(a) and 51183);
- Had a service provider who is not the parent (if a minor) or a spouse (Title 22 CCR §51181);

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- And was not receiving advance payment for services (MPP Handbook §30-780.4).

Effective April 1, 1999, W&IC §14132.95 provided that the medically needy who were aged, blind and disabled recipients with a share of cost (SOC), including a zero SOC, are eligible for PCSP if they meet the other requirements of the program. (All County Welfare Directors Letter (ACWDL) No. 99-13, March 29, 1999; All-County Letter (ACL) No. 99-25, April 19, 1999; Assembly Bill (AB) No. 2779) This means that effective April 1, 1999, an individual no longer needed to receive a categorical aid payment or be a categorically needy beneficiary in order to receive PCSP.

Since most hearings involve disabled adult recipients or applicants who have a need for at least one personal care service, do not have a spouse provider or receive advance pay, those cases should properly be identified as PCSP (or combined PCSP/IHSS) rather than IHSS cases. Cases involving any service issue that are PCSP or PCSP and IHSS residual should be written for the CDHS and the CDSS. Cases that are IHSS residual should be written only for CDSS. PCSP cases that involve only eligibility issues (which do not relate to need for services) should be written for CDHS only.

Since IHSS is a social services program and PCSP is a Medi-Cal program, it is critical that an Administrative Law Judge determine which program is at issue. When a hearing involves a denial of an application which results from something other than a lack of need for services (e.g., excess property, transfer of property, not living in own home, etc.), the county must complete a needs assessment in order to establish whether there is a need for at least one personal care service and thus should be evaluated under PCSP rather than IHSS.

For example, a 65 year-old single man who receives Social Security disability benefits applies for IHSS. During the application process, the county discovers that he transferred \$20,000 to his son two months prior to the application.

Before the county can evaluate this property transfer, it must determine if the case is IHSS and subject to IHSS and SSI rules, or is a PCSP case and subject to Medi-Cal rules. Since the applicant is disabled and could not have a spouse provider, he is potentially eligible for PCSP. The county must do a full needs assessment BEFORE evaluating the property transfer.

If the county determines the applicant has no need for any personal care service (e.g., ambulation, dressing, bathing), the county would consider the case to be IHSS residual and evaluate the property transfer under IHSS and SSI rules. (All County Letter No. 00-35 addresses periods of ineligibility for improper property transfers.)

If the county determines that the applicant had a need for at least one personal care service, and if there was no advance pay issue, the case is a PCSP case subject to Medi-Cal rules. Under Medi-Cal rules there are no disqualifying transfers for persons living at home. The property transfer would thus be irrelevant.

In addition to the different funding involved, the following chart explains many of the differences between IHSS residual and PCSP:

IHSS RESIDUAL	PCSP
Presumptive Disability may be established if the applicant is not employed and has no expectation of employment within the next 45 days, and if in the county's judgment the applicant has a physical or mental impairment expected to last at least one year or end in death.	Presumptive disability may be established if the applicant has a condition listed in the "PD Categories" (listed on page 22C-3.6 of the Medi-Cal Eligibility Procedures Manual), the condition is verified by a medical source and there was no Title II or SSI denial within the past 12 months based on the same medical condition.
Eligibility determinations based on IHSS or SSI rules (e.g. excess property, transfer of property, not living in your own home, residency).	Eligibility determinations based upon Medi-Cal rules.
Overpayments are caused when: the recipient fails to use direct advance payment for the purchase of authorized hours, there is an excess service authorization, the recipient pays less than or fails to pay the correct share of cost, the recipient does not spend the restaurant meal allowance.	Potential overpayments are caused when the recipient or person acting on his/her behalf willfully fails to report facts and those facts, considered with other information would result in ineligibility or an increased share of cost, or the recipient fails to report other health care coverage (see also MPP §30-768.5).
By statute, own home includes "the home or abode of their own choosing". By regulation, own home means the place a person chooses to reside. CDSS construes "own home" more narrowly than does CDHS.	By statute, PCSP may be provided in the "beneficiary's home and other locations as may be authorized by the Director." By regulation, home means that place in which the beneficiary chooses to reside. "Own home" is construed more broadly than in IHSS residual.
By regulation, minor is under age 18. Welfare and Institutions Code §12300(d) refers to the Family Code which provides that when the parent is the provider for his/her child, a child means an unmarried child under age 18, or a non-self supporting full-time high school student until the time the child completes the 12 th grade or attains age 19, whichever occurs first.	Child is generally a person under age 21. Persons under age 21 are considered adults as follows: for a blind or disabled person age 18 to 21 living in the home of a parent and not currently enrolled in school or a vocational program; a person aged 18 to 21 not living in the home of a caretaker relative, not claimed as a tax dependent of his/her parents and not receiving out-of-home care from a public agency; and a

	<p>person 14 to 18 years old who is not living in the home of a parent or caretaker relative and does not have a parent , caretaker or legal guardian handling any of his/her financial affairs.</p>
<p>If the parent is the provider, the minor may receive most IHSS services.</p>	<p>If the parent is the provider for a minor child, there is no PCSP eligibility. The case is an IHSS residual case. Once the minor becomes 21 or is otherwise classified as an adult, he/she may receive PCSP in his/her own home with a parent provider.</p>
<p>Protective Supervision, restaurant meal allowance, toe nail cutting, and respite care are covered services.</p>	<p>Protective supervision, restaurant meal allowance, toe nail cutting and respite care are not covered services. If a claimant meets the requirements for PCSP and also establishes a need for any of the above services, the case is both PCSP and IHSS residual.</p>
<p>Non-severely impaired persons including those who require protective supervision may only receive 195 hours of services monthly.</p>	<p>Non-severely impaired person who requires protective supervision may receive total assessed PCSP hours plus up to 195 hours of protective supervision so long as combined total hours do not exceed 283 monthly.</p>
<p>Share of cost is based on IHSS regulations.</p>	<p>The share of cost to be paid to the PCSP provider is the lesser of that computed using IHSS regulations (based on the concept that this IHSS share of cost would have been applied if the PCSP program had not been implemented) or using Medi-Cal rules. Note that many Medi-Cal programs have no share of cost so that the county is required to consider whether an applicant or beneficiary is eligible for any no share of cost program including Pickle (for former SSI recipients) and the Federal Poverty Level (FPL) rules (if a non-parent is the provider for a child).</p> <p>Counties treat no share of cost as if it is \$0. With the implementation of the Aged and</p>

	Disabled FPL program, effective January 1, 2001, a PCSP eligible person with net non-exempt income less than \$926, would qualify for PCSP with no share of cost.
An underpayment means a recipient was entitled to more service than authorized or paid a share of cost greater than the correct amount. Also, counties must issue retroactive benefits for IHSS benefits wrongfully denied (even if the recipient did not receive the services that should have been authorized.)	Underpayments may be corrected by reducing future shares of cost or, for PCSP services received, underpayments may be corrected by the county following its procedures for IHSS underpayments. However, there is no underpayment correction for services that were not received..
No retroactive eligibility. Note: Eligibility begins when the county receives notice of a potential need (i.e., phone call from applicant, guardian, neighbor; or the date a letter is received in county office, etc.) and services have been provided.	Up to three months retroactive eligibility.

The following chart lists the authority that applies to IHSS residual and to PCSP on some issues.

Issue IHSS Authority PCSP Authority

Presumptive Disability	MPP §30-759.31	MEPM §22-C.3.1-3.13
Resources	MPP §30-773; 20 CFR 416	Title 22 CCR §§50401-50489.9; ACWDL 90-01
Transfer of Property	MPP §30-773; 20 CFR 416; ACL 00-35	Title 22 CCR §§50408-50411 (see parareg 487-1); ACWDL 90-01
Overpayments	MPP §30-768	Title 22 CCR §50781
Own Home	MPP §30-701(o)(2), W&IC §12300(a)	Title 22 CCR §51145.1, W&IC §14132.95(a)(1)
Minor Child	MPP §30-701(m); W&IC §12300(d)	Title 22 CCR §§50014, 50030
Protective Supervision	MPP §30-757.17	None

Share of Cost	MPP §§30-701(n), 30-701(s)(3), 30-755.31, 30-775	Title 22 CCR §§50603, 50653, 50262, 50501-50571; Pickle Handbook; ACWDL 92-23, 00-57, 00-68, 01-18, etc.
Underpayments	<i>Leach v. Swoap</i> , MPP §30-768.4	Title 22 CCR §50653.3
Beginning Date of Aid	MPP §30-009.231	Title 22 CCR §50197

NEEDS ASSESSMENT

When the issue involves a needs assessment, IHSS regulations apply regardless of whether the case is IHSS residual or PCSP (see Title 22 CCR §51350(a)). In addition, the Medi-Cal program defers to CDSS Adult Programs when there are issues of policy interpretations involving a needs assessment such as generally not allowing for waiting time at the doctor's office as part of medical transportation or not allowing ambulation outside the home.

Judges should contact CDSS Adult Programs for needs assessment issues, including policy interpretations. If the issue involves eligibility, judges should contact Adult Programs if the case is an IHSS residual case and the appropriate Medi-Cal eligibility analyst if the case is a PCSP case.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - February 21, 2001*

Item 01-02-02A

Changes in Managed Care Regulations and Clarification of Policies

There were many changes made to Medi-Cal Managed Care regulations involving Two-Plan model counties. These regulation changes are in Barclays California Code of Regulations (CCR) Register 2000 No. 51 dated December 22, 2000.

The regulations that are impacted by these changes are CCR §§53845, 53881, 53886, 53887, 53888, 53889, 53891, 53892 and 53895. The chart below compares the previous regulation and the new regulation for some, but not all of the changes:

Title 22 CCR	Prior to December 19, 2000	Effective December 19, 2000
§53845	This section did not specify that beneficiaries who were enrolled	§53845(e) specifies that beneficiaries enrolled in Medicare HMO, CHAMPUS