DEPARTMENT OF SOCIAL SERVICES
744 P Street, MS 19-96, Sacramento, California 95814

November 8, 2007

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

ALL-COUNTY LETTER NO.: 07-46

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: CHANGES TO THE CASE MANAGEMENT, INFORMATION AND PAYROLLING SYSTEM (CMIPS) FOR SHARE OF COST REIMBURSEMENT TO RECIPIENTS FOR OVERPAID OUT OF POCKET PAYMENT OF MEDICALLY RECOGNIZED EXPENSES

REFERENCE: ALL-COUNTY LETTER 06-13 (May 5, 2006), CHANGES TO THE CASE MANAGEMENT, INFORMATION AND PAYROLLING SYSTEM TO ENSURE MEDI-CAL SHARE OF COST COMPLIANCE AS THEY RELATE TO THE IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS WAIVER (IPW) PROGRAM, THE PERSONAL CARE SERVICES PROGRAM (PCSP) AND THE IHSS-RESIDUAL (IHSS-R) PROGRAM

This All-County Letter (ACL) provides counties with information about changes to the Case Management, Information, and Payrolling System (CMIPS) to allow reimbursement to a recipient for overpaid Medi-Cal Share of Cost (SOC) as the result of missing the State's payment of medically recognized expenses (also known as Buy-Out) at the beginning of the month through no fault of the recipient. This ACL contains information from both a programmatic and technical perspective and will provide county personnel with guidance on when it is appropriate to use the new X-27 Special (SPEC) Transaction and instructions on how to use it.

Also included in this ACL is information on other issues that have come to light since the implementation of the In-Home Supportive Services Plus Waiver (IPW). Covered topics will include couples' cases with a SOC, the new Residual Recipient Report, an update on incorrectly coded Status Eligible cases, accessing the new Share of Cost Detail Screen (SOCD), and Notice of Action (NOA) issues.

Background

The implementation of the IPW required that the IHSS program comply with existing Medi-Cal rules and regulations. One of the changes which has significantly impacted

IHSS recipients is IHSS and Medi-Cal SOC processing. Medi-Cal rules require that all Medi-Cal recipients obligate their entire Medi-Cal SOC before payments for services are allowed. Providers may collect SOC payments from a recipient on the date that services are rendered or providers may allow a recipient to "obligate" payment for rendered services. Obligating payments may be used to clear a SOC. SOC obligation agreements are between the recipient and the provider. Medi-Cal will not reimburse the provider for SOC payments obligated, but not paid by the recipient. This means IHSS recipients with a Medi-Cal SOC are now subject to the same SOC spend-down processing as all other Medi-Cal beneficiaries. The spend-down refers to the amount of SOC paid by the recipient to the IHSS provider or providers of other medically necessary medical services and applied against the recipient's Medi-Cal SOC on MEDS to reduce the recipient's Medi-Cal SOC obligation. To this end, CMIPS was modified to operate as a "real time" Point of Service (POS) terminal as used by other Medi-Cal providers. These modifications allow POS processing against IHSS recipient cases when timesheets and other types of payment transactions are processed. CMIPS interfaces with the Medi-Cal Eligibility Data System (MEDS) to determine if the IHSS recipient has an outstanding Medi-Cal SOC and if so, that outstanding SOC is deducted from the payment for IHSS services to the provider.

Near the end of each month, the Department of Health Care Services (DHCS) produces a MEDS Monthly Renewal File containing all Medi-Cal recipients. CMIPS sends a file containing all IHSS cases to DHCS which is matched to the MEDS Monthly Renewal File. The response file to this match is returned to update CMIPS with the latest Medi-Cal eligibility information. CMIPS performs a SOC comparison to identify the Buy-Out amount, as described below, for each recipient that will be paid by the State. Finally, this information is returned to DHCS to apply the State's Buy-Out payments to the individual Medi-Cal SOC files. This process usually runs about a week before the end of the month based on a pre-determined schedule established by DHCS. The MEDS Monthly Renewal File also transmits to CMIPS the recipient's eligibility for federal financial participation (FFP) for the next calendar month.

Under Welfare and Institutions Code, section 12305.1, an individual with a SOC receiving services from the Personal Care Services Program (PCSP) or IPW, who is otherwise eligible for IHSS-R, is eligible for a comparison of their Medi-Cal and IHSS SOCs and is responsible for meeting the lesser of the two SOCs. The State will "Buy-Out" the difference between the two SOCs. The purpose of the Buy-Out is to ensure recipients are not disadvantaged by the State moving IHSS recipients into the Medi-Cal PCSP or IPW which often have a higher SOC than the IHSS-R SOC. The Buy-Out is funded solely through the State General Fund (SGF). IHSS recipients must be indicated as Medi-Cal eligible on the MEDS Monthly Renewal File to have the State make a Buy-Out payment on

their behalf. The amount of the Buy-Out is based on the information that existed at the time the MEDS Monthly Renewal File and CMIPS Response File was processed.

After the MEDS Monthly Renewal File is processed against CMIPS, the MEDS eligibility and SOC information for the next month is compared to the IHSS eligibility and SOC information. A file is produced and transmitted to DHCS to request the processing of the Buy-Out for FFP eligible cases for the following month. After this file is processed, DHCS will not accept any retroactive or subsequent Buy-Out payments. Results of the State Buy-Out payments are recorded on the new Share of Cost Detail (SOCD) screen.
For various reasons, some IHSS recipients are not included in the Buy-Out. In some instances, this can result in the recipient overpaying their share of cost. (For detailed information on the State's Buy-Out, see ACL 06-13, 3.1.) Payments of excess SOC resulting from changes to the Medi-Cal SOC subsequent to the Buy-Out should be submitted to DHCS Beneficiary Services Center (BSC) on a Conlan II claim packet. Claim packets can be obtained by calling (916) 403-2007 or TDD (916) 635-6491 or by writing to Medi-Cal at:

California Department of Health Care Services
Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008

New IHSS Recipients

New IHSS recipient cases should be entered into CMIPS in "R" status as soon as possible to establish communication between CMIPS and MEDS. Due to the timing of the MEDS Monthly Renewal File process, a new IHSS recipient will rarely be included in the Buy-Out during their first month of eligibility. These recipients are responsible for their entire Medi-Cal SOC for the first month of IHSS eligibility and are not eligible for X-27 SPEC transaction reimbursement.

No Medi-Cal Renewal Record

In a number of cases recipients are not included in or are indicated as not eligible for Medi-Cal on the MEDS Monthly Renewal File. (This may occur through no fault of their own, i.e., their renewal packet was complete and submitted timely but processed too late to be included in the monthly Medi-Cal Renewal File.) Although Medi-Cal eligibility may be retroactively reinstated, these individuals would not have been part of the Buy-Out and, therefore, will be subject to their entire Medi-Cal SOC. If the Medi-Cal SOC exceeds the IHSS SOC for the month these recipients may be eligible for an X-27 SPEC transaction reimbursement, which will be discussed further in this ACL. Recipients who are not

included in the Buy-Out expenses, because they have not fulfilled their Medi-Cal eligibility requirements, will be responsible for their entire Medi-Cal SOC amount and are not eligible for an X-27 SPEC transaction reimbursement.

Depending on each individual's unique situation, the individual may be eligible for reimbursement either through an X-27 SPEC transaction for the current month and one month prior, or by filing a claim under the Conlan II claiming process. When evaluating an individual's circumstances for potential reimbursement or recommendation to file a Conlan II claim, it is important to remember and consider the following points:

- Recipients can be ineligible for Medi-Cal at any time for a variety of reasons, but DHCS and the Medi-Cal Eligibility Workers have the sole responsibility for determining Medi-Cal eligibility and making changes to a recipient's eligibility status.

- An individual may be eligible for full-scope Medi-Cal but that does not always mean they will be FFP eligible.

- To participate in the PCSP or IPW an individual must be FFP eligible as well as full-scope Medi-Cal eligible.

- No Buy-Out will be made for recipients who are not eligible for the SOC comparison. To be eligible for the SOC comparison a recipient must have a Medi-Cal SOC and be otherwise eligible for IHSS-R.

IHSS Residual cases with both an IHSS SOC and a non-FFP Medi-Cal SOC will have a SOC comparison and Buy-Out at the same time payment is made for eligible IPW and PCSP cases. The recipient will be responsible for the lower of the two SOCs. If the recipient misses the Buy-Out through no fault of their own and pays out-of-pocket expenses in excess of their SOC responsibility, they may be repaid using a C02 SPEC Adjustment transaction.

The CMIPS Medi-Cal Eligibility Detail (MELG) screen displays the information received from MEDS regarding the recipient's Medi-Cal eligibility status, FFP status and Medi-Cal SOC. It will also indicate the date the displayed information from MEDS was processed in CMIPS. It is important to remember that because of the three day processing time involved in file transfers between the two systems, the information displayed in each system may not match.

The Buy-Out can be verified using the CMIPS SOCD screen for a specific month. A specific monthly SOCD screen will also display any X-27 SPEC transaction reimbursement payments made by the county to the IHSS recipient. (The SOCD screen is described in greater detail later in this ACL.) Recipients who are interested in filing a Conlan II claim should be referred to the DHCS BSC.

No Retroactive Buy-Out

DHCS is unable to accept retroactive payments from CDSS when Medi-Cal reinstates a beneficiary, retroactively adds a Medi-Cal SOC, or makes a change to the Medi-Cal SOC after the MEDS Monthly Renewal File has been processed. For example, if a recipient's annual Medi-Cal renewal packet is not processed before the MEDS Monthly Renewal File is created, the recipient will not be included as a Medi-Cal eligible recipient on the MEDS Monthly Renewal File and will not receive the Buy-Out. Later, when the renewal packet is processed and eligibility is reestablished, these individuals become technically "eligible" for the SOC comparison and in most cases, eligible for the Buy-Out and are responsible for the lower SOC. However, because "retroactive Buy-Out" is not possible, a SOC inquiry from any Medi-Cal provider eligibility terminal, including CMIPS, will display the full Medi-Cal SOC for these recipients. When CMIPS processes an IHSS timesheet for the eligibility month, a POS spend down will process on MEDS deducting any remaining outstanding SOC from the provider's pay warrant. In this case, the recipient is responsible for paying the SOC amount to the provider.

Depending on the individual circumstances, the recipient described above may be eligible for reimbursement of out-of-pocket SOC payments in excess of the amount for which they would have been responsible had the SOC comparison occurred. It is important to remember that in order to be considered for either an X-27 SPEC transaction reimbursement or a Conlan II claim for any excess SOC situation, the recipient must have experienced an actual out-of-pocket expense for the excess SOC amount.

New X-27 SPEC Transaction

A new transaction, the X-27 SPEC was developed to reimburse recipients who through no fault of their own have paid out-of-pocket SOC expenses in excess of their obligation after the SOC comparison. Providers cannot be paid using an X-27 SPEC transaction.

The X-27 SPEC transaction may only be used when the recipient was not included in the Buy-Out, through no fault of their own, and actually experienced an out-of-pocket expense in excess of their SOC obligation for which they are entitled to be reimbursed. An X-27 SPEC transaction is funded solely through State General Fund monies and is only used for the Buy-Out.

In order to be eligible for an X-27 SPEC transaction reimbursement, the recipient's exclusion from the Buy-Out must be through no fault of their own, e.g., they submitted their paperwork timely but it was not keyed soon enough to be included on the MEDS Monthly Renewal File. Therefore, a recipient should not be excluded from the Buy-Out for more than two months, i.e., the current month and one month prior.

Cases with extended months of exclusion from the Buy-Out, i.e., more than the current month and one month prior, should be reviewed carefully to determine the circumstances and resolve the issue surrounding the extended period of exclusion. Recipients should be advised that they may submit a Conlan II claim to request reimbursement of these excess SOC payments. These claims will be forwarded to the CDSS for adjudication.

It is important at this point to reiterate that individuals are only eligible for reimbursement using the new X-27 SPEC transaction if they were <u>not</u> responsible for the delay in establishing their Medi-Cal eligibility.

- This means, for example, if the recipient did not submit their renewal packet timely, they are **not eligible** for reimbursement because they did not comply with Medi-Cal rules and regulations.

- If the individual did submit their renewal packet **timely**, but it was processed after the MEDS Monthly Renewal File was run processed for the next month, they may be eligible for reimbursement through the X-27 SPEC transaction since they met their timely obligation.

- Counties must determine the recipient's/county's culpability in the recipient's exclusion from eligibility on the MEDS Monthly Renewal File for each applicable month before using the X-27 SPEC transaction.

- X-27 SPEC transactions cannot be keyed for periods prior to June 1, 2006, when the SOC POS was implemented.

- X-27 SPEC transactions cannot be done for more than the current month and one month prior if appropriate. All other excess SOC reimbursement claims should be referred to the DHCS Conlan II BSC at the number specified on page three to request a claim packet.

All X-27 SPEC transactions will be subject to Quality Assurance review.

Conlan II Claim vs. X-27 SPEC Transaction

The State has been reviewing the complex issues surrounding excess SOC payments and the Buy-Out with the goal of identifying the appropriate mechanism for reimbursement of these claims. One of the key issues is that a recipient's exclusion from the Buy-Out does not clearly fall within the Conlan II Implementation Plan. Additionally, Conlan II claims are paid using a State/county/federal sharing ratio, while the Buy-Out must be made using SGF monies only. Therefore, only Conlan II payments can be made using the Conlan II sub-system developed for that purpose.

Because of the complexity of evaluating claims for Conlan II versus non-Conlan excess SOC reimbursement eligibility, all recipient SOC reimbursement requests covering periods outside the current month and one month prior should be referred to the Conlan II BSC. The BSC will forward all IHSS claims to the CDSS APB for evaluation.

Claims that fall entirely within the Conlan II requirements will be entered into the Conlan II sub-system. Recipients will receive a Conlan II denial NOA for any part of the claim that falls outside the parameters of a Conlan claim. That notice will advise them that their other excess SOC claim will be evaluated on its own merits and, if approved, will be paid by the CDSS Adult Programs Division using a special CMIPS transaction established for that purpose.

X-27 Transaction Delete and Void Processing

CMIPS allows same-day deletion of an X-27 SPEC transaction. If after that time a warrant resulting from an -27 SPEC transaction needs to be voided or replaced, the initial X-27 transaction must be voided using an S01, S02, S03 or V05 SPEC VOID transaction. If a replacement warrant is necessary, **the initial transaction must be voided and a new X-27 SPEC transaction must be keyed. The void/replace SPEC transactions used in normal warrant processing are not allowed against an X-27 SPEC transaction.**

Excess Share-of-Cost Situations

An excess SOC situation occurs when a recipient obligates a payment for a Medi-Cal eligible expense to a Medi-Cal provider such as a doctor's office visit, prescriptions or other eligible expenses, and that payment is not credited by the Medi-Cal provider against their Medi-Cal SOC at the time of their visit. This most frequently occurs when the doctor, dentist, or pharmacy does not complete the POS/SOC transaction at the time of service, but only checks to see if the recipient has an unmet SOC obligation without actually obligating the payment received from the individual. When this happens, no actual system transaction is performed so MEDS does not spend down the individual's SOC.

Later, when an IHSS timesheet is keyed, CMIPS processes a POS spend-down transaction, and because the doctor or pharmacy failed to apply the SOC obligated during the recipient's visit, MEDS will indicate an outstanding SOC amount that has not been spent down by the amount obligated at the doctor or pharmacy. CMIPS will spend-down as much of the SOC as possible and deduct it from the provider's pay warrant. The recipient is expected to pay the deducted SOC amount to the provider. When this happens, a SOC overpayment occurs because the recipient has been required to obligate the same SOC twice. Later, when the doctor/dentist/pharmacy attempts to complete the POS/SOC transaction, the payment can no longer be processed against the recipient's account because the SOC has already been reduced by the SOC amount withheld from the provider's pay warrant.

This situation is not a missed Buy Out; this is excess SOC paid by the recipient. Do not use an X-27 SPEC for this transaction. Counties should give recipients information on how to obtain a Conlan II claim packet. Filing a Conlan II claim does not guarantee that the recipient will be reimbursed. Reimbursement is decided on a case-by-case basis depending on the individual facts of each unique situation.

X-27 Transaction Process

When it is determined that the recipient should be reimbursed for a missed Buy-Out, the county may issue a reimbursement using the X-27 SPEC transaction. The X-27 SPEC transaction can only be used to reimburse a recipient, not a provider. The recipient must have paid a SOC in excess of the SOC for which they are responsible. Recipients cannot be <u>reimbursed</u> for an amount they have not paid. A new Notice of Action (NOA 527) is produced each time an X-27 SPEC transaction is processed in CMIPS. These NOAs are printed by Electronic Data Systems (EDS). The original is mailed to the recipient and a copy is mailed to the specific county district office for inclusion in the recipient's case file. The NOA advises the recipient of the amount they are being reimbursed and includes the recipient's appeal rights. For example, if the recipient does not feel he or she has been reimbursed for the correct amount, he or she may file for a State Hearing.

Keying the X-27 SPEC Transaction

The new X-27 Emergency SPEC Transaction must be keyed against an IHSS recipient case. The following rules apply to the X-27 SPEC transaction:

- May be keyed against an IHSS recipient case only and cannot be used to pay a provider

- X-27 SPEC may be keyed for a single eligibility month only (no partial months)

- IHSS recipient case must have a MELG record for the eligibility month
- IHSS recipient case must have an IHSS provider with eligibility for the payment month
- IHSS recipient must be Medi-Cal eligible for the eligibility month
- IHSS recipient case(s) must not have an IHSS SOC which exceeds the IHSS Need

The following data entry fields are required:

- FROM – Must be the first day of an eligibility month
- TO – Must be the last day of an eligibility month
- GROSS – The amount to be paid to the IHSS recipient (do not use the NET amount and do not attempt to key any hours or hourly rates)
- AUTH # - The county authorization number associated with the X-27 SPEC transaction

The following edits may be encountered when keying the X-27 SPEC transaction:

- FROM DATE CANNOT BE BEFORE 06/01/2006 – HARD EDIT - From date on SPEC X-27 cannot be prior to June 1, 2006.
- NO RECIPIENT ELIGIBILITY SEGMENT – HARD EDIT – The IHSS Recipient case was not eligible for the time period for which the X-27 is being attempted.
- NO RECIPIENT MEDS ELIGIBILITY – FORCE? – SOFT EDIT – The MELG record indicates the IHSS recipient was not eligible for Medi-Cal in the eligibility month being attempted. User must verify recipient Medi-Cal eligibility through MEDS.
- SOC EXCEEDS NEED – FORCE? – SOFT EDIT – The IHSS SOC on the IHSS recipient case exceeds the IHSS GROSS. If the recipient is part of a couple's case, verify that the aggregated IHSS SOC does not exceed the aggregated IHSS GROSS for all related cases. Use the SOCD screen to see all related cases in an eligibility month.

- INVALID DATE RANGE – HARD EDIT – This edit will appear if any of the following conditions occur: 1) FROM date is not the first day of a month. 2) TO date is not the last day of a month. 3) When the FROM and TO date exceeds a single eligibility month.

- FIELD NOT REQUIRED – HARD EDIT – Data was entered in either the HRS or RATE field.

- REPLACEMENT NOT ALLOWED ON X-27 – An attempt was made to process a REPLACEMENT SPEC transaction against an X-27 payment. X-27 transactions must be VOID, then reissued as an additional X-27 transaction.

These instructions and edits will be included in the CMIPS 2000 Manual update.

X-27 SPEC Transaction Warrant Message

To assist counties and recipients in the easy identification of X-27 SPEC transaction SOC reimbursement warrants, the following messages will be printed on the warrant stub:

- In the YTD wage box the message "REC REIM" will print

- In the IHSS PROGRAM INFORMATION section, the message, "****ATTENTION- RECIPIENT SHARE OF COST REIMBURSEMENT** will print

In the timesheet section the message, "THIS IS NOT AN AUTHORIZED TIMESHEET, DO NOT USE" will print

Share of Cost Detail Screen (SOCD)

To assist counties in determining if the Buy-Out actually occurred for a particular recipient, a new screen, the SOCD screen has been developed. The SOCD screen is generally accessed via the MELG screen. The MELG has been enhanced to allow entry of an "X" to the left of the first column labeled "S." When an "X" is placed under the "S" column next to a month on the MELG screen, pressing "enter" will bring up the SOCD screen. Inserting "X"s next to multiple lines on the MELG will bring up the SOCD screens for each month in sequential order. In approximately the middle of the SOCD screen month-specific information on the payment is displayed. This line shows the payment Date, payment Amount Requested (difference between the two SOCs based on information received from MEDS via the last MEDS Monthly Renewal File processing interface), the Amount Applied (amount DHCS accepted), the Medi-Cal SOC, the IHSS SOC, the IHSS Authorized Services Amount, and an Error Code column. If the recipient was not included in the

Buy-Out, an edit message will be displayed “NO BUY-OUT FOR ELIGIBILITY MONTH”. Detailed information on this screen is contained in the CMIPS 2000 User’s Manual. Section V, I-1 through I-5. (October 1, 2006 release).

The SOCD screen also contains A RECIPIENT REIMBURSEMENT HISTORY section which will list all X-27 SPEC transactions keyed for a specific eligibility month. Up to thirty (30) X-27 SPEC transactions may be viewed on the SOCD screen. (These enhancement instructions will be added to the CMIPS 2000 User’s Manual with the next quarterly update.) The following fields will display:

- RECORDS XX –XX OF XX – Indicates the number of X-27 transactions which exist for the eligibility month
- TXN DATE – The WARRANT PAID DATE – This field will be the date the SPEC transaction was keyed. When the State Treasurers Office (STO) warrant file is processed in CMIPS this date will be updated to the warrant issue date. (Updates like the WARR screen currently does)
- TRANSACTION – All X-27 transactions will be indicated as RECIPIENT REIMBURSEMENT
- OPERATOR – The EDSNET User ID of the individual who keyed the X-27 transaction
- VOID – The date a VOID transaction was keyed against the X-27 transactions
- OPERATOR – The EDSNET User ID of the individual who keyed the X-27 VOID transaction

The RECIPIENT REIMBURSEMENT section of the SOCD screen is scrollable. If more than six (6) X-27 transactions exist for an eligibility month then the F11 key scrolls forward; the F10 key scrolls backward through the Recipient Reimbursement History records (X-27 SPEC transactions). The F7 key pages back to the previously displayed SOCD screens and the F12 key will return you to the MELG screen.

New Monthly Recipient Reimbursement Report

A new report, the Monthly Recipient Reimbursement Report, was designed to provide counties with statistical information on the X-27 SPEC transactions processed by their county. This report will be sorted by County, District Office, and IHSS Case Number. It runs at the end of the month along with other month-end payroll reports. It is important to note that recipient reimbursements <u>will not</u> appear on the report. The report will be

available to counties in the CMIPS Online Reports under the Management group. (See attached sample.)

Other Issues and Reminders

Handling SOC for Couples Cases

Unlike the IHSS-R program, which handles each individual's SOC separately, Medi-Cal handles couples as two members of the same family budget unit (FBU), with a single SOC shared by all members of that FBU. CMIPS does not distinguish whether or not a case is a "Couples Case."

While CMIPS does not allow the designation of couples' cases, they are easily identified in MEDS based upon the Medi-Cal Case Number which will display all members of the FBU on the MEDS SOCR screen. When the Buy-Out is processed, CMIPS will aggregate IHSS recipient cases with the same Medi-Cal Case Number for evaluation. In CMIPS, cases which carry the same Medi-Cal Case Number in a specific eligibility month will be listed in the "RELATED IHSS CASES" section of the SOCD screen.

The Medi-Cal SOC on the RELB screen is the Medi-Cal FBU SOC. When IHSS couples' cases are entered in CMIPS the IHSS SOC is distributed, at the discretion of the county IHSS Social Worker between each member of the IHSS couple. When the IHSS cases are evaluated for the Buy-Out the entire Medi-Cal FBU SOC is compared to the aggregated IHSS couple's SOC on all related cases to determine and "Buy-Out" the difference. When working with couples' cases it is important to keep in mind the difference in how the two shares of cost are displayed.

If one member of a couple's case is either IPW (2L) or PCSP (2M) and the other member is in the Residual (2N) program, all cases will be considered in the evaluation for the Buy-Out. However, CMIPS will process a POS spend-down transaction on only the 2L or 2M portion of the case thereby reducing the Medi-Cal SOC. The Residual program individual's case will be processed according to IHSS-R regulations, but the IHSS SOC deduction will not be applied through the POS against the Medi-Cal eligible recipient's Medi-Cal SOC.

Additionally, effective with the June 1, 2006 POS implementation, it is no longer possible for a recipient, either an individual or member of a couple's case, to designate which of their providers will assume the share-of-cost deduction from their wages. Under the new spend-down process, the SOC will be applied against the first timesheet keyed and processed. If that timesheet does not obligate all of the SOC, then any remaining SOC will be obligated against the next POS spend down transaction processed by any Medi-Cal

provider or when another timesheet is processed through CMIPS. Spend-down processing will continue until the entire SOC obligation is met for the month.

Residual cases are handled and processed like they were prior to the POS implementation. Residual SOC cases have the SOC deducted from the provider's warrants as the timesheets are submitted. No change in this process has occurred.

Clarification of Use For X-01, X-15 and C-02 SPEC Transactions

X-01 SPEC Transaction

An X-01 SPEC transaction is used to make payments resulting from a State Hearing decision. Because of the complexity and uniqueness in determining the resolution of each SOC reimbursement request, APD and the State Hearings Division have agreed that cases that come to hearing for adjudication of appeals related to SOC will be remanded to the county to work with staff from APD to resolve. Working together, the county and APD will determine those cases eligible for reimbursement through the X-27 SPEC transaction and those that should be referred for filing of a Conlan II claim. Counties who receive orders to pay cases that fall into these criteria should contact the APB, IHSS Plus Waiver/Conlan Unit for assistance.

X-15 SPEC Transaction

With the modifications to CMIPS and instructions contained in this ACL, counties may **not** use the X-15 SPEC transaction to reimburse recipients for out-of-pocket SOC expenses in excess of their obligation. This and all other SPEC transactions involve state/county/federal sharing ratios and must not be used for this purpose. However, there may still be rare instances where it is appropriate to use the X-15 SPEC transaction when directed to do so by APB Systems Unit staff.

C-02 SPEC Transaction

The C-02 SPEC transaction was historically the mechanism for making adjustments when there was a retroactive adjustment to the SOC amount. Because of the requirements of the SOC comparison and the SOC POS process, this transaction can no longer be used for IPW and PCSP cases. IPW and PCSP SOC adjustments after June 1, 2006 should be referred to the Conlan II claim process. The C-02 SPEC transaction can still be used for IPW and PCSP cases when the adjustment is prior to the implementation of SOC POS on June 1, 2006 and for all IHSS-R cases regardless of time period.

Automatic Conversion of Aid Codes 10, 20, 60

Status Eligible cases (Medi-Cal Primary Aid Codes 10, 20 and 60) previously identified incorrectly in MEDS as FFP=N resulted in a 2N Funding Source in CMIPS. Medi-Cal eligibility records processed by CMIPS with an Aid Code of 10, 20, or 60 and an FFP=N indication will be automatically changed to FFP=Y. This processing change was effective with the August 2006 MEDS Renewal processing and should no longer be an issue. Counties can verify this entry by accessing the MELG screen and looking at the "FFP" column. Please contact the CDSS Adult Programs Systems Unit with case specific information if a case with an Aid Code of 10, 20, or 60 and a 2N Funding Source code is identified.

Enhancements to the CMIPS NAMR and SSNR Screens

The NAMR and SSNR screens have been enhanced to allow the entry of an "M" in the Recipient Select field, which will provide direct access to the MELG screen associated with that recipient. In order to accomplish this, place the "M" just to the left of the recipient's name, then press enter. Only one individual name can be selected at a time.

Addition of Funding Source Identification to Notices of Action

At the request of many counties, the IHSS Funding Source indication (2L, 2M, 2N) has been added to the IHSS NOAs in the Case Number field to the right of the ten-digit IHSS recipient case number. It is now possible to identify which funding source was in affect when a particular NOA was issued.

Timely Notice vs. Adequate Notice

Because recipients receiving their services through IPW and PCSP must meet their Medi-Cal SOC, DHCS is responsible for providing them with a "timely notice" when they experience a change in their SOC. Counties are responsible for providing "adequate" notice to the recipient if there is a corresponding change to the recipient's calculated IHSS SOC amount. (California Department of Social Services Manual of Policies and Procedures sections 22-001 and 22-071). In IPW and PCSP cases, the calculated IHSS SOC amount is used only for purposes of the SOC comparison. However, NOAs advising IHSS-R recipients of changes to their IHSS SOC must still be made timely. Depending on the timing of the change to the SOC amount, particularly if Medi-Cal makes a retroactive change, recipients may not get the full benefit of the Buy-Out. These situations should be evaluated for eligibility for X-27 SPEC transaction reimbursement or referred to the Conlan II, BSC.

Request for Alien Identification Report

Counties have requested a report that would identify aliens who cannot participate in the IPW or PCSP programs because of their alien status. This is a determination made by DHCS. Unfortunately, the information CMIPS receives from MEDS only indicates that the recipient is not eligible for FFP full-scope Medi-Cal. Therefore, CMIPS cannot identify this segment of the IHSS-R population. However, the alien restriction information is located on the "QE" screen in the MEDS system. Counties should work with their Medi-Cal Eligibility Workers to determine the reason the recipient is not eligible for FFP full-scope Medi-Cal.

Automation of the NOA 350

While the State realizes that including a separate NOA 350 explaining the different IHSS programs with the recipient's assessment NOA is not an ideal process, this may be necessary until the implementation of CMIPS II. The State has looked at various alternatives and currently this option has the least impact on county workload. Revisions to the wording of the current NOA 350 are underway.

NEW NOA MESSAGE FOR RECIPIENT SOC REIMBURSEMENT

527	You are being reimbursed $X,XXX.XX of overpaid share of cost for the period of MM/YYYY because you were not included in the State's payment of medically recognized expenses for that period.
526	Your request for reimbursement of overpaid share of cost for the period MM/YYYY because you were not included in the State's payment of medically recognized expenses for that period is denied. Contact your IHSS Social Worker for additional details.

Attached with this letter are several examples of situations that illustrate the appropriate use of the X-27 SPEC transaction. Each example has a narrative explanation as to why the situation in the example either does or does not qualify for X-27 SPEC transaction reimbursement. Also attached are two X-27 SPEC transaction Reimbursement Worksheets with instructions. These worksheets are not required and are provided for optional county use. Remember, county use of the X-27 SPEC transactions is limited to the current month and one month prior. All other requests for SOC reimbursements should be submitted to the BSC on a Conlan II Claim Form.

If you have any questions regarding this letter, please contact Eileen Carroll, Chief, Adult Programs Operations Bureau at (916) 229-4000.

Sincerely,

Original Document Signed By:

EVA L. LOPEZ
Deputy Director
Adult Programs Division

Attachments

c: CWDA

SAMPLE CASE
ELIGIBLE FOR x-27 SPEC TRANSACTION REIMBURSEMENT

Case Study: Sophia Marks
Case: 9999999999
SSN: 999-99-9999

Sample Assumption: Recipient called regarding a SOC overpayment the first part of December and the case is being reviewed right away

- Situation: Until November this recipient was eligible for A&DFPL/Medi-Cal with a "0" IHSS SOC.
- Effective 11/01/06 she had an IHSS SOC of $45. and a Medi-Cal SOC of $821.
- On Nov. 22, 2006 Medi-Cal again qualified her for A&DFPL through MEDS.
- Current CMIPS system information still shows a Medi-Cal SOC of $821 and an IHSS SOC of $45.

Would the reimbursement for November be done through Conlan II and the reimbursement forDecember through transaction X-27?

The facts according to MEDS and CMIPS
The information shown in the chart below was taken from the screen(s) shown in ( ) below the column title.

Month	**Case Name**	**MEDS SOC** (MELG & SOCR)	**IHSS SOC** (CMIPS)	**State's MRE Amount**	**Actual Amount of State MRE** (MEDS SOC – IHSS SOC)	**First Pay Period SOC** (WARD)	**Second Pay Period SOC** (WARD)	**Payroll SOC Deductions** (WARD)	**Balance on MEDS** (SOCR)	**Adjustment**
Nov		1091.00	0.00	1091.00	1091.00	0.00	0.00	0.00		
Dec		821.00	282.00	539.00	539.00	N/A	N/A	N/A	N/A	*$282.00???

*This is only reimbursable if the recipient has made an out-of-pocket payment. The provider has to submit timesheets before it can even be determined there was an out-of-pocket expense.

Pertinent Data: Recon File Process Date10/26/06.

Since the change to the recipient's SOC happened after the Recon File was processed for November, the recipient was not adversely affected for November. CMIPS processed the State's monthly payment for Medi-Cal Recognized Expenses (MRE) for the entire Medi-Cal SOC for November. A review of the warrant (WARR) screen shows that CMIPS did not deduct any SOC from any provider's pay warrant. Therefore, since the State's payment for MRE is not recipient money and there were no deductions from the provider's pay warrants, there is nothing to refund to the recipient for November.

For December, the MRE payment was processed on information effective 11/22/06. The next change was not made until 11/28/06 after the Recon File had been processed for the December payment of MRE. CMIPS correctly processed the Buy-Out based on the information in the system at the time. In this case, the recipient could be reimbursed up to $237, calculated as $282.minus the $45 IHSS SOC for which they are responsible, ***but only*** after the timesheets are processed. Until this point in time there is no over-payment, the recipient has not actually paid out any money towards her SOC. The X-27 SPEC Transaction is for **reimbursement** of an over-payment of MRE SOC money paid to her IHSS provider.

So far, no timesheets have been processed for any of this recipient's providers so the recipient has not paid out any money for which she needs to be reimbursed. Remember, the system no longer makes a total SOC adjustment at the beginning of the month. Under Medi-Cal rules SOC payments are processed in "real time" when the provider accesses the system whether by a POS terminal in the doctor's office or when CMIPS processes a timesheet. The X-27 SPEC Transaction is not to be issued at the beginning of the month because an error was made in State's MRE payment.

When the X-27 SPEC Transaction is used, it must be made clear to the recipient why they are receiving the warrant.

In addition, the MELG screen still shows a November SOC of $1,091 and for December a SOC of $821. The only way the MELG screen gets updated is by receiving information from MEDS via the CMIPS/MEDS interface. As long as this information remains "as current" in MEDS, CMIPS will continue to use it. Only Medi-Cal can make corrections to their information. At the same time, since CMIPS interfaces with MEDS before it deducts any SOC from the provider's warrants, if MEDS has been corrected to zero, there is nothing there for CMIPS to deduct. For this reason, corrections can not be processed without researching each case's individual circumstances.

SAMPLE CASE
NOT ELIGIBLE FOR X-27 SPEC TRANSACTION REIMBURSEMENT

Case Study: Felicia Hunter
Case: 0000000000
SSN: 999-99-9999

Situation: Medi-Cal case closed in error 8/31/06 due to Cal-Win conversion problems. Later reopened with a SOC. Client paid the higher Medi-Cal SOC of $550 rather than the IHSS SOC of $314 for both September and October 2006. Amount = $241.02 for PP2 in September and October 2006 (Balance of SOC due was $5.02 for PP2 if correct SOC of $314 was used; $308.98 SOC deducted for PP1 in September and October and $241.02 deducted from PP2 for those months.

Contact:

The facts according to MEDS and CMIPS
The information shown in the chart below was taken from the screen(s) shown in ( ) below the column title.

Month	**Case Name**	**MEDS SOC** (MELG & SOCR)	**IHSS SOC** (CMIPS)	**Buy-Out Amount**	**Actual Amount Bought Out** (MEDS SOC – IHSS SOC)	**First Pay Period SOC** (WARD)	**Second Pay Period SOC** (WARD)	**Total Payroll SOC Deductions** (WARD)	**Balance on MEDS** (SOCR)	**Adjustment**
August		504.00	314.00	190.00	190.00	308.98	0.00	308.98	550.00	5.02*
September		550.00	314.00	236.00	0.00	308.98	241.02	550.00	0.00	236.00**
October		550.00	314.00	236.00	0.00	308.98	241.02	550.00	0.00	236.00**

*__August__: According to CMIPS records the recipient should have paid another 5.02 to meet their SOC obligation. Based on Medi-Cal records which include a retroactive increase in the Medi-Cal SOC, the recipient should have paid another $51.02 to meet their SOC obligation.
**__September/October:__ Only eligible for reimbursement (CONLAN II) if this amount was actually paid to the IHSS provider in addition to the $314 SOC the recipient is responsible for paying to meet their Medi-Cal SOC obligation.

Pertinent Data: Medi-Cal eligibility not reported to CMIPS until 9/14/06 for both September and October. According to CMIPS segment 027, this case was in “T” status as of the end of August. “T” status not changed to “E” until October 5, 2006. CMIPS correctly processed this case for all months based on the information contained in the database. This case does not meet the criteria for a missed “Buy-Out” for the purposes of an X-27 Spec Transaction. This is a retroactive Medi-Cal eligibility change. In fact, according to the SOCR screen MEDS changed the Medi-Cal SOC for August to $550 from the $504 which was originally transmitted to CMIPS. CMIPS used the March 25, 2006 (segment 025) information for processing the August Buy-Out. No Buy-Outs were processed for September or October since the case was in “T” status. SOC deductions for September and October were based on information

received from MEDS on September 14, 2006 which indicated a $550 Medi-Cal SOC. Since no timesheets had been received prior to receiving the information from MEDS, CMIPS used the Medi-Cal SOC for processing.

County Action: Recipient needs to be advised to file a Conlan II claim for reimbursement of overpaid Medi-Cal SOC due to retroactive changes made by Medi-Cal. Recipient must have paid their provider the correct SOC amount plus some portion of the Buy-Out amount to be eligible for reimbursement. The recipient is only eligible for reimbursement of that portion of the Buy-Out amount that was actually paid by them to the provider. Remember, this is a Medi-Cal SOC and Medi-Cal sees the IHSS program as just another Medi-Cal provider. From their viewpoint, the recipient can't be reimbursed unless they have actually overpaid their SOC.

SAMPLE CASE
NOT ELIGIBLE FOR X-27 SPEC TRANSACTION REIMBURSEMENT

Recipient:: Fozzie Bear
Case: 0000000000
SSN: 999-99-9999

IHSS Provider: Tavia Miller

Complaint: I have an email from Shaylah explaining the situation to one of her co-workers. The constituent says IHSS is inaccurately billing her for her share of cost. Her share of cost is $539.97. They are taking out an additional $45 at the end of the month and moving it to the next month, and by doing this, she never reaches her required shared costs amount, making her ineligible for Medi-Cal.

Contact: Shaylah Marks

The facts according to MEDS and CMIPS
The information shown in the chart below was taken from the screen(s) shown in ( ) below the column title.

Month	**Case Name**	**MEDS SOC** (MELG & SOCR**)**	**IHSS SOC** (CMIPS)	**Buy-Out Amount**	**Actual Amount Bought Out** (MEDS SOC – IHSS SOC)	**First Pay Period SOC** (WARD)	**Second Pay Period SOC** (WARD)	**Payroll SOC Deductions** (WARD)	**Balance on MEDS** (SOCR)	**Adjustment**
August			585.11	236.00	236.00	539.97	45.03	585.00	0.00	0.00
September		821.00	585.11	236.00	236.00	539.97	45.03	585.00	0.00	0.00
October		821.00	585.11	236.00	236.00	539.97			0.00	0.00
November		821.00	585.11	236.00	236.00	539.97			0.00	0.00
December		821.00	585.11	236.00	236.00					
		821.00								

SAMPLE CASE C

Pertinent Data: CMIPS records indicate this recipient's IHSS SOC has been $585.11 since at least March 2006. The Medi-Cal SOC has been $821 during the same period. CMIPS has been correctly calculating the payroll deductions, $539.97 from the first pay period and $45.03 from the second pay period since the first pay period wages were insufficient to cover the entire SOC. Why the recipient thinks their SOC is only the first amount, $539.97 is unknown, however, what may be happening is confusion on the part of the recipient due to the new way CMIPS processes the payroll and deducts SOC. Prior to June 2006, CMIPS deducted both the Buy-Out and SOC at the first of the month. Now with the changes in processing required by Medi-Cal rules, CMIPS only deducts the Buy-Out amount at the beginning of the month and then deducts any available SOC as timesheets are submitted. This means that if there aren't enough hours submitted on the first timesheet submitted to cover the entire SOC for the month, CMIPS will deduct it from the next timesheet submitted. In this case, the second timesheet period is the last two weeks of the month and therefore, the remaining SOC amount isn't deducted until after the first of the following month when the second pay period timesheet is processed. The recipient is probably used to having their SOC certified at the beginning of the month under the old procedure and that doesn't happen any more under Medi-Cal rules. In case she asks, it isn't optional to change back to the old procedure. Medi-Cal rules also state that the recipient has the right to pay their SOC anywhere (i.e. the doctor, dentist, not just her provider). Additionally, under Medi-Cal rules the SOC cannot be deducted in advance of the hours worked by her provider. Timesheets cannot be submitted before the hours are actually worked.

With the exception of December, the recipient has been Medi-Cal certified every month. While the month of December has not been completed, a review of both the Medi-Cal and CMIPS information shows the SOC information unchanged.

SAMPLE CASE
ELIGIBLE FOR X-27 SPEC TRANSACTION REIMBURSEMENT

Case: Shallabah Marks
SSN: 999-99-9999
Situation: Recipient complaining that too much SOC is being deducted from her provider's warrants.
Contact: (999) 999-9999

The facts according to MEDS and CMIPS
The information shown in the chart below was taken from the screen(s) shown in ( ) below the column title.

Month		**MEDS SOC** (MELG & SOCR**)**	**IHSS SOC** (CMIPS)	**Buy-Out Amount**	**Actual Amount Bought Out** (MEDS SOC – IHSS SOC)	**First Pay Period SOC** (WARD)	**Second Pay Period SOC** (WARD)	**Payroll SOC Deductions** (WARD)	**Balance on MEDS** (SOCR)	**State MRE Payment Adjustment**
JAN		748.00	553.50	194.50	0.00	643.63	104.37	$ 748.00	0.00	194.50
FEB		836.00	553.50	282.50	0.00	643.63	192.37	$ 836.00	0.00	282.50
MAR		836.00	553.50	282.50	283.00	553.00	N/A	553.00	0.00	0.00
									TOTAL	**$477.00**

Pertinent Data:

- The only information was entered into CMIPS in time for the Recon File Processing was done in February in time for the State's payment of Medi-Cal Recognized Expenses (MRE) for March 2007. CMIPS correctly paid the State's Medi-Cal Recognized Expense ($283) portion of the Medi-Cal SOC leaving a balance of $553 which was deducted from the provider's warrant for the first pay period for March. The provider was issued a warrant for the balance.

- For the prior months, CMIPS did not receive any information from MEDS in time to do the SOC comparison and pay the State's Medi-Cal Recognized Expense portion of the Medi-Cal SOC. CMIPS can only do the SOC comparison and make the State's payment for MRE if the information is transmitted by MEDS prior to the monthly payment.

County Action:

This case is eligible for an X-27 SPEC Transaction reimbursement if the delay in posting the information to CMIPS was not the recipient's fault. That means if the recipient completed and submitted all paperwork timely, cooperated with the county social worker, etc. The X-27 SPEC is only available for reimbursement to the recipient when a payment of MRE by the State is missed through no fault of the recipient. **The recipient must experience an actual out-of-pocket expense to be eligible for reimbursement.**

This example is clearly an X-27 SPEC Transaction because it involves the State's once-a-month payment of Medi-Cal Recognized Expenses. The payment /reimbursement involves only State General Fund money. Reimbursements for other excess share-of-cost overpayments should be referred to the Conlan II Business Service Center number in the All-County Letter.

Providing the recipient has met the eligibility criteria, the county should process an X-27 SPEC Transaction to reimburse the recipient for the out-of-pocket payments for January and February. It is the responsibility of the county to ensure that the recipient has actually made and out-of-pocket payment for which he/she needs reimbursement.