



CDSS

WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

744 P Street, MS 8-17-12, Sacramento, CA 95814 www.cdss.ca.gov



EDMUND G. BROWN JR.
GOVERNOR

DRAFT

ALL-COUNTY LETTER NO.: 11-XX

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER WAGE REIMBURSEMENT FOR UNPAID EXCESS MEDI-CAL SHARE OF COST DEDUCTIONS

REFERENCE: ALL-COUNTY LETTER (ACL) No. 07-11, ACL No. 07-46

This All-County Letter (ACL) provides information to counties regarding a new process developed for reimbursing IHSS providers for incorrect Medi-Cal Share of Cost (SOC) pay warrant deductions when the recipient has not paid the deducted SOC to the IHSS provider.

Background

Currently, some recipients are required to pay a Medi-Cal share of cost (SOC) in order to receive Medi-Cal benefits, including IHSS. When a provider for those individuals submits a timesheet, the IHSS program Case Management, Information and Payrolling System (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 amount is deducted from the provider's pay warrant(s) for that time period. CMIPS then generates letters to the IHSS recipient and provider indicating the recipient is required to pay the amount deducted from the pay warrant for the Medi-Cal SOC to the provider.

If the Medi-Cal SOC listed in MEDS is incorrect when the timesheet is processed then an incorrect deduction is made from the provider's pay warrant. Currently, if the Medi-Cal SOC was incorrect and the deducted amount is greater than what the corrected amount is and the recipient has paid the provider the greater amount, the recipient may file a claim for reimbursement using the Beneficiary Reimbursement Process (Conlan II). However, there was no process to directly reimburse the provider if the recipient has not paid the provider the higher, incorrect Medi-Cal SOC.

REASON FOR THIS TRANSMITTAL

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

New Provider Reimbursement Process

The California Department of Social Services (CDSS) has developed a process to directly reimburse providers who have had an incorrect Medi-Cal SOC deduction withheld from their pay warrant if they have not been paid by the recipient. A new claim form has been created to facilitate this process and is attached. This new process will be available effective XXXX. When either a recipient or provider contact the county regarding an incorrect Medi-Cal SOC deduction from a provider pay warrant, the county shall take the following steps:

1. Determine if the provider is due reimbursement for an incorrect Medi-Cal SOC deduction by reviewing both MEDS and CMIPS systems to check if the amount taken from the provider's pay warrant for the pay period in question is greater than the Medi-Cal SOC for the same period.
2. a. If the amount taken from the pay warrant is **less than or equal to** the Medi-Cal SOC indicated in MEDS **for the period of time in question**, the county will inform the recipient and provider (in writing) that the correct Medi-Cal SOC was taken, and that if the recipient disputes the Medi-Cal SOC, they should contact their Medi-Cal Eligibility Worker.

OR

- b. If the amount taken from the pay warrant is **greater** than the Medi-Cal SOC **for the period of time in question**, the county will complete the County Verification section of the Provider Wage Reimbursement Claim Form (Claim Form) and then forward it to recipient and provider to be completed and executed by both the recipient and provider and returned to the county. If there is more than one pay period in question, complete a separate Claim Form Addendum (Attached hereto) for each pay period and submit with the original Claim Form.
3. Upon receipt of the Claim Form by the recipient and provider, the county will verify that it has been completed correctly, signed by both the recipient and provider, and then send it to CDSS at the following address:

California Department of Social Services
Litigation and Appeals Bureau
744 P Street, MS 9-9-04
Sacramento, CA 95814

CDSS has responsibility for the final decision regarding the provider's eligibility for reimbursement and for initiating reimbursement of any monies owed to the provider. A new reimbursement special transaction (SPEC X-31) has been created in CMIPS for this purpose to be used by state staff only. A copy of the final decision will be mailed to the recipient, the provider, and the county in each case.

Camera-Ready Copies and Translations:

Counties may access a camera-ready version of the Claim Form (in English) on CDSS' Forms/Brochures web page at: _____. Questions about accessing the form may be directed to the Forms Management Unit at FMUdss@dss.ca.gov or via telephone at (916) 657-1907.

CDSS is in the process of translating the Claim Form. Language Translation Services (LTS) will make available camera-ready copies of the Claim Form translated into Spanish, Armenian, and Chinese as they are completed. Once they are available, you may access these translated forms at _____.

Each county shall provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations as required by the Dymally Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and by State regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115).

Should you have any questions regarding this ACL, please contact the Litigation and Appeals Bureau at (916) 651-3488.

Sincerely,

EILEEN CARROLL
Deputy Director
Adult Programs Division

c: CWDA

Attachment

**In-Home Supportive Services (IHSS)
Retroactively Adjusted Medi-Cal Share of Cost (SOC)
IHSS Provider Wage Reimbursement Claim Form
Page One of Two**

NOTE: This form must be returned to the county IHSS office for verification. **DO NOT** mail this form directly to the State as it will be returned to you unprocessed.

Section A: Provider Information (must be completed by Provider)

1. Name (print clearly):	2. Address:
3. Telephone Number:	4. Date of Birth:
5. Pay Period (dates/month/year) SOC was Incorrectly Deducted:	6. Amount Claimed: \$

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form, **and any Addenda attached hereto**, is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount(s) claimed herein.

Signature of Provider

Date

Section B: Recipient Information (must be completed by Recipient)

7. Name (print clearly):	8. Address:
9. Telephone Number:	10. County IHSS Case Number:

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form, **and any Addenda attached hereto**, is true and accurate to the best of my knowledge and belief. I authorize Medi-Cal to receive and release such information in connection with processing claims and any other lawful purpose related to participation in the IHSS Program. I understand that all personal health information will be treated as confidential and will not be disclosed for any other purpose. **I have not previously and do not intend to file a Conlan II claim, assuming a satisfactory resolution is reached pursuant to this procedure, and I have not paid and do not intend to pay this provider for the amount(s) claimed herein.**

Signature of Recipient

Date

***** COUNTY USE ONLY *****

**In-Home Supportive Services (IHSS)
Retroactively Adjusted Medi-Cal Share of Cost (SOC)**

**IHSS Provider Wage Reimbursement Claim Form
Page Two of Two**

Claimant / IHSS Provider Name (print) _____

IHSS Case Number _____

Section C: County Verification

1. Name of Medi-Cal Eligibility Worker:	2. Telephone # of Medi-Cal Eligibility Worker:
3. Name/Title of Staff Completing Verification:	4. Telephone # of Staff Completing Verification:
5. MEDS Month/Year of Service & SOC Displayed:	6. CMIPS Warrant Month/Year & SOC Deducted:
7. Total Amount Claimed by Provider: \$	8. Amount Verified for Payment to Provider: \$

I have reviewed the CMIPS and MEDS warrant data and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period in question and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

Signature of County Staff
(Supervisory Level)

Date

Printed Name

**In-Home Supportive Services (IHSS)
Retroactively Adjusted Medi-Cal Share of Cost (SOC)**

**IHSS Provider Wage Reimbursement Claim Form Addendum
(Additional Pay Periods)**

Claimant / IHSS Provider Name (print) _____

IHSS Case Number _____

Section A: Provider Information (must be completed by Provider)

Pay Period (dates/month/year) SOC was Incorrectly Deducted:	Amount Claimed: \$
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Section C: County Verification

MEDS Month/Year of Service & SOC Displayed:	CMIPS Warrant Month/Year & SOC Deducted:
Total Amount Claimed by Provider: \$	Amount Verified for Payment to Provider: \$

I have reviewed the CMIPS and MEDS warrant data and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period in question and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the *Amount Verified for Payment to Provider* box, above.

Signature of County Staff

Date