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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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### 2A - MEDI-CAL ELIGIBILITY QUALITY CONTROL (MEQC) PROCESS DESCRIPTION

The Program Review Section, Medi-Cal Eligibility Branch has the responsibility for MEQC. The primary purpose of MEQC is to ensure that persons who are entitled to Medical Assistance Only (MAO) are given eligibility by identifying sample cases that were incorrectly denied or discontinued and identifying the reasons for the errors.

MEQC activities are federally mandated by the Center for Medicare and Medicaid Services (CMS) and designed under federal rules and authorization. Reviews are completed for the federally eligible part of the Medi-Cal program; therefore, state-only funded cases are excluded from review.

#### 1. Overview

MEQC audits the county eligibility determination process based on a Geographic Sampling Pilot Project (GSP) initiated July 1, 1999. Prior to the GSP, MEQC reviewed a random sample of MAO cases for all 58 counties. The number of MEQC case reviews selected for each county was proportionate to its share of the statewide MAO beneficiary population. Under the GSP, only the 25 counties with the largest MAO population are included for the regular random sample. The remaining 33 counties are included in the Periodic Case Review (PCR) process. Under the PCR, counties are scheduled to have 10-50 cases reviewed on a periodic basis. A chart of California counties' MAO populations as of June 2002 is included in this procedure. The 25 large and 33 small counties are identified with the corresponding MAO population. The 25<sup>th</sup> county has changed as of April 2003 from Santa Cruz to Madera based on the MAO population.

During the life of the GSP, the State's error rate as identified by the Federal Government is frozen at 0.635 percent. This percent is the computed dollar error rate for fiscal year 1997, the most recently completed MEQC period prior to the inception of the GSP. The terms of the GSP preclude MEQC fiscal repercussions or sanctions for the duration of the pilot project. An annual report summarizing all MEQC activities is submitted to CMS on an annual basis to comply with the terms of the GSP.

In addition to the MAO monthly sample and the PCR, a Negative Action Case Review (NCR) is completed on a select number of counties each year. The NCR is an audit of persons denied or discontinued from the Medical Assistance Only (MAO) programs. The negative action is compared to the information in the case record for appropriateness and timeliness.

Other reviews have been developed based on identified needs. These reviews are categorized as Focused Reviews (FR). The FR is a specialized review of an issue specific to a county or specific to a program. See Article 2C for a list of current FCRs.

#### 2. Review Process

The Medi-Cal eligibility review process for the MEQC sample differs from all other reviews. All cases in the MEQC sample are given a full investigation. This includes a review of the physical case record, the county's automated eligibility system as appropriate, and a field investigation if indicated. The field investigation may consist of a contact with the beneficiary

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or the beneficiary's representative through a home visit, phone call, or by mail. In addition, contacts with other sources may be made to verify information and research public records. A match to the Income Eligibility Verification Applicant System will be included for each case. All other review types are limited to the case record and the county's automated eligibility systems.

### 3. Sample Size

#### a. MEQC Sample

The MEQC sample for the 2003-2004 GSP will be conducted in the 25 large counties and is projected to be 2,520 cases. (14 cases monthly X 12 months X 15 staff persons, assuming fully trained experienced staff). The number of cases for each of the 25 counties is proportionate to the MAO population within the county. The sample is randomly selected from the recipient eligibility history file.

#### b. PCR Sample

The PCR sample for the 2003-2004 GSP, will be conducted in some but not all of the 33 small counties. The number of cases to be reviewed in each county will be proportionate to the MAO population within the county. The larger of the small counties will have no more than 50 cases reviewed. The smaller of the small counties will have no fewer than 10 cases reviewed.

#### c. NCR Sample

All counties, regardless of size, will be included in the NCR process. The number of cases to be reviewed in each county will be proportionate to the MAO population within the county. The largest county, Los Angeles, would have no more than 240 cases selected for review. The smallest county, Alpine, would have no more than 10 cases selected for review.

#### d. FR Sample

The size of an FR varies based on the focus of the review. In most cases the minimum number of cases is 50. As with the PCR and NCR, some reviews are based on the MAO population within the county.

### 4. Eligibility Review

The MEQC, PCR and FR reviews determine whether the sample cases were actually eligible for Medi-Cal benefits, the program to which they are entitled and the accuracy of the share of cost. The reviews normally occur the second month after the month of eligibility.

The NCR review determines whether the county took an appropriate action to deny or discontinue Medi-Cal benefits. The review usually occurs the third month after denial or discontinuance of eligibility.

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### 5. Appeal Process

When a case included in the MEQC sample is determined to have a discrepant case finding, a letter will be issued to the county. The letter identifies the discrepancy and the type of case finding. The county is allowed to appeal case findings of eligibility and liability errors. There is no appeal process for indeterminate, procedure, or pertinent case findings.

Cases included in the PCR, NCR, and FR process are not subject to the appeal process. Counties will be provided an opportunity to respond to discrepant case findings based on the review format and negotiated time frames. Individual case letters are not issued. Instead, the report for each of the processes will include a listing of cases and the findings for review. See Article 2B for more detail.

### 6. Corrective Action

Medi-Cal only eligibility error findings are transmitted to the counties on a flow basis through individual case letters for the MEQC sample. The counties are expected to correct individual cases involved. See Article 2B for more detail.

The findings from all MEQC reviews are used to identify focused reviews specific to a county or in general. Counties are encouraged to use the findings to identify patterns that indicate the need for corrective action within the county, including refresher training or revised county procedures.

### 7. County Consolidated Summary Report

A Consolidated Summary Report is completed for each of the 25 large counties designated by the GSP for each six-month period within the GSP. The reports for the April through September period are issued in January of each year. The reports for the October through March period are issued in July of each year. See Article 2B for more detail.

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### Medi-Cal Eligibility Quality Control Counties

25 Largest Counties  
(94 % CA MAO Population)

Los Angeles	1,171,454
Orange	186,117
San Diego	153,087
San Bernardino	139,217
Riverside	119,207
Fresno	110,075
Santa Clara	90,910
Kern	85,866
Sacramento	79,332
Alameda	67,429
Tulare	61,562
Ventura	56,588
San Joaquin	56,375
Stanislaus	53,807
Monterey	43,184
San Francisco	42,572
Contra Costa	41,852
Santa Barbara	34,292
Merced	32,366
San Mateo	30,148
Sonoma	22,895
Solano	22,630
Butte	22,608
Imperial	20,852
Madera	<u>17,845</u>
	2,762,270

### Periodic Case Review Counties

33 Smallest Counties  
(6 % CA MAO population)

Santa Cruz	17,171
Shasta	15,763
Kings	15,065
San Luis Obispo	14,499
Yolo	12,094
Humboldt	11,143
Mendocino	9,526
Sutter	9,392
Placer	8,026
Napa	7,290
Marin	7,113
El Dorado	6,734
Yuba	6,628
Tehama	6,267
Lake	5,419
Siskiyou	4,399
Nevada	4,374
San Benito	3,521
Glenn	3,312
Tuolumne	3,204
Colusa	3,131
Del Norte	2,869
Calaveras	2,423
Lassen	2,065
Inyo	1,746
Amador	1,710
Plumas	1,432
Mariposa	1,207
Modoc	1,054
Trinity	990
Mono	707
Sierra	218
Alpine	<u>114</u>
	190,606

*Data from June 2002 Medi-Cal Beneficiary Count Report, Medically Indigent and Medically Needy*

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### 2 B - - MEDI-CAL ELIGIBILITY QUALITY CONTROL (MEQC) CORRECTIVE ACTION REVIEW (CAR) PROCESS

Under the Geographic Sampling Pilot (GSP), cases included in the Medical Assistance Only (MAO) sample are subject to all components of the MEQC CAR process. Cases included in all other reviews will follow the definition of case discrepancy findings but have separate corrective action components based on the type of review.

#### 1. Case Finding

The MEQC Analyst will determine a case finding for all cases reviewed. The case finding will be used to determine the entries into the MEQC Database on the Q5 System and used for the Consolidated Summary Report (See No. 6 below). In some case situations, more than one case finding may be identified. When this occurs, the following order of case findings will be used:

##### a. Indeterminate

The Section 1931(b) program is currently excluded from the MAO monthly MEQC sample, and is monitored through the Focused Case Review (FR) process. Because of the complexity of the Medi-Cal programs, cases with Section 1931(b) eligibility might be included in the MAO sample. Beginning with the October 2001 sample month, the MEQC Analyst will consider the implications of the Section 1931(b) program on other persons in the Family Budget Unit (FBU). When a discrepancy is noted, an Indeterminate finding will be documented for the county's consideration but will not be counted as a hard error citation towards the county's error rate.

##### b. Eligibility/Liability Error

An eligibility/liability error exists when at least one member of the MFBU receives Medi-Cal benefits to which he or she is not entitled.

An eligibility error exists under the following situations when a person receives Medi-Cal and was not eligible for any scope of services.

- An eligibility error with ineligible services error exists when a beneficiary receives full scope services and is only eligible for restricted services. This would include a pregnant woman who was eligible for pregnancy related services under the Asset Waiver Program who was issued full scope benefits.

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- If any case member has excess resources for all scope of services, there is an eligibility error. However, if the cost of medical services received in the review month exceeds the amount of excess resources, the final case error finding will be understated liability. The error amount will be the amount of excess resources.
- As of December 11, 2000, an eligibility error will be cited when the County Welfare Department (CWD) cannot locate the case record and there is insufficient information in the electronic file to justify the benefits that were issued.

A liability error exists when there is a difference of \$400 or more in the amount of the share of cost (SOC) calculated by the county as compared to the SOC calculated by State Quality Control (QC). This change became effective with the April 2002 sample month.

- If the State SOC computation is less than the SOC computed by the county, the liability is an overstated SOC error.
- If the State SOC computation is more than the SOC computed by the county, the liability is an understated SOC error.

c. Procedural Error

A procedural error exists when there is a difference between the case record information and an error in how the agency treated the information that does not result in an eligibility/liability error. Procedural errors include those case situations in which:

- The amount of the SOC calculated by the county as compared to the SOC calculated by State QC is less than \$400. This change became effective with the April 2002 sample month.
- The change, which caused the error, occurred in the administrative period.
- The difference would not cause a difference in eligibility or liability.



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d. Pertinent Information

A pertinent information situation exists when there are changes or unreported information that has no impact on the review month but may be of importance for future months of eligibility.

e. Dropped Cases

A case drop situation exists when one of the following situations occur:

- All beneficiaries are cash assistance recipients or in a 100% federally funded program. For example, cases for persons receiving medical assistance under the Refugee Resettlement Program are not included in the MAO sample. These cases would not normally be selected through the automated sampling pilot but if included will be dropped without any MEQC review.
- The beneficiary moves out of the state after the review month and there is insufficient information available to complete the case. An eligibility error is cited when a beneficiary moves out of the state prior to or during the administrative period.
- The beneficiary cannot be located to complete the review or refuses to cooperate with the review process and there is insufficient information in the case record to complete the review.

2. Administrative Period

All MEQC reviews require the examination of case circumstances and eligibility as of the review month. The MEQC Analyst will evaluate eligibility based on the administrative period. This period covers two months – the review month and the month prior to the review month. If an error occurs due to a change during the administrative period, an eligibility/liability error will not be cited unless the CWD completed an incorrect change.

There are situations in which the administrative period is not applied.

- The eligibility status of the case was incorrect as of the review month and would remain incorrect regardless of the change in circumstances.
- The agency incorrectly adjusted the eligibility/liability status of the case based on a change reported during the administrative period.

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- Terminated Continuing Medi-Cal Coverage (CMC) or Transitional Medical Care (TMC) cases are erroneously extended past the time limit for the program. For CMC cases this is a four-month time limit. For TMC, a six-month time limit applies.
- The case contains a Continuous Eligibility (CE) infant or pregnant woman and the provisions of CE eligibility apply. The income for the review month may be the income used to determine the initial month of CE eligibility for the pregnant woman that is carried through to the end of CE for the infant.
- The case contains a Continuing Eligibility Children (CEC) child and the provisions of CEC eligibility apply. The income for the review month may be the income used to establish a new period of CEC eligibility.

The income to be used will be determined by the type of case under review and based on the income rules for that specific program. In computing the SOC, the MEQC Analyst will use the following procedures:

- a. With the inception of April 2002 case reviews, calculate the SOC using the averaged income received in the review month. If there is a difference between the SOC calculated by the CWD and the SOC calculated by the State of less than \$400, no further calculations are necessary. If the SOC is \$400 or more go to step b.
- b. With the inception of April 2002 case reviews, if the SOC based on the averaged income received in the review month differs by \$400 or more, calculate the SOC using the income received in the administrative month prior to the review month. If the difference in the SOC is less than \$400, no further calculations are necessary. If the SOC is \$400 or more go to step c.
- c. With the inception of April 2002 case reviews, if the difference in the SOC is greater than \$400 in the review month and the prior month, calculate the SOC using the income received two months prior to the review month. If the difference in the SOC is less than \$400, no further calculations are necessary. If the SOC is \$400 or more go to step d.
- d. With the inception of April 2002 case reviews, if the difference in the SOC from step c is greater than \$400, an error must be cited.

The case facts must be evaluated to determine error responsibility in those cases with a \$400 or more SOC difference. If it is determined that the error is beneficiary caused, the converted review month income will be used to compute the SOC. When the error is deemed to be agency caused, use the converted income received two months prior to the review month. If the

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CWD completes a budget change during the administrative period it must include budget information available as of the date of the budget change. If information affecting the SOC is disregarded and the result is an error of \$400 or more, an agency error will be cited.

### 3. Corrective Action

Medi-Cal only (MAO?) eligibility error findings are transmitted to the counties on a flow basis through individual case letters for the MEQC sample. The counties are expected to review and take corrective action on the individual cases involved. Only those case letters identifying eligibility/share of cost errors will include a request for the CWD to respond within 10 calendar days. This response process is covered under the Appeal Process (see #4 below). In all other situations except for dropped cases, a follow-up Corrective Action Review (CAR) is conducted six months following the close of the review period to determine if corrective action has occurred. The CWD will be contacted to request information for cases, which cannot be reviewed through the State MEDS system. (See #5 below for the Dropped Case process.)

The findings from all MEQC reviews are used to identify focused reviews specific to a county or in general. Counties are encouraged to use the findings to identify patterns that indicate the need for corrective action within the county, including refresher training or revised county procedures.

### 4 Appeal Process

When a case included in the MEQC sample is determined to have a discrepant case finding, a letter is authorized for issuance by the MEQC Regional Manager with responsibility for the county. The letter identifies the discrepancy and the type of case finding. This action initiates the Appeal process.

#### a. First Level Appeal

The CWD has 10 working days from the date of the letter to disagree with a QC error. If the County disagrees with the cited error(s), a written first level appeal is returned to the PRS Regional Manager with responsibility for that county. The appeal response is evaluated with any additional facts provided by the county. One of four actions will then result:

- The error will be rescinded and the case considered correct with no additional issues.
- The error will be rescinded and a new letter issued because of procedural

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or pertinent information issues ending the appeal process.

- The error will be modified and a new error letter issued continuing the appeal process into a second appeal level. The county will not be given an additional first level appeal. This includes those situations in which the original error occurred because the county was unable to provide the case record and there was insufficient information in any automated system to determine the accuracy of the scope of services and/or share of cost.
- The original error will be sustained continuing the appeal process into a second appeal level.

b. Second Level Appeal

If the county continues to disagree with the case finding, a second level appeal may be made to the Section Chief, Program Review Section. The second level appeal must be made within 30 calendar days of dismissal of the first appeal.

The County will be instructed to send second level appeals to:

Tom Welch, Chief  
Department of Health Services  
Program Review Section  
MS 4610  
P.O. Box 942732  
Sacramento, CA 94234-7320  
FAX: (916) 552-9478

The appeal response is evaluated with any additional facts provided by the county. One of four actions will then result:

- The error will be rescinded and the case considered correct with no additional issues.
- The error will be rescinded and a new letter issued because of procedural or pertinent information issues ending the appeal process.
- The original error will be sustained ending the appeal process.

Cases included in the Periodic Case Review (PCR), Negative Case Action Review (NCR) and Focused Review (FR) process are not subject to the appeal process.

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based on the review format and negotiated time frames. Individual case letters are not issued. Instead, the report for each of the processes will include a listing of cases and the findings for review.

### 5. Dropped Cases

A case will be dropped when the MEQC Analyst is unable to complete a review because the beneficiary cannot be located to complete the review or refuses to cooperate with the review process. In addition, a case will be dropped when there is insufficient information in the case record to complete an accurate eligibility determination. This analysis will be based on what information is available from the case record, from contact with the beneficiary and third party sources. A letter will be sent to the CWD advising of the noncooperation and dropped case status. The County will be requested to attempt to contact the beneficiary and obtain cooperation with the MEQC review process and evaluate for discontinuance of Medi-Cal benefits if the beneficiary is noncompliant.

If the beneficiary cooperates with the MEQC review process within 45 days of the case drop notification, the MEQC Analyst will advise the County that the beneficiary has cooperated and the change in case status. If the beneficiary cooperates with the County and provides the information and/or verifications missing from the case review, the County should forward to the MEQC Analyst in order for the review to be completed. Cooperation with the Medi-Cal Quality Control process is mandated by federal regulation under 42 CFR 431.800 and 431.801. If the beneficiary does not cooperate, the case will be excluded when calculating the County's quality control accuracy rate.

### 6. County Consolidated Summary Report

A Consolidated Summary Report is completed for each of the 25 large counties designated by the GSP for each six-month period within the GSP. The county receives an individual letter specific to the county and in comparison to the other 24 large counties included in the MEQC sample activity. The reports for the April through September period are issued in January of each year. The reports for the October through March period are issued in July of each year.

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### 2 C - - MEDI-CAL ELIGIBILITY QUALITY CONTROL (MEQC) PROGRAM REVIEW SECTION (PRS) OFFICES

The Program Review Section (PRS) is contained within the Medi-Cal Eligibility Branch (MEB). The Section is divided into three regions. Each region has specific county MEQC activity assignments.

#### 1. Offices

##### HEADQUARTERS

Tom Welch, Chief  
Program Review Section  
MS 4610  
PO Box 942732  
Sacramento, CA 94234-7320

Phone: (916) 552-9445  
Fax: (916) 552-9478  
E-mail: [twelch@dhs.ca.gov](mailto:twelch@dhs.ca.gov)

##### CENTRAL REGION

Mary Brown, Chief  
Central Program Review Region  
MS 4610  
PO Box 942732  
Sacramento, CA 94234-7320

Phone: (916) 552-9442  
Fax: (916) 552-9478  
E-mail: [mbrown1@dhs.ca.gov](mailto:mbrown1@dhs.ca.gov)

##### COASTAL REGION

John Lim, Chief  
Coastal Program Review Region  
185 Berry Street, Suite 270  
San Francisco, CA 94107

Phone: 415-904-9702  
Fax: 415-904-9711  
E-mail: [jlim@dhs.ca.gov](mailto:jlim@dhs.ca.gov)

##### SOUTHERN REGION

Jose Morales, Chief  
Southern Program Review Region  
311 South Spring Street, Room 217  
Los Angeles, CA 90013

Phone: 213-897-0980  
Fax: 213-897-0976  
E-mail: [jmorales@dhs.ca.gov](mailto:jmorales@dhs.ca.gov)

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### 2. County Assignments

Most MEQC activities are handled by the PRS MEQC Regions identified below. Staff from other Regions may be involved based on the review and available resources.

<u>County</u>	<u>MEQC Region</u>	<u>County</u>	<u>MEQC Region</u>
Alameda	Coastal	Orange	Central
Alpine	Central	Placer	Central
Amador	Central	Plumas	Central
Butte	Central	Riverside	Southern
Calaveras	Central	Sacramento	Central
Colusa	Central	San Benito	Coastal
Contra Costa	Coastal	San Bernardino	Southern
Del Norte	Coastal	San Diego	Central
El Dorado	Central	San Francisco	Coastal
Fresno	Coastal	San Joaquin	Central
Glenn	Central	San Luis Obispo	Southern
Humboldt	Coastal	San Mateo	Coastal
Imperial	Central	Santa Barbara	Southern
Inyo	Southern	Santa Clara	Coastal
Kern	Southern	Santa Cruz	Coastal
Kings	Coastal	Shasta	Central
Lake	Coastal	Sierra	Central
Lassen	Central	Siskiyou	Central
Los Angeles	Southern	Solano	Coastal
Madera	Coastal	Sonoma	Coastal
Marin	Coastal	Stanislaus	Central
Mariposa	Coastal	Sutter	Central
Mendocino	Coastal	Tehama	Central
Merced	Coastal	Trinity	Central
Modoc	Central	Tulare	Coastal
Mono	Southern	Tuolumne	Coastal
Monterey	Coastal	Ventura	Southern
Napa	Coastal	Yolo	Central
Nevada	Central	Yuba	Central

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2D -- REQUIRED STATISTICAL REPORTING -- MC 237

The Caseload Movement and Activity Report (Medical Assistance Only) (MC 237) is used to measure both intake and continuing case activity and movement. Data submitted on the MC 237 report is used for two important functions:

- o Mandated federal reporting, and
- o Allocations to counties of Medi-Cal administration subvention dollars.

It is therefore extremely important that the MC 237 report be submitted in a timely manner and that the report data be accurate.

1. Certification/Submission Due Date

One copy of the MC 237 shall be completed and returned by the tenth working day of the calendar month following the report month to the Medical Care Statistics Section, State Department of Health Services.

The county person completing the MC 237 shall sign and date the form, as indicated on the bottom of the page, and ensure that the county and report month spaces are completed. Reports should be sent to:

Department of Health Services  
Medical Care Statistics Section  
714 P Street, Room 1476  
P. O. Box 942732  
Sacramento, CA 94234-7320

When data is not available or has not been reconciled, transmit a report by the due date containing all available information and estimates of missing information. Forward missing data no later than the tenth working day of the second month after the report month.

Questions concerning the completion of this report should be referred to the Medical Care Statistics Section, phone (916) 445-2547, or to the County Administrative Expense Section, phone (916) 445-1635.

2. Scope of Report

The MC 237 report shall be used to report intake and continuing (approved) caseload movement and activity for Medical Assistance Only cases consisting of persons eligible under any of the following Medi-Cal categories or program:



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- a. Medically Needy -- Long-Term Care  
Aid Codes 13, 23, and 63
- b. Medically Needy -- No Share of Cost/Share of Cost  
Aid Codes 14, 17, 24, 27, 34, 37, 64, 65, and 67
- c. Medically Indigent  
Aid Codes 02, 45, 53, 82, 83, 86, and 87
- d. Pickle Eligibles/COBRA Widow(ers)/Twenty Percent Social Security Disregards  
Aid Codes 16, 26, 36, 46, and 66
- e. Aid to Families with Dependent Children -- Post-Eligibility -- Four Month/Nine Month Continuing  
Aid Codes 39, 54, or 59  
Aid Codes 30, 35, 40, 42, 77, and 78 with a pre/post indicator indicating post-eligibility
- f. Aid to Families with Dependent Children -- Extended Eligibility -- Edwards v. Myers (see line 17 on form MC 237)  
Aid Code 38
- g. Title IV-E AAP/AFDC-FC Children Placed in California by an Out-of-State Agency  
Aid Codes 03 or 45
- h. Retroactive Medi-Cal Eligibles  
Aid codes with a pre/post indicator indicating preeligibility
- i. Medi-Cal Special Treatment Programs  
Aid Codes 71, 72, 73, and 74

Do not report on the MC 237 activity of cases eligible under the Indochinese Refugee cash grant program (Aid Code 01) or the In-Home Supportive Services Program (Aid Codes 18, 28, and 68).

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3. Medi-Cal Case -- Definition

All activity counts shall be reported in terms of Medi-Cal cases. A Medi-Cal case is one Medi-Cal Family Budget Unit (MFBU), as defined in California Administrative Code, Title 22, Section 50110. A Medi-Cal case may contain only one person, several persons all eligible under the same aid code, or several persons in the same MFBU eligible under more than one of the aid codes listed under Scope of Report, a. through g., above. Medi-Cal-only children in an AFDC-cash family shall be reported as one Medi-Cal case.

4. Refer to forms section for copy of MC 237 and the line-by-line instructions.



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### 2E — ETHNIC ORIGIN/PRIMARY LANGUAGE DATA COLLECTION

#### 1. Background

In April 1975, the State Department of Social Services (DSS) (formerly State Department of Benefit Payments) developed a process for counties to use to report data on the ethnic origin and primary language spoken for Aid to Families with Dependent Children, Social Services, and nonassistance Food Stamp beneficiaries. This report was necessary to meet the requirements of the federal Civil Rights Act of 1964.

In order to meet those same requirements of the Civil Rights Act, it was necessary for the Department of Health Services (DHS) to collect ethnic origin and primary language data for Medi-Cal-only beneficiaries. To accomplish this, the following procedures have been established.

#### 2. County Reporting of Ethnic/Language Data to the State

- a. Counties will report ethnic/language data for Medi-Cal-only beneficiaries using DSS form ABCD 350. This is a summary data form; it is already used to report this data for the other public social services programs.
- b. The ABCD 350 must be submitted by the eighth (8th) working day of May each year and the second report by the eighth working day of November each year.
- c. Reports submitted each May will summarize data on all persons who were Medi-Cal-only eligible in April; reports submitted each November will summarize data on Medi-Cal-only eligibles for October. Persons who apply in April/October, but are not determined eligible during that month for that month, will not be counted.
- d. Form ABCD 350 is included in the Forms Section of this Manual.
- e. Ethnic origin data reported on the ABCD 350 is a count of eligible cases, by ethnic category. Primary language data is a count of eligible cases, by language category.
- f. When data are unavailable or have not been reconciled, counties should transmit a report by the due date containing all available information, and a note should be attached indicating when the Department can expect to receive the rest of the report. Missing data must be forwarded as soon as it becomes available.

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- g. Medi-Cal-only primary language case counts on the ABCD 350 should equal the total continuing cases counts on the MC 237 form (line 10).
- h. Counties must specify, in a footnote to the "Other Non-English" category figure on the ABCD 350, the number of Medi-Cal-only cases that speak each language not specified on the ABCD 350. The numbers of cases in the footnote must equal the "Other Non-English" category figure on the ABCD 350.

3. Collecting Ethnic/Language Data

- a. At the time of reapplication, face-to-face restoration, or redetermination, counties will obtain ethnic/language data, on current continuing eligibles whose cases do not already have that data. If a case does not have a face-to-face interview as part of the redetermination, ethnic/language data will be requested as part of the redetermination-by-mail process.
- b. DHS has prepared a form (MC 257) to be filled out by those current continuing eligibles whose ethnic/language data must be collected by mail. Counties must include a self-addressed stamped envelope so the form can be returned to the county. Counties may order this form from DHS through the normal forms ordering process. A copy of the form is included in the Forms Section of this Manual.
- c. Applicants are to choose their ethnic/language categories themselves as much as possible. For this reason, the CA 1 application form has been changed to show the categories and allow new applicants to check the ones that apply. If the category selection on the CA 1 is not done before the application interview, or a second party applied on behalf of the applicant, the applicant should be given the opportunity at the interview to complete or revise the categories selected. If the applicant refuses to select categories at the interview, the eligibility worker (or government worker representing the welfare department at the interview) must select categories based on observation of the applicant.
- d. The ethnic origin determined for the applicant will also be assigned to all other members of the Medi-Cal Family Budget Unit. The primary language determined for the applicant will be the language for that case.
- e. If ethnic/language data on a case is recorded on a form other than the CA 1, that form will be retained in the case file.

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4. Informing Beneficiaries of the Need for Ethnic Origin and Primary Language Data

- a. Applicants/eligibles must be told that the ethnic origin and primary language data is being requested to measure and evaluate the county's compliance with the Civil Rights Act of 1964 and to permit a comparison of the ethnic composition of Medi-Cal eligibles with that of the employees assigned to serve these eligibles. The data will also help to assure that county employees have the language skills necessary to communicate fully and to provide the same level of service to all. The information requested is for these statistical purposes only and does not affect the Medi-Cal eligibility of persons giving the data. Applicant refusal to provide the data also will not affect his or her Medi-Cal eligibility.
- b. As described in paragraph 2.b, the MC 257 form is a form for eligibles to indicate their ethnic/language categories on and return to the county. This form also explains the reasons for collecting the data and the fact that eligibility is not affected by the data. Although it is a mail-out form, it can be used as an explanation aid at interviews if so desired.

5. Ethnic Origin/Primary Language Categories

- a. Ethnic origin and primary language data will be reported on the ABCD 350 under the following categories:

ETHNIC ORIGIN		PRIMARY LANGUAGE	
<u>Category</u>	<u>ABCD 350 Code</u>	<u>Category</u>	<u>ABCD 350 Code</u>
White (not of Hispanic origin) . . . . .	1	Spanish . . . . .	1
Hispanic . . . . .	2	Chinese . . . . .	2
Black (not of Hispanic origin) . . . . .	3	Japanese . . . . .	3
Asian or Pacific Islander . . . . .	4	Korean . . . . .	4
American Indian or Alaskan		Filipino (Tagalog) . . . . .	5
Native . . . . .	5	Other Non-English (specify	
Filipino . . . . .	7	in footnote) . . . . .	6
		English . . . . .	7

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b. Definitions of the ethnic origin categories are as follows:

White (not of Hispanic origin) -- all persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Hispanic -- all persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race..

Black (not of Hispanic origin) -- all persons having origins in any of the black racial groups of Africa.

Asian or Pacific Islander -- all persons having origins in any of the original peoples of the Far East, Southeast Asia, Indian Subcontinent, or the Pacific Islands. This area includes, for example China, Japan, Korea, and Samoa. Although persons of Filipino descent would normally be included under the category, because of a state requirement, Filipinos will be reported separately under the ethnic category "Filipino".

American Indian or Alaskan Native -- all persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.

Filipino -- all persons having origins in the original peoples of the Philippine Islands.

c. When coding primary language data:

- (1) Remember that "primary language" is the language the individual must use in order to communicate with the eligibility worker, either directly or through an interpreter. If the person can communicate in both English and another language, English is the primary language of the case.
- (2) Assign only one primary language to a case: that of the applicant.

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**2G — CASE RECORD RETENTION**

Section 50111 provides that the county department must follow the requirements in Division 23, Manual of Policies and Procedures (MPP), governing case record retention.

Generally, counties must retain Medi-Cal case records documenting eligibility as well as budget documents for three and one-half years after the case is closed. Records are supposed to be retained for three years after the State submits its claim to the Federal Government. Because of the length of time required for Medi-Cal providers to submit claims and for the claims to be processed, the Medi-Cal expenditure report will not be submitted until six months to a year from the month of service.

In open cases, budget documents, i.e., MC 176M, must be retained for three and one-half years after the last month that budget was effective. For example, if the case is an aged person whose budget is redetermined annually, the documents must be retained for three and one-half years after the last month that particular budget document was used. However, in the case of pending litigation or court orders, the Department may require counties to retain specified classes of cases beyond this period.

Applicable portions of Division 23, MMP, are as follows:

"23-350 DISPOSITION OF WELFARE RECORDS

"23-351 DEFINITIONS OF WELFARE RECORDS

".1 The welfare case history consists of all documents and forms relating to eligibility determinations for public assistance including, but not limited to, documents necessary to support the granting or denying of aid, case narratives, personal documents, budget forms, referrals to and from other agencies, and correspondence to and from the recipient.

".11 A case narrative is the chronological listing of data or events recorded throughout the life of the case, which does not appear elsewhere in the case record, or which is necessary to augment or reconcile data or information recorded in forms or correspondence.

".12 Personal documents of the recipient are those documents owned by a recipient which have been placed in the case history.



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"13 Permanent records are those which are necessary to document the recipient's continuing eligibility for public assistance. Examples of such records include birth certificates, marriage licenses, divorce decrees, court orders mandating spousal or child support, certain Special Circumstances Program records (Section 46-425), and Emergency Loan Program records which pertain to the nonrepayment of loans (Section 46-335).

\* \* \*

**"23-353 RETENTION PERIODS**

"The general statute in California (Welfare and Institutions Code Section 10851) requires that public social service records (aid and services) be maintained for three years from the last date of aid or services. It also provides that certain records in active cases may be destroyed after three years. Federal law (45 CFR 74.20) requires that case records which provide the basis for fiscal claims are to be retained for three years, starting on the day the state submits the last expenditure report to HHS for the period. In the case of supplemental expenditure reports this might require retention for a much longer period than three years.

"Under these requirements, counties shall ensure that records needed to prove eligibility may not be destroyed unless three years have passed from the date the last state expenditure report was made to HHS for the period in which such records were last used to document eligibility.

**" .1 Case Narratives**

"The Board of Supervisors may authorize destruction within the rules stated above.

**" .2 Other Case Documents**

"The Board of Supervisors may authorize destruction within the rules stated above. However, documents which were not necessary to show eligibility may, with board authorization, be destroyed when they are over three years old.

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- " .3 Permanent records, as specified in Section 23-351.13, shall be retained until all records for that particular case are destroyed.

\* \* \*

- " .8 Records Related to Civil or Criminal Actions

"Notwithstanding the above, if a civil or criminal action is commenced before the expiration of the retention period, no portion of the case record of such person shall be destroyed until such action is terminated.

\* \* \*

"23-355 DESTRUCTION OF CASE RECORDS

- " .1 All case histories are confidential and caution must be taken in their destruction to maintain confidentiality, and to prevent unauthorized disclosure.
- " .2 All original personal records of a recipient should be returned to the recipient or to his/her family by certified letter once the case has been closed. If they cannot be returned, they should be destroyed as part of the case history."

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2H -- CONFIDENTIALITY OF MEDI-CAL CASE RECORDS

State law (Section 14100.2, Welfare and Institutions (W&I) Code) provides in part that:

- "(a) All types of information, whether written or oral, concerning a person, made or kept by any public office or agency in connection with the administration of any provision of this chapter,...and for which a grant-in-aid is received by this state from the United States government pursuant to Title XIX of the Social Security Act shall be confidential, and shall not be open to examination other than for purposes directly connected with the administration of the Medi-Cal program.
- "(b) Except as provided in this section and to the extent permitted by federal law or regulation, all information about applicants and recipients as provided for in subdivision (a) to be safeguarded includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation of personal information, and medical data, including diagnosis and past history of disease or disability.
- "(c) Purposes directly connected with the administration of the Medi-Cal Program...encompass those administrative activities and responsibilities the State Department of Health Services and its agents are required to engage in to ensure effective program operations. Such activities include, but are not limited to: establishing eligibility and methods of reimbursement; determining the amount of medical assistance; providing services for recipients; conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Medi-Cal Program; and conducting or assisting a legislative investigation or audit related to the administration of the Medi-Cal Program.
- \* \* \*
- "(h) Any person who knowingly releases or possesses confidential information concerning persons who have applied for or who have been granted any form of Medi-Cal benefits...for which state or federal funds are made available in violation of this section is guilty of a misdemeanor."

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Current Medi-Cal regulations at Section 50111 require the county department to follow the requirements of Division 19, Manual of Policies and Procedures (MPP), governing confidentiality of Medi-Cal case records.

Those sections of Division 19, MPP, which apply also to the Medi-Cal program provide in pertinent part:

**"CHAPTER 19-000 CONFIDENTIALITY OF RECORDS**

**"19-001 CONFIDENTIALITY OF RECORDS -- OBJECTIVE AND SCOPE**

"In accordance with W&I Code, Section 10850, and 45-Code of Federal Regulations, Section 205.50 (a), these regulations were created to protect the applicants and recipients against identification, exploitation, or embarrassment that could result from the release of information identifying them as having applied for or having received public assistance. They also outline under what circumstances and to whom such information may be released. These regulations pertain to all records, papers, files, and communications pertaining to the following public social service programs, both aid and services, administered or supervised by the State Department of Social Services (SDSS): AFDC (including WIN and Child Welfare Services), APSB, SSP (all segments), and Title XX, unless otherwise indicated. These regulations bind public and private agencies with whom the county contracts to perform any part of the covered public social service programs. The SDSS programs not covered by these regulations have their own rules regarding records and confidentiality which are to be referred to when dealing with such records, e.g., food stamps in Section 63-201.3 and Adoptions in Title 22 of the California Administrative Code. The term public social services programs is defined as both assistance and social service programs administered or supervised by SDSS or the State Department of Health Services.

**"19-002 INFORMATION THAT IS CONFIDENTIAL**

**".1 General**

"Names, addresses, and all other information concerning the circumstances of any individual for whom or about whom information is obtained is confidential and shall be safeguarded. This is true of all information whether written or oral.

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"No disclosure of any information, obtained by a representative, agent, or employee of the county, in the course of discharging his or her duties, shall be made, directly or indirectly, other than in the administration of public social service programs. (This includes acknowledgement by a welfare department receptionist or telephone operator that a person is receiving assistance.)"

**NOTE:** This provision does not affect the county welfare department's responsibility to provide verification of Medi-Cal eligibility when requested by Medi-Cal providers, as required by Article 14D — "Verification of Medi-Cal Eligibility". Such information is used in the administration of the Medi-Cal program.

"Disclosure of information which identifies by name or address any applicant or recipient of public social services to federal, state, or local legislative bodies and their committees without such applicant or recipient's consent is prohibited. Such bodies include the United States Congress, the California State Senate and Assembly, city councils, and county board of supervisors. Exceptions to this rule are found in Section 19-004.3 of this division regarding audits, and MPP, Section 25-480, concerning discharge of accounts.

"Both the release and possession of confidential information in violation of the rules of this division are misdemeanors.

### ".2 Federal Tax Information

#### ".21 Definition

"For the purposes of this section, the term 'tax information' means any information supplied by the Internal Revenue Service (IRS), concerning a taxpayer's identity, the nature, source, or amount of his/her earned income, unearned income (including interest or dividends), payments, receipts, deductions, exemptions, credits, assets, liabilities, net worth, tax liability, tax withheld, deficiencies, over-assessments, or tax payments.

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**".22 Confidentiality and Disclosure**

"No employee or former employee of the county who has or had access to tax information in any manner connected with his/her service shall disclose any tax information obtained by him/her except for the purposes provided in Section 20-006.

**".23 Safeguards**

"Counties shall establish the following safeguards in order to protect the confidentiality of, and to prevent the unauthorized disclosure of, tax information received from IRS:

- ".231 Establish and maintain a secure area or place in which IRS tax information shall be stored;**
- ".232 Restrict access to the tax information only to persons whose duties or responsibilities require access to this information;**
- ".233 Provide other such safeguards or controls as prescribed by IRS guidelines and necessary or appropriate to protect the confidentiality of tax information;**
- ".234 Report annually in a format prescribed by SDSS the safeguard procedures utilized by the counties for ensuring that the confidentiality of tax information is being maintained; and**
- ".235 The county shall destroy IRS source material upon the independent verification of IRS tax information or upon completion of appropriate case action, whichever is earlier. Methods of destruction shall be those used for confidential material."**

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"Penalties for Unauthorized Disclosure of Tax Information

"State Tax Information (Franchise Tax Board)

"'Except as otherwise provided in this article, it is a misdemeanor for the Franchise Tax Board or any member thereof, or any deputy, agent, clerk, or other officer or employee of the state (including its political subdivisions), or any former officer or employee or other individual, who in the course of his or her employment or duty has or had access to returns, reports, or documents required under this part, to disclose or make known in any manner information as to the amount of income or any particulars set forth or disclosed therein.'

"Federal Tax Information (Internal Revenue Service)

"a) Criminal Penalties

"'It shall be unlawful for any person (not described in paragraph (1)) willfully to disclose to any person, except as authorized in this title, any return or, return information (as defined in Section 6103 (b)) acquired by him or another person under subsection (d), (i) (3) (H) (1), (1) (6), (7), (8), (9), (10), or (11), or (m) (2) or (4) of Section 6103. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding \$5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution.'

"b) Civil Damages

"'If any person who is not an officer or employee of the United States knowingly, or by reason of negligence, discloses any return or return information with respect to a taxpayer in violation of any provision of Section 6103, such taxpayer may bring a civil action for damages against such person in a district court of the United States.'"

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**"19-003 NONCONFIDENTIAL INFORMATION**

"Statistical information and social data, that is not identified with a particular individual may be released.

"Examples of information that may be released would include, but are not limited to such information as statements of the number of recipients, total expenditures per program or administration, average grant figures, and other general information concerning the caseload as a whole.

**"19-004 RELEASE OF CONFIDENTIAL INFORMATION**

**".1 General Rule**

"11 Confidential information may be released without the consent of the applicant/recipient, only for purposes directly connected with the administration of public social services except as specified in Section 19-004.4. Public social services are defined as aid or services administered or supervised by SDSS or State Department of Health Services.

**".2 Contractors**

"Whenever a contract is entered into with a public or private agency which involves the release of confidential information, the contract shall contain a provision ensuring that such information will be used in accordance with the restrictions found in W&IC, Section 10850, and this division.

**".3 Public Officials**

".31 Certain public officials, and their duly appointed agents and deputies, are entitled to examine confidential information. The right of public officials, including law enforcement personnel, to examine public assistance records does not exist if the request is for a purpose not connected with the administration of the public social service programs. Examples of situations under which information may not be given out include, but are not limited to such

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things as traffic violations, tax fraud investigations, or criminal investigations not related to welfare.... Both the release and possession of confidential information in violation of these regulations is a misdemeanor. The officials who are entitled to examine confidential information include, but are not limited to:

**".311 District Attorney or County Counsel**

"(a) In the administration of aid, it is necessary to disclose information to these officials when they are conducting investigations, prosecutions, criminal or civil proceedings directly connected to public social services....

**".312 State Department of Social Services, State Department of Health Services, Department of Health, Education and Welfare (HEW), and county welfare departments within the State of California.**

"(a) These agencies, their representatives and employees shall have access to public social services records as needed in the administration of public social services.

**".313 County Auditor"**

Not applicable.

**".314 Audits**

"(a) Federal, State, and County auditors having direct or delegated authority are authorized to examine records as necessary to perform fiscal audits and/or procedure reviews. Legislative bodies and their committees authorized by law to conduct audits or similar activities in connection with the administration of public social services shall be permitted to examine records.

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"(b) Such committees include, but are not limited to, the California Joint Legislative Audit Committee, the California Auditor General and their staff....

".315 Legislatures and their Committees

"(a) Refer to Section 19-002 for the prohibition against release of confidential information to legislatures without applicant/recipient consent. Any releases made to legislatures or their committees should be accompanied by the warning that Welfare and Institutions Code, Section 10850, makes the use or release of the information for a purpose not directly connected with the administration of public social services a misdemeanor.

".4 Exception to General Rule — Law Enforcement Officials"

NOTE: The provisions of 19-004.4, providing for the release of certain information to law enforcement officials, do not apply to the Medi-Cal program.

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"19-005 RELEASE TO APPLICANT/RECIPIENT OR AUTHORIZED REPRESENTATIVE

".1 Information Supplied By the Applicant/Recipient

"Information relating to eligibility that was provided solely by the applicant/recipient contained in applications and other records made or kept by the county welfare department in connection with the administration of the public assistance program shall be open to inspection by the applicant/recipient or his/her authorized representative.

".2 Authorizations

"For purposes of this section, an authorized representative is a person or group who has authorization from the applicant/recipient to act for him/her.

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**".21 Written Authorizations**

"Except as otherwise provided, all authorizations are to be written.

"Written authorizations shall be dated and shall expire one year from the date on which they are given unless they are expressly limited to a shorter period or revoked. In cases involving pending appeals or state hearings, the time period, unless the authorization is expressly limited or revoked, shall extend to the final disposition of the issue involved in the fair hearing or, where applicable, by the courts.

"When the authorized representative and the applicant/recipient, or responsible relative caring for the AFDC child are both present, no written authorization is required for that particular occasion.

**".22 Telephone Authorizations**

"Telephone authorizations may be accepted in lieu of a written authorization where the circumstances insure that the applicant or recipient has adequately identified himself or herself to the county. A telephone authorization is temporary and should be followed up by a written authorization.

"Acceptable items of identification are to be determined by the county but may include such items as case numbers, driver's license numbers, social security account numbers, or the mother's maiden name. The procedure for telephone authorizations will usually involve the applicant or recipient first calling their eligibility worker and notifying the worker of whom will be calling on their behalf. This call will authorize the release of confidential information.

Examples of typical circumstances for releasing confidential information by telephone authorization include inquiries from medical offices, welfare rights organizations, or legislators calling on behalf of the recipient.

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"3 Applicant/Recipient Written Requests for Assistance to Legislators

"Written inquiries to members of legislative bodies signed by applicants or recipients of public social services concerning the recipient of public social services may serve as authorization for release of information sufficient to answer such an inquiry.

"4 Release of Information in Conjunction With a State Hearing

"The applicant/recipient or his/her attorney or authorized representative may inspect the case records including the entire case narrative relating to the applicant or recipient which are held by DSS, DHS, or any agency supervised by DSS with the following exceptions listed below in Section 19-006.

"19-006 INFORMATION WHICH MAY NOT BE RELEASED TO THE APPLICANT/RECIPIENT

"Privileged Communications

"Portions of the applicant/recipient's record which would qualify as privileged communications as defined by the Evidence Code. This would include Sections 954 (lawyer-client) and 1041 (identity of informer).

"Note: The physician-patient privilege in Evidence Code, Section 990, et seq., belongs to the patient and may be waived by him/her. The right of the patient to inspect his/her records is confined to record maintained by the CWD and does not extend to the records kept by the physician."