State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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September 11, 2020

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
ALL HCBS WAIVER ADMINISTRATORS/COORDINATORS

Letter No: 20-15

SUBJECT: Retroactive eligibility and reimbursement under Spousal Impoverishment for In-Home Supportive Services/Community First Choice Option (References: All County Welfare Directors Letters 17-25 and 18-19)

Purpose

The purpose of this All County Welfare Directors Letter (ACWDL) is to build on, and not supersede, ACWDLs 17-25 and 18-19 by expanding on existing policy guidance. These letters provided guidance for retroactive eligibility and reimbursement under Spousal Impoverishment (SI) for married couples or registered domestic partners who need Home and Community Based Services. This letter clarifies the role of the County Eligibility Worker (CEW) with respect to cases where Medi-Cal eligibility has been established retroactively and the beneficiary requested retroactive eligibility and reimbursement for In-Home Supportive Services.

Background

ACWDLs 17-25 and 18-19 provided counties with instructions on determining current and retroactive Medi-Cal eligibility under the Spousal Impoverishment provisions and right to file a claim for reimbursement. Additionally, counties were instructed to perform retroactive Medi-Cal eligibility determinations for two groups: 1) the IHSS/CFCO population and 2) married individuals or registered domestic partners who had requested IHSS or Home and Community Based Services and were either denied or discontinued from Medi-Cal due to exceeding the property limit. Currently, there is an existing process in place for both Medi-Cal and IHSS reimbursements. DHCS sent outreach letters to individuals who were potentially impacted by the expansion of the

spousal impoverishment provisions to the HCBS population (see Medi-Cal Eligibility Division Information Letters I 18-03 and I 20-19). Not everyone who received a mailer was entitled to a retroactive reassessment.

Eligibility for Retroactive IHSS

ACWDLs 17-25 and 18-19 provided information on how beneficiaries may submit both Medi-Cal and IHSS reimbursement claims under the Beneficiary Reimbursement Process. Beneficiaries shall be instructed to submit a claim for reimbursement under the Beneficiary Reimbursement Process (also known as the Conlan process).[1] To begin the process, the beneficiary calls the Beneficiary Service Center (BSC) at (916) 403-2007,[2] who will provide them with the necessary forms and instructions for filing a claim. When IHSS claims are submitted to the BSC, they are routed to the California Department of Social Services (CDSS) for adjudication. Below are three scenarios that the CEW may encounter when processing retroactive eligibility under SI for IHSS/CFCO and the appropriate referral process for the beneficiary to obtain reimbursement.

Scenario 1: The applicant or beneficiary requires a retroactive IHSS eligibility determination because they were denied or discontinued from Medi-Cal and were later found retroactively eligible for Medi-Cal.

In this situation, the beneficiary shall be referred to the local IHSS county office and must complete an application and assessment as a part of the determination for IHSS including retroactive benefits. An IHSS county social worker will complete an IHSS needs assessment to determine whether the individual is eligible to become an IHSS recipient and the level of IHSS services that should be authorized. A needs assessment is a requirement for IHSS-CFCO.

The CEW must also instruct the beneficiary to submit a claim for reimbursement under the Beneficiary Reimbursement Process, as described above, once a needs assessment has been completed and they have been determined eligible. CDSS Conlan staff may request from the CEW a copy of the Doctor's Verification form and the date the spousal impoverishment provisions first apply. The Doctor's Verification form (MC 604 MDV) may be part of the county's Medi-Cal eligibility case record and is different from the IHSS Needs Assessment.

[1] As the result of a court order issued on November 17, 2006, in the litigation entitled Conlan v. Shewry, Medi-Cal can reimburse beneficiaries for covered medical and/or dental expenses that have been paid.
[2] The TDD phone number is (916) 635-6491.

Once the supporting documentation is submitted to CDSS via the Beneficiary Reimbursement Process, CDSS will determine the beginning date of the reimbursement period using the date of the doctor's verification of a need for nursing facility level of care and the date of Medi-Cal eligibility. The end date of the reimbursement period is the IHSS authorization date where the needs assessment determines the applicant or beneficiary meets IHSS/CFCO eligibility. Once the beginning and end dates are determined, CDSS will reimburse the minimum monthly allocation for CFCO, 195 hours, for each month within this period.

Scenario 2: Beneficiary is already a recipient of IHSS/CFCO but their Share of Cost is reduced or eliminated.

In this situation, the beneficiary shall be instructed to submit a claim for reimbursement under the Beneficiary Reimbursement Process, as described above.

After the county determines the applicant or beneficiary meets the criteria for retroactive eligibility and reduction of share of cost under SI for IHSS/CFCO, and the supporting documentation is submitted to CDSS via Beneficiary Reimbursement. CDSS will:

1. Review the Medi-Cal eligibility record to determine what was the share of cost before reduction;
2. Compare to the share of cost after reduction; and
3. Reimburse the difference in the same manner as outlined in the Beneficiary Reimbursement process.

Scenario 3: Beneficiary is enrolled in the IHSS Program but does not currently meet CFCO eligibility.

In circumstances where the beneficiary is enrolled in the IHSS program and did not meet CFCO eligibility at the time of the needs assessment, but did meet it at a prior specific time, the beneficiary will be required to provide a doctor's verification in order to submit a SI claim for reimbursement under IHSS/CFCO. The doctor's verification will need to indicate that the beneficiary had a need for nursing facility level of care during an identified time during which the beneficiary was eligible for Medi-Cal and it must also indicate that the beneficiary's mental or medical impairment would last at least 12 months or end in death within 12 months. Claims submitted for reimbursement that meet this circumstance will be reviewed using the same process specified in Scenario 1.

Implementation

As instructed in ACWDL 17-25 and in this ACWDL, counties shall establish and maintain their own lines of communication between staff establishing eligibility for IHSS and Medi-Cal for the purposes of identifying CFCO individuals. If the IHSS retroactive assessment indicates the individual does not meet the clinical criteria for being a CFCO recipient, CEWs shall follow the instructions in ACWDL 18-19 regarding changes in circumstance ending the continuous period of institutionalization.

If you have questions regarding this letter, please contact the IHSS/WPCS Unit at (916) 552-9105 or by email at Wpcsrequests@Dhcs.ca.gov.

Original Signed By

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