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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

January 12. 2015

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 15-02
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY QMB/SLMB/QI COORDINATORS

SUBJECT: Out-Of-Pocket Personal Care Services Costs Used to Meet the Medi-Cal Share-Of-Cost

The purpose of this letter is to clarify the process for applying out-of-pocket personal care services expenses toward the Medi-Cal share-of-cost (SOC), or to meet a future month SOC in accordance with the provisions of the Medi-Cal Eligibility Procedures Manual (MEPM), Article 10-R, "Application of Old and Current Medical Bills Toward Share-of-Cost (Includes Hunt v. Kizer Procedures)". This clarification is effective immediately upon receipt of this All County Welfare Directors Letter (ACWDL) and may be applied retroactively under certain circumstances, as listed below.

Background

Since the implementation of ACWDL 05-21, "The In-Home Supportive Services Independence Plus 1115 Demonstration Project Implementation and Changes to Processing In-Home Supportive Services Cases", the process utilized for determining Medi-Cal eligibility and certifying the Medi-Cal SOC for those needing personal care or In-Home Supportive Services (IHSS) is the same as the process used for all other Medi-Cal eligible individuals. ACWDL 05-21 stated that the Medi-Cal determination of eligibility and SOC replaced the determination previously done by IHSS. IHSS is a Medi-Cal covered benefit except for state-only IHSS-Residual cases.

Previous to this ACWDL, Title 22, California Code of Regulations (CCR), Section 50551.6 and MEPM, Article 10-E, placed limitations on using out-of-pocket costs for personal care services to lower income in determining the Medi-Cal SOC. These limitations required that the need for the personal care services be assessed and approved by IHSS, and only the out-of-pocket costs for the approved hours could be used as an income deduction.

Policy Clarification

The limitations described in Title 22, CCR, Section 50551.6 and MEPM, Article 10-E, which allowed personal care services assessed by county IHSS programs to be used as an income deduction are no longer applicable. These services are now provided as a Medi-Cal benefit and out-of-pocket costs for personal care services can be used to meet the Medi-Cal SOC. Because the personal care services can be used to meet the Medi-Cal SOC, they may not be used as an income deduction. Moreover, the limitations that were placed on using personal care services as an income deduction do not apply to using those services to meet the Medi-Cal SOC.

Out-of-pocket personal care services must be prescribed by a physician, nurse case manager, assessed as part of the IHSS Assessment of Need (but not provided under the IHSS program), or be included in the beneficiary's plan of care as necessary to prevent him/her from being moved to a long term care facility for essential treatment. The documentation from the physician or nurse case manager must certify that the beneficiary may remain safely in his/her home with the provision of the personal care services and/or any IHSS hours already assessed. The prescription or plan of care may be for multiple months. IHSS assessed hours or services need not be used first before applying the out-of-pocket expenses for personal care services toward meeting the SOC.

The out-of-pocket expenses for personal care services used toward meeting the Medi-Cal SOC need not be assessed by IHSS, or be provided by an IHSS provider so long as the plan of care or prescription specifies the need for at least one personal care service in order for the ancillary services to be allowed to meet the SOC. Personal care services are services which are required to accomplish the activities of daily living and are defined in Title 22, CCR, Section 51183(a). Ancillary services are described in Title 22, CCR, Section 51183(b).

The provider may be a family member. The provider may also be an IHSS provider providing hours beyond those paid for by the IHSS program, or that were assessed by IHSS but were part of a program-wide reduction in hours. Personal care services used to meet the Medi-Cal SOC may exceed the maximum assessed hours for the IHSS program, as long as the need for the hours is documented. This may be a temporary increase needed by a beneficiary being discharged from a hospital who wishes to avoid a nursing home stay, or the extended hours may prove necessary on a more consistent basis to avoid nursing home stays when a beneficiary's care needs increase.

Certain personal care services may require licensing or certification while others do not. Assuring proper licensing and certification for providers who are not IHSS providers is the responsibility of the beneficiary; however, the county must ensure that condition number three in the MEPM, Article 10R, page 10-R-3, is met. Article 10R requires that the services provided must be intended and used solely for the health care and medical

treatment of the individual. If the county is uncertain about whether the services provided meet this standard, then the county may request a statement from the authorizing provider stating that this condition is satisfied. Furthermore, the county may still disallow these services despite the authorizing provider's statement if the county determines that the statement is contrary to common sense.

Frequently Asked Questions

1) Question - Are daily hours of incurred costs for unmet need from the IHSS Assessment allowable as an expense to spend down the SOC?

   Answer – Yes. The reduction may be applied either to meet the SOC in the month in which the expense was incurred or, if the beneficiary is still financially responsible for paying the expenses and the Hunt v. Kizer guidelines are met, in future months.

2) Question - Is the beneficiary required to verify the expense of the paid attendant care hours each month and if so, what is acceptable verification?

   Answer – Yes. The beneficiary must verify these expenses each month in order to meet the SOC. The following are examples of acceptable verification:

   - Receipts specifying the services provided and the provider.
   - Canceled checks to the provider accompanied by timesheets or other documentation showing the care provided and the provider.
   - Credit card statements showing payments to the provider accompanied by timesheets or other documentation showing the care provided.
   - Invoices showing payments billed to the beneficiary for services from the provider.

   PLEASE NOTE: These expenses need not be accompanied by proof of payment if they are used for current month and must be unpaid if applied to future month's SOC pursuant to Hunt v. Kizer.

3) Question - Should the County apply the reduction to the SOC in the month the expense is incurred or the month following after the receipts are provided?

   Answer - If the beneficiary is meeting the SOC in the month the expenses were incurred, then the expenses or receipts should be credited to that month. If the beneficiary is choosing to use unpaid expenses to meet a future month's SOC under Hunt v. Kizer, then the expenses would be applied to a future month after the expenses were approved for Hunt v. Kizer.

4) Question - Can the out-of-pocket personal care expenses be used retroactively to meet the SOC in a month prior to the current month?

   Answer - As with other medical expenses used to meet the SOC for ongoing cases, the expenses may be applied to the month in which they were incurred for up to a year from the date the service was provided. For cases newly established that have retroactive Medi-Cal eligibility, the out-of-pocket personal care expenses would be applied as per current policy for meeting a retroactive SOC. For cases with unpaid medical costs seeking to reduce a previous month's SOC, the procedures in the MEPM Article 10-R must be followed.

5) Question – Is there a specific hourly rate for services that the county should use in evaluating whether the charges for the personal care services are correct?

   Answer – No. , The county should evaluate the claim to see if it is reasonable and should ask for more detail if the information is not enough to make that determination. Counties should use the prevailing rate charged for the delivery of such services within the area where the services are received. For instance, if the beneficiary presents an invoice for a free-lance provider who is not associated with a personal care agency, unlicensed/not certified, and providing services not usually requiring skilled licensed/certified providers, that indicates the hourly rate is over $100, then the county may wish to obtain more documentation from the beneficiary to ensure the charge is reasonable. If there is no basis for the hourly rate and the hourly rate exceeds the rate normally charged for that service in the city or county, then the county may allow only the prevailing rate to be applied to the SOC.

6) Question - Can the beneficiary hire an accountant to handle his or her financial affairs and the cost be allowed either as an expense in the Medi-Cal budget or as an expense to reduce the SOC?

   Answer - No. There is no Medi-Cal income deduction allowed in federal or State law for accountant services. Additionally, the costs will not be allowed as a personal care service to meet the SOC as accountant costs are not a medical expense. (Please see condition 3, MEPM, Article 10-R, page 10-R-3, and paragraph 8 above.)

7) Question - Can prorated room and board expenses for a medically necessary out-of-pocket personal care service provider be used to meet the SOC?

   Answer - No. The prorated share of out-of-pocket personal care service provider room and board costs may not be used to meet the SOC. There are other ways to meet the 24-hour care need that would meet the medical necessity requirement

without requiring room and board for the provider. For instance, around-the-clock care can be met by employing different shifts of providers.

If you have any questions concerning this policy clarification, please contact Leanna Pierson at (916) 327-0408 or by email at Leanna.Pierson@dhcs.ca.gov.

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