STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1912

April 26, 1982

TO: ALL COUNTY WELFARE DIRECTORS Letter No. 82-19

IMPLEMENTATION OF AB 251, SECTION 106

This letter is to inform you that Assembly Bill 251, Section 106 (Chapter 102, Statutes of 1981) is ready to be implemented. Section 106 allows the Department to contract with counties the collection of Medi-Cal beneficiary overpayments. The implications of the Section effects both the eligibility function as well as the collection function.

The Legislature made this change based upon a pilot project that revealed that the counties could collect Medi-Cal beneficiary overpayments in a more cost efficient manner than could the State. With the full implementation of Title 22, Sections 50781 - 50791, it is expected that gross collections for these overpayments could be $1.9 million annually. This is a dramatic increase over the Department's collections of $352,300 for FY 80/81.

Contact the Chief, General Collections Section, (916) 322-2280 for information regarding contracts.

Filing of Regulations

Emergency regulations were filed on December 30, 1981 to implement provisions in AB 251. The regulations, which became effective January 1, 1982, have been sent to all Eligibility Manual holders with Manual Letter No. 63. The revisions to the regulations are also attached to this letter.

Eligibility Information

In accordance with C.A.C., Title 22, Section 50791, AFDC eligibility workers should refer AFDC overpayments to Medi-Cal eligibility workers to determine whether: a) there was ineligibility for Medi-Cal, b) Medi-Cal eligibility existed under any other program, and c) there was a potential Medi-Cal overpayment.

In order to process potential overpayments in a cost effective and expeditious manner, eligibility workers may seek a waiver from the beneficiary for the ten day notice requirements (specified in Section 50179) that appears in Section 50781(c). The authority for this waiver exists in Section 50015(a)(2)(B) on adverse actions. In addition, we recommend that eligibility workers refer only those potential overpayments that exceed $50.00 in the period of overpayment.

Forms

A copy of the final draft of revised forms MC 239E and MC 215 and accompanying instructions, as well as the instructions for form MC 609, are enclosed for your use. When the forms have been mass produced, you may order them from the warehouse through the normal procedures.

Overpayment Referrals

With the regulation changes in the Eligibility Workers' Manual, there should be a dramatic increase in the volume of potential overpayments. It is our request that statistics on the number of potential overpayment referrals be kept on a monthly basis beginning April, 1982. We ask that the statistics for the first three months be forwarded, at the end of June, 1982, to:

Department of Health Services
General Collection Section
1250 Sutterville Road, Room 226
Sacramento, CA 95822

We will assemble these reports and will share them with counties.

Administrative Costs - Overpayment Detection

The State Department of Health Services intends to cover justified costs for pre-collection activities. Currently it appears as if there will be adequate funds to cover this activity. Initially, the Department's County Administrative Expense Unit will prepare an estimate of the cost for the pre-collection activities in the counties. If a deficiency bill is introduced to the Legislature, then an increase in the estimate will be included to meet the costs incurred by the pre-collection activities in the final quarter of FY 81/82.

The County Administrative Expense Unit will be sending a questionnaire regarding the increase eligibility activities to the counties. Once the questionnaires are returned, the County Administrative Expense Unit will be able to determine necessary allocation adjustments for FY 1981-82 and 1982-83.

County Welfare Department Collection Costs

Counties that choose to place the Medi-Cal overpayment collection function in the County Welfare Department are instructed to claim the related administrative costs in the appropriate cost pool on the County Welfare Department administrative expense claim (DFA 325.1), group II allocable support costs. Any questions regarding the claiming process, please contact:

Department of Social Services
Fiscal Policy & Procedures Bureau
(916) 445-7046

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Services

FOR COUNTY USE ONLY

Case Name: _____

State Number: _____

Co. | Aid | Serial Number

VOLUNTARY REQUEST FOR WITHDRAWAL OF APPLICATION OR DISCONTINUANCE OF ELIGIBILITY OR WAIVER OF 10 DAY ADVANCE NOTICE OF ACTION

☐ I, _____ (Name), voluntarily want to withdraw my _____ (Date) application for Medi-Cal because _____

_____

_____

I understand that my Medi-Cal eligibility will not be determined.

☐ I, _____ (Name), voluntarily agree to have my share of cost increased effective _____ (month/year), thereby waiving my right to a 10 day advance notice of action. I agree to this increase in the share of cost in order to avoid an overpayment in the month of _____ (month/year).

☐ I, _____ (Name), voluntarily want my Medi-Cal eligibility to be discontinued because: ☐ I don't want/need Medi-Cal beyond _____ (Month).

☐ Other (explain): _____

_____

_____

I understand that the above request will not interfere with my right to a State hearing, and that I may reapply for Medi-Cal at any time.

I understand that if my Medi-Cal eligibility is being discontinued or my share of cost is being increased and I request a State hearing before the effective date of the action, the county's action will be delayed.

_____
Signature of Applicant or Beneficiary

_____
Date

MC 215 (3/82)

State No.: _____
Cnty. Aid Serial FBU

MEDI-CAL
NOTICE OF ACTION
OVERPAYMENT

District: _____

Persons Affected: _____

_____

Telephone No. ( ) _____
Area Code

We have determined that the Medi-Cal program has incorrectly paid $ _____ (1) for your health care costs for th

month(s) of _____ (2). You are responsible for repaying this amount because:

A. ☐ Your quarterly share of cost should have been increased because:

_____ (3)

and you did not report this information to the county:

☐ on your statement of facts ☐ within ten days of the change stated above

(4) The overpayment was computed as follows:

1 Share of Cost Period	2 Correct Net Income	3 Correct Maintenance Need	4 Correct Share of Cost (2–3)	5 Share of Cost You Met	6 Possible Overpayment (4–5)	7 Amount Paid By Medi-Cal	8 Overpayment (lower of box 7
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
						Total	$

B. ☐ You should have been ineligible for Medi-Cal for the month(s) of _____ (5)

because you had property worth $ _____ (6) which is $ _____ (7) above the allowable property lim

of $ _____ (8). Medi-Cal paid for $ _____ (9) of your health care costs during the time you had excess property

You are responsible for reporting $ _____ (10) (the lower of your excess property or the amount Medi-Cal paid

C. ☐ Other:

D. ☐ Send your check or money order for $_____ (11) to: _____ (12)
within 30 days.

Signature of EW _____ (13) Date: _____

The regulations which require this action are California Administrative Code, Title 22, Sections 50781 through 50791 which defin Medi-Cal overpayments and your repayment responsibilities.

If you have any questions, please contact _____ (14) at _____ (15)

Signed _____ (16) Title _____ (17) Date _____ (18)

PLEASE SEE REVERSE SIDE OF THIS NOTICE

MC 239E (4/82)

f you are dissatisfied with the action described on the other side, or ıny other county action, you may request a state hearing before a ıearing Officer of the State Department of Social Services. This ıearing will be conducted in an informal manner to assure that veryone present is able to speak freely. Your county worker can ıelp you request a hearing. If you decide to request a hearing, you ıust do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

State Regulations Available

State Regulations, including those covering state hearings, are avail-ble at the local office of the county welfare department.

Authorized Representative

You can represent yourself at the state hearing. You can also be rep-esented by a friend, attorney or any other person, but you are xpected to arrange for the representative yourself. You can get help n locating free legal assistance by calling the toll-free number of Public Inquiry and Response Unit (800) 952-5253.

nformation Practices Act Notice

The information you are asked to write in below is needed to rocess your request, and processing may be delayed if your request s incomplete. A case file will be set up by the Chief Referee. You ıave a right to examine the materials that make up the record for ecision and may locate this record by contacting Public Inquiry and Response Unit (phone number shown above). Any information you rovide may be shared with the county welfare department, with the J.S. Department of Health and Human Services, Authority: W&IC 0950.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this ent notice to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814

Los Angeles County Residents send to:
Fair Hearing Section
P.O. Box 10280
Glendale, California 91209

You may also request a hearing by calling the toll-free number Public Inquiry and Response Unit.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

Teletypewriter (TTY) only: (800) 952-5434*

*You will have to dial "1" first.

The State Public Inquiry and Response Unit can provide you w further information about your hearing rights or files. Assistance also available in some languages other than English, includi Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

REQUEST FOR A STATE HEARING

Name _____ Phone Numl

Address _____ City _____ State _____ Zip Cc

am requesting a State hearing because of an action by the welfare department of _____ county related Medi-Cal.

Reasons for my request:

_____

_____

_____

_____

speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Instructions
MC 239E
Notice of Action
Demand for Payment/Overpayment

General Instructions

Note: If the potential overpayment period does not exceed $50, do not complete this form.

The MC 239E is completed in part by (1) the county department (county), and in part by (2) the Department of Health Services Recovery Section (Recovery) or the County Collection (Co. Coll.) Unit staff responsible for the collection of Medi-Cal beneficiary-caused overpayments. These instructions include the action to be taken by both. The original and two copies should be completed.

If a Medi-Cal Family Budget Unit (MFBU) has both an income-based overpayment and a property-based overpayment, two separate MC 239Es can be used.

If an MC 239E is sent, and additional Medi-Cal costs are later identified that are subject to recovery, a second MC 239E must be sent as part of any follow-up recovery action, explaining the situation.

Upon completion of the portions of the MC 239E that are the responsibility of the county, send all three copies of the MC 239E to the Recovery Section or the county unit responsible for the collection of overpayments. In those instances where the eligibility worker suspects fraud, send the original of the MC 609 along with the MC 239E to the Central Complaints Section.

Upon completion of the remaining blanks, the Recovery Section or the Co. Coll. Unit will send the original MC 239E to the beneficiary. Send one copy to the county welfare department making the referral. The second copy will be retained by Recovery Section or the Co. Coll. Unit.

Block-by-Block Instructions

Return address box (upper right-hand corner of form): To be completed by Recovery or Co. Coll. Unit. Enter the address of Recovery or the Co. Coll. office to be contacted regarding payment.

Address box: To be completed by the county. Enter the name and full address of beneficiary or the person acting on his/her behalf.

State Number (County): Enter the 14-digit Medi-Cal ID number which includes the county number, aid code, serial number, and FBU number. If the case's state number (other than units of aid code) changed during the time of potential overpayment, fill out a separate form for each number.

District (County): For county use.

Persons affected (Recovery or Co. Coll.): Enter the names of all the persons in the MFBU who received Medi-Cal services during the overpayment periods shown on the form. Also list the area code and telephone number of the beneficiary.

The blanks on the attached sample form included with these instructions have been numbered to help in determining how the remainder of the form is to be completed.

Blank (1) (Recovery or Co. Coll.): Enter the amount of the actual overpayment for which repayment is being requested.

Blank (2) (Recovery/County Coll.): List those months in which there was an actual overpayment. If there are several consecutive months, an inclusive "month" description may be used. Be sure that if the form describes a property-based overpayment, the months of excess property are included in this blank.

Income-Based Overpayments

Box A (County): Check this box if the overpayment is due to a change which should have increased the share of cost (SOC). Complete Blank (3), and all boxes of Blank (4).

Blank (3) (County): Enter the reason(s) why the SOC should have increased (increased income, change in family composition, etc.). Check whether the person failed to report the information on the Statement of Facts at the time of application or whether the person, already on Medi-Cal, failed to report change affecting the SOC within ten days. If different reasons apply to different periods, link each reason to its period in the description.

Blank (4) Box (1) (County): List the SOC periods in which there was a potential overpayment. If the beneficiary did not meet his/her SOC in an SOC period in which the SOC should have been higher, do not list that period.

Note: If there are more than three SOC periods involved, list the information on the additional periods on a separate sheet of paper and attach to the Notice of Action. Make a note "continued on a separate sheet" in the margin.

Blank (4) Box (2) (County): List the correct net income for each of the SOC periods in which there was a potential overpayment.

Blank (4), Box (3) (County): List the correct maintenance need for each of the SOC periods in which there was a potential overpayment.

Blank (4), (Box (4) (County): Subtract the amounts in Box (3) from the amounts in Box (2). This is the correct SOC for each of the SOC periods in which there was a potential overpayment.

Blank (4), Box (5) (County): Enter the SOC the beneficiary met in each of the SOC periods in which there was a potential overpayment.

Blank (4), Box (6) (County): Subtract the amounts in Box (5) from the amounts in Box (4). These amounts are the possible overpayments for each of the SOC periods in question.

Blank (4), Box (7) (Recovery or Co. Coll.): Enter the lower of the possible overpayment (Box (6)) or the amount paid by Medi-Cal (Box (7)).

Blank (4), Box (8): For each SOC period, choose the lower of the amount in Box (6) or Box (7). The lower amount is the actual overpayment for that SOC period. Add all the actual overpayments and show the total overpayment in the "Total" Box.

Property-Based Overpayments

Box "B" (County): Check this box if the overpayment is due to excess property and complete Blanks (5) through (9).

Blank (5) (County): Enter the inclusive period of months that the MFBU had excess property.

Blank (6) (County): Enter the amount of the excess property held by the beneficiary during the excess property period as computed per Title 22, California Administrative Code, Section 50786. See Medi-Cal Eligibility Manual procedures, Article 16, for examples of excess property computation.

Blank (7) (County): Enter the amount of the property reserve in excess of the property limit.

Blank (8) (County): Enter the appropriate property limit based on family size.

Blank (9) (Recovery or Co. Coll.): Enter the amount of health care costs paid by Medi-Cal during the period the MFBU was ineligible.

Blank (10) (Recovery or Co. Coll.): Enter the lower of the excess property (Blank (6)) or the amount paid by Medi-Cal (Blank (8)). This is the total amount the MFBU must repay.

Other

Box C (County): Enter an explanation here if overpayment is due to ineligibility other than excess property, or if this is a supplemental overpayment calculation, based on new costs found for a known overpayment period.

Remainder of Form

Box D (Recovery or Co. Coll.): Has a preprinted check, because Blanks 11-17 will always be filled out.

Blank (11) (Recovery or Co. Coll.): Enter the total overpayment the MFBU is responsible for repaying (from Blank (4), Box (8), Total or Blank (9)).

Blank (12) (Recovery or Co. Coll.): Enter the address where the beneficiary should send his/her check or money order repaying the overpayment.

Blank (13): Signature of eligibility worker and date of signature.

Blank (14) (Recovery or Co. Coll.): Enter the name of the person the beneficiary should contact if he/she has any questions regarding the overpayment and the resonsiblity to repay it.

Blank (15): Enter the address and/or telephone number of the person who should be contacted regarding the overpayment.

Blank (16): Signature of Recovery/Co. Coll. person who completes and sends out the MC 239E.

Blank (17): Title of the person signing the MC 239E.

Blank (18): Date MC 239E is completed and sent.

FOR COUNTY USE ONLY
(✓ for attachments)
☐ CA2 ☐ MC 217
☐ MC 210 ☐ MC 239E
☐ MC 216 ☐ OTHER

CONFIDENTIAL
MEDI-CAL COMPLAINT REPORT

FOR DHS USE ONLY
Case Number _____
Date: _____

Complainant name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Provider Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Provider Number: _____

Recipient Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Social Security #: _____

Recipient's 14-digit Medi-Cal #: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Birth Date _____

Dependent's Names Birthdates Social Security # 14-digit Medi-Cal Number

Possible violation: _____

Synopsis of Complaint:

Complaint taken by: _____

Date: _____

FOR DHS USE ONLY

Closure Statement: _____

Investigator name: _____ Date: _____

DHS SUPERVISOR USE ONLY

Assigned to: _____ Action taken: ☐ Case Opened: _____

☐ Unfounded ☐ Closed : _____

☐ Other ☐ Referred to: _____

Supervisor: _____ Date: _____

INSTRUCTIONS
MC 609
MEDI-CAL PRELIMINARY INVESTIGATIONS REPORT

The MC 609 is to be completed by the county welfare department in those instances where a potential overpayment exist and the county feels that the overpayment may have been due to fraud.

Case No. -- Leave blank.

Date -- Leave blank.

Complainant name -- Enter the name of the eligibility worker making the referral and the name of county welfare department.

Address -- Enter the address of the county welfare department.

Telephone -- Enter the eligibility worker's telephone number.

Provider name, number, address, and telephone -- Leave blank.

Recipient name and number -- Enter full name and complete 14 digit Medi-Cal number of the beneficiary who incurred the potential overpayment. If the potential overpayment was incurred by a couple or family, list the case name and the complete Medi-Cal number for that person. Also include the beneficiary's Social Security number and date of birth.

Address -- List the beneficiary's current address.

Telephone -- List the beneficiary's current telephone number.

Synopsis of Complaint

1. If a person has been acting on behalf of the beneficiary (e.g., a guardian or conservator), list that person's name, address, and telephone number. State whether this person completed the Statement of Facts, MC 210, or CA 2 and the Responsibilities Checklist, MC 217, on behalf of the beneficiary.

2. List all family members who incurred a potential overpayment; list the complete Medi-Cal number for each one.

3. Explain in detail the reason for the overpayment and why you think there was intent to provide misinformation or fraud.

4. Give the source of the income or property that caused the overpayment.

5. Signature and date the eligibility worker completes the form, with the office address and telephone number.

Do not complete the remainder of the form.

Send the original of the MC 609 along with the MC 239E to the Central Complaints Section, 714/744 P Street, Sacramento, CA 95814.