

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET

P.O. BOX 942732

SACRAMENTO, CA 94234-7320



July 26, 1993

All County Medi-Cal Program Managers
All County Administrative Officers
All County Policy Liaisons

Letter No.: 93-51

UNUSUAL MEDICAL EXPENSES (UME)

This letter is intended to provide counties with the most recent developments in this subject area.

This All County letter is divided into three parts as follows:

A) Summary of E-Mail #92-114 dated September 23, 1992

1. Counties were instructed to disregard any increase in needs-based VA pension or needs-based compensation, if increase was the direct result of Unusual Medical Expenses (UME).
2. Counties were asked to query the VA Administration when an individual has income in addition to VA and medical expenses exceeding five percent of the annual VA payment rate (see Enclosure A).
3. Until UME is verified by the VA, counties were instructed to assume that none of the VA payment is due to a UME situation and to include the entire VA payment when determining the share of cost.
4. These instructions were effective October 10, 1991, and were to have been applied to Medi-Cal applications submitted December 1992 or later and at the time of the next reinvestigation for continuing cases. Furthermore, counties were asked to apply these instructions to any cases that were closed after October 10, 1991 and were now being reopened.

B) Additions to E-Mail #92-114 related to the verification of veteran's benefits.

1. Our initial instructions asked counties to verify UME by means of correspondence with their VA regional office. Sacramento County called and advised us that the local Veterans Service Office was able to provide the needed information. We encourage counties who have good working relationships with their local Veteran's offices to utilize this resource. If your local VA office is uncooperative, you should continue to utilize your VA regional office.
2. We have also developed, with assistance from Sacramento County, language for use on a CA 5 if counties decide to use their local offices to verify UME (see Enclosure B). For those counties wishing to use Veterans Administration Regional offices, I have included a suggested format that was acceptable for the regional Veterans office in San Francisco (see Enclosure C) and addresses for Veterans Regional offices (see Enclosure D).

All County Medi-Cal Program Managers
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C) Miscellaneous

1. If verifications confirm receipt of UME, share of cost adjustments should be made as provided by California Code of Regulations, Title 22, Section 50653.3.
2. We have also been advised by Medicaid Regional Memorandum No. 93-68 that UME should not be treated as income under any circumstance. In addition, UME should not be reported to the Medi-Cal Third Party Liability Branch.

If you have any questions, please contact Armando Martinez of my staff at (916) 657-1487.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

ENCLOSURE A
MAXIMUM VA PAYMENT RATE CHART

RATES EFFECTIVE DECEMBER 1, 1992 *1

Maximum VA Annual Rate for Aid and Attendance (A&A)
Veteran = \$12,180 (\$634 base + \$381 A&A x 12)

Maximum VA Annual Rate for Housebound (HB)
Veteran = \$9,312 (\$634 base + \$142 A&A x 12)

Maximum VA Annual Rate for Aid and Attendance (A&A)
Widow = \$8,160 (\$425 + \$255 A&A x 12)

Maximum VA Annual Rate for Housebound (HB)
Widow = \$6,240 (\$425 + \$95 HB x 12)

*1 Reflected in January 1993 payment

RATES EFFECTIVE DECEMBER 1, 1991 *1

Maximum VA Annual Rate for Aid and Attendance (A&A)
Veteran = \$11,832 (\$616 base + \$370 A&A x 12)

Maximum VA Annual Rate for Housebound (HB)
Veteran = \$9,036 (\$616 base + \$247 A&A x 12)

Maximum VA Annual Rate for Aid and Attendance (A&A)
Widow = \$7,920 (\$413 base + \$247 A&A x 12)

Maximum VA Annual Rate for Housebound (HB)
Widow = \$6,060 (\$413 base + \$92 HB x 12)

*1 Reflected in January 1992 payment

RATES EFFECTIVE DECEMBER 1, 1990 *1

Maximum VA Annual Rate for Aid and Attendance (A&A)
Veteran = \$11,400 (\$594 base + \$356 A&A x 12)

Maximum VA Annual Rate for Housebound (HB)
Veteran = \$8,712 (\$594 base + \$132 HB x 12)

Maximum VA Annual Rate for Aid and Attendance (A&A)
Widow = \$7,644 (\$398 base + \$239 A&A x 12)

Maximum VA Annual Rate for Housebound (HB)
Widow = \$5,844 (\$398 base + \$89 HB x 12)

*1 Reflected in January 1991 payment

VERIFICATION AND REFERRAL

NOTE: DO NOT COMPLETE THIS FORM UNLESS ONE OF THE FOLLOWING IS KNOWN: VETERAN'S SOCIAL SECURITY NO. AND DATE OF BIRTH, MILITARY SERIAL NO., OR VETERANS ADMINISTRATION IVA CLAIM NO.

Original and three copies County Veterans Service Office
One copy Case File

Social Security Number (SSN) — You must provide the veteran's SSN if known to assist in the evidence gathering process and to explore potential benefits. The furnishing of a SSN of family members is a condition of eligibility required by Section 402(a)(25) (AFDC) and Section 1137(a)(Medi-Cal) of the Social Security Act. Failure to cooperate may result in denial or discontinuance of aid as required by MPP Sections 40 157 and 44 103 (AFDC) and Title 22 CAC Section 50168 (Medi-Cal).

Enter Name and Address of County Veterans Service Office

VETERAN'S SERVICE OFFICE
123 Main St.
Anywhere, Ca. 91212
ATTENTION: John Smith
UME VERIF.

FAMILY NAME (Last, First, Middle) M. SAMPLE	
WORKER NUMBER H000	TELEPHONE NUMBER 978-0000
CASE NAME UNUSUAL, MED. E.	
CASE NUMBER 34-67-0123456	APPLICANT/RECIPIENT PHONE NO 456-1000

Please verify any VA benefits being received by veteran/dependent including Aid and Attendance (A and A) if applicable.

Please determine veteran's/dependent's eligibility for veterans' benefits (see below if requesting A and A).

1. VETERAN'S NAME (LAST, FIRST, MIDDLE) Unusual, Med E.		BIRTHDATE 10-20-20		BIRTHPLACE CALIF.		LIVING? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
FG/U ONLY HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO		VETERAN'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE) 10 MARK PLACE SAC, CA 95800				DATE OF DEATH PLACE OF DEATH	
CLAIM NO.		SOCIAL SECURITY NUMBER		MILITARY SERIAL NUMBER		DATE ENTERED SERVICE	
						DATE DISCHARGED	
						BRANCH OF SERVICE	
2. NAME OF CLAIMANT Unusual, Wife		RELATIONSHIP Wife		BIRTHDATE 11-20-20		SOCIAL SECURITY NUMBER 732-32-3232	
						ADDRESS SAME	
3.							
4.							
REQUEST FOR AID AND ATTENDANCE DETERMINATION FOR MEDICAL (MIA) ONLY CASES				MEDICAL ID NUMBER		SHARE OF COST	
<input type="checkbox"/> VETERAN <input type="checkbox"/> WIDOW <input type="checkbox"/> PARENT						\$	
5 MONTHLY INCOME		SSA		CIVIL SERVICE		OTHER	
\$		\$		\$		\$	
				WIDOW'S/PARENT'S MONTHLY GROSS INCOME		SSA	
				\$		\$	
LIVING IN <input type="checkbox"/> NURSING FACILITY		<input type="checkbox"/> INDEPENDENT LIVING SITUATION					
NAME AND ADDRESS OF NURSING FACILITY							

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the welfare department to release the above information to the County Veterans Service Office and the veteran's Administration for purposes of identifying or obtaining benefits available to the persons identified above. I also authorize the County Veterans Service Officer and the veteran's Administration to release their findings (to be noted below).

SIGNATURE (OR MARK) OF VETERAN/DEPENDENT/FC REP	DATE	SIGNATURE OF WITNESS TO MARK	DATE
Signature	12/17/92		

—TO BE COMPLETED BY COUNTY VETERANS SERVICE OFFICE—					Remarks: 1. NEED VERIF. EFF. _____ MO/YR 2. THE VA BENEFIT WITHOUT UME WOULD BE \$ _____ EFF _____ MO/YR
	1-Veteran	2-Claimant	3-Claimant	4-Claimant	
Monthly Benefit	\$	\$	\$	\$	
Beginning Date (month/Day/Year)					
Ending Date (month/Day/Year)					
Emp Sum Payment (last 6 Months)	\$	\$	\$	\$	
Monthly Benefit is being paid, please check:		Eligibility Status (Please check)			
<input type="checkbox"/> Compensation		<input type="checkbox"/> No Basic Eligibility			
<input type="checkbox"/> Pension		<input type="checkbox"/> Claim Initiated			
<input type="checkbox"/> Other (see Remarks section)		<input type="checkbox"/> Claim Being Reviewed			
<input type="checkbox"/> Includes A and A benefits of \$ _____		<input type="checkbox"/> Claim Denied			

Enter Name and Address of County Welfare Department

VETERANS SERVICE REPRESENTATIVE (PRINT)	
TELEPHONE NO	DATE

Enter Name and Address of Veterans Affairs
Regional Office - Attention: Adjudication Unit

	ELIGIBILITY WORKER (PLEASE PRINT)	
	WORKER NUMBER	TELEPHONE NUMBER
	CASE NAME	
	CASE NUMBER	APPLICANT RECIPIENT PHONE NO.

The VA beneficiary shown below is also a Medi-Cal beneficiary who has been in long-term care since _____. We need to know the amount of her/his VA benefits after excluding reimbursements for unusual medical expenses (UME). Please provide a breakdown of VA payments for the period _____ to _____.

VA Beneficiary:
VA Claim Number:
Beneficiary's Social Security Number:

Effective Date	Total Monthly Amount	Amount Without UME *

Adjudication Employee: _____ Date: _____

Title: _____ Phone: _____

Enter Name and Address of County Welfare Department

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* To be used in computing the Medi-Cal Budget.

ENCLOSURE D

**Addresses for Department of Veterans Affairs
Regional Offices (VARO)
Department of Veterans Affairs
Regional Office
211 Main Street
San Francisco, CA 94105**

**Department of Veterans Affairs
Regional Office - Federal Building
11000 Wilshire Boulevard
Los Angeles, CA 90024**

**Department of Veterans Affairs
Regional Office
2022 Camino Del Rio North
San Diego, CA 92108**

DRAFT PROCEDURES
MEDI-CAL ELIGIBILITY MANUAL

10. Treatment of Veteran's Unusual Medical Expenses

This section contains information regarding the treatment of Unusual Medical Expense (UME).

BACKGROUND

Health Care Financing Administration issued new instructions concerning the treatment of Unusual Medical Expenses pursuant to an injunction arising from the Sherman v. Griepentrog case. This lawsuit prohibits Nevada and other Ninth District states from considering increases due to UME as income when determining a beneficiary's share of cost.

PROCEDURES

- Counties must disregard that portion of a needs-based VA pension or needs-based compensation that is the direct result of an Unusual Medi-Cal Expense. Eligibility workers should query the Veterans Administration when an individual has income in addition to veteran's benefits and when beneficiaries have medical expenses exceeding five percent of certain veteran payment rates. The veteran payment rate information is contained in All County Letter No.: _____, and will be updated annually.
- Counties have the option of verifying Unusual Medi-Cal Expenses by mailing a CA 5 to their local Veteran's Service office or by contacting one of the Veterans Affairs Regional offices using the suggested format. Example of a completed CA 5, format of a letter for use in contacting a Veterans Affairs Regional office and addresses of the Veterans Affairs Regional offices are provided.

NOTE: If verifications confirm receipt of UME; share of cost adjustments should be made pursuant to California Code of Regulations, Title 22, Section 50653.3.

VETERANS' BENEFITS VERIFICATION AND REFERRAL

NOTE: DO NOT COMPLETE THIS FORM UNLESS ONE OF THE FOLLOWING IS KNOWN: VETERAN'S SOCIAL SECURITY NO. AND DATE OF BIRTH, MILITARY SERIAL NO., OR VETERANS ADMINISTRATION CLAIM NO.

Original and three copies County Veterans Service Office
One copy Case File

Social Security Number (SSN) — You must provide the veteran's SSN if known to assist in the evidence gathering process and to explore potential benefits. The furnishing of the SSN of family members is a condition of eligibility required by Section 402(a)(25) (AFDC) and Section 1137(a)(Medi-Cal) of the Social Security Act. Failure to cooperate may result in denial or discontinuance of aid as required by MPP Sections 40 157 and 44-103 (AFDC) and Title 22 CAC Section 50168 (Medi-Cal).

Enter Name and Address of County Veterans Service Office

VETERAN'S SERVICE OFFICE
123 Main St.
Anywhere, Ca. 91212
ATTENTION: John Smith
UME VERIF.

ELIGIBILITY NUMBER (Last 4 Digits)	
M. SAMPLE	
WORKER NUMBER	TELEPHONE NUMBER
H000	978-0000
CASE NAME	
UNUSUAL, MED. E.	
CASE NUMBER	APPLICANT/RECIPIENT PHONE NO
34-67-0123456	456-1000

Please verify any VA benefits being received by veteran/dependant including Aid and Attendance (A and A), if applicable.

Please determine veteran's/dependant's eligibility for veterans' benefits (see below if requesting A and A).

1. VETERAN'S NAME (LAST FIRST MIDDLE)		BIRTHDATE		BIRTHPLACE		LIVING?	
Unusual, Med E.		10-20-20		CALIF		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
OR FG/U ONLY		VETERAN'S ADDRESS (NUMBER STREET CITY STATE ZIP CODE)		DATE OF DEATH		PLACE OF DEATH	
IN HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO		10 MARK PLACE SAC, CA 95800					
A CLAIM NO		SOCIAL SECURITY NUMBER		MILITARY SERIAL NUMBER		DATE ENTERED SERVICE	
						DATE DISCHARGED	
						BRANCH OF SERVICE	
2. NAME OF CLAIMANT		RELATIONSHIP		BIRTHDATE		SOCIAL SECURITY NUMBER	
Unusual, Wife		Wife		11-20-20		732-32-3232	
3.							
4.							

REQUEST FOR AID AND ATTENDANCE DETERMINATION FOR MEDICAL (MA) ONLY CASES				MEDICAL ID NUMBER		SHARE OF COST		EFFECTIVE DATE	
<input type="checkbox"/> VETERAN <input type="checkbox"/> WIDOW <input type="checkbox"/> PARENT						\$			
V'S MONTHLY INCOME		SSA		CIVIL SERVICE		OTHER		WIDOW'S PARENT'S MONTHLY GROSS INCOME	
\$		\$		\$		\$		\$	
LIVING IN: <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/> INDEPENDENT LIVING SITUATION									
NAME AND ADDRESS OF NURSING FACILITY									

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the welfare department to release the above information to the County Veterans Service Office and the veteran's Administration for purposes of identifying or obtaining benefits available to the persons identified above. I also authorize the County Veterans Service Officer and the Veterans' Administration to release their findings (to be noted below).

SIGNATURE (OR MARK) OF VETERAN/DEPENDENT/FC REP	DATE	SIGNATURE OF WITNESS TO MARK	DATE
Signature	12/17/92		

V — TO BE COMPLETED BY COUNTY VETERANS SERVICE OFFICE —					Remarks:	
	1-Veteran	2-Claimant	3-Claimant	4-Claimant		
Monthly Benefit	\$	\$	\$	\$		
Beginning Date (Month/Day/Year)						
Ending Date (Month/Day/Year)						
UMP Sum Payment (est 6 Months)	\$	\$	\$	\$	1. NEED VERIF. EFF. _____ MO/YR 2. THE VA BENEFIT WITHOUT UME WOULD BE \$ _____ EFF _____ amount _____ MO/YR	
Monthly Benefit is being aid, please check:		Eligibility Status (Please check)				
<input type="checkbox"/> Compensation		<input type="checkbox"/> No Basic Eligibility				
<input type="checkbox"/> Pension		<input type="checkbox"/> Claim Initiated				
<input type="checkbox"/> Other (see Remarks section)		<input type="checkbox"/> Claim Being Reviewed				
<input type="checkbox"/> Includes A and A benefits of \$ _____		<input type="checkbox"/> Claim Denied				

Enter Name and Address of County Welfare Department

VETERANS SERVICE REPRESENTATIVE (PRINT)	
TELEPHONE NO	DATE

**Enter Name and Address of Veterans Affairs
Regional Office - Attention: Adjudication Unit**

	ELIGIBILITY WORKER (PLEASE PRINT)	
	WORKER NUMBER	TELEPHONE NUMBER
	CASE NAME	
	CASE NUMBER	APPLICANT RECIPIENT PHONE NO.

The VA beneficiary shown below is also a Medi-Cal beneficiary who has been in long-term care since _____. We need to know the amount of her/his VA benefits after excluding reimbursements for unusual medical expenses (UME). Please provide a breakdown of VA payments for the period _____ to _____.

VA Beneficiary:
VA Claim Number:
Beneficiary's Social Security Number:

Effective Date	Total Monthly Amount	Amount Without UME *

Adjudication Employee: _____ Date: _____
 Title: _____ Phone: _____

Enter Name and Address of County Welfare Department

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* To be used in computing the Medi-Cal Budget.

Addresses for Department of Veterans Affairs
Regional Offices (VARO)
Department of Veterans Affairs
Regional Office
211 Main Street
San Francisco, CA 94105

Department of Veterans Affairs
Regional Office - Federal Building
11000 Wilshire Boulevard
Los Angeles, CA 90024

Department of Veterans Affairs
Regional Office
2022 Camino Del Rio North
San Diego, CA 92108

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET

P.O. BOX 942732

SACRAMENTO, CA 94234-7320



July 26, 1993

TO: All County Welfare Directors
All MEDS Coordinators
All Medi-Cal Program Specialists/Liaisons

Letter No.: 93-53

CALIFORNIA ELIGIBILITY VERIFICATION AND CLAIMS MANAGEMENT SYSTEM (CA-EV/CMS)

The purpose of this letter is to summarize the status of activities related to the design of the California Eligibility Verification and Claims Management System (CA-EV/CMS). This automated verification system will eliminate the current paper Medi-Cal cards for most categories of Medi-Cal beneficiaries and allow Medi-Cal providers access to Medi-Cal Eligibility verification by using the plastic State of California Benefits Identification Card* which looks like a credit card or by entering client identifiers into an on-line system. Many providers will use a Point-of-Service (POS) device. As part of the overall enhancement, the State is automating the existing manual Share of Cost (SOC) process.

The State has been meeting regularly with counties during the past year to help establish the approach for implementing CA-EV/CMS and the SOC enhancement. Although some of these developments have been discussed at California Welfare Directors Association (CWDA) and County MEDS Advisory Group (CMAG) meetings, we want to inform you in a more comprehensive manner to ensure that all counties have the same information. This letter will summarize the general components of CA-EV/CMS and the implications of its use by the counties. A separate All County Welfare Directors Letter has addressed the SOC enhancement.

ON-LINE ELIGIBILITY VERIFICATION PHASE-IN

The use of the State of California Benefits Identification Card for on-line verification will be phased in over a period of six months. The five counties of Butte, Napa, Orange, Santa Clara, and Yuba, which represent ten percent of the statewide Medi-Cal population have agreed to be the phase-in counties and will be the first to implement the new process in January 1994. For implementation, the remaining counties have been divided into the following three groups, each of which represents approximately 30 percent of the Medi-Cal population:

* generic reference term

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The order of the implementation will occur as follows:

January 1994	Phase-In Counties:	
	Butte	Napa
	Orange	Santa Clara
	Yuba	
April 1994	Los Angeles County	
May 1994	Southern California	
	Fresno	San Bernardino
	Imperial	San Diego
	Inyo	San Luis Obispo
	Kern	Santa Barbara
	Kings	Tulare
	Riverside	Ventura
June 1994	Northern California	
	Alameda	Nevada
	Alpine	Placer
	Amador	Plumas
	Calaveras	Sacramento
	Colusa	San Benito
	Contra Costa	San Francisco
	Del Norte	San Joaquin
	El Dorado	San Mateo
	Glenn	Santa Cruz
	Humboldt	Shasta
	Lake	Sierra
	Lassen	Siskiyou
	Madera	Solano
	Marin	Sonoma
	Mariposa	Stanislaus
	Mendocino	Sutter
	Merced	Tehama
	Modoc	Trinity
	Mono	Tuolumne
	Monterey	Yolo

STATE OF CALIFORNIA BENEFITS IDENTIFICATION CARD AND CARD CARRIER

The card will be mailed to the Medi-Cal/County Medical Services (CMSP) program client in a "card carrier" (similar to those used for mailing credit cards) with some basic beneficiary information. The front of the card will contain limited information such as name, gender, date of birth, issue date, and a client identifier (the

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Social Security Number (SSN) or a unique Client Identification number (CIN) if the beneficiary has a pseudo number. A "check digit" will be added at the end of the SSN and CIN. A "check digit" is created by a computer program using an algorithm and is used by EDS and some billing software programs to verify accurate input of the Medi-Cal identification number.

LINKING STATE OF CALIFORNIA BENEFITS IDENTIFICATION CARD AND CALIFORNIA DRIVERS LICENSE/IDENTIFICATION CARD

At a time yet to be determined, Department of Health Services (DHS) plans to link the State of California Benefits Identification Card with the California Drivers License/Identification Card. This will not happen until additional research has been completed and appropriate legislative authority established.

PAPER MEDI-CAL CARDS

In order to meet the needs of the minor consent Medi-Cal clients and others who require "immediate need" Medi-Cal cards, a paper Medi-Cal card will continue to be generated by the counties. The paper Medi-Cal card format is unchanged except for "x-ing" or "**-ing" out the MEDI and POE labels.

BENEFICIARY NOTIFICATION

DHS will send informational stuffers in English and Spanish about the forthcoming State of California Benefits Identification Card and the new share of cost system to Medi-Cal and CMSP eligibles beginning in November 1993, two months before they receive their first State of California Benefits Identification Card and new SOC instructions. This will ensure that each Medi-Cal and CMSP eligible in the phase-in will receive two informational stuffers before the paper card and/or MC 177 SOC form is eliminated. Medi-Cal and CMSP eligibles will also receive a stuffer during the phase-in month.

LOST/DESTROYED MEDI-CAL CARDS

The process will be similar to the present process. The only difference would occur if someone later "finds" their "lost" State of California Benefits Identification Card. Should that occur, the "lost" card should be destroyed and the new card with its new issue date should be used. If a replacement card is issued, the previous card will be deactivated.

RETURNED (UNDELIVERABLE) CARDS

The returned (undeliverable) State of California Benefits Identification Card will be sent to the State. DHS will report occurrences of returned plastic ID cards to the counties.

MEDI SERVICE RESERVATION SYSTEM

CA-EV/CMS will establish a MEDI reservation system which allows the provider to "reserve" a MEDI service when making an appointment for (1) the current month, and (2) for the future month AFTER renewal (near the end of the month), when the MEDI-CAL beneficiary shows eligibility for the future month as "current month".

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POINT-OF-SERVICE DEVICES (POS)

We are not planning to provide county welfare departments point-of-service devices for the plastic card. Counties can continue to use screen prints off MEDS.

MEDI-CAL PAMPHLET

Publication No. 102, the Medi-Cal pamphlet entitled "MEDI-CAL - What it Means to You" will be updated with information about CA-EV/CMS and will be available in early 1994.

FORMS

Currently, the only forms which require changes are the Notice of Action forms which relate to SOC.

MEDS MANUAL REVISION

If there are system changes that affect screens, transactions, or any activities that the counties perform, DHS will issue a MEDS Manual update.

PROVIDER TRAINING

DHS, Electronic Data Systems, Delta Dental and various provider groups have formed a provider training work group and are developing provider bulletins and provider training sessions. We will ensure that counties receive Medi-cal eligibility information that was sent to providers.

COUNTY TRAINING

Training will be a "train the trainer" level training and will be conducted regionally in conjunction with the State of California Benefits Identification Card implementation schedule.

DHS views the On-Line Eligibility Verification project as another step toward automating the welfare system. We appreciate your participation in the discussions concerning the design of CA-EV/CMS. If you have any questions about CA-EV/CMS, please contact Sue Miller of my staff at (916) 657-3184.

Sincerely,

ORIGINAL SIGNED BY
Angeline Mrva for

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch