

CHAPTER 8

CMIPS & SHARE-OF-COST

TROUBLE SHOOTING GUIDE

Point Of Service

Point of Service - A Medi-Cal recipient may meet their Share-of-Cost with any medical service, including payments for prescriptions, health plan co-payments, and payments to their IP's. Payments are made at the "Point" that services are received.

EXAMPLE:

When a recipient goes to the pharmacy, doctor, or other Medi-Cal provider and pays for medication or services:

- The Medi-Cal provider enters the amount the recipient has paid into the Point Of Service terminal and "spends down" the recipient's SOC.
- The ongoing balance of each recipient's SOC case is kept in MEDS until the Medi-Cal SOC is fully paid and the recipient's SOC case is "certified."
 - A recipient's SOC case is "certified" when they have paid their SOC obligation for the month.
- After a recipient's SOC is certified, remaining Medi-Cal covered services are paid by Medi-Cal.

Spend-down

Spend-down refers to paying off the monthly Medi-Cal SOC. This is done by the client paying for medical services and the payment is then applied to the SOC. See example above.

Buyout

- CMIPS compares the Medi-Cal SOC with the IHSS SOC. The recipient eligible for the SOC comparison is responsible for paying the lower amount.
- The difference between the two SOC amounts is paid for by California Department of Social Services (CDSS). This amount is the "buyout".

EXAMPLE:

If the Medi-Cal SOC is \$500, and the IHSS SOC is \$300, the Buy-Out amount would be the difference between the two, \$200. This means the recipient is responsible for the \$300 IHSS SOC. Once the recipient pays the remaining \$200, the case is "certified" eligible for Medi-Cal purposes.

- The Buy-Out is processed once a month around the 25th.
- *Retrospective Buy-Out processing will not occur.* This means:
 - Once the monthly Buy-Out has processed, *no additional Buy-Out processing will occur for the current month or any prior months.*

- Recipients whose recently granted cases were not part of the monthly Buy-Out will be responsible for paying their entire Medi-Cal SOC.
- Recipients can (if necessary) take or send receipts to their Medi-Cal Eligibility Worker and the worker can apply them to their Medi-Cal SOC

No SOC Determination Needed

Cases that are coded as “pickle” do not need a SOC determination if Personal Care Services are needed. The case will be entered in CMIPS with a SOC aid code. Income is entered as \$0 or \$1.00.

Aid Codes 14, 16, 26, 36, 66, 6A, or 6C are treated the same as status eligible if PCSP eligibility exists.

Pickle:

- 16 - Pickle Eligible - Aged
- 26 - Pickle Eligible - Blind
- 36 - Disabled COBRA Widow(er)
- 66 - Pickle Eligible - Disabled
- 6A - Disabled Adult Child - Blind
- 6C - Disabled Adult Child – Disabled

Also treated as Status Eligible

- 14 – Aged Medically Needy
- 24 – Blind
- 64 – Disabled
- 6V– Waiver cases

6G– 250% Working disabled – Use aid code 18, 28, or 68 as appropriate. Income is entered as \$0 or \$1.00.

IHSS Residual (2N) Cases

2N cases are not eligible to full Federal Financial Participation (FFP) Medi-Cal and are funded from State and County sources. It’s important that these cases be reviewed and corrected (if necessary) *as soon as possible* to receive Federal funding.

Share-of-Cost Cases

Cases may change to a 2N secondary aid code when:

- The recipient information in CMIPS doesn’t match the recipient information in MEDS.
- The Medi-Cal Worker takes a negative action on the Medi-Cal case.
 1. Check the Medi-Cal Eligibility Look-up Screen (MELG) in CMIPS for Medi-Cal eligibility. If the case shows FFP – N there is no FFP eligibility for the month indicated.
 2. Review the Monthly Renewal Exception Report for the case in question.
 3. Compare the SOC-293 with the MEDS printout and check for inconsistent information.
 4. Research and correct where needed, verify with the recipient. (See “Monthly Renewal Exception Report” instructions.)

5. It takes approximately 3 days for the information to be updated into the system.
- If the secondary aid code does not correct:
 1. Submit to the Social Work Supervisor (SWS) for review.
 2. If still unable to correct the SWS should contact the IHSS Automation Coordinator for possible help from the State.
- Negative actions by the Medi-Cal worker:
 1. Check MELG screen for date and status.
 2. Client may cooperate before the buy out occurs.
 3. If not, a reimbursement may be necessary (see below “Incorrect SOC Withheld”).

Status Eligible (SSI/SSP)

Any status eligible cases that have an incorrect secondary aid code cannot be corrected through the CMIPS system. See “Medi-Cal Exception Reports”.

Medi-Cal Eligibility Look-up (MELG) Screen

The MELG Screen is fully described in the CMIPS MANUAL page IV-D-2.

Important Fields To Check

FFP: Federal Financial Participation full Scope Medi-Cal – This indicates whether or not (Y-Yes) or (N-No) the recipient is eligible to federally funded Medi-Cal. All recipients with FFP = N will be assigned to the IHSS Residual Program (2N).

MES: Medi-Cal Eligibility Status – The three-digit Medi-Cal Eligibility Status.

- 501- Medi-Cal not certified
- 301- Medi-Cal Certified
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LAST DT - The last date that the eligibility month information was updated by a MEDS Response Update.

Incorrect SOC Withheld

If the recipient or the Individual Provider (IP) state that the incorrect SOC was withheld from the IP’s paycheck the Social Worker will:

1. Verify what the correct SOC should be by using MELG and RELB screens in CMIPS for current information. Contact the Medi-Cal Worker if necessary.
2. Research:
 - a. Was recipient eligible to a buyout?
 - b. Did the buyout occur?
 - c. Did the client receive credit for payments made to services other than IHSS?
3. Verify what amount was withheld from the IP’s paycheck using the Warrant Summary (WARR) screen. CMIPS Manual pages VIII-C-1
4. Determine if reimbursement is appropriate.
5. If reimbursement is appropriate because the buyout did not occur:
 - a. The recipient has not paid the SOC to the IP; the IP would be reimbursed for any *incorrect* SOC amount withheld.
 - b. The recipient has paid the SOC to the provider; the client can be reimbursed *if the payment can be verified*. Verification can include:

- Canceled checks.
- Receipt for the SOC paid to the IP signed by both the IP and the recipient.

Reimbursement Procedures

CMIPS MANUAL Page XI-A-1

The Special Pre-Authorized Transaction (SPEC) screen is used to issue various payments and adjustment transactions. *When appropriate* this is the method used to reimburse a recipient or an IP. All reimbursements must be thoroughly researched by the Social Worker and the Social Work Supervisor. The reimbursement must be approved and signed by the Social Work Supervisor and the Program Manager. Public Authority will issue the SPEC payment as instructed when all of the correct steps have been followed.

WX15 CHANGE IN LAW – Currently used for Buyout issues only, this method is used when payment is necessary due to a change in law. Funding comes from State and County sources only, not federal. Transactions may be keyed against a Provider or a Recipient case.

WX25 STATUTORY MAX EXCESS – Used to pay a provider for:

- Hours in excess of 195 hours Statutory Maximum.
- Recipient cases which have a Medi-Cal Secondary Aid Code of 2L (IHSS+ Waiver) or 2N (Residual) for the payment period.
- May not be keyed against a recipient who has a Medi-Cal Secondary Aid Code of 2M for the payment period.
- Payment may not exceed the 283 Hour Statutory Maximum.
- May be keyed against a *Provider* case only.

When a secondary aid code changes and the statutory maximum on a case decreases to 195 hours the system will not allow payment over the 195 hours, even when the client has not received timely notice of the change. This transaction is used to pay the provider for those hours.

CMIPS ONLINE REPORTS - CMIPS MANUAL PAGE XIV-Index -1

The reports below are used to help with case management and alert staff to specific types of information.

Weekly Statutory Max Report - CMIPS MANUAL PAGE XIV-gg-1

Review Weekly and make corrections.

This report indicates cases where the Medi-Cal Secondary Aid Code has not been changed when:

- A parent or spouse provider is added or terminated or;
- There is a change to the recipient's Federal Financial Participation (FFP) status.

These changes affect the recipient's case in the following manner:

1. The Medi-Cal Secondary Aid Code is changed from PCSP (2M), to Waiver (2L), or Residual (2N); the recipient is Non Severely Impaired and the hours *are greater than the 195 hours Statutory Maximum*.
2. Medi-Cal Secondary Aid Code is changed from Waiver (2L) or Residual (2N) to PCSP (2M) and the recipient is Non Severely Impaired with hours *less than the 283 Statutory Maximum and showing unmet need*.

Important Fields to Check

AUTH HRS - The number of hours currently authorized on the recipient case.

UNMET NEED - The current unmet need on the recipient case.

Social Worker Procedure

To verify changes of the FFP, use the Medi-Cal Eligibility Look-up Screen (MELG).

- *Until action is taken to correct the case, CMIPS will not allow payment for the time period affected.*
- The Social Worker will need to review the case and adjust the authorized hours. A NOA will be produced to notify the recipient of the action.
- CMIPS will allow payment of the timesheet up to the Statutory Maximum hours.
- Remaining hours may be paid through a new (Special) SPEC transaction developed to pay providers for hours worked above the Statutory Maximum.
- Before a SPEC transaction can be used, 195 hours must be paid through the TIME screen.
- The W/X 25 SPEC transaction will allow Public Authority to make payment for hours worked in excess of the Statutory Max. This will allow payment to the IP when a client did not receive a timely Notice of Action. This is not a permanent process.
- Up to 283 hours may be paid until the recipient receives a timely IHSS NOA.

Non-Severely Impaired clients have *less* than 20 hours of Personal Care services weekly. Personal Care services are indicated with an * on the SOC 293.

Maximums:

195 hours – Non-Severely Impaired – IHSS-R(2N) and IPW (2L)

Up to 283 hours – Severely Impaired - IHSS-R (2N) and IPW (2L); all PCSP cases.

Monthly Renewal Exception Report - CMIPS MANUAL UPDATE NOT REFLECTED AS OF 9/11/06

Review monthly and make corrections.

This report alerts staff to cases that have discrepancies between the MEDS and CMIPS cases. Cases appearing on this report *will* have the Monthly Buy-Out and Spend-Down processed as appropriate.

The following discrepancies may appear on this report:

- MEDS CIN DOES NOT MATCH IHSS CIN
- MEDS SSN DOES NOT MATCH IHSS SSN
- MEDS DOB DOES NOT MATCH IHSS DOB
- MEDI-CAL SOC, BUT IHSS CASE NOT 18, 28 OR 68
- IHSS SOC GREATER THAN MEDS SOC
- IHSS SOC UPDATE REQUIRED
- MEDI-CAL ELIGIBILITY TERMINATED
- RECIPIENT ADMITTED TO LONG TERM CARE IHSS CASE NOT IN L STATUS
- RESIDUAL CASE IHSS SOC GREATER THAN NEED

Daily Response Exception Report - CMIPS MANUAL UPDATE NOT REFLECTED AS OF 9/11/06

Produced daily and should be reviewed by the worker at least once a week.

This report alerts staff to differences between IHSS and Medi-Cal eligibility or case data. Social Workers are expected to review these reports and determine if action is required against the IHSS case.

If a case is reported in the following category, the indicated action should be taken:

- **MEDI-CAL ELIGIBILITY DENIED** – The Social Worker should verify how this denial of Medi-Cal eligibility impacts the recipient’s IHSS eligibility and take appropriate action.
- **MEDS DOB DOES NOT MATCH IHSS DOB** – When the DOB in MEDS and CMIPS does not match, Buy-Out and Spend-Down processing may be affected.
 - The Social Worker must verify DOB and make sure the appropriate system is updated. If necessary the recipient must be contacted and written verification of the correct date of birth obtained. If the DOB is incorrect in the Medi-Cal case, forward a copy of the documentation (such as a birth certificate or passport) to the Medi-Cal worker. The Medi-Cal Worker cannot update the Medi-Cal case without written documentation.

SSI/SSP Terminations - CMIPS MANUAL PAGE XIV-Z-1

Produced monthly, review and take action.

No Time Sheet Activity - CMIPS MANUAL PAGE XIV-M-1

Produced monthly, review and take action.

Provider 300 + Paid Hours - CMIPS MANUAL PAGE XIV-S-1

Produced monthly, review and take action.

Application/Approval/Denial/Termination - CMIPS MANUAL PAGE XIV-A-1

Produced monthly, review and take action.

Overdue Assessment Listing - CMIPS MANUAL PAGE XIV-P-1

Produced monthly, review and take action.

Meds Alerts

A MEDS alert notifies staff that a case has an inconsistency and needs to be reviewed; action on the case may be needed. The tables below shows the *Critical Alerts*

Alert Number	Alert Definition
1501	County ID/MEDS-ID Conflict
1502	County ID/Birthdates Conflict
1503	Client Index Number/MEDS-ID Conflict
1504	Client Index Number/MEDS-ID vs. County ID/MEDS-ID Conflict
1510	Transaction Failed MEDS Name/Birthdates Match Criteria

Alert Number	Alert Definition
2003	MEDS-ID/Birthdates Conflict
2005	Transaction County-ID Does Not Match MEDS
2015	Recipient Already Active in Requesting County
2078	Recipient Already Active in Another County
2130	Deceased Per MEDS – Contact Your MEDS Liaison
9004	Active Medi-Cal Recipient – Deceased Per SSA Buy-In