STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714 / 744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

654-0499

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(Supersedes N.L. 07-0598)

California Children Services (CCS) Administrators and Medical Consultants and State Children's Medical Services Branch (CMS) Regional Offices Staff

SUBJECT: REPLACEMENT TO NUMBERED LETTER (N.L) 07-0598; HEALTHY FAMILIES (HF) PROGRAM REFERRALS TO THE CCS PROGRAM

This letter replaces N.L. 07-0598 dated May 29, 1998, related to HF program referrals to The revised text is in "***Italics and Bold***" for your convenience.

I. HF Program Background:

The enactment of Assembly Bill 1126 (Chapter 623, Statutes of 1997) created the HF program, California's implementation of the National Children's Health Initiative (Title XXI of the Social Security Act). The HF program is a state and federally-funded health, dental, and vision insurance program for children between one year and 18 years of age whose family incomes are between 100 percent and 200 percent of the federal poverty level. The health insurance coverage program is administered through the Managed Risk Medical Insurance Board (MRMIB) and the health care benefits will be provided to participating families through a broad range of competing health plans in each county where a health plan is established. The participating health plans have been selected through a solicitation process and the scope of benefits are similar to those received by children of state and local government employees through California's Public Employees Retirement System and Department of Personnel Administration benefit programs. The HF Program began on July 1, 1998.

Under the HF enabling legislation, the services authorized by the CCS program to treat a plan's subscriber's CCS-eligible medical condition are excluded from the plan's responsibilities. The participating health plan's responsibility for providing all covered medically necessary health care and case management services changes at the time that CCS eligibility is determined by the CCS program for the plan subscriber. The health plan is still responsible for providing primary care and prevention services not related to the CCS-eligible medical condition to the plan subscriber so long as they are within the HF program scope of benefits. The health plan also remains responsible for children referred to but not determined to be eligible for the CCS program.

The HF program statute Section 12693.62 of the Insurance Code provides for this exclusion and Section 12693.68 permits MRMIB to require all participating health plans to develop protocols with the local CCS programs in order to establish viable policies and procedures for screening, referring, and coordinating services for children needing services outside the scope of the plan. MRMIB has determined that the Memoranda of Understanding (MOU) will serve as the conduit to initiate and develop referral activities with the local CCS programs. This will facilitate developing written policies and procedures for identifying and referring health plan subscribers diagnosed or suspected of having a CCS-eligible medical condition to the local CCS program.

Federal law provides enhanced Federal Financial Participation (FFP) for states with a plan approved under Title XXI of the Social Security Act. For those CCS-eligible children who are identified as enrolled in HF program, FFP may be claimed under specific circumstances at a 65 percent match, with the state and county share being 17.5 percent each as long as the specific costs can be identified.

II. CCS Program Responsibility:

The local CCS program is responsible to work closely with HF participating health plans within its county to develop written policies and procedures for the identification and referral of plan subscribers who are diagnosed or suspected of having a CCS-eligible medical condition (refer to N.L. 03-0398). It is the expectation of the CMS Branch that those individuals enrolled in the HF program who are referred to CCS and meet the program's medical eligibility criteria will begin to receive case management services IMMEDIATELY. This applies to all CCS-eligible medical conditions except for Medically Handicapping Malocclusion. Determination of medical eligibility for orthodontics should follow the guidelines set forth in N.L. 07-0395.

Financial eligibility and a portion of the residential eligibility for the CCS program will be considered completed upon enrollment into the HF program as the enrollment contractor is required to determine these components by using an eligibility determination process similar to that used by Medi-Cal and the CCS programs. Each HF program applicant is required to be a California resident with legal immigration status and the family must provide proof of income that cannot exceed 200 percent of the federal poverty level. Local county residential eligibility, however, is not completely established during the HF eligibility determination. The eligibility determination process used by the HF program enrollment contractor is acceptable as determination of CCS financial eligibility for a potential CCS applicant. This will reduce the CCS eligibility determination process which may result in some decrease of workload.

Therefore, in order to facilitate the enrollment in CCS, for purposes of program eligibility, children who have been determined to be financially and residentially eligible for HF are to be presumed residentially eligible once CCS medical eligibility has been determined. If the residence specified in the CCS referral form or request for service form is an address within the county, this shall be accepted by the local CCS program to initiate the CCS application process and to provide authorization of medical services in those cases where CCS medical eligibility is determined. If the address is in another county, the referral form or request for service form shall be sent to that county. A copy of the form identifying this action shall also be sent to the health plan. The families are still required to submit a completed and signed CCS application, complete the program eligibility interview, and sign a Program Services Agreement.

To meet the mandates on the CCS program for implementation of the HF program, changes are required in the accepting and processing of a referral for a HF plan subscriber. These changes affect the process of a referral with or without the receipt of a signed CCS program application and issuing of an authorization for services prior to determination of program eligibility.

III. Policy Guidelines for Processing a Referral to the CCS Program for a HF Subscriber

A. Upon confirmation of medical eligibility for a child who is a HF plan subscriber, the CCS program will issue an authorization for the services determined to be medically necessary, regardless of receipt of a signed CCS application or completion of the CCS eligibility process. ***However, Medical Therapy Unit services can only be provided after medical eligibility for the Medical Therapy Program (MTP) has been confirmed and when the family has provided a signed CCS application, consent for MTP services form and Program Services Agreement. THERE SHALL BE NO EXCEPTIONS TO THIS POLICY.***

B. The CCS program will follow the CCS program requirements for informing a parent/legal guardian of the referral to the CCS program and that the program eligibility requirements (submitting a signed application, completing residential eligibility determination, and signing a CCS Program Services Agreement) ***must be met within the required timeframe.***

IV. Policy Implementation

When CCS program staff receives a referral/request for service from a HF program participating health plan that serves the county, the following policies shall be applied:

A. Review CCS referral/request for service;

1 CCS staff shall review referral/request for service to determine that the patient's address is within the county.

a. If patient's address is within the county, the referral/request for service shall be processed.

b. If patient's address is in another county, the referral/request for service shall be sent to that county with a copy of the form identifying the action sent to the health plan ***liaison of record. The recipient county shall accept the date of referral based on date received in original county.***

B. Process CCS referral/request for service

1. CCS staff shall initiate the application process upon receipt of a referral or a request for service.

2. The first and second notice to the applicant/family shall indicate that a referral from a HF provider is required by law for children identified or suspected of having a CCS-eligible medical condition as the HF program is not responsible for the provision of, or payment for, services to treat a confirmed CCS-eligible condition.

3 The notice shall also indicate that their child, with a confirmed CCS-eligible medical condition ***will have medically necessary CCS program benefits (including special care center services, maintenance and transportation) authorized*** until a completed application is received and residential eligibility is determined.

4. Families should be encouraged to submit a signed and completed CCS application and complete the residential eligibility process as soon

possible in order for CCS to provide on-going case management and payment for services related to the CCS-eligible medical condition.

5. A courtesy copy of the second and final notice shall also be sent to the HF health plan liaison of record.

C. Determine medical eligibility

1 CCS program staff shall determine medical eligibility by reviewing the submitted documentation within five days of receipt of referral as specified in N.L. 20-0997 (with the exception of orthodontics as previously mentioned).

2. If the information is inadequate, additional information shall be requested from the referring provider. ***A copy of the letter requesting the information shall be sent to the family and the health plan liaison of record. Once the additional information is received, the five-day timeframe shall go into effect.***

3. CCS staff shall also review the panel status of the provider and, if the provider appears eligible for panel status but is not currently on the CCS panel, should request that the provider complete a CCS panel application if he/she wishes to provide CCS-covered services to the client.

D. HF program referrals that are not medically eligible

CCS program staff shall work with the HF health plans to develop a policy and procedure in accordance with the MOU addressing those cases where a child has been referred to CCS but does not meet program medical eligibility.

E. Authorization of Services

1 When medical eligibility has been determined the child shall be presumed eligible for CCS.

a. A CCS case shall be opened when medical eligibility is determined and a service(s) is to be authorized.

b. The CCS case is opened by assigning a permanent CCS case number (the same way a permanent case number is assigned to a

Medi-Cal beneficiary who is full scope without a share of cost with no signed application or program services agreement).

b. CCS staff shall issue an authorization for medically necessary services for the child that does not exceed 60 days from the date the request for service is received.

2. Medically necessary services delivered by a CCS-paneled and/or approved provider from the time of referral to the determination of medical eligibility shall be covered.

F. Completing residential and financial eligibility

1. CCS program staff shall schedule these applicants/families for an eligibility interview as soon as possible after receipt of a completed application.

2. The applicant/family is not required to meet a separate CCS financial eligibility determination. The basis for this exception is that the HF program conducts a financial eligibility determination which is consistent with that of the CCS program to ensure that the applicant's/family's income is between 100 percent and 200 percent of the federal poverty level. Like CCS, the HF program requires the family to provide documentation (including current employee pay stubs, signed statements from the employer showing gross earnings and copies of income tax returns) of their gross income. ***There may be cases where CCS will be serving a child in a large family whose income is between 100 percent and 200 percent of the federal poverty level but is in excess of the $40,000 CCS program limit. This exception has been provided for in California's "State Child Health Plan Under Title XXI of The Social Security Act." CCS Program statutes, regulations, and procedure manual will be changed to reflect this exception.***

3 The applicant is required to meet CCS residential eligibility requirements. The CCS program staff shall **verify county of residence of the applicant**. As stated previously the HF program verifies that applicants are California residents with legal immigration status. ***CCS program requirements related to the residence of the family are not applicable for HF subscribers in accordance with California's "State Child Health Plan Under Title XXI of The Social Security Act." CCS program statute,***

regulations, and procedure manual will be changed to reflect this exception.

4. The applicant/family shall be exempt from paying the $20 annual assessment fee because of their participation in a government-sponsored health insurance program.

5. ***Families of known HF subscribers are not required to make application to the Medi-Cal program on behalf of the child as part of the CCS program's eligibility determination process.***

6. The applicant/family is required to sign the CCS program services agreement.

G. Applicants/families who fail to complete the application process;

CCS program staff shall issue a final notice to the applicant/family, with a courtesy copy to the HF program health plan liaison of record if the applicant/family fails to submit a completed application.

2. The final notice shall contain the following statements:

   a. ***If the HF subscriber is medically eligible for CCS, the CCS program will provide authorize and pay for medically necessary services to treat the child's CCS-eligible medical condition;***

   b. ***CCS is only responsible for payment of a HF subscriber's medical care related to the CCS-eligible medical condition that is delivered by a CCS-paneled or approved provider;***

   c. ***CCS is not responsible for the payment of any medical care following termination of HF coverage unless a signed and completed CCS application is received, residential eligibility for CCS is determined, and the applicant/family has signed a CCS Program Services Agreement;***

   d. ***Families are encouraged to submit a signed and completed CCS application and complete the enrollment process for determining residential eligibility and signing the CCS program services agreement to ensure continued medical case management and***

payment for services related to the treatment of a CCS-eligible medical condition.

H. Applicants/families who complete and sign the CCS application but have not completed the program's residential eligibility process

1. *CCS program staff shall issue a final notice, not a Notice of Action, to the applicant/family with a courtesy copy to the HF program health plan liaison of record if the applicant/family fails to complete the CCS residential eligibility process.*

2. *The notice shall contain the following statements:*

   a. *Since the HF subscriber is medically eligible for CCS, the CCS program will continue to serve the HF subscriber's medical needs related to the CCS-eligible medical condition;*

   b. *CCS is only responsible for payment of a HF subscriber's medical care related to the CCS-eligible condition that is delivered by a CCS-paneled or approved provider;*

   c. *CCS is not responsible for the payment of any medical care following termination of HF coverage unless the CCS eligibility process has been completed prior to the termination date;*

   d. *Families are encouraged to complete the CCS residential eligibility process and to sign a Program Services Agreement to ensure continued medical case management and payment for services related to the CCS-eligible medical condition.*

I. If a HF subscriber/subscriber's does not submit a completed CCS application and/or complete the CCS residential eligibility process, including signing a Program Services Agreement, the case will remain open and CCS will continue to provide medical case management, including the authorization of any CCS benefit/service that is medically necessary to treat the CCS-eligible condition, as long as the child maintains HF coverage and the family accepts authorization of services to CCS-paneled or approved providers. If these conditions are not met, the CCS case is to be closed and the family, provider and HF health plan liaison of record are to be notified of this action.

J. *When HF subscribers are provided medical case management, including authorization of services, without a signed application and/or without completing CCS residential eligibility within the 60-day period after the date of referral, the local CCS program is responsible for the following:*

1. *Making all reasonable attempts to encourage and assist the subscriber/subscriber's family to complete the CCS application and residential eligibility process;*

2. *Sharing equally in the cost of care for these HF subscribers.*

K. *When HF subscribers are provided medical case management, including authorization of services, without a signed CCS application and/or have not completed CCS residential eligibility beyond the 60-day period from the date of referral the local CCS program is responsible for the following:*

1. *Continue to make contact with the subscriber/subscriber's family to encourage and assist them to complete the CCS application "residential eligibility process."*

2. *Send copies of claims received for authorized services provided after the 60-day period, accompanied by a MEDS print out confirming HF eligibility on the date of service, to the appropriate CCS Regional Office for claims processing. Claims for these HF subscribers will be paid with 100 percent state funds.*

L. *Annual CCS program re-determination process for HF subscribers*

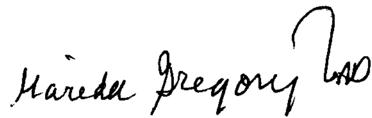
1. *If the HF subscriber has a CCS application and Program Services Agreement on file, the annual re-determination shall include verification of HF coverage, re-determination of residential eligibility, determination of financial eligibility if HF coverage has terminated, and completion of a new signed Program Services Agreement;*

2. *If the HF subscriber does not have a CCS application and Program Services Agreement on file, the annual re-determination shall consist of verification of current HF status.*

M. Applicants/Families who choose to complete the application process within 60 days after having been sent the notices identified in G.2 and H.2 shall not have to submit a new application.

These policies will be updated the next revision of the CCS Procedure Manual as well as the CCS "Case Management Procedure Manual Using CMS Net."

If you have any questions or concerns, please contact David Jimenez at (916) 654-6039.



Maridee A. Gregory, M.D., Chief
Children's Medical Services Branch