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TO: All County California Children Services (CCS) Offices, State Children Medical Services (CMS) Regional Offices, Genetically Handicapped Persons Program (GHPP), and State CMS Staff

SUBJECT: CCS RESPONSIBILITIES FOR CASE MANAGEMENT OF MEDI-CAL ELIGIBLE BENEFICIARIES

Areas of confusion over California Children Services (CCS) case management responsibilities for Medi-Cal children has caused problems for local CCS programs since the CCS application process was formally instituted in July 1992. In the absence of written policy and procedures on Medi-Cal case management, county CCS programs have differed in how case management for Medi-Cal-eligible children has been handled. In addition, with the implementation of Medi-Cal managed care in several of the larger counties, the lack of clear guidance on CCS case management responsibility for Medi-Cal beneficiaries has resulted in delaying the access of specialty care for Medi-Cal children since CCS services are "carved out" of the majority of the Medi-Cal managed care plan contracts.

The purpose of this numbered letter is to clarify the CCS case management responsibilities for children who are Medi-Cal beneficiaries. All Medi-Cal-eligible children with potentially eligible CCS medical conditions are to be referred to the local CCS program for medical case management.

Title 22 of the California Code of Regulations, Section 51013, California Children Services, states:

> "A beneficiary under age 21, who has a medical or surgical condition which would qualify for services under California Children Services, shall be referred to that program for case management and prior authorization by the appropriate local or state administrative agency for California Children Services . . . ."

Case management for the Medi-Cal-eligible population includes:

- the determination of medical eligibility;
- the determination of the most appropriate provider(s) to provide care;
- the authorization of medically necessary services; and
- linkage and coordination of the child's care with the authorized provider(s) and agencies in the community.

Irrespective of whether the parent/guardian directly applies to the CCS program, case management activities for full-scope Medi-Cal beneficiaries **without** a share of cost (SOC) shall be initiated prior to the receipt of a CCS application by the CCS program when all of the following requirements are met:

1. The Medi-Cal beneficiary has a CCS-eligible condition or there are medical findings of a suspected CCS-eligible condition;

2. Medi-Cal eligibility of the beneficiary has been confirmed as full scope, without a share of cost, for the month of service;

3. The provider requesting the service is a CCS approved provider;

4. The service(s) requested is/are medically necessary to treat a CCS-eligible medical condition or one that is associated with, or complicated by, the CCS-eligible condition; and

5. The service is a Medi-Cal benefit.

Simultaneously with the determination of medical eligibility, the CCS program shall initiate the program application process with the parent/guardian in order for Medi-Cal beneficiaries to qualify for CCS-funded program services that are not Medi-Cal benefits.

Clients who are full-scope Medi-Cal beneficiaries **without** SOC who have not signed a CCS application or CCS Program Services Agreement may be authorized by CCS for Medi-Cal services with the following statement on the authorization: "This authorization is limited to Medi-Cal benefits based on patient's continued Medi-Cal eligibility." This statement must be added to any authorization for a Medi-Cal beneficiary to ensure providers are aware that the CCS program is not responsible for payment of those medical services not covered by the Medi-Cal program.

Authorizations for Medi-Cal beneficiaries, with no SOC shall be time limited and include:

1. Inpatient hospitalization--specified number of days based on utilization review by medical consultant/designee.

2. Physician Services--limited to those services provided during an approved hospital stay or to outpatient services for a specified period of time.

3. Other health care providers--limited to no more than a three-month period or for specifically identified and quantifiable services (such as durable medical equipment [DME], medical supplies, prescription drugs, etc.)

CCS-funded services can be authorized for this population once there is a signed CCS application and CCS Program Services Agreement. Likewise, before any services may be authorized for clients who are Medi-Cal beneficiaries **with** SOC or Limited Scope Medi-Cal, there must be a signed CCS application. If treatment services are to be authorized, there must be a signed CCS Program Services Agreement.

There are increasing numbers of children receiving case management services through regional centers who have been made eligible for the Medi-Cal Developmental Disabilities Waiver. Waiver eligibility entitles these children to receive full-scope Medi-Cal benefits, on their own family budget unit, without consideration of the family's income. A number of these children have families whose income is well above the $40,000 income limit for the CCS program. When a waiver-eligible child is in need of services that are not Medi-Cal benefits, the local CCS program should request the family to complete a CCS application, including verification of residential and financial eligibility. Confirmation of a family's income being over $40,000 will limit authorization of care to Medi-Cal benefits only. If the family has other insurance coverage for the child they should receive services in accordance with requirements for any other full scope Medi-Cal eligible with third party coverage.

As a final reminder: Please note that determination of CCS medical eligibility and issuing of authorizations based on eligibility for Medi-Cal beneficiaries, full scope without a SOC should *NOT* be delayed waiting for families to apply and complete program application requirements. Authorizations for medically necessary services, limited to Medi-Cal benefits, must be issued as soon as possible after determination of medical eligibility.

If you have any questions, please contact your Regional Office Medical Consultant.

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