



State of California-Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGER
Governor

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Index: Eligibility

TO: ALL COUNTY CALIFORNIA CHILDREN SERVICES (CCS)
ADMINISTRATORS, MEDICAL CONSULTANTS, HEALTHY FAMILIES
(HF) PROGRAM HEALTH PLAN LIAISONS, AND CHILDREN'S
MEDICAL SERVICES (CMS) BRANCH AND REGIONAL OFFICE STAFF

SUBJECT: UPDATED CCS POLICIES RELATING TO CHILDREN WHO ARE
HEALTHY FAMILIES SUBSCRIBERS

The purpose of this Numbered Letter (N.L.) is to provide local CCS programs and CMS Regional Offices with a comprehensive update of CCS program policies for CCS clients who are also HF subscribers. Since the last inclusive HF policy letter (N.L. 02-0203), there have been a number of program changes including the 2004 enhancement to the Children's Medical Services Network (CMS Net) and accompanying CCS claims adjudication system modifications. These changes have required altering how CCS case manages and authorizes services for HF subscribers with a confirmed CCS eligible medical condition. This N.L. supersedes N.L. 19-0605, N.L. 02-0203, and N.L. 01-0299.

Discussion

New Medi-Cal Eligibility Data System (MEDS)/CCS aid codes

New MEDS and CCS aid codes have been established for identifying HF subscribers. MEDS established aid code "0C" as a new HF aid code for assignment to and identification of Access For Infants and Mothers (AIM) linked infants who have transitioned into the HF program. The HF Administrative Vendor, Maximus, began assigning this aid code in September 2004. However, it has only recently become operational for claims processing purposes.

CMS Branch established new CCS aid code "9U" to assign to CCS clients who are HF subscribers when the family has not completed CCS program eligibility. This aid code will be operational in CMS Net and for claims processing purposes in November 2006. Also, at that time the CMS Branch will use the income verification information that the Managed Risk Medical Insurance Board (MRMIB) has provided CCS to perform an initial conversion in the CMS Net system to differentiate the cases that are assigned "9R" from those that should be assigned "9U". When the "9U" aid code becomes operational, children who were initially assigned aid code "9R" and are currently on the Branch's list as having annual income "under" \$40,000 and identified in CMS Net as having incomplete CCS program eligibility, will automatically be changed to CCS aid code "9U".

Transition of AIM-linked infants into the HF program

N.L. 24-0905, dated September 20, 2005, was issued to inform CCS programs that effective July 1, 2004, infants born to mothers participating in the AIM program were being transitioned into the HF program, and to provide policies for serving the new sub-population of HF subscribers. The letter also stated that Maximus had already begun assigning the new MEDS aid code "0C" to these infants on September 1, 2005, and had implemented a conversion process to change the aid code (from "9H" to "0C") assigned to AIM-linked infants enrolled in HF prior to that date.

However, due to system constraints, Maximus was only able to convert the aid code to "0C" for infants enrolled in HF on or after December 31, 2004, leaving the AIM-linked infants enrolled prior to that date with the "9H" aid code assignment. Since this sub-population of HF subscribers can have retroactive eligibility back to the date of birth and is also exempt from CCS prior authorization requirements, it is important that they are properly identified. Based on experience with this sub-population of HF subscribers, CCS can assume that the infants enrolled in HF and who were born between July 1, 2004 and December 30, 2004, are AIM-linked if their date of birth and HF start date are the same. MRMIB is available to provide verification of linkage anytime there is an uncertainty on the AIM linkage of a HF subscriber.

CCS case management of HF subscribers who do not complete CCS program eligibility

In July 2005, N.L. 19-0605, informed local CCS programs that CCS clients who are HF subscribers and who have not completed CCS program eligibility would no longer have their CCS services reimbursed using 100 percent state general fund for the match for the Title XXI federal funds. The establishment of CCS aid code "9U" will enable tracking these children separately from those HF subscribers that are "over" income for CCS and are deemed financially eligible for the program. Counties are expected to follow-up with families to educate them on the importance of completing CCS program eligibility for their child. If follow-up is unsuccessful, the counties can include these children on their lists of names sent to the Branch for forwarding to MRMIB for verification of family income. Since these children have not completed CCS program eligibility at the time CCS services are authorized, providers must be informed that the child is only eligible if HF eligibility is also present at the time of delivery of authorized services. Failure to include this message on the authorization puts the provider at risk of providing services and having their claims denied for reimbursement by the CCS fiscal intermediary, Electronic Data Systems (EDS).

HF subscribers whose family income is in excess of CCS financial eligibility

County CCS programs are authorized, under existing law, to perform financial eligibility determinations to confirm if a HF subscriber is "over" income for CCS and is thus deemed financially eligible for the program. Counties may choose to require a family to complete a financial eligibility determination or may allow the family to declare its annual household income (as provided for in N.L. 17-0901).

Policy and Policy Implementation

I. HF Referrals to CCS:

A. Processing a HF Subscriber Referral

1. A HF subscriber referral/initial request for service shall be reviewed to determine if the child's address is within the county to which the referral is sent. The address should be checked against the subscriber's MEDS file address to confirm that it matches the information provided on the referral.

At the same time HF program eligibility should be verified to confirm that the child is assigned MEDS aid code "9H" or "0C". If the HF subscriber's address

is within the county and the child is confirmed to have MEDS aid code "9H" or "0C", the referral/request for service shall be processed immediately.

If the subscriber's address is in another county, the referral/initial request for service shall be sent to the appropriate county. A copy of the referral identifying the required action shall be sent to the HF plan liaison.

The county to which the referral is sent shall accept the date of referral to CCS as the date the referral was first received in the county initially receiving the request.

2. The CCS application process shall be initiated upon receipt of a referral/initial request for service. Even if a HF subscriber's family does not submit a completed and signed CCS application, the child is eligible for CCS if he/she has a confirmed CCS-eligible medical condition and the family accepts CCS authorizations to approved providers. The CCS program should encourage families to submit a signed, completed CCS application and to provide the CCS program with residential and financial eligibility information for determination of the appropriate CCS aid code assignment. If the family fails to submit a CCS application, CCS should continue to authorize services as long as the child has a CCS eligible medical condition and remains enrolled in HF. A courtesy copy of both the second and final application notices shall be sent to the HF plan liaison of record.

B. Determination of Medical Eligibility

1. CCS shall determine medical eligibility within five days of receipt of referral/initial request for service, if the medical documentation submitted with the referral is adequate to make the determination. (This does not apply to determination of eligibility for Medically Handicapping Malocclusion.) If the medical documentation is inadequate, CCS shall immediately request adequate documentation from the **referring provider**. CCS shall also send a copy of the request for medical documentation to the family and the HF plan liaison. If difficulty in obtaining the information is encountered, CCS should enlist the assistance of the HF plan liaison to obtain the medical documentation.
2. CCS shall review the referring provider's approval status. If the provider is not CCS approved, but appears eligible for approval, the CCS program shall

inform the provider of the requirements for completion of the CCS provider application in order to receive authorizations to provide services to the referred child. **Local CCS programs and HF plans can access the CCS Provider Directory, including Approved Providers and Special Care Centers on the CCS webpage at www.dhs.ca.gov/ccs.** Questions on CCS provider participation should be directed to the CMS Branch, Provider Services Unit, at (916) 322-8702.

C. Referrals for HF Subscribers with Medical Conditions Ineligible for CCS

CCS shall provide a copy of any denial letter or Notice of Action and use the HF management report process (discussed below) to notify HF plans when a referred HF subscriber does not meet CCS medical eligibility criteria.

D. Authorization of Services Awaiting Completion of Program Eligibility

If a HF subscriber has a CCS eligible medical condition, medically necessary services shall be authorized to an appropriate CCS approved provider. Aid code "9U" should be assigned.

E. Completion of CCS Program Eligibility

1. CCS shall allow HF subscribers the choice of either scheduling an appointment for a program eligibility interview or submission of the necessary documents by mail.
2. CCS programs may accept MRMIB's determination of financial eligibility. However, due to the difference in the way that the two programs determine financial eligibility, CCS programs may perform a CCS financial eligibility determination to confirm whether a HF subscriber's family income is over CCS financial eligibility. CCS county programs have the discretion to require the HF subscriber population to complete the CCS financial eligibility process or to allow the family to self-declare its annual household income (as provided for in N.L. 17-0901). The procedure that the county chooses to implement should be applied uniformly to all newly referred HF clients. The only exception is for a family that fails to respond. In this situation, information on the HF subscriber should be submitted to the CMS Branch for a MRMIB financial verification (see Section III).

3. CCS shall explain to families the relationship between HF and CCS and the importance of completing the CCS program eligibility process.
4. CCS shall request that the family provide proof of residency in the county or use the residential information on MEDS to verify the HF subscriber's county of residence.
5. HF subscribers are exempt from payment of CCS program enrollment and assessment fees.
6. HF subscribers who complete CCS program eligibility and are determined to be residentially and financially eligible for CCS with an annual family income "under" \$40,000 shall be reassigned CCS aid code "9K". These children will remain eligible for CCS even if their HF coverage lapses.
7. HF subscribers who complete CCS program eligibility and are determined to be residentially and financially eligible for CCS with an annual family income "over" \$40,000 shall be reassigned aid code "9R". They will not remain eligible for CCS if their HF coverage lapses.
8. If HF coverage ends for a CCS client with aid code 9U who has not completed CCS program eligibility, the county should contact the HF subscriber's family to see if they are still interested in applying and becoming eligible for the CCS program so that the child can continue to receive CCS services.

F. CCS Program Eligibility Not Completed

1. If the HF subscriber's family does not submit a completed CCS application or does not complete the entire program eligibility process, CCS shall authorize medically necessary services when
 - the individual has a CCS eligible medical condition; and
 - the family accepts the authorization of services to CCS approved providers.

Assignment of aid code "9U" should be continued.

2. The CCS case shall be closed if either of the conditions in F.1 above is not met. The family, provider, and HF plan liaison of record shall be notified of case closure and a Notice of Action sent when appropriate.
3. CCS shall continue to encourage and assist the HF subscriber's family in completion of the CCS application and program eligibility review process. Local CCS programs should consider additional follow-up activities (e.g., phone calls to the family/HF subscriber; resending the application/program eligibility letters) to encourage the family to provide the necessary documentation to complete CCS program eligibility. The family should be informed that if they are determined to be CCS income eligible, CCS will continue to authorize medically necessary services for the eligible medical condition even if the child loses HF coverage.
4. Funding of CCS authorized services for HF subscribers who do not complete the CCS program eligibility process is identical to those who have completed the process and determined to be financially eligible for CCS. The non-federal share of cost for such services will be shared by the State and the counties in accordance with the provisions of Section 123940 of the Health and Safety Code.

G. Authorization of Services for HF Subscribers

1. All new authorizations for HF subscribers residing in counties on CMS Net are to be issued as web based service authorization requests (SARs).
2. SARs that are issued for a HF subscriber who has not completed CCS program eligibility (CCS aid code "9U") must include a message in the "Special Instructions Box" indicating the child is only eligible for CCS services if HF eligibility is also present. This will ensure that providers are not at risk of providing services only to have claims denied by EDS.
3. If services are authorized for a HF subscriber who is confirmed as "over" income for CCS (i.e., the subscriber is deemed financially eligible and assigned CCS aid code "9R") the SAR must include a message in the "Special Instructions Box" alerting the provider that the child is only eligible if HF eligibility is also present.

4. Request for authorization of services for HF subscribers who entered the program as AIM-linked infants (i.e., subscribers who are assigned MEDS aid code "OC" or are otherwise determined to be AIM linked as described above) and who have received services that were initially provided without prior authorization by CCS cannot be denied based on lack of timeliness of referral. These requests for authorizations shall be reviewed for medical necessity and to ensure that the provider is CCS approved.

H. Annual Eligibility Re-determination

1. If the HF subscriber originally completed CCS program eligibility upon referral to CCS, the annual re-determination shall include verification of:
 - a. Eligible medical condition
 - b. Continued HF enrollment
 - c. Residency in the county
 - d. Financial Eligibility
2. The above verification must also take place if enrollment in a HF plan has been terminated.
3. If the HF subscriber has not previously completed CCS program eligibility, at the time of annual re-determination CCS shall continue to encourage the subscriber's family to complete the application and the program eligibility process described in H.1 above. CCS programs should consider using the additional follow-up activities identified in F.3 above.

II. Assigning CCS Aid Codes to HF Subscribers

- A. HF subscribers are initially assigned aid code "9U" when determined to have a CCS eligible medical condition.
- B. If the program eligibility process is completed, aid code "9U" shall be changed to "9K" if the family's annual income is less than \$40,000.

- C. If the program eligibility process is completed, aid code “9U” shall be changed to “9R” if the family’s annual income is over \$40,000.
- D. If the program eligibility process is not completed and verification of income by MRMIB indicates a family’s annual income is less than \$40,000, continue assignment of aid code “9U”.
- E. If the program eligibility process is not completed and verification of income by MRMIB indicates a family’s annual income is over \$40,000, aid code “9R” shall be assigned.

CCS Aid Code	Description	Funding Ratio
9U	Assigned to children who are medically eligible for the CCS program and enrolled in a Healthy Families’ plan but have not completed CCS program eligibility.	The funding ratios for this aid code are 17.5% County, 17.5% State and 65% Title XXI.
9K	Assigned to children enrolled in a Healthy Families’ plan when they are determined to be medically eligible and have completed CCS program eligibility with a family income < or = to \$40,000.	The funding ratios for this aid code are 17.5% County, 17.5% State and 65% Title XXI.
9R	Assigned to children who are medically eligible for the CCS program and enrolled in a Healthy Families’ plan but whose family income is > than \$40,000.	The funding ratios for this aid code are 35% State and 65% Title XXI.

- III. HF Subscribers Whose Family’s Annual Adjusted Gross Income (AGI) are “Over” \$40,000
 - A. The CCS program shall determine whether the family’s annual AGI is greater than \$40,000 based either on a CCS financial eligibility determination or by requesting the family to “self declare” its annual income.

- B. If the family completes CCS financial eligibility and their state tax return information confirms that they are “over” income for CCS, a copy of the tax form shall be maintained in the client’s chart and made available upon request to the CMS Branch.
- C. If the family self-declares its annual income, the CCS self-declaration form titled “HF Statement of Annual Income” can be:
1. Completed when the family comes in for the program orientation interview;
 2. Mailed if program eligibility is conducted by mail; or
 3. Verbally declared by the family if program eligibility is conducted by telephone.

A copy of the declaration form shall be maintained in the client’s chart and made available upon request to the CMS Branch.

- D. County CCS programs shall provide to the CMS Branch a list of HF subscribers whose families have declared that their annual incomes are greater than \$40,000 and/or the HF subscriber’s family has failed to provide CCS with their California state income tax form or the “HF Statement of Annual Income”.
- The list should be in alpha order and include the subscriber’s name, date of birth and the Client Index Number linked to the Subscriber’s HF eligibility.
 - The list shall be submitted by FAX to (916) 327-1123 or encrypted email to the CMS Branch to the attention of Erin Winter (ewinter@dhs.ca.gov). If the county’s list is substantial it is preferred that the names be submitted on an excel spreadsheet that is password protected.
- E. County CCS programs participating in CMS Net should no longer forward approved claims for services authorized with a web based SAR for subscribers with an annual family income “over” \$40,000 to the CMS Branch. Such claims should be submitted directly by the provider to EDS for adjudication. For HF subscribers who are assigned aid code “9R”, the EDS claims processing system will automatically process these claims for services authorized by a web based SAR with 100 percent state match.

IV. Providing Tracking Lists to HF Plan Liaisons

A. Tracking List Requirements

1. The current CCS/HF Memorandum of Understanding requires CCS programs to submit a current list of CCS clients who are HF subscribers to the HF plan on a monthly basis. CCS programs should coordinate the submission of these lists with the designated HF plan liaison staff.
2. The lists shall include, at a minimum:
 - Name
 - CCS case number
 - Client index number
 - Date of birth
 - Social security number if known
 - CCS-eligible medical condition
 - Date of eligibility and status (if case closed, provide the reason for ineligibility and the date closed).
 - Referral source and primary care provider on file, if known.
3. Tracking lists should be mailed to the HF plan addresses identified in the most current CCS Information Notice on the CCS webpage or as indicated by individual Plan Liaisons.

B. Sources of Tracking Lists

1. CCS counties participating in CMS Net should use the HF management reporting mechanism available through the CMS Net system for producing tracking lists.

2. Counties not on CMS Net shall use their proprietary computer systems to provide tracking lists containing at least the minimum data identified above.

V. Other HF Policies

A. CCS/HF Clients With Full Scope No Share of Cost Medi-Cal

1. If a HF subscriber is identified in MEDS as also having full scope, no share of cost Medi-Cal, the CCS program shall consider the HF subscriber to be a Medi-Cal beneficiary.
2. Claims submitted to EDS for adjudication pursuant to a CCS SAR will be paid from Medi-Cal funds.
3. Claims submitted to EDS for payment pursuant to a legacy CCS service authorization should be coded the same as for any other Medi-Cal beneficiary. The claim must have the client's Medi-Cal identification number, the provider's Medi-Cal provider number and either a "4" or "8", as applicable, in the TAR control number box.
4. The client will remain eligible for both programs during the HF annual eligibility period, as long as the family continues to pay the child's HF premiums. When the HF program re-determines eligibility at the time of the annual review process, HF coverage should be terminated due to the child's eligibility for full scope, no share of cost Medi-Cal.

B. Referral to Medi-Cal

1. HF subscribers referred to CCS for determination of medical eligibility shall not be referred to Medi-Cal.
2. A Medi-Cal referral is only appropriate in the following situations:
 - a. If at the time of the CCS annual re-determination review process, a CCS client has lost HF coverage and the family's income appears to qualify the child for Medi-Cal; or
 - b. The CCS client has an eligible medical condition that results in a significant disability, which may qualify the client for Supplemental Security Income.

C. HF Co-payments

1. Services authorized by the CCS program for the treatment of a CCS eligible medical condition are not subject to the co-payment requirements of the HF Program.
2. CCS providers should not charge or collect from families a HF co-payment for CCS authorized services.
3. If a HF subscriber's family is charged co-payments for services authorized by CCS, the provider should be informed that this is not allowed.

D. Providing HF Plans with Copies of Authorizations, Denials and Notice of Actions (NOAs)

1. Copies of authorizations, denials of service and NOAs shall be sent to the appropriate HF Plan Liaison of record. This information is needed by the plan in order to appropriately case manage the child's medical care.
2. Since many of the HF plans have access to the CMS Net Provider Inquiry Project (PIP) which allows viewing of authorizations, denials, NOAs and other correspondence, county CCS programs may want to negotiate with the plan on using PIP as the vehicle for the plans to obtain this documentation. If the plan agrees, then the use of PIP can replace the MOU requirement for providing such documentation.

If you have any questions regarding this N.L., please contact your Regional Office Administrative Consultant.

Original signed by Harvey Fry for Marion Dalsey, M.D.

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