DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

December 7, 2000

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[X] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[X] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

ALL-COUNTY LETTER NO. 00-83

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: **THE DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER – DETERMINING ELIGIBILITY FOR THE PERSONAL CARE SERVICES PROGRAM**

Assembly Bill 2779, Chapter 329, Statutes of 1998, amended the Welfare and Institutions Code Section 14132.95, and the Department of Health Services received approval of a state plan amendment, to allow the provision of Personal Care Services as a covered benefit to medically needy aged, blind, or disabled persons. The purpose of this All County Letter is to inform counties of this change in statute and to provide counties with instructions on evaluating medically needy, Regional Center consumers, who are in the Department of Developmental Services Home and Community-Based Services Waiver (DDS Waiver), for Personal Care Services Program (PCSP) eligibility.

Background

Institutionally deemed children who are approved for the DDS Waiver are those who are under the age of eighteen, living at home, not currently eligible for zero share-of-cost Medi-Cal and who meet the target criteria set forth in the DDS Waiver. Children are evaluated as if they are institutionalized, so institutional deeming rules apply to them. Through institutional deeming, under the DDS Waiver, children meeting the criteria above may be determined as Medi-Cal eligible regardless of their parent's resources or income. The Department of Developmental Services estimates this population to consist of approximately 1300 cases. A list of Regional Center contacts and the areas each center serves is attached. (See Attachment I & II)

The Health Care Financing Administration has recently approved full expansion for six regional centers (Eastern Los Angeles, North Bay, Valley Mountain, Westside, Alta

California, and Kern). Full expansion is expected to occur within other regional centers by the end of the year. Regional Centers that have been federally approved for full expansion may also enroll institutionally deemed persons age eighteen years of age and older in the DDS Waiver. Counties should follow the same Medi-Cal eligibility rules for these persons as are used for persons under the age of eighteen, meaning that no income or resources of a parent or a spouse can be used in determining Medi-Cal eligibility for the DDS waiver for this population.

What is Institutional Deeming?

Deeming, as defined in the Manual of Policies and Procedures 30-701, means "procedures by which the income and resources of certain relatives, living in the same household as the recipient, are determined to be available to the recipient for the purposes of establishing eligibility and share of cost." An individual living in an institution does not have income or resources of a parent or spouse considered in the person's Medi-Cal eligibility determination. Since certain DDS Waiver consumers are deemed or considered eligible for institutionalization, all income and resources of a parent or a spouse are excluded by county Medi-Cal workers when determining their Medi-Cal eligibility and share of cost.

How is institutional deeming applied to IHSS and PCSP?

Institutionally deemed persons may not qualify for the In-Home Supportive Services (IHSS) residual program because the income and resources of the parent or spouse must be considered in determining eligibility. The IHSS residual program services are **not** provided under the Medi-Cal State Plan. As a result**, not all of the IHSS regulations apply to the institutionally deemed waiver population.**

Under the Medi-Cal State Plan personal care service is a Medi-Cal benefit provided through the Personal Care Services Program (PCSP). Under the DDS Waiver the consumer is eligible for full-scope Medi-Cal benefits. Although these consumers may not meet the IHSS program eligibility criteria, they may be eligible for services under PCSP because of their Medi-Cal eligibility status.

The DDS Waiver consumer is eligible for PCSP only if he or she meets **all PCSP eligibility requirements.** Specifically, the parent of the minor child **may not** be paid as the provider of services in the Personal Care Services Program under Welfare & Institutions Code, Section 14132.95(f) nor may there be advance pay status in the event that the parent is not the provider.

Determination of Eligibility

The Regional Centers have been instructed by DDS to inform consumers or the parent/legal guardians or spouse to contact the IHSS Program Manager in their local county welfare department to request an assessment for PCSP eligibility. County Medi-Cal staff should receive a Department of Developmental Services Waiver Referral form directly from the Regional Centers. (See Attachment III) This referral form will alert the county that the consumer is a DDS waiver consumer.

It is important to insure that eligible DDS Waiver consumers are not being denied services they are entitled to receive through PCSP based on parental or spousal income and resources. In determining PCSP eligibility for these regional center consumers the county should:

- First, the county Medi-Cal worker will determine Medi-Cal eligibility and share of cost as specified under Medi-Cal Procedures Section 19 D. If the applicant is not eligible for no share of cost Medi-Cal using regular rules, the county Medi-Cal worker should apply institutional deeming rules and exclude all income and resources of the parents or spouse when determining eligibility.
- Report eligibility to the Medi-Cal Eligibility Data System (MEDS) using an aid code of 6V or 6W if a consumer is found eligible.

- Refer the case to the county IHSS staff who will:

    - Review the consumers' application.
    - Verify full-scope Medi-Cal eligibility. (The 6V or 6W aid code should be reflected on the MEDS screen. This code is specifically used for individuals who are qualified for the DDS Waiver and would not ordinarily qualify for Medi-Cal). The Case Management, Information and Payrolling System (CMIPS) will issue instructions on the appropriate use of aid codes through a separate ACL. Until the 6V and 6W codes are available in CMIPS, an alternative method will be used. Counties are to set up these cases in aid code 60, then call the Electronic Data System (EDS) Help Desk at (916) 636-4280 to have it changed to aid code 64 (which is a closed MN aid code with no share of cost). The case will remain in aid code 64 until the 6V and 6W codes are effective in CMIPS. It is the responsibility of each county to keep track of these cases.
    - Inform parent/guardian to get all the necessary information from the Regional Centers if additional information is needed.
    - Approve the client for PCSP if the client is deemed eligible,
    - Refer the client, if appropriate, to the Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, which may provide supplemental services. (See Attachment IV)

Assessment

When the recipient is an institutionally deemed child, a non-parent provider may provide PCSP services even if the parent is present in the home. Therefore, counties should assess these children in a manner that will provide the services needed to allow them to remain in the home. The cap of 283 hours for allowable PCSP services remains unchanged.

DSS is working in collaboration with DDS and DHS to implement the changes to law and regulation needed to address the role of the parent in caring for the minor child who qualifies for personal care services.

Denied Cases

It is possible that some DDS Waiver consumers may have been denied PCSP coverage based on the income and resources of a parent or spouse. Other children may have been denied because the parent is the child's provider, creating ineligibility for PCSP. However, these parents shall be given the option of hiring another provider so the child may become eligible for PCSP.

Each county shall make an effort to identify these cases. These cases would have been in the DDS Waiver and known to the county's Medi-Cal staff. County social work staff shall complete another eligibility determination. If the client meets PCSP eligibility requirements, the social worker shall notify the applicant and/or parent of theireligibility.

If you have any questions regarding this letter, please contact Alan Stolmack, Chief, Adult Programs Branch at (916) 229-4582.

Sincerely,

Original Signed By
DONNA L. MANDELSTAM on 12/7/00

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Attachments

- Department of Developmental Services Waiver Referral Form
- Department Developmental Services Center for Medicare and Medicaid Services Regional Center Contacts
- How Request an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services

Attachment I

DDS/HCBS WAIVER AND PCSP ELIGIBLE POPULATION ESTIMATES

As of May 2000, population estimates were as follows:

Regional Center	Add Institutional Deeming
Alta California	72
Kern	8
Eastern Los Angeles	2
Valley Mountain	70
Westside	66
North Bay	12
**********"irlt**********	**********-lrlt***** **'lrk*******'k'k**
Harbor	10
Inland	30
East Bay	20
Frank Lanterman	4
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Redwood Coast	3
Orange (DOC)	135
San Gabriel/Pomona	7
Far Northern	219
Central Valley	50
**********'lrlrlt**********	**********'k'k**********
Golden Gate	20
North Los Angeles	43
San Diego	96
Tri-Counties	143
San Andreas	223
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South Central	20
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Total	1,253

Department of Health Services
Medi-Cal Operations Division

EARLY and PERIODIC SCREENING, DIAGNOSIS, and TREATMENT (EPSDT)

SCOPE:

- The EPSDT regulations make available under the EPSDT program certain medically necessary diagnostic and treatment services to full-scope eligible beneficiaries which heretofore have not been covered under the Medi-Cal schedule of benefits. These additional services are referred to as "EPSDT Supplemental Services".

- EPSDT supplemental services, unless exempted in section 51340.1, are subject to prior authorization from the local Medi-Cal field office or Children's Medical Services/California Children Services Program (CMS/CCS) office. EPSDT supplemental services may include, but are not limited to, additional services beyond those otherwise limited to two per month. These "Medi-reserved" services include psychology, chiropractic, occupational therapy, speech therapy, audiology, and acupuncture.

AUTHORITY:

- Title 42, United States Code, Sections 1396(a)(l0)(A), 1396a(a)(43), l396d(a)(4)(B), and 1396d(r);
- Welfare and Institutions Code 14132(v); and
- Title 22 California Code of Regulations sections 51051, 5l 184, 51242, 51304, 51340, 51340.1, and 51532.

PROVIDER MANUAL REFERENCE:

* Provider Bulletins: Inpatient/Outpatient and Allied Health, February 1995; June, 1995; and November, 1995.
- Manual Replacement Pages: None have been released to date.

BACKGROUND:

- The EPSDT program is a federally mandated benefit for full-scope Medi-Cal eligible under 21 years of age (per the Omnibus Budget Reconciliation Act of 1989 [OBRA '89].

- Federal Medicaid law requires that states provide medically necessary screening, vision, hearing, and dental services to Medi-Cal beneficiaries under 21 years of age. Additionally, federal Medicaid law mandates that any service a state is permitted to cover that is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by EPSDT screening, must be provided to beneficiaries under 21 years of age whether or not the service or item is otherwise included in the State's Medicaid plan.

* In order to maintain compliance with federal law, the Department filed EPSDT regulations on an emergency basis on March 25, 1994, effective April 4, 1994 and which became final on April 27, 1995.

PROVIDER TYPES:

* All traditional Medi-Cal provider types, such as physicians, psychologists, etc., may enroll in Medi-Cal to provide services for the general Medi-Cal population as well as EPSDT supplemental services as long as services are within the provider's scope of practice However, .these types of providers must be currently enrolled with an active Medi-Cal provider number before any services, including EPSDT supplemental services, may be rendered. In addition, Medi-Cal providers who are currently enrolled and in good standing, need not re-enroll to provide EPSDT supplemental services.

* In addition to the traditional Medi-Cal provider types, certain practitioners who are members of the healing arts professions may provide EPSDT supplemental services if such services are not available through existing Medi-Cal providers. These providers may be enrolled in Medi-Cal as EPSDT Supplemental Services Providers and are limited to providing only EPSDT supplemental services. Initial enrollment procedures require that the provider first obtain an approved Treatment Authorization Request (TAR) for services. Once enrolled and assigned their own provider number, EPSDT Supplemental Services Providers need not re-enroll to provide subsequent EPSDT supplemental services as long as the provider remains in good standing. However, subsequent EPSDT supplemental services, whether for the same person or another beneficiary, will still require prior authorization.

MEDICAL NECESSITY UNDER EPSDT:

Overall, there are three ways in which EPSDT supplemental services may be determined medically necessary:

1. The requested EPSDT supplemental service can meet the existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population; or,

2. The requested EPSDT supplemental service can meet distinct, EPSDT service specific requirements as set forth in section 51340.1; or,

3. If the criteria of number 1 cannot be met, and if the criteria of number 2 above are not applicable to the service, then the requested EPSDT supplemental service must be evaluate d under the expanded medical necessity criteria established in the EPSDT regulations in title *22* California Code of Regulations section 51340(e)(3), as summarized below:

   A The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

B. The supplies, items, or equipment to be provided are medical in nature.

C. The services are not requested solely for the convenience of the beneficiary, family physician, or another provider of services.

D. The services are not unsafe for the individual EPSDT-eligible beneficiary and are not experimental.

E. The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary's appearance.

F. Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

G. The services to be provided:

(l) Are generally accepted by the professional medical and dental communities as effective and proven treatments for the conditions for which they e proposed to be used.

(2) Are within the authorized scope of practice of the provider and are an appropriate mode of treatment for the health condition of the beneficiary.

H. Available scientific evidence, as described in the bullet immediately above, demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.

L The predicted beneficial outcome of the services outweighs potential harmful effects.

AUTHORIZATION OF SERVICES:

- If the patient is a full-scope eligible Medi-Cal recipient, all TAR.s for EPSDT services must be submitted to the field office responsible for that particular TAR category. Effective October 1, 1997, Medi-Cal field offices have been regionalized to allow adjudication of selected TAR categories. In the table below, the TAR categories listed have been regionalized to the designated field offices.

- If the patient is a California Children Services (CCS) client and the request is for a service to treat or ameliorate a CCS-eligible condition, the request must be forwarded to the local CCS office (no change with regionalization).

- If the patient is a managed care plan recipient, the request must be forwarded to the managed care plan for consideration (no change with regionalization).

- If the patient is a fee-for-service Medi-Cal recipient, and the service is for in-home shift nursing. the request must be submitted to the local In-Home Operations office (see attached) (no change with regionalization).

- All requests, regardless of service requested and regardless of place of submission, must be accompanied by documentation of medical necessity for the requested service.

Those TAR categories not listed remain in the local field office:

FRESNO Oxygen and Respiratory Equipment Hearing Aids Prosthetics & Orthotics	**LOS ANGELES** Detoxification (South) In-Home Operations (South)	**SAN JOSE** Medical Supplies Incontinence Supplies Intravenous Equipment
SAN DIEGO Transportation (South)	**SACRAMENTO** Transportation (North) In-Home Operations (North)	**SAN BERNARDINO** Nursing Facilities (NF A&B)
SANFRANCISCO		
Subacute Care (Adult & Pediatric) Organ Transplants (Except Kidney)	Durable Medical Equipment (DME) Detoxification (North) Out-of-State Authorizations	Occupational Therapy Physical Therapy Speech Therapy Podiatry