



# PARTNERS FOR CHILDREN - CCNSL Ongoing Responsibilities



F-CAP	Authorizations/Utilization	Communication/Support	Monitoring/Maintenance
<p><b>Initial F-CAP</b></p> <ol style="list-style-type: none"> <li>Review each section for completeness and appropriateness. Verify that services requested are appropriate to meet identified care needs and goals.</li> <li>Discuss and clarify any questions or concerns with the Care Coordinator (CC).</li> <li>Approve, sign, date and return to CC. Retain copy in the participant's CCS file.</li> <li>Issue authorizations for PFC services requested on F-CAP</li> </ol> <p>Enter all appropriate data into the PFC Database</p> <p><b>60-day F-CAP Reviews and Interim Updates/Revisions</b></p> <ol style="list-style-type: none"> <li>Ensure the F-CAP is re-submitted at least every 60 days. <ul style="list-style-type: none"> <li>Review each section for changes and additions</li> </ul> </li> <li>Also review the F-CAP anytime there is an LOC redetermination or an additional request for services.</li> <li>Approve, sign, date and return to CC. File any updated sections in the participant's CCS file.</li> <li>Issue authorizations for PFC services as appropriate.</li> </ol> <p>Enter all appropriate data into the PFC Database</p>	<p><b>SARs</b></p> <ol style="list-style-type: none"> <li>Ensure requests do not exceed limit for specified service.</li> <li>Ensure authorizations are issued to approved providers, and include the PFC Special Instruction in the "Special Instructions" area of the SAR.</li> <li>Authorize requested waiver services and State Plan Services on separate SARs.</li> </ol> <p>The CCSNL is not responsible for authorizing Community services that are non Medi-Cal benefits.</p> <p>Enter all appropriate data into the PFC Database</p> <p><b>Utilization Management</b></p> <ol style="list-style-type: none"> <li>Evaluate that the services requested address the patient's goals as described in the F-CAP at least every 60 days or when there is a change in status of the participant.</li> <li>Review paid claims data to assure the frequency, amount and duration of all services (waiver and State Plan) are provided in accordance with the F-CAP.</li> </ol> <p>This is to ensure that the provider can appropriately meet the needs of the participant and family.</p>	<p><b>Communication</b></p> <ol style="list-style-type: none"> <li>Maintain communication with Care Coordinator, participant and family, Multidisciplinary Team, Special Care Center Team, and referring physician.</li> <li>Provide guidance and training to participant/family and Care Coordinator as needed to ensure compliance with waiver requirements.</li> <li>Maintain on-going communication with CMS Branch and provide required waiver reporting.</li> <li>Serve as a CCS liaison to Care Coordinator.</li> <li>Provide on-going technical assistance to participating agencies, individual nurse providers, and Special Care Centers related to waiver participation and services.</li> <li>Oversee on-going communication between Care Coordinator and referring CCS providers and use feedback to improve coordination of care and the PFC program.</li> <li>Summarize all communication with the participant/family and the Care Coordinator in CMSNet case notes.</li> </ol> <p>Enter all appropriate data into the PFC Database.</p>	<p><b>Oversight and Monitoring of the PFC Services</b></p> <ol style="list-style-type: none"> <li>On a monthly basis, or more if needed, contact the participant/family to: <ul style="list-style-type: none"> <li>Review the content of the F-CAP to verify that the services requested are appropriate to meet the care needs and goals identified in the F-CAP.</li> <li>Ensure that services are provided in frequency and duration as authorized and in accordance with the F-CAP.</li> </ul> </li> <li>Ensure ongoing participant/family access to CCS resources and case management through telephone, email or direct contact.</li> <li>Participate in PFC case management conferences related to a specific waiver participant and family to coordinate waiver and State Plan (regular Medi-Cal) services. The care conference may be within CCS or at various health care facilities.</li> <li>Provide information, with CC input, regarding range of services, support groups and community resources to the participant and family.</li> </ol> <p>Enter all appropriate data into the PFC Database.</p>



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Health & Welfare	Assurances	Remediation	Transition
<p><b>Monitoring and Reporting</b></p> <ol style="list-style-type: none"> <li>Ongoing monitoring to ensure the health, safety and welfare of PFC participants.</li> <li>Ensure on-going risk assessments are done by the CC including abuse, neglect and exploitation.</li> <li>Review F-CAP for any risk factors, including psychological. Follow up with CC to determine if intervention is needed or already reported.</li> <li></li> <li>Document all reported or observed critical events or incidents that may affect the health, safety and welfare of waiver participant. <ul style="list-style-type: none"> <li>Document use of L&amp;C complaint line when indicated</li> <li>Document all Complaint-Incident Intake Reports submitted</li> <li>Notify the appropriate agency State CMS Branch and L&amp;C.</li> <li>Send copies of all completed Reports to State CMS Branch.</li> </ul> </li> <li>Follow up on any reported critical incidents or events within 30 days including contact with the CC and/or family as appropriate.</li> <li>Document actions and recommendations of L&amp;C or other agency, and the event/incident resolution.</li> <li>Continue waiver services if an event or complaint is filed.</li> </ol> <p>Enter all appropriate data into the PFC Database.</p>	<p><b>Quality Assurance and Improvement Activities</b></p> <p>The CCSNL is responsible at the County level for implementing the Federal Assurances and Quality Improvement activities included in the PFC waiver approval. See the CMS Assurances document for descriptions.</p> <ol style="list-style-type: none"> <li>Participate in preparation for program review and State CMS Branch audits of the PFC providers and county CCS program.</li> <li>Collect necessary data using the PFC Database and CMSNet.</li> <li>Record monthly contacts with participant/family, providers and CC.</li> <li>Monitor PFC performance measures and follow the remediation plan for each measure.</li> <li>Identify and report issues with service delivery by PFC providers and referrals to CMS Branch waiver staff and Licensing and Certification, as appropriate.</li> <li>Prepare and implement corrective action plans and other remediation actions based on the performance measures at the County level and in conjunction with CMS Branch staff.</li> <li>Monitor all corrective action plans for compliance and resolution.</li> </ol> <p>Enter all appropriate data into the PFC Database</p>	<p><b>Remediation Process</b></p> <p>Upon discovery of non-compliance, for any assurance/performance measure, the CCSNL will, in conjunction with the State CMS Branch as needed, and within 15 working days:</p> <ul style="list-style-type: none"> <li>Review the data</li> <li>Determine the reason for non-compliance</li> <li>If appropriate, develop a corrective action plan with a timeline</li> </ul> <p>Document (using case notes in CMSNet) the steps noted above.</p> <ul style="list-style-type: none"> <li>Include any suggestions for preventing similar failures in the future, i.e. suggested system or process changes.</li> </ul> <p>The County will follow-up and ensure action plan was completed.</p> <p>The CMS Branch will follow-up with County to ensure corrective action plans are completed.</p> <p>Enter all appropriate data into the PFC Database</p>	<p><b>Transitioning Off of the Waiver</b></p> <p>If needed, provide assistance to the participant and family in the dis-enrollment process and work with the CC in facilitating the smooth transfer to:</p> <ul style="list-style-type: none"> <li>Another county not participating in PFC</li> <li>Hospice</li> <li>Adolescent Transition Care Plan Team</li> </ul> <p>Enter all appropriate data into the PFC Database.</p>