

California Children's Services Monitoring and Oversight Workgroup Meeting

December 19, 2022



Agenda

Welcome and Meeting Information	12:00-12:05
Roll Call	12:05-12:10
November Meeting Summary and Workgroup Feedback	12:10-12:15
CCS Case Management Definition and Activities	12:15-12:45
Memorandum of Understanding (MOU) Execution Process and Timeline	12:45-1:20
Grievance Process	1:20-1:45
Break	1:45-2:00
Compliance Activities	2:00-2:50
Enforcement Proposal	2:50-3:50
Public Comment	3:50-3:55
Next Steps	3:55-4:00

Housekeeping & Webex Logistics

Do's & Don'ts of Webex

- » Participants are joining by computer and phone (link/meeting info on [California Children's Services \(CCS\) Monitoring and Oversight Program website](#))
- » Everyone has been automatically muted upon entry
- » CCS Monitoring and Oversight Workgroup Meeting members: 'Raise Your Hand' or use the Q&A box to submit Questions
- » Other participants: Use the Q&A box to submit comments/questions or 'Raise Your Hand' during the public comment period
- » To use the "Raise Your Hand" function click on participants in the lower right corner of your chat box and select the raise hand icon
- » Live closed captioning will be available during the meeting

Note: The Department of Health Care Services (DHCS) is recording the meeting for note-taking purposes

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Workgroup Members

1. **Alicia Emanuel**, National Health Law Program
2. **Anna Leach-Proffer**, Disability Rights California
3. **Beverly Eldridge**, Stanislaus County CCS
4. **Dawn Pacheco**, Glenn County CCS
5. **Eileen (Chris) McSorley**, Lake County CCS
6. **Jolie Onodera**, California State Association of Counties
7. **Francis Chan, MD**, Loma Linda University Health
8. **Guillermina (Mina) Andres**, Tulare County CCS
9. **Hannah Awai, MD**, Sacramento County CCS
10. **Heidi Merchen**, Napa County CCS
11. **Holly Henry**, Lucile Packard Foundation for Children's Health
12. **Jack Anderson**, County Health Executives Association of California*
13. **Janet Peck**, Butte County CCS
14. **Jody Martin**, Mono County CCS
15. **Katherine Barresi**, Partnership HealthPlan of California

* Indicates delegate

Workgroup Members (Continued)

16. **Kathryn Smith**, Children's Hospital Los Angeles
17. **Katie Schlageter**, Alameda County CCS
18. **Kristen Dimou**, San Diego County CCS / Medical Therapy Program (MTP)
19. **Lori Gardner**, Madera County CCS
20. **Lorri McKey**, Colusa County CCS
21. **Mary Doyle, MD**, Los Angeles County CCS
22. **Meredith Wolfe**, Humboldt County CCS
23. **Michelle Laba, MD**, Orange County CCS
24. **Mike Odeh**, Children Now
25. **Nancy Netherland**, Caregiver Representative/California Children's Trust - Caregiver Engagement
26. **Norma Williams**, Del Norte County CCS
27. **Pip Marks**, Family Voices of California
28. **Richard Chinnock, MD**, Loma Linda University Children's Hospital
29. **Susan Skotzke**, Parent/Family Advisory Committee, Central California Alliance for Health
30. **Tanesha Castaneda**, Santa Barbara County CCS
31. **Teresa Jurado**, Parent Mentor, Stanford Children's Health / Lucile Packard Children's Hospital

DHCS Staff

- » **Susan Philip**, Deputy Director, Health Care Delivery Systems
- » **Pamela Riley, MD**, Assistant Deputy Director, Quality and Population Health Management and Chief Health Equity Officer
- » **Joseph Billingsley**, Assistant Deputy Director, Integrated Systems
- » **Cortney Maslyn**, Division Chief, Integrated Systems of Care Division (ISCD)
- » **Jill Abramson, MD**, Medical Consultant, ISCD
- » **Cheryl Walker, MD**, Medical Consultant, ISCD
- » **Megan Sharpe**, MTP Specialist, ISCD
- » **Annette Lee**, Branch Chief, Quality and Monitoring, ISCD
- » **Sabrina Atoyebi**, Branch Chief, Medical Operations, ISCD
- » **Michael Luu**, Section Chief, Monitoring and Oversight, ISCD
- » **Katie Ramsey**, Unit Chief, County Compliance, ISCD

Sellers Dorsey Staff

- » **Mari Cantwell**, Director, California Services/Strategic Advisor
- » **Sarah Brooks**, Director/Project Director
- » **Meredith Wurden**, Senior Strategic Advisor/Subject Matter Expert
- » **Marisa Luera**, Director/Subject Matter Expert
- » **Alex Kanemaru**, Senior Consultant/Project Manager

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November Meeting Summary

During the November meeting, the workgroup reviewed and provided feedback on the following topics:

- » Draft *Roles and Responsibilities Matrix and Table*
- » Proposed grievance definitions and process
- » Training proposal
- » CCS compliance survey proposal
- » Key program policy updates

Workgroup feedback during the November meeting and subsequent homework items are incorporated in today's presentation and discussion

Homework from November Workgroup

CCS training proposal

- » Feedback requested from workgroup members on training proposal including DHCS, county, and onboarding requirements

CCS compliance survey proposal

- » Feedback requested from workgroup members on CCS compliance survey proposal definitions and process

Draft Roles and Responsibilities Table and related Matrix for MOU

- » Feedback requested from workgroup members on *Roles and Responsibilities Table and Matrix* including DHCS and county roles and responsibilities

DHCS | County MOU Execution Process and Timeline Poll

- » SurveyMonkey poll was resent to better understand each county's organizational processes, levels of review, and timeline to execute the MOU

Workgroup Feedback on Training Proposal

- » Workgroup member feedback on the training proposal included requests for:
 - » Clarification on some language including “adequately trained staff”
 - » Specific county personnel conducting training requirements (e.g., CCS administrator or Senior Nurse)
 - » Trainings specific to county model types
 - » Clarification on how DHCS will communicate when new training courses are available
 - » Program overview should include state and county responsibilities including CCS county model types and general program eligibility

Workgroup Feedback on CCS Compliance Survey Proposal

- » Workgroup member feedback on the CCS compliance survey proposal included requests for:
 - » Additional details on timelines in the Surveying Numbered Letter (NL)
 - » Changing the verbiage from “survey” to “audit”
 - » Additional details regarding annual/quarterly reports in the Surveying NL
 - » More information on the enforcement process
 - » Changing county reporting requirements from calendar to business days
 - » Counties to have the opportunity to review and respond to deficiencies prior to DHCS publishing results on the annual/quarterly reports and surveys

Workgroup Discussion

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Proposed CCS Case Management Definition

- » DHCS reviewed case management definitions and is proposing a CCS-specific case management definition
- » Definitions considered were presented in previous CCS Monitoring and Oversight Workgroup meetings
- » Today, DHCS will outline the core activities tied to the CCS-specific case management definition, which takes into account the feedback from stakeholders [e.g., Children's Regional Integrated Service System (CRISS)]
- » The finalized core case management activities identified will be included in the MOU
- » Additional feedback was received; however, the presentation was already finalized at the time of receipt. Thus, this feedback is not incorporated in the presentation.

Proposed CCS Case Management Definition (continued)

“The California Children’s Services (CCS) case management is a beneficiary- and family-centered approach to care that ensures needed clinical and non-clinical services are made available to each CCS beneficiary to address and assist with the CCS eligible condition(s) through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch and person-centered; ensuring beneficiaries have access to needed medical, social, educational, and other services deemed necessary.”

Definition Color Legend

- » Text from DHCS: Quality and Population Health Management
- » Text from DHCS: Enhanced Care Management
- » Text from Centers for Medicare & Medicaid Services

CRISS Activities | CCS Case Management

DHCS reviewed the CCS case management definition submitted by CRISS. Core case management activities were identified, and modified as applicable, to be incorporated in the MOU for the following categories as outlined in the subsequent slides:

- » Case Findings
- » Support to Family Navigation
- » Assessments, Interventions, and Coordination of Care
- » Management of Transitions

Appendix at the end of this presentation includes:

- » CRISS activities not recommended as CCS case management core activities. Note that some of the activities are included in the roles and responsibilities matrix as they are CCS requirements but not tied to case management directly.
- » Definitions reviewed and considered in developing the CCS case management definition

CRISS Activities | CCS Case Management (continued)

Core Activity	Details
<p>Case Finding</p>	<p>In the event the beneficiary does not qualify, or a specific service is not authorizable or related to the CCS eligible condition, consult with the family about other resources available to them to meet their needs</p>
<p>Support for Family Navigation</p>	<p>Support patient participation in the community by providing information on community-based activities, such as resources for exercise and socialization for children with physical disabilities</p> <p>Educate, explain, and link families to resources to help them obtain services their children need including but not limited to CCS, Medi-Cal, County mental health, Regional Centers, public health nursing and/or schools</p> <p>Educate families about the CCS regionalized system of care and community resources (i.e., peer and family support organizations)</p> <p>Reach out to families who are having difficulty maintaining their Medi-Cal enrollment and troubleshoot challenges in maintaining Medi-Cal eligibility</p> <p>Provide consultation and support to the patient’s educational team in the school setting when requested by patients and/or their families</p> <p>Educate families on available transportation resources and provide maintenance and transportation services when they are needed</p>

CRISS Activities | CCS Case Management (continued)

Core Activity	Details
Assessments, Interventions, and Coordination of Care	Link patients to appropriate CCS-paneled physicians, CCS Special Care Centers (SCC), and CCS-approved hospitals, according to program guidelines and standards
	Arrange Private Duty Nursing services, as medically necessary, and engage in agency nursing resource finding as needed
	Review the care plan established by CCS-authorized specialists and SCC; assist the patient and family in identifying and utilizing the most appropriate resources to accomplish the recommended care plan while assessing the understanding of and responsiveness to overall care plan. Ensure coordination of the child's care plan between SCC, community physicians, and the MTP
	Arrange home-based therapies, as medically necessary, and assist in identifying appropriate agencies
	Facilitate referrals for mental health services and pediatric palliative care services, in accordance with State guidance
	Maintain overview of utilization of services across the healthcare system to limit duplication and ensure access to the most appropriate services

CRISS Activities | CCS Case Management (continued)

Core Activity	Details
Assessments, Interventions, and Coordination of Care (continued)	Coordinate and ensure access to vaccines, well-child visits and screenings, and oral health care
	Determine and coordinate referrals to appropriate social support services to meet the needs of patients, including services that address social determinants of health needs such as CalFresh and Women, Infants & Children (WIC) Program
	Link and/or refer patients to appropriate pharmacies and/or providers for their medication needs; appropriate medical home; and programs that coordinate appropriate dental care as determined by the patient's needs and preferences
	Coordinate appointments with Durable Medical Equipment (DME) vendors and collaborate to identify DME that is appropriate
	Conduct multidisciplinary case management team conferences, including CCS professional staff, community providers and families as needed to address complex needs and challenges to care coordination
	Provide professional support to ensure that families remain engaged

CRISS Activities | CCS Case Management (continued)

Core Activity	Details
Management of Transitions	Assist patients, families, hospital discharge planners, and community partners to ensure safe and successful transitions from the hospital to the home and/or community, when applicable
	Partner with families to accomplish a smooth transition from the pediatric to the adult healthcare system
	Provide transition assessment and intervention at appropriate age for client and, for selected clients, conduct internal analyses of patients' transition needs and develop a transition plan

Workgroup Discussion

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DHCS | County MOU Execution Process and Timeline Poll

- » On October 25, DHCS sent out a poll requesting information regarding counties' MOU execution process and timeline
- » On November 8, the poll was resent to workgroup members and counties based on feedback received during the November CCS Monitoring and Oversight Workgroup meeting
- » On December 19, the results of the poll were shared with the workgroup

Q1: Who (individual's title, not name) within your county's organization will physically be signing the MOU?

- » The findings from this question indicated the following would ultimately sign the MOU:
 - » Most commonly the Board of Supervisors
 - » Less commonly the CCS Administrator or County Counsel
 - » Other responses included:
 - » Director of Department
 - » County Administrative Officer (CAO) or Assistant CAO
 - » CCS County Program Administrator and County Health Officer
 - » Board of Supervisors Chair or designee if so, requested in the Board Agenda Item

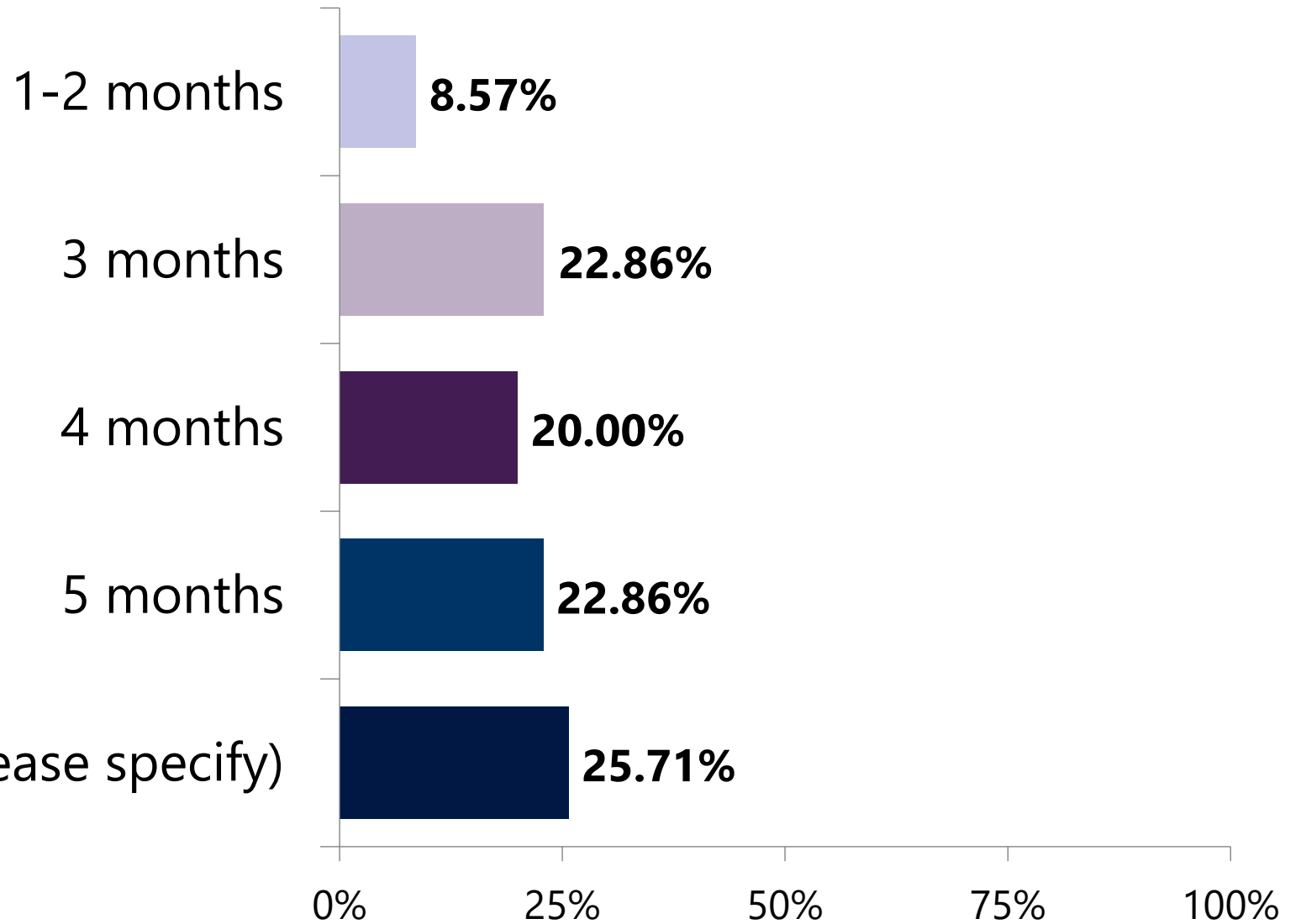
Q2: Provide a brief description of your county's MOU review and sign off process, including levels of review that must be completed and who has final sign off authority. In your response, include who is responsible for ensuring the MOU is signed in a timely manner.

- » MOUs are submitted into NOVUS, approved by Director of Public Health, Quality Management, Department Head of Health and Human Services, and Board Clerk. Final sign-off is Public Health Director.
- » This will include review by all applicable departments: Fiscal, Risk Management, Personnel, County Counsel, Health and Human Services Agency Director, Public Health Director. After review and interaction with the author of the MOU, the item will be placed on the Board of Supervisors agenda for action.

County's MOU Review and Sign Off Process (continued)

- » Division Manger review, Assistant Agency Director Review, County Counsel, Agency Director Review and approval.
- » Collaborative MOU development by parties, review and approval by county counsel, review and approval by Risk Management, final sign off authority is HSA Director/Director of Admin Services.
- » The Public Health Department initiates a request with the Human Services Department to process the MOU. This requires review by both departments, county counsel and the CAO to ultimately be submitted to the Board of Supervisors.

Q3: What is your county's general timeline for review and approval of an MOU?



More than 5 months (please specify)

More than Five (5) Months (please specify) Responses

- » The minimum timeframe is six (6) months
- » Unknown for this MOU at this time
- » Depending on time and effort of the review, 6-8 months. If County Counsel finds something, it will take longer.
- » It can be anywhere from 3-9 months depending on feedback from county counsel and concerns that may arise
- » Dependent upon County Counsel time frame, it can be 2-6 months
- » Depends on changes that are requested during the review process
- » Could be 10 -12 months
- » Depending on the Board of Supervisors meeting dates
- » MOUs usually move through the Program/Division level in the first month and then takes 1-2 months with Contracts and Compliance. County Counsel usually takes 2-4 months to review and approve MOUs.

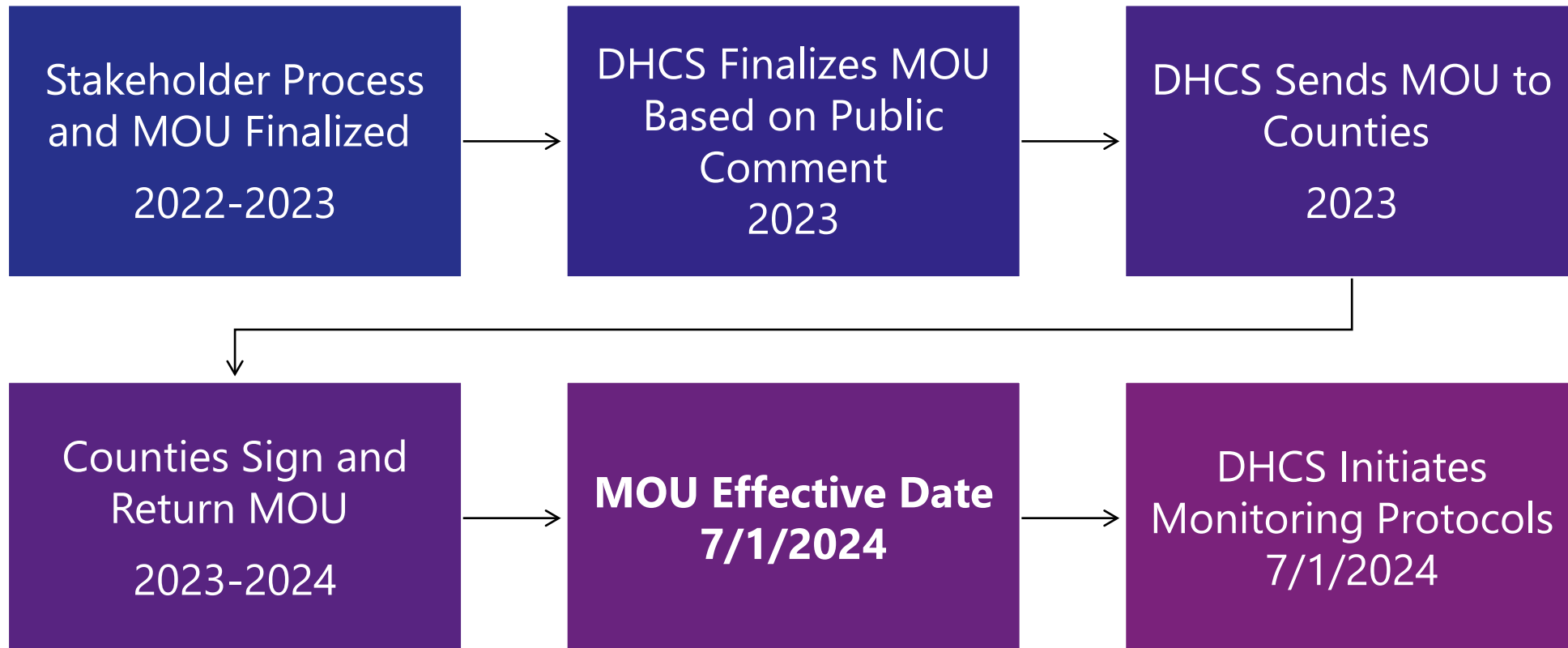
Overall Results

- » Each county will have their own:
 - » Signatories
 - » Process for execution
 - » Timeline
- » Most counties will execute the MOU within five (5) months, but the timeline will vary depending on feedback from County Counsel and Board of Supervisor meeting dates

Updated DHCS MOU Timeline

As previously announced, the MOU effective date was changed from January 1, 2024, to July 1, 2024, to align with:

- » Child Health and Disability Prevention program sunset
- » Fiscal Year 2024-2025



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Grievance Submission Clarification

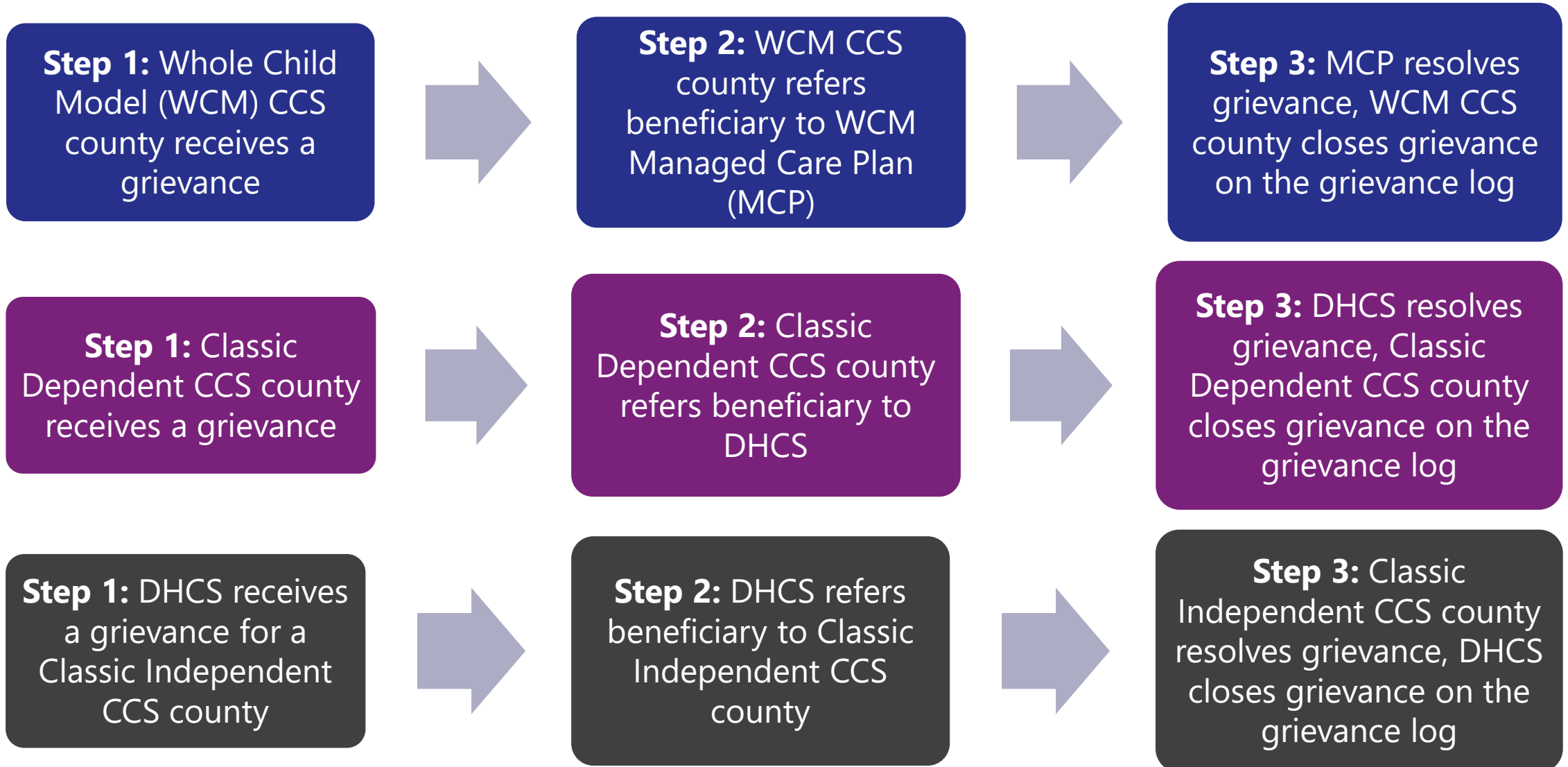
» **Description of Issue**

- » As part of the grievance process, “CCS representatives must be permitted to submit Grievances orally, in-person, via telephone, or in writing (via mail or email) during traditional business hours, Monday through Friday”

» **Intent**

- » Counties will only be expected to respond to submissions during business hours
- » Grievance NL will have details on how grievances will be tracked and reported

Examples: Grievance Routing



Grievance NL

- » Key elements the Grievance NL will include:
 - » Define relevant key terms like “grievance,” “standard,” “expedited,” etc.
 - » Policy for county intake of CCS beneficiary grievances
 - » Grievance routing to appropriate entity when the grievance is outside of the CCS program’s responsibility
 - » Timelines for resolving grievances
 - » Policy for documenting and reporting grievances

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Progression of Compliance Activities Discussion to Date

June

- CCS Monitoring and Oversight Workgroup began discussion on compliance activities
- Solicited workgroup feedback on Plan and Fiscal Guidelines performance measures
- Solicited workgroup member feedback on proposed compliance activities/metrics

July

- During the CCS Monitoring and Oversight Workgroup, introduced **domain** and **compliance activities/metric selection criteria**
- Followed up with workgroup members for technical specifications for proposed compliance activities/metrics

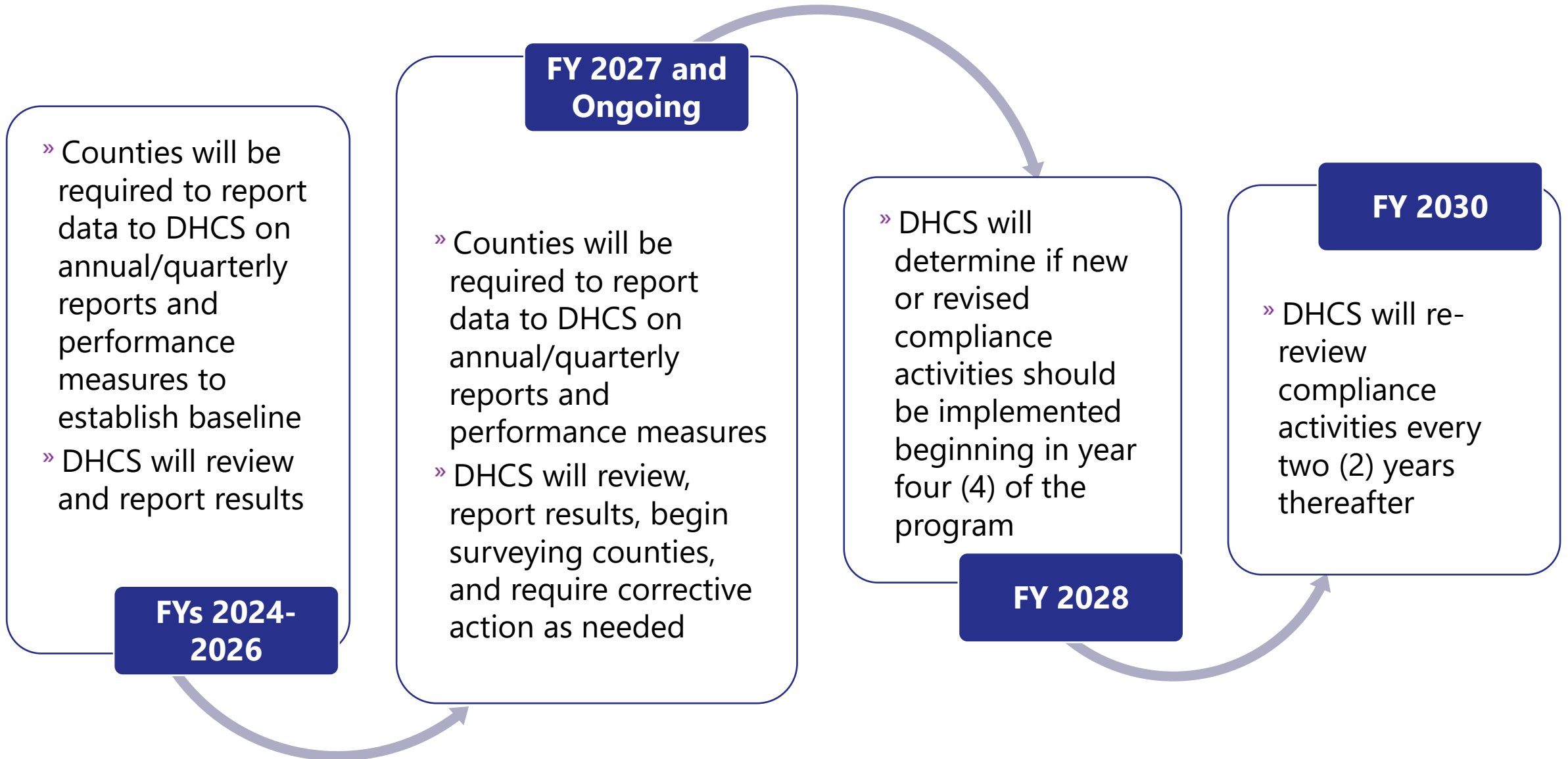
August-September

- Dr. Pamela Riley/Quality & Population Health Management consulted on the performance measures selection process and proposed performance measures

October-December

- DHCS evaluated feasibility of proposed compliance activities
- Proposed compliance activities to workgroup based on DHCS' assessment of overall feasibility

Compliance Activities Timeline



Compliance Activities

- » The goal is to develop oversight and monitoring of county administration of the CCS program. As part of this effort, it was determined that oversight and monitoring of the administration of the CCS program will occur through the following:
 - » **Quarterly Report**- Set of compliance activities local county CCS programs submit to DHCS quarterly, and DHCS currently has state guidance* to enforce
 - » **Annual Report**- Set of compliance activities local county CCS programs submit to DHCS annually, and DHCS currently has state guidance* to enforce
 - » **Performance Measures**- Overall program evaluation metrics, submitted to DHCS annually, and DHCS is currently drafting state guidance* to enforce compliance thresholds
 - » **Triennial Survey**- Set of compliance activities evaluated through a desk, on-site, or virtual survey triennially, and DHCS currently has state guidance* to enforce
- » The compliance activities evaluated through quarterly reports, annual reports, and triennial surveys are directly pulled from the *MOU Roles and Responsibilities Table* attachment. The performance measures are meaningful overall program evaluation metrics to track and report the performance and quality of care for CCS beneficiaries throughout California.

*State guidance means there is current CCS program guidance outlining these specific roles and responsibilities. This was established through statutes, regulations, Numbered Letters, or the CCS Program Administrative Case Management Manual.

Domains

Based on priority areas previously defined by the workgroup, domains were established based on the core programmatic functions as identified by workgroup members:

1. Access to Care
2. Administrative*
3. Authorizations*
4. Case Management/Care Coordination
5. Eligibility
6. Quality^

*Administrative Coordination and Benefits/Services were removed as they were deemed duplicative of #2 & #3. Additionally, Grievances/Appeals/State Fair Hearing was removed as it is captured in the other domains.

^The Quality domain was added and will be addressed in future initiatives by DHCS, including the CCS Quality Metrics Workgroup

Proposed Compliance Activities

Type of Compliance Metric	Total # of Metrics	Domains					
		1. Access to Care	2. Administrative	3. Authorizations	4. Case Management / Care Coordination	5. Eligibility	6. Quality (TBD)
Quarterly Report	3	X		X			
Annual Report	5	X	X			X	
Performance Measures	6	X			X		
Survey Metrics	10		X		X	X	

Plan and Fiscal Guidelines

#	Current PFG Performance Measures	Annual Report	Performance Measure	Triennial Survey
1	Medical Home		X	
2	CCS Eligibility Determination			X
3	Specialty Care Center (SCC) Annual Visit	X		
4	Transition Planning*		X	
5	Family Participation	X		

* PFG Performance Measure was modified to begin at age 17, be completed by age 20, and will include adult medical home, identified adult specialist, and authorized representative/legal guardian (if needed)

Quarterly Reports

#	Primary Domain	Metric	Compliance Metric
1	Authorizations	Service Authorization Request (SAR) Authorization	SARs authorized within five (5) business days for CCS beneficiaries
2	Access to Care	Resolution of Appeals	Reviewed appeals and mailed responses with the basis for the decision, including pertinent facts and supporting statutes, or regulations to the CCS beneficiary, authorized representative, or legal guardian within 21 calendar days
3	Access to Care	Resolution of Grievances	Acknowledged all standard grievances within five (5) business days, resolved standard grievances within 30 business days, and expedited grievances within three (3) business days

Quarterly Report Due Dates

Reporting Period	Due Date**
Q1: July, August, September	November 15
Q2: October, November, December	February 15
Q3: January, February, March	May 15
Q4: April, May, June	August 15

** If any due dates land on a non-business day, the local county CCS programs must submit their report on the next business day

Annual Reports

#	Primary Domain	Metric	Compliance Metric
1	Access to Care	CCS beneficiaries who attended an annual SCC visit	Ensured CCS beneficiaries who were authorized for a SCC attended an annual SCC visit
2	Administrative	Medical Therapy Unit (MTU) Locations	Verified MTU locations received DHCS approval (matching address of county submission to DHCS list)
3	Administrative	MTP Chart Audit	Verified counties have a policy and procedure to ensure monthly chart audits are performed
4	Administrative	Federal Financial Participation (FFP) Time Studies	Prepared and submitted FFP time studies
5	Eligibility	Annual Medical Review (AMR) Completion	Completed CCS beneficiary AMRs prior to program eligibility end dates

Annual Report Due Dates

Reporting Period	Due Date*
Fiscal Year: July - June	October 1

** If any due dates land on a non-business day, the local county CCS programs must submit their report on the next business day

Performance Measures

#	Primary Domain	Metric	Compliance Metric
1	Access to Care	CCS Beneficiary Annual Visit with PCP or Specialist	Ensured CCS beneficiaries had a visit with a PCP or specialist during the reporting period
2	Case Management/Care Coordination	Medical Home	Ensured CCS beneficiaries have a medical home indicated in CMS Net Medical Home field
3	Case Management/Care Coordination	SCC Visit within 90 days of Referral	CCS beneficiaries with select conditions (cystic fibrosis, hemophilia, sickle cell, leukemia, diabetes) have a documented visit with a SCC within 90-days of referral
4	Case Management/Care Coordination	Transition Planning	At age 17, began to develop the transition plan for all high-risk CCS beneficiaries and shared the transition plan with the PCP and MCP, including: <ol style="list-style-type: none"> a. The adult medical home b. The identified adult specialist c. Authorized representative/legal guardian (if needed)

Performance Measures (continued)

#	Primary Domain	Metric	Compliance Metric
5	Case Management/Care Coordination	Transition Planning	At age 20 years, the exit summary for the transition plan for all high-risk CCS beneficiaries was developed and shared with the CCS beneficiary, authorized representative, or legal guardian (if necessary), PCP, and MCP, including: <ol style="list-style-type: none"> a. The adult medical home b. The identified adult specialist c. Authorized representative/legal guardian (if needed)
6	Case Management/Care Coordination	MTP First Therapy Evaluation/Session	Ensured CCS MTP Medi-Cal beneficiaries had a first therapy evaluation/session

Performance Measure Due Dates

Reporting Period	Due Date*
Fiscal Year: July - June	November 30

** If any due dates land on a non-business day, the local county CCS programs must submit their report on the next business day

Survey Metrics

#	Primary Domain	Metric	Compliance Metric
1	Administrative	Intercounty Transfers / Care Coordination Between Counties	Pending state guidance and measure on continuity of services
2	Administrative	Enter NICU and HRIF Determinations into CMS Net	Enter NICU and HRIF program eligibility determinations into CMS Net within 10 business days and submitted corresponding policies and procedures
3	Administrative	Electronic Visit Verification (EVV)	Pending state guidance and measure on EVV
4	Administrative	MTP Referral	Review applicable CCS beneficiary files to ensure MTP referral (i.e.: look at files with specific diagnosis codes)

Survey Metrics (continued)

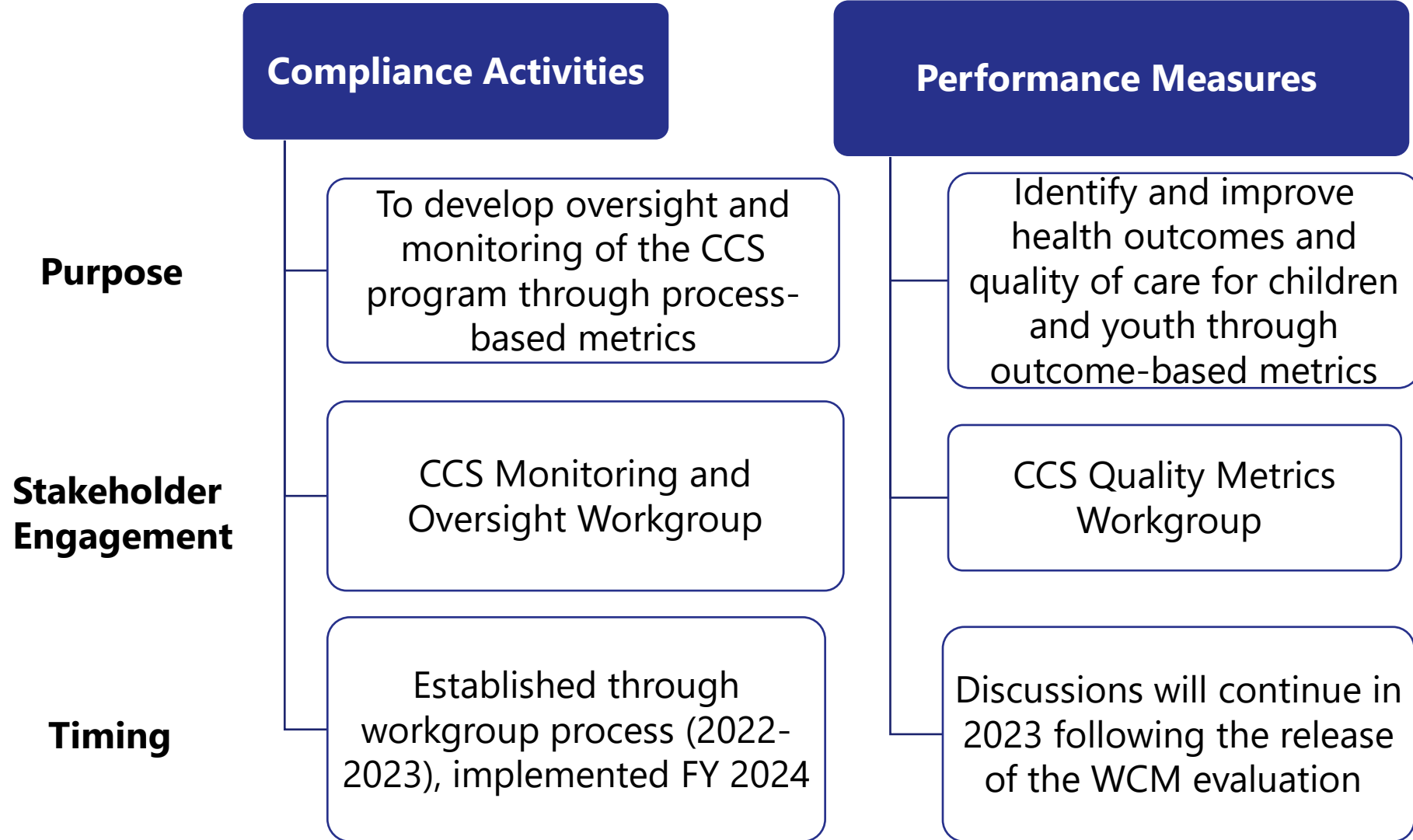
#	Primary Domain	Metric	Compliance Metric
5	Case Management/Care Coordination	Case Management and Coordination of Services	Verified counties have policies and procedures that specify coordination activities, necessary after-care services, and communication requirements among the following parties including but not limited to: primary care physicians (PCP), specialty providers, hospitals, public health nurses, and CCS program case managers
6	Case Management/Care Coordination	Case management and Coordination of Services	Verified counties have policies and procedures for regular communication with WCM MCPs to facilitate the care of CCS beneficiaries including, but not limited to, WCM MCP liaison and Utilization Management Director
7	Eligibility	Determines Program Eligibility: Neonatal Intensive Care Unit (NICU) and High-Risk Infant Follow-up (HRIF)	NICU and HRIF eligibility determined within five (5) business days

Survey Metrics (continued)

#	Primary Domain	Metric	Compliance Metric
8	Eligibility	Medical Eligibility	Determined within five (5) business days
9	Eligibility	Financial Eligibility	Determined within 30 business days
10	Eligibility	Residential Eligibility	Determined within 30 business days

Scope of CCS Metric/Measure Efforts

For the CCS program, DHCS is working on a few different efforts around metrics:



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Compliance Activities	2:00-2:50
Enforcement Process	2:50-3:50
Public Comment	3:50-3:55
Next Steps	3:55-4:00

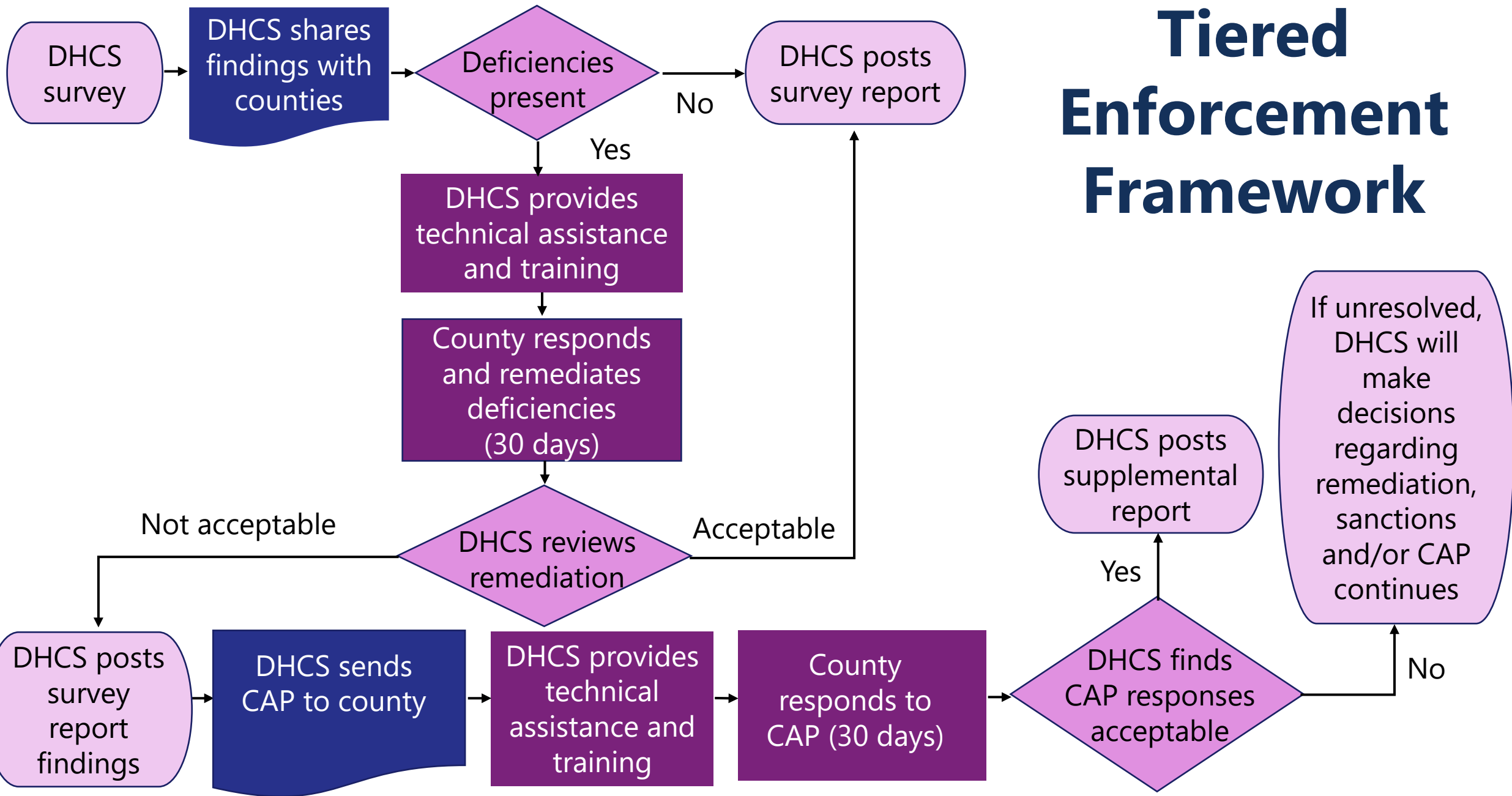
Overview

- » Enforcement process is intended to support and hold counties accountable to the compliance, monitoring, and oversight of CCS program, including the Medical Therapy Program
- » Proposal contains a tiered enforcement approach with multiple touchpoints to support counties throughout the process
- » DHCS will take stakeholder input into consideration when identifying Enforcement Actions and/or Sanction amounts
- » In cases where a county may not be able to comply with applicable state laws and regulations, or meet MOU obligations due to extenuating circumstances, DHCS may exempt a county based on the county's Good Faith Efforts
- » The proposed enforcement process aligns with other DHCS programs and ensures compliance to deliver care in a standardized, consistent manner across the state and in partnership with county CCS programs

Definitions

- » **Corrective Action:** Specific identifiable activities or undertakings of the CCS program responsible party to address program deficiencies or problems
- » **Corrective Action Plan (CAP):** Proposed remediation plan to address identified deficiencies
- » **Enforcement Actions:** Sanction or CAP imposed on a county when deficiencies are unresolved
- » **Finding:** The results of a Survey, either compliant or deficient
- » **Good Faith Effort:** A determination that a county has taken all reasonable action necessary to meet compliance standards and exhausted all methods to resolve deficiencies
- » **Notice of Corrective Action:** A notice from DHCS indicating a CAP is required
- » **Remediation:** The action to remedy identified deficiencies
- » **Sanction:** Financial penalty imposed on a county

Tiered Enforcement Framework



Corrective Action Plan

- » DHCS will provide technical assistance and/or training to the county, as appropriate
- » When a county fails to comply with applicable state laws and regulations, or meet MOU obligations, DHCS may require a CAP from the county
 - » The county is required to complete a CAP documenting the remediation efforts taken to ensure state laws and regulations, or meet MOU obligations, within 30 calendar days
 - » If DHCS determines the CAP submitted is unacceptable or if the CAP is not closed within 30 calendar days, the county is required to provide monthly status updates to DHCS and provide supporting documentation until DHCS determines the CAP is acceptable
 - » DHCS may require or impose a CAP and/or sanction on a county for any finding
 - » For example, sanctions may be imposed on a county together with a CAP, in lieu of a CAP, or if the county fails to meet CAP requirements

DHCS Approved Exemptions

- » The goal is to meet compliance standards
- » DHCS may allow compliance exemptions in cases where a county may not be able to comply with applicable state laws and regulations, or meet MOU obligations
 - » The state will consider exemptions on a case-by-case basis
 - » Counties are required to provide justification/rationale for this request
 - » These instances should be rare and justified
 - » Should DHCS determine a county has demonstrated a Good Faith Effort relative to any finding, DHCS may modify the Enforcement Action
 - » Counties will still be required to meet compliance requirements, but DHCS may extend timelines, modify sanction amounts, etc.
 - » Exemptions are **not** available when counties are generally not able to meet compliance requirements, but rather for extenuating circumstances
 - » Example of exemption:
 - » Natural disasters such as wildfires or major public health crisis which may impact county's ability to provide services

Considerations for Enforcement Actions

- » The enforcement process is intended to support and hold counties accountable to the compliance, monitoring, and oversight of the CCS program. DHCS plans to be thoughtful when determining the severity of sanctions and sanction amounts and will consider the following:
 1. The nature, scope, and gravity of the violation, including potential harm or impact on beneficiaries
 2. The good or bad faith of the CCS responsible party
 3. The CCS responsible party's history of violations
 4. The willfulness of the violation
 5. The nature and extent to which the CCS responsible party cooperated with DHCS' survey process or other programmatic reviews
 6. The nature and extent to which the CCS responsible party aggravated or mitigated any injury or damage caused by the violation
 7. The nature and extent to which the CCS responsible party has taken corrective action to ensure the violation will not recur

Considerations for Enforcement Actions (continued)

8. The financial status of the CCS responsible party, including whether the sanction will affect the ability of the CCS responsible party to come into compliance
9. The financial cost of the health care service that was denied, delayed, or modified
10. Whether the violation is an isolated incident
11. The monetary penalty necessary to deter similar violations in the future
12. Any other mitigating factors presented by the CCS responsible party

Workgroup Discussion

Agenda

Welcome and Meeting Information	12:00-12:05
Roll Call	12:05-12:10
November Meeting Summary and Workgroup Feedback	12:10-12:15
CCS Case Management Definition and Activities	12:15-12:45
Memorandum of Understanding (MOU) Execution Process and Timeline	12:45-1:20
Grievance Process	1:20-1:45
Break	1:45-2:00
Compliance Activities	2:00-2:50
Enforcement Process	2:50-3:50
Public Comment	3:50-3:55
Next Steps	3:55-4:00

Agenda

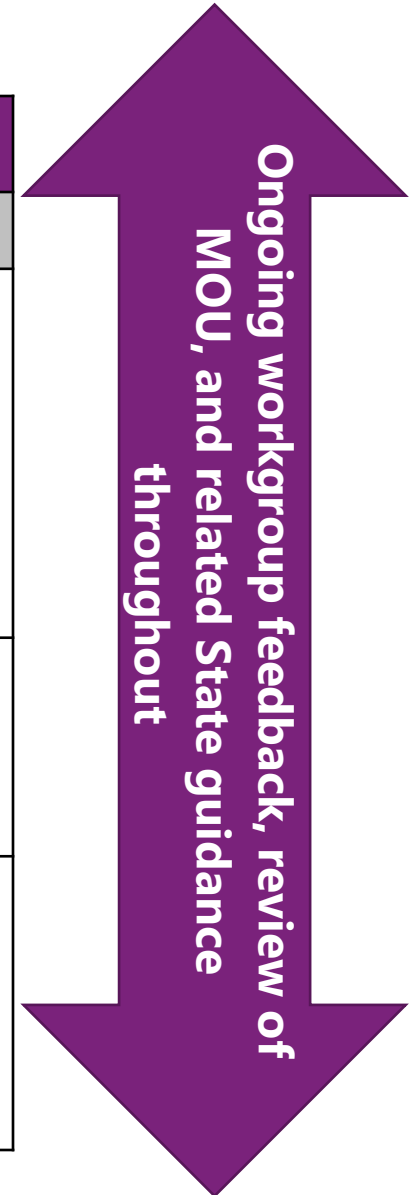
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Next Steps	3:55-4:00

Next Steps

- » **Meeting summary**
- » **Homework following meeting:**
 - » Enforcement proposal
 - » Compliance activities

Timeline

CCS Monitoring and Oversight Workgroup Timeline*		
Year	Meeting Date	Activity
2022	December 19	<ul style="list-style-type: none"> Propose enforcement process Propose performance measures and process for updating Finalize training proposal Finalize survey proposal Finalize DHCS county MOU execution process and timeline
2023	January 30	<ul style="list-style-type: none"> Continue performance measures and process for updating Finalize enforcement process Review NLS related to training and surveying
	March 13	<ul style="list-style-type: none"> Finalize performance measures and process for updating Review NLS related to performance measures and enforcement Prepare MOU template for public comment



*Dates and meeting content are subject to change.

Workgroup Meeting Logistics

Meeting notices and materials to be posted on the [DHCS website](#).

2023 Workgroup Meeting Dates

» January 30

» March 13

Contact Information

- » For more information, questions, or feedback regarding the CCS Compliance, Monitoring, and Oversight Program, including the development and implementation of the California Advancing and Innovating Medi-Cal initiatives to enhance oversight and monitoring of the CCS program and workgroup activities, please email Sarah Brooks at SBrooks@sellersdorsesey.com or Alex Kanemaru at AKanemaru@sellersdorsesey.com.
- » For assistance in joining the CCS Monitoring and Oversight Workgroup meetings, including information about meeting details and obtaining assistive services, please email CCSMonitoring@dhcs.ca.gov.

The background of the slide is a purple-tinted image featuring a stethoscope on the right side and a line graph on the left. The graph has a vertical axis with numerical markers at 3, 6, 9, 12, and 15. The text "Thank you!" is centered in a large, white, sans-serif font.

Thank you!

Appendix

CRISS Case Management Activities Not Included in DHCS Core Activities

- » The following are activities from the CRISS case management definition document that are not recommended to be included in the definition because they are not related to case management, although some may be incorporated into the MOU as a required responsibility. The activities below identified as *"Not included in the MOU or the Case Management Activities"* are outside the scope of county responsibilities.

CRISS Case Management Activities Not Included in DHCS Core Activities (continued)

CRISS Grouping	CRISS Activities Not Recommended to be included in the CCS Case Management Definition	DHCS Rationale
Case Finding	Engage in active case finding, to identify children and adolescents who may benefit from CCS services	Not included in the MOU or the Case Management Activities
	Receive referrals from any source, including families, health care providers, schools, or community members	Included in MOU R&R: Eligibility – Determines program eligibility: Medical
	Determine medical eligibility for CCS diagnostic, treatment, High Risk Infant Follow-Up (HRIF) and MTP services	Included in MOU R&R: Eligibility – Determines Program Eligibility: NICU and HRIF
	Determine residential eligibility	Included in MOU R&R: Eligibility – CCS Residential and Financial Eligibility and Enrollment Fee Determination
	Determine financial eligibility	Included in MOU R&R: Eligibility – CCS Residential and Financial Eligibility and Enrollment Fee Determination

CRISS Case Management Activities Not Included in DHCS Core Activities (continued)

CRISS Grouping	CRISS Activities Not Recommended to be included in the CCS Case Management Definition	DHCS Rationale
Case Finding (continued)	Identify and review all relevant clinical reports, as well as requests from specialists, primary care providers, pharmacies, DME vendors, the family, and other providers. This includes contacting providers and researching electronic medical records to identify clinical information to support eligibility determination and to inform a case management plan.	Included in MOU R&R: Case Management – Coordination of Services

CRISS Case Management Activities Not Included in DHCS Core Activities (continued)

CRISS Grouping	CRISS Activities Not Recommended to be included in the CCS Case Management Definition	DHCS Rationale
Assessments, Interventions, and Coordination of Care	Authorize services related to the CCS eligible condition	Included in MOU R&R: Authorizations – Service Authorization Requests (SAR)
	Review medical necessity for all requests for benefits requiring separate authorization	Included in MOU R&R: Authorizations – Service Authorization Requests (SAR)
	Adjudicate requests for second opinions and out-of-state services	Included in MOU R&R: Authorizations – Service Authorization Requests (SAR)
	Adjudicate requests for inpatient and outpatient rehabilitation for physical disabilities	Included in MOU R&R: Authorizations – Service Authorization Requests (SAR)
	Authorize Private Duty Nursing services, as medically necessary, and engage in agency nursing resource finding as needed	Included in MOU R&R: Authorizations – Service Authorization Requests (SAR)

CRISS Case Management Activities Not Included in DHCS Core Activities (continued)

CRISS Grouping	CRISS Activities Not Recommended to be included in the CCS Case Management Definition	DHCS Rationale
Assessments, Interventions, and Coordination of Care (continued)	Authorize home-based therapies, as medically necessary, and assist in identifying appropriate agencies	Included in MOU R&R: Authorizations – Service Authorization Requests (SAR)
	Authorize DME that is appropriate and medically necessary for client	Included in MOU R&R: Authorizations – Service Authorization Requests (SAR)
Management of Transitions	Identify medical records needed to facilitate transfers between jurisdictions, and provide those records to the appropriate parties	Included in MOU R&R: Eligibility – Inter-County Transfer Requests

CRISS Case Management Activities Not Included in DHCS Core Activities (continued)

CRISS Grouping	CRISS Activities Not Recommended to be included in the CCS Case Management Definition	DHCS Rationale
Provider Support and Assurance of Standards	Facilitate the provider paneling application process as needed	Not included in the MOU or the Case Management Activities
	Highlight gaps in available services – as identified by providers, families, and CCS program staff – for our state counterparts in Integrated Systems of Care Division	Not included in the MOU or the Case Management Activities
	Review services provided to ensure that they meet CCS program standards	Not included in the MOU or the Case Management Activities
	Concurrently review inpatient stays to ensure appropriate level of service and to negotiate and arrange inter-facility transfers when necessary	Included in MOU R&R: Eligibility – Inter-County Transfer Requests
	Troubleshoot provider billing and reimbursement challenges	Not included in the MOU or the Case Management Activities
	Recruit interested providers to the CCS program	Include in MOU R&R: Administrative – Recruitment

CRISS Case Management Activities Not Included in DHCS Core Activities (continued)

CRISS Grouping	CRISS Activities Not Recommended to be included in the CCS Case Management Definition	DHCS Rationale
Provider Support and Assurance of Standards (continued)	Educate health care providers about the CCS regionalized system of care	Include in MOU R&R: Administrative Coordination – System of Care Education
	Foster close relationships with providers and SCCs in the community and surrounding regions to always ensure best practices	Include in MOU R&R: Coordination of Care – Best Practices
	Assist healthcare providers in identifying resources for needed ancillary clinical services, such as DME, specialized laboratory services, etc.	Include in MOU R&R: Case Management – Case Management and Coordination of Services
	Assist healthcare providers and families in identifying resources for needed medical supplies, such as incontinence supplies, diabetic supplies, or enteral nutrition products	Include in MOU R&R: Case Management – Case Management and Coordination of Services

Appendix: Case Management Definitions Reviewed

» [DHCS Population Health Management Strategy and Roadmap, July 2022 \(Sep\)](#)

» *"An approach to care that ensures that needed programs and services are made available to each beneficiary, regardless of beneficiary's Risk Tier, at the right setting."*

» [CalAIM Enhanced Care Management \(ECM\) Policy Guide, Page 4](#)

» *"Enhanced Case Management [ECM] is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems."*

Appendix: Case Management Definitions Reviewed (continued)

» [ECM Policy Guide](#), Page 27 (Sep)

- » *"Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the MCP, and include:*
 - » *Initial Health Assessment (IHA);*
 - » *Individual Health Education Behavioral Assessment (IHEBA);*
 - » *Identification of appropriate Providers and facilities (such as medical, rehabilitation and support services) to meet Member care needs;*
 - » *Direct communication between the Provider and Member/family;*
 - » *Member and family education, including healthy lifestyle changes when warranted; and*
 - » *Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies"*

» [ECM Policy Guide](#), Page 27-28 (Sep)

- » *"Complex Case Management Services are provided by the MCP, in collaboration with the Primary Care Provider, and include, at a minimum:*
 - » *The same services as covered by Basic Case Management;*
 - » *Management of acute or chronic illness, including emotional and social support issues, by a multidisciplinary case management team;*
 - » *Intense coordination of resources to ensure the Member regains optimal health or improved functionality;*
 - » *With Member and Primary Care Provider (PCP) input, development of care plans specific to individual needs, and updating of these plans at least annually"*

Appendix: Case Management Definitions Reviewed (continued)

» [Centers for Medicare & Medicaid Services](#)

» *"Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. "Targeted" case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness."*

» [Title 42 Code of Federal Regulations Section 440.169](#)

» *"Services furnished to assist individuals, eligible under State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services in accordance with [Section 441.18](#)."*

» *"Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))"*

Appendix: Case Management Definitions Reviewed (continued)

» [Centers of Medicare and Medicaid Services: State Plan Under Title XIX of the Social Security Act, 42 CFR 440.169](#)

» *“Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:*

» *Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include*

» *Taking client history;*

» *Identifying the individual’s needs and completing related documentation;*

» *Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;*

» *Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that*

» *Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;*

» *Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and*

» *Identifies a course of action to respond to the assessed needs of the eligible individual;”*

Appendix: Case Management Definitions Reviewed (Continued)

- » [Centers of Medicare and Medicaid Services: State Plan Under Title XIX of the Social Security Act, 42 CFR 440.169](#)
 - » *“Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - » *Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and**
 - » *Monitoring and follow-up activities:*
 - » *Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual’s needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:*
 - » *Services are being furnished in accordance with the individual’s care plan;*
 - » *Services in the care plan are adequate;*
 - » *Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.”*

Appendix: Case Management Definitions Reviewed (continued)

» [New York Codes, Rules, and Regulations, Section 505.16 – Case Management](#)

- » *“Those services which will assist persons eligible for medical assistance to obtain needed medical, social, psychosocial, educational, financial, and other services; and are meant to assist persons identified as high users of services, or as having problems accessing medical services, or as belonging to certain age, diagnostic or specialized program groups, on a statewide basis or limited to persons residing in definable geographic areas.”*

Appendix: Case Management Definitions Reviewed (continued)

» [Stanford Children's Health](#)

- » *"Provides support to patients and families while in the hospital. Our Case Managers collaborate with other services to plan and coordinate your child's inpatient and post-hospital care. Registered Nurse (RN) case managers function as a liaison between the treatment team and physician, patient & family, and payer. The RN case manager is responsible for discharge planning, coordination of care, referral to appropriate resources, and utilization management. Members of the case management team may include: A Medi-Cal coordinator who initiates and submits Medi-Cal Treatment Authorization Request's for all inpatient services. A CCS coordinator who submits medical documentation for all CCS inpatient referrals and service extensions. Case management liaisons who support RN case manager functions. Others who secure funding and/or coordinate resources for underfunded patients as necessary."*

Appendix: Case Management Definitions Reviewed (continued)

Children's Regional Integrated Service System (CRISS)

Case Finding

- » *Engage in active case finding, to identify children and adolescents who may benefit from CCS services*
- » *Receive referrals from any source, including families, health care providers, schools or community members*
- » *Determine medical eligibility for CCS diagnostic, treatment, HRIF, and MTP services*
- » *Determine residential eligibility*
- » *Determine financial eligibility*
- » *Identify and review all relevant clinical reports, as well as requests from specialists, primary care providers, pharmacies, durable medical equipment (DME) vendors, the family, and other providers. This includes contacting providers and researching electronic medical records to identify clinical information to support eligibility determination and to inform a case management plan*
- » *In the event the case does not qualify, or a specific service is not authorizable or related to the CCS eligible condition, consult with the family about other resources available to them to meet their needs*

Appendix: Case Management Definitions Reviewed (continued)

[CRISS](#)

Assessments, interventions, and coordination of care

- » *Link patients to appropriate CCS-paneled physicians, CCS Special Care Centers, and CCS approved hospitals, according to program guidelines and standards*
- » *Authorize services related to the CCS eligible condition*
- » *Review medical necessity for all requests for benefits requiring separate authorization □Review plan of care established by CCS-authorized specialists and Special Care Centers; assist the family in identifying and utilizing the most appropriate resources to accomplish the recommended care plan*
- » *Adjudicate requests for second opinions and out-of-state services*
- » *Adjudicate requests for inpatient and outpatient rehabilitation for physical disabilities*
- » *Arrange and authorize Private Duty Nursing services, as medically necessary, and engage in agency nursing resource finding as needed*
- » *Arrange home-based therapies, as medically necessary, and assist in identifying appropriate agencies.*
- » *Facilitate referrals for mental health services as needed*
- » *Facilitate referrals for pediatric palliative care services, and oversee the provision of those services*
- » *Facilitate referrals for pediatric palliative care services, and oversee the provision of those services*
- » *Ensure coordination of the child's care plan between Special Care Centers, community physicians, and the Medical Therapy Program (MTP)*

Appendix: Case Management Definitions Reviewed (continued)

[CRISS](#)

Assessments, interventions, and coordination of care

- » *Maintain overview of utilization of services across the healthcare system, in order to limit duplication and ensure access to the most appropriate services*
- » *Link patients to appropriate pharmacies for their medication needs and assist providers in determining same. For example, this would include requests by providers to assist in determining which pharmacy may offer compounding services for a specific medication*
- » *Link and/or refer patients to appropriate medical home as determined by patient's needs and preferences*
- » *Link and/or refer patients to programs that coordinate appropriate dental care as determined by patient's needs and preferences*
- » *Coordinate appointments with durable medical equipment (DME) vendors and collaborate to identify DME that is appropriate and medically necessary for client*
- » *Assess patient/family understanding of and responsiveness to overall care plan*
- » *Conduct multidisciplinary case management team conferences, including CCS professional staff as well as community providers and families as needed, in order to address complex needs and challenges to care coordination*
- » *Provide professional support to ensure that families remain engaged and children are not lost to follow-up; at minimum, conduct an Annual Medical Review to know when professional support is needed to ensure that families remain engaged and children are not lost to follow-up*

Appendix: Case Management Definitions Reviewed (continued)

[CRISS](#)

Support for family navigation

- » *Explain resources available to families and help them to navigate systems in order to obtain the services their children need. This includes services provided by CCS, Medi-Cal, County mental health, Regional Centers, public health nursing and schools*
- » *Educate families and health care providers about the CCS regionalized system of care*
- » *Provide consultation and support to the patient's educational team in the school setting when requested by patients and/or their families. Educate families on available transportation resources and provide maintenance and transportation services when they are needed*
- » *Link families to helpful community resources, such as peer and family support organizations*
- » *Support patient participation in the community by providing information on community-based activities, such as resources for exercise and socialization for children with physical disabilities*
- » *Reach out to families who are having difficulty maintaining their Medi-Cal enrollment and troubleshoot challenges to maintaining Medi-Cal eligibility*

Management of transitions

- » *Identify medical records needed to facilitate transfers between jurisdictions, and provide those records to the appropriate parties*
- » *Work with selected clients, families, hospital discharge planners, and community partners to ensure safe and successful transitions from the hospital to the home and community*
- » *Work directly with families to accomplish a smooth transition from the pediatric to the adult healthcare system.*
- » *Provide transition assessment and intervention at appropriate age for client and, for selected clients, conduct internal analyses of patients' transition needs and develop a transition plan*

Appendix: Case Management Definitions Reviewed (continued)

[CRISS](#)

Provider support and assurance of standards

- » *Recruit interested providers to the CCS program*
- » *Highlight gaps in available services – as identified by providers, families, and CCS program staff – for our state counterparts in the Integrated Systems of Care Division (ISCD)*
- » *Facilitate the provider paneling application process as needed*
- » *Educate health care providers about the CCS regionalized system of care*
- » *Foster close relationships with providers and special care centers in the community and surrounding regions to ensure best practices at all times*
- » *Review services provided in order to ensure that they meet CCS program standards*
- » *Concurrently review inpatient stays to ensure appropriate level of service and to negotiate and arrange inter-facility transfers when necessary*
- » *Assist healthcare providers in identifying resources for needed ancillary clinical services, such as DME, specialized laboratory services, etc.*
- » *Assist healthcare providers and families in identifying resources for needed medical supplies, such as incontinence products, diabetic supplies or enteral nutrition products*
- » *Troubleshoot provider billing and reimbursement challenges*