California Children's Services Monitoring and Oversight Workgroup Meeting

June 30, 2022

DHCS

Agenda

Welcome and Meeting Information	12:00-12:05
Roll Call	12:05-12:10
May Meeting Summary	12:10-12:15
Assumptions and Parking Lot	12:15-12:25
Landscape Review and Gap Analysis	12:25-1:00
Compliance Framework and Program	1:00-2:00
Break	2:00-2:10
Memorandum of Understanding (MOU) Development	2:10-3:10
Compliance Metrics and Standards	3:10-3:45
Public Comment	3:45-3:55
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 will be 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: 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 Christine McSorley,** Lake County CCS
6. **Farrah McDaid-Ting,** 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. **Janet Peck,** Butte County CCS
13. **Jody Martin,** Mono County CCS
14. **Katherine Barresi,** Partnership HealthPlan of California
15. **Kathryn Smith,** Children's Hospital Los Angeles

Workgroup Members

16. **Katie Shlageter,** Alameda County CCS
17. **Kristen Dimou,** San Diego County CCS/Medical Therapy Program (MTP)
18. **Lori Gardner,** Madera County CCS
19. **Lorri McKey,** Colusa County CCS
20. **Mary L. Doyle, MD,** Los Angeles County CCS
21. **Meredith Wolfe,** Humboldt County CCS
22. **Michelle Gibbons,** County Health Executives Association of California
23. **Michelle Laba, MD,** Orange County CCS
24. **Mike Odeh,** Children Now
25. **Nancy H Netherland,** Kids and Caregivers
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 FAC, 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
- **Joseph Billingsley,** Assistant Deputy Director, Integrated Systems
- **Bambi Cisneros,** Assistant Deputy Director, Managed Care
- **Dana Durham,** Division Chief, Managed Care Quality and Monitoring
- **Jill Abramson, MD,** Medical Consultant, Integrated Systems of Care Division (ISCD)
- **Cheryl Walker, MD,** Medical Consultant, ISCD
- **Megan Sharpe,** Medical Therapy Program 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,** Associate Director / Subject Matter Expert
- **Alex Kanemaru,** Senior Consultant / Project Manager

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May Meeting Summary

- During the May meeting, the workgroup reviewed and provided feedback on the following topics:
  - Assumptions and parking lot
  - Whole Child Model (WCM) reform efforts
  - California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) overview
  - Landscape review
  - MOU structure, compliance framework and program, and prioritization process

Workgroup feedback will be incorporated in today's presentation and discussion.

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Assumptions (May Meeting)

Based on the May workgroup meeting, the following assumptions have been added:

- Throughout this process and especially through the MOUs, clear definitions and roles and responsibilities will be established.
- CCS Monitoring and Oversight program will be developed with consideration of managed care oversight and monitoring activities and will align where possible.
- Deliverables developed through this process will be done through the lens of the currently existing Numbered Letters (NLs), Plan and Fiscal Guidelines (PFGs), and existing law.
- Process will take into consideration county's unique status (e.g., dependent, WCM, etc.).
- Ensuring family voices are heard; inclusion in the process.
- Metrics and standards identified through this process will inform existing programmatic requirements.

See Appendix for additional assumptions developed by the CCS Monitoring and Oversight workgroup.

Parking Lot

Issue Description	Raised On	Venue to Address
ECM and CCS case/care management intersection	4/25/2022	**ECM workgroup on Children/Youth Population of Focus**
Budget/financing	4/25/2022	Independent DHCS discussions with CHEAC and stakeholders
Respite rates for registered nurses	4/25/2022	Addressed via stakeholder communication
WCM dashboard data accuracy	4/25/2022	Quarterly CCS Advisory Group Meeting
WCM evaluation and lessons learned	5/23/2022	10/12 - CCS Advisory Group Meeting

Bolded items have been updated based on questions and feedback during the April and May CCS Monitoring and Oversight workgroup meeting.

Parking Lot – Policy Updates & Revisions

Document(s)	Scope of Update/Revision	Venue to Address	Timing	Status
Plan and Fiscal Guidelines	Update to harmonize with current program status	• CCS Advisory Group Meeting • *Upcoming* - CCS County Administrator Quarterly Meeting • Contact Medical Operations Branch at CCSredesign@dhcs.ca.gov	Estimated Published Date Winter 2022	In development
CCS Administrative Case Management Manual	Estimated to begin late 2022		*First Meeting:* Quarter 1 Fiscal Year 23-24	Ongoing
Numbered Letters	Ongoing – revise as needed		As needed	Ongoing

Workgroup Discussion

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CCS Documents and Other Relevant Materials

1. **Title 22, Division 2, Subdivision 7**
2. **Health and Safety Code (HSC), Chapter 3 of Part 2 (commencing with Section 123800)**
3. **CCS Administrative Case Management Manual**
4. NL/Information Notice (IN) Inventory
5. PFGs
6. CCS Manual of Procedures
7. All Plan Letters
8. Medi-Cal Request for Procurement
9. CCS Provider Standards
10. Children's Medical Services (CMS) Net/Microsoft Business Intelligence (MSBI)
11. Relevant State and federal requirements (e.g., Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Title V/children with special health care needs)
12. WCM dashboard and non-WCM dashboards
13. Other significant guidance documents (e.g., Comprehensive Quality Strategy)
14. Current MOUs between managed care plans and counties
15. CCS Monitoring and Oversight Workgroup and CCS Advisory Group meeting notes and input
16. WCM Division of Responsibility Chart
17. Historical audit tools
18. Draft Population Health Management Strategy and Roadmap 2022

Bolded items were identified as foundational CCS documents during the April workgroup meeting and in subsequent discussions

Goal and Outcomes of Landscape Review

- **Goal:** Organize currently existing and historical background and best practice information to inform the development of the compliance framework and MOU.
- Outcomes of the landscape review include:
  - Matrix of core program activities, including the specific authority or requirement
  - Crosswalk of roles and responsibilities
  - Inventory of required CCS reports
  - Overview of CCS current and historical compliance, oversight, and monitoring activities
  - Compliance program best practices
  - Overview of Medi-Cal managed care monitoring and oversight activities
  - Inventory of CCS data sources
  - Overview of EPSDT requirements
  - Compilation of established program definitions
- Materials will be provided on a flow basis; process will be iterative based on workgroup needs and discussion.

Gap Analysis

- In addition, the landscape review will inform the gap analysis by identifying:
  - What compliance activities currently exist compared to state and federal best practices.
  - What is needed to achieve a robust compliance program related to data, metrics, and other requirements.
  - Gaps in county administration and interpretation of program operations.
  - Tracking and developing best practices to handle complaints, grievances, and appeals.

Reporting Requirements Tool Responses

- Several workgroup members responded to the requested tool outlining existing or historical CCS reports to the state that included several collaborative county responses.
- Nearly all reporting is currently done through the PFG for budgetary information and for existing performance measures.
- As part of this exercise, some counties also called out activities and requirements that may be a desired reviewable function as well as information to be documented should a survey occur.

Reporting Requirements Tool Responses

Some of these additional items included:

- Case management – administrative and patient care
- Individualized Education Plan team participation
- MTP utilization review and dispute resolution
- Case finding activities
- Linkage to after-care services
- Medical, residential, and financial eligibility determinations
- Application for services
- Diagnostic services availability
- Maintenance and transportation

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Elements of Compliance Program

Authority
Clarify who is responsible for compliance and roles and responsibilities.

Standards and Procedures
Written policies and procedures that articulate *commitment to compliance* and *how* compliance is met.

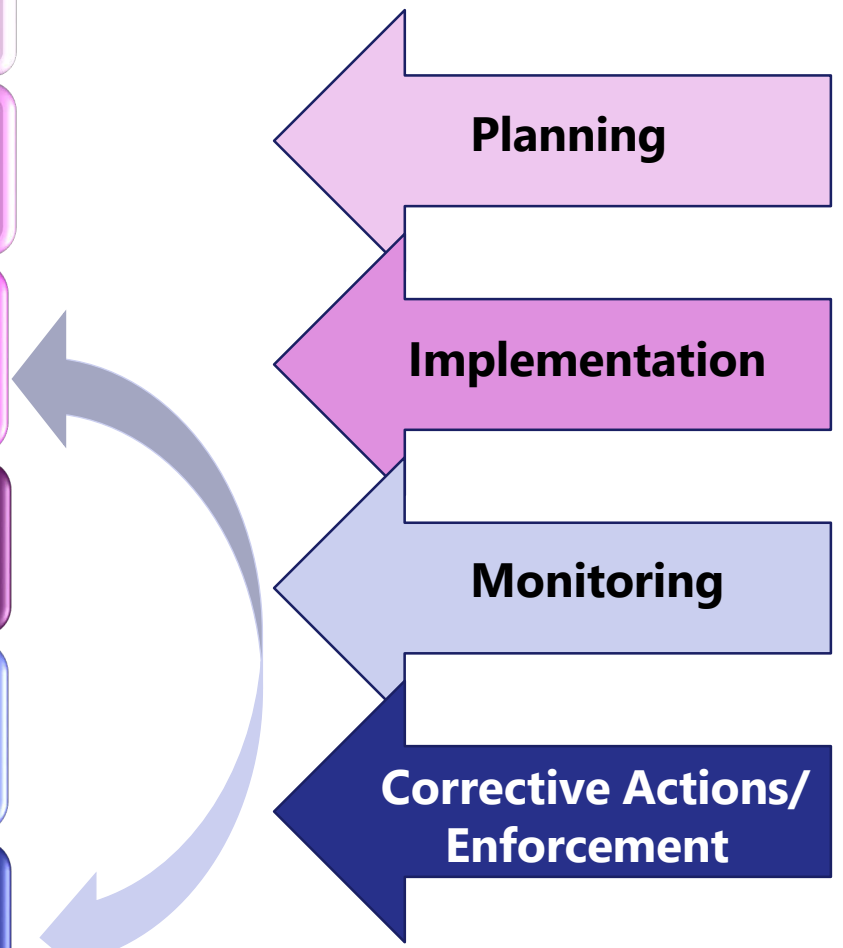
Training
Effective training and education for staff and leadership according to functional areas.

Communication
Effective lines of communications to assess risks, raise compliance concerns, and make adjustments.

Monitoring and Surveying
Reasonably designed monitoring and surveying systems, using analysis and reporting to assess compliance risks.

Corrective Actions and Enforcement
Reasonable steps to respond appropriately to findings and to develop corrective actions.

Compliance Framework



Stakeholder Input **Transparency**

Compliance Program Best Practices

- **Program Outcomes**
  - Operate in accordance with applicable state and federal laws and regulations
  - Prevent fraud, waste, and abuse or other compliance issues
  - Identify compliance issues early
  - Create culture of compliance
  - Build program confidence
  - Program improvement and standardization
- **Overall includes aspects of compliance prevention, detection, and corrective action.**

Compliance Program Best Practices *(cont.)*

- **Authority**
  - Establish responsible person for compliance responsibilities
- **Standards and Procedure**
  - Clear state policy describing compliance program – outlined in MOU, NL, and related documents
  - Expectations and requirements for local written policies and procedures
  - Reporting procedures, such as for data
- **Training**
  - Focus on key compliance issues and core functional areas
  - Regularly maintained and updated training materials
  - Incorporation as part of new staff onboarding
  - Ongoing training (state and local level)

Compliance Program Best Practices *(cont.)*

- **Communication**
  - Quick response by both the state and local program on identified issues
  - Complaints monitoring
  - Clearly identified communication avenues, such as through designated email, established liaison, and call number
  - Make key program documents and guidance transparent, such as available on website
- **Monitoring and Surveying**
  - Set baseline to identify trends
  - Risk assessments based on past behaviors and regularly revisit them to identify areas of improvement
  - Regularly scheduled monitoring and reporting
- **Corrective Action and Enforcement**
  - Ongoing analysis to identify root causes of issues, identify areas of risk, and vulnerability
  - Tracking status of findings and ensure issues have been addressed

DHCS Historical and Existing Oversight

- **Historical Oversight Functions**
  - Local CCS program assessments based on written and statutory requirements (e.g., HSC, Welfare and Institutions Code [WIC], PFGs)
  - NICU and hospital reviews
  - The state program conducted desk and onsite visits, plus other site visit survey requirements (e.g., infection control, and emergency information materials, etc.) per CCS standards
  - Counties historically reported appeals log data to the state
  - Onsite CMS Net trainings
  - Evaluation of Outpatient Rehabilitation Centers (OPRC) every two years utilizing the OPRC Certification Survey checklist
- **Currently Existing Oversight Functions**
  - Some counties currently report on the five existing performance measures and plan and budget requirements in the PFGs
  - Annual program data requested every April for MTP

Prioritization Process

- Core programmatic functions as identified by workgroup members:
  - **Eligibility - Financial, residential, and medical**
  - **Case Management/Care Coordination**
  - Administrative – budget/fiscal, reporting requirements
  - Administrative Coordination – engagement and coordination with delivery system partners; existence of MOUs with Regional Centers, MCPs, etc.
  - Authorizations
  - Benefits/Services
  - Grievance, Appeals, and Fair Hearings
  - Access to Care

Bolded items identified as key priorities for consideration of compliance program

Discussion Questions

- Are there any compliance program best practices that are integral to the success of the CCS program?
- Are there any activities that occurred historically that address compliance program best practices and supported CCS program integrity?
- What is the scope and frequency of surveys that you would like DHCS to conduct (e.g., onsite, desk audits, virtual)?

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MOU Structure

- Base MOU for all counties
  - Basic core functions
- Specific attachment for each model type, including:
  - WCM counties
    - Independent counties
    - Dependent counties
  - Classic
    - Independent counties
    - Dependent counties
- Utilization of HSC and Title 22 to inform MOU
- The MOU will:
  - Reference authorities or key policies
  - Minimize duplication when possible
- Compliance program

Proposed MOU Outline

I. Background
II. Purpose
III. Scope of Work
IV. Organizational Structure
V. Term
VI. Data and Information Sharing
VII. Oversight and Monitoring
    a) Surveys
    b) Reporting requirements
    c) Performance measures and process
    d) Training
    e) Corrective Action
VIII. Grievances and Appeals
IX. Confidentiality
X. Liability and Indemnity
XI. Amendments
XII. Liaisons
XIII. Business Associate Agreement
XIV. Attachments (County Model Specific)
    a) County, DHCS, Managed Care Plan (as applicable) Roles and Responsibilities
XV. Appendices
    a) Definitions

Roles and Responsibilities

Based on workgroup feedback, the following table will be built out based on CCS status and core programmatic functions.

	Dependent	WCM Dependent	WCM Independent	Independent
Medical Eligibility, including Annual Medical Review (AMR)	DHCS	DHCS	County	County
Residential Eligibility	County	County	County	County
Financial Eligibility	County	County	County	County
Service Authorization Requests (including NICU)	DHCS	MCP	MCP	County
Coordination of Services	DHCS	MCP	MCP	County

Roles and Responsibilities – Resources

- **WCM Role and Responsibilities**
  - Created with the transition to the WCM carve-in to managed care.
- **Case Management Improvement Project (CMIP) MOU**
  - CMIP is a voluntary program created for counties to partner with state regional offices to assist with determining medical eligibility and processing service authorizations.

Attachment Roles and Responsibilities:
WCM, Independent

DHCS - ISCD	County – CCS Administrator	Managed Care Plan
Medical Eligibility - *Annual Medical Review (AMR) [Sources: NL XXX, WIC XXX, CCR]*		
DHCS will conduct annual reviews of the CCS counties' AMR processes.	The [County] CSS program/state shall determine medical, financial, and residential eligibility, initially and on an annual basis, for a CCS-eligible condition based on evaluation of provided documentation.	[MCP] shall provide necessary documentation and medical records/case notes/reports to the county CCS program to assist with medical eligibility determination.

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Compliance Metrics and Standards

- With stakeholder input, DHCS will establish a set of program metrics to support program oversight that will focus on core program performance (versus quality) of the CCS program.
- With workgroup input, a process for updating, reviewing, and refreshing the identified measure set will be developed.
- As oversight and monitoring functions mature, the state will begin to incorporate quality measures. DHCS anticipates discussion of quality measures occurring through a separate workgroup process.
- Additional standards and expectations will be included, such as for reporting and budgeting.

Compliance Metrics and Standards *(cont.)*

Metric Types

- *Process:* Indicates whether an action took place
  - Generally, the metrics identified by this workgroup will be process-oriented.
  - Example: The county shall determine financial eligibility under provisions of Section 123870 of the HSC within 30 days of receipt of documentation needed.

- *Outcome:* Evaluates impact of service or intervention
  - Outcome metrics are typically multifactorial and can take time to improve.
  - Outcome measures will be considered for inclusion in the final set of metrics and standards based on workgroup feedback.

Existing CCS Performance Measures

- **Measure 1. Medical Home** – Children in the CCS program will have a designated primary care physician and/or a physician who provides a medical home.
- **Measure 2. Determination of CCS Eligibility** – Children referred to CCS have their program eligibility determined within the prescribed guidelines.
- **Measure 3. Specialty Care Center (SCC)** – Presence of annual team conference report and referral of child to SCC.
- **Measure 4. Transition Planning** – Children, 14 years and older, who are expected to have chronic health conditions that will extend past the twenty-first birthday will have documentation of a biannual review for long term transition planning to adulthood.
- **Measure 5. Family Participation** – Degree to which the CCS program demonstrates family participation.

Data Sources – CMS Net

As we begin the process of identifying compliance metrics and standards, CMS Net will be a key resource for pulling CCS data inputs. To better understand the usability of this resource, we have the following questions for discussion:

1. From your perspective, what are the greatest benefits and challenges with CMS Net?
2. Where can additional directions and technical assistance help ensure more uniformity in data inputs?
3. How useful is MSBI? Do you use this platform, related reports, or create your own reports?

Other Key Data Sources & Considerations

- Are there other key sources of data that should be explored?
  - CCS case charts and plans
  - WCM/CCS dashboard and WCM reporting template data
- What data challenges exist related to existing programmatic function and related roles and responsibilities?

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Next Steps

- Meeting summary
- **Homework:** Follow-up questions on:
  - Existing metrics
  - Additional data sources
  - Compliance program build out
- DHCS may reach out to workgroup members with program questions.

Updated Timeline

ACTIVITIES

- Compliance framework
- Define prioritization process
- Compliance metrics and standards

ACTIVITIES

- Begin development of MOU templates
- Continue and finalize compliance metrics and standards
- Process for reviewing and updating metrics and standards

ACTIVITIES

- Continue development of MOU templates
- DHCS/county implementation workplan

ACTIVITIES

- Finalize MOU templates
- Draft and finalize supporting INs

Stakeholder Input

Workgroup Meeting Logistics

Meeting notices and materials to be posted on the DHCS website.

2022-2023 Workgroup Meeting Dates

- July 25
- August 22
- September 26
- October 24
- November 21
- December 19
- January 23

Contact Information

- For more information, questions, or feedback regarding the CCS Monitoring and Oversight Program, including the development and implementation of the CalAIM initiatives to enhance oversight and monitoring of the CCS program and workgroup activities, please email Sarah Brooks at SBrooks@sellersdorsey.com or Alex Kanemaru at AKanemaru@sellersdorsey.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.

Thank you!

DHCS

Appendix

CalAIM

DHCS intends to provide enhanced monitoring and oversight of all 58 counties to ensure continuous and unwavering optimal care for children. To implement the enhanced monitoring and oversight of CCS in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and state requirements.

CalAIM Proposal

Authorizing Statute

Assembly Bill 133, Article 5.51, established CalAIM subsection (b), requiring DHCS to consult with counties and other affected stakeholders to develop and implement all of the following initiatives to enhance oversight and monitoring of county administration of the CCS program:

- Establish statewide performance, reporting, and budgetary standards, and accompanying audit tools used to assess county compliance with federal and state requirements applicable to the CCS program.
- Conduct periodic CCS quality assurance reviews and audits to assess compliance with established standards.
- Assess each CCS program to ensure appropriate allocation of resources necessary for compliance with standards, policies, guidelines, performance, and compliance requirements.
- Determine and implement a process to inform each CCS program of, and make available on its internet website, the latest standards, policies, guidelines, and new performance and compliance requirements imposed.
- Establish a statewide tiered enforcement framework to ensure prompt corrective action for counties that do not meet established standards.
- Require each county to enter into a MOU with DHCS to document each county's obligations in administering the CCS program.

Assumptions

- The process will be transparent and cooperative.
- DHCS will consider the workload impact to counties and the state:
  - Processes will be streamlined, using technology when available
  - Identified best practices will be incorporated
- Activities may result in operational changes for some counties, resulting from standardization of the program.

Assumptions (April Meeting)

Based on the April workgroup meeting, the following assumptions have been added:

- This process will be member centric.
- A process to inform each CCS program of, and make available on its internet website, the latest standards, policies, guidelines, and new performance and compliance requirements is required.
- There will be separate MOU templates based on distinct county model types.
  - e.g., classic, independent, dependent (small and large), WCM
- Measures identified through this process will include actions within county control.
- The DHCS/county work plan timeline will take into account county review processes (e.g., Board of Supervisors, County Counsel, County Director's Office).

CMIP Overview

Overview: CMIP is a voluntary program created for counties to partner with state regional offices to assist with determining medical eligibility and processing service authorizations. There are 3 CMIP levels and CMIP level 3 includes 4 sublevels A-D of increasing responsibilities for determining medical necessity and medical eligibility.

Responsible Party	Level 1	Level 2	Level 3A	Level 3B	Level 3C	Level 3D
State	Determine medical eligibility and service authorizations	Initial medical eligibility determination and initial service authorizations	Initial medical eligibility determination and initial service authorizations	Initial medical eligibility determination only		-
County	Determine residential and financial eligibility and coordination of services	Continued medical eligibility determination, residential and financial eligibility, continued authorization of services previously determined medically necessary by the state, and coordination of services	All other responsibilities	All other responsibilities		Only 3D counties can determine initial medical eligibility

CMIP Roles and Responsibilities for Dependent Counties

Responsibilities	Approvals	Level 1	Level 2	Level 3A	Level 3B	Level 3C	Level 3D
Medical Eligibility	Initial	DHCS	DHCS	DHCS	DHCS	DHCS	County
	Continued	DHCS	County	County	County	County	County
Residential/ Financial Eligibility	All	County	County	County	County	County	County
Authorizations	Initial	DHCS	DHCS	DHCS	County	County	County
	Continued	DHCS	County	County	County	County	County
Coordination of Services	All	County	County	County	County	County	County

Dependent Counties in each CMIP Level

	Level 1	Level 2	Level 3A	Level 3B	Level 3C	Level 3D
County	Calaveras, Glenn, Imperial, Inyo, Mariposa, Mono, Plumas, San Benito, Sierra, Tehama	Amador, Colusa, Nevada, Tuolumne		El Dorado, Kings, Madera, Sutter	Yuba	