CCS Administrators Survey Summary

Contents

Biggest unmet needs you most frequently encounter for your CCS clients and their families

Lack of Access to Care & Transportation issues

- Reliable transportation assistance and lack of local providers of care that are CCS paneled continues to be a barrier **(REPORTED BY MULTIPLE RESPONDENTS)**
- Transportation obstacles to SCCs **(REPORTED BY MULTIPLE RESPONDENTS)**
- Our county is geographically large and the population tends toward the city in the western part of the county. We find it difficult to establish some services in the other half of our county since vendors and providers do not have enough financial incentive to provide services there. Our families in those regions may have to drive very long distances or forgo some services altogether.
- Access to specialty providers - far distance to drive to reach the providers. And limited care coordination to navigating the healthcare system (appointments, insurance, MD recommendations)
- Lack of local providers in rural areas (audiologists, physical and occupational therapists for those that don't quality for MTU, endocrinologist that takes Medi-Cal for 18-21 year olds)
- Mental health support for the whole family and transportation.
- Specialist care, dental care, and behavioral health in rural county.
- Transportation to specialty appointments. Nearest specialty care is 6 hours away (one way). Delayed and complex reimbursement system for families to get funding for the travel.
- Specialty care services for patients over 18 years old.
    - a. Endocrinology SCC will not see patients over 18 years old if not established in their practice.
    - b. Many specialty services are closed for new referrals due to capacity, including but not limited to + HIV, endocrine, rheumatology etc.
- Audiology services for all ages, including newborn screening, lack of hearing aid providers, and patients over 18 years old.
- Dental services under anesthesia due to lack of operating room time provided to dentists.

- Therapy for patients that are not MTP eligible.
- Requested services that require CCS State approval such as cochlear implants, are often delayed due to no response.

MTU

- Therapy staff cutbacks
- Therapies at MTU

Care Coordination

- And limited care coordination to navigating the healthcare system (appointments, insurance, MD recommendations
- Gaps in care coordination and nurse case management

Needs related to WCM

- Families no longer have a case manager assigned to them.
- Kids are being lost to services. Example: Partnership does not ensure babies referred by New Born Hearing Screening Program are having their hearing tested; larger medical center has complained to local CCS that referrals they have made to CCS via Partnership are not getting to CCS
- Partnership does not offer true case management. If families don't respond to 3 phone calls there is no other attempt to reach the family. There is **no ongoing case management** unless there is a problem brought to Partnership's attention. Once it is resolved the case is closed to further case management"
- The biggest unmet needs for CCS Clients are lack of consistent case management with the burden of identifying case mangemnt needed by the parent. We are a phase II WCM County. The MCP has indicated that the parents need to ask for case management and once the "issue" is resolved, the case is closed. The other difficulty CCS Patients are experiencing is the lack of M&T (maintenance and transportation funding).
- Access to specialty providers outside of the Health Plans network -- WCM clients no longer have access to the best medical specialists for their medical condition.
- Lack of intensive case management for complex medical conditions resulting in delays in care and fragmented communication, no single point of contact
- Lack of reliable and/or appropriate transportation
- Difficulty navigating the MCP system (WCM clients)

Mental & Behavioral Health, Social Support

- Psycho-Social help
- Mental health support for the whole family
- psychosocial support

SDOH

- Housing
- Food

CCS Admin. Processes

- CCS referrals that are not yet open as cases.
- Delays in cases requiring ISCD review.
- Extreme delay in State response for annual reviews, initial eval, Transfers, SARs, etc. We currently have cases that are over 90 days.
- Requested services that require CCS State approval such as cochlear implants, are often delayed due to no response
- Timely processing of SARs

Transition

- transition practices
- Endocrinology SCC will not see patients over 18 years old if not established in their practice.

Whole child wellness

- whole child wellness

Insurance/Medi-Cal Managed Care

- Medi-Cal churn
    - when we were case managing we coached families about maintaining their Medi-Cal, now we are experiencing more

and more families with dropped funding and unable to see a provider for a scheduled appointment due to the dropped funding

- Difficulty with the managed care covering health care needs while waiting for CCS eligibility.

Priorities/issues to address in next 5 years:

Care coordination

- Comprehensive care coordination and oversight from State of care coordination (WCM)

Case management

- Improved case management for families
- Fully define and implement Case Management by the Health Plans
- Creation of small caseloads of higher acuity patients

CCS Eligibility

- Consider regulation change making CCS eligibility not diagnosis dependent but on the need for case management
- Updating the financial eligibility requirements

Communication

- Better communication/direction from State CCS
- Better communication between MCP and county regarding case management issues and whether they were resolved satisfactorily
- Improve communication and direction from the state to the counties.
- Direct communication with CCS representatives at State Level (updated contact lists available easily online)
- Communication on regular basis related to case status
- Better communication from ISCD regarding eligibility, annual renewals, and eligibility for new referrals. We are not receiving returned emails.
- Improve/increase support, training, and communication from the State office to county staff
- Responsiveness of DHCS to address concerns
- Expiring annual renewals without a contact person to talk to. We have had three recently that expired without contact from the state though we submitted documents three months ahead of time.
- Establish improved communication and cooperation between State agency and County agencies. We are all one organization and State often behaves as if we are separate entities.
- Restarting CCS statewide meetings

WCM

- Ensure WCM clients still have access to the best providers in the State, vs Health Plans rerouting patients to in-network, lesser qualified providers
- have the plan case manage dropped funding the way that the counties must
- Improve CCS referrals particularly in Whole Child Model counties
- have the plans case manage all CCS clients the way that the counties did, including outreach to folks to maintain their Medi-Cal

Workforce issues

- Difficulty finding physical therapists in the MTU
- More local paneled providers and specialists
- Staff retainment
- Lack of Nurses
- Develop provider network for allied health professionals.
- Full time CPS/CCS liaison for additional case management and support for our patients that are suffering medical neglect

Increase Rates

- Increase payments to providers which will encourage increased providers
- Advocacy to increase rates so there are more CCS/Medi-Cal providers and clients are able to get necessary services sooner.
- Enhanced reimbursement for serving CCS patients apart from neonatology (already disproportionately being compensated when there is poor reimbursement for the provision of medical home and other subspecialty services)
- Improve reimbursement rates for difficult-to-recruit vendors and providers
- Increase pay rates to entice more providers to become paneled

Administration/Technology

- CMS storing of client charts
- easier system for SAR's and such. very cumbersome
- Reduce the amount of paper with intake of clients
- Electronic Health Exchange
- Enhancing CMSNet to become a complete EMR system
- Information exchange between Managed Care and CCS
- The State needs to implement an electronic way to send case info, instead of fax, to assist with streamlined processes and Counties can confirm information has been received at the State level
- Update CMS web to include the ability to upload medical records and documents, keeping everything in one place
- Improve access to services via adding document storage to CMSNet and allowing MCPs read only access.
- CCS therapists across the county to communicate in order to share ideas or provide more consistent services across the state
- Improving the E-SAR capability - removing the faxing system
- Transitioning to all electronic charts

Evaluation

- Develop a robust data analysis system for the CCS program that allows for evaluation of outcomes measures and the development of data driven best practices
- Evaluation method for CCS - WCM & Classic
- New performance measures for the program that the County has easy access to the data and can track performance and make necessary changes.
- Ensuring WCM children are receiving the same level of benefits as classic-CCS children

Medical Home

- Define, create and implement standards for Medical Homes. All CCS clients to have an appropriate medical home.

Inter-county Transfers

- Finalize the Inter-County Transfer Numbered letter
- Transfers from/to non-managed care Medi-Cal counties
- Improving the transfer process between counties - creating a standard protocol for all counties to be on the same page
- Improve inter-county transfer process in/out of WCM counties.

Medi-Cal coverage/Medi-Cal managed care

- Medi-cal covering care until CCS eligibility is determined
- Create an aid code that pends the Medi-Cal for CCS eligible clients rather than dropping the Medi-Cal the Medi-Cal is pended so that folks do not experience a lapse in care
- Family's ability/ease to get guidance/information from Managed Care Medi-Cal entity
- Receiving ICU/NICU referrals from MCP. We get them from the provider but not from the MCP and don't know where they are in this process.
- Medi-Cal approved PDN (private duty nurses) providers
- Ensuring on-going Collaboration with MCMCP
- Stop the CHURN. This leads to poor case management and fragmented services

- Minimize lack of coverage due to Medical-Cal churn, transfer between counties
- Managed care is not working and making people choose a managed care and removing them from fee for service is terrible.
- Requiring the Medi-Cal MCPs to become CCS literate
- Require [Medi-Cal Managed Care Plan] to keep their children for 30-60 days when they fall off of [Medi-Cal Managed Care Plan] but still have fee for service Medi-cal.

Case determination and SAR authorizations

- Quicker response from State for case determinations (transfers, annual reviews, SAR auths, etc.)
- PROCESSING OF SAR'S
- Decrease SAR processing time/timely not episodic approvals
- Improving the timeliness in SARs being reviewed by SCRO
- Timely medical determinations of cases
- Vast inequality between independent and dependent counties in regard to timeliness of authorizations & opening cases
- Improved processing time for cases requiring ISCD review
- Improve approval of authorizations through use of eSARs from all providers.
- TIMELY ACCESS TO [entity that processes the eligibility for dependent counties] STAFF

SDOH

- Full time CCS social worker to support our CCS patients and families with social needs and transition to adult services

Transition

- Full time CCS social worker to support our CCS patients and families with social needs and transition to adult services
- Transition to adult care
- Improve transition planning for families

Standards/regulations/eligibility/enforcement

- Adapting regulations for whole person care
- State guidelines (in the form of Numbered Letters) which are clear, relevant and updated periodically
- Provide PDN (private duty nurse) Policy or Numbered letter
- Written, definitive guidance from the state on new CCS responsibilities (e.g. Private Duty Nursing)
- establish consistent standards within the program, adhering to SB586
- Update regulations related to new tech/medical advancements
- Expedition of Numbered Letters from the time of approval to publication
- CCS paneling requirements for providers
- Revise the Medical Eligibility regulations to reflect the current state of medicine and improve preventative access to care (e.g. literature driven standardized methods of determining Cerebral Palsy eligibility that allow for MTU intervention earlier and before significant tone has developed)
- Updates to outdated State Numbered Letters that provide policy guidance to Counties.
- Improve accountability/oversight of Medi-Cal Managed Care plans.
- Establish a baseline for minimal services for ALL counties that includes a social worker. Big counties provide more comprehensive service and smaller counties barely provide the basics.
- Updating Plan and Fiscal Guidelines and caseload standards
- Policies which are consistent throughout the counties (i.e, Private Duty Nursing)
- Looking at regulations /determining if changes are needed
- Increase the family income threshold

Mental and Behavioral Health

- Behavioral Health
- Increase mental health support for families
- All clients and families will be screened and appropriately referred to mental health services

State capacity issues

- Adequate staffing at the State level to issue policy guidelines and do site visits
- Requiring DHCS/ISCD personnel to become CCS literate

Transportation

- More streamlined Maintenance and Transportation. It is too difficult for families
- Provide creative ways for transportation reimbursement for clients to include things like UBER, LIFT or Ride share programs.
- Improve the M&T benefit through the Health Plans, outsourcing this benefit has resulted in serious problems

DME/Medical Supply Vendors

- Finding vendors that will take our clients, as we are not using CPT Codes, and they feel the reimbursement is too low with HCPC Code.

Referrals/Identification of cases

- Ensure that CCS eligible children are being referred to the program.
- Improve proactive identification of cases for MTU svcs (early)
- Improve CCS referrals particularly in Whole Child Model counties

Provider and Community Partner Education

- Expanding understanding of CCS program to physicians
- Outreach & Education for Community partners

Whole Child Care

- Whole child care at a County program level -not MCP

Other issues:

- Improved website with educational resources for staff and families including educational blackboard for CCS staff for statewide education and sharing of resources

Challenges in Capacity for Programs:

Staffing and Provider supply

- Recruiting and retaining nurse case managers. Identifying adult providers for our clients upon aging out of the program.
- Our biggest challenge in the MTU, is finding physical therapists. We are currently working with 2 contractors since the end of January and have not been able to find anyone to come to Merced. One of the contractors stated a couple of weeks ago that the physical therapists want more than what they/we are offering.
- Physical therapists are in short supply
- We lack some specialty providers and have to send children out of the county for care. Also, with large caseloads, it makes it hard to truly case manage these families in the way they deserve.
- We consistently struggle to maintain full staffing. In part this is due to our inability to pay some positions a competitive wage compared to private providers in the community. Caseloads for our staff can easily exceed recommended limits because of this.
- We would like to be more available to provide case coordination.
- Trying to get nurses
- our long time CCS manager retired in December, we hired a new one who only stayed 6 mos, it is currently vacant and we are trying to fill the void but have not had any applicants for the position.
- MTP staffing due to delays in Human Resources.
- We currently are staffed with 1 Supervisor who is covering 2 programs and providing full time coverage for a vacant PHN nurse case manager position. In addition, we only have one other PHN nurse case manager who works part time to cover the entire CCS caseload. Our county is experiencing difficulties in recruitment of

PHNs. Our support staff consists of 2 full time medical office assistants and 1 half time. We will be losing 1 one of the full time positions due to retirement.

- High volume of staffing turnover, particularly in administrative roles; inconsistencies of operations from County to County; lack of community awareness resulting in a high volume inappropriate referrals and delays in appropriate referrals.
- We have been unable to recruit pediatric trained healthcare providers, therapists which slow down access to care.
- 1. Clerical staff toxic attitudes and poor customer service, supported by their union representative. 2. Clerical staff not caring to perform assigned duties, and refuse to learn new procedures within their scope of job duties. 3. Human resources lack of support and action when staff behavior and performance issues need to be addressed. 4. Human resources 6 month delay in responding to requests for discipline. 5.RN caseload size, (430-450 patients) does not allow for in depth case management, especially without ancillary support staff
- Staffing. Hard to recruit qualified nurse case managers. Lack of ability to provide incentives to families to participate in family advisory committees. Lack of good performance measures to keep staff focused on outcomes.
- Not enough staff assigned to the program
- Staffing certain positions e.g. PT, due to low pay and small pool of pediatric therapists. Challenges with Private Duty Nursing and upcoming legal implications of daily outreach to find nurses to cover approved hours.
- Finding ways to engage families without a budget for staff and resources.
- Finding qualified staff, especially Physical Therapists, Occupational Therapists and Public Health Nurses. recruiting and retaining nurse case managers. Identifying adult providers for our clients upon aging out of the program.
- Difficulty with transitions to adult care - not the priority at this time due to staff time.

Issues related to WCM

- With the implementation of Whole Child Model, our program downsized from 9 FTE to 4 FTE. This means if one person is on vacation, or on maternity leave, or if a position becomes vacant, there is no back up and it becomes very challenging for the remaining staff to keep up with the workflow. No position has a second person for back up anymore.
- Inability of medical directors to do annual reviews due to lack of information/ thorough care coordination and poor communication from Medi-Cal managed care plan
- There are few medical reports received for the annual medical reviews which slows the review process down. The constant on and off of Partnership Medi-cal and the choppy case management that the local CCS office has to provide. Any problems local CCS has with Partnership requires examples. We provide examples. The problem is not resolved because it has to go through multiple people.
- We are in Phase 2 of the WCM and we are still trying to obtain the necessary guidance from ISCD but they have hobbled the WCM counties with lack of adequate communication.
- We are a WCM, waiting for our allocation, not confident, the funds will cover the minimum staffing standard. The lack, inconsistent and/or delayed response by DHCS verbally or in writing makes it difficult to develop processes and procedures within County CCS and with MCP.
- There is unanticipated/unfunded workload remaining at the counties that was not planned as part of WCM, such as AMRs taking much longer than the State-allocated 12 minutes, since the Health Plans are not able to provide medical records needed for AMR. Counties are also chasing the Medi-Cal churn as clients fall on and off of Medi-Cal. Inter-county Transfers are significantly more complex, with difficulty obtaining records from the Health Plan. Complexities of straddling communication with the Health Plans, use of SFTP for constant PHI data transfer, weekly, monthly, quarterly meetings with the Health Plans to troubleshoot and problem solve implementation and transition issues.
- Budget changes due to the WCM. Uncertainty if staffing will continue at capacity, currently awaiting allocations notification based on baseline submission. Discrepancy of guidance from the

state, and programmatic references/ resources are no longer available on the website. Which can lead to delays in service delivery.

- Lots of major program changes this year. Capacity has been affected in attempting to align with the changes and develop new program structure and routine.
- Lack of medical documentation (responsibility of MCP, but they have not successfully met it) to perform eligibility determination at Annual Review requires us to hunt down records from providers, many of whom think CCS no longer exists and are not motivated to provide since we are no longer payers. Still struggling w lack of clerical support, so few remaining CCS staff (1 eligibility worker, 1 PHN, 1 administrator) must do everything that needs to be done.
- We are understaffed for the amount of work that remains with the county. Managing the dropped funding cases creates a large amount of work while case managing the CCS eligible client through the most difficult part of case managing, up front work is very dense and done by the counties for these dropped funding cases
- Not receiving information on referrals from managed care Medi-Cal entity.
- Increased complexity in the health care system such as children transferring in & out of whole child model counties, Medi-Cal managed care plans sub-contracting with Independent Physician Associations (IPA's) who then contract with non-CCS paneled specialists

Guidance, Communication, Referrals and SARs, & IT

- Main challenge is receiving guidance from the State. Many questions from PDN to county transfers have key components that only the State can give guidance on.
- Having to review 262 charts for AMRs/closures/opening due to ISCD staff not sending web messages regarding the status of cases. There is no communication with the county CCS office.
- Lack of clear policy direction at the State level in terms of evaluating certain medical benefits (2) Lack of subject matter experts to consult on for certain benefits of the program (audiologist, nutritionist) (3) Lack of expertise about coding to assist providers with appropriate reimbursement (4) Lack of provider support for rapid enrollment in Medi-Cal which affects paneling (5) Multiple priorities that require IT support and having limited IT support/resources
- The capacity issue comes with the eSARs, these come fast, but this is also a comfort level. Also, it depends on if the case is already renewed or not.
- Lack of communication with [ENTITY THAT PROCESSES THE ELIGIBILITY FOR DEPENDENT COUNTIES] staff is challenging. It is difficult to contact anyone in the office, there is a lack of notification when the alpha list is changed. CCS referrals are not being opened as cases. We are not being notified when cases opened, when we get referrals, etc. Urgent cases are not expedited - which is extremely concerning. There is little to no communication occurring.
- Yes, no access to CMS net with need to ask for assistance from State Employees to complete CCS requirements
- TIMELY PROCESSING OF NEW REFERRALS
- inadequate direction/communication from the state on programs transferred to the counties to manage, lack of subject matter expert consultants to review requests for services (audiology, nutrition, nurses).
- The lack of understanding of the CCS program and how it functions at a County level (ISCD/DHCS), as well as, lack of empathy.
- Yes, pending SARS extended review time---they can sit in the queue up to 4 months....Need more nurse reviewers
- It is very difficult for us to perform as a dependent county when SARs take anywhere from 1-3 months for approval. It have become so delayed that some service providers have asked to pass our local office to try and cut back time. It is creating barriers to care and delaying care that these children need.

Local strategies/Initiatives developed or implemented to improve services or outcomes for CCS clients and/or their families that could be scaled and implemented in counties statewide:

Case Management and Eligibility/Referrals/Annual Reviews

- Case management redesign and stratification of patients by level of case management needed
- Nursing clerical answering straight forward case management calls from families and providers swiftly giving answers
- Use of specialized nursing teams to improve the efficiency of evaluations & case management (e.g., dedicated team to review all new referrals (rapid eligibility determination team); dedicated team to do all NICU cases)
- We are tracking the NICUs and how long we are case managing clients before MCP picks up. We are tracking overdue annual renewals so they do not fall between the cracks. We are tracking the administrative call log of our case management time accrued.
- We have implemented an intake team to handle all new referrals coming in. The open referrals are handed off to the ongoing case teams to case manage.
- We have started meeting with families face to face in our office when working on getting them through the eligibility process and annually thereafter. It has helped to decrease lots of questions and gives them a face for CCS.
- We developed a "Lifetime Diagnosis List" that we use to auto-approve some AMRs.
- Local nurse has been doing additional authorizations and annual reviews due to difficulty in getting timely state approval. Broadening the local nurse's scope of duties.
- CCS PHN NURSE IS DOING ALL ANNUAL REVIEWS.

Care Coordination

- We are fortunate that we have been subcontracted by the Health Plan of San Mateo to administer the care coordination and utilization management for the Whole Child Model

Medical Home

- Medical home telephone survey to assess missing components of an assigned medical home and measures to address inadequacies; (3) Regional models of care for endocrine and rheumatology to connect special care centers with community level subspecialists to delegate care and enhance access;

Working with Providers

- Regular provider orientation sessions on CCS, SARs, billing, etc.) Provider outreach and site visits to identify transition resources
- The creation of a Provider Relations Committee that focuses on education, training, and information to any/all healthcare practitioners on a County level

Medical Therapy Unit

- Medical therapy unit public health nurses (this is not new but has been very effective for the family and the PHN) and the recently ended palliative care program.
- Implementation of a staff development and training unit for on boarding and educating consistently newly hired CCS staff
- We have implemented an approach to medical therapy eligibility determination that has reduced the time it takes to get our MTU clients from the registration process to the MTU.

Briefly, we have developed a team that meets weekly to determine eligibility, process the case and assign an MTU in as few steps as possible. Present at the meeting are CCS physicians for eligibility determination and documentation, MTU staff for MTU assignment, Financial staff for application and financial work, Nurse staff for accessing EMR to allow for speedy determination of eligibility.

- We developed a process that has lowered our average age of MTU eligibility and significantly increased the number of children under 1 year of age made eligible for the MTU. We worked with our HRIF and Neuro teams to fully explain the ME requirements of the MTU and the documentation necessary based on their exam for a child to be made eligible. We developed a Therapy Team (described above) to act more nimbly to determine eligibility. When needed we reach out directly to the provider or send them a specific request for missing documentation. Once we have documentation that establishes MTU eligibility for an under 3 client we quickly move those children to MTU assignment. As the HRIF and Neuro teams have become more familiar with the exam required for these babies, our ability to get them to the MTU has moved the needle toward a younger age of eligibility to allow the MTU team earlier interventions.

Whole Child Model

- Coordination with FQHC which includes weekly telephone calls
- We have sent out info regarding M&T and how to contact MTM. We have sent out letters to families regarding their Medi-Cal lapsing. WCM issues call log to keep track of problems. Open communication with PHP.
- We have looked a scopes of work to save time of the different disciplines. Also, we have reduced the back and for in the intake unit between clerical and nurse. The nurses to more eSARs
- We collaborate with the MCMCP in our area to provide optimal services and quite frankly, we are training the MCMCP in CCS.
- Continue to keep the lines of communication opened with Partnership; work with the other WCM counties to implement changes.

Social Services and Transition support

- We are also working on developing our social services to include more transition support and support groups for clients and caregivers.
- Offering transition appointments in MTC - including PHN, SW, Therapy staff, MD.

Intercounty transfers

- Intercounty transfer document. This info is used to eliminate interruption of treatment and services when a client moves to another county and hasn't been enrolled into the managed care plan.

Administrating CCS

- Created a 5-year strategic plan, incorporating a SWOT analysis of County issues to overcome. Resulted in several pivotal areas of focus including a paperless initiative to digitize all records and expedite communication with health partners and other counties.
- We are working on engaging the managed care plans in a regional solution for resources for private duty nursing.
- Established communication between northern counties to discuss issues and concerns and work for consistent implementation of policy and practices.
- We continue to make improvements within our county, mostly focusing on quality improvement and more efficient processes.

Family Engagement and Community Outreach

- Another area has been the outreach efforts which resulted in a Community Outreach Workforce to integrate into the community through families, schools, and non-medical entities to educate and inform about services within CCS;

- We have also focused on areas where we need to improve, such as family engagement.
- We are still small enough although really increasing our numbers to talk with families to walk them through issues and or see them at home from time to time.
- We personally talk with all our families!!
- We work really hard to attend as many IEP/IFSP meetings as possible for our CCS children. We have created a release of records with our school nursing staff to collaborate on children with special health care needs. By creating this open communication, the school professionals can be aware of all the medical needs, resources can be identified, and the school services can match medical services. All of this works to improve the quality of life and feeling of normalcy for the child in school and around peers.
- Home visits are important for some CCS clients to better understand the needs of the client, if funding could be increased to implement a home visit for some of the more critical cases CCS families may stay out of the hospitals and lower overall costs to the state

Length of time spent as a County CCS Administrator:

- The average amount of time spent as a CCS Administrator or within CCS of the respondents that answered this question was about **8 years**
- The shortest amount of years worked was **less than half a year**, and the longest was **23 years**