	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1318</p>	<p>Lead Department: Care Management</p>
<p>Title: Pediatric Complex Case Management</p>	
<p>Original Date: 4/22/2021</p>	<p>Date Published: 02/26/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

Purpose:

To define the Central California Alliance for Health (the Alliance) Care Management, Complex Case Management program and process for identifying pediatric members for Complex Case Management (CCM).

Policy:

The Alliance will provide Complex Case Management and Care Coordination in collaboration with a Primary Care Provider (PCP) to members with high risk or more complex health care needs. The Alliance uses a variety of sources to identify members who may benefit from CCM services. CCM is provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. CCM includes Basic Case Management.

Definitions:


California Children's Services (CCS): CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through the Medical Therapy Unit (MTU).

The Alliance has executed a Memorandum of Understanding (MOU) with each of the county CCS Programs within its service area. The MOUs delineate the roles and responsibilities of both the Alliance and the CCS Program for coordinating care and ensuring the non-duplication of services.

California Children Services (CCS): Provider: means any of the following Providers when used to treat Members for a CCS condition:

- A. A medical Provider that is paneled by the CCS program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.
- B. A licensed acute care hospital approved by the CCS program.
- C. A special care center approved by the CCS program.

Care Coordination: are services included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person-Centered Planning and Discharge Planning, and are included as part of a functional Medical Home.

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Case Management: is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates care plans designed to optimize members' health care across the care continuum. It includes empowering members to exercise their options and access the services appropriate to meet their individual health needs, using communication, education, and available resources to promote quality outcomes and optimize health care benefits. The Alliance is contractually responsible for providing Comprehensive Case Management, including coordination of care, to ensure the provision of all medically necessary services, whether those services are delivered within or outside of the Alliance's provider network. The Alliance provides Comprehensive Case Management for medically necessary services, including both basic and complex case management.


CCS Case Management: involves case management and care coordination. CCS Case Management is a Member and family centered care approach to ensure needed clinical and non-clinical services for the CCS-Eligible Condition, are made available to each WCM Member through comprehensive, interdisciplinary, and person-centered care management and Care Coordination provide case finding, authorizations for services and Care Coordination to ensure that WCM Members have access to CCS paneled Providers, equipment, and services necessary for treatment of the CCS-Eligible Condition.

All WCM members will be assigned a Pediatric Complex Case Manager (CCM), who will service as the point of contact for the provision of case management services and the facilitation of care coordination. This may include other care managers and service Providers that serve WCM members, such as Enhanced Care Management and Community Supports providers. When members are eligible and choose to receive both CCS Case Management, the Alliance may assign some or all functions to be delivered by a qualified ECM provider. Additionally, if the WCM member is also enrolled in ECM through Medi-Cal, the individual care plan must also be referenced in ECM-related care management activities.

Complex Case Management: is the systematic coordination and assessment of care and services provided to members by a multidisciplinary team. The core team includes:

1. PCP/The Patient Centered Medical Home (PCMH);
2. Nurses;
3. Social Workers;
4. Care Coordinators;
5. Health Educators;
6. Registered Dietitian;
7. Medical Directors; and
8. Pharmacists.

Complex Case Management (CCM): is provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. Pediatric Complex Case Management is administered by Alliance CCM staff who have knowledge of, and receive adequate training on the CCS program,

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and have clinical experience with CCS-eligible members or pediatric patients with complex medical conditions.

High Risk Infant Follow-Up Program (HRIF): The HRIF program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. The Alliance is responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.


Medical Therapy Program (MTP): The MTP is a program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders. PT and OT services are provided at Medical Therapy Units (MTUs). MTUs are outpatient clinics located in designated public schools. The Alliance makes referrals to

and coordinates with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services, and other non-MTU services.

Person-Centered Planning: is a highly individualized and ongoing process to develop individualized care plans that focus on a member's abilities and preferences. Person-Centered Planning is an integral part of Basic and Complex Case Management and Discharge Planning.

Procedures:


1. Complex Case Management: Alliance members are identified for participation in Complex Case Management (CCM) services based on the following criteria:
 - a. Utilization patterns, based on medical, pharmacy, and/or claims analysis;
 - b. Hospital ED and readmission data;
 - c. Quality studies and reports;
 - d. Internal Alliance referrals
 - e. Provider, case manager, and self-referrals; and
 - f. Health Information Forms (HIFs) and Health Risk Assessments (HRAs) or Pediatric Health Risk Assessments (PHRAs) on newly enrolled Alliance members and members with CCS eligibility. These are Department of Healthcare Services (DHCS) approved screening tools to identify the needs of all newly enrolled Medi-Cal members within 90 days—or sooner—of their enrollment.
2. Health Risk Assessments for Pediatric Members with Disabilities:
 - a. The Alliance will identify all newly enrolled Seniors and Persons with Disabilities (SPD) members and will attempt to contact them within 44 days of enrollment to complete a DHCS approved HRA tool. A DHCS-approved Pediatric HRA (PHRA) will be utilized for non-CCS SPD members under the age of 18 and all CCS SPD members up to age 21.

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- b. Each response on the HRA/PHRA tool will be scored, and the total score will be used to stratify members as low or high risk.
- c. Low risk members will receive Basic Case Management services from their PCP through the Patient Centered Medical Home, as outlined in Alliance Policy 405- 1312 - PCP Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.
- d. High risk members will be offered CCM services from the Alliance, in collaboration with the PCP.
- e. SPD members will be reassessed for the need for CM assistance at least annually, or as needed based on a change in condition(s) or need for support.

3. Pediatric CCM: PHRA for Members with CCS Eligibility:

- a. The Alliance will identify all members who may qualify for CCS eligibility and will work with the applicable County CCS Program to receive an eligibility determination.
- b. When CCS eligibility is suspected or confirmed, the Alliance will utilize a DHCS- approved stratification process to classify the member as being low risk or high risk within a minimum of 45 days. The stratification will focus on the following elements:
 - i. Review of medical utilization and claims processing data, including data received from the county and DHCS.
 - ii. Utilization of existing member assessment or survey data; and
 - iii. Telephonic or in-person communications, if available at the time of review
- c. If the member has no previous data or assessments to leverage for the risk stratification process, the member will automatically be categorized as high-risk until such time as additional data or assessments can be utilized to make a risk determination.
- d. Members who are identified by the stratification as being high risk will be assigned to an RN Case Manager for CCM services. The RN Case Manager will conduct the PHRA within a minimum of 90 days of enrollment and/or confirmation of CCS eligibility, to confirm the member's status as high risk. If the member is re-determined to be high risk, the RN Case Manager will use the information from the PHRA to develop an individualized care plan for the member. If the PHRA determines that the member is low risk, then we offer case management services.
- e. Members who are identified by the stratification as being low risk will be assigned to a Care Coordinator. The Care Coordinator will complete the PHRA within a minimum of 120 days of enrollment and/or confirmation of CCS eligibility to confirm the member's status as low risk. If the member is re-determined to be low risk, the Care Coordinator will offer assistance with any

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unmet needs. If the PHRA determines that the member is high risk, then the Care Coordinator will offer CCM services and will transfer the case to the RN Case Manager if accepted by the member/family.

- i. A member's risk level can be reassigned at any time, based on changes in the member's condition(s) or need for support.


The Alliance will refer members to local county CCS programs if members are suspected of having a MTP eligible condition. As a part of the CCS eligibility review, local county CCS programs review and determine MTP eligibility.

Referrals for medically necessary specialty services and follow-up treatment, as prescribed by the MTU Conference Team Physician are submitted by the MTP.


- f. The Alliance assumes responsibility of coverage for PICU/NICU eligible newborns through their second month of life when the newborn's mother is Medi-Cal eligible and an enrolled member. The Alliance reviews authorizations and determines if services meet CCS NICU requirements.

4. **Pediatric Complex Case Management Services:** The Alliance Pediatric Complex Case Management team will engage pediatric members and their families/caregivers in-person and via written, telephonic, and/ or electronic communications. Members that are deemed high risk are contacted within 30 days to opt into the voluntary Pediatric CCM services, which shall include:

- a. A comprehensive pediatric health risk assessment to establish an initial care plan and goals. The assessment will be conducted by appropriately licensed and qualified individuals. The assessment will draw general conclusions about the individual's ability to fulfill their care plan and achieve optimal health for their current state and abilities.
- b. Some aspects of the assessment may not be appropriate for pediatric members, such as activities of daily living for infants. In this case, the qualified assessor will not this in the member's assessment. It's permissible for parents and caregivers to assess health status for young children.
- c. The assessment includes:
 - i. General Health Status and clinical history. The clinical history will also include an assessment as to whether the condition is stable/controlled or otherwise. Past procedures, medications, hospitalizations and ED visits. Note: the Case Manager will make a reasonable attempt to elicit dates from the member and their family/caregivers.
 - ii. Current medications, including dosage, route and frequency
 - iii. self-reported health status, as is developmentally appropriate Information on events leading up to the need for complex case management
- iv. Assessing Cognitive function in context of the member's developmental Milestones

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- v. Assessing history of behavioral health hospitalizations and visits as developmentally appropriate
 - vi. Assessing substance use, including tobacco use, as developmentally appropriate
 - vii. Primary Care needs, including linkage to a PCP/medical home
 - viii. Specialty Care needs and history related to a CCS diagnosis, if applicable;
 - ix. Screen for activities of daily living or daily functioning and assessing motor developmental milestones as appropriate;
 - x. Mental Health status;
 - xi. Durable Medical Equipment needs, if applicable;
 - xii. Social Determinants of Health (SDOH) for member and family; which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals, including transportation and housing. The CM will assess for at least two SDOH domains.
 - xiii. Cultural beliefs (which may impact the member's health);
 - xiv. Member and caregiver's primary language spoken at home;
Life Planning Activities: Assessing if caregivers have life planning in place for member and offer life planning resources as appropriate;
 - xv. Visual and Hearing Needs, Preferences, or Limitations. These include inquiring about glasses use, hearing aid use and any congenital or perinatal issues which may impede the pediatric members audio/visual processing.
- d. Intense coordination of resources to promote optimal health and function. This will include assessing the adequacy of the member's health benefits regarding the ability to fulfill members treatment plan and determine whether the resources available to the member are adequate to fulfill the treatment plan. It may include but is not limited to, behavior health, Durable Medical Equipment (DME), Physical Therapy, Speech Therapy, Occupational Therapy, and more.
- e. Community Resources are assessed for eligibility and availability to determine eligibility and appropriateness. This will include but is not limited to, community mental health, transportation, wellness organizations, palliative care programs, and nutritional support. The CM will assess both eligibility and availability of the given program for the member, should a community program be deemed relevant for the member.
- f. An Individual Care Plan (ICP) that is developed specific to the individual needs identified in the assessment, in collaboration with both the member and the PCP. The ICP will have specific, measurable and timebound goals and prioritization of goals (high, medium, low). Resources to be utilized, including appropriate level of care. Planning for continuity of care, including transition

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of care and transfers between settings. Collaborative approaches to be used, including encouraging and documenting level of family participation. The ICP will include measurable objectives and timetables to meet the needs for the services listed below.


- g. As part of the care planning process, the case manager will identify potential barriers associated with completion of the care plan.
- h.
 - i. The Alliance will coordinate services identified in the member's ICP including:
 - 1. Primary and preventive care services with specialty services
 - 2. CCS Approved Special Care Centers (SCCs), which provide diagnostic and/or treatment services for CCS medically eligible conditions in inpatient and outpatient settings
 - 3. MTU
 - 4. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, including palliative care
 - 5. Regional center services
 - 6. Home and community-based services
 - 7. High Risk Infant Follow-up Program:

Age-Out Planning: The Alliance identifies and tracks CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the Alliance, for at least three years after they age-out of the WCM program, to the extent feasible. The Alliance uses report based on CCS eligibility to identify members aging out at age 17, if not yet already identified.


Subsequently, the Alliance develops a Care Coordination plan to assist the member in transitioning out of the CCS Program. Those members are followed accordingly, and case management is provided as noted below. Once members turn 21, a warm hand off is provided to the adult care management team. The adult care management resumes the established plan of care and care coordination for at least 3 years post age out, tailoring the case management to the member's needs.

Within 12 months of a CCS member aging out of the program, the Alliance develops a Care Coordination plan to assist the member in transitioning out of the CCS Program. The plan includes, at a minimum:

- a. Identifying the Member's CCS-Eligible Condition;
- b. Planning the needs of the Member to transition from the CCS Program;
- c. A communication plan with the Member in advance of the transition;

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- d. Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS qualifying condition(s); and
 - e. Continued assessment of the Member through first 12 months of the transition.
- 8. Pediatric Provider Phase-Out: The Alliance provides care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the services of a pediatric provider.
- ii. In addition, the ICP will facilitate a member's ability to access community resources and other agencies, including referrals for behavioral services (family history) such as specialty mental health services and substance use (family history for infants and young children) disorder services, and/or referrals for regional center services, as appropriate.
- iii. The ICP will be completed within 90 days of the assessment for all high-risk members and transitioning members. CCM will assess the progress of member against the ICP to determine if member is progressing against their goals.
- i. The Alliance will provide ongoing information, education and support so that the pediatric member's family understands the goals, treatment plan, and course of care for their child or youth. To help members manage a condition and are based on instructions or materials provided to them or to their caregivers. This includes:
 - i. The family's role in the Case Management process, including the amount, type, and strength of bonds between the member and caregivers to ensure it is sufficient for member;
 - ii. Health education which will allow the member and/or caregivers to help self-management the member in a home environment.
 - iii. What it means to have primary or specialty care for their child or youth;
 - iv. When it is time to call a specialist, a primary care doctor, or seek urgent or emergency care;
 - v. What an interdisciplinary team is; and
 - vi. What community resources are available, including local family resource centers or empowerment centers, Regional Centers, and other support services. If members under the age of 21 are not eligible or accepted by a Regional Center or local government health program for Targeted Case Management (TCM) services, the Alliance ensures access to comparable services under the EPSDT benefit.ⁱ
- j. Case managers will develop and communicate a follow up schedule to assess

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members progress against their care goals. Members will be contacted and reassessed/monitored as appropriate to their condition and as needed based on risk stratification, while they are being case managed by the Alliance Pediatric Complex Case Management team.


i. The follow up includes the following:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.
- Self-management support.
- Determining when follow-up is not appropriate.


k. Members may be discharged from Pediatric CCM services when the member achieves the ICP goals; when the member is no longer determined to be high risk and whose needs would be met through a lower level of intervention; when the member requests disenrollment from CCM services, or if the member is unable to be contacted. The Alliance will notate denial in the member's medical record as evidence of compliance.

l. A member may re-enroll in CCM services at any time.

5. Primary Care Provider (PCP): The PCP provides both Basic Case Management services and Complex Case Management services to members. These responsibilities are referenced in Alliance Policy 404-1313 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.
6. CCS Public Health Nurse Case Management and Care Coordination: The Alliance will allow a Member eligible for CCS to continue to receive case management and care coordination from their current CCS public health nurse unless this requirement is waived by DHCS in accordance with Welfare and Institutions Code, Section 14094.13(h). The Member or the Member's parents, custodial parents, legal guardians, or other authorized representatives, must make the request to continue with their current CCS public health nurse within 90 days of their transition to the Whole Child Model, in accordance with Welfare and Institutions Code, Section 14094.13(e) and (f).
7. Care Management and Care Coordination for the CCS-Eligible Member Across the Health Care System: The Alliance provides care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams, and as well as coordination of care plans across specialties including mechanisms to track completion of follow up visits, if applicable.

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- a. The Alliance makes good faith efforts to confirm whether members receive referred treatments and documents when, where, and any next steps following treatment. If a member does not receive referred treatments, the Alliance follows up with the member to assist in planning next steps in care coordination. identifies barriers and adjusts referrals, if warranted and appropriate. The Alliance attempts to connect with the provider to whom the member was referred to and may facilitate a warm hand off to necessary treatment, as well as follow up to determine if members acted on referrals.
- b. The Alliance provides case management and care coordination, including referrals to subspecialists, if not previously referred by the Primary Care Physician (PCP), and service authorizations for CCS-eligible members and their families.
8. **Data and Information Sharing:**
 - a. Inter-County Transfer (ICT): The Alliance works with the county CCS programs for the exchange of ICT data. When the Alliance receives notification of an ICT, the Alliance verifies member address change and completes transfer documentation, sending ICT data including medical records and case management information to ensure an efficient transition of CCS members and allow for continuity of care of already approved service authorization requests.
 - b. Determinations and Redeterminations: The Alliance works with the county CCS programs in sharing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed for each CCS-eligible member. If the County CCS Program is missing documentation for the annual medical redetermination, The Alliance will provide all available documentation. This may include documented attempts to obtain the required documentation, no later than 60 calendar days before the member's program eligibility end date, unless the County CCS Program confirms that all necessary medical information is already available or not needed.
 - c. NICU Acuity Assessment: The Alliance reviews authorizations and determines if services meet CCS NICU requirements and refers to the county CCS program all members identified as meeting the criteria for the NICU acuity assessment in order to capture the CCS referral.
 - d. High-Risk Infant Follow-Up Program: The Alliance refers to the county CCS program all members identified as High-Risk Infant Follow-Up (HRIF) in order to capture the CCS referral.
 - i. The Alliance notifies the county CCS program in writing of all CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services within 15 calendar days of the loss of coverage.
9. Screening and Referrals: See Alliance Policy 405-1319 "Screening and Referral of


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Medically Eligible Children to California Children’s Services Program” for further details. The Alliance provides screening, diagnostic, and treatment services in accordance with APL 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL, to identify potential CCS-eligible members. The Alliance will promptly refer potential CCS-eligible members to the County CCS program for a CCS eligibility determination if the members:

- a. Demonstrates a potential CCS eligible condition(s) as outlined in the CCS Eligibility Manual, including members who are suspected of having possible CCS condition(s) resulting from diagnostic services or who are undergoing diagnostics for CCS;
- b. Presents at the Emergency Department, provider, or facility for other primary conditions, and demonstrate a potential CCS eligible condition(s); or
- c. Demonstrates a potential MTP eligible condition.

The Alliance covers all medically necessary major organ transplants (MOT) for CCS-eligible members. The Alliance will directly refer pediatric members or authorize referrals to a CCS-approved Special Care Center (SCC) for an evaluation within 72 standard hours of the member’s PCP or specialist identifying the member as a potential candidate for the Major Organ Transplant (MOT). The Alliance authorizes the request for MOT after the SCC confirms that the member is a suitable candidate for the MOT. For more information, please see Alliance Policy 404-1723 Major Organ Transplant.

10. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT): The Alliance covers SABIRT services for members 11 years of age and older, including pregnant women as indicated. The Alliance identifies and refers members requiring treatment services to the County, or other resources as appropriate. The Alliance assists members in locating services in- and out-of-network, as applicable and treatment for SABIRT services is not to be contingent upon a referral.
 - a. SABIRT services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists.
 - b. The Alliance provides psychotherapy to members, through the Plan’s Managed Behavioral Health Organization (MBHO), to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder.

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References:

Alliance Policies:

- 401-1505 - Childhood Preventive Care
- 404-1201 - Authorization Request Process
- 405-1319 - Screening and Referral of Medically Eligible Children to California Children's Services (CCS) Program
- 405-1312 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home
- 405-1313 - Adult Complex Case Management
- 404-1723 - Major Organ Transplant Authorization Process
- 405-1112 - Care Management of Seniors and Persons with Disabilities for Medi-Cal
- 408-1305 - Behavioral Health Services
- 405-1306 - Community Care Coordination Services

Impacted Departments:

- Utilization Management
- Member Services Pharmacy
- Provider Services
- Quality Improvement and Population Health

Regulatory:

- Medi-Cal 2020 waiver

Legislative:

Contractual (Previous Contract):


- Medi-Cal Contract, Exhibit A, Attachment 10, Provision 8.B. (MMC Final Rule)
- Medi-Cal contract, Exhibit A, Attachment 11, Provision 2.A - 2.D
- Medi-Cal contract, Exhibit A, Attachment 18, Provision 11.A - 11.E
- Medi-Cal Contract, Exhibit E, Attachment 1
- Medi-Cal Contract, Exhibit E, Attachment 3, Provision

Contractual (2024 Contract):

- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.7
- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.9
- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.14

DHCS All Plan Letter:

- APL 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities
 - APL 21-015 Attachment 2 Major Organ Transplant
 - APL 21-014 - Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
 - APL 21-013 - Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans.
 - APL 22-006 - Plan Responsibilities for Non-Specialty Mental Health Services
 - APL 24-015 - California Children's Services Whole Child Model Program
- NCQA (Effective 08/29/2024):

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PHM 5C NCQA

Supersedes:

APL 23-034 CCS WCM Program was superseded by 24-015

Other References:

WCM NL 10-1224 - California Children's Services Whole Child Model Program

Attachments:

Lines of Business This Policy Applies To

- ☐ DSNP
- ☒ Medi-Cal
- ☐ Alliance Care IHSS

LOB Effective Dates

(01/01/2026 - present)

(01/01/1996 - present)

(07/01/2005 - present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
10/11/2021	10/11/2021	Tammy Brass, RN UM/CCM Manager	UMWG
01/18/2022	01/18/2022	Tammy Brass, RN UM/CCM Manager	UMWG
06/07/2022	06/07/2022	Paige Harris UM/CCM RR Supervisor	UMWG
7/26/2022	7/26/2022	Paige Harris, Regulatory Reporting Supervisor	UMWG
03/24/2023	03/24/2023	Jennifer Mockus, Community Care Coordination Director	UMWG
07/02/2024	07/02/2024	Kelsey Riggs, RN, Complex Case Management Manager - Pediatric (RN)	UMWG
08/29/2024	08/29/2024	Kelsey Riggs, RN, Complex Case Management Manager - Pediatric (RN)	UMWG
01/16/2025	01/16/2025	Kelsey Riggs, RN, Care Management Director	UMWG

ⁱ DHCS Medi-Cal Contract [Amendment 43], Exhibit E, Attachment 1 - Definition, Part N.

ⁱⁱ DHCS APL 22-006