MetaStar
GUIDING CHANGE IN HEALTH CARE SINCE 1973

Children with Medical Complexity (CMC)
CY 2026 Record Review

Section 1: Eligibility and Enrollment

Indicator	Indicator Label	Indicator Description
1.1	Member met the eligibility requirements of the program	Measures compliance with eligibility requirements for the CMC program by confirming that children under age 26 have chronic health conditions involving three or more organ systems and requiring three or more specialists, along with meeting specific healthcare utilization criteria or anticipated future needs. Applies only to members newly enrolled during the review period.

Section 2: Initial Comprehensive Assessment

Indicator	Indicator Label	Indicator Description
2.1	Initial comprehensive assessment included all required criteria	Ensures the initial comprehensive assessment includes a review of the member and family's strengths, concerns or priorities, family goals for case management, scheduling preferences, review of medical records, equipment and technology usage (as applicable), who lives at home/who is involved in the member's care, resources needed for education and developmental needs, social and community context (informal supports), and neighborhood and home environment, Applies only to members newly enrolled during the review period.
2.2	At least three sources provided input into the initial comprehensive assessment	Measures a comprehensive assessment by obtaining input from at least three sources, such as the member's family, medical providers, social workers, county workers, secondary caregivers, or educators; reviewing medical records also counts as input from medical providers. Applies only to members newly enrolled during the review period.

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Section 3: Care Plan

Indicator	Indicator Label	Indicator Description
3.1	The initial care plan was developed within 30 days of the enrollment date	Ensures the initial care plan within 30 days of the member's program enrollment date. Applies only to members newly enrolled during the review period.
3.2	The care plan was updated at minimum of every six months	Ensures the care plan is reviewed and updated at minimum of every six months. Applies only to members that are enrolled six months or more.
3.3	Care plan included individualized and family-centered details	Confirms that the case manager develops a written care plan based on the comprehensive assessment, including a child summary, diagnosis and medical history with provider details, primary contact number and assigned complex care team, medication list, care staff, applicable community and educational supports, symptoms to monitor before hospital visits, and notes for the Emergency Department as needed.
3.4	The care plan included goals and specific actions to achieve it	Ensures the care plan includes goal(s) that address medical, social, educational/developmental, and other identified needs, with each goal supported by a course of action that is specific, individualized, and clearly aligned with the member's assessed needs. Actions must outline the steps to achieve the goal(s), reflect the nature of the goal (e.g., medical, social, educational), and demonstrate how progress will be made toward meeting the members' needs. Goals must be functional meaning: what is to be achieved and why, focusing on the positive outcome or benefit that will result from accomplishing the goal. It goes beyond just stating an action—it explains how meeting the needs will facilitate better outcomes for the member in their medical, social, and educational/developmental spaces.
3.5	An interpreter and/or translation services were utilized as appropriate	Confirms that interpreter services are provided when required or requested by the member or family, and that a translated copy of the care plan is made available in the member or family's preferred language.

		Applies only to members where the record identifies a language interpretation or translation need.
3.6	The care plan was distributed to the family and medical specialists	Verifies that the care plan is shared with the member/family in accordance with family preferences with documented evidence of distribution such as delivery receipts (e.g., hand delivery, postal mail, fax, email), provider notification of portal access, or a signature/attestation confirming receipt. The care plan must be made accessible to appropriate medical providers. Evidence of a shared care plan could be through hand delivery, postal mail, fax, email, etc. For hospitals that utilize an Electronic Health Record system, a policy/procedure or workflow document detailing the process of provider access to the care plan would suffice.

Section 4: Ongoing Monitoring and Service Coordination

Indicator	Indicator Label	Indicator Description
4.1	Service coordination occurred as required	Verifies that coordination and follow-up of referrals and member/family needs identified in the care plan, case notes, or task lists are conducted and documented. Referrals must be tracked from initiation through completion, with follow-up confirming that the referral addressed the intended need. Communication should reflect efforts to ensure the referral was helpful and identify any next steps when a member or family has a need or request.
4.2	Evidence of family contact	Assesses whether the care team maintains monthly contact with the family, and if a less frequent reciprocal contact is agreed upon, verifies that the justification is clearly documented in the member's record.
4.3	Evidence of rounds during inpatient hospital stay	Ensures the care team makes rounds during members' inpatient hospital stay. Applies only to members hospitalized during the review period.
4.4	Attempts made to contact family after hospitalization	Evaluates whether the care team contacts the member or family within three business days of

		hospital discharge, and if contact is not made within that timeframe, confirms that the reason, attempts, and communication methods used are documented in the member's record. Applies only to members hospitalized during the review period.
4.5	Evidence of timely and comprehensive hospitalization follow-up	Assesses whether the care team contacts the member or family within three business days of hospital discharge, and if contact occurs later, confirms that the reason is documented in the member's record. Additionally, verifies that the care team reviews discharge instructions, medication or equipment adherence, and symptoms to monitor with the member or family, or documents if the family declines to discuss these elements. Applies only to members hospitalized during the review period.
4.6	Evidence of ongoing supportive contacts	Validates that, when requested and appropriate, the care team attends specialty appointments, arranges acute care visits, communicates with medical providers on behalf of the member, and contacts other collateral supports such as service or program providers. Only applicable when case notes and other documentation reviewed identifies these were needed or occurred.

Section 5: Transition Planning

Indicator	Indicator Label	Indicator Description
5.1	Evidence of program disenrollment steps	Confirms that when a member graduates from the CMC program or transitions to adult specialists, the care team completes program disenrollment steps, including identifying the member's adult primary care provider or other specialist designated by the family, ensuring an up-to-date provider listing is available, and documenting discussions with the member and family about preparing for disenrollment. Applies only to members who exit the program for graduation or due to transitioning to adult specialists during the review period.

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Section 6: Expanded Practices

Indicator	Indicator Label	Indicator Description
6.1	Quality of Life	Identifies qualitative examples of involvement in the community when applicable.
6.2	Family Advocacy	Identifies qualitative examples of increasing family knowledge and skills when applicable.
6.3	Clinical Practice	Identifies qualitative examples of coordinating medical care when applicable.