

**California Children's Services (CCS) Redesign  
Health Homes, Care Coordination, and Transitions  
Technical Workgroup (TWG)  
Kick-off Webinar Summary Notes  
Thursday, March 26, 2015, 9-11am PST**

The complete recording of this webinar and final PowerPoint slides are available [here](#).

Health Homes, Care Coordination, and Transitions TWG Co-chairs: Jill Abramson, MD (DHCS), Hannah Katch (DHCS), Jess Schumer, MD (UCLA)

Health Homes, Care Coordination and Transitions TWG Members: Kris Calvin (American Academy of Pediatrics, CA), Richard Chinnock, MD (California Specialty Care Coalition), Juno Duenas (Family Voices), James Gerson, MD (HealthNet), Brian Hansen (DHCS - Managed Care Quality and Monitoring Division), Domonique Hensler (Rady Children's Hospital – San Diego), Erica Jewell (Miller Children's Hospital/Long Beach Memorial Medical Center), Carol Kurushima (Valley Children's Hospital), Susan Mora (CMS - Riverside County Department of Public Health), Katie Schlageter (Alameda County CCS), Christopher Wecks (CCS parent), Amy Westling (Association of Regional Center Agencies)

Welcome and Introductions

Michaela Ferrari (UCLA) welcomes the TWG members to the call, introduces the co-chairs, takes roll to see who is present, and encourages everyone on the webinar to submit nominations for CCS parents/caregivers who may want to participate in the TWG.

She then introduces Jess Schumer, MD (UCLA), to review the goals and purpose of the Health Homes, Care Coordination, and Transitions TWG.

Dr. Schumer reviews the main directive of the TWG, which is to develop specific recommendations for implementing health homes and improving care coordination and transition planning for CCS enrollees. In that vein, she suggests that TWG members' input on three specific questions will be requested today and in the coming weeks:

1. What are the essential elements of a medical/health home for children with CCS-eligible conditions, and what are the considerations for location of those homes (in specialty vs. primary care clinics, in urban vs. rural locations, etc.)?
2. How should the MTP and specialty care centers be included in the redesign efforts?
3. What are the essential elements of a transition plan, and what entity(ies) should be responsible for their creation?

With those questions in mind, Dr. Schumer notes that DHCS and UCLA are requesting TWG members' feedback on three specific documents, as they relate to health homes, care coordination, and transitions. Anastasia Dodson (DHCS) suggests that these documents should be viewed as "building blocks" to start from, and that TWG members should think about

what the essential elements of an organized system of care *are*, and of those elements, what is missing from those documents and needs to be added in:

1. [Packard's Summary "Standards for Systems of Care for Children and Youth with Special Health Care Needs"](#)
2. [The 2011 CCS Pilot Request for Proposals \(RFP\)](#)
3. Subject-relevant terms in UCLA's CCS Redesign Definitions Document

All materials were sent to members of this TWG via email on March 25, 2015, and feedback is requested by April 3, 2015.

#### California Health Homes for Patients with Complex Needs (HHPCN) Presentation

Dr. Schumer then introduces Brian Hansen (DHCS), to present on DHCS' work to implement the Affordable Care Act's (ACA) Section 2703 HHPCN Program. Mr. Hansen notes that all of the information in his presentation is from DHCS' November, 2014 draft concept paper, available [here](#). Mr. Hansen gives an overview of Section 2703, which creates an optional intensive care coordination benefit for Medicaid enrollees with chronic conditions. The program, which is 90% federally funded for the first eight quarters, pays for a package of six care coordination services (but not direct medical or social services). Mr. Hansen then describes California Assembly Bill (AB) 361, which authorizes the State to implement Section 2703 (federal legislation). The State's bill allows flexibility in how the program is implemented, but does require evaluation within two years of implementation, specifies that no additional General Fund money can be used, and requires the inclusion of frequent health care utilizers and those experiencing homelessness as part of the target population (along with providers experienced in caring for such populations).

Mr. Hansen then outlines the goals of both California and Medi-Cal in implementing HHPCN. He notes that the State's goals align closely with the Triple Aim, with some additional Medi-Cal objectives, which include:

1. Ensure sufficient provider infrastructure and capacity to implement HHPCN as an entitlement program
2. Ensure that health home providers appropriately serve members experiencing homelessness
3. Increase integration of physical and behavioral health services
4. Create synergies with the Coordinated Care Initiative (CCI) in the eight participating counties
5. Maximize federal funding while also achieving fiscal sustainability after eight quarters of federal funding

Keeping that in mind, Mr. Hansen reiterates that the focus of CA AB 361 and DHCS' proposal is on frequent utilizers of health services and those with chronic conditions that are likely to be responsive to intensive care coordination (including those with Serious Mental Illness (SMI) and Substance Use Disorders (SUD)). Their goals are to reduce inpatient stays, ED visits, and

negative health outcomes, and improve patient engagement. Care coordination will include coordination of behavioral health (BH) services and linkages to social services, such as supportive housing. A draft list of chronic physical and behavioral health conditions from the concept paper are noted. Mr. Hansen explains that acuity and intensity of service needs will be accounted for both in eligibility determination and tiering of services and payments. Geographic considerations are described, including the possibility for a phased-in approach to begin with the Coordinated Care Initiative (CCI) counties, with other counties to follow pending completion of the readiness review process.

The entities in the Health Home Network will be divided into three categories: the lead entity, or Medi-Cal Managed Care Plans, the community-based care management entities, and community and social support services. These entities will provide the six core care coordination services, which in California will include:

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care
4. Individual and family support
5. Referral to community and social support services
6. The use of HIT/HIE to link services, as feasible and appropriate

Mr. Hansen explains that DHCS is currently assessing the care coordination activities that are currently being provided by managed care plans, in order to avoid duplication of services. The intent is to provide complimentary services to create a “total package,” rather than being duplicative. The federal Centers for Medicare and Medicaid Services (CMS) have come up with a list of eight recommended quality measures; while they have not yet released regulations to codify these measures, they may do so in the future. In the meantime, DHCS is requesting stakeholder input on the State’s specific quality measures and evaluation plan.

Mr. Hansen then details the payment methodology, which will likely be a per-member, per-month (PMPM) capitation payment that accounts for tiering based on patient acuity. The lead entities (Medi-Cal Managed Care plans) would pay the care management entities, the details of which are still being worked out. He closes the presentation by walking through the timeline for implementation, starting with the design stage which began in September 2014, through the completion of the initial evaluation in January 2018. He notes that a revised version of the concept paper should be available in April 2015, and that they will continue to engage with stakeholders, plan partners, and follow the CCS Redesign process. He reminds everyone that more information is and will continue to be available at the Health Homes [website](#).

#### Health Homes Q&A with TWG Members

Hannah Katch (DHCS) thanks Mr. Hansen for his presentation, and reminds everyone that while there is significant overlap with some of the HPCN Program’s priorities and those of the CCS Redesign, there are many other health and medical home concepts that are successful and should be considered in the Redesign process. She also reminds listeners that the availability of the HPCN program will be limited to a specific population that will not include the entire

CCS population, and that the program will also be geographically limited in its initial stages. Ms. Katch then opens the discussion up for questions from the audience.

1. Juno Duenas (Family Voices) asks the speakers how the consumer is involved in the model Mr. Hansen presented. Mr. Hansen responds that there will be care managers to work directly with the consumers, and that the consumer will be involved in creating their own care plan with the aforementioned care manager. Ms. Dodson adds that as it relates to CCS patients, the model would also involve parents and families of the enrollee. Ms. Duenas reminds everyone that it is important for patients to also be both decision makers in their own care, as well as in how the system works.
2. James Gerson, MD (HealthNet) asks if the Health Homes would be co-located with behavioral health providers. Mr. Hansen responds that there is no particular requirement for the health homes to be co-located, but rather the emphasis is on integration of care and on allowing patients to access primary care where they currently prefer to get care, which in some cases may be through a behavioral health provider.
3. Dr. Gerson asks a subsequent question about how the providers who currently operate on a fee-for-service (FFS) basis would be incorporated into the PMPM model that Mr. Hansen described. Mr. Hansen responds that the PMPM is about how DHCS pays the managed care organizations, but not about how the health plans pay the providers; they have not yet outlined any requirements for the latter. Dr. Gerson emphasizes that he thinks it would be difficult for the FFS providers to provide care management due to resource limitations and cost. Ms. Dodson responds that this is something they will take into consideration with the CCS Redesign, and reiterates that Mr. Hansen and Ms. Katch are specifically describing the ACA Section 2703 Health Homes model, not a CCS-specific health home.
4. Erica Jewell (Miller Children's Hospital/Long Beach Memorial Medical Center) suggests that the Section 2703 Health Homes population likely has higher acuity levels than most CCS enrollees, but that the CCS enrollees who are transitioning to adult care might be better suited to the care coordination provided by the HHPCN population. Ms. Katch reiterates that the CCS Redesign and HHPCN Program are somewhat parallel, but for those CCS enrollees who are also eligible for the HHPCN Program, it will be important to make sure that the combination of those programs' services are delivered effectively. In addition, there may be some helpful components of the HHPCN Program that the CCS Redesign can adopt or adapt.
5. Richard Chinnock, MD (California Specialty Care Coalition) asks if his understanding is correct that not all CCS patients would be in a Medi-Cal Managed Care plan (as there are some CCS-only enrollees), and that the HHPCN also would not include all CCS enrollees. Mr. Hansen confirms that this understanding is correct.
6. Christopher Wecks (parent representative), suggests that given the concern about adequate provider networks for CCS, a way of growing the networks "organically" after the Redesign is completed would be to allow health homes to refer to out-of-network providers, who could then become in-network providers through a more efficient paneling process. Ms. Dodson responds by acknowledging that provider networks are an important issue and noting that there is a CCS Redesign TWG devoted specifically to it, and that DHCS is aware that any changes in the CCS program have to be sensitive to enrollees being able to continue accessing their current providers. In addition, as far as new models and new children coming into CCS is concerned, the State wants to ensure that federal Health Home network

requirements and CCS network requirements intersect so that commonalities can be leveraged. Mr. Hansen reiterates that the HHPCN Program is a Medicaid entitlement benefit, so everyone eligible has to be able to access its services, hence wanting to leverage existing delivery system infrastructure.

7. Susan Mora (CMS – Riverside County DPH) asks about duplication of care coordination services, and Mr. Hansen clarifies that if a person were receiving two distinct sets of health home services, that would be prohibited. In many cases, such as the CCI, DHCS is hoping to leverage the existing care coordination being provided and add additional services as needed to make a comprehensive package.

Ms. Katch and Mr. Hansen close the Q&A portion by suggesting that stakeholders look at the HHPCN documents and submit feedback to DHCS about the considerations that need to be made for CCS enrollees who are also eligible for the Section 2703 HHPCN program.

### Title V Needs Assessment Update

Ms. Ferrari introduces Jill Abramson, MD (DHCS), to present on the results of the Title V Needs Assessment Survey as it pertains to health homes, care coordination, and transition for Children with Special Health Care Needs (CSHCN). Additional resources on the Title V Needs Assessment can be found [here](#). Dr. Abramson begins by clarifying that the Title V definition of CSHCN is broader than the CCS-eligible definition, but that there is a focus on the CCS program in California for the purpose of the block grants, and therefore the goals of the CCS Redesign and Title V Needs Assessment are overlapping.

Dr. Abramson notes that the purpose of the Title V Needs Assessment is to:

1. Assess both the health care needs of CSHCN in California, and the system of care for CSHCN
2. Establish what the Title V role is in addressing those needs
3. Assess Title V's progress toward meeting its [Six Core Objectives for CSHCN](#)

Dr. Abramson reviews the logic model for the Needs Assessment, noting that the focus of the presentation today will be on the survey results as they pertain to MCH population needs, program capacity, partnerships and collaboration. She describes the Needs Assessment methods, which were conducted with the help of the Family Health Outcomes Project (FHOP) at UCSF and consisted of key informant interviews, family, physician, and administrator/medical consultant surveys, focus groups, and data from the [National Survey of Children with Special Health Care Needs](#) (NS-CSHCN) and Children's Medical Services (CMS) Net. They also established a Title V stakeholder group that provided input on the surveys and focus groups.

Dr. Abramson notes the potential for response bias in the family survey, since it was administered by county CCS program staff, and the fact that regional response bias also exists – some regions are not adequately represented in the survey responses. She discusses the physician survey response rates, and notes that they tried to balance the regional variation in their focus group representation.

Moving onto the results of the Needs Assessment, Dr. Abramson first discusses family satisfaction with services, noting that the majority were either “very satisfied” or “satisfied.” Among those who expressed dissatisfaction, access to medical supplies was the biggest issue. Most respondents were also satisfied with the Special Care Centers and their case managers – if they knew they had one. Ninety-four percent of respondents said they have a primary care provider (PCP). Dr. Abramson notes a discrepancy in the number of diagnoses indicated from the survey data (3) compared with the CMS Net data (1.6), which she says is an important consideration for the CCS Redesign, suggesting that perhaps basing care in the Special Care Centers might not work well for enrollees with multiple diagnoses. She also goes on to note that the data seem to indicate that California fares worse in being able to get referrals for care compared with the national data (from NS-CSHCN).

Dr. Abramson then describes some of the areas of need discovered in the Needs Assessment. She again notes respondents’ difficulty access Durable Medical Equipment (DME), and details the various reasons given. In addition, lack of access to timely care – both from specialty and PCPs – particularly in rural areas leads to increased ED usage. Focus groups noted poor communication between primary and specialty providers from the parents’ perspective, particularly for enrollees with multiple conditions. Delays in payments to physicians for CCS services were also noted, along with difficulty in fulfilling the medical home concept. Finally, Dr. Abramson noted that only 28% of respondents with CCS enrollees aged 14 or older had their providers discuss transition with them, with physicians also noting difficulty finding providers who will care for adults with special health care needs who they can refer CCS enrollees to. Transition, then, in addition to interpreter services, are some areas of need to be taken into consideration in the CCS Redesign. Dr. Abramson closes with some very positive feedback from parents of CCS enrollees, and reiterates that the Title V Needs Assessment represents a broader population than just CCS, and that the CCS Redesign may be more focused on service delivery systems change rather than the whole public health system.

Ms. Dodson then notes that the next step should be to integrate the information gleaned from the Title V Needs Assessment with the work conducted in the CCS Redesign thus far, to translate all of the research into action.

#### Title V Q&A with TWG Members

Ms. Ferrari then opens up the conversation again for questions related to the Title V presentation, or to comments on health homes, care coordination, or transitions as they relate to the CCS Redesign generally.

1. Domonique Hensler (Rady Children’s Hospital – San Diego) asks Dr. Abramson for her opinion about what to do regarding the issue with patients’ difficulty accessing DME, as it is something Rady has struggled with. Dr. Abramson says it seems to be tied to the rates DME vendors are paid, in addition to the paperwork. Another respondent suggests that there should be a published list of CCS DME providers made available throughout the State so that enrollees know who they can access equipment from, particularly in rural counties.
2. Ms. Jewell comments that reimbursement is needed for transition education and coordination. She also echoes another respondent’s comments regarding duplication of services, in regard to the multiple programs and organizations providing case management services, and lack of standard for or coordination of those services. Dr. Gerson suggests that we should build off of the existing CCS case managers, and redefine and expand their roles beyond just administrative case management.

3. A comment from the chat box noted that network adequacy is a problem in rural counties.
4. Another comment from the chat box says that duplication of services often occurs when patients are referred to non-paneled providers by their CCS providers, which is frustrating for the families, the providers, the county, etc.

Ms. Dodson reminds everyone that DHCS is requesting written feedback on the three documents that were sent to TWG members, as they relate to health homes, care coordination, and transitions for CCS enrollees. She also notes that specific comments on stratification tools, care coordination partners, electronic medical records, etc. would be appreciated. Those comments are to be submitted by April 3 to Michaela Ferrari. Ms. Ferrari then introduces the Data TWG's Data Request Form, which can be submitted to her ([michferrari@ucla.edu](mailto:michferrari@ucla.edu)) by other TWG and RSAB members to request information to aid in their Redesign efforts.

Ms. Dodson thanks everyone for attending and closes the meeting.