

California Children's Service Redesign
Health Home Model Workflow Process
April 13, 2015

In order to more effectively serve the children and youth with special health care needs including those children eligible for the California Children's Services (CCS) program, Health Net recommends the use of the Health Home State Plan Option under Section 2703 of the Affordable Care Act in the Two-Plan and Geographic Managed Care Counties. The Health Home Option allows states to provide enhanced funding to target populations with chronic conditions in order to expand care coordination and supportive services. While states cannot limit the Health Home Option by age, DHCS could use the CCS diagnosis codes as the base of the targeted population or the more general consideration of one of more chronic conditions. This approach would also allow for the continuation of the Health Home after the child has aged out of the CCS program.

The designation of the Health Home for children in the CCS program would be a joint partnership between the CCS program and the Medi-Cal Managed Care Plan (MCP) in which the child is enrolled. The partnership will be maintained over the course of the child's enrollment in Medi-Cal; however, the locus of primary responsibility may shift as the child's condition changes. The engagement of both the MCP and the CCS program over the span of the child's eligibility for CCS will allow for a more effective transition between the programs and improve coordination of care.

As envisioned, the use of the Health Home could be expanded beyond CCS eligible children to other children with special health care needs that may not be eligible for CCS but require a higher level of medical management and care coordination.

We describe below the detailed process including the workflow from identification of the need to the care management process at the Health Home.

Step 1: Identification of a Child or Youth with Special Health Care Needs (CYSHCN) within a Provider Office

If child is identified by a Medi-Cal Managed Care (MMC) Primary Care Physician (PCP) in a delegated Preferred Provider Group (PPG) as potentially having one or more chronic conditions as a result of the Initial Health Assessment (IHA), the child will then be referred to the PPG's Care Manager (CM or Care Coordinator) to have a comprehensive biopsychosocial risk assessment.

If a child is identified by a MMC PCP that is in a fee-for-service direct network payment arrangement, the PCP completes the IHA to determine if the child has one or more chronic conditions, and then refers the child for a comprehensive biopsychosocial assessment by a designated Medi-Cal Managed Care Plan (MCP) nurse care manager.

If a child is identified by an entity outside of the MCP but is enrolled in an MCP, the child should be referred back to the PCP for an IHA and referral if indicated for full assessment.

Step 2: Referral to CCS Regional Office

Upon completion of the risk assessment, the child's case is referred to the CCS Regional Office to determine CCS eligibility. The IHA and medical records are provided to the Regional Office for full review of the child.

If the child is found eligible for CCS, the MCP and PCP are informed of the eligibility by the CCS Regional Office. If a child is not found eligible, a CCS medical director will review the denial and provide documentation to the MCP and PCP as to the reason for the denial and providing them with the right to appeal.

If an infant requires care in a Neonatal Intensive Care Unit, the child is directly referred to the CCS Regional Office for CCS eligibility. The CCS Regional Office is responsible for informing the MCP of the CCS eligibility determination.

If a child is not eligible for CCS but has special health care needs, the MCP will be informed of the denial. MCP will then assign an appropriate Health Home within the MCP's contracted network of providers and follow procedures detail in Step 4.

Step 3: CCS Eligible Children – Risk Stratification and Health Home Assignment

A CCS care manager will review all CCS cases and designate each child as high or low risk based on the acuity level and number of chronic conditions.¹

If the child's condition is acute and limited in nature, the child would be considered low risk. Health Home assignment would be made by MCP based on the provider requesting the initial CCS referral. The CCS condition would be treated by a CCS-paneled provider; however, the primary CM and responsibility for care for the child is retained within managed care.

If the child's condition is chronic in nature and the child is at risk for deterioration without significant specialty care intervention, a CSS paneled provider with the appropriate expertise would be assigned as the Health Home for the child.

- The CCS care manager acts as the primary care manager and has responsibility for developing a whole person/family-centered care plan, the development and scheduling of an Interdisciplinary Care Team (IDCT) and co-ordination of services.
- Care coordination responsibility is maintained by the CCS care manager.

¹ A standard risk assessment tool is needed. DHCS could consider requesting foundation support for the development of the tool or requesting assistance from NCQA.

- Services including preventive care, unrelated to the CCS conditions would remain the responsibility of the primary care provider (MCP).
- The MCP or delegated PPG would also assign a care manager to interact with the CCS care manager upon request and transition services when the child's conditions stabilize or the child is no longer eligible for CCS.

If the child's condition is chronic in nature but stable, the MCP will assign the child to a Health Home and maintain primary responsibility either directly or via its delegated PPGs for the child.

- The MCP or delegated PPG will assign a care manager, develop an ICP and schedule IDCT meetings as needed. The MCP will be responsible for assisting the family in accessing both CCS and MCP services and coordination between systems of care.
- CCS will maintain responsibility for all CCS covered services and the CCS care manager will continue to act in partnership with the MCP/PPG care manager as necessary.

Step 4: Care Management

All care managers with primary responsibility for the child shall perform the following tasks:

- Completes member/family centric Individual Care Plan (ICP) and needs assessment.
- Refer to appropriate specialist(s) including but not limited Home and Community Based Services, Medical Therapy Program, Regional Centers, and Behavioral Health Providers.
- Shares ICP with PCP and Specialist and other providers, as needed.
- Coordinates care between specialists, PCP and ancillary services.
- Arranges and is responsible for Interdisciplinary Care Team (IDCT) virtual meetings as needed with member/family, PCMH/Health Home, Specialist, ancillary providers, etc.
- Repeats ICP every 6 months or sooner if there is a change in the member's health condition.
- Assistance in transitions of care as well as planning for transitioning the child out of CCS when appropriate.

Step 5: Health Home Payment

DHCS shall pay for Health Home services depending upon the member's primary Health Home assignment.

- If the child is assigned to a CCS Health Home, DHCS shall pay the CCS provider a monthly fee-for-service case rate for each child within the Health Home.
- If the child is assigned to a MCP Health Home, DHCS shall pay a supplemental PMPM amount based for each child assigned to an MCP Health Home regardless of the child's eligibility for CCS.