



**Health Home Questions
From Dr. Robert Moser's Webinar
October 24, 2013**

Has the per-member per-month rate been decided yet?

No. The State's actuaries are working with the project team to determine that.

Will pharmacies have a role in this?

Absolutely. HH members will still receive pharmacy services from their established providers. Health Home services are provided in addition to all the other services a member receives under KanCare.

Is there a contract a pharmacy has to sign for this and information available on what our role is? Will the members be locked in to that pharmacy provider?

No. If you are already contracted for KanCare, you will continue to provide pharmacy services per usual to HH members. HH members will not be "locked into" certain pharmacies. People who are in HHs will continue to have the same relationships they already have with their physical and behavioral health care and long term supports and services providers.

Would a person with only a chronic physical (but no mental illness) be served by a CMHC who is an HHP?

They could be only if the CMHC meets all of the standards and qualifications for Health Home Partners (HHP) under the second State Plan Amendment (SPA) for people with diabetes or other chronic conditions and it contracts to be a HHP with one or more MCO. The person would also have to be assigned to the CMHC by their MCO and choose not to change to a different HHP.

Will individuals be able to receive targeted case management if they are in a HH?

No. The Centers for Medicare and Medicaid Services (CMS) have stated that targeted case management (TCM) and certain HH services are duplication, so a member who is eligible for HH services will need to choose to be in a HH or to receive TCM. The State has determined that, for people with intellectual or developmental disabilities (I/DD) who are also eligible for HHs, the HH must contract with the person's TCM provider to provide some HH service in lieu of TCM if the person chooses to be in the HH.

Has the role of the TCM for I/DD members been clarified?

Yes. See the response immediately above.

What about case management? Will participants in Health Home model be able to keep their current case manager?

Please see the response above.



How will TCM's in CSP's and independent case management agencies be affected by the Health Home Model?

HHs will be required to contract with any agency or individual that provides TCM to a person with I/DD who chooses to remain in a HH. That agency or person can also continue to provide TCM to other people with I/DD who are not in HHs.

If someone opts out of health home will similar services be available to them, i.e. TCM?
People with I/DD will still have TCM available to them if they opt out of HHs.

Do you have any guidelines regarding the ratio of members to specific providers in a health home, i.e. 500 members per RN at a CMHC?

No, although the actuaries are using some assumed ratios to help build the rate the State will pay the MCOs for HHs.

Are children included in the Healthy Home program or what ages are being considered for this program?

Any child who meets the definition of having a serious mental illness, outlined in the SPA (found here: http://www.kancare.ks.gov/health_home.htm), or who has a chronic condition outlined in the second SPA (still being written) will be offered a HH. Since both diabetes and asthma will be included in the second SPA, there will be a significant number of children eligible for HHs.

Will persons w/ cognitive delays but no mental health or physical health issues be automatically included in the July 2014 group?

No.

Will KS be using the CMS SMI definition as opposed to the current KS SPMI definition to determine the MH population needing to be identified?

The State has defined serious mental illness as a person who has one or more diagnoses listed in the SPA posted here: http://www.kancare.ks.gov/health_home.htm. States can define their HH target population how they want, within the limits of the language regarding HHs in Section 2703 of the ACA.

What services would fall outside of the health home and be reimbursed separately by the MCO?

Any physical or behavioral health service the person already can receive under KanCare, including physician, hospital and pharmacy services, mental health or substance use disorder services or home and community based services already covered in KanCare. If the person also receives home and community based waiver services, those also will continue to be reimbursed separately.

How will HHP representatives interface with MCO Care Coordinators? Who is "in charge"?

Given that HHs are to be person-centered, the person is in charge. Whichever half of the HH (MCO or HHP) provides care coordination will take the lead in monitoring the health action plan and ensuring services are well-coordinated and all providers involved are communicating with one another.



Can HH partners contract services out?

Yes, but they will need to be responsible for meeting the qualifications and standards outlined in the SPA. They could meet some of those through contracting out, but they will be held accountable by the MCO in the contract between the MCO and the HHP.

Please define your expectation for "comprehensive care management" (it appears from the diagram that this falls under the MCO responsibility). As the description provided by the MCOs in their published material, this is very encompassing, however, in my experience thus far, I have seen this function only as "pre-authorizations" but not the care management that encompasses the social determinants of health that so many of these beneficiaries lack.

The diagram you're referring to in the PowerPoint presentation is only for illustration purposes. There is not an expectation that the MCO will always provide comprehensive care management; the HHP may do so. Health Homes are expected to be intense and very focused care coordination. Comprehensive care management within the HH is defined in the first SPA as: Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from a HH, and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), Health Home partner (HHP), member, family/support persons/guardian, and health services and social service staff.

Critical components of comprehensive care management include:

- Knowledge of the medical and non-medical service delivery system within and outside of the member's area
- Effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers
- Ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc.
- Monitoring and follow-up to ensure that needed care and services are offered and accessed
- Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances

What is the expectation from the HHP for "care coordination" and what is reasonable reimbursement in your opinion to help fund this service?

Care coordination within the HH in the first SPA is defined as:

Implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a member's progress towards achievement of goals, and revising the HAP as necessary to reflect the member's needs. Care coordination:

- Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals
- Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care



- Involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects
- Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports
- Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact
- Creates and promotes linkages to other agencies, services, and supports

The PMPM payment for HHs to the MCO is currently being developed. The MCO will pay a portion of that PMPM to the HHP, as a PMPM for the bundle of HH services the HHP provides.

Please explain the difference between Care Management and Care Coordination.

Please see the two responses immediately above. Care management is about getting the member in the HH and engaged, as well as developing the Health Action Plan. Care coordination is the implementation and ongoing monitoring of the plan.

Has the state set a requirement as to a percentage of the population be in a HH?

No. We know there are about 36,000 people who would be eligible for the SMI HH, but we don't know how many will opt out. We don't have an estimate for the second SPA related to the other chronic conditions since we are still determining what conditions will be included. We cannot require people to remain in HHs so there is not benefit to setting an expectation for HH membership.

Who will identify those individuals needing a Health Home?

The MCOs will identify and tentatively assign people to HHs, based on the criteria laid out by the State. Hospitals will also refer people that they see in their ERs to HHs if they believe they may be eligible.

Where are the terms "chronic" and "serious" conditions clearly defined?

Those two terms are used in these ways:

1. The ACA spells out broadly who can be a Medicaid HH by stating the person must have either two chronic conditions or one condition and be a risk for another, or have one serious and persistent mental illness. The ACA then lists a few conditions and notes the Secretary of Health and Human Services can approve others. Generally, chronic means a condition that is long-lasting, not likely to be cured, but able to be managed.
2. Kansas is defining "one serious and persistent mental illness" as having one or more diagnoses from this list:
 - Schizophrenia
 - Bipolar and major depression
 - Child disintegrative disorder
 - Delusional disorders
 - Personality disorders
 - Psychosis not otherwise specified
 - Obsessive-compulsive disorder
 - Post-traumatic stress disorder

How will the customers know about health homes and what they provide?



The State is working on some communication materials that we will share soon with providers to help them educate consumers. We will also hold some consumer meetings across the state to talk with consumers, help them understand HHs and answer their questions.

So, it looks like there could be multiple HHPs in a given geographic region, all competing with one another, but also perhaps all engaging in contracts with one another for specific services?

In order to provide members with a choice of HHPs, as CMS requires, there must be at least two HHPs available in each county. There is nothing to preclude HHPs from contracting with each other to provide some HH services, but they would not be required to do so.

Is it possible to have the same HHP working with all three MCO's?

Yes. We hope HHPs will contract with all three MCOs to provide members with a choice of HHPs no matter which MCO the member is associated with.

What steps should community providers be taking right now?

Learn as much as you can about HHs by going to the KanCare Health Homes web page (http://www.kancare.ks.gov/health_home.htm) and reach out to the MCOs if you are interested in becoming a HHP. You should also talk with hospitals and other providers in your area, so you can begin collaborating with providers who will be providing services that need to be coordinated by HHs. You can sign up for the *Health Homes Herald*, our monthly newsletter, which will help to keep you informed, by sending your information via the healthhomes@kdheks.gov e-mail. In the newsletter, you'll find announcements of any state-sponsored meetings or presentations that may be occurring in your area about health homes.

Now, patients are all doing what they want and the PCP has no control of it. Why do you think your model will work?

Patient engagement is a key component of health homes. Inclusion of providers with whom the member already has a relationship with will help with that. The MCO and the HHP will work together to get, and keep, the member engaged. One of the six core HH services is health promotion which is designed to engage the member in taking an active role in helping to manage his or her chronic conditions. The Kansas HH model also includes Peer Support as a way to help with this.

Will a Health Home be a substitute for residential home services?

No. A Health Home is not a place for someone to live, it is a set of services intended to provide intense and focused coordination of other physical, behavioral and long-term supports and services so the person's health outcomes will be improved.

Will we be able to receive a copy of the PowerPoint presentation?

The presentation can be retrieved here: http://www.kancare.ks.gov/health_home.htm