

# Health Homes

# 101



# INTRODUCTION

- The term “health home” is unique to Medicaid
- Health homes are an option which states can choose to provide within their Medicaid programs
- A health home is not a building, but is a comprehensive and intense system of care coordination that integrates and coordinates all services and supports for people with complex chronic conditions

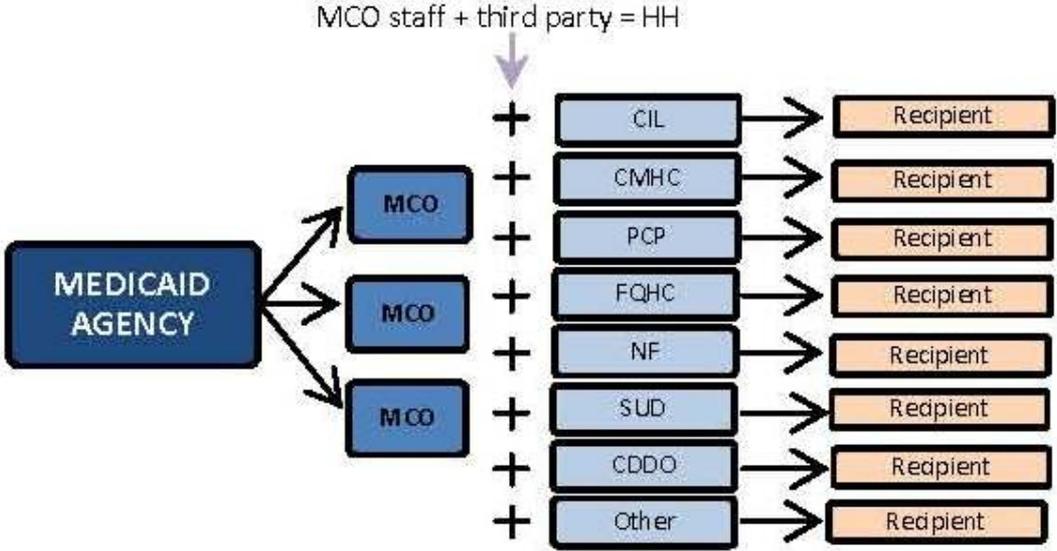
# INTRODUCTION

- Intended for people with certain chronic conditions
- Health homes can include what has been called a medical home
- Health homes do not replace acute care services, like physician visits, pharmacy, hospital care, therapies, etc.

# SIX CORE SERVICES

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- Individual and family support (including authorized representative)
- Referral to community and social support services, if relevant
- Use of HIT to link services

# KANCARE HEALTH HOME MODEL



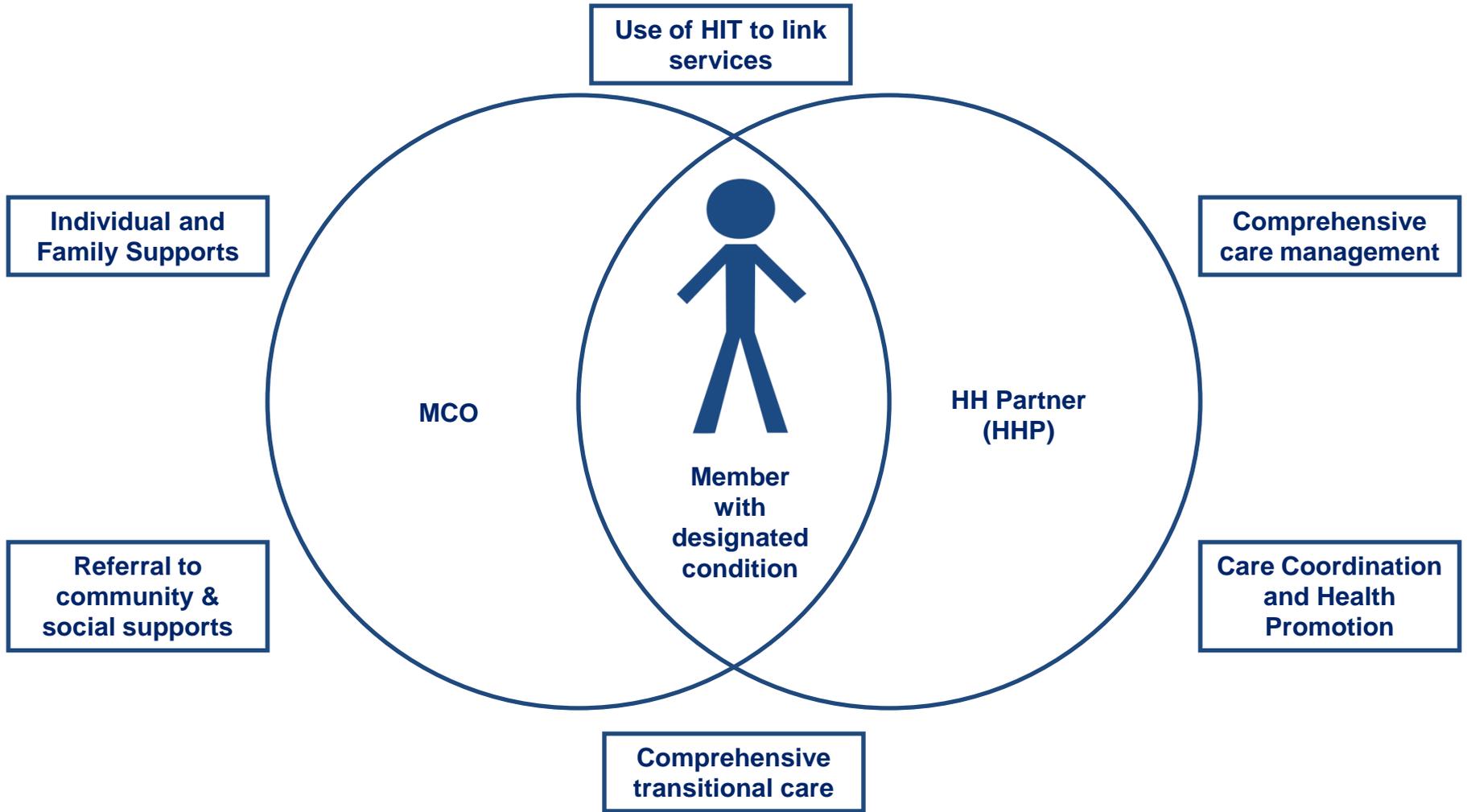
# KANCARE HEALTH HOME MODEL

- A partnership between the managed care organization (MCO) and another entity (Health Home Partner – HHP) that is appropriate for the consumer
- Model offers flexibility for providing health home services within a capitated, fully risked-based managed care delivery system

# KANCARE HEALTH HOME MODEL

- Flexibility critical since Kansas is a largely rural state and familiar community providers are important
- Health home recipients likely have experience with, and preferences for, different types of HHPs depending upon where they live and what Medicaid population they belong to

# SERVICE STRUCTURE



# PARTNERING TO PROVIDE SERVICES

- Some health home services provided by the MCOs and some by the HHP
- Some services may be jointly provided by the two
- Division of services, as well as payment between the MCO and the HHP, will be spelled out in contract between the MCO and HHP

# HEALTH HOMES

## IMPROVING HEALTH

Health home ensures:

- Critical information is shared among providers and with consumer
  - Consumer has tools needed to help manage his chronic condition
  - Necessary screenings and tests occur timely
  - Unnecessary emergency room visits and hospital stays are avoided
  - Community and social supports are in place to help maintain health
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# MEET EARLEEN

Earleen is  
41 years  
old

Earleen is unemployed  
but interested in  
employment

Earleen  
has  
bipolar  
disorder

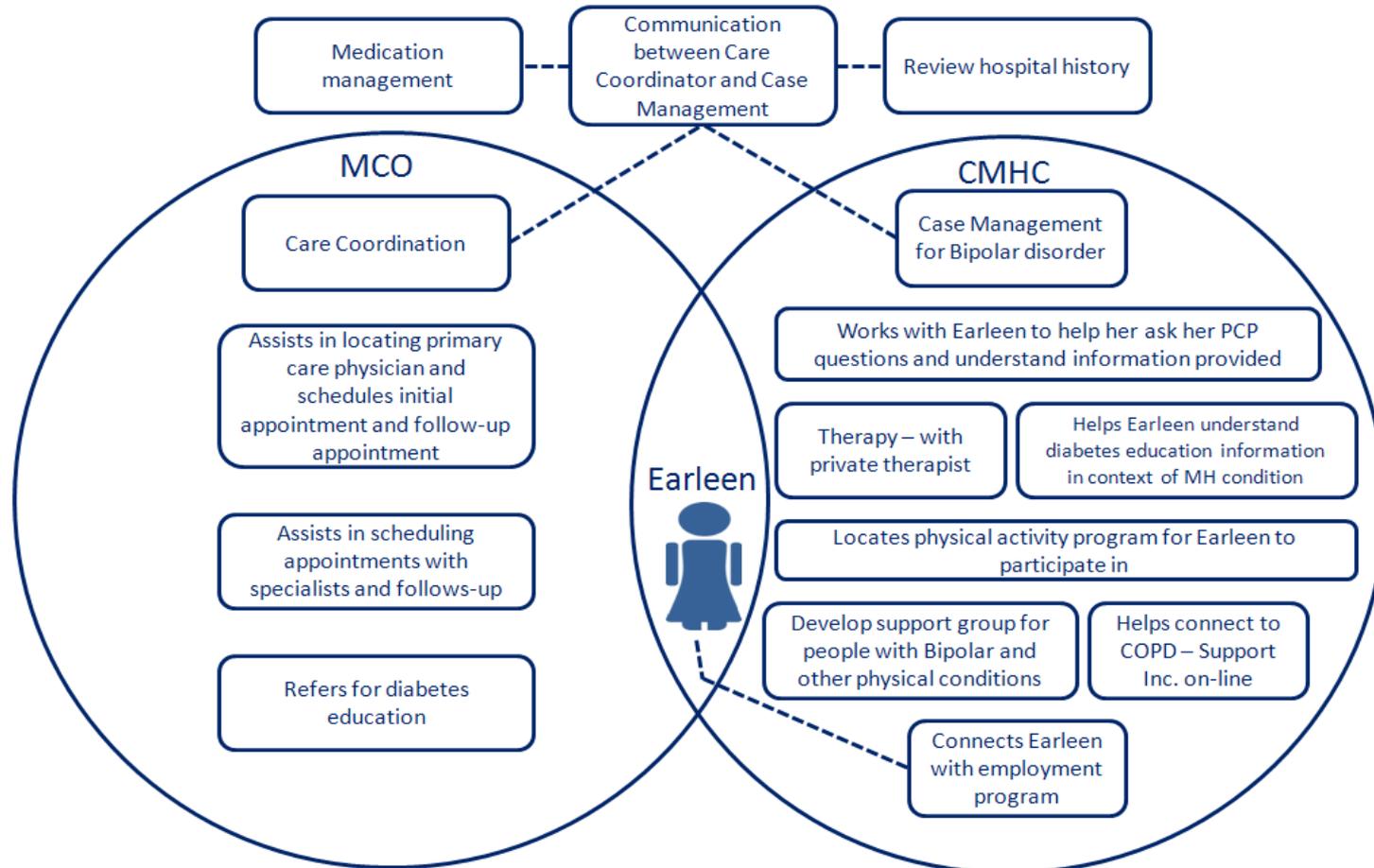
Earleen has  
diabetes



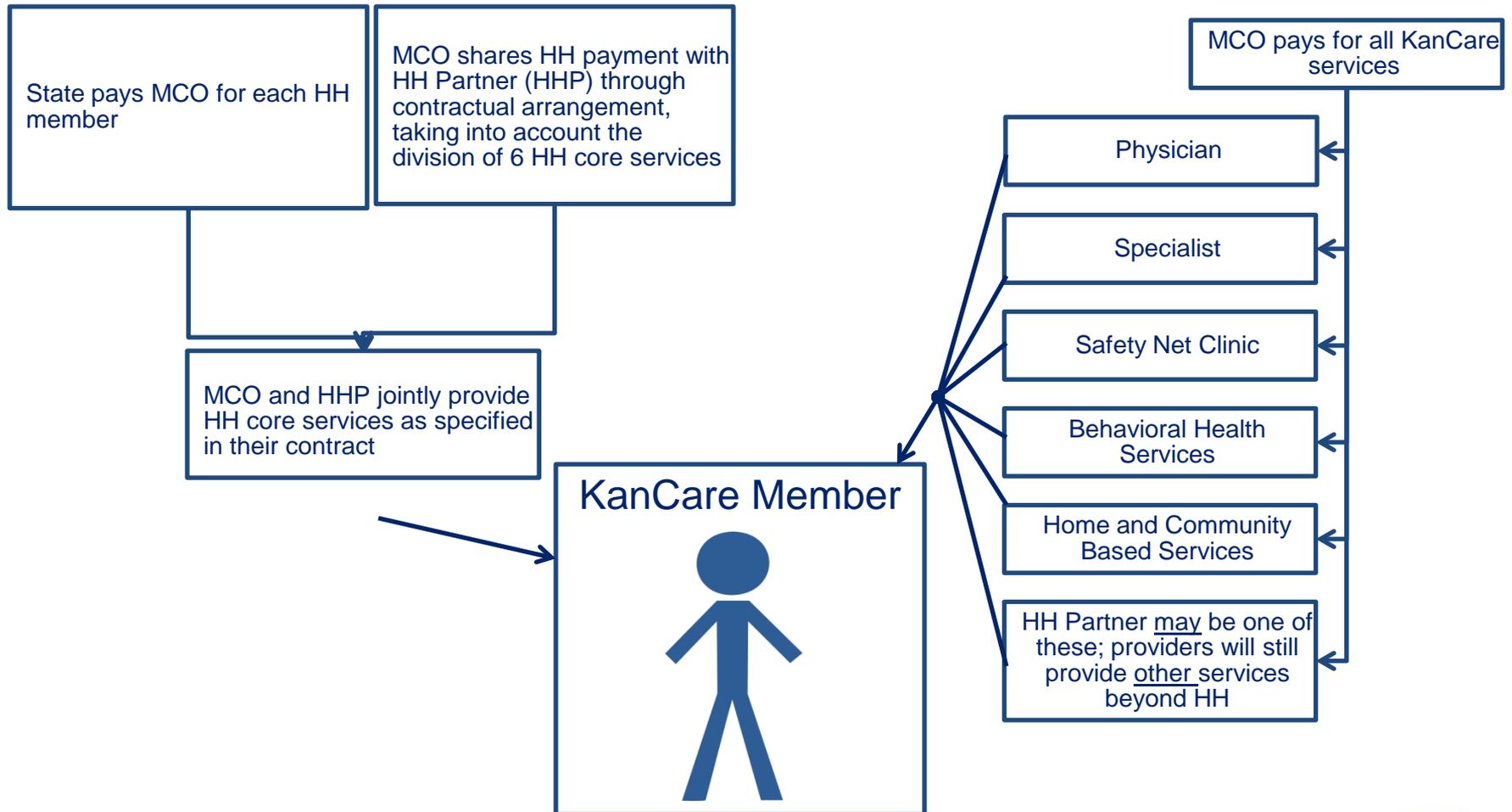
Earleen has  
COPD

Earleen has been admitted to the  
hospital 4 times in the past year.

# EARLEEN IN A HEALTH HOME



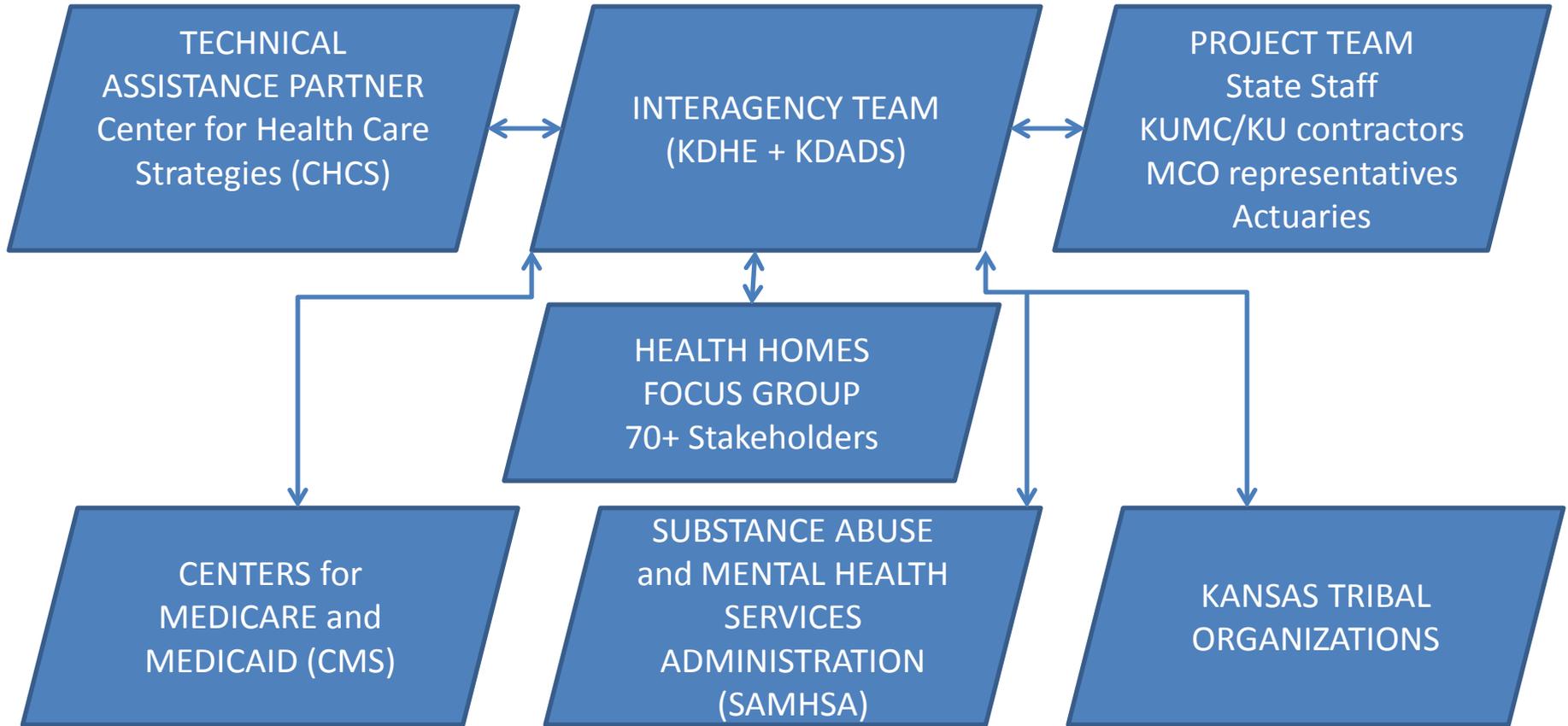
# PAYMENT STRUCTURE



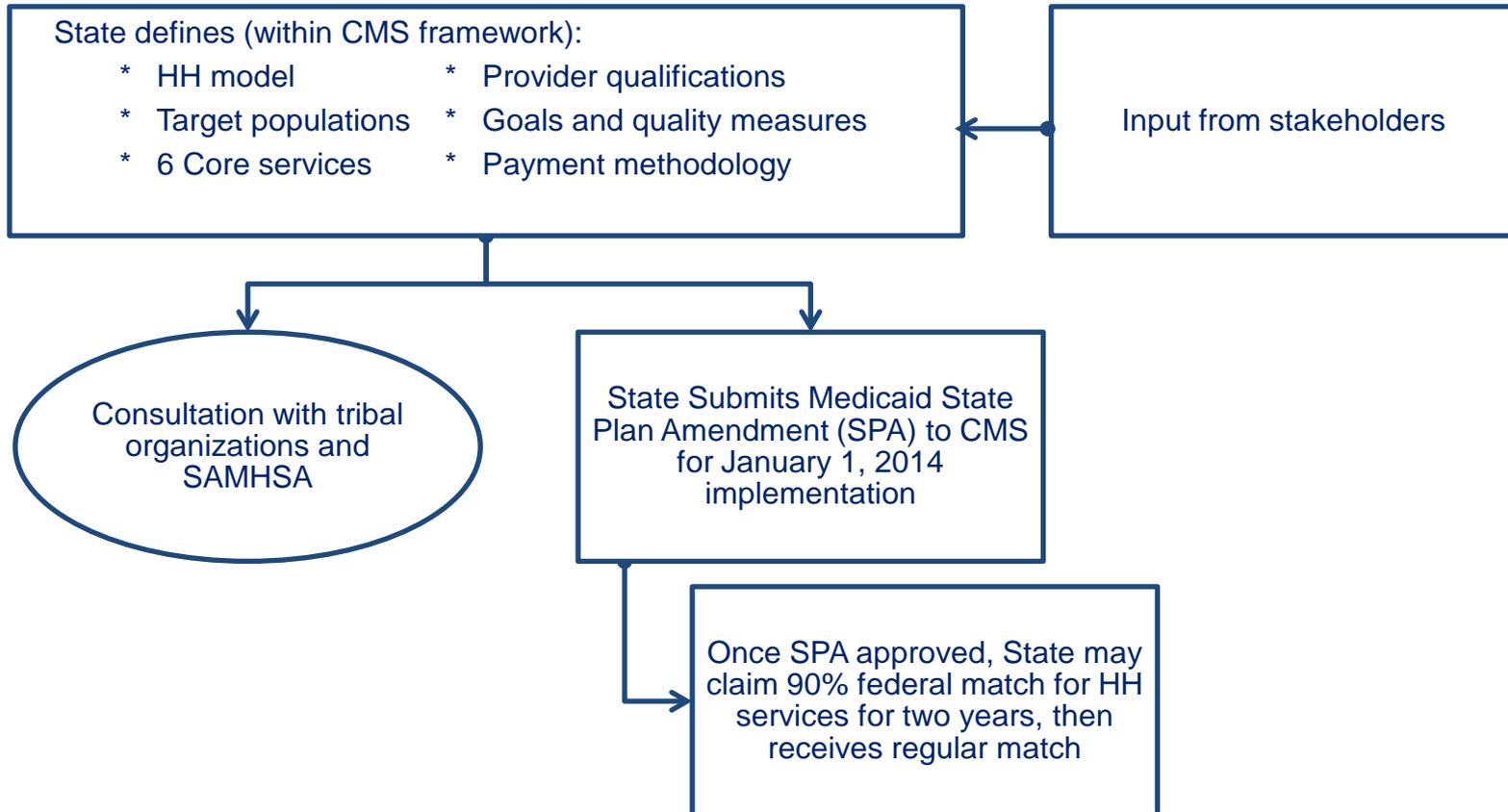
# HEALTH HOMES PROJECT STRUCTURE

- Interagency team of KDHE and KDADS staff
- Technical assistance partner – Center for Health Care Strategies (CHCS)
- Project team of state staff, university and actuary partners, with MCO representatives
- Health Homes Focus Group – 70+ stakeholders who provide advice and input

# HEALTH HOMES PROJECT STRUCTURE



# PROCESS FOR FEDERAL APPROVAL





[www.kancare.ks.gov](http://www.kancare.ks.gov)

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