

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.

ELIGIBILITY FOR HEALTH HOMES

Must be eligible for Medicaid, and has at least:

- Two chronic conditions;
- One chronic condition and is at risk for another chronic condition; or
- One serious and persistent mental illness

CHRONIC CONDITIONS

- Mental health condition
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- Being overweight, as evidenced by a body mass index over 25.
- Section 1945(h)(2) of the ACA authorizes the Secretary to expand the list of chronic conditions

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

OTHER STATES

- To receive federal funding for health homes, states must amend their State Medicaid Plans
 - 11 states currently operate Medicaid health homes programs
 - 3 states operate them using two State Plan amendments (SPAs)
 - Remaining states have a single SPA
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PERMISSABLE MODEL #1

A designated provider: May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, other

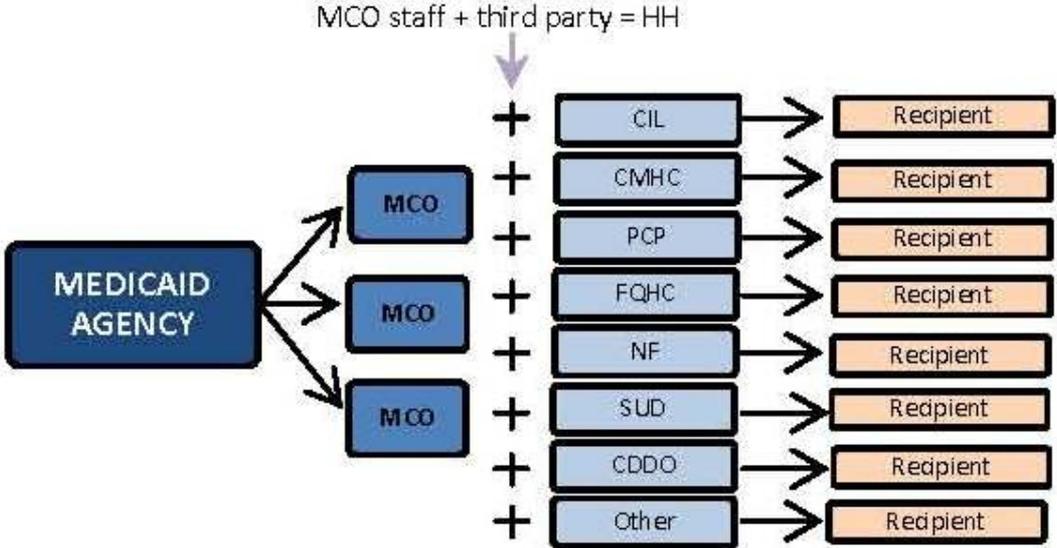
PERMISSABLE MODEL #2

A team of health professionals: May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, etc.

PERMISSABLE MODEL #3

A health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative medicine practitioners and physicians' assistants

KANCARE HEALTH HOME MODEL



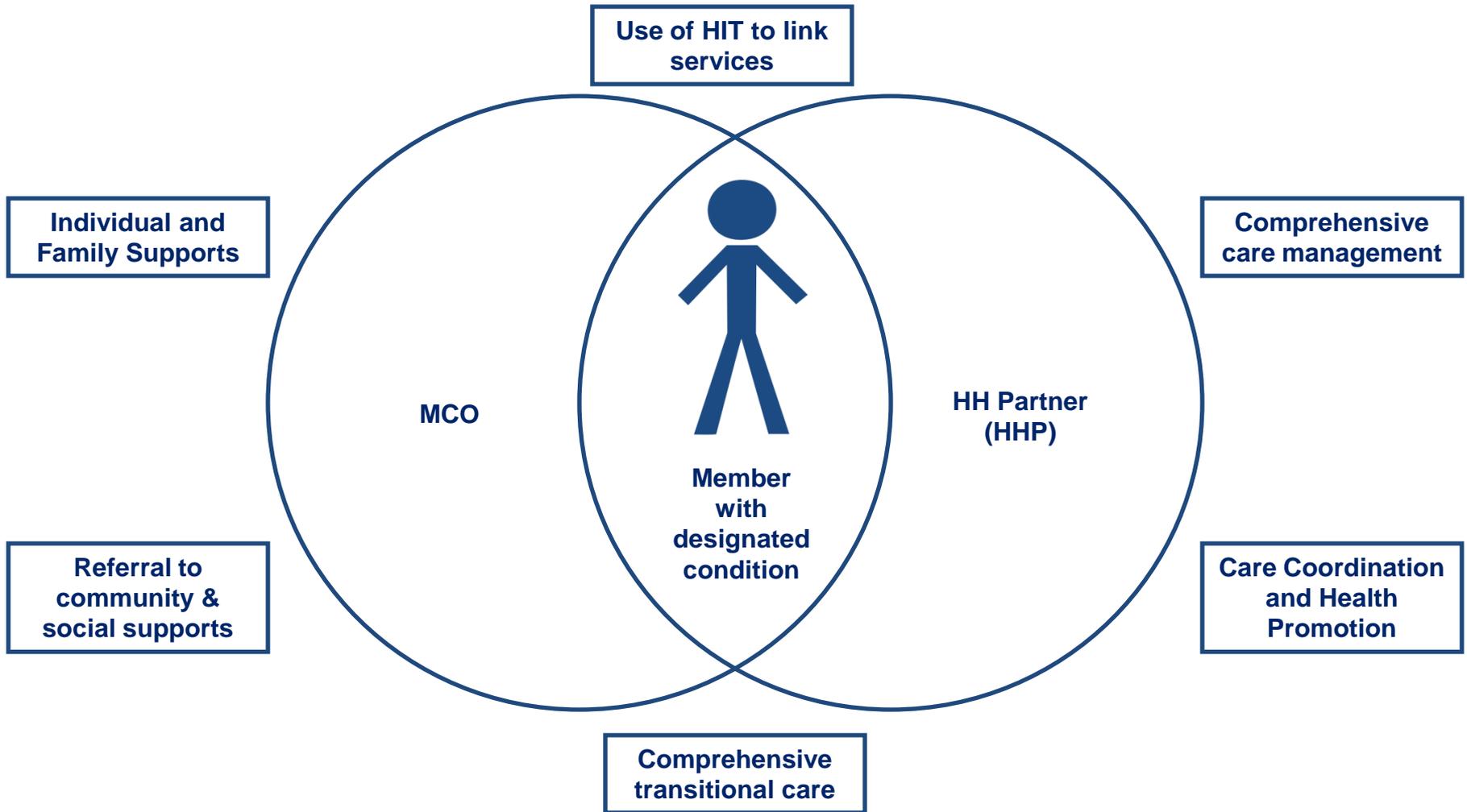
KANCARE HEALTH HOME MODEL

- 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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TARGET POPULATIONS

- First target population is people with serious mental illness (SMI)
- Implementation January 2014
- Second target population yet to be determined, but will include people with diabetes
- Implementation July 2014
- All HH members must be in KanCare

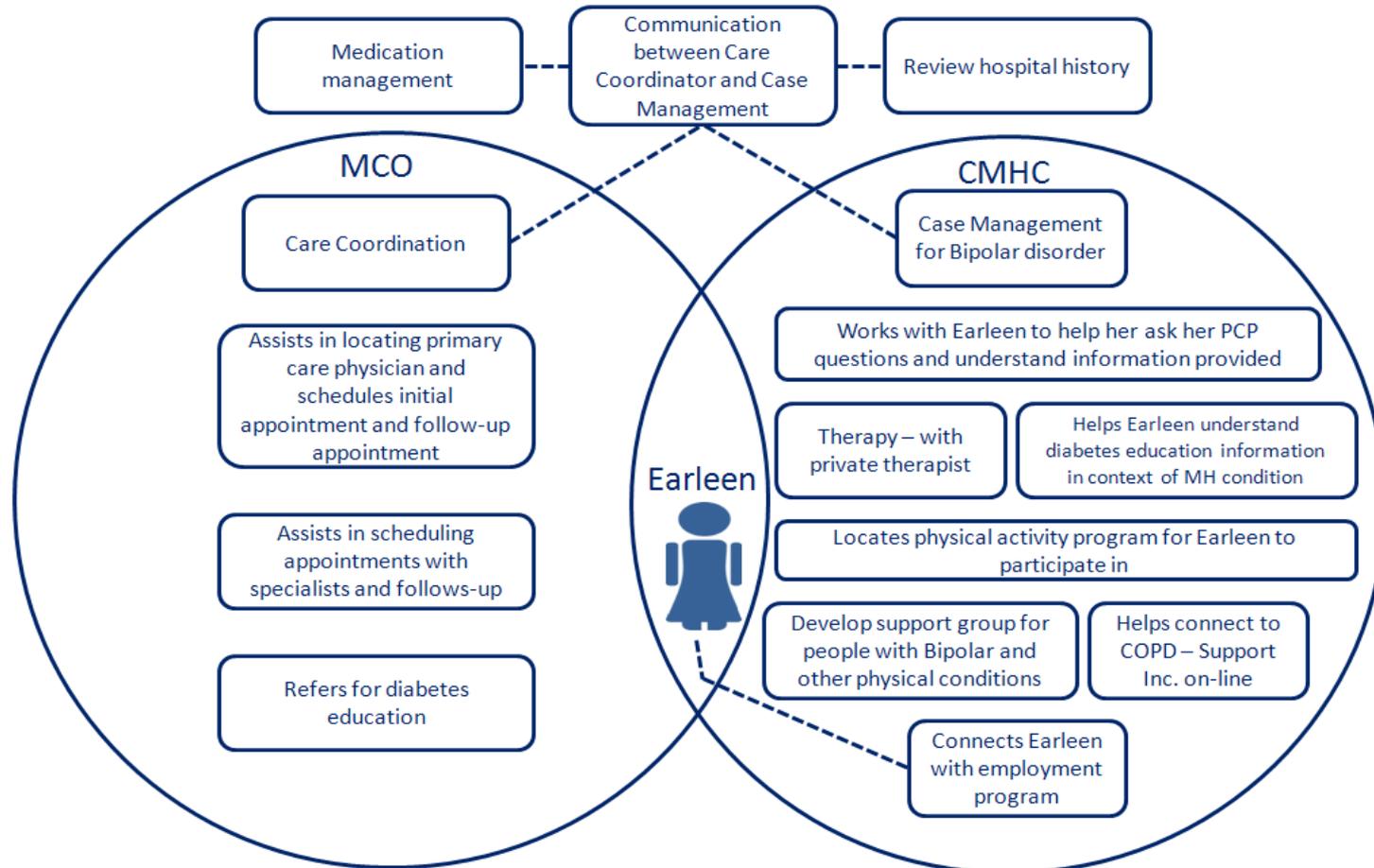
ENROLLMENT

- Passive enrollment with “opt out” feature
 - Enrollee will receive a letter and have some period to choose to opt out
 - Will have a choice of health home provider, but will be required to remain in the health home for some period of time
 - Can change for “good cause” reasons
 - Grievance and appeal rights
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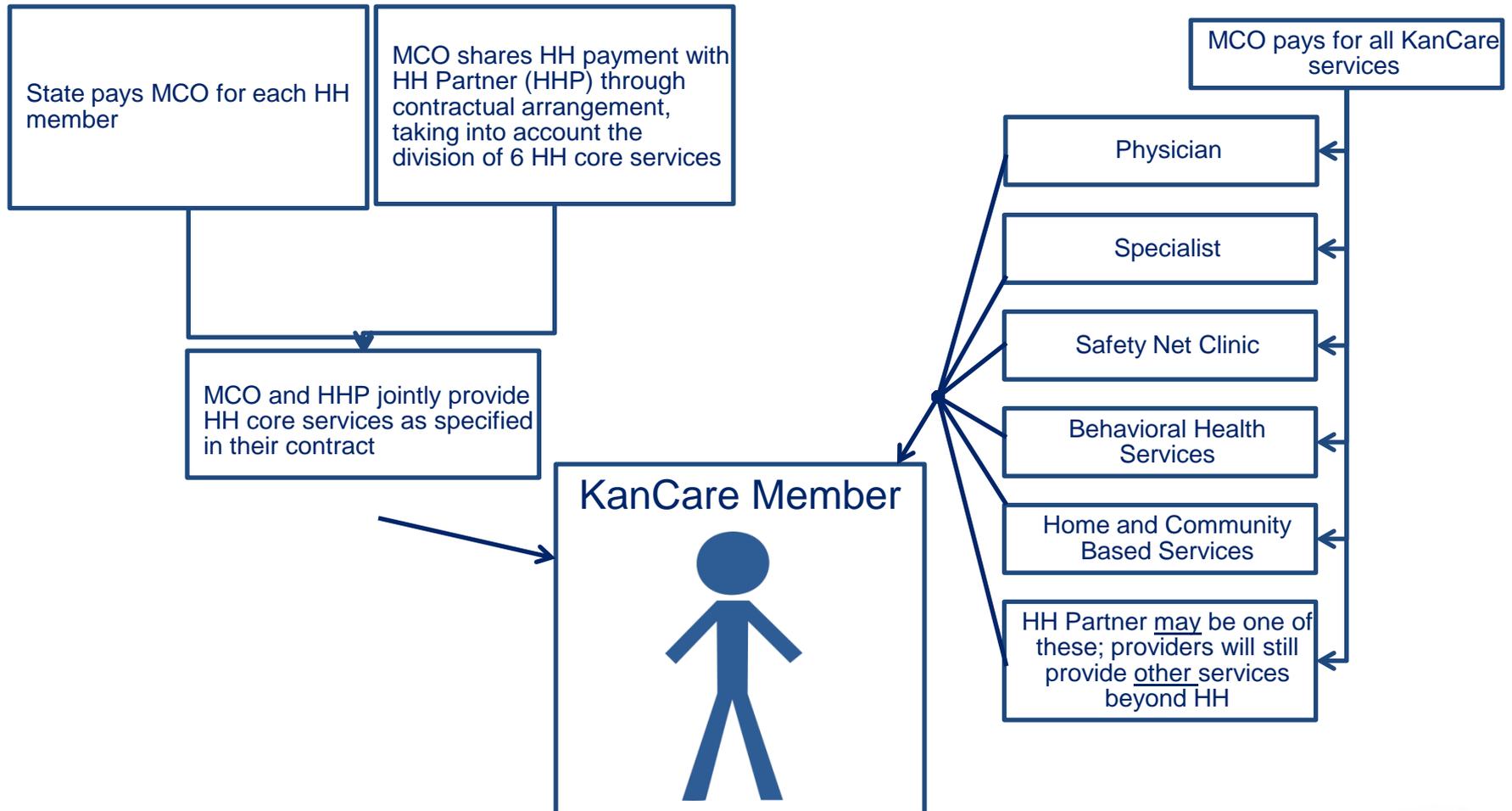
MEET EARLEEN



EARLEEN IN A HEALTH HOME



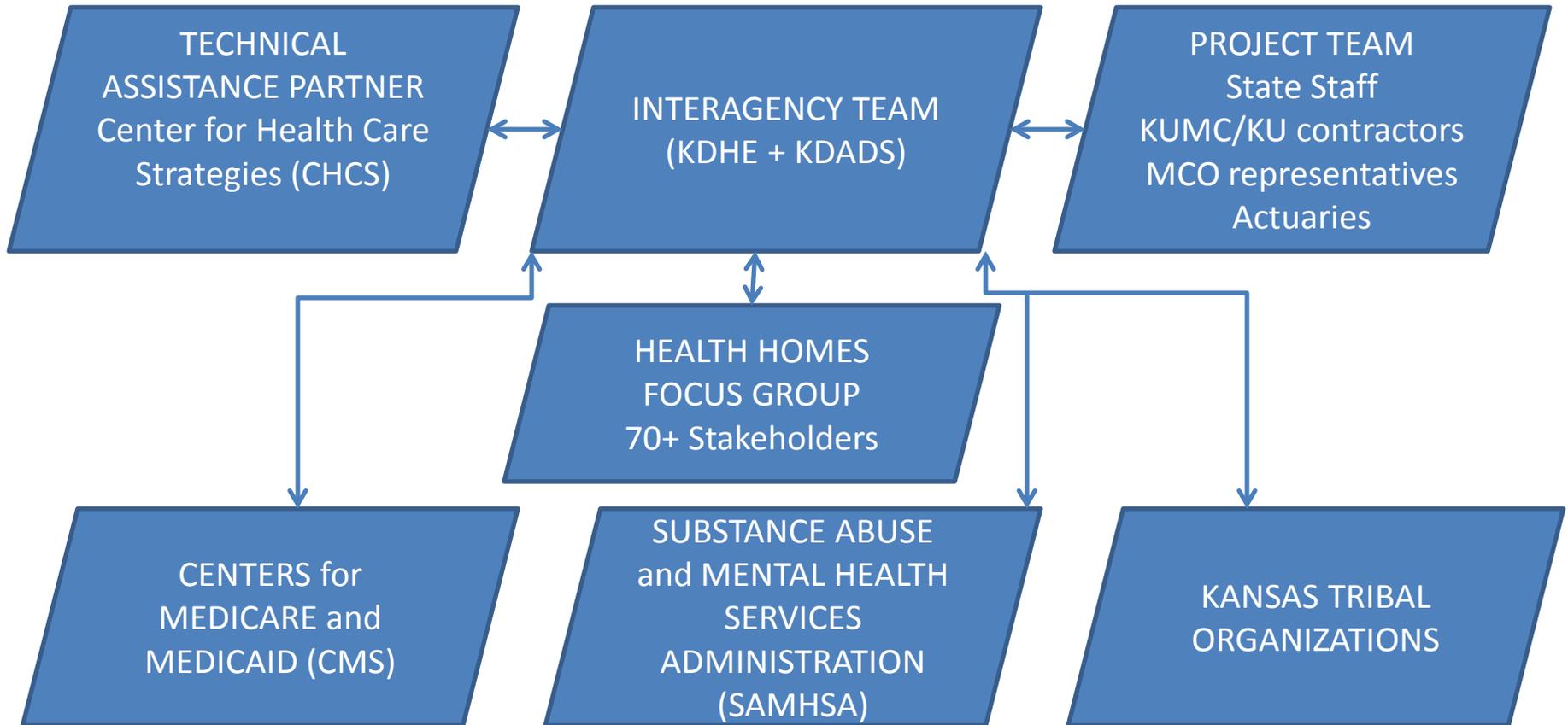
PAYMENT STRUCTURE



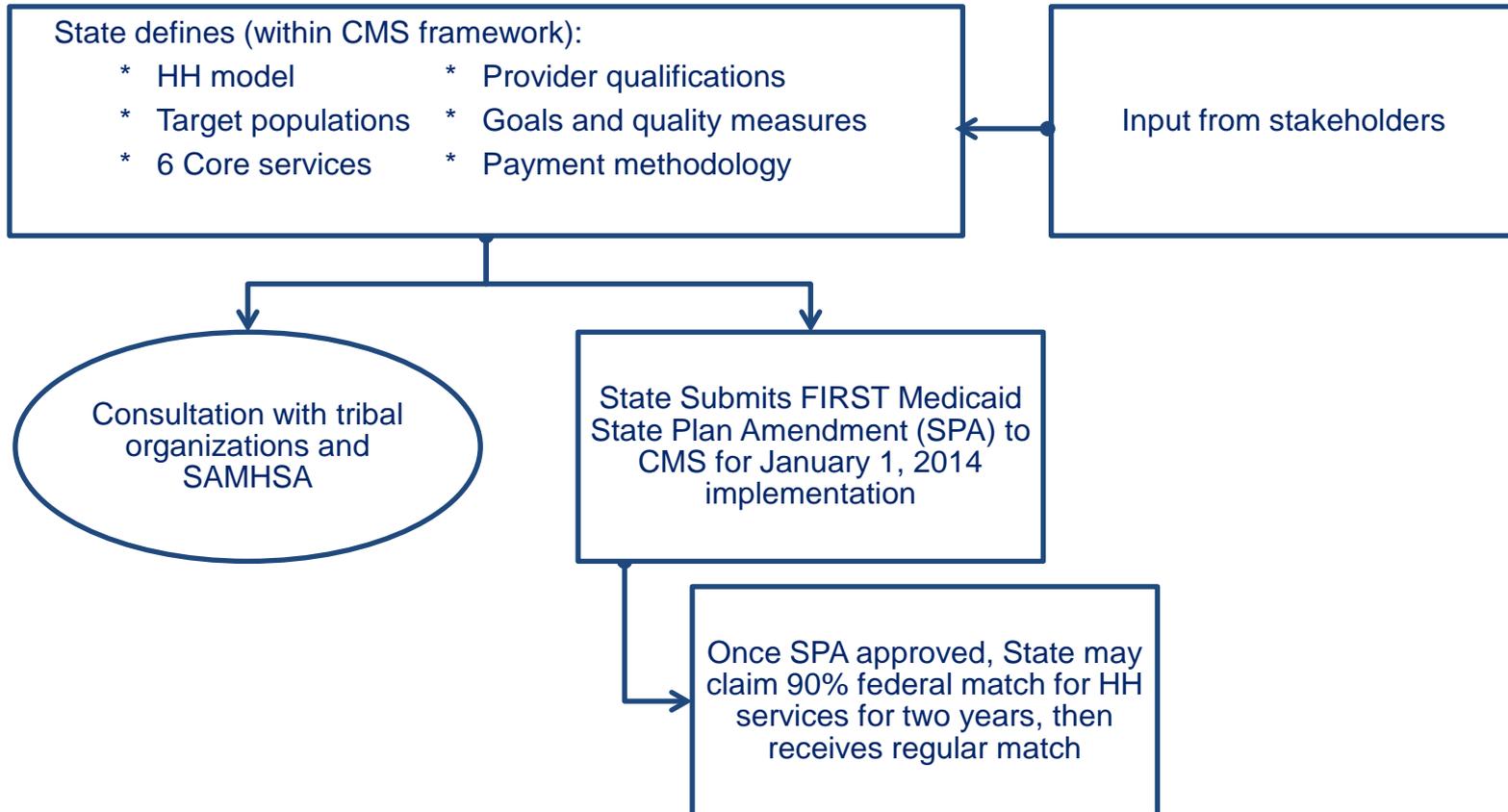
HEALTH HOMES PROJECT STRUCTURE

- 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





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