HEALTH HOMES PROVIDER STANDARDS

INTRODUCTION

- CMS State Medicaid Directors Letter (SMDL) lists 11 components states must support health home providers in doing
- These form the framework for health home provider standards
- States must describe the provider standards they will apply to health home providers in the SPA

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11 SMDL COMPONENTS

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders

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11 SMDL COMPONENTS

- Coordinate and provide access to mental health and substance abuse services
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families

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11 SMDL COMPONENTS

- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
- Coordinate and provide access to long-term care supports and services
- Develop person-centered care plan for each individual that coordinates and integrates all clinical and non-clinical health-care related needs and services

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11 SMDL COMPONENTS

- Demonstrate capacity to use health information technology (HIT) to link services, facilitate communication among team members and between health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate

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11 SMDL COMPONENTS

- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

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OUR PROCESS

- Reviewed other states' SPAs
- Gathered initial thoughts from Focus Group
- Explored accreditation
- Gathered reactions from April Forum participants
- Established sub-group and prepared draft definitions

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OUR PROCESS

- Got input from Focus Group
- Got input from our technical assistance partner (Center for Health Care Strategies)
- Consult with SAMHSA
- Share with CMS

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TWO SPAS

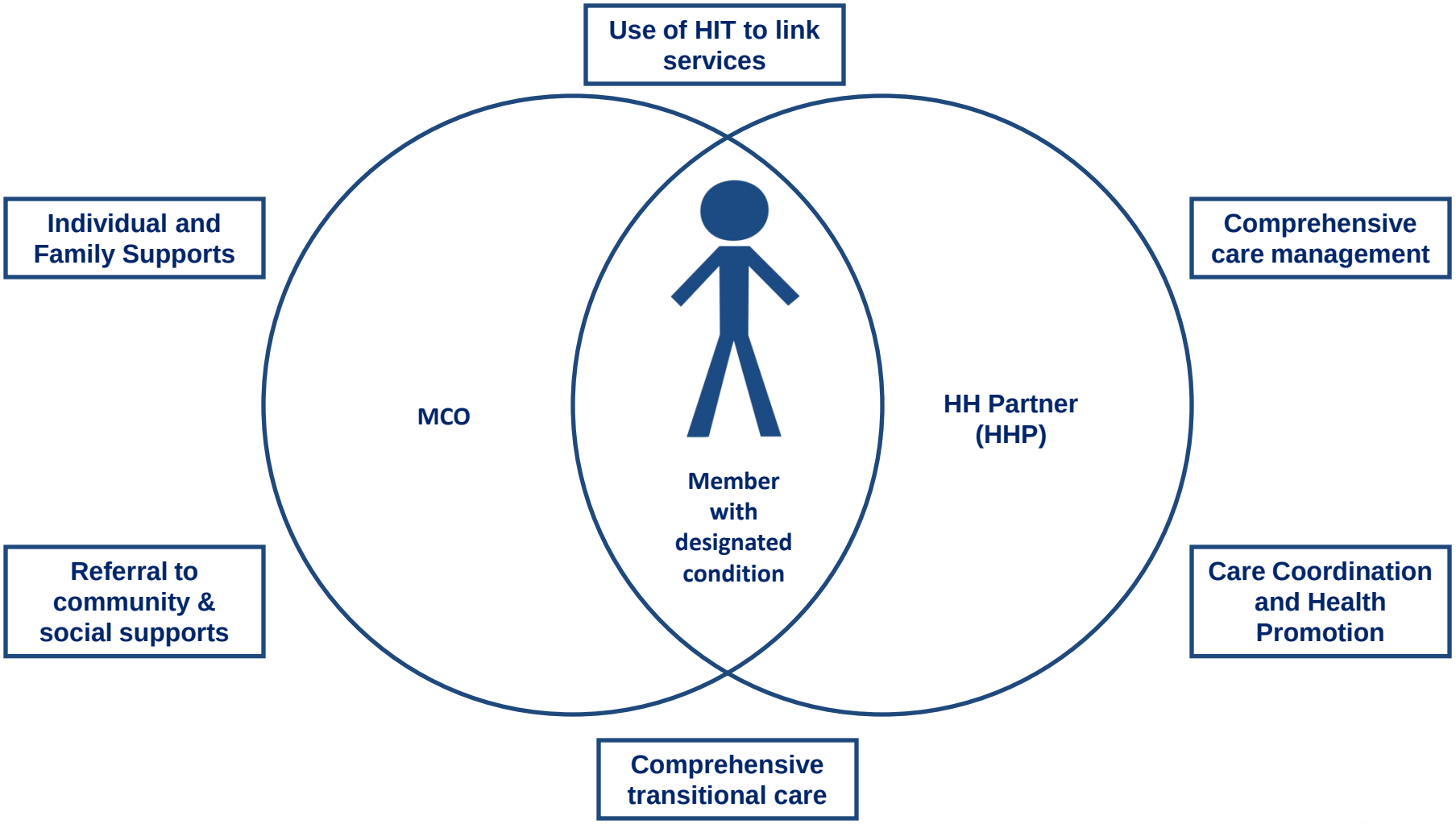
- HHS Sub-cabinet, led by Lt. Governor, approved submitting two SPAs
- Developed provider standards as though for a single SPA
- Have not yet included professional staffing requirements and qualifications

WHO MUST MEET THE STANDARDS?

- KanCare Health Homes will be provided jointly by MCO (Lead Entity) and community provider (Health Home Partner)

- Standards initially defined without regard to who provides them, then identified as Lead Entity's, HHP's or joint

SERVICE STRUCTURE



DRAFT STANDARDS

- For complete draft standards, refer to June 28, 2013 document posted at :

http://www.kancare.ks.gov/health_home.htm

LEAD ENTITY

- Must be a KanCare managed care organization contracted with the Kansas Department of Health and Environment/Division of Health Care Finance
- Must maintain a valid Certificate of Authority issued by the Kansas Department of Insurance

HEALTH HOME PARTNER

- Must enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements
- Must provide appropriate and timely in-person care coordination activities. Alternative communication methods may be used, if appropriate.

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HEALTH HOME PARTNER

- Must have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals
- Must agree not to refuse enrollment of any eligible health home enrollee, except in cases where the safety of the enrollee or health home staff is at serious risk

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JOINT STANDARDS

- Must provide 24-hour, seven days a week availability of information and emergency consultation services
- Must ensure access to timely services for enrollees, including seeing enrollees within seven days of discharge from an acute care or psychiatric inpatient stay
- Must ensure person and family-centered and integrated health action planning that coordinates and integrates all clinical and non-clinical health care related needs and services

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JOINT STANDARDS

- Must provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy
- Must establish a formal agreement with health service entities in order to assure appropriate access to a range of outpatient behavioral and physical health services for all of its health home enrollees. Or, the health home includes a team of co-located health professionals to provide outpatient physical and behavioral health services.

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JOINT STANDARDS

- Must establish a data-sharing agreement compliant with all federal and state laws and regulations, when necessary, with other providers
- Must demonstrate ability to perform each of the following functional requirements (these are some of the 11 components):

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JOINT STANDARDS (from 11 Components)

- Coordinate and provide the six core services outlined in Section 2703 of the Affordable Care Act
- Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders

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JOINT STANDARDS (from 11 Components)

- Coordinate and provide access to mental health and substance abuse services
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
- Demonstrate capacity to use HIT to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate

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JOINT STANDARDS (from 11 Components)

- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

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JOINT STANDARDS

- Uses an EHR system and/or demonstrates the capacity to use HIT to facilitate the sharing of health information, plan(s) of care, and linking of services between the interdisciplinary team of providers and the MCO partner
- Is using, developing, or will provide plans to use technology to facilitate exchange of information with the individual, family care givers, and health service clinicians and providers
- Demonstrate the ability to report required data for both state and federal monitoring of the program

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NEXT STEPS - STATE

- Incorporate feedback from the Forum in development of the SPA
- Submit the SPA to CMS
- Target date for HH implementation is January 1, 2014

NEXT STEPS - STAKEHOLDERS

- Learn more about Health Homes development - check for updates on KanCare website
- Reach out to the MCOs if interested in being a HH partner
- Analyze your agency's readiness to be a HH partner

QUESTIONS?

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Kansas Department of Health and Environment

http://www.kancare.ks.gov/health_home.htm

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