

**Health Homes Webinar**  
**Payment Structure – SPA 1 & 2**  
**March 25, 2014**

**Presenter:** Melissa Warfield – KDHE Division of Health Care Finance

**Moderator:** Sonja Armbruster – Public Health Initiatives Coordinator, WSU Center for Community Support & Research

**Moderator:** Hello, this is Sonja Armbruster at CCSR and we're glad to have you on the call today. Online it looks like we have about 80 people dialed in so far, so “welcome”. This spring, our Health Home webinar series will continue to be scheduled the last two Tuesdays of each month throughout the spring. These are intended to highlight the tools and resources that are available to potential Health Home Partners. Just a few quick housekeeping items, this and all of our presentations are recorded for future viewing on the KanCare website. All of your lines have been muted and should remain so during the entirety of the presentation. I just want to point out that if you are having any trouble with the slides such as accessing them through GoToWebinar, they are already available on the KanCare website on the Health Home section. If you have any questions during the call or during the webinar, please use the question box that appears on your desktop as part of the GoToWebinar layout. This will be the method for asking questions during the presentation and please type your questions related to today's webinar at any time and our staff will see these and ask them of the presenters. Because of the large number of people participating, we will not be taking questions via telephone. Please limit your questions to the topic of today's webinar. Any other questions may be referred to Samantha Ferencik and her email will appear at the end of the presentation.

So, last week we had many of you on the line, as well, and you did a great job of not waiting until the very last minute to present your questions, so feel free to ask questions throughout. What I'm sure you're about to see is some new information. Today's primary presenter is Melissa Warfield from KDHE's Division of Health Care Finance. Today we are going to be highlighting the payment methodology and...reviewing the payment methodology and give you a chance to ask questions both of Melissa and of the MCO representatives that are on the call. So with that I'm going to pass it to you, Melissa. Thank you so much.

**Melissa Warfield:** Thank you Sonya. So the purpose for our webinar today is to provide information to the participant so you have an increased knowledge of the basic payment structure and payment principles for the Health Homes initiative, the four levels of payment rates and the payment methodology behind them, and the frequency which rates will be reviewed and are adjusted for the future. Next slide please.

So we are going to begin with the basic payment structure and payment principles for the Health Homes program. The Health Homes Program Manual – we have two Health Homes, drafts, of the Health Homes Program Manuals: one is for the State Plan Amendment 1 or for the Serious Mental Illness Population. And then Program Manual Two is for the Chronic Conditions Health Homes Population. The State Plan Amendment and both of these program manuals are still in draft form so you can see them after approval and you can find the actual

document listed there on that link on slide six. Next slide please.

This next slide shows you how to navigate to the Health Homes website via the KanCare website, so from the KanCare website “Home” like under Policies and Reports, you will see a link titled “Health Homes and KanCare”. Next slide please.

And then a link for providers and then informational materials for providers and information is listed for the serious mental illness population, our State Plan Amendment, and then for chronic conditions, as well. Next slide

The basic payment structure for the Health Homes program – each MCO will be paid a retrospective per member/per month payment for each member enrolled in a Health Home once a Health Home service is delivered. One per member/per month payment regardless of the number of services provided in a month will be issued by the State to the KanCare MCO. If no Health Home services are provided in a month, no payment will be made to the MCO from the State.

The KanCare MCOs will contract with Health Home Partners to provide some or all of the six core Health Home services. The three MCOs each have different models which were presented at the stakeholder's meeting on March 24, 2014, pardon me, March 21<sup>st</sup> and those presentations can be found on our Health Home's website. The number and types of services will be negotiated and described in the contract between the MCO and the Health Home Partner. Payments from the MCO to the Health Home Partner will most likely be in a per member/per month format, but other arrangements can be made and negotiated to meet KDHE Division of Health Care Finance approval.

Payment principles – the State Health Home payments to the MCOs are structured to be adequate in ensuring quality services are sustainable. The MCO payments to the Health Home Partners, in turn, will also be structured to be adequate to provide quality services and sustainability for the program. The State Health Home payments to the MCOs are actuarially sound as defined by the American Academy of Actuaries.

The rate development process – the State and its actuaries use a four "level" approach to capture the different levels of need. The levels of need were created by combining KanCare Rate Cohorts that contain members similar in their utilization of Case Management and other Health Home-like services. KanCare Rate Cohorts are groups of members who are similar in their Medicaid eligibility category in overall utilization of services.

The Serious Mental Illness KanCare rates - the Serious Mental Illness KanCare Rate Cohort levels are...we have four levels. Each of the KanCare Rate Cohorts are divided into four levels and what you're seeing on slide 16 are all of the KanCare Cohorts that qualify for Level 1. KanCare Rate Cohorts and level groups are based on Medicaid eligibility criteria that includes utilization of care, levels of care, income eligibility criteria, etc. and they cannot be manipulated or changed by a Health Home Partner or the MCO. There is a note here on the slide that I would like to draw your attention to that kind of defines what the “Dual” and “Non-Dual” reference is in relation to the Rate Cohort title. Next slide please

On slide 16, you will see all of the KanCare Rate Cohorts that qualify for Level 2 according to the SMI Health Homes population. Next slide please.

Here you will see the Level 3 KanCare Rate Cohorts for the Health Home program. Next slide.

And then finally Level 4.

Other considerations with the SMI Health Home Rates – the State actuaries examine the following information when locking in the rates: the target population criteria as outlined in the State Plan Amendment and the SMI Health Homes Program Manual, professional salary and benefit costs related to professionals outlined in the State Plan Amendment, service utilization and also non-medical loading, also referred to as administrative costs.

The professional costs for the SMI Health Homes population - In the State Plan Amendment - in the Program Manual, you will see we have defined five primary professionals to deliver SMI Health Home services. Professionals are physicians, a psychiatrist, nurse care coordinator, social worker and a peer support specialist.

Service Utilization – rates are developed under the assumption that a payment from the state to the MCOs will only be made once a Health Home service is utilized. The MCO will be paid regardless of how many services are used in a month, as long as at least one Health Home service is delivered to the member. Next slide.

So on slide 22, you will see the staffing costs associated with the SMI and Health Home rates. At the top you will see the physician and/or the Behavioral Health Professional Service and cost per visit associated with Comprehensive Care Management, Health Promotion and Comprehensive Transitional Care at \$125/\$50/\$125 respectively. Across the middle, the burden rate which includes costs associated with taxes, insurance and other employment-related benefits. Then further down on the table you will see the nurse care coordinators, the social workers and the peer support specialist. This services in the Health Homes program that we have identified today we will be providing, and then their salaries, the burden rate, their total compensation, the distribution of professionals between the different services, the total cost for each service and then the cost per hour assuming 48 working weeks in the year at 40 hours per week, which includes 10 days of paid time off and 10 federal holidays. Next slide, please.

The Health Home cost per visit for the SMI population – so for Comprehensive Care Management the cost per visit is \$125 and the cost per hour is \$45.31. For Care Coordination, it's \$45.31 and for Health Promotion you can see the cost there for each visit and also for the hour. Comprehensive Transitional Care has the cost per visit per hour breakdown. Individual and Family Support comes to \$21.42 and the Referral to Community and Support Services is also listed there, as well.

The Non-medical Loading or Administrative Costs – measures the dollars associated with components of the Health Homes program such as administration, profit, IT costs associated

with electronic health records, and telephone calls— all as a percentage of the Health Home rates. For the SMI population, the non-medical load or the administrative costs associated within the rates is 12% of the final rate; another way of explaining this is that of the entire final SMI rates for the medical load is 88% of the full rate. Next slide please.

On slide 25, you will see the final per member/per month rate by each level and then also you will see the population distribution there to the right, as well. For Level 1, all of the KanCare members qualifying to be in Level 1 would be paid \$117.21 per member/per month; Level 2 – \$153.51; Level 3 would be \$185.17; Level 4 is \$327.48. The average is \$171.79 and as you can see, only about 11% of the SMI population falls in the Level 4; it's kind of distributed between Level 1 and Level 3.

Then on population distribution percentage is the amount of the Health Home members anticipated to fall into each category. As all of you know, the Medicaid eligible population is always changing, as are the eligibility groupings and movement in and out of the eligibility grouping. Next slide please.

We're now going to move on to the Chronic Condition rates and on Slide 27, you will see all of the KanCare Rate Cohorts that qualify for Chronic Conditions Level 1. Again, Cohorts are based on eligibility criteria that cannot be changed by the Health Home Partner or the MCO. There are a few differences in the Health Home Chronic Conditions Cohort grouping compared to the SMI grouping. One of those differences is that Breast and Cervical is Level 1 in Chronic Conditions, and it was a Level 2 in SMI. Next slide please.

On Slide 28, you will see all of the KanCare Rate Cohorts that qualify for a Level 2 grouping and Chronic Condition Health Homes. Next slide.

Slide 29 is the KanCare Rate Cohorts for Level 3 in Chronic Conditions and autism is a Level 3 in Chronic Conditions and it was a Level 1 in the SMI population.

And then finally the Level 4 grouping and work is Level 3 Chronic Conditions, it was a Level 4 in SMI, so you will see that work cohort is missing from the Level 4 in chronic conditions. And again that note that dual and non-dual refer whether the Cohort also has Medicare coverage.

The KanCare Health Home rates for Chronic Conditions – the State's actuaries examines the following information while developing the rates for chronic conditions: the target population criteria, again as outlined in the State Plan Amendment and the Program Manual, the professional salary and benefit costs, service utilization and non-medical loading and/or administrative costs.

Then, in the State Plan Amendment, you will again find we have defined three primary professionals to deliver the chronic conditions Health Home services. This is a little bit different than the SMI professionals. You have a physician, a nurse care coordinator and a social worker.

Service utilization for Chronic Conditions rate development – rates were developed under the assumption that a payment from the State to the MCOs will only be made once a Health

Home service is utilized. The state will pay the MCO regardless of how many services are used in a month, as long as at least one Health Home service is delivered to the member within that month.

On Slide 34 you will see the Chronic Conditions Health Home staffing costs grid. It's just a little bit different than the SMI staffing costs grid as we don't have as many professionals. The professionals for Chronic Conditions again are the physician, the nurse care coordinator and the social worker. You can see the cost per visit for the physician are listed there at the top. The same burden rate applies for just a few of professionals at 28% burden rate to compensate for costs associated with taxes, insurance and other benefits. You will see the salaries listed there for each professional and then the services denoted there as to which service each professional is to provide. The burden rate total compensation, the distribution of professionals between the services, the total cost and the cost per hour including 48 working weeks in a year at 40 hours a week which includes 10 days of paid time off and 10 federal holidays. While those two assumptions denoted there at the footer are still the same, but a little bit different distribution than the services defined because we don't have as many professionals with this particular target population. Next slide please.

The Chronic Conditions Health Home cost per visit/per hour are listed on slide 35. For comprehensive care management, we have \$125 cost per visit and the cost per hour is \$56.52. For Care Coordination it's \$52.79. For Health Promotion per visit it's \$50 and per hour it's \$52.79. Comprehensive Transitional Care per visit is going to be \$125 and per hour it's \$56.52. Individual and Family Support is at \$45.31 as is Referral to Community and Support Services.

The Non-medical Loading and Administrative Costs associated with the Chronic Conditions Health Homes target population – the non-medical load measures the dollars associated with components of the Health Homes program such as administration, profit, IT costs associated with electronic health records and telephone calls all as a percentage of the Health Home rate. So for chronic conditions the non-medical load or administrative load is 10% of the final rate or 90% of the final rate is the medical load or medical associated costs. Our actuaries developed a slightly lower non-medical load for these rates because we were already compensating the KanCare MCOs at 12% non-medical load for the SMI rates so their administrative costs should be a somewhat lower with the chronic conditions program in Health Homes because they are already receiving some non-medical loading in the SMI rates.

The final Chronic Conditions Health Home per member/per month rates that will be effective July 1 for Level 1 it will be \$108.31, for Level 2 is \$142.61, Level 3 is \$208.46 and Level 4 is \$421.25 with an average of \$147.89. So some of these rates are a little bit lower in Level 1 and quite a bit higher in Level 4. Again, the population distribution is listed there to the right of the table and again, this is the amount of Chronic Conditions Health Home population members anticipated to fall into these categories. Again, the total Medicaid population is always changing as are the groupings and movements in and out of the eligibility grouping. As you can see, there are very few members that will actually fall into Level 4 for the Chronic Conditions Health Home population. Next slide.

OK, we are going to take a look at this time in this webinar to talk to all of the participants about the I/DD Targeted Case Management providers and their role in the Health Homes program. For I/DD Health Home members, the MCO and/or the Health Home Partners must include the Targeted Case Management provider as part of the Health Home team for any member. The MCO or the Health Home Partner must: 1) contract with the TCM provider if the I/DD member wishes to continue the relationship with that provider (please note that the I/DD member has a choice, this is not a mandate); 2) the MCO and the Health Home Partner also must provide a minimum per member/per month payment to the TCM providers of \$137.32 for those in the SMI population; 3) the MCO and the Health Home Partner must also provide a minimum per member/per month payment of \$208.75 to TCM providers serving I/DD Health Home members. The TCM provider will be responsible for various components of the six core Health Homes services and these will be determined at the time the Health Action Plan is developed. These minimum TCM payments are the weighted average of the TCM and Comprehensive Care Management service utilization and also TCM dollars and the regular KanCare per member/per month rate for all Level 4 members, which is where all I/DD members fall regarding the Health Home rates or the Chronic Conditions population and also the SMI population.

Health Home Rate Review – the state and its actuaries will review the Health Home per member/per month rate methodology six months after program implementation. That will be January 2015. At that time, the rates could be adjusted based on service utilization and other data and other information that we receive after the program was implemented. After the six-month rate evaluation, an annual review of the rates will be conducted and we review all KanCare rates on an annual basis. So we will roll the Health Home rate review process into our annual KanCare rate review process.

Okay so I know we've covered a lot of material and our university partners at WSU are now going to start facilitating the questions that you may have and myself and other members of the State Health Home team, as well as the MCOs will do our best to answer as many questions as we can with the time that's remaining in this webinar.

**Sonja:** Excellent, thank you Melissa. So for those of you that might have a question on your minds, I can tell you that right now we have seven questions from the group and there are 108 people signed in at this moment, so I anticipate you will be asking me more difficult questions. But before we really get started, one of the first questions was “who are the MCO representatives on the call?” So for those of you who are one of the MCO representatives, you can hit \*6 to unmute your line to be able to take questions. So if I could hear who is representing Amerigroup today – you can hit \*6 to unmute your line.

**Steve Clark:** My name is Steve Clark and do you want me to give email addresses?

**Sonja:** We will give them an email address. There is one at the end, so I just wanted to know who was on the line. Thank you Steve, and from Sunflower? Do we have a representative from Sunflower today?

**Dr. Sosunmolu Shoyinka:** I'm the Medical Director for Behavioral Health with Sunflower.

**Sonja:** Excellent, thank you for letting us know.

**Jeanine Meiers:** And this is Jeanine also with Sunflower.

**Sonja:** OK, great.

**Dr. Sosunmolu Shoyinka:** Jeanine is our Project Manager for this.

**Sonja:** Excellent, thank you for both being on and from United, who's your representative today? (pause – no one answered) Well, hopefully we will hear from them if they find the opportunity to unmute at \*6.

Okay. so I'm going to take the questions in the order that we've received them thus far and the first one is about spend-down cohorts. The question is: spend-down cohorts...are those that have met spend-down or all of spend-down?

**Melissa Warfield:** In reference to the cohorts, it's all spend-down members. Now I will repeat the answer...in reference to the cohorts with the specific question here, that includes all spend-down members in KanCare. Now I will add a little bit of information to that answer and say that Health Home services are not available for any member that has not met their spend-down; it is not an eligible service to meet spend-down so if there is any member that is in KanCare that is falling into a spend-down cohort, that spend-down must be met before Health Home services can be issued or utilized to that particular member.

**Sonja:** Thank you. We have two questions at least that I have seen regarding the practitioners for the Chronic Conditions Health Home SPA and one was: may PAs provide services and then a second that was similar was: do nurse practitioners and PAs fall into the physician category or is the physician category only MDs or DOs?

**Becky Ross:** This is Becky Ross, our intent is that the physician category is only for MDs and DOs. We are taking under advisement the issue around physician assistants and APR's or I mean ARNPs, sorry.

**Sonja:** Thank you. Another question is for the newbies on the call, can you explain how the State will pay for this program? Where does the money for Health Homes come from?

**Melissa Warfield:** That's a really good question. The Health Homes program is part of the Affordable Care Act and we will receive and get funding from the Centers for Medicaid and Medicare Services. They also call that CMS and for the first two years of the program, CMS will give the State of Kansas, and any state implementing a Health Homes program, 90% of the funding and then the State will have to fund 10% of that program and again, that is for the first two years of the program...

**Sonja:** Thank you.

**Melissa Warfield:** ...that we will receive that enhancement. Sure.

**Sonja:** We have a question about slide 38 and the question was: is number three referring to just the Chronic Conditions SPA? So, I backed up the slides.

**Melissa Warfield:** Yes, that's a great question. There's a lot of information regarding the TCM rule that we have and we did kind of condense a lot of the back information into one slide, so I appreciate your question. I will also refer the questionnaire to our Program Manual for SMI. I think we have a little bit different narrative there that might help explain that. But the short answer to the question is yes, so bullet number three – in that minimal payment amount is applicable to Chronic Conditions. Number two \$137.32 is applicable to the SMI.

**Sonja:** Thank you. The next question is related to foster care and I/DD. What level would a child with I/DD have if he or she is also in foster care?

**Melissa Warfield:** I don't have enough information on that particular situation regarding eligibility to really answer that question. That's something that's coming from a particular provider and they need to take that specific example and situation to their MCO representative and tie that out there.

**Sonja:** So the MCOs would help answer when a...

**Melissa Warfield:** Any specific questions that they may have regarding potential Health Home members and their eligibility criteria relating to cohorts.

**Sonja:** OK, we have several questions related to that and I'll just share them so that the MCOs might be ready to think about things like when a member falls into two levels – how do they determine which level the participant is considered under?

**Melissa Warfield:** Right, well I will answer that question because that is a little bit different. There's no such circumstance in which any KanCare member will fall into two rate cohorts. I think what might be attempting to be asked is what if someone qualifies for a level under SMI and/or perhaps Chronic Conditions because it is possible that someone who meets the eligibility criteria for SMI and/or Chronic Conditions. If that is the case, the MCO will use the data that they have for that particular member and make an assignment for one Health Homes group or another, so either SMI or Chronic Conditions. But the member also has a choice. Choice most of the time, always trumps all things that we have and the member could always choose and work with their providers and MCOs to determine what choice they would like to make, whether that would SMI or Chronic Conditions. But there is never a KanCare member that will fall in one rate cohort and another – it's just one.

**Sonja:** OK, so just one more question related to the two levels – the specific question what was a child with SED who is also receiving I/DD – how would they determine which one they fall in? Does that go to the MCO?

**Melissa Warfield:** That's definitely something that they need to take that specific member's circumstances and situation and call member services or the assigned MCO and work that out. That's just not enough information for me to determine where they may fall. That's a very member by member, very specific criteria that we are not going to address here.

**Sonja:** Another question that is very similarly related to the SMI Health Homes – if a member qualifies for both SMI and Chronic Conditions – they will be assigned and then the member would have a choice? You answered that already. So this is related to physicians – can you give a few examples of how the physician will be used in the Health Home services and how the physician services would differ from other Health Home providers as the social worker, etc.?

**Becky Ross:** This is Becky Ross and I can answer that. For both Health Homes, the physician is really a consulting role and he would be involved in helping to develop the Health Action Plan with everyone else on the person's team, he or she would be available for consultation, but the physician in the Health Home team is not meant to replace the individual's own personal physician.

**Sonja:** Thank you Becky. There's a follow-up question about PAs and how soon we will know if PAs may participate? So you indicated it was under advisement...is there a timeline, I guess is the question?

**Becky Ross:** Well, we will definitely have to know before we present the SPA at the end of April, so it will be sometime in the next couple of weeks.

**Sonja:** Gotcha. So we have a very specific question about billing for TCM's and Health Home services. Will the TCM portion of Health Homes components also cover the Care Coordination/Comprehensive Case Management? Will this be billed as TCM as currently billed or only through a contract with the Health Home partner?

**Melissa Warfield:** OK, so that's a very good question. The reason that we have included the inclusion of that Targeted Case Manager on slide 38 and within this program is that we...the State understands that the TCM's relationship with the I/DD population is very important and for the I/DD members of KanCare to have a successful transition into Health Homes if they choose to include their TCM provider, we know that they will most certainly work really well to help ease the transition. One of the guidelines that CMS has issued, not just in Kansas, but to all states that have implemented the Health Homes program, is that Target Case Management services cannot be billed for any KanCare member that is enrolled in the Health Homes program and that is because CMS views TCM and Health Home services to be pretty much the same and that is duplicative and they are not going to pay twice for something. So if any member is enrolled in the Health Homes program, they cannot receive TCM services. That does not mean that a Targeted Case Management provider has no role in the Health Homes program. They have a very important role to play in this program, most specifically for I/DD members and that's why we are providing the minimum per member/per month payment for that particular provider type within this program.

**Sonja:** Thank you. We have about four more questions in the queue right now. The first is about a Health Action Plan. Can the Health Action Plan for the SMI population be completed by an RN or does there have to be an MD involved with the creation of the Action Plan?

**Becky Ross:** You're getting into specifics that we will probably address at our next webinar

because I think that we are covering the Health Action Plan then. Essentially, the Health Action Plan is going to be developed by the team. The Care Coordinator is to lead that process, but various members of the team and other providers who are outside the Health Homes would be involved in it and not necessarily sitting down at the table and having a long in-person meeting. This could be done virtually, electronically and in a number of different ways, but we expect the team to participate in the development of that Health Action Plan.

**Sonja:** This next question is about payment on slide 35, is the cost per visit/per hour...if the State Health Homes is paying the MCOs, or will the provider receive a portion of that PMPM cost? I guess that's the question.

**Melissa Warfield:** That's a very good question. The rates that the State will pay the MCO is listed on slide 25 for SMI and slide 37 for Chronic Conditions. So again, 25 and 37 are the final full rates that the State will be paying to the MCO and of that rate, all Health Home providers will be contracting and negotiating with MCOs to determine who will provide which services and then how much of each of the rates that are listed on these two slides for the MCO keep and what will be down-streamed to the provider. Also make sure that all of the participants on the call know that certainly for our providers is that your regular medical care payment to the MCOs for the physician...that won't change. That will continue to be paid as you have contracted with the MCOs once this program is implemented. These Health Home rates do not replace any future service billing that you have with the MCOs, nor does that disrupt or change any of the KanCare per member/per month payment that the State is paying for the MCO. These rates that are presented on slide 25 and 37 are in addition to the fee for service payments providers that are already billing MCOs, and in addition to the rates that the State is already paying for each member per month within KanCare. So this is in addition and there needs to be some contracting and...contracts most likely between providers and MCOs but it doesn't replace anything other than if someone is in Targeted Case Management...it's in addition to.

**Sonja:** Thank you, Melissa. I think we have about three or four more questions here. One is related to Targeted Case Management. Can providers bill Targeted Case Management during the period when a member is meeting spend-down and not eligible for their Health Home? Could this help them meet their spend-down?

**Melissa Warfield:** Yes, as an answer to that question, before a member has met spend-down, TCM can be billed because again, as I answered previously, Health Home services cannot be delivered to a KanCare member until spend-down has been met. Well, TCM services could be billed and delivered to a KanCare member prior to spend-down being met, but once spend-down is met and enrollment in the Health Homes program takes place, TCM billing cannot take place. We can bill for it, but you probably won't be paid for it through the MCO.

**Sonja:** So there was another question about levels, which is: how did the levels get assigned? So I think we covered this, but it was pretty fast on the slides.

**Melissa Warfield:** Let me...just let me go back to that information. So the levels were assigned based on our KanCare Cohort groupings, which was based on eligibility criteria and

the groupings were within the KanCare Rate Cohorts for Health Homes was developed mostly by service utilization and eligibility formularies and service utilization formularies. And that differs a little bit between the two different populations which is while you'll see some...a few differences between the SMI and the Chronic Conditions level groups.

**Sonja:** And as a follow-up question for that related to the dual eligible pieces on each of the slides, can you reiterate what that dual eligible part means?

**Melissa Warfield:** Sure. Dual eligible just means that any KanCare member falling in that Rate Cohort is not just eligible for KanCare and/or Medicaid, but for also eligible for Medicare. And that really doesn't have anything to do with the Health Homes program, it's just the title of that KanCare Rate Cohort. Any dual eligible which are folks that are eligible for Medicaid and Medicare are also eligible for Health Homes, so it really doesn't have any implication on the Health Homes program, on the level on the Rate Cohorts, it's just part of the Rate Cohorts title because that's part of their eligibility, but not eligibility for the Health Home.

**Sonja:** So, I anticipate that I'm not fully asking the question correctly...so when we post the question and answer, this specific question will get answered. There is one more billing question: Will a DD Targeted Case Management agency bill the Health Home Partner for the MCO for reimbursement of services provided? Which I think is getting into, how does the contracting case work, so the question as it's written is: Will a DD Targeted Case Management agency bill the Health Home partner for the MCO for reimbursement of services provided?

**Melissa Warfield:** That can vary; it could vary by the MCO because each MCO is developing very different plans on how they are going to work with Health Home Partners and delivering Health Home services to KanCare members. That also depends on what the Targeted Case Management agency is able to do. If they are able to come to the MCO and deliver the majority of the services depending on what that MCO plan is, then they'll probably have a direct contract with the MCO. If that Targeted Case Management provider only wants to provide TCM services, again that could depend – they could contract directly with the MCO, depending on the MCO and the MCO's plan with Health Homes or they may contract with the Health Home Partner – it just varies. So I would encourage that particular provider to reach out to the three MCO KanCare plans and start the conversations on what their role may be with the program.

**Sonja:** So we introduced the MCOs and have not given any questions directly to them. I just wanted to give them a chance to weigh in. Are there questions you've heard thus far that you'd like to weigh in on? Either Amerigroup or Sunflower.

**Ben Pierce:** This is Ben Pierce from United; I joined a little bit late but I would just kind of echo what Melissa was saying on that last question regarding the TCM relationship. We are happy to work with those providers directly and if they are interested in performing and are able to perform all six services under the Health Home, then certainly that arrangement would make sense. But for a relationship that they may want to have with another Health Home Partner, if they are not providing all six, we won't be having separate or split payments on that. We will be focused on a single payment to a primary Health Home Partner and then if

there is a subcontractal relationship between the Health Home Partner and a TCM, we would expect that any reimbursement would occur at that level.

**Sonja:** Excellent, thank you Ben for weighing in there. We have a similar kind of contractual question which is not exactly the topic of the webinar but I think we can answer it with the folks that we have on the call today. The question is: will physicians need to sign a new contract with the MCOs or will it be an addendum to their current contracts?

**Melissa Warfield:** I am going to defer that question to our MCO partners that are on the line and have them answer that question from their respective plan.

**Sonja:** Excellent, so we'll go down the group. We'll start alphabetical order, so the question is: Will the Health Home process be a new contract or will there be addendum's to the current contract? So Amerigroup...

**Steve:** Yes, this is Steve with Amerigroup. The intent is if the provider is already contracted, we'll probably go ahead and do an amendment or an addendum in the agreement. And I say probably because that's the route that we are leaning towards. It doesn't appear that we are really need to do another contract with the providers that are already contracted with us.

**Sonja:** Thank you and Jeanine with Sunflower...

**Jeanine:** Yeah it's the same for us. As long as our plan is that they have an existing contract with us, it will be an amendment.

**Sonja:** Thank you and Ben with United...

**Ben:** It will be the same for us. For any providers that may not be contracted with us already so you don't have any kind of arrangement or agreement, I would strongly encourage you to reach out to your network manager if you know them or have a relationship already or if not, you can certainly feel free to contact us via the Health Homes mailbox there and we can get you referred and start the initial contracting process on that.

**Sonja:** Excellent. Thank you all. I believe we are at the end of the questions that we can answer today.

**Jeanine:** I'm sorry, this is Jeanine and I have one question from Ashley, but I think she's having trouble unmuting her phone. She has the question of will the codes...the S0281 be added to...

**Melissa Warfield:** Jeanine – Jeanine – this is Melissa. We will not be fielding these questions right now from the MCOs. This is not the forum for that, but we can take that offline.

**Jeanine:** Oh, okay thank you.

**Sonja:** Excellent, OK, so thank you all for your great questions today. We have a couple that are pretty specific that we see and want to encourage you that we have received your

questions and we will be working with our KDHE partners to get those answered and posted.

All of the webinars that have happened thus far are available on the KanCare website and here's just a preview of the webinars to come. Next month, we'll be talking about the Health Action Plan and talking about the Health Information Technology Basics. Your feedback via the evaluations will help determine some of the future topics so in about an hour, you will be given an evaluation and we encourage you to fill that out because we do read them and take them seriously. So thank you all for participating today. Thank you so much Melissa for your presentation. Just a last reminder that the Regional In-person Meetings are happening in about a week and we have six locations. Just to let you know that we are full in Topeka, so if you were hoping to attend in Topeka and haven't registered already, you may want to visit us in another location. I believe we are all set for today – thank you so much for participating and we'll all talk to you soon.