

**Health Homes Webinar Series:  
Targeted Case Management  
June 17, 2014**

**Presenters:** Becky Ross, KDHE Division of Health Care Finance

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

**Sonja:** I'm Sonja Armbruster and I'm here at Wichita State University Center for Community Support and Research to support this effort for KDHE. I'm here with Vanessa Lohf and Kristina Helmer and we will be helping monitor the webinar throughout the conversation today. This series is presented to highlight tools and resources available to potential Health Homes Partners. This webinar, and all of the Health Home webinar series presentations are recorded for future viewing on the KanCare website. The slides for today are already posted. For each webinar, answers to questions raised during the presentation have been answered and posted. In a moment, Becky will give you a quick tour about how to locate those materials on the KanCare website.

Before we begin, just a few quick housekeeping items...all of your lines have been muted and will remain so for the entire presentation. There are well over 100 people registered for this, and approximately that many already on the line, so we will have lines muted throughout the presentation, however there will be a question box for you to ask questions throughout the webinar. You can expect to see a thank you email after the webinar with a short survey; feedback is important so that we can improve your future experiences and future meetings. If you look in the upper right-hand corner, you should all have a 'question' box that appears on your desktop as part of the GoToWebinar layout. This is the method that we will be using for asking questions during the presentation. You may type your questions related to today's discussion at any time and we will be theming these and will ask the panelists about that at the end of the presentations. Because of the large number of folks participating on the phone, we will not be taking questions live over the phone. Any additional questions may be referred to Becky Ross. At the end of the presentation, her email will appear and you can send emails her way.

Today's presenter is Becky Ross from the Kansas Department of Health and Environment: Division of Health Care Finance. The purposes for today include: increasing participant understanding of the Centers for Medicare and Medicaid Services portion on Health Home services and Targeted Case Management, highlight the differences and similarities between Health Home services and Targeted Case Management, and allow participants to ask staff from KDHE and the MCOs questions regarding Health Home services versus Targeted Case Management.

We know we have representatives from all three of the Managed Care Organizations on the line ready to listen and hear your questions. With that, I will turn it over to you Becky Ross – thank you.

**Becky Ross:** Thanks, Sonja. What you are seeing now is the front page of the KanCare website. That's how you navigate to our Health Homes webpages. You can see the highlighted box there and it will take you to Health Homes in KanCare. This is our front page for Health Homes and most of you are going to be interested in the Provider information, so you just click anywhere on that picture and that will take you to this page where you can see on the left-hand side the Health Homes webinar series and the arrows highlighting the informational materials for Providers. That will give you all that information that's listed there on that page.

So today we are going to talk about Targeted Case Management and just as some background, we have known for a long time through our cost and utilization data in Medicaid...that people who are now served through KanCare, including people with I/DD, have spent more time in hospitals and emergency rooms, they have less well-managed chronic conditions or serious mental illness. So that was one of the reasons we decided that KanCare was important for our Medicaid population...to try to produce some better health outcomes for folks and make sure that get their primary care to the appropriate service settings and that their chronic conditions were better managed. We know that TCM (Targeted Case Management) adds value to services that members receive, but it clearly doesn't produce greater health outcomes by itself. So we need to do more.

CMS has imposed some requirements on us related to Health Homes – many requirements, but the ones we are going to focus on today are...we can't duplicate service or payment for people in Health Homes and TCM (Targeted Case Management), CMS sees as similar to Health Home services, so they have essentially told states that people in Health Homes cannot also get Targeted Case Management. So rather than have folks choose one or the other, we believe we have come up with a solution that will help folks.

We know that folks with intellectual and developmental disabilities have very strong and often long-lasting relationships with their Targeted Case Managers. We also know that there are lots of Targeted Case Managers providing services to this population. We want to assure people with I/DD that they won't have to make a choice between going into a Health Home or staying with their Case Manager. First, we incorporated almost all of the activities in the definition of Targeted Case Management into our six core Health Home services, but then we also have some other guarantees that I will talk about in a minute. This essentially allows the Health Home Care Manager/Care Coordinators to be more hands-on in their provision of services. Those of you who are Targeted Case Managers know that there has been some restrictions on what you can do directly with an individual.

So one of our projections is that we require the Lead Entity or the Health Home Partner that serves members with I/DD in Health Homes that they must contract with that person's Targeted Case Management Provider to provide components of Health Home services that are equivalent to Targeted Case Management activities. We also have a guarantee in terms of payment, so our per member/per month payment that is made to the Lead Entity for each type of Health Home, Chronic Conditions or SMI (Serious Mental Illness), guarantees a minimum payment per month for TCM providers who serve members of I/DD in those Health Homes. Those last two bullets there show you what those minimum

payments are. That will either come to the Targeted Case Management Provider from the Health Home Partner or the MCO, depending upon the MCO and the contractual arrangement that they have with their Health Home Partners. So, in some cases as a Targeted Case Manager, you may be contracting with the Lead Entity to provide services within the Health Homes. In other instances, you may be contracting with the Health Home Partners.

The Targeted Case Manager who performs part or all of a particular task is within a Health Home service, so we will walk through sort of a breakdown of the Health Home services and compare them to the Targeted Case Management definition and their tasks. But those activities will be negotiated during the contracting process, so as you contract with the Health Home Partner or the MCO, it will lay out in that discussion what you're going to do as a Targeted Case Manager within the Health Home for the individual that you serve.

So first let's go over the qualifications. We have some professionals that are required for each type of Health Home, but I'm going to focus on the Nurse Care Coordinators and what we would call the Social Worker...that's just a category in the State Plan Amendment. We can define it any way we want and you will see that we have. So for Chronic Conditions Health Homes, we have Nurse Care Coordinators, and they have to be an RN, Advanced Practitioner, Bachelor's Nurse or an LPN. We also have what we are calling the "Social Worker" or Care Coordinator for both types of Health Homes. You can see there that there's a variety of life ensures that can meet the requirements for that Care Coordinator. So the Care Coordinator can be a Bachelor of Social Work, licensed in Kansas, could have a bachelor's degree in a related field or be a Mental Health or an I/DD Targeted Case Manager or a substance abuse disorder person-centered case manager. So anyone who meets any one of those qualifications would meet the qualifications here for a Care Coordinator in a Health Home.

So let's walk through the task by task comparison between Targeted Case Management and Health Homes. A Targeted Case Manager does a number of things related to assessment, so they participate in the BASIS Assessment, which is the statewide eligibility and services information system, they complete required assessments, they gather information for assessments, they obtain documentation. If you look on the Health Home side you see some very similar activities: conducting the comprehensive needs assessment, gathering input from family, guardian, the member, folks who support the person and service providers, and then coordinating and collaborating with all of the team members to promote continuity and consistency of care.

In terms of developing the plan, the TCM is involved in the person-centered plan, the behavioral support plan, an IEP if they are working with someone who is still in school, providing input to the integrated services plan, which is the plan that integrates what's happening in the community with what the MCO or Care Coordinator is seeing from their end, and ensures that the consumer and the decision-makers are all participating.

On the Health Home side, we have the Health Home Action Plan which is a brief plan that should incorporate pieces from the other plans that the Targeted Case Manager has been involved in, and you see there what the Health Action Plan includes in terms of goals and

strategies, the services that are provided, the role of the team members, and the references to other plans that contribute to those goals.

So Coordination of Care – the Targeted Case Manager is involved in a number of tasks related to referral and you'll see there on the Health Home side, there's also referral kinds of things happening, so the Health Home member gets referred for a variety of services and it receives assistance for completing applications. There's monitoring activities on both sides there, there's ensuring that the Care Plan is implemented and on the Health Home side, the Care Coordinator makes sure that the progress toward goals and the Health Action Plan is occurring and revising the Plan, as needed.

The Targeted Case Manager also shares information and documents activities. And both of these tasks also occur within Health Homes. So you can see for Care Coordination, there's a lot of similarity between Targeted Case Management activities and Health Home activities for that service.

If you look at Health Promotion, there's not as much occurring on the TCM side; it's sort of condensed into one task about referring the consumer to providers of Health Promotion. On the Health Home side, it's a little more direct. You could be referring someone to somebody else to provide some Health Promotion. For example, you could refer somebody to a chronic disease self-management support or some other sort of class or Health Promotion activity that someone could provide for the individual, but you might actually be providing some of that yourself in terms of providing information to the individual, it could be online information, it could be brochures, it could just be working with somebody to help them understand a little bit more about their chronic condition, and also linking them to self-help resources, if that is appropriate.

Again for Comprehensive Transitional Care, the TCM activities are pretty condensed into that one bullet there in terms of coordinating transition between long-term care facilities and community services or the reverse. In Health Homes, there's a lot more going on. We think this is a pivotal service for Health Homes because if folks don't get good transitional care when they leave an inpatient setting, the likelihood of them returning to that setting is sooner rather than later is much higher, so we expect the Health Home in this service to provide a lot more hands-on in terms of working with the hospital or whatever other inpatient setting, communicating the transition plan to everyone involved, assuring timely follow-up, making sure that there is access to transportation so that appointments that need to be scheduled following the discharge are occurring, working to reconcile medications, getting prescriptions filled if somebody comes out of the hospital so they are not waiting for medication and coordinating other therapies...for example, if somebody comes out and they need some rehabilitative therapy, we want to make sure that that person gets that. So on the Health Home side, it's a little more robust than the Targeted Case Management side, but there's still similarity between Targeted Case Management and some of the Health Home activities.

Now if we look at Member and Family Support, again like Care Coordination, we see a lot of overlap between the two sides of things. So for the Targeted Case Manager, there's monitoring and follow-up, identify changes, making referrals for the consumer or family

member or responsible person too, activities or resources that can make sure the individual gets what they need and providing information to the consumers and MCO's and Care Coordinator.

On the Health Home side, similar activities. There's going to be providing that support, making sure that what the individual needs related to their treatment plan or Health Action Plan is being provided, assessing strengths and needs, identifying support and resources. So a lot of similarity in this particular Health Home service between Case Management and the Health Home.

Finally, Referral to Community Supports and Services. Again there is quite a bit of overlap so linking a person to providers that they need to see for health care or educational activities, for social activities or social support, referring the consumer to preventative resources that provide those direct services and support, helping the consumer figure out some informal support or working with them to get some informal support going, and obviously reporting abuse or neglect.

Similarly on the Health Home side, we are going to be identifying resources that could help the individual...linking them up with those resources, helping the member and the family or the support folks to advocate for access to care, identifying those natural or informal supports, particularly services that are unavailable in the community, and then follow through and help the member access those needed services.

Health Information Technology – I mentioned early on when we talked about assessment that Targeted Case Manager has a role to play in BASIS, which is one of the data systems that you're going to continue to be working with. You may have internal electronic systems within your agency to document things, including the Plan of Care for an individual on the HCBS Waiver. On the Health Home side, Health Information Technology is used to link the team members and provide information regarding services to all of the team members as it's appropriate. So I think you can see that there is a lot of similarity between the Targeted Case Management tasks and the activities that occur in the six Health Home Services. Now, I think we are ready for questions.

**Sonja:** OK, thank you Becky for that overview of the differences and similarities between Targeted Case Management and the Health Home services. We have about a dozen questions and I invite any of you participants on the call and webinar to go ahead and use this time now to direct your questions to the question box and we'll try to get those questions answered. The first question I would like to pose is: "can a Targeted Case Manager contract with more than one Health Home?"

**Becky:** Absolutely, and you probably will because your consumers may very likely be assigned to different Health Homes.

**Sonja:** Excellent, thank you. The next question was related to training: will there be formalized training for these Health Home specific services like there is training for Mental Health Case Management?

**Becky:** The state is not providing that training, but I do know that WSU CCSR recently received a grant from the Kansas Health Foundation to work with Care Coordinators in the development of the Health Action Plan. So there will be some training occurring around that. The MCOs will be providing some training, and the Health Home Partners may also either be accessing some training or developing some of their own.

**Sonja:** Excellent, thank you Becky. We have a couple of questions about staff roles and one of those is: “can the same person be the Targeted Case Manager who is also the Health Home Care Coordinator?”

**Becky:** There is nothing to preclude that.

**Sonja:** Another marginally related question to the staff roles is: “could the I/DD Case Manager or the Targeted Case Manager also work with non-I/DD individuals, so for example, if they had a chronic conditions support or SMI support?”

**Becky:** Absolutely.

**Sonja:** Great, thank you. A second question about staff roles is: “what was the role of the physician in relationship to the Case Managers within a Health Home?”

**Becky:** It depends on which physician you are talking about. Each type of Health Home, SMI or Chronic Conditions, has to have a physician consultant who is part of the Health Home. Then a member may also have a different physician who is their primary care physician. In some cases, it may be the same physician, but not always. So the physician consultant, if he or she is not the primary care physician he or she will be involved in the development of the Health Action Plan, the consulting physician will be available for consultation on particular issues that come up. The primary care physician will continue his or her role as the primary care physician, but they will be looped-in through the Care Coordinator of the Health Home. So they will be privy to other things that are going on that they may not know now as the primary care physician. Both the consulting physician and the primary care physician should be involved in the development of the Health Action Plan, either in person, but in the case of the primary care physician, it's probably going to be electronically where you are sharing what you are doing with the Health Action Plan and letting them know what's going on with it.

**Sonja:** Thank you. Related to that question about the physician consultant: “does the physician consultant have to be licensed in Kansas?”

**Becky:** Yes.

**Sonja:** Thank you. We have a number of questions about the Nurse Care Coordinator role and...basically just what is the role of the Nurse Care Coordinator?

**Becky:** Well, a Health Home Partner can use both the Nurse Care Coordinator and the social worker to do care coordination activities. Obviously, the Nurse Care Coordinator has a clinical background, so he or she is going to have a stronger role related to either the

physical health care or behavioral health care of the individual. The Social Worker Care Coordinator has the background for community supports and services and making referrals to services. So both of them are going to play similar roles and they will, as the Health Home Partners get set up, determine who's going to do for which for the caseload. Obviously not everybody is going to...Care Coordinators will have the larger caseload, for example than Targeted Case Managers now carry. So there will be a need for both the Nurse Care Coordinator and the Social Worker Care Coordinator to do specific things for the same individual.

**Sonja:** Excellent, thank you. One more staff role question...or at least one more: "what will the Health Home Case Manager need to do in relationship with the HCBS Waiver Services and KDADS licensing?"

**Becky:** You will continue to have to meet the requirements that are placed on you by KDADS for the HCBS Waiver Services. There are specific requirements CMS has laid out for all of our HCBS Waivers, so those will have to continue to be met, either within the Health Home setting by the Targeted Case Manager there or for some population who won't have a Targeted Case Manager within the Health Home...outside of the Health Home.

**Sonja:** Thank you. One more staffing related question: "for the TCM I/DD group, who will be responsible for doing the Health Action Plan? Will the Health Action Plan be led by the Targeted Case Manager or by the Health Home Partner? Some combination?"

**Becky:** Well that will be negotiated at the time you contract. If an I/DD agency is the Health Home Partner and some of the Targeted Case Managers work for that agency, then it would probably make sense for the Targeted Case Managers there to develop the Health Action Plan. But we want clinical involvement in that development, as well, because we are looking at health goals. So I think that will be negotiated in terms of who's going to take the lead on that, but everyone on the team will be involved in developing the Plan.

**Sonja:** Thank you. One of the slides in this presentation indicated that the Care Coordinator will be going to appointments – is that a requirement or only if needed by the client?

**Becky:** It's not a requirement, but we do...as one of the requirements to be a Health Home Partner, we require that they must have the capacity to accompany members to appointments when necessary. That's really at the discretion of the Health Home Partner as to when it might be necessary to accompany someone to an appointment. That's one of the differences between Health Homes and Targeted Case Management. Right now, CMS prohibits Targeted Case Managers from receiving any reimbursement for TCM if they accompany an individual to an appointment. Within the Health Homes, that is allowable; it's not required of every individual for every appointment and it's really up to the Health Home Partner to determine when somebody would need a Care Coordinator or the TCM or somebody else to go with them to an appointment.

**Sonja:** So on that same note, clarifying even more discreetly, is it the expectation that scheduling and attending appointments is going to be completed by the Health Home Partner or will they follow up on the residential who is making and keeping the appointments?

**Becky:** It's going to depend on the individual and where they're living and how they are supported. Again, I think as you enter into your contract with Health Home Partners, those things will need to be outlined and then for each individual, there's going to have to be some flexibility.

**Sonja:** So just so the MCOs and Becky know, we have dozens of questions and we are searching for the ones that seem to repeat or be standing out most significantly. Let's do a couple more along this line and then we will shift to a couple other topics that we have clearly themed through here. One of these is about...the RN and the Nursing Office already does a lot these functions and how will that translate to Health Home Partners? So thinking about how does the work that's already getting done get coordinated with the new Health Home Partner that might be outside their agency?

**Becky:** It's incumbent upon a Health Home Partner to know everybody who's involved in providing service to the individual. First of all, they would need to know that that RN is there doing some of that work. Then, of course...the Health Home Partner is going to be ultimately responsible for care coordination and for the outcome. So they may decide that they want to take on some of that work directly. Or they may simply continue to have the RN at the agency do it and coordinate the other way, so that the RN is letting the Health Home Partner know who set up this appointment, and it's happening at this time, so then the Health Home Partner can note that and then follow up to see what happened after the appointment.

**Sonja:** Excellent, thank you. I have a question about Nurse Care Coordination versus Social Work Care Coordination: "do you have to have...for Health Home Partners...do they have to have both a Nurse Care Coordinator and a Social Worker Care Coordinator, or could it be either?"

**Becky:** We have actually...I think I'm going to have to answer that question later. I don't have the SPA in front of me to know if we actually had an either/or...I'm thinking that it's both, but I want to confirm that.

**Sonja:** Understood. There are a couple of questions that folks have posted that can be found in those State Plan Amendments, including definitions for chronic conditions and definitions for SMI, so I would encourage some of the folks to visit those definitions that are available on the KanCare website that Becky toured earlier. There are a few questions that we have related to process that I would like to highlight related to when clients will be receiving letters and how Targeted Case Managers will know that their clients have received letters. So I'm not sure if that's a question for you Becky or if that's for the MCOs, but there are several questions that are curious about when will the client find out that they have been invited to participate in a Health Home and how might the TCM be notified that their clients are being sent letters?

**Becky:** They will receive their letters sometime in the first week of July and that will go to the consumer or whoever is listed as the responsible party in our eligibility system. I know this is an issue for folks, but the MCOs will also then send a letter to whoever has been assigned as the Health Home Partner. So it's going to be incumbent upon the MCOs, the Health Home Partner, and whoever receives the letter for the individual to communicate to make sure that everybody else knows what's happening for that individual.

**Sonja:** OK, so there are several questions about choice and assuring that the clients have a choice and one of those is: "what if an independent Case Manager refuses to contract for Health Home services with a Health Home Partner and then requires that their clients make that choice? What are the things in place to think about?"

**Becky:** Well we would want to know about that because that is unethical, first of all. We do not expect anyone who is serving as a Targeted Case Manager to coerce someone to stay with them and not go into a Health Home. Part of the reason that we have set up these guarantees is so that I/DD consumers don't have to make that choice. But if the TCM is wanting to force that choice, then that's really unethical and they and the MCOs are going to know about that.

**Sonja:** Thank you. I think that answer several questions that are related to how we assure that there will be choice for the clients assigned to Health Home services. There are a number of questions about payment and it's difficult to theme all of them, so I will just start in no particular order. There are questions about the minimum payment that was listed on the slides...is that a guaranteed minimum for the Health Home Partner or is that a guaranteed minimum to the MCO? How does that work?

**Becky:** That's a guaranteed minimum to the Targeted Case Management Provider. I would encourage you that if you haven't been to a presentation or you haven't heard information around payment to go on the website; there is an actual paper that lays it all out, including the rates that the State is paying the MCO for each type of Health Home and each level of member in the Health Home, as well those guarantees, but those two amounts that I talked about...the \$137. Something and the \$208.75...that's a guarantee for the Targeted Case Management Provider. So either the Health Home Partner or the MCO will pay at least that amount of money to the Targeted Case Management Provider each month for that I/DD member, as long as services are provided.

**Sonja:** Thank you. Is the DD TCM per member/per month paid to the MCOs for Waiver users only?

**Becky:** No, it's anyone who has an I/DD TCM.

**Sonja:** OK, so we just have a couple of more questions related to process. There was a question about: "when will we have a list of who is eligible for a Health Home? Will TCMs receive a list of their clients who are eligible for a Health Home or will they need to rely on their clients to learn they've received a letter?"

**Becky:** Well they should receive something from the Health Home Partner for the individual. As I said, the MCOs will be sending out letters to the member or the responsible party and to the Health Home Partner that they are assigning the individual to. Then following that, the MCOs will send a list to the Health Home Partners of their members. They should be indicating that this individual has a TCM, so the Health Home Partner then should be able to send a list to the TCM Provider.

**Sonja:** Great and this leads to a related timeline question: so the Health Home Partner will be notified in early July and so will the client...“is the expectation that the Health Action Plan will be written and ready to be go by 8/1?”

**Becky:** No, no we are not expecting services for the Health Action Plans to start until August.

**Sonja:** So related to that: when is the first date that an agency can bill for Health Home services?

**Becky:** Well, I don't know that I need to give an exact date, but it will be sometime in August.

**Sonja:** Gotcha. This is grouping several questions related to that...

**Becky:** We are essentially allowing July as sort of a “choice period,” even though there's no actual “choice period.” Members can opt out at any time, but the MCOs have to have some period of time that they say, “OK, this member has not opted out, so we can get started...” and they will notify the Health Home Partners and the Health Home Partners will get going with services. So that will start in August.

**Sonja:** So can the agencies continue to bill TCM until the Health Home is actually started?

**Becky:** Yes...yes.

**Sonja:** Excellent, thank you.

**Becky:** And for members who have a spend down, if they are in unmet spend down status, and therefore not eligible to receive Health Home services, you can provide Targeted Case Management in that window, but you need to be very careful to make sure that you are verifying that the person does have an unmet spend down. Then they can use the Targeted Case Management service to meet their spend down.

**Sonja:** Thank you. One more question and it's a fairly complex question so I'm going to read it word for word: “if the contract is going to be through the Health Home Partner and not bill directly to the MCOs (so it's a sub-contracting group), can the Health Home Partner take a percentage of the payment as processing like the CDDOs did when they had monthly encounters many years ago?”

**Becky:** No, this is a minimum guarantee, so they must pay the Targeted Case Management Provider at least those two amounts that I talked about – the \$137 and the \$208.

**Sonja:** Excellent, thank you. There are a couple of actuarial questions and I'm just going to summarize them, clarifying that there was a 12% administration fee calculated into the overarching payment structure and so one of the questions was: “does this come out of the rate that's published or is that in addition to the rate that is published?”

**Becky:** It is part of the rate that's published.

**Sonja:** There was a question that came in after you mentioned the spend down piece: “please clarify the unmet spend down related to using TCM to meet the spend down”.

**Becky:** Sometimes...and this may not be true for waiver folks, but folks have a spend down amount that they must meet in order to be eligible for Medicaid, so when you look them up on the KMAP look-up, it will show the amount of spend down that is remaining. The amount of medical expenses that they must incur to become eligible again for Medicaid to pay for their services. We've been told by CMS that folks in Health Homes can't get Health Home services when they are in unmet spend down, because you're only eligible for Health Homes if you are Medicaid eligible and you are actually in eligibility status. We can't use Health Home services as incurred medical expenses, but they could use any other sort of medical expense, including Targeted Case Management services as an incurred expense. So if you want to provide some Targeted Case Management services and bill the consumer, they can use that as an incurred expense to meet their spend down and then become eligible again for their Health Home services. Now it's going to be very tricky as I would caution you to be very careful about doing that, because people go in and out of spend down all the time and may not be aware of other expenses that they have so you are going to have to be checking that, so you are going to have to be checking that KMAP site a lot to make sure that...you know, maybe you look at it at 10 o'clock in the morning and then at 2 o'clock, maybe there's an incurred expense and they are now in met spend down status.

**Sonja:** Thank you and I think maybe we can do a couple more questions. Unrelated, but related to distinguishing choice: “if the consumer refuses...is eligible for a Health Home, and wants to keep their TCM...they are eligible for Health Home and they want to keep their TCM and they don't want to join the Health Home, what happens? Do they lose the Health Home or does the TCM have to become part of the Health Home?”

**Becky:** If the member doesn't want to be part of the Health Home, he or she opts out. All they have to do is return the opt out form that comes with their letter or call HP and tell them they want to opt out and they will just continue receiving their regular services and they won't receive any Health Home services.

**Sonja:** (Pause) Here's a specific question related to the billing that we've addressed in previous webinars: “will the I/DD TCM continue to bill in the same manner or will this be specifically sent under the Health Home code?”

**Becky:** OK, if you are an I/DD TCM Provider and you're working with members who are in Health Homes, you would simply work with your Health Home Partner (assuming that's who you have your contract with)...now that's going to be different for the MCO, but if you have a contract with the Health Home Partner to be part of the Health Home as a TCM provider, you can essentially work out any agreement you want. You're not going to be billing a claim through our claim system or through the MCOs claim system; you're going to be telling the Health Home Partner, "I provided this or these services this month..." and then they will provide you the monthly amount. So there won't be a code that you are billing because you're not going through a claims system. Now that will be different if you are...at least one of our MCOs is planning to retain many of the Health Home services for HCBS Waiver members. So you would, in all likelihood, then have your contract with that MCO and it will be different with them and you'll have to work with them to learn what they want you to do related to that. But if your contract is with the Health Homes Partner, then they are going to say, "We want this from you and here's how you get your payment," and it won't be that you're billing a claim either through KMAP or through the MCO.

**Sonja:** Thank you. So what would an agency need to do to begin the contracting process with a Health Home Provider?

**Becky:** They need to ask their community mental health center in their area, the federally qualified health clinic, the CDDOs who might be in their areas...if they are planning to become Health Home Partners and start those conversations today. They could also reach out to the MCOs, the MCOs know who they are working with to get contracted for Health Home Partners.

**Sonja:** (Pause) As an RN, can a Health Home bill for my services when I go out to the resident's site and do an assessment, or wound care teaching or teaching on disease management?

**Becky:** (Pause) OK, please repeat that question.

**Sonja:** Let me try to do that again. The question is coming from an RN who wants to know: "could the Health Home bill for my services when I go to the resident's site and provide teaching on disease management or do an assessment onsite?"

**Becky:** Well they could, but if that service is already part of the residential service that gets paid for through the HCBS Residential Service, they probably shouldn't, because that's going to be a duplication.

**Sonja:** I think that was the heart of the question was related to duplicate services, so thank you for that. OK, we had many, many questions come in and I think we have covered the majority of the themes, but I will assure you that we will seek answers for all of the questions that came in during the webinar and those questions and answers will be posted in the next week or two...usually sooner than that. You can see on the screen now the contact information from the three MCOs and for Becky Ross who has been taking all of your questions. Thank you for those answers, Becky. Thank you all for participating in this webinar series today and those over the last five months. Just a reminder that this

webinar has been recorded and will be posted in the next few days for future viewing on the KanCare website. A reminder that you all will receive a thank you email asking you to complete a short survey. Thank you so much and have a great day.