

**Health Homes Webinar Series:
A Primer for Primary Care Providers
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Presenters: Becky Ross, KDHE Division of Health Care Finance

Moderator: Vanessa Lohf – Public Health Initiatives Project Specialist, WSU Center for Community Support & Research

Vanessa: We want to welcome those of you who are here to the Health Home Webinar Series. This series is presented to highlight tools and resources available to potential Health Homes Partners in cooperation with KDHE. My name is Vanessa Lohf and I'm a Project Specialist here at the Center for Community Support and Research at Wichita State University and I'm going to be serving as your moderator today. This webinar, and all of our past webinar presentations in this series, have been recorded and posted for future viewing on the KanCare website. For each of those webinars, we have also posted a transcript, as well as the answers to any questions that are raised during the presentation. In just a moment, our presenter will give you a quick tour about how to locate those materials on the KanCare website.

Just a few quick housekeeping items: all of your lines have been muted and will remain so for the entirety of the presentation. You should all have a question box that appears on your desktop as part of the GoToWebinar layout. This will be the method that you use for asking questions during our presentation. You can type your questions into that box that are related to today's discussion at any time during the presentation and our staff will theme these and ask them of our presenters at the end of the presentation. Because of the significant number of folks that we are going to have participating, we are not taking questions via telephone. Again, please limit those questions to the topic of today's webinar. Any other questions you may have will be referred to staff at KDHE or the MCOs and their email addresses will appear toward the end of the presentation. You will get a webinar thank you note after the webinar is over and that will include a short survey where you can provide us feedback to help enhance the experience in the future.

The purpose of today's webinar is to increase your understanding of the Health Homes Initiative that's going to be launching on July 1st. We are going to highlight how Primary Care Providers can participate and point you toward the tools to get started on becoming a Health Home Partner. Today's presenter is Becky Ross and she is the Medicaid Initiatives Coordinator at the Kansas Department of Health and Environment: Division of Health Care Finance. Becky, I'm going to turn it over to you.

Becky: Thanks, Vanessa. What you are seeing now is the front page of the KanCare website and the arrow there is highlighting where you can click to go to the Health Homes website. This is the front page of our Health Homes website and as Providers, you would be most interested in the information in the Provider box, so just click on that picture and it will take you to some resources for Providers. This page is where you can get the tools that Vanessa was talking about; you can also get Program Manuals and other information. You see there, down toward the end of the links on the left-hand side, the Health Homes Webinar Series. That's where you can go to get today's presentation and after we are done, a recording and a

transcript and the questions and answers will be posted.

So we are going to start out talking about just what a Health Home is. The term is unique to Medicaid because this is a Medicaid Initiative and to be eligible, individuals have to be Medicaid individuals. So it's an option that we are selecting in our Medicaid program. Like a medical home, it's not a building, but it is a comprehensive and intense system of care coordination for people who have complex chronic conditions. So, Health Homes are intended for both children and adults with these certain chronic conditions. The federal government actually tells us what the list of chronic conditions are and in Kansas we have selected diabetes, asthma and serious mental illness to begin with in Health Homes. Health Homes don't replace their regular acute-care services that folks are getting now under KanCare, so they would continue to get physician visits, pharmacy, hospital care, etc. Health Home services are in addition to that.

One of the primary goals of Health Homes is to reduce avoidable emergency room visits and inpatient stays, and also to improve health outcomes for the individuals in Health Homes. Some data that highlights why Health Homes are important...68% of people that have mental illness also have co-occurring conditions like asthma, diabetes, high blood pressure, and obesity. People with mental illness, in general, die 25 years earlier than the general population because of the chronic conditions that they have. In Medicaid, we have a high prevalence of diabetes, much higher than the state or national prevalence. So you see there about 21% of our adults in Medicaid have diabetes or pre-diabetes and there you see an amount that we pay in Medicaid for those folks. Now all of those expenditures are not just for diabetes-related expenditures; many of these folks are receiving long-term support from services, as well as physical health care and behavioral health care. But that's the total cost for that segment of our population and the cost per person.

So let's talk a little bit about the differences between a Health Home and a Primary Care Medical Home or a Patient-Centered Medical Home. Health Homes can be PCMHs. In fact, we encourage practices that are PCMH recognized to become Health Homes because you are well-placed to do that. Health Homes services though, expand a little bit more than a Patient-Centered Medical Home. In PCMH, the medical home is led by the physician; in the Health Home, there are some additional linkages to community and social supports. In the PCMH, the physician is responsible for coordinating all of the individual's health care needs and making arrangements for other specialists and other Providers to see the individual. In the Health Homes, there is enhanced coordination of medical and behavioral health care, and we really want that to move toward integration of physical and behavioral health care. It's also focused on the needs of people with multiple chronic illnesses, it doesn't tend to focus on the single disease.

So these are the core services for Health Homes...to be a Health Home you must be providing these six services to the individual. Now these are in addition to services that they already receive, and you'll note that the last two services listed there – 'Member and Family Support and Referral' to 'Community Supports and Services'. Those are really, I think, what makes Health Homes slightly different from PCMH's in that we are looking beyond physical and behavioral health care into long-term supports and services. Many folks who are receiving Medicaid need a lot of support to remain in their communities, so they are getting

certain home and community-based services, they need housing support, they need some employment support, and that doesn't mean that the Health Home has to provide that; but the Health Home has to be able to refer the individual to services and supports that can provide those.

Our Kansas Model is unique in Health Homes across the nation. There are about 15 states now that have Health Home programs in Medicaid. Ours is a partnership between what we call the Lead Entity or the Managed Care Organization in KanCare and the Health Home Partner which is a Provider in the community. To be a Health Home Partner, you have to be one of a certain "Provider type" - different Provider types and you must be willing to contract with at least one KanCare MCO. We think our Model provides flexibility to support existing relationships. Our folks have a lot of close relationships with community providers and we want to make sure that we can retain those whenever possible. There's a shared payment structure so the MCO receives some funding which they take some of and pass the rest along to the Health Home Partner. In contrast between the MCOs and the Health Home Partners and subcontracts between the Health Home Partners and other Providers determine who's providing the services and how they are being paid for and we will talk in more detail about that.

We think this is a nice picture of how our Model approaches Health Homes, so as I said it's a partnership between the MCO or the Lead Entity and the Health Home Partner who is the community provider. Together, they form the Health Home and together, they determine who's going to provide the six services. In many cases, the Health Home Partner may be providing all of the six services and the MCO is managing the administrative portion of assigning the person, providing data, sharing that with the Health Home Partner and dealing with the collection of solid measures and reporting those to the state and so forth. In other cases, the MCO may actually be providing some of these services and then the Health Home Partner would provide the rest. We also allow for the Health Home Partner to subcontract to provide some of these services. For example, for people with serious mental illness, all of our community mental health centers have signed up to be Health Home Partners. If I'm at a community mental health center and I don't feel that I'm well-placed to do Health Promotion, but I know that my local health department does a really good job with that, I might subcontract with that local health department to do that service and then maybe I do the other five and I'm the Health Home Partner that contracts with the MCO.

(Pause) How a person gets placed in a Health Home is tied to the rules that the federal government has to begin with for the program. They tell us what the chronic conditions are. Now we get to define those more specifically and people are chosen, then, based on those chronic conditions, either medical or behavioral conditions and the amount and type of services they are using. Qualified people will get a letter beginning in July telling them that they qualify for Health Homes and that they can choose to opt out, so it is voluntary. We assign people, but then we allow them to opt out and they can do that by returning the form or making a phone call. So, obviously, not everyone in KanCare will be able to be in a Health Home.

We have two target populations. The first is folks with serious mental illness, so that's adults or children that have one of these diagnoses that are listed there. The MCOs will mine their

data to determine who has a primary diagnosis of one or more of those mental illnesses there on the right-hand side.

Our second population, and probably the population that most of you are interested in, is what we are calling chronic condition and those are people that have asthma or diabetes, including pre-diabetes or metabolic syndrome, who also are at risk of developing another chronic condition from the list there on the right-hand side of the slide. So they can't just have asthma or diabetes; they have to have one of those chronic conditions and be at risk for one of those other ones listed on the right-hand side of the slide. Or...they could have diabetes or asthma and have some indicators as we see on this next slide that tell us that their asthma is probably not going to be very well controlled, so they are living with a smoker or they smoke themselves, they have some sort of environmental exposures or there's a missed quality of care indicator, so from claimed or clinical records, we can tell that there are some things that are telling us that their asthma is likely not very well controlled.

We have the same...there are some more clinical indicators there, so ER visits and so forth. We have the same issues with diabetes, so they live with a smoker, they smoke themselves, or they demonstrate that they have uncontrolled diabetes or there's a missed quality of care indicator, they are going to the ER for diabetes-related issues, or they are admitted to the hospital in the last 12 months, or note there in the top 25th percentile of the Lead Entity's risk stratification...all of our MCOs...the Lead Entities have tools that they use to stratify their members and lay out who is at the highest risk for more utilization of services and higher cost. So someone could have diabetes and then fall into that top 25th percentile and that would make them eligible. So there is a lot of ways that someone with asthma or diabetes can become eligible for the Chronic Conditions Health Home. But just having asthma or diabetes that is well-controlled will not likely make them eligible for the Chronic Conditions Health Home.

So, the individual has to be eligible for Medicaid, the MCO assigns them to a Health Home Partner based on the claims and other information that the MCO has available to them. They are going to look at: does the individual have a relationship with a particular Provider in their geographic area who is also a Health Home Partner? If not, then they will look for another Health Home Partner in their geographic area and so on, so they will try to make a smart assignment based on the information that they have. We also have a process that allows Providers in the community to refer individuals to Health Homes and that will begin a couple of months after we launch Health Homes; we are going to get started with the folks that we have, but there will be a referral form available to Providers to submit to the MCO.

The Health Home team varies a bit depending on the type of Health Home. So a Chronic Conditions Health Home includes a physician...we allow a PA or an APRN in rural areas, because we know that there is difficulty getting enough physicians out there, the Health Home must also have a Nurse Care Coordinator, which can be any one of those categories of nurses, and then they have to have a Social Worker Care Coordinator and we define those very specifically in our Program Manuals that are out there on the web. For the SMI Health Home, we've also added of course a psychiatrist, and a Peer Support Specialist or Peer Mentor.

So let's talk about payment for the Chronic Conditions Health Home. The basic structure is that we pay the MCO a per member/per month payment at the end of each month for everyone enrolled in Health Homes if the service was delivered that month. So unlike their KanCare rate, they don't get it whether or not services are delivered, a Health Home service must be delivered in order to trigger the payment from the MCO. There's one payment regardless of the number of services, so it's essentially a bundled monthly rate that gets paid for Health Home services. If there is no service provided in the month then we make no payment to the MCO and they would make no payment to the Health Home Partner. Again, just to emphasize Health Home payments don't replace existing KanCare payments.

As I said earlier, the MCO is going to contract with Health Home Partners Community Providers to do some or all of the six core services. The contract between the MCO and the Health Home Partner will lay out who's doing what and what the payment rate is. Then the payment from the MCO to the Health Home Partner must also be a PM/PM. So we are going to pay the MCO a monthly rate, the MCO is going to pay the Health Home Partner a monthly rate, again regardless of how many Health Home services were provided, but one MUST be provided in the month to trigger a payment. There can be some other arrangements like Shared Savings or Incentives, but we will be reviewing and approving those.

We used a four level approach to set the payment rate, so there will be four levels of payment that we make to the MCO for the Chronic Conditions Health Home and we did that by combining the KanCare Rate Cohorts and that's kind of complex and I don't want to go into a lot of detail here but we essentially have 52 or 54 rate cells that we pay the MCOs for all the people of KanCare. Our actuaries essentially took those and collapsed them into four levels of roughly similar people so the Health Home rate level is somewhat driven by Medicaid eligibility category and overall utilization of services.

So our actuaries did a lot of work for us, which is why we have to pay them a lot of money. They look at the target population, they used a couple years of base data, they looked at the cost for the mix of professionals that we're requiring in a Health Home, they looked at service utilization for the population for some certain services like inpatient hospital and how many times people were coming in and out of the hospital, case management services, and so forth. And then they included some non-medical load or some administrative costs, they looked at the Bureau of Labor Statistics for Kansas-specific data about the professional costs. Rates were developed basically under the assumption that they would only be paid once a service was used, and they would be paid regardless of how many services were used in a month.

So what you are seeing here are the four rate levels with the administrative amount...you will see another table here in a minute. These amounts over here on the right-hand side are actually part of the full payment, so when I show you the full payment rate, just remember that this \$10.83 of it in Level 1 is for the administrative load. We are expecting the MCOs and the Providers to use to pay for their administrative costs including HIT and other things.

So here are the four rates for this Health Home and you will see that Level 4 is our highest level because those are the folks who we expect to use a lot of services and have a lot of both physical and/or behavioral health needs. Then you see the population distribution there,

so we've calculated a weighted average rate for your reference there. Now I want to emphasize that these are the rates that we pay the MCO; as a Provider – as a Health Home Partner, you would negotiate with the MCO your rate from within this amount. For those of you who really are interested in all of the work behind the development of these rates, you can go to the Program Manuals on the website and get lots more detail about how these were built.

So, how do you get started if you want to be a Health Home Partner? Well, we have some Provider requirements. First of all, you have to be licensed or be certified in Medicaid or enrolled as a Medicaid Provider as one of a dozen agencies. We have listed some there that are related to primary care or physical health care, so if you are one of these Provider types, you meet the first requirement. (Pause) Then, you have to fill out what we call our Planning and Preparedness Tool. It's kind of a readiness self-assessment that you do for your practice or your agency, you complete that and you send it into us. You let us know which MCOs you are interested in working with and then we will pass it along to those MCOs. That Tool is available there on our website.

The purpose of the Tool is to help you understand what we are asking of Health Home Partners and also to help you determine where you are in terms of being able to do all that work, assessing your strengths and challenges. If you're not yet ready to be a Health Home Partner, helping you figure out how to become one. So for the MCOs, the Tool helps them evaluate who they can contract with right now and who they might need to work with and perhaps contract with down the road. The Tool is not to determine whether or not you are accepted or rejected, we take all of the Tools and pass them on to the MCOs you want to work with. We keep track of that so that as they turn in their network reports, we can see which Providers they are working with and make sure that if they are not going to contract with somebody, they are letting you know specifically why and what the issues were.

So, answer the Tool based on your internal honest analysis of your current practices and processes as to where you are today...think about who you are serving, how often, you need to document the infrastructure of your organization, you should include all of the organizational leaders in your agency or practice and talk about the results together and think about what you might have to do for next steps as Health Homes get ready to roll out. Once the Tool is received from us to the MCO, the MCO has 10 days to schedule a follow-up conversation. That could be in-person or via telephone. Oh, I'm sorry...they have 10 days access to acknowledge the receipt of the Tool. Then, within 45 days they should have a follow-up conversation. Then, they have 10 days after that follow-up discussion to provide you a contract amendment and then you have 10 days to sign and return. Those are just general timelines that we have set just so that people can track how things ought to be happening. You know, if we get a call from a Provider saying that they haven't heard anything from the MCOs, we can track back and see what's going on.

We have reviewed the contract template and so the MCOs are out now talking with Providers. The MCOs have an expectation to provide training to Health Home Partners. We've been doing webinars on specific topics and we encourage you to go look at them if you haven't participated in previous ones. We implement Health Homes shortly thereafter we'll begin a Learning Collaborative that WSU will facilitate to provide ongoing information and support to

Health Home Partners.

And now I think we are ready for questions.

Vanessa: Thank you Becky, that was very helpful. I have just one question so far, so I would like to remind everyone who's participating online that there is a question box as part of the GoToWebinar layout and you can type those questions at any time and we will theme those and give those to Becky. Becky, the first question I have for you is to clarify this last slide when you say that the MCOs have 10 days, is that 10 business days or calendar days?

Becky: It's calendar days.

Vanessa: Great, thank you very much. Another question regarding the levels of care: could you repeat again how they determine the levels of care for the members?

Becky: Sure. Right now when we pay KanCare rates to the MCOs, we have something like 52 or 54 rate cells, so we... our actuaries categorize people into sub-populations and some of that relates to their Medicaid eligibility category. So, for example, if they are a pregnant woman or they are a poverty level child or they are an SSI (Supplemental Security Income) recipient, then they fall into a category called that. In some cases, age plays a part, so we have age ranges, so it could be an SSI recipient who is 19 to 45 and then that could be broken out into whether or not you're also eligible for Medicare, so you could be an SSI – 19 to 45 – dual or non-dual, depending on whether or not you also have Medicare eligibility. So they are pretty complicated...there's actually a table – a crosswalk in the Program Manuals. You can find that in the Payment section and see all of the rate cell categories and how we rolled those into the four levels. So those folks, by virtue of being in a particular eligibility category, tend to use services in a similar way. Although we aren't dividing folks up by acuity, in a sense they are sort of falling into acuity-based levels because of the eligibility group that they are in.

Vanessa: Becky, just to clarify: all of that is determined prior to the assignment so the Provider does not have to figure that out, correct?

Becky: Right and neither does the MCO. That is determined...we pass or our fiscal intermediary, HP, passes an eligibility file to the MCOs on a regular basis to show them who their eligibles are for KanCare and what rate cell they are in and the same thing will happen once the MCOs send the list of people that they are assigning to Health Homes, that will go to HP and then HP will match them up to their KanCare rate cell. The MCOs will be able to share that with the Health Home Partners, but it's not something that the MCOs or Providers can influence because it starts with their Medicaid eligibility group.

Vanessa: We have a few more questions rolling in, so thank you all for that. Very quickly before I ask you some additional questions about contracting, can you reiterate that Health Home services are in addition to what's already being provided?

Becky: Right, so if I'm in a Health Home I would still see my doctor if I needed a physical or if I was having an upper respiratory complaint, I would go to my Primary Care Physician. If he

or she was *not* my Health Home, I would still be getting Health Home services from my Health Home...they would be coordinating care, they would know, or find out that I had seen my PCP and they would include that information in my record. They will share information back to the PCP. Now if my PCP *is* my Health Home, I would still see him or her for the acute-care services, but they would also be able to bill for Health Home services that they are providing me – any of those six services that we listed earlier in the presentation.

Vanessa: Great, thank you very much. I do have several questions about contracting, so I'm going to try to put them in kind of a progressive order for you. First of all: will there ever be a deadline to apply to become a Health Home Partner?

Becky: No.

Vanessa: Wow – that was easy, thank you very much. Then, will patients with mental health issues be automatically assigned to a mental health provider and then possibly subcontracted back to their PCP?

Becky: OK, what will happen generally there is if the person with SMI has an existing relationship with their CMHC, then in all likelihood they will be assigned to the CMHC for the Health Home. What would happen then is that they would continue to see their PCP and the PCP would continue to bill for their regular services and the CMHC would act as the Health Home. So they would have a Care Coordinator who's working with the Primary Care Provider to make sure that information is shared back and forth. Some CMHCs are, I think, entering into contractual relationships with the Primary Care Providers to serve as physician consultants for the Health Home. If the person is eligible for both types of Health Homes, they could conceivably be assigned to a Chronic Conditions Health Home that may be, you know, like a Primary Care Clinic or a Primary Care Provider is operating. Depending on what their relationships are and what the MCO is seeing in terms of their needs...you know, what services are they using most? Are they in and out of the hospital a lot for their diabetes and maybe their mental illness is pretty well controlled and they just get med checks. In that in that case the person would probably be assigned to a Chronic Conditions Health Home.

Vanessa: OK, thank you. Can individual Providers sign up or does it have to be the entire practice?

Becky: An individual Provider can sign up, but he or she must be able to provide the six services or subcontract with somebody to help provide them and must have the constellation of professionals that we lay out in the Program Manual.

Vanessa: Great, thank you very much. I'm going to ask these next two questions of you, Becky, but MCO Partners, if you want to weigh in, please be sure to unmute your phones. The next question is whether all contracts have been reviewed for all three of the MCOs and are they available? And then are they reaching out to practices or is it the other way around?

Becky: We have reviewed them for all three MCOs and we did share them with some Associations for review and they are all...they should all be reaching out to practices. Now what's happening is we require that Tool to come into us so that's who they are starting with.

So, if you have not done a Planning and Preparedness Tool, I would encourage you to get that in as quickly as possible. You can still reach out to the MCOs and they can start working with you, but we...we want that Tool in just so we have that on file and we can make sure that the MCOs are being responsive to you.

Vanessa: Thank you. One more along that line and I'm going to read this one word for word: if we have contacted the MCO with questions or negotiations about the contract amendment we were sent and have not yet received a response or come to an agreement with the MCO, does the 10 day rule still apply?

Becky: No. If you're talking about the 10 day rule to get a contract signed, no, and that's really just...we wanted to make sure that practices weren't necessarily holding up the process unnecessarily, but we understand that it sometimes takes some time to work out and negotiate rates.

Vanessa: OK. Then, as a Primary Care Provider, how will we interact with a Health Home Partner whose member presents to us with an already developed Health Action Plan?

Becky: Hopefully you would have been involved in the development of the Health Action Plan. If you were already the Primary Care Provider for that person, you should have been involved, at least to the point of it being shared with you for your review. If you are becoming the Primary Care Provider for somebody maybe who enters a Health Home and doesn't have a Primary Care Provider, you can certainly weigh in on that Health Action Plan. You can contact the Care Coordinator and talk with the individual themselves about a need for adding a health goal or modifying a health goal. The Health Action Plan is not something that is going to be static, so we fully expect the Health Home Partner and the Care Coordinator there to make sure that it's a workable plan and that it's going to meet the individual's needs and that as goals are met that new goals are added or that if goals need to be modified, they are modified. Everybody who's part of the team, including the Primary Care Provider and Specialty Providers, can weigh in on that and make recommendations.

Vanessa: Great, thank you. One more question: with the Learning Collaborative that you spoke of that is going to be facilitated by Wichita State, is that going to be open to anyone, or is that only for folks that are designated Health Home Partners?

Becky: It's going to be open to Health Home Partners. We are allowing Association Membership because we know that, particularly for Primary Care Providers, it's going to be tough sometimes for you to be able to attend them all the time, particularly the in person thing. Out of necessity, it has to be managed, so we can't include all the subcontracting partners and that sort of thing. We've had some conversations with Wichita State about as new Health Home Partners are identified or Providers are starting to begin the process to become a Health Home Partner, we might need to have a...sort of a two separate tracks, so kind of the ongoing process of – I'm a new Health Home Partner or I'm trying to be a Health Home Partner and I need some assistance with that versus the existing Health Home Partners who are already up and running and the Learning Collaborative is really around identifying issues and areas for improvement and developing continuous quality improvement processes.

Vanessa: Great, thank you very much. That kind of segues into reminding everyone that most of the information that was sent out to you today was via the Kansas Academy of Family Physicians and they have been talking a lot with Becky and making sure that you all get the information that you need to participate, so we want to thank them for their help in that. The other Associations were very instrumental as well and so we want to make sure that they continue to be included in our Learning Collaborative, as well as the other opportunity that we have for Care Managers to do training on writing quality Health Action Plans and so we will be talking about that more in the near future, as well.

Becky, I think those are the last questions that I have other than folks are wondering about getting the slide set for today, so I will remind everyone that we will post today's slide set, as well as a recorded audio and video version of today's webinar to the KanCare website. It will take us a few days to get that transcript complete, so it will probably be the end of this week or early next week. Thank you, Becky, very, very much for your time and information today. Thank you all for your time and participating. You will get a thank you email and please be sure to fill out that survey. Thank you all and have a great day.