



WICHITA STATE
UNIVERSITY

Health Homes Webinar Series: Targeted Case Management

Rebecca Ross

KDHE Division of Health Care
Finance

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Welcome!

- The Health Home Webinar Series is presented to highlight tools and resources available to potential Health Home Partners
- Posted on the KanCare website for future reference
- Thank you for calling in! All caller phones are muted for the duration of the presentation.
- Enter questions via “Question” box on your screen



Purposes for Today

- Increase participant understanding of the Centers for Medicare and Medicaid Services (CMS) position on Health Home (HH) services and Targeted Case Management (TCM)
- Highlight the differences and similarities between HH services and TCM
- Allow participants to ask staff from KDHE and MCOs questions regarding HH services versus TCM



KanCare Website

KanCare
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Latest News – Upcoming Events
Meetings for Members with Serious Health Conditions
I/DD Waiver Services' Incorporation into KanCare
Open Enrollment for Members with Jan. 1 Anniversary
Important message for Members (Video)

About Us News Workgroups/Council I/DD Health Plans Contact Us

Medicaid for Kansas

KanCare Consumer Assistance: 1-866-305-5147

Consumers
Benefits & Services
Apply for Medicaid/KanCare
Choosing a KanCare Health Plan
Events
Frequently Asked Questions
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Providers
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Policies & Reports
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KanCare Quality Measurement
Health Homes in KanCare
Readiness Activities
Delivery System Reform Incentive
Annual and Quarterly Reports

About Us
What is KanCare?
Kansas Medicaid Reform
Sect. 1115 Waiver and Comments
News
Advisory Council & Workgroups
Frequently Asked Questions

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Medicaid for Kansas

Health Homes in KanCare

Consumers

Providers

FAQs

News and Events

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KanCare Website

The screenshot shows the KanCare website header with the logo and navigation menu. Below the header is a banner image of a green field with the text 'Medicaid for Kansas'. The main content area is titled 'Health Home in KanCare' and contains a 'Providers' section. A red arrow points to the 'Informational Materials for Providers:' link in the left-hand menu.

Providers

Informational Materials for Providers:

- Health Home
- Provider Regional Meetings
- Approaches to Health Homes
- Payment Principles and Parameters:
- Services
- Informational Materials for Providers:**
- Stakeholder Meetings
- Health Homes Webinar Series
- Contacts

Serious Mental Illness (SMI)

- SMI State Plan Amendment
- KanCare Health Homes Program Manual – SMI
- SMI Health Homes Provider Requirements
- SMI Health Homes Services and Professional Requirements
- Target Population Estimates
- Crosswalk of DSM-IV-TR diagnoses and DSM-5 diagnoses for SMI Target Population
- KanCare Health Homes Payment

Chronic Conditions (CC)

- CC State Plan Amendment
- KanCare Health Homes Program Manual – CC
- CC Health Homes Provider Requirements
- CC Health Homes Services and Professional Requirements
- Kansas CC Health Homes Target Population
- Target Population Estimates (.xlsx)
- KanCare Health Homes Payment

Health Action Plan

Health Home Services and Targeted Case Management

Introduction

Cost and utilization data indicate that people served through KanCare, including people with I/DD:

- spend more time in hospitals and emergency rooms, and
- have less well-managed care of their chronic conditions and/or serious mental illness

While TCM adds value to the services that consumers receive, this service alone is not enough to improve health outcomes.

CMS Health Home Requirements

Services and Payment

- CMS does not allow duplication of service or payment for people in Health Homes.
- CMS views TCM and some of the six core services within Health Homes as similar; therefore, people in Health Homes cannot receive both TCM and HH services.



State Response

- Recognizes that people with intellectual or developmental disabilities (I/DD) in Kansas have strong relationships with their TCM and that there are many providers of this service.
- Assures people with I/DD that participation in HH will not result in losing their relationship with their case manager.
- Incorporates almost all of the activities in the definition of TCM into the definitions of the six core HH services.
- Allows HH Care Managers/Care Coordinators to be more “hands on” in their provision of services.

State Response (cont.)

- Requires that a Lead Entity (LE) or Health Home Partner (HHP) who serves a person with I/DD in a HH must contract with that person's TCM to provide those components of Health Homes that are equivalent to TCM activities
- Guarantees a Per member/Per month (PMPM) payment of no less than \$208.75 per month for TCM providers serving members with I/DD in a Chronic Conditions (CC) Health Home
- Guarantees a PMPM of no less than \$137.32 per month for TCM providers serving members with I/DD in a Serious Mental Illness (SMI) Health Home

Responsibility for HH Services



- A TCM may be performing part, or all, of the tasks defining a Health Home service
- Activities performed by the TCM within the Health Home are negotiated during the contracting process

Qualifications

CC Health Homes

- Nurse Care Coordinators
 - MCOs must ensure the HHP has at least one RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards.

CC and SMI Health Homes

- Care Coordinator
 - MCOs must ensure the HHP has a Care Coordinator to support the Health Home in meeting the provider standards and delivering Health Home services to enrollees. The Care Coordinator must:
 - be a BSW actively licensed in Kansas, or
 - a BS/BA in a related field, or
 - a Mental Health (MH) or an I/DD TCM or
 - a substance use disorder, person centered, case manager

TCM/Health Home Comparison

Assessment

Targeted Case Management (TCM)

- Participates in the BASIS assessment
- Completes the Statewide Needs Assessment
- Obtains consumer's history
- Gathers information necessary to complete the assessment
- Identifies consumer's needs and completes the assessment instrument
- Obtains related documentation

Health Home

- Conducts a comprehensive needs assessment to determine HH member's physical, behavioral and social needs, including information from existing assessments
- Obtains input from the member, family/guardian, support persons and service providers
- Coordinates and collaborates with all team members to promote continuity and consistency of care



Plan Development

TCM

- Develops/updates Person Centered Plan/Behavioral Support Plan, including goals and actions
- Participates in the development of the IEP
- Discusses service options, needs and preferences
- Provides input into the Integrated Services Plan
- Ensures active participation of consumer and authorized decision maker

Health Home

- Develops the Health Action Plan (HAP) in conjunction with HH member, family/support, guardian, and service providers
- HAP includes:
 - Goals and strategies that specifically address physical and behavioral health needs, as well as social needs
 - Where medical and non-medical services will be provided
 - The role of team members in implementing the HAP
 - References to components of other plans that contribute to HAP goals

Coordination of Care

TCM

- Referral and related activities
 - refers consumer to educational, medical, and social programs which provide direct assistance, including assistance to complete applications
- Seeks informal supports
- Ensures that the care plan is implemented
- Monitors and follows-up on changes in consumer's status

Health Home

- Implementation of the HAP
- Locates needed services
- Refers HH member for medical, behavioral, educational, and social assistance, and assists with completing applications
- Ensures member can access services (transportation, comprehension, etc.)
- Schedules appointments, attends appointments, and follows-up after appointments
- Monitors progress toward achieving the goals in the HAP, revising the HAP as needed

Coordination of Care (cont.)

TCM

- Shares information with pertinent individuals
- Documents activities

Health Home

- Shares information among HH team members
- Documents progress



Health Promotion

TCM

- Refers consumer to providers of health promotion, disease management and prevention, health self-management, etc.



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Health Home

- Assists member to develop the knowledge and skills necessary to self-manage their care
- Assesses member's understanding of medical/behavioral condition(s), and willingness to engage in self-management
- Links member to self-help resources, e.g., diabetes management, tobacco cessation, or provides education if resources not available in the community

Comprehensive Transitional Care

TCM

- Coordinates member's transition from long term care facility to community based services or vice versa



Health Home

- Develops a plan to transition member from emergency departments, hospitals, and other inpatient units to home, long-term care facilities, rehabilitation facilities, etc.
- Communicates the transition plan to everyone involved with member
- Ensures timely follow-up care and ensures access (transportation)
- Reconciles medication with appropriate team members
- Addresses access to medication
- Coordinates other therapies, e.g., occupational, physical and community supports

Member and Family Support

TCM

- Provides monitoring and follow-up for consumer, family or responsible person, and providers
- Identifies changes in needs and status of consumer
- Refers consumer, family or responsible person to activities and resources that ensure that the care plan is implemented
- Notifies and provides information to the consumer's MCO Care Coordinator

Health Home

- Provides support for member, families/support persons and guardians, in order to improve member's adherence to, and family support for, the treatment plan and successful HH outcome
- Assesses strengths and needs
- Identifies supports needed
- Locates resources to eliminate barriers
- Refers for self-help, peer, family support services



Referral to Community Supports and Services

TCM

- Links consumer with medical, social, or educational providers
- Refers consumer to resources and other programs that provide direct services and supports
- Seeks informal supports for consumer
- Reports adult neglect or abuse



Health Home

- Determines services necessary for member to achieve the most successful outcomes, including long-term care, mental health and substance use services, employment, housing, transportation, etc.
- Identifies available resources
- Assists member and family/support persons to advocate for access to care
- Identifies natural supports if services unavailable in the community
- Follows through until the member has access to needed services

Health Information Technology

TCM

- May use agency's internal electronic system to document, POC, BASIS, etc.

Health Home

- Utilizes Health Information Technology (HIT) to link team members and information regarding services



Questions?

Contact Information

Becky Ross – KDHE

healthhomes@kdheks.gov

Leslie Banning – Amerigroup

KSHealthHome@amerigroup.com

Jeanine Meiers – Sunflower State Health Plan

LEN_SFSPHOMEHEALTH@centene.com

Ben Pierce – United Healthcare

uhckshealthhomes@uhc.com

**Thank you for
participating!**