



WICHITA STATE
UNIVERSITY

Health Homes Webinar Series: A Primer for Primary Care Providers

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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



Purpose for Today

- Increase participant understanding of the Health Homes initiative
- Highlight how Primary Care providers can participate
- Tools to get started on becoming a Health Home Partner



KanCare Website

KanCare
AD ASTRA PER ASPERA

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)

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KanCare Consumer Assistance: 1-866-305-5147

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Readiness Activities
Delivery System Reform Incentive
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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

What is a “Health Home”?

Introduction

- The term “Health Home” is unique to Medicaid
- Health Homes are an option that states can choose to provide within their Medicaid programs
- A Health Home is not a building, but is a comprehensive and intense system of care coordination that integrates and coordinates all services and supports for people with complex chronic conditions



Introduction

- Health Homes are intended for children and adults with certain chronic conditions
- In Kansas, this include Diabetes, Asthma, and Serious Mental Illness
- Health Homes do not replace acute care services like physician visits, pharmacy, hospital care, therapies, etc.
- Goal is to reduce avoidable ER visits and inpatient stays and improve health outcomes

Making the Case

- 68% of people with mental illness have one or more co-occurring conditions:
 - Asthma
 - Diabetes
 - High Blood Pressure
 - Obesity
- People with mental illness die earlier than the general population

- Substance Abuse and Mental Health Services Administration (SAMHSA)

Making the Case

Diabetes in Medicaid (FY2011)

- Diabetes prevalence for adult beneficiaries – 20.5% (n = 37,577)
- Net payment by Kansas Medicaid:
 - \$559,307,804 (36.1% of total expenses)
 - \$14,884/per person



Health Homes (HH) vs. Patient-Centered Medical Home (PCMH)

PCMH

- Model of care provided by physician-led practices
- Responsible for coordinating all of the individual's health care needs and arranging care with other qualified physicians and support service providers

HH

- Expands the PCMH model to build linkages to other community and social supports
- Enhanced coordination of medical and behavioral health care
- Focused on the needs of persons with multiple chronic illnesses

Core Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Member and Family Support
- Referral to Community Supports and Services



These services are in addition to the services that members currently receive.

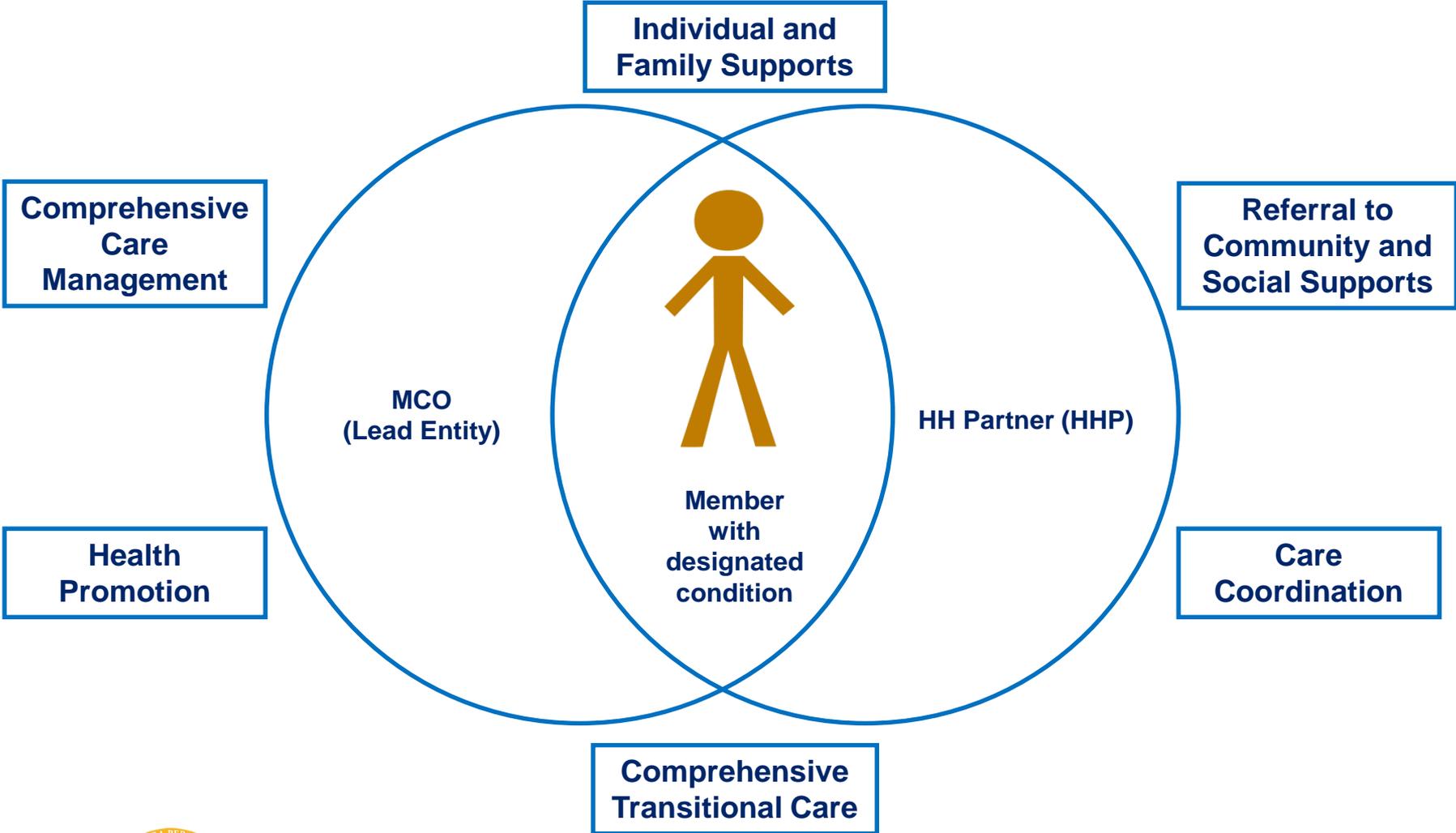
The Model in Kansas

Kansas Model



- Partnership between the Lead Entity (MCO) and a Health Home Partner (3rd Party in the community)
- Provides flexibility within the KanCare framework while supporting existing relationships
- Shared payment structure
- Contracts and subcontracts determine services provided and payment structure

Health Homes Service Structure



Who Decides When a Person Needs Health Homes?

- The Federal government has rules telling State Medicaid programs who can be in Health Homes.
- People are chosen based on their medical or behavioral conditions and the amount and type of services they are using.
- Qualified individuals will get a letter beginning in July telling them about Health Homes.
- Not everyone will be able to be in a Health Home.



Serious Mental Illness (SMI)

Target Population:

- Individuals (adults & children) with a severe mental illness (SMI)
- Includes anyone with a primary diagnosis of one or more of the following:
 - Schizophrenia
 - Bipolar and major depression
 - Delusional disorders
 - Personality disorders
 - Psychosis not otherwise specified
 - Obsessive-compulsive disorder
 - Post-traumatic stress disorder

Chronic Conditions (CC)

Target Population:

- People who have asthma or diabetes (including pre-diabetes and metabolic syndrome) who also are at risk of developing:
 - Hypertension
 - Coronary artery disease
 - Depression
 - Substance use disorder
 - Being overweight or obese (Adult: BMI \geq 25; Child: age-adjusted)

OR...

Chronic Conditions (CC) (cont.)



- Current smoker or exposure to second-hand smoke
- Environmental exposures
- Missed quality of care indicator:
 - No evidence of inhaled steroid prescription in last 12 months
 - Evidence of more than one rescue medication in the prior 6 months

Chronic Conditions (CC) (cont.)



- One or more ER visit for asthma or asthma-related complication in the prior 12 months
- One or more hospital admission for asthma or asthma-related complication in the prior 12 months
- In the top 25th percentile of Lead Entity's risk stratification for persons with primary condition

Chronic Conditions (CC) (cont.)



- Current smoker or exposure to secondhand smoke
- Uncontrolled diabetes (as demonstrated by HbA1c or glucose tests)
- Missed quality of care indicator:
 - No HbA1c, LDL cholesterol, or HDL/Triglyceride level in the prior 12 mo.
- One or more ER visit for diabetes or diabetes-related complication in the prior 12 months

Chronic Conditions (CC) (cont.)



- One or more hospital admission for diabetes or diabetes-related complication in the prior 12 months
- In the top 25th percentile of Lead Entity's risk stratification for persons with primary condition
- Non-compliance in taking medication regularly

How are Members assigned?

- Currently eligible for Medicaid – assigned by MCO (Health Home Lead Entity)
 - Based on information the LE has from claims and other data

OR

- Referral by a provider in the community (*This could be YOU!*)
- Based on:
 - Target population
 - Available HHPs in the geographic area
 - Existing relationships with HHPs

The Health Home Team



Chronic Conditions Health Home includes:

- Physician (May also be PA or APRN)
- Nurse Care Coordinator (RN, APRN, BSN, or LPN)
- Social Worker/Care Coordinator

SMI Health Homes add:

- Psychiatrist
- Peer Support Specialist/Peer Mentor

Payment Information (Chronic Conditions)

Basic Payment Structure

- Each **MCO** will be paid a **retrospective** per member per month (PMPM) payment for each member enrolled in a Health Home, once a service is delivered.
- One PMPM payment, regardless of number of services provided in a month.
- If no Health Home services are provided in a month, no payment is made to the MCO or the Health Home Partner.
- Health Home payments **do not** replace existing KanCare payments

Basic Payment Structure

- **MCO** will contract with **Health Home Partners (HHP)** to provide some or all of the six core Health Home services.
- Number and type of services will be negotiated and described in the contract between MCO and HHP
- PMPM Payment from **MCO** to **HHP**
- Other arrangements, such as shared savings or incentives, can be negotiated (pending KDHE approval).

Rate Development Process

- State used a four “level” approach to capture different levels of need.
- Levels of need were created by combining KanCare Rate Cohorts that contain members who are similar in their utilization of case management and other services.
-
- KanCare Rate Cohorts are groups of members who are similar in their Medicaid eligibility category and overall utilization of services.

CC Health Home Rates

- **Actuarial considerations and assumptions:**
 - Target population criteria
 - State fiscal year 2010-2012 base data
 - **Professional costs** – mix of professional costs, specific professional salaries, benefits and costs of member visits
 - Service utilization
 - Non-medical loading, or administrative costs
 - Bureau of Labor Statistics – Kansas specific data

Service Utilization

- Rates developed under the assumption that a payment will only be made once a service is utilized.
- Paid regardless of how many services used in a month.

Non-medical Loading (Administrative Costs)

- Measures the dollars associated with components such as administration, profit, IT, costs associated with electronic health records (EHR), and telephone calls as a percentage of the Health Home rate.

CC Health Home Rate Level	Non Medical %	Non-Medical PMPM
Level 1	10.00%	\$10.83
Level 2	10.00%	\$14.26
Level 3	10.00%	\$20.85
Level 4	10.00%	\$42.13

CC Health Home PMPM Rate (7/1/14)

Level	CC HH Rate	Population Distribution
Level 1	\$ 108.31	54.95%
Level 2	\$ 142.61	19.05%
Level 3	\$ 208.46	22.70%
Level 4	\$ 421.25	3.29%
Average Rate	\$ 147.89	

Getting Started

Provider Requirements

- Meet State licensing standards or Medicaid provider certification and enrollment as one of twelve types of agencies, including:
 - Federally Qualified Health Center/Primary Care Safety Net Clinic
 - Home Health Agency
 - Hospital-based Physician Group
 - Local Health Department
 - Physician-based Clinic
 - Physician or Physician Practice
 - Rural Health Clinic

Step 1:

Planning & Preparedness Tool (PPT)

- Each potential Health Home Partner must complete a PPT and submit to Samantha Ferencik at KDHE (sferencik@kdheks.gov)
- Available online: http://www.kancare.ks.gov/health_home/providers_materials.htm



Purpose of the Tool: For Providers



- Understand ability to support progress toward becoming a Health Home Partner (HHP)
- Assess strengths & challenges in undertaking different approaches to integration
- Set & prioritize goals toward becoming a HHP

Purpose of the Tool: For MCOs



- Assist in evaluating, supporting and contracting with potential HHPs
- NOT to determine whether “accepted” or “rejected”
- Roadmap to working with potential HHPs

How to Use the Tool

- Answer based on an honest analysis of current practices and processes
- Pre-work:
 - Identify who you serve and how often
 - Document the infrastructure of what makes your organization unique
- Include leaders from all levels of the organization
- Discuss results as a team
- Identify goals & next steps

What's Next?

- Upon receipt of the PPT from KDHE, MCO has 10 days to schedule a follow-up conversation that should occur in-person or via telephone within 45 days of receiving the completed tool
- MCO has 10 days after follow-up discussion to provide potential HHP with contract amendment
- Potential HHP has 10 days to sign and return
- Some specific contract requirements included in the Program Manuals
- Contract templates reviewed by KDHE
- MCOs provide training to HHPs
- Learning Collaborative begins in Fall 2014 to provide ongoing information and support



Questions?

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**Thank you for
participating!**