KanCare Health Home Program Manual – Serious Mental Illness (SMI)

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Preface

The purpose of this Manual is to provide Medicaid policy and billing guidance to providers participating in the KanCare Health Homes Program for people with serious mental illness (SMI). It is intended to provide:

- Instructions about how to become a Health Homes Partner
- Guidance about Health Homes services
- Information relating to billing procedures
- Links to additional information

Policy statements and requirements governing the Health Homes Program are included. The Manual is formatted to incorporate changes as additional information and periodic clarifications are necessary.

Before rendering service to a consumer, providers are responsible for familiarizing themselves with all KanCare procedures and regulations, currently in effect and those issued going forward, for the Health Homes Program. The Health Homes Program is an optional service under the Kansas State Medicaid State Plan.

Note: Although every effort has been made to keep this program manual updated, the information provided is subject to change. Medicaid program policy concerning this Health Homes initiative may be found on the Health Homes page of the KanCare website listed below.

http://www.kancare.ks.gov/health_home.htm

Introduction

Statutory Authority of Health Homes

The goal of Health Homes is to improve care and health outcomes, lower Medicaid costs, and reduce preventable hospitalizations, emergency room visits and unnecessary care for Medicaid members.

Health Homes is an option afforded to States under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703, allows states under the state plan option or through a waiver, the authority to implement Health Homes effective January 1, 2011. The purpose of Health Homes is to provide the opportunity to States to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness. States approved to implement Health Homes will be eligible for 90 percent Federal match for Health Homes services for the first eight (8) fiscal quarters that a Health Homes state plan amendment is in effect.

State Medicaid Director Letter: Health Homes for Members with Chronic Conditions

State Medicaid Director Letter (SMDL), #10-024, Health Homes for Enrollees with Chronic Conditions, provides preliminary guidance to States on the implementation of Section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Members with Chronic Conditions." A link to the State Medicaid Director's letter has been provided below for additional information:
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

On July 28, 2014 the US Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) approved Kansas' State Plan Amendment (SPA) # 14-0014 for individuals with serious mental illness (SMI). The following is the link to all CMS-approved Health Homes SPAs: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html .

Section 1: The Health Homes Service Model

1.1 Overview of the Health Homes Model

Health Homes is a care management service model where all of the professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status. It is anticipated that the provision of appropriate care management will reduce avoidable emergency department visits and inpatient stays, and improve health outcomes. With the member's consent, health records will be shared among providers to ensure that the member receives needed unduplicated services.

The Health Homes model of care differs from a Patient-Centered Medical Home (PCMH). The PCMH is a model of care provided by physician-led practices. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranging for appropriate care with other qualified physicians and support service providers. The Federal Patient Protection and Affordable Care Act anticipates that the Health Homes model of service delivery will expand on the traditional medical home model to build linkages to other community and social supports and to enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses.

1.2 Federal Health Homes Population Criteria

Health Homes services are provided to a subset of the Medicaid population with complex chronic health and/or behavioral health needs whose care is often fragmented, uncoordinated and duplicative.

This population includes categorically and medically needy beneficiaries served by Medicaid managed care or fee-for-service and Medicare/Medicaid dually eligible beneficiaries who meet Health Homes criteria. Individuals served in a Health Homes must have at least two chronic conditions; or one qualifying chronic condition and be at risk of developing another; or one serious mental illness. The chronic conditions described in Section 1945(h)(2) of the Social Security Act include, but are not limited to, the following:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Overweight as evidenced by a body mass index (BMI) of 25
- HIV/AIDS
- Other Chronic Conditions

Note: As of November 2012, Health and Human Services (HHS) announced HIV/AIDS as an additional diagnosis to the list of qualifying chronic conditions.

1.3 Federal Core Health Homes Services

The Health Homes service delivery model is designed to provide cost-effective services that facilitate access to a multidisciplinary array of medical care, behavioral health care and community-based social services and supports for individuals with chronic medical and/or behavioral health conditions. Health Homes services support the provision of coordinated, comprehensive medical and behavioral health services through care coordination and

integration. The goal of these core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT), and avoid unnecessary care.

Section 1945(h)(4) of the Social Security Act defines Health Homes services as "comprehensive and timely high quality services" and includes six Health Homes services to be provided by designated Health Homes providers.

Health Homes Services include:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
5. Individual and family support, which includes authorized representatives; and
6. Referral to community and social support services if relevant.

1.4 Federal Health Homes Provider Functional Requirements

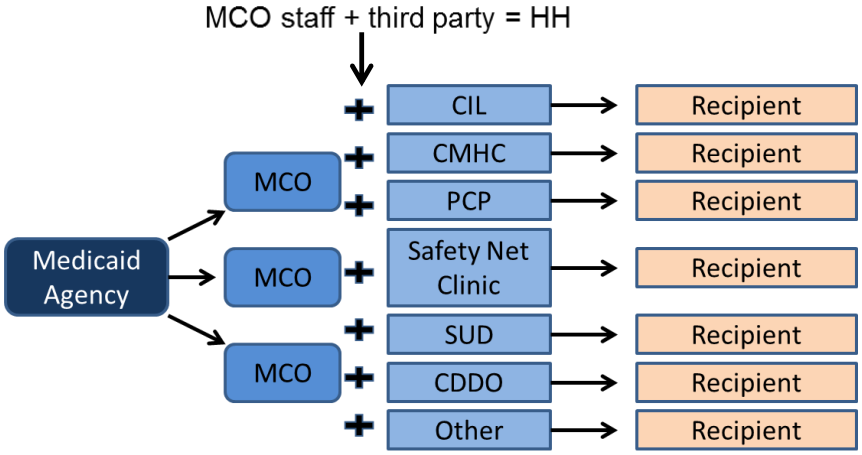
The Health Homes model of service delivery supports the provision of timely, comprehensive, high-quality Health Homes services that operate under a whole person approach to care. The whole-person approach to care addresses all of the clinical and non-clinical care needs of the individual. Section 1945(b) of the Social Security Act requires providers of Health Homes services to address/provide the following functional components.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use Health Information Technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Additional information regarding Federal Health Homes Functional Requirements may be found at:
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

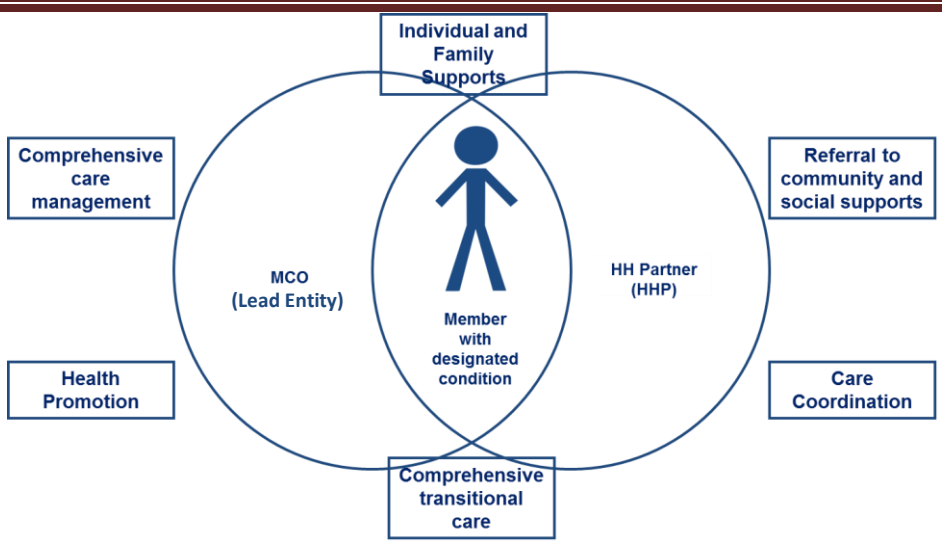
1.5 Kansas Health Homes Model

The Kansas model for Health Homes is a partnership between the managed care organization (MCO) and another entity (Health Homes Partner) that is appropriate for the consumer as in this diagram, modified from a similar one published by the Center for Health Care Strategies in the brief *Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System* by Dianne Hasselman and Deborah Bachrach (June 2011):



This model offers the greatest flexibility for providing Health Homes services within the KanCare managed care framework, while still supporting existing relationships between members and the community providers they may have experience with and preferences for. Such flexibility is important since Kansas is a largely rural state, with a few well-defined urban areas, and familiar community providers, such as community mental health centers are important.

In this model, the three KanCare managed care organizations (MCOs) will serve as the Lead Entities (LEs) for Health Homes and will contract with community providers to be Health Homes Partners (HHPs). Together, they will provide the six core services and share the payment provided by the State. The contracts between the LEs and the HHPs will spell out which entity is providing each of the core services and how the payment will be divided. The diagram below illustrates how the two entities, together, form the Health Homes.



NOTE: The placement of the six services is random and for illustrative purposes only.

1.6 Target Populations for KanCare Health Homes

The first two target populations Kansas has chosen to receive Health Homes services are people with serious mental illness (SMI) and people with chronic conditions (CC).

The **SMI population** is defined as 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

The **CC population** is defined as people who have asthma or diabetes (including pre-diabetes and metabolic syndrome) that also are at risk of developing:

- Hypertension
- Coronary artery disease
- Depression
- Substance use disorder
- Being overweight or obese (Adult: BMI ≥ 25; Child: age-adjusted)

For more details about Health Homes for people with chronic conditions, please refer to the *KanCare Health Homes Program Manual – Chronic Conditions*, available here: http://www.kancare.ks.gov/health_home/providers_materials.htm .

Once the CC Health Home is implemented, if a person qualifies for both target populations, he or she may only receive services from one type of Health Homes. A person who qualifies for both target populations will be able to choose which type of Health Homes he or she wishes to receive service from.

The State will be adding target populations to the Health Homes in the future. Providers will be notified in various ways about these additions (i.e., provider bulletins, e-mail, Health Homes web page).

1.7 Kansas Services and Professional Qualifications for SMI Health Homes

Health Homes' requirements differ, depending upon which population a Health Homes is designed to serve.

The following table lays out the definitions of the six core services for the KanCare SMI Health Homes program, along with the professional requirements associated with the six services.

KanCare SMI Health Homes Services and Professional Requirements

KanCare SMI Health Homes Services and Professional Requirements

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
Comprehensive care management involves Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from a HH, and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), Health Homes partner (HHP), member, family/support persons/guardian, and health services and social service staff. Critical components of comprehensive care management include: • Knowledge of the medical and non-medical service delivery system within and outside of the member's area • Effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons,	Psychiatrist Nurse Care Coordinator Physician Social Worker/Care Coordinator	LE or HHP LE or HHP LE or HHP HHP	Licensed to practice psychiatry in Kansas RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Homes in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. MD/DO must be actively licensed to practice medicine in Kansas. For children, pediatricians are preferred. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the Health Homes in meeting the provider standards and deliver Health Homes services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
guardians, and service providers • Ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, and understanding of health conditions, etc. • Monitoring and follow-up to ensure that needed care and services are offered and accessed • Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances			
Care coordination is the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a member's	Nurse Care Coordinator Social Worker/Care Coordinator	LE or HHP HHP	RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Homes in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the Health Homes in meeting the provider standards and deliver Health Homes services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
progress towards achievement of goals, and revising the HAP as necessary to reflect the member's needs. Care coordination: • Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals • Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care • Involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects • Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports • Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact • Creates and promotes linkages to other agencies, services, and supports			employed directly or contracted with the HHP.
Health promotion involves engaging members in HH care by phone, letter, HIT and community "in reach" and outreach,	Psychiatrist	LE or HHP	Licensed to practice psychiatry in Kansas

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
assessing members understanding of health condition/health literacy and motivation to engage in self-management, e.g., how important is the person's health status to the member, how confident the member feels to change health behaviors, etc., assisting members in the development of recovery plans, including self-management and/or relapse prevention plans, linking members to resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on member needs and preferences, and assisting members to develop the skills and confidence that will enable them to independently identify, seek out and access resources that will assist in managing and mitigating their conditions, and in preventing the development of secondary or other chronic conditions. Health promotion: • Encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health • Places a strong emphasis on self-direction and skills development, engaging members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment	Nurse Care Coordinator Physician Social Worker/Care Coordinator	LE or HHP LE or HHP HHP	RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Homes in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. MD/DO must be actively licensed to practice medicine in Kansas. For children, pediatricians are preferred. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the Health Homes in meeting the provider standards and deliver Health Homes services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
• Ensures all health action goals are included in person centered care plans • Provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions based upon the member's preference • Offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations.			
Comprehensive transitional care is specialized care coordination designed to facilitate transition of treatment plans from hospitals, ED, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. It may also involve identifying members not participating who could benefit from a HH. Comprehensive transitional care involves developing a transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. For each HH member transferred from one caregiver or site of care to another, the HH coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation.	Psychiatrist Nurse Care Coordinator Physician Social Worker/Care Coordinator	LE or HHP LE or HHP LE or HHP HHP	Licensed to practice psychiatry in Kansas RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Homes in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. MD/DO must be actively licensed to practice medicine in Kansas. For children, pediatricians are preferred. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the Health Homes in meeting the provider standards and deliver Health Homes services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
Comprehensive transitional care involves collaboration, communication and coordination with members, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers. It is designed to ease transition by addressing the members understanding of rehab activities, LTSS, self-management, and medications. It includes scheduling appointments scheduling and reaching out if appointments are missed. It may also include evaluating the need to revise the HAP. The transition/discharge plan includes, but is not limited to, the following elements: • timeframes related to appointments and discharge paperwork • follow-up appointment information • medication information to allow providers to reconcile medications and make informed decisions about care • medication education • therapy needs, e.g., occupational, physical, speech, etc. • transportation needs • community supports needed post-discharge • determination of environmental (home, community, workplace) safety			State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.
Member and family support involves identifying supports needed for members, family/support persons/guardians need to manage member's conditions and assisting	Nurse Care Coordinator	LE or HHP	RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Homes in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
them to access these supports. It includes assessing strengths and needs of members, family/support persons/guardians, identifying barriers to member's highest level of health and success, locating resources to eliminate these barriers, and advocating on behalf of members, family/support persons/ guardians, to ensure that they have supports necessary for improved health. Included in this service is assistance to complete paperwork, provision of information and assistance to access self-help and peer support services, and consideration of the family/support persons/guardians need for services such as respite care. To promote inclusion, consideration is given to accommodating work schedules of families, providing flexibility in terms of hours of service, and teleconferencing. The goal of providing member and family support is to Increase member's, family/support persons and guardians understanding of effect(s) of the condition on the member's life, and improve adherence to an agreed upon treatment plan, with the ultimate goal of improved overall health and quality of life. Member and family support: • Is contingent on effective communication with member, family, guardian, other support persons, or caregivers • Involves accommodations related to	Social Worker/Care Coordinator Peer Support Specialist/Peer Mentor/Recovery Advocate	HHP HHP	in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the Health Homes in meeting the provider standards and deliver Health Homes services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP. The Certified Peer Support Specialist (mental illness) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for mental Illness, meet education and age requirements, pass state-approved training through a state contractor and complete criminal, state abuse/neglect registry, and professional background checks. Additionally, the Certified Peer Support Specialist must self-identify as active in stable recovery and be a present or former primary recipient of mental health services. For HHPs active in calendar year 2014, a Certified Peer Support Specialist certified in both Level 1 and Level 2 is a required staff member by June 30th, 2016. The Certified Peer Mentor (Substance Use Disorder) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for substance use disorder, be employed by a licensed or certified Substance Use Disorder provider; meet

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
culture, disability, language, race, socio-economic background, and non-traditional family relationships • Promotes engagement of members, family/support persons and guardians • Promotes self-management capabilities of members • Involves ability to determine when members, families/support persons, and guardians are ready to receive and act upon information provided, and assist them with making informed choices • Involves an awareness of complexities of family dynamics, and an ability to respond to member needs when complex relationships come into play			age, training, and supervision requirements, and self-identify as active in stable recovery from alcohol and/or illicit substance use for at least one year. If employed in the same agency in which the individual received services, the Certified Peer Mentor must have completed services at that agency for a minimum of six months. The Recovery Advocate must meet the defined KDADS Behavioral Health requirements for mental illness and/or substance use disorder, meet age, training, and supervision requirements, and self-identify as active in stable recovery for a minimum of one year.
Referral to community supports and services includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paper work, identifying natural supports if services providers are unavailable in the member's community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible. Community supports and services	Nurse Care Coordinator Social Worker/Care Coordinator	LE or HHP HHP	RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Homes in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the Health Homes in meeting the provider standards and deliver Health

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
include long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. Referral to community and social support services involves: • A thorough knowledge of the medical and non-medical service delivery system within and outside of the member's area • Engagement with community and social supports • Establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc. • Fostering communication and collaborating with social supports • Knowledge of the eligibility criteria for services • Identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary	Peer Support Specialist/Peer Mentor/Recovery Advocate	HHP	Homes services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP. The Certified Peer Support Specialist (mental illness) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for mental Illness, meet education and age requirements, pass state-approved training through a state contractor and complete criminal, state abuse/neglect registry, and professional background checks. Additionally, the Certified Peer Support Specialist must self-identify as active in stable recovery and be a present or former primary recipient of mental health services. For HHPs active in calendar year 2014, a Certified Peer Support Specialist certified in both Level 1 and Level 2 is a required staff member by June 30th, 2016. The Certified Peer Mentor (Substance Use Disorder) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for substance use disorder, be employed by a licensed or certified Substance Use Disorder provider; meet age, training, and supervision requirements, and self-identify as active in stable recovery from alcohol and/or illicit substance use for at least one year. If employed in the same agency in which the individual received services, the Certified Peer Mentor must have completed services at that agency for a minimum of six months. The Recovery Advocate must meet the defined KDADS Behavioral Health requirements for mental illness

Service	Professional(s)	Lead Entity (LE) or Health Homes Partner (HHP)?	Professional Qualifications
			and/or substance use disorder, meet age, training, and supervision requirements, and self-identify as active in stable recovery for a minimum of one year.

For specific health information technology (HIT) requirements related to each of the six core Health Homes services, please refer to Section 10 of this Manual.

Section 2: Provider Requirements for SMI Health Homes Participation

2.1 Lead Entity Requirements

For all KanCare Health Homes target populations, the requirements for the Lead Entities are the same. The Lead Entity must:

1. Maintain a valid certificate of authority as a Health Maintenance Organization from the Kansas Insurance Department;
2. Have NCQA accreditation for its Medicaid managed care plan;
3. Must have authority to access Kansas Medicaid claims data for the population served;
4. Must have a statewide network of providers to service members with SMI; and,
5. Must have the capacity to evaluate, select and support providers who meet the standards for HHPs, including:
    a. Identification of providers who meet the HHP standards;
    b. Provision of infrastructure and tools to support HHPs in care coordination;
    c. Gathering and sharing member-level information regarding health care utilization, gaps in care and medications;
    d. Providing outcome tools and measurement protocols to assess HHP effectiveness; and,
    e. Developing and offering learning activities that will support HHPs in effective delivery of HH services.

2.2 Health Home Partner Requirements

The requirements for Health Homes Partners vary, depending upon the target population served by the Health Homes; however, every Health Homes are encouraged to include the targeted case management (TCM) provider for any Health Homes member who has an intellectual or developmental disability (I/DD). The Lead Entity or the HHP is encouraged to contract with the TCM provider if the I/DD member wishes to continue the relationship with that provider. The TCM provider will be responsible for various components of the six core Health Homes services and these will be determined at the time the Health Action Plan is developed.

For Health Homes members with SMI, the Health Homes Partner must:

1. Meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following:
    a. Center for Independent Living
    b. Community Developmental Disability Organization
    c. Community Mental Health Center
    d. Community Service Provider – for people with intellectual / developmental disabilities (I/DD)
    e. Federally Qualified Health Center/Primary Care Safety Net Clinic
    f. Home Health Agency
    g. Hospital – based Physician Group
    h. Local Health Department
    i. Physician – based Clinic
    j. Physician or Physician Practice
    k. Rural Health Clinics
    l. Substance Use Disorder Provider;
2. Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements;
3. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;

4. Provide appropriate and timely in-person care coordination activities. Alternative communication methods in addition to in-person such as telemedicine or telephonic contacts may also be utilized if culturally appropriate and accessible for the enrollee to enhance access to services for members and families where geographic or other barriers exist;
5. Have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals;
6. Agree to accept any eligible enrollees, except for reasons published in Section 4 of this Manual;
7. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the HHP on care coordination and hospital / ER notification;
8. Commit to the use of an interoperable EHR through the following:
    a. Submission of a plan, within 90 days of contracting as a HHP, to implement the EHR;
    b. Full implementation of the EHR within a timeline approved by the Lead Entity; and,
    c. Connection to one of the certified state HIE, KHIN or LACIE, within a timeline approved by the Lead Entity.

2.3 Lead Entity and Health Home Partner Joint Requirements

For all KanCare Health Homes, the Lead Entity and the Health Homes Partner must jointly meet several requirements. This means that one or the other must be able to meet the requirement at any one time.

For Health Homes members who are SMI, the Lead Entity and the Health Homes Partner must jointly:

1. Provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees;
2. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay;
3. Ensure person and family-centered and integrated health action planning that coordinates and integrates all his or her clinical and non-clinical health care related needs and services;
4. Provide quality-driven, cost-effective Health Homes services in a culturally competent manner that addresses health disparities and improves health literacy;
5. Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers;
6. Demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner:
    a. Coordinate and provide the six core services outlined in Section 2703 of the Affordable Care Act;
    b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines;
    c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
    d. Coordinate and provide access to mental health and substance abuse services
    e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
    f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team

and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and,

g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;

7. Demonstrate the ability to report required data for both state and federal monitoring of the program.

2.4 Preparedness and Planning Tool

Each potential HHP must complete the Kansas Health Homes Preparedness and Planning Tool (PPT) and submit it to KDHE. The tool can be found at: http://www.kancare.ks.gov/health_home/providers_materials.htm or in Appendix B of this manual.

Once the completed tool is received, copies will be sent, electronically, to the MCOs with which the HHP indicates it would like to contract. The MCOs shall respond to potential HHPs within 10 days of receiving the completed Tools. Within 45 days of receiving completed Tools, the MCOs will have a follow-up discussion (either in-person or over the phone) with potential HHPs regarding their readiness to serve as a HHP. After the follow-up discussion, the MCOs will have 10 days to provide potential HHPs with a contract amendment and the potential HHPs will have another 10 days after receiving the contract amendment to sign and return the contract amendment to the MCO.

The PPT is designed to help the potential HHP make a realistic examination of its ability to provide Health Home services and determine what its strengths and areas for transformation are. Ultimately, the MCOs as the Lead Entities will make the decision about contracting with potential HHPs, but KDHE has directed that they must offer providers feedback on the completed PPT and allow providers additional opportunities to complete the tool and request to contract.

Section 3: Lead Entity Contracts with Health Home Partners

3.1 State Requirements for Lead Entity Contracts with Health Homes Partners

KDHE will require that contracts between the Lead Entities and HHPs contain the following provisions:

- HHPs can limit panels by the number of people served in the Health Homes, or to KanCare members already being served or in the provider's panel.
- HHPs are strongly encouraged to provide Care Coordination, Comprehensive Transitional Care and demonstrate the capability of using HIT to link services. The Lead Entity or a subcontractor may provide the other core Health Homes services.
- The PMPM payment issued by the MCO to the HHP will be reflective of the number and type of services being provided to the consumer by the HHP.
- HHPs providing HH services to members with intellectual or developmental disabilities
- (I/DD) must contract with the members' targeted case management (TCM) provider if the members wish to continue their relationship with the TCM provider.

KDHE will review the templates for contracts between the Lead Entities and the HHPs. If a Lead Entity proposes a contract that employs a payment method other than a PMPM to the HHP, KDHE will not only review the contract, but must approve it as well.

3.2 Indicators of Health Homes Partner's Underperformance

The Lead Entities (MCOS) have jointly developed a list of situations that would signal to them a HHP might be underperforming either in a Health Homes process or quality area. Each of the Lead Entities will also have specific performance indicators they may look at.

HHP Underperformance Criteria - Health Homes Processes
Failure to maintain required staffing
Failure to provide services (as per HHP contract)
Inadequate documentation on file for service delivery
Failure to submit timely and accurate claim for HH service
Non-compliance with contract
Failure to implement an Electronic Health Record (EHR)(any stage)
Failure to maintain HH enrollee membership
No contact with enrolled members
Inadequate collaboration with other providers and/or Lead Entity (MCO)
Failure to submit data/reports as required
Failure to participate in training/meetings as required
Failure to pay Targeted Case Management providers (for I/DD members) according to the State guidelines
HHP Underperformance Criteria - Health Homes Quality
Poor or minimal documentation
Inadequate use of evidence-based guidelines or care guidelines
Care not provided in timely manner
Enrollee/member complaints
Inadequate improvement in service delivery from baseline as determined by completion of Preparedness and Planning Tool
Lack of use of health information technology as provided by the Lead Entities (MCOs)
Insufficient evidence supporting holistic care (addressing all member needs)
Failure to targeted improvements on HH Quality Goals (?)
Inadequate response to clinical needs of assigned members
Inadequate supports provided to member and/or providers during periods of transition of care

Section 4: Member Assignment, Enrollment and Discharge

4.1 Medicaid Eligibility Determination for Health Homes Members

To be eligible for Health Homes, a person must first be eligible for Medicaid. Health Homes are not available to children in the Children's Health Insurance Program (CHIP) portion of KanCare because Health Homes are a State Medicaid Plan service. Eligibility for Medicaid is determined by state staff at either the KanCare Eligibility Clearinghouse or at Department for Children and Families (DCF) offices throughout the state.

Medically Needy Medicaid beneficiaries are eligible for Health Homes services only as long as their spend down amounts are met for the applicable spend down periods. Provision of Health Home services cannot be used to meet their spend down amounts.

4.2 Member Assignment

KanCare members who are determined eligible for Medicaid are assigned to Health Homes by their MCO (Health Homes Lead Entity), based on information the Lead Entity already has from

claims and other data, or as a result of a referral by a provider in the community. The assignment will be made based upon which target population the member is in, which HHPs are available in the member's geographic area and what existing relationship the member may already have with any HHPs in their area. Members have the right to choose from among available HHPs in their area, with certain limits.

Members who are eligible for both types of Health Homes, SMI and CC, may choose which type of Health Homes they want to participate in, but the Lead Entity will make a default assignment to the type of Health Homes which seems most appropriate for the member, based on the member's conditions and claims and other data available.

When a Health Homes member is identified, the Lead Entity will send an assignment letter to the member or responsible party listed on the member's Medicaid case explaining:

- Health Homes and their benefits
- Why the member is eligible
- Which HHP the member has been assigned
- How to choose a different HHP
- How to opt out of Health Homes
- That the member can opt out of Health Homes any time

A sample letter can be found here:
http://www.kancare.ks.gov/health_home/providers_materials.htm or in Appendix B of this manual.

The State's Enrollment Broker, Hewlett Packard Enterprises (HP), will receive opt out information and verify Lead Entity files of Health Homes members against opt out information received.

Opting out of Health Homes, with the exception of children in state custody, will be accomplished through completing and mailing in the Opt Out Form included with the assignment letter or calling the number provided in the letter and on the Opt Out Form. If neither of these methods is employed, the Lead Entity will assume the person is a Health Homes member. Members will be able to opt out at any time after the initial assignment letter is received; however, the opt out may not take effect until the month after the month following the receipt of the opt out information if that receipt occurs after the 20th of the month. For example, if a member opts out October 27th, his opt out will not take effect until December 1. If he opts out October 18th, his opt out will take effect November 1. The 20th of each month is the cut-off date for preparation of the opt files that are transmitted from HP to the MCOs each month.

Members who opt out of Health Homes will be reassessed annually by their MCO and another opportunity to participate in Health Homes will be offered at that time. If a member opts out of Health Homes, but later wants to join a Health Home or one of the member's providers submits a referral form, the MCO will send an invitation to the member whether or not a year has passed since the member originally opted out.

Assignment letters will be sent on the first day of each month. Any referrals from providers that result in identification of additional Health Homes members will result in assignment letters being sent the first day of the following month.

4.3 Member Assignment for People with I/DD

The Lead Entity will notify assigned Intellectual/Developmental Disability Targeted Case Managers (I/DD TCMs) of new Health Home assignments that are on their caseload. This applies to new Health Home member assignments that receive I/DD HCBS waiver services or are on the I/DD HCBS waiver wait list.

The Lead Entity will assist in coordinating care for these assigned members with the TCM and the Health Home Partner to avoid any treatment gaps. The Lead Entities will mail the TCM a letter of notification of Health Home assignment. I/DD TCMs will be notified at the same time Health Home assignment letters are mailed at the first of the month. The notification letters will be sent on the first business day of each month. Included in the notification will be the assigned Health Home Partner.

Lead Entities will ensure that HHPs are notified that they have an I/DD HCBS waiver member or I/DD member on the wait list assigned and will facilitate contact with the I/DD TCM by the 10th of the month in order to coordinate care and contract with the I/DD TCM. The Health Home assignment becomes effective on the first day of the following month that the member receives their assignment letter. If the member chooses to opt out of the Health Homes program, they will have until the 20th of each month to opt out, which will be effective the first day of the following month I/DD TCMs will not be allowed to bill when the Health Home assignment becomes effective.

Should the MCOs fail in timely notification they will be responsible for the TCM payments. TCMs not otherwise contracted with a HHP are responsible for timely review and processing of MCO notifications regarding Health Home enrollment of members in the I/DD waiver or on the I/DD wait list to ensure that duplication of services does not occur.

4.4 Member Assignment for Children in State Custody

HH assignment letters will be sent to foster families for children in foster care. However, the decision to opt a foster child in or out of participating in Health Homes is the responsibility of the agency who has custody of the child or their designee. The State's enrollment broker, HP Enterprises, will not accept opt out information provided by foster families. Lead Entities will not accept requests for HHP changes from foster families.

When a foster care child is moved to another part of the state, the foster care contracting agency will initiate a request for a change in HHP if the child's current HHP does not cover the area to which the child is moved. DCF foster care contractors and Lead Entities are jointly responsible for coordinating these changes to ensure minimal disruption of Health Homes services.

4.5 Choice of Health Home Partner

Members have the right to choose a different Health Home partner at any time. If the member desires, the member does not have to continue receiving Health Home services while this change request is being processed. Members should contact their MCO if they wish to change their Health Home partner. The MCOs can assist the member by providing a list of alternative Health Home partners in their area. Please be aware that Health Home partner changes, like all other administrative work, have a specific process and associated timeline. Examples of the Health Homes Assignment, Opt In/Out and Change processes can be found here: http://www.kancare.ks.gov/health_home/download/Diagram_Opt_in_out_timeline1.pdf

4.6 Health Homes Partner Refusal of Member Assignment

A HHP may not refuse to accept a member assigned by any Lead Entity with which the HHP contracts for Health Homes services, except for some limited reasons. These reasons include, but are not limited to:

- The member has been previously discharged by the HHP with applicable notice in writing provided
- The member resides outside the geographic range served by the HHP, e.g. a Community Mental Health Center
- The member is outside the age range parameters established by the HHP, e.g. a pediatrician is not required to serve adults
- The HHP has reached its capacity to provide HH services
- The HHP is a Tribal 638/Indian Health facility and wishes to limit its HH activities to Native Americans
- The HHP is a provider of services to people with intellectual or developmental disabilities (I/DD), and wishes to limit its HH activities to those with I/DD
- The member has refused Health Home services. The assigned HHP has documented at least two attempts to contact the member within a month. (In this case, if the member still refuses Health Home services and will not officially opt out he or she should be disenrolled by the MCO as a Health Home member.)
- The member poses a danger to himself or herself, or to HHP staff

Any other reason for refusing to serve a potential Health Homes member must be approved by both the State Health Homes Manager and the Lead Entity. The HHP must submit the reason for refusal on the HHP Member Assignment Refusal Form to the State Health Homes Manager, copying the appropriate Lead Entity staff. The form can be found here: http://www.kancare.ks.gov/health_home/providers_materials.htm or in Appendix B of this manual.

In cases where the member poses a danger, the Lead Entity will attempt to find a HHP that can serve the member. If it cannot, the Lead Entity may serve as both the Lead Entity and HHP for the member until an appropriate HHP can be found. If this is longer than 60 days, continuing to serve as both Lead Entity and HHP will require written permission from the State Health Homes Manager.

Lead Entities must outline provisions for refusal to serve Health Home members in their contracts with HHPs and their Health Homes provider manuals. These provisions must align with the information in this manual.

4.7 Health Homes Enrollment and Discharge

For operational purposes the Lead Entity may establish an internal timeline during which opt out information is expected to be returned; however, all parties need to be aware that opt out information can be submitted at any time. The Lead Entity will be responsible for informing HHPs of the members assigned to each HHP. This will be the signal to initiate contact with the member and begin the Health Action Plan process.

The Lead Entity will be responsible for handling any requests for a change of HHP assignment at any time during the member's eligibility for Health Homes. A member must choose from available HHPs in the Lead Entity's network which serve the area where the member lives.

Lead Entities are responsible for coordinating transfers of information when Health Homes members change KanCare MCOs, either during regular choice periods or due to good cause

reasons. If the HHP is contracted with both the receiving and transferring MCO, there is no need for the member to select another HHP. If the member's current HHP is not contracted with the receiving MCO, the MCO should either work to contract with the current HHP or help the member choose a different HHP.

There will be reasons some Health Homes members are discharged from Health Homes. These include:

- The member deciding to opt out of Health Homes at any time
- The member having a catastrophic illness or event, like end stage renal disease that makes it unlikely the member will continue to benefit from Health Homes – the member will be ineligible for Health Homes services
- The member loses Medicaid eligibility or eligibility for the Health Homes Program

The Lead Entity will establish procedures it and the contracting HHPs will follow when any of these situations occur so that the Health Homes member receives timely and clear communication, is dealt with equitably and is notified of any applicable appeal rights.

To officially discharge a member from their Health Home, the HHP must submit a completed Health Homes Discharge Form to the Lead Entity and send a copy to the State Health Homes Manager. The form can be found here: http://www.kancare.ks.gov/health_home/providers_materials.htm or in Appendix B of this manual.

A member losing Medicaid eligibility due to an unmet spend down amount, will not require completion of a Health Homes Discharge Form; however, the HHP must ensure that the member has met their designated spend down in order to receive Health Homes services.

KanCare members in institutional settings will be excluded from Health Homes. KanCare Lock-In members will also be excluded from Health Homes.

Section 5: Health Action Plan

The Health Action Plan (HAP) is a tool developed by the member, Lead Entity, HHP, and others who will be involved, to document goals the member will pursue within the Health Homes, and the progress toward meeting those goals. Each Health Homes member is required to have a HAP. The expectation is that a HAP will be completed within 90 days of the HHP making contact with a member. The HAP is developed by the member with the assistance of the Health Homes Care Coordinator, with input from others who are participating in the Health Homes, including those people the member chooses to include in the process. Attempts to complete a HAP within the 90 days should be documented fully. Any attempts at outreach or member engagement leading up to, but falling short of HAP completion should be detailed in the member's records.

A HAP can only be considered complete if it has been reviewed face to face with a member. Basic HAP initiation and completion criteria is as follows:

- HAP initiation is required within 90 days of the HHP making contact with a member.

- HAP initiation at minimum includes completion of Sections 1-3 of the HAP, excluding the Behavioral Health subsection of Section 3.

- Members with no initiated HAP after 6 months (month 7 forward) may be subject to claims payment recoupment based upon clinical record review by the MCO.

- HAPs should be reviewed face to face at least once every 90 days following the initial HAP completion. Updates should be applied as needed to demonstrate the member's progress toward stated goals.

A complete bio-psycho-social assessment should be completed for each Health Home member in preparation for the HAP. There is a wide variety of different assessment instruments that can be used in combination to complete such an assessment, or the HHP can develop its own instrument. Information about many available assessments can be found here: http://www.kancare.ks.gov/health_home/providers_additional_resources.htm

The HAP is developed in a face-to-face meeting with the member, and any other members of the Health Homes team available to participate. The HAP may be updated as often as necessary, however it must be updated a minimum of quarterly in a face-to-face meeting between the member and the care coordinator.

Health Homes have been promoted as an intensive care coordination effort which will result in improved health and quality of life, as well as reduced health care costs. Quarterly face-to-face meetings occur with the care coordinator and the member, and do not necessarily involve the entire team. Quarterly face-to-face meetings between the member and care coordinator are warranted for the following reasons:

- Health Homes care coordination involves a relationship that engages members in their self-care and encourages and supports adherence to a treatment plan. This type of relationship involves more interaction with the member, including more face-to-face visits than might typically occur in a traditional care coordination model.

- If the traditional care coordination model was effective, it is likely that fewer people who receive case management would need Health Homes services. Given that claims and payment data indicate that a number of them would benefit from a Health Homes, the need to try a more "hands on" care coordination approach is warranted.

- Care coordinators within a Health Homes are allowed to provide direct services if necessary, such as providing transportation for medical visits, working with the member to understand medical information, etc., which typically involves face-to-face contact, therefore quarterly contact should not be a hardship.

- Problems with physical or behavioral health, in the member's environment, may be more apparent during a face-to-face encounter, than over the telephone.

The HAP is not intended to replace any specific treatment plans or person centered support plans already required. It is designed to capture some minimal critical information that can be shared with all providers involved with the member. Additionally, it is necessary to assign specific responsibilities to providers and the member related to health goals.

The HAP includes:

- Demographic information
- Contact information

- Physical and behavioral health information
- Whether there is a Home and Community Based Services waiver plan in place, and the type of waiver plan
- Whether the member has an Advanced Directive, and where it is located
- Health Homes goals, steps to achieve each goal, strengths and needs, measureable outcomes, start date, progress
- Signatures

The Health Action Plan form and instructions may found here: http://www.kancare.ks.gov/health_home/providers_materials.htm and in Appendix B of this manual.

Section 6: Member Referral Process

6.1 Hospital Requirements

Section 2703 of the Affordable Care Act requires that hospitals participating under the state Medicaid Plan or waiver of such plan must refer individuals with chronic conditions who seek or need treatment in an emergency department to a Health Homes. Such a referral must be made using the Kansas Health Homes Referral Form, found here: http://www.kancare.ks.gov/health_home/providers_materials.htm or in Appendix B of this manual.

6.2 Referrals from Other Providers

Other providers may refer Medicaid members to Health Homes through their MCO, based on the criteria outlined in Section 1.6 of this manual. Such a referral must be made using the Kansas Health Homes Referral Form, found here: http://www.kancare.ks.gov/health_home/providers_materials.htm or in Appendix B of this manual.

6.3 Referrals from Health Home Partners

In most cases, referrals to the Health Home program can be made by simply completing the Referral Form, found here: http://www.kancare.ks.gov/health_home/providers_materials.htm or in Appendix B of this manual. Completion of this form indicates that the referring party believes the member in question to be eligible for the Health Homes program. After receipt of the Referral Form, the member's MCO will determine the final eligibility status of the member and will assign the member to a Health Home according to this eligibility determination.

6.4 Expedited Referrals

In some cases, members may express a desire to be referred to the Health Home program. An Expedited Referral Form should be used when a member has expressed such a desire **and** when the referring HHP is willing to accept the member into their Health Home program. These two criteria will allow faster assignment of the member to their chosen Health Home Partner. Please note that this is the only circumstance in which the Expedited Referral process is warranted. Only contracted Health Home partners are allowed to utilize the Expedited Referral process. The Expedited Referral Form can be found here: http://www.kancare.ks.gov/health_home/providers_forms.htm or in Appendix B of this manual.

6.5 Urgent Referrals

On rare occasions providers may encounter members who demonstrate a dire need for immediate placement with a Health Home. Examples may include, but are not limited to, instances when the member's housing, safety or health are in peril. If you believe that the

member you are working with has a unique situation that warrants an Urgent Referral to the Health Homes program please call the member's MCO to discuss the Urgent Referral process.

Section 7: Claims Submission and Billing

7.1 Billing Codes and Modifiers

Health Homes is considered a bundled service, so individual core services provided within any month will not be billed for as fee-for-service. Payment to the Lead Entity, from the State, is a per member per month (PMPM) payment made retrospectively each month and, unless pre-approved by the State, payment to the HHP will be a PMPM. In order for a HHP to receive the Health Homes PMPM payment agreed upon between the Lead Entity and the HHP, the HHP must provide the member with at least one Health Home service during the month for which the claim is submitted. Services should be documented per the information provided in the Section 12: Health Homes Documentation Requirements of this manual and as required by the Lead Entity-HHP contract.

The billing codes and modifiers for Health Home services are outlined in the table below.

Core Services	Type = Serious Mental Illness	Type = Chronic Condition
Comprehensive care management	S0280 UC HE	S0280 UC
Care coordination	S0281 UC HE	S0281 UC
Health promotion	S0280 U1 HE	S0280 U1
Comprehensive transitional care	S0281 U1 HE	S0281 U1
Patient and family support	S0280 U8 HE	S0280 U8
Referral to community and social support services	S0281 U8 HE	S0281 U8

Modifiers:

UC – This modifier will be defined as "maintenance of plan" when billed with procedure code S0280 (rather than initial plan). Also, S0280 will be defined as C*omprehensive Care Management* and S0280 as C*are Coordination* when billed with modifier UC.

U1 – This modifier will be defined as "maintenance of plan" when billed with procedure code S0280 (rather than initial plan). Also, S0280 will be defined as *Health Promotion* and S0281 as *Comprehensive Transitional Care* when billed with modifier U1.

U8 – This modifier will be defined as "maintenance of plan" when billed with procedure code S0280 (rather than initial plan). Also, S0280 will be defined as *Patient and Family Support* and S0281 as *Referral to Community and Social Support Services* when billed with modifier U8.

HE – This modifier is currently defined as mental health program. Appending this modifier will denote the *Severe Mental Illness* Health Homes type. The omission of this modifier will denote the *Chronic Conditions* Health Homes type.

Although the official description of the S0280 and S0281 CPT codes implies "initial" and "maintenance," that construct does not apply to Kansas Health Homes. Both codes can be billed at any time during the Health Homes experience. In other words, there is no requirement that S0280 "Initial" occur prior to S0281 "Maintenance," nor is there a requirement that S0281 "Maintenance" occur after S0280 "Initial."

Although the "initial" and "maintenance" meanings associated with the official CPT codes do not apply to Kansas Health Homes, there is meaning in the combination of CPT codes and modifiers. Each code and modifier combination represents one of the six core services.

Claims that do not have the correct code and modifier, including the HE modifier signifying an SMI Health Home claim, will be denied. Diagnoses codes are required on Health Home claims. They are used to assist in reporting, rate review and program evaluation efforts. The ICD-9 diagnosis code 780.99, "other general symptoms", and the ICD-10 diagnosis code R68.89, "other general symptoms and signs" are not an acceptable diagnosis codes since they provide no meaningful information. The diagnosis code should be one that relates to the type of Health Home, i.e. SMI, or to the particular Health Home service. For example, an SMI Health Home member may talk with a care coordinator who discusses some educational material related to the member's diabetes. The diagnosis code on the claim, with the health promotion code, should relate to diabetes.

Medicare and other third party liability (TPL) edits will be bypassed for Health Home services.

Health Homes claims should be billed on separate forms than other KanCare claims to avoid Front End Billing issues and denials by the Lead Entities (MCOs).

Providers should use the Kansas Medical Assistance program Portal (KMAP) to determine whether a member is assigned to a Health Homes and if the member has an unmet spend down amount. Providers will bill only Health Homes services for members assigned to a Health Homes who have met his or her spend down. If a member has an unmet spend down amount, claims for targeted case management (TCM) can be submitted until the member's unmet spend down amount has been met. In this situation only, there is the possibility that claims for TCM and HH services may be submitted in the same month. In no other situation will TCM claims be allowed for Health Homes members.

7.2 Health Homes Program Outreach and Due Diligence

The checklists below will help Health Home partners identify action steps and suggest research methods to locate and engage clients. The HHPs should incorporate these steps in their operations.

CHECK LIST 1 – Incorrect/missing phone number: Recommend the following be done at the time of the call:

☐ Send Mailing
☐ Check alternate database/resource (Lead/MCO systems/DCF)
☐ Connect with most recent pharmacy or provider; leave note for beneficiary/checking for new address or phone

All attempts at outreach should be documented. Attempted address, phone number, date, time, should all be included in each note. Any individual contacted should have name/contact info listed.

CHECK LIST 2 – Beneficiary that cannot be located at listed address

☐ Check alternate database/resource (Lead Entity/MCO systems/DCF)
☐ Connect with most recent pharmacy or provider; leave note for beneficiary/checking for new address or phone

All attempts at outreach should be documented. Attempted address, phone number, date, time, should all be included in each note. Any individual contacted should have name/contact info listed.

CHECK LIST 3 - Correct number or valid address confirmed, but can't reach or leave message:

☐ Attempt another early morning or evening call, if possible
☐ Follow-up with another phone call within 7 days
If unable to connect after 7 days, attempt alternate methods:
☐ Send Mailing
☐ Check alternate database/resource (Lead Entity/MCO systems/DCF)
☐ Connect with most recent pharmacy or provider; leave note for beneficiary/checking for new address or phone

All attempts at outreach should be documented. Attempted address, phone number, date, time, should all be included in each note. Any individual contacted should have name/contact info listed.

Lead Entities will not remove members who are not engaged from the panel listings in the absence of a Refusal or Discharge Form. If no contact is made a one-time payment for outreach can be received.

<u>NOTE</u>: FOR ITEM 4 to Apply, Contact Must be made with Member/Guardian

CHECK LIST 4 - Beneficiary contacted, but is not fully engaged and has not Opted Out:

☐ Ask permission to either send or drop off additional information.
☐ Ask permission to call person back after he/she had a chance to review the information. Give specific timeframe and then call back as stated. A shorter timeframe (e.g. 1 or 2 weeks) is typically more effective.
☐ Ask permission to keep the person informed about the Health Home program.
☐ Propose that the person remains in the program on a trial basis.
☐ Propose that the person remains in the program to support their future needs.
☐ If you believe the beneficiary is high risk and insists on opting out, connect with that person's medical provider. Share the benefits of the HH program, informing the provider of that service being available to the beneficiary.
☐ Encourage Member to contact Lead Entity/MCO Member Services for Program Information, PCP Assignment Confirmation
☐ Opt Out Information provided only upon member request

All attempts at outreach should be documented. Attempted address, phone number, date, time, should all be included in each note. Any individual contacted should have name/contact info listed.

7.3 Health Homes Billing Scenarios

The billing matrix below will assist HHPs in billing for good faith outreach attempts. Please consult with each Lead Entity (MCO) for more specific information about their billing instructions.

Health Homes Billing Scenarios					
No.	**Scenario**	**Billable?**	**Min Threshold to Bill as HH Service**	**MCO/Notes**	**Typically Bill As**
1	Calling Members to discuss Health Homes (Initial Outreach)	Y		Documentation must indicate that the conversation was comprehensive in nature. Including, but not limited to program education, education on the services the Health Home Partner offers, and appointment scheduling.	Care Coordination Health Promotion
2	Follow Up Calls to Members for Engagement Purposes (Contact Made with Member)	Y		Member engagement activities may be billed for up to 90 days post enrollment. All outreach is fully documented. See **Checklist #4** on Required Outreach Activities	Care Coordination Health Promotion
3	Follow Up Calls to Members for Health Home Service Delivery(Contact Made with Member, Member agreed to participate.)	Y		All Outreach is Documented Notes appropriately Depict the service delivered.	
4	Good Faith Effort to contact the member. Outreach is unsuccessful.	Y	Outreach should include at minimum: -At Least 2 Telephonic and 1 Mailed Communication Attempts -Research of Alternate Member Contact Information Using MCO Portals and Claims History -Conducting a Site Visit of the Member's Address	Billable **once**. Refusal Form Should be Submitted to MCO All Outreach is Documented (Does not have to occur with 30 days of assignment.) See **Checklist #1-3** on Required Outreach Activities	Health Promotion
5	Face to Face Member Interactions	Y		All Activity is Documented Notes appropriately depict the service delivered.	

Note: If a single interaction with a member could cover multiple services from the 6 Core Service List. Then all appropriate services should be coded on the claim form.

Note: "Member" in the chart above may be interpreted as Responsible Person for the member or a family member in the Case of Individual and Family

Supports.

Note: If staff safety is a concern then a site visit is not required for Good Faith Effort, this should be detailed in the documentation. For ongoing member interactions staff safety should always be considered. HHP Staff should request consultation with MCO staff if safety during face to face visits is a concern.

Section 8: Health Home Partner Marketing Guidelines

Health Homes are an important set of services available to Medicaid members with serious mental illness and should work diligently to engage assigned members so that care among various providers can be well-coordinated and chronic conditions can be well-managed. To engage some SMI Health Home members it will be necessary to send mailings and offer low-cost incentives to encourage members to visit the Health Home or meet with Health Home staff. Federal Medicaid regulations allow these sorts of contacts with members who have been assigned to specific Health Homes.

Health Homes may also share information about Health Homes and their benefits with non-enrolled members as long as the information is general in nature and distributed to the entire group of consumers served by the specific Health Home agency.

Federal regulation (42 CFR 438.104) prohibits "any communication, from an MCO, PIHP, PAHP, or PCCM to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's or PCCM's Medicaid product."[1] Health Homes, while not mentioned specifically in the regulation, serve similar functions as the other entities mentioned and should refrain from both marketing to non-members, as well as exerting any undue influence or coercion when talking with Medicaid beneficiaries they serve in other ways.

KDHE expects Health Home staff to adhere to these standards. KDHE also expects the KanCare MCOs to help their contracted HHPs understand and adhere to these standards.

Section 9: Rate Calculation and Methodology

When developing the Health Homes rates, the state outlined the following payment structure and principles:

Basic Payment Structure

1. The State will pay each MCO a retrospective per member per month (PMPM) payment for each member enrolled in a Health Homes, once a service is delivered. The MCO will be paid the PMPM payment regardless of the number of services delivered to a member in a month. If no Health Homes services are delivered in a month, the PMPM payment will not be issued by the state to the MCO.
2. The MCO will contract with HHPs to provide some or all of the six core Health Homes services. Some services may be provided jointly by the MCO and the HHP and some services will be provided by the MCO. All of this will be negotiated and described in their contract. Payment will also be negotiated. Most often, the MCO will pay the HHP an agreed-upon PMPM, but other arrangements (e.g., shared savings model, incentive payments for outcomes) may be negotiated. The State will review and approve such non-PMPM payment arrangements.

Payment Principles

1. State Health Homes payments to the MCOs are structured to be adequate in ensuring quality Health Homes services are sustainable.
2. MCO payments to HHPs will be structured to be adequate in ensuring quality Health Homes services are sustainable.

[1] PIHP- Prepaid Inpatient Health Plan; PAHP - Prepaid Ambulatory Health Plan; PCCM – Primary Care Case Manager

3. State Health Homes payments to the MCOs are actuarially sound.

Rate Development Process

The state's actuary used a four "level" approach to capture the different levels of need in the SMI population. The 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 eligibility category and overall utilization of services; therefore members are placed in the four levels as a result of their KanCare Rate Cohort, not as the result of provider or MCO determination. The four levels are detailed in the table below. The key to acronyms in the table are also explained below.

Eligibility Acronym	Explanation
SSI - Supplemental Security Income	Members receive income from the Social Security Administration because they are disabled and they or their families have low income
TA – Technology Assisted	Members receive TA waiver services
TAF – Temporary Assistance to Families	Members or their families receive a cash benefit due to low income
PLE – Poverty Level Eligibility	Members meet the poverty level established for Kansas Medicaid eligibility
LTC – Long Term Care	Members are in a nursing facility or receive frail elderly or physically disabled waiver services
Dual/Non Dual	Indicates whether or not the members also receive Medicare services
SED – Seriously Emotionally Disturbed	Members receive SED waiver services
TBI – Traumatic Brain Injury	Members receive TBI waiver services
WORK – Work Opportunities Reward Kansans	Members are eligible for a specific waiver, but want to work and need some personal assistance services

KanCare Rate Cohort	Level 1
Autism Non Dual	Level 1
Foster Care/Adoption Non Dual M & F <1	Level 1
Foster Care/Adoption Non Dual M & F 1 - 6	Level 1
ICF/MR (Private only)	Level 1
M-CHIP	Level 1
Medically Needy Aged, Blind, and Disabled Dual M & F < 65	Level 1
Mental Health Nursing Facility Both	Level 1
Refugees Non Dual All Ages M & F	Level 1
Spend Down Medically Needy Aged, Blind, and Disabled Dual M & F < 65	Level 1
Spend Down Medically Needy Aged, Blind, and Disabled M & F Dual 65+	Level 1
SSI Aged, Blind, and Disabled Dual M & F 22 - 44	Level 1
SSI Aged, Blind, and Disabled Dual M & F 45 - 64	Level 1
SSI Aged, Blind, and Disabled Dual M & F 65+	Level 1
SSI Aged, Blind, and Disabled Non Dual M & F < 1	Level 1
TA	Level 1
TAF & PLE 1 - 5	Level 1
TAF & PLE 6 - 14	Level 1
Working Disabled M & F All Ages	Level 1
KanCare Rate Cohort	**Level 2**
Breast and Cervical Cancer	Level 2
Foster Care/Adoption Non Dual M & F 13 - 17	Level 2
Foster Care/Adoption Non Dual M & F 7 - 12	Level 2
LTC Dual	Level 2
SSI Aged, Blind, and Disabled Non Dual M & F 1 - 5	Level 2
TAF & PLE 15 - 21 F	Level 2
TAF & PLE 15 - 21 M	Level 2
TAF 22 - 29 F	Level 2
TAF 22 - 34 M	Level 2
TAF 30 - 34 F	Level 2
TAF 35 +	Level 2
KanCare Rate Cohort	**Level 3**
Foster Care/Adoption Non Dual M & F 18 - 21	Level 3
Medically Needy Aged, Blind, and Disabled Non Dual M & F < 65	Level 3
Medically Needy Families Non Dual All Ages M&F	Level 3
PLE Pregnant Woman < 30	Level 3
PLE Pregnant Woman 30+	Level 3
SED	Level 3
Spend Down Medically Needy Non Dual	Level 3
SSI Aged, Blind, and Disabled Dual M & F < 22	Level 3
SSI Aged, Blind, and Disabled Non Dual M & F 22 - 44	Level 3
SSI Aged, Blind, and Disabled Non Dual M & F 45 - 64	Level 3
SSI Aged, Blind, and Disabled Non Dual M & F 6 - 21	Level 3
TAF & PLE < 1	Level 3
KanCare Rate Cohort	**Level 4**
Child Institution Non Dual All Ages M & F	Level 4
Developmentally Disabled Dual < 45	Level 4
Developmentally Disabled Dual 45+	Level 4
Developmentally Disabled Non Dual	Level 4
LTC Non Dual	Level 4
Medically Needy Aged, Blind, and Disabled M & F Dual 65+	Level 4
TBI	Level 4
WORK	Level 4

The following was also examined in developing the SMI Health Homes rates:

- Target population criteria
- Professional costs for physicians, psychiatrists, nurse care coordinators, social workers and peer support specialists
- Service utilization
- Non-medical loading, or administrative costs

Professional Costs

The professional costs associated with providing Health Homes services center around the staffing of the Health Homes team, and involves the five following professionals: physician, psychiatrist, nurse care coordinator, social worker and peer support specialist. The Occupational Employment Statistics database from the Bureau of Labor Statistics, which outlines the Kansas specific annual salary for these professionals, information from the state and consulting clinicians with years of medical experience were utilized by the actuaries to determine salaries. The cost associated with physicians and psychologists is on a per visit basis for the Health Homes services they provide. All other professional costs are based on an annual salary with a burden rate for additional costs associated with payroll taxes, worker's compensation and health insurance, paid time off, training and travel expenses, vacation and sick leave, pension contributions and other benefits.

Service Utilization

The SMI Health Homes rates were developed under the assumption that a payment will only be made once a service is utilized, and will be paid regardless of how many services are utilized in a month. The following table outlines the assumptions the state's actuaries made to attribute the time required from each professional for each service, and accounts for any overlap that may occur between services due to the coordinated nature of a Health Homes.

SMI Health Homes Staffing Cost:

Physician/BH Professional or Specialist

Professional	Service	Cost/Visit
Physician/BH Professional		
	Comprehensive Care Management	$ 125.00
	Health Promotion	$ 50.00
	Comprehensive Transitional Care	$ 125.00

Nurse Coordinator/Social Worker/Peer Support Specialist

Burden Rate	28.00%

Professional	Service	Salary	Burden Rate	Total Compensation	Distribution[1]	Total Cost	Cost/Hour[2]
Nurse Care Coordinators							
	Comprehensive Care Management	$ 80,720	28.00%	$ 112,111	30%	$ 33,633	$ 17.52
	Care Coordination	$ 80,720	28.00%	$ 112,111	30%	$ 33,633	$ 17.52
	Health Promotion	$ 80,720	28.00%	$ 112,111	50%	$ 56,056	$ 29.20
	Comprehensive Transitional Care	$ 80,720	28.00%	$ 112,111	30%	$ 33,633	$ 17.52
	Individual and Family Support	$ 80,720	28.00%	$ 112,111	10%	$ 11,211	$ 5.84
	Referral to Community and Support Services	$ 80,720	28.00%	$ 112,111	10%	$ 11,211	$ 5.84
Social Workers							
	Comprehensive Care Management	$ 54,890	28.00%	$ 76,236	70%	$ 53,365	$ 27.79
	Care Coordination	$ 54,890	28.00%	$ 76,236	70%	$ 53,365	$ 27.79
	Health Promotion	$ 54,890	28.00%	$ 76,236	50%	$ 38,118	$ 19.85
	Comprehensive Transitional Care	$ 54,890	28.00%	$ 76,236	70%	$ 53,365	$ 27.79
	Individual and Family Support	$ 54,890	28.00%	$ 76,236	20%	$ 15,247	$ 7.94
	Referral to Community and Support Services	$ 54,890	28.00%	$ 76,236	20%	$ 15,247	$ 7.94
Peer Support Specialist							
	Individual and Family Support	$ 15,080	28.00%	$ 20,944	70%	$ 14,661	$ 7.64
	Referral to Community and Support Services	$ 15,080	28.00%	$ 20,944	70%	$ 14,661	$ 7.64

[1] *Distribution of professionals between services.*

[2] *Assumes 48 working weeks in the year at 40 hours/week. This includes 10 days of paid time off and 10 Federal holidays.*

SMI Health Homes Service Cost per Visit/Hour:

Service	Cost/Visit or Cost/Hour
Comprehensive Care Management	
Cost/Visit	$ 125.00
Cost/Hour	$ 45.31
Care Coordination	$ 45.31
Health Promotion	
Cost/Visit	$ 50.00
Cost/Hour	$ 49.05
Comprehensive Transitional Care	
Cost/Visit	$ 125.00
Cost/Hour	$ 45.31
Individual and Family Support	$ 21.42
Referral to Community and Support Services	$ 21.42

Non-Medical Loading (Administrative Costs)

The non-medical load measures the dollars associated with components such as administration, profit, IT, costs associated with electronic health records (EHR), and telephone calls and is expressed as a percentage of the Health Homes rate. The state's actuaries also reviewed non-medical expenses in other programs deemed comparable to the Kansas Health Homes program, on both a PMPM and percentage basis.

SMI Health Home Rate Level	Non-Medical %	Non-Medical PMPM
Level 1	12.00%	$14.06
Level 2	12.00%	$18.42
Level 3	12.00%	$22.22
Level 4	12.00%	$39.30

SMI Health Homes PMPM Rates, Effective July 1, 2014:

Level	Rate	Estimated Target Population Distribution
Level 1	$117.21	27.01%
Level 2	$153.51	32.09%
Level 3	$185.17	30.27%
Level 4	$327.48	10.63%
Average Rate (Weighted)	*$171.79*	

I/DD Targeted Case Management Providers

MCOs or HHPs are encouraged to include the targeted case management (TCM) provider as part of the Health Homes team for any member who has an intellectual or developmental disability (I/DD). If such contracts are entered into, Lead Entities/HHPs must provide a minimum payment of:

1. $137.32 to TCM providers serving IDD SMI Health Home members who are on the HCBS waiver.
2. $53.36 to TCM providers serving IDD SMI Health Home members who are not on the HCBS waiver.

The contracted TCM provider will be responsible for various components of the six core Health Homes services and these will be determined at the time the Health Action Plan is developed.

If Lead Entities/HHPs do not contract with the TCM provider, the IDD HH member may:

1. Choose another TCM provider who is/will contract with the HHP;
2. Choose a different HHP who is contracted with their TCM provider;
3. Elect not to have a TCM provider as part of their Health Home; or,
4. Opt out of Health Homes, although TCM providers shall not exert pressure on IDD members to opt out of Health Homes. (Please refer to *Rules of Conduct for Case Managers Serving People With Developmental Disabilities* found at: http://www.aging.ks.gov/HCBSProvider/Documents/DD_CM_Rules_Conduct_REVISED.pdf)

SMI Health Homes Rate Review

The state and its actuaries will review the SMI Health Homes PMPM rate methodology six months after program implementation. At that time, the rates could be adjusted. After the six month rate evaluation, an annual review of the rates will be conducted.

Section 10: Grievances and Appeals

HHPs have the same grievance and appeal rights as permitted providers under KanCare. The HHP must file its Health Homes grievance or appeal, including payment issues, with the Lead Entity (MCO) involved. Each MCO has established processes that must meet federal regulations and are described in their contract with the HHP or in their provider manual. HHPs can generally appeal to the State after exhausting the MCO process. For definitive information on grievances and appeals, please refer to your agreement with the Lead Entity. For information concerning Kansas Medicaid Fair Hearings, please refer to the Kansas Administrative Procedures Act, K.S.A. 77-501 et seq., and K.A.R. 30-7-64 et seq.

Section 11: Health Information Technology

Implementation of an Electronic Health Record (EHR) will be required of all Lead Entities and Health Homes Partners to facilitate the sharing of patient information across health settings. EHRs are a necessary component to the success of Health Homes.

Health Homes Partners must commit to the use of an interoperable EHR through the following:

- Submission of a plan to the Lead Entity, within 90 days of contracting as a HHP, to implement the EHR;
- Full implementation of the EHR within a timeframe approved by the Lead Entity; and;
- Connection to one of the two certified state Health Information Exchanges within a timeframe approved by the Lead Entity:
    - Kansas Health Information Network (KHIN) or
    - Lewis And Clark Information Exchange (LACIE).

Each of the six core services in the SMI Health Homes program also has specific health information technology requirements outlined below:

Comprehensive Care Management

Both the MCOs and the HHPs will utilize certified health information exchange (HIE) networks including the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE) to share patient health information across various Health Homes provider settings. HHPs must meet this HIT standard within a timeframe agreed to by the Lead Entity in order to participate in Health Homes. A portion of potential HHPs currently do not use EHRs. These organizations will be required to develop a plan to implement EHRs within the specified time frames outlined in provider standards. Details of the health action plan will be documented in the EHR to facilitate the sharing of patient needs across Health Homes providers. The use of HIT via established networks will ensure that providers are updated on changes to patients' health action plans and care requirements. HIT will allow for the continuous monitoring of patient outcomes and the appropriate changes in care and follow up.

Care Coordination

The use of HIEs will facilitate access to patient information across health care settings which will allow for ongoing care coordination. Lead Entities and HHPs use of KHIN and/or LACIE will allow for documentation, execution, continuous monitoring, and updates to the health care plan that will impact patient outcomes, treatment options, and follow-up. Until HHPs and Lead Entities are fully connected to HIEs, Lead Entities must provide a bi-directional electronic method for viewing and sharing data with the HHP.

Health Promotion

Lead Entities and HHPs will use secure emails, member web portals and smart phone applications to promote, manage, link, and follow-up on health promotion activities including patient engagement, health literacy, and recovery plans.

Comprehensive Transitional Planning

Electronic and telephonic 24x7 notifications of hospitalizations to the Lead Entities will be shared through secured e-mail or other secure electronic means with HHPs. HHPs will use secure portals of Lead Entities websites to assist in developing transition plans.

Individual and Family Support

Lead Entities will modify existing member portals that will be used as a communication tool to encourage individual and family support services. The portal will be available to members and will outline information relating to medical and behavioral conditions, evidence based treatment options, and links to local and national support resources. HHPs will use their existing websites and secure e-mail to share information with members.

Referral to Community and Social Support Services

The Health Homes member portal managed by the Lead Entities and accessible to members will include information and links to community and social support resources. HHPs will use their existing websites and secure e-mail to share information with members.

Section 12: Health Homes Documentation Requirements

Each Lead Entity will have some specific requirements, spelled out in their contracts with HHPs, but all three have agreed to some basic documentation requirements that are designed to

demonstrate HHPs have provided specific core Health Homes services. The following table describes these requirements.

Health Homes Partner Documentation Requirements

Service	Documentation	Examples of HIT
Comprehensive Care Management	Health Action Plan (HAP) in the patient record; notes in the patient record with date and time (including duration), discussion points with the member or other practitioners, indication that the Plan was shared with all other treating practitioners and others involved in providing or supporting care.	Data or reports used to identify participants assigned to the Health Homes by the MCO, used to develop or recommend the Health Action Plan; evidence of sharing the HAP with the participant, other practitioners or the MCO via electronic means.
Care Coordination	Patient record entries with date, time, practitioner providing the service, referral, follow-up or coordination activity with the member, treating practitioners and others involved in providing or supporting care. Patient record note could denote an ER visit, hospital admission, phoning member with lab results, discussing a consult with another treating practitioner, etc.	System entries including patient notes; distribution of the HAP or other notes to the MCO; sharing of lab or other results; retrieving information from the MCO to track hospital, ER, and other utilization.
Health Promotion	Health promotion activities document activities to engage member in care, including outreach, assessment of member's health literacy, summary of health education and resources provided.	Evidence of the use of data pulled from the system to identify participant health promotion needs; notes of health promotion interactions; resources to which the participant is directed to address educational and health literacy needs.

Service	Documentation	Examples of HIT
Comprehensive Transitional Care	Documentation in the patient record as to medication reconciliation and other key treatments or services with other health systems/places of service. Documentation should include date, time, practitioner from the HHP and what specific elements of the Health Action Plan, or the Plan itself, were shared and with what other health system or place of service and to achieve which specific Health Action Plan goal. Attention to the appropriate providers to address the follow-up care is extremely important; e.g. transmission of the Health Action Plan to a physical therapist who will be treating a member post knee replacement.	Use of the system to identify admissions, discharge needs, to update HAP based on revised needs, document the scheduling and notification to participants of follow-up appointments.
Individual and Family Support	Documentation of the assessment of psycho- social or community support needs including the identified gaps and recommended resources or resolutions to address the gaps. Date, time, practitioner, service recommendations and discussion with the member, family (or other support persons), and/or guardian should all be included.	Use of the system to share assessment of community support or psychosocial assessments; update of the HAP as applicable to address same; patient record entries; collaboration with other practitioners as to resource information provided or recommended.
Referral to Community and Social Support Services	Documentation in the member record of the date, time and contact at a referral source and/or the date and time that a referral follow through or discussion was convened to address the gaps from the Individual and Family Support assessment process.	Use of the system to share assessment of community support or psychosocial assessments; update of the HAP as applicable to address same; patient record entries; collaboration with other practitioners as to resource information provided or recommended.

Section 13: Quality Goals and Measures

KDHE, in cooperation with varied stakeholders and representatives from KDADS, MCOs and KUMC partners and advised by Kansas Foundation for Medical Care, the External Quality Review Organization of Kansas, formed a quality sub-group to develop quality goals and measures to assess the Health Homes delivery model. The Health Homes quality program incorporates federally required reporting for eight mandated areas comprised of hospital admission, chronic disease management, coordination of care, program implementation,

processes and lessons learned quality and clinical outcomes, cost savings and admissions to skilled nursing facilities.

To assess quality improvements and clinical outcomes, the State will collect clinical and quality of care data for the CMS Core Set of Measures and state-specific quality goals. This assessment may include a combination of claims, administrative, and qualitative data. Where possible, Kansas utilizes metrics where benchmark data is currently available and collected, such as HEDIS (Healthcare Effectiveness Data and Information Set). Data for each goal and measure will be collected through defined quality processes aligned to state and regional benchmarks as defined in the Kansas Health Homes Quality Goals and Measures included in Appendix C.

Section 14: Health Homes Learning Collaborative

A Learning Collaborative will be convened and will include multiple program components to support provider implementation of Health Homes. A design team of interested organizational partners, including representatives from KDHE, MCOs, Health Homes partners, and Association partners, will identify evolving learning needs as well as ways to address those needs. This team and all Learning Collaborative activities will be facilitated by an organization selected by KDHE to provide coordination and support for the Collaborative.

Learning Collaborative activities will be made available to staff of contracting Health Homes Partners, MCOs, and KDHE in a variety of formats, including in person and electronically. Organizational leadership agree to participate in learning activities, including in-person sessions and regularly scheduled calls and participate in peer to peer learning that will allow continual quality improvement of the Health Homes system. Ongoing training and education for staff and potential consumers about Health Homes will be provided by system partners and will inform, but not replace, Learning Collaborative activities.

APPENDIX A: Contact Information

State Health Homes Manager

Rick Hoffmeister, BSN RN
Division of Health Care Finance
Kansas Department of Health and Environment

RHoffmeister@kdheks.gov

Amerigroup Health Homes

KSHealthhome@amerigroup.com

Amerigroup Member Services: 1-800-600-4441 (callers will be routed to Health Homes staff)

Sunflower State Health Plan Health Homes

LEN_SFSHPHEALTHHOME@centene.com

Providers can call 877-644-4623

Members can call 877-644-4323

http://www.sunflowerhealthplan.com/

United Healthcare Health Homes

uhckshealthhomes@uhc.com

Members can call 1-877-542-9238

APPENDIX B: Forms

Health Action Plan Instructions

The Health Action Plan (HAP) is a tool to document goals that the member will pursue within the Health Home. The HAP also documents the proposed process for achieving these goals, as well as progress made in achieving the goals. The HAP is developed by the member and Care Manager or Coordinator with input from others who are participating in the Health Home, and anyone else the member chooses to include in the process. A comprehensive assessment is completed prior to or during the development of the HAP. The HAP is developed in a face-to-face meeting with the member, and any other members of the Health Home team available to participate.

The expectation is that a HAP is completed within 90 days of making contact with a member. Attempts to complete a HAP within the 90 days should be documented fully. Any attempts at outreach or member engagement leading up to, but falling short of, HAP completion should be detailed in the member's records.

After completion of the initial HAP, HAPs should be updated at minimum every 90 days in a face to face setting with a 90 day update cycle being the goal.

Drop down boxes are provided for some information, while other information must be typed in. Not all information requested will apply to each member. When information does not apply, please indicate this in the HAP. All applicable areas of the HAP must be completed in full; whether completed in an electronic health record or on the form posted on the state's website.

Section I
Complete all areas of the demographic information for the member.

Section II
Complete all lines for each contact as applicable. If not applicable, type in N/A.

Section III
Provider: Complete all lines for each provider selected

Kan Be Healthy Screen: Is the child up to date on his/her age related health screenings? If yes, what was the date of the last screening?

Health Risk Assessment: Did you complete a holistic assessment or utilize other provider data to answer your assessment questions? What is the date you completed your assessment?

Common Valid Assessments:

a. ComCAM 13 – Caregiver Activation Measure

b. PAM – Patient Activation Measure

c. History and Physical

d. FACT – Health Home survey assessment

e. GAD7 – General Anxiety Disorder Scale

f. PHQ-9 – Depression Patient Health Questions

g. CAGE Alcohol Detection Questionnaire

h. DAST-10 – Drug Abuse Screening Test

i. Fall Free Plan

j. FLACC Pain Assessment

k. Katz Index of Independence in Activities of Daily Living

l. Wong-Baker Faces

Physical Health:

Physical Health Diagnoses: utilize the MCO portal, other provider information, assessment findings, your clinical systems to list all of the associated physical health diagnoses.

Height: Enter the height in feet/inches or inches (5' 4" or 64")

Weight: Enter the weight in pounds (150 lbs or 150.5 lbs)

Cardio:

BP: Enter the blood pressure with a systolic and diastolic result (140/90)

Diabetes: Members with a confirmed diagnosis of diabetes only. Enter Pending if test is in progress or requested.

A1c: Enter the result as indicated by lab results

LDL-c: Enter the results as indicated by lab results

Obesity:

BMI: Utilize a BMI chart or use BMI calculator tool

(http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm)

Tobacco Use: If member uses tobacco, please provide a description of the current use.

Behavioral Health:

Mental Health Diagnoses: utilize the MCO portal, other provider information, assessment findings, your clinical systems to list all of the associated behavioral health diagnoses.

Depression Screening performed: This may be performed by the HHP using the PHQ9 or other valid tool, or by another provider. Provide the date the screening was performed.

Substance Use Disorder Brief Screen: This may be performed by the HHP using the short form SBIRT, Audit-C or other valid tool, or by another provider. Provide the date the screening was performed.

Substance Use Disorder Assessment: This may be completed by HHP or by another provider.

Medication Reconciliation: The process of identifying the most accurate list of all medications that the patient is taking (over the counter and prescribed), including name, dosage, frequency, and route, by comparing the medical record or provider Medication Administration Record (MAR) to an external list of medications obtained from a patient, hospital, MCO portal, or other provider. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. Reconciliation should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care. This process comprises five steps: (1) develop a list of current medications; (2) develop a list of medications to be prescribed; (3) compare the medications on the two lists; (4) make clinical decisions based on the comparison; and (5) communicate the new list to appropriate caregivers and to the patient. Each medication is to be listed on the HAP.

Section IV
Indicate whether the member has a Home and Community Based Services waiver plan in place, and the type of waiver plan. It is important to understand all of the medical and waiver benefits available to the member so as to ensure appropriate utilization and management of services.

Section V
Indicate whether the member has an Advanced Directive. Provide education for members who may not understand the concept of an Advanced Directive.

Section VI
Members may have as few as one Health Home goal or they may have several. Health Home goals should be member driven and relate to some aspect of their health and well being. Gaps in health care access, service delivery or self-care management skills are preferred. Written goals should follow the SMART principle:

S= Specific, what exactly will be done

M= measurable, how will you know the goal has been achieved?

A= achievable, is the goal written in a way that makes sense and appropriate for that particular person

R= realistic, is it too hard, too long of a time frame, or maybe too easy?

T= timely, is the deadline/timeframe appropriate for the goal and the member?

http://keltymentalhealth.ca/healthy-livingits-everyone/tools-resources/my-healthy-living-pinwheel

Goal: The goal line contains the entire SMART goal. Example of a SMART goal: Earleen will choose one Primary Care Physician (PCP) to oversee her medical care and make an appointment to have a diabetes check by March 31, 2015.

- **Steps to Achieve Goal**: Address the steps that will be taken to achieve the goal, including who is responsible to assist the member in achieving the goal and where services will be provided.
    - Earleen's Care Coordinator will
        - assist her to choose a PCP and schedule her first appointment
        - assist her in setting up transportation
        - prepare a list of questions

    - attend the first appointment with Earleen to help her explain her medical issues, her participation in a Medicaid Health Home, and help her to understand the information provided by the PCP
    - educate Earleen regarding how to set up transportation through her MCO for future appointments with her PCP
    - help Earleen fill medications and complete any ordered tests
- **Strengths and Needs**: This section should address any strengths that may help the participant to achieve the goal, or needs that may prove a barrier to achieving the goal. Consideration should be given to such areas as family or community support, communication, education, socio-economic status, housing, transportation, etc.
    - Earleen has a sister with whom she currently lives, however she is unable to provide much support in terms of Earleen's physical or behavioral care, including transporting her to and from appointments. Earleen will need transportation, and will need someone to go with her to her initial visit, at a minimum.
- **Measureable Outcome(s)**: This section should state how it will be determined that this goal was met.

The Care Coordinator will contact Earleen once weekly to provide support in achieving this goal

- **Start Date**: Indicate the date the goal is established.
- **Completion Date**: Indicate the date the goal was met.
- **Progress**: Document any progress toward achieving the goal.
    - Earleen selected a PCP from a list provided by her Care Coordinator. With the assistance of her Care Coordinator, she scheduled her first appointment for 4/1/2015 at 1:30 PM. Her Care Coordinator will meet her at her initial appointment.

Section VII

Section VII includes the hand written signature of the participant, as well as the signatures of those who participated in developing the HAP and their relationship to the participant. The physician does not need to sign the HAP unless involved in the development of the plan. Copies of the HAP should be given to the participant, the PCP, those who participated in developing the HAP, as well as anyone else involved in achieving the goal(s) established in the HAP within 30 days of completion. This sharing of information helps to ensure all providers in the member's care network are aware of the member's participation in Health Homes and are able to review the care summary and advise of any discrepancies or concerns.

HEALTH ACTION PLAN

SECTION I. Demographic Information

Member Name: _____ **KanCare ID No.:** _____

Address: _____

Phone: _____ Date of Birth: _____ Gender: Select

Primary Language: _____ Race: Select

SECTION II. Additional Contact Information

Parent/Foster Parent/Legal Guardian: _____

Address: _____ Phone: _____

Medical Power of Attorney: _____

Address: _____ Phone: _____

KanCare MCO: _____

MCO Care Manager: _____

Address: _____ Phone: _____

Health Homes Partner: _____

Health Homes Care Coordinator: _____

Address: _____ Phone: _____

Other Support Person: _____

Address: _____ Phone: _____

SECTION III. Physical and Behavioral Health

Provider: Select _____

Address: _____ Phone: _____

Kan Be Healthy Screen: Select (Children only) Date: _____

Health Risk Assessment: Select Date: _____

Physical Health:

Physical Health Diagnoses: _____

Height: _____ Weight: _____ Date: _____

Cardio: BP: _____ Date: _____ Diabetes: A1c: _____ Date: _____

Obesity: BMI: _____ Date: _____ LDL-c: _____ Date: _____

Tobacco use: Select Describe current usage if yes: _____

Behavioral Health:

Mental Health Diagnoses: _____

Depressions Screening performed: _____ Date: _____

Substance Use Disorder Brief Screen: Select Date: _____ _____

Substance Use Disorder Assessment: Select Referral: _____ Date: _____

Results of Screening: _____

Drug(s) of Choice: _____

Medication/Reconciliation:

Medication Name	Dosage and Frequency	Prescribed By	Additional Information about Medications

SECTION IV. Existing Plan (If applicable)

Do you have an existing plan? Select

Plan type: Select

SECTION V. Advanced Directives

Advanced Directives: Select

SECTION VI. Goals and Steps to Achieve (Goals must address needs and must have measurable outcome)

Goal:

Steps to Achieve Goal:

Strength and Needs:

Measurable Outcome:

Start Date: Completion Date:

Progress (date):

Goal:

Steps to Achieve Goal:

Strength and Needs:

Measurable Outcome:

Start Date: Completion Date:

Progress (date):

Goal:

Steps to Achieve Goal:

Strength and Needs:

Measurable Outcome:

Start Date: Completion Date:

Progress (date):

Goal:	
Steps to Achieve Goal:	
Strength and Needs:	
Measurable Outcome:	
Start Date:	Completion Date:
Progress (date):	

SECTION VII. Signatures

Completed by:	Select	**Date:**
Completed by:	Select	**Date:**
Completed by:	Select	**Date:**
Completed by:	Select	**Date:**
Completed by:	**Other:** Describe Other:	**Date:**

Preparedness and Planning Tool Instructions

This Preparedness and Planning Tool will be used for two distinct purposes. The first purpose is to help providers determine their understanding of Health Homes services and requirements and serve as a roadmap for providers looking to become Health Homes Partners (HHPs). The second purpose is to provide the MCOs some information to help them in their discussion with interested providers.

This Preparedness and Planning Tool is designed to allow you to answer questions based on an honest analysis of the current practices and processes within your organization. This Tool is meant to be a conversation-started for your agency, hopefully facilitating discussion leading to a clearer understanding of your organization's role related to Health Homes in Kansas.

Providers:

This tool is meant to assist you in understanding the expectations for HHPs. Please remember that the MCOs strongly encourage potential HHPs to be able to provide Care Coordination and Comprehensive Transitional Care and also be prepared to use HIT by the target date indicated on this Tool. Completing this Tool will allow you to understand your existing operational and cultural infrastructure to determine if you can support greater integration and be a HHP. We encourage you to collaborate and consult with other providers to address the health needs of your population and this tool may provide a framework for these collaborative efforts. Your organization may build formal relationships through care compacts with primary care providers or build informal referral networks of primary care and specialty providers, for example. The Tool will ask you to answer questions related to these issues. After completing the Tool, organizations will be able to:

- Understand the current state of the organization's ability to support progress toward becoming a HHP.
- Assess the organization's strengths and challenges in undertaking different approaches to integration.
- Set and prioritize goals for your organization's move to becoming a HHP

MCOs:

This tool is meant to assist you in evaluating, supporting and contracting with potential Health Homes Providers (HHPs). This tool is not meant to serve as a measuring stick to determine which potential HHPs are accepted or rejected. As with the providers, we hope that this tool will serve as a "roadmap" to help you work with potential HHPs in contracting.

All completed Tools will come directly to the State and will then be distributed to the MCOs. Potential HHPs are encouraged to work with all three MCOs. Though you will interact directly with providers related to contracting for HHPs, the State expects regular reporting of the development of HHP networks.

Process for Submission:

The Tool should be completed electronically and sent directly to Samantha Ferencik at the Kansas Department of Health and Environment: sferencik@kdheks.gov

Once electronically submitted and received, the completed Tools will be reviewed and sent on to the three MCO partners. The State will monitor and track the submission and review of the completed Tools.

One of the goals of Health Homes in Kansas is to initiate a process of transformation among providers. Given this goal, we encourage providers to ask the MCOs for suggestions, advice, and feedback regarding the results of their Tool. In such cases where the MCO deems the agency unable to become an HHP by their target date, the agency may ask the MCO to provide them with ideas and strategies for reaching a state of readiness. Agencies may also request that they be re-evaluated by the MCO at a later date. Potential HHPs may submit and/or resubmit the Preparedness and Planning Tool at any time but are encouraged to work with the MCO(s) to develop a timeline for resubmissions.

MCO Response:

After receiving and considering potential HHPs' Preparedness and Planning Tools, MCOs must provide each potential HHP with a response and a plan regarding their target date to become an HHP. Not all agencies who submit the Tool will be in a position to immediately become a HHP. However, the State expects the MCOs to work with all agencies to bring them closer to becoming HHPs. The MCO response should indicate their evaluation of the reasonableness of the agency's target date to become a HHP as well as an evaluation of their existing level of preparedness. The MCOs shall respond to potential HHPs within 10 days of receiving the completed Tools. Within 45 days of receiving completed Tools, the MCOs will have a follow-up discussion (either in-person or over the phone) with potential HHPs regarding their readiness to serve as a HHP. After the follow-up discussion, the MCOs will have 10 days to provide potential HHPs with a contract amendment and the potential HHPs will have another 10 days after receiving the contract amendment to sign and return the contract amendment to the MCO.

Preparedness and Planning Tool for Potential Health Homes Providers

Contact Information

Agency Contact Person: Click here to enter text.

Address: Click here to enter text.

Phone: Click here to enter text. **Email:** Click here to enter text.

Agency Director or CEO: Click here to enter text.

Address: Click here to enter text.

Phone: Click here to enter text. **Email:** Click here to enter text.

Agency's target date to become a Health Homes Partner: Click here to enter a date.

The State encourages all potential HHPs to work with all three MCOs. However, you have a choice regarding who the State shares your tool with. Please check the boxes of those MCOs with which you wish to share your tool.	
Sunflower	Y/N
United	Y/N
Amerigroup	Y/N

Purpose and Instructions

Purpose of the Preparedness and Planning Tool

This Preparedness and Planning Tool will be used for two distinct purposes. The first purpose is to help providers determine their understanding of Health Homes services and requirements and serve as a roadmap for providers looking to become Health Homes Partners (HHPs). The second purpose is to provide the MCOs some information to help them in their discussion with interested providers.

Providers:

This tool is meant to assist you in understanding the expectations for HHPs. It will allow you to understand your existing operational and cultural infrastructure to determine if you can support greater integration and be a HHP. The MCO's strongly encourage potential HHPs to be able to provide Care Coordination and Comprehensive Transitional Care and to be prepared to use HIT by the target date indicated on this tool. We encourage you to collaborate and consult with other providers to address the health needs of your population and this tool may provide a framework for these collaborative efforts. Your organization may build formal relationships through care compacts with primary care providers or build informal referral networks of primary care and specialty providers, for example. The Tool will ask you to answer questions related to these issues. After completing the Tool, organizations will be able to:

- Understand the current state of the organization's ability to support progress toward becoming a HHP.

- Assess the organization's strengths and challenges in undertaking different approaches to integration.
- Set and prioritize goals for your organization's move to becoming a HHP

MCOs:

This tool is meant to assist you in evaluating, supporting and contracting with potential Health Homes Providers (HHPs). This tool is not meant to serve as a measuring stick to determine which potential HHPs are accepted or rejected. As with the providers, we hope that this tool will serve as a "roadmap" to help you work with potential HHPs in contracting.

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How to use the Tool

This Preparedness and Planning Tool is designed to allow you to answer questions based on an honest analysis of the current practices and processes within your organization. This Tool is meant to be a conversation-starter for your agency, hopefully facilitating discussion leading to a clearer understanding of your organization's role related to Health Homes in Kansas.

1) **Pre-work:**

Prior to beginning the assessment, it will be helpful to work with staff in your organization to collect:

- Data on demographics, service utilization, and other characteristics of your current population (who you serve and how often).
- Information on current clinical, operational, and cultural practices and processes (the infrastructure of what makes your organization unique).

2) **Tool Sections:**

- Health Homes Core Services
- Health Homes Information Technology
- Health Homes Provider Standards
- Health Homes, Lead Entity Joint Standards

Processes for Completing the Tool:

- We recommend that you select a group of leaders and staff that have expertise on all levels of the organization (e.g., finances, operations, clinical processes, leadership practices, staff practices) to complete the Tool. The time needed to complete it will vary depending on the availability of data/information within your organization. You may ask specific individuals to complete specific sections of the assessment or you may ask a few individuals to complete as much of the assessment as possible.
- When finished, we recommend that you come together as a team to discuss the results and come to a consensus on final responses.
- After completing the tool we suggest setting up time with key leaders to identify your goals and next steps

Process for Submission:

The Tool should be completed electronically and sent directly to Samantha Ferencik at the Kansas Department of Health and Environment: sferencik@kdheks.gov

Once electronically submitted and received, the completed Tools will be reviewed and sent on to the three MCO partners. The State will monitor and track the submission and review of the completed Tools.

One of the goals of Health Homes in Kansas is to initiate a process of transformation among providers. Given this goal, we encourage providers to ask the MCOs for suggestions, advice, and feedback regarding the results of their Tool. In such cases where the MCO deems the agency unable to become an HHP by their target date, the agency may ask the MCO to provide them with ideas and strategies for reaching a state of readiness. Agencies may also request that they be re-evaluated by the MCO at a later date. Potential HHPs may submit and/or resubmit the Preparedness and Planning Tool at any time but are encouraged to work with the MCO(s) to develop a timeline for resubmissions.

MCO Response:

After receiving and considering potential HHPs' Preparedness and Planning Tools, MCOs must provide each potential HHP with a response and a plan regarding their target date to become an HHP. Not all agencies who submit the Tool will be in a position to immediately become a HHP. However, the State expects the MCOs to work with all agencies to bring them closer to becoming HHPs. The MCO response should indicate their evaluation of the reasonableness of the agency's target date to become a HHP as well as an evalutation of their existing level of preparedness. The MCOs shall respond to potential HHPs within 10 days of receiving the completed Tools. Within 45 days of receiving completed Tools, the MCOs will have a follow-up discussion (either in-person or over the phone) with potential HHPs regarding their readiness to serve as a HHP. After the follow-up discussion, the MCOs will have 10 days to provide potential HHPs with a contract amendment and the potential HHPs will have another 10 days after receiving the contract amendment to sign and return the contract amendment to the MCO.

The Tool

I) Understanding your Population

The following questions will help your organization consider how the demographics of the people you serve relate to your becoming a HHP and may affect potential models of integration. You may not be able to answer all questions asked below. The responses to these questions will help you think about the appropriate integration approach for the organization. For example, if 75% of the population already has primary care providers, building integration in-house may not be necessary as the primary care or behavioral health care needs of many individuals are already being met by existing providers. In that case, building formal or informal relationships with local primary care providers may be the best option. Conversely, a population with significant physical health needs and low primary care coverage may require a more intensive integration model to best meet their needs.

1) General Population

1. Most prevalent (top five) diagnoses codes:
    1. Click here to enter text.
    2. Click here to enter text.

3. Click here to enter text. 4. Click here to enter text. 5. Click here to enter text.
2. Total number of individuals seen in past 12 months: Click here to enter text.
3. Total number of visits to the whole organization in past 12 months: Click here to enter text.
4. Where individuals who are served by the organization live (i.e. counties, cities/towns, areas within a city): Click here to enter text.
5. Based on the physical health information available to you, percentage of your population with multiple chronic conditions (MCC)? Click here to enter text. *For example, SMI and diabetes or diabetes and coronary heart disease.*
6. Percentage of your population who do **not** have either a primary care provider (PCP) or a regular source of behavioral health care, if applicable? Click here to enter text.
7. Do you know the total number of individuals seen in your organization who visited the emergency department within the last year? Y/N What was the total number of visits? Click here to enter text.

2) Kansas Health Homes Service Definitions

The following six Core Services are essential components of Health Homes. Though it is desirable for a potential Health Homes to be able to provide most of these services, you may subcontract with other providers to ensure that all of these services are available. If you plan to, or already do, subcontract for the provision of services please attach documentation to support this arrangement. Appropriate documents may include dates of discussions (when subcontracts are pending), MOUs, contact persons for subcontracting organizations, and contract copies demonstrating that a subcontract has been established. Where subcontracts have already been established, the subcontracting agency should respond to the appropriate portions of this Tool.

For each area where a subcontract is arranged or anticipated, please attach a letter of support from each subcontracting agency to this finished Tool.

Comprehensive Case Management Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from a HH, and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), Health Homes Partner (HHP), member, family/support persons/guardian, and health services and social service staff.	
Critical components of Comprehensive Care Management include:	
1) Do you provide Comprehensive Care Management through knowledge of the medical and non-medical service delivery system within and outside of the member's area?	Y/N
2) Do you provide Comprehensive Care Management through effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers?	Y/N

3) Do you provide Comprehensive Care Management through ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc.?	Y/N
4) Do you provide Comprehensive Care Management through monitoring and follow-up to ensure that needed care and services are offered and accessed?	Y/N
5) Do you provide Comprehensive Care Management through routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances?	Y/N
Do you/will you subcontract for this service?	Answer: Y/N
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Comprehensive Case Management. (0-10 with 10 being a high level of readiness) What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?) Click here to enter text.	Score: Select
Care Coordination Care Coordination is the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a member's progress towards achievement of goals, and revising the HAP as necessary to reflect the member's needs.	
Critical components of Care Coordination include:	
1) Do you provide Care Coordination that is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals?	Y/N
2) Do you provide Care Coordination that supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care?	Y/N
3) Do you provide Care Coordination that involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects?	Y/N
4) Do you provide Care Coordination that engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports?	Y/N
5) Do you provide Care Coordination that implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact?	Y/N
6) Do you provide Care Coordination that creates and promotes linkages to other agencies, services, and supports?	Y/N

Do you/will you subcontract for this service?	Answer: Y/N
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Care Coordination. (0-10 with 10 being a high level of readiness) What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?) Click here to enter text.	Score: Select
Health Promotion Health promotion involves engaging members in HH care by phone, letter, HIT and community "in reach" and outreach, assessing members understanding of health condition/health literacy and motivation to engage in self-management, e.g., how important is the person's health status to the member, how confident the member feels to change health behaviors, etc., assisting members in the development of recovery plans, including self-management and/or relapse prevention plans, linking members to resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on member needs and preferences, and assisting members to develop the skills and confidence that will enable them to independently identify, seek out and access resources that will assist in managing and mitigating their conditions, and in preventing the development of secondary or other chronic conditions.	
Critical components of Health Promotion include:	
1) Do you provide Health Promotion that encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health?	Y/N
2) Do you provide Health Promotion that places a strong emphasis on self-direction and skills development, engaging members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment?	Y/N
3) Do you provide Health Promotion that ensures all health action goals are included in person centered care plans?	Y/N
4) Do you provide Health Promotion that provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions based upon the member's preference?	Y/N
5) Do you provide Health Promotion that offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations?	Y/N
Do you/will you subcontract for this service?	Answer: Select
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Health Promotion. (0-10 with 10 being a high level of readiness) What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?) Click here to enter text.	Score: Select
Comprehensive Transitional Care	

Comprehensive transitional care is specialized care coordination designed to facilitate transition of treatment plans from hospitals, ED, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. It may also involve identifying members not participating who could benefit from a HH. Comprehensive transitional care involves developing a transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. For each HH member transferred from one caregiver or site of care to another, the HH coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation. Comprehensive transitional care involves collaboration, communication and coordination with members, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers. It is designed to ease transition by addressing the members understanding of rehab activities, LTSS, self-management, and medications. It includes scheduling appointments scheduling and reaching out if appointments are missed. It may also include evaluating the need to revise the HAP.	
The transition/discharge plan includes, but is not limited to, the following elements:	
1) Do you provide Comprehensive Transitional Care timeframes related to appointments and discharge paperwork?	Y/N
2) Do you provide Comprehensive Transitional Care follow-up appointment information?	Y/N
3) Do you provide Comprehensive Transitional Care medication information to allow providers to reconcile medications and make informed decisions about care?	Y/N
4) Do you provide Comprehensive Transitional Care medication education?	Y/N
5) Do you provide Comprehensive Transitional Care therapy needs, e.g., occupational, physical, speech, etc.?	Y/N
6) Do you provide Comprehensive Transitional Care transportation needs?	Y/N
7) Do you provide Comprehensive Transitional Care community supports needed post-discharge?	Y/N
8) Do you provide Comprehensive Transitional Care determination of environmental (home, community, workplace) safety?	Y/N
Do you/will you subcontract for this service?	Answer: Select
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Comprehensive Transitional Care. (0-10 with 10 being a high level of readiness) What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?) Click here to enter text.	Score: Select
Member and Family Support Member and Family Support involves identifying supports needed for members, family/support persons/guardians need to manage member's conditions and assisting them to access these supports. It includes assessing strengths and needs of members, family/support persons/guardians, identifying barriers to member's highest level of health and success, locating resources to eliminate these barriers, and advocating on behalf of members, family/support persons/ guardians, to ensure that they have supports necessary for improved health. Included in this service is assistance to complete paperwork, provision of information and assistance to access self-help and peer support services, and consideration of the family/support persons/guardians need for services such as respite care. To promote inclusion,	

consideration is given to accommodating work schedules of families, providing flexibility in terms of hours of service, and teleconferencing. The goal of providing member and family support is to Increase member's, family/support persons and guardians understanding of effect(s) of the condition on the member's life, and improve adherence to an agreed upon treatment plan, with the ultimate goal of improved overall health and quality of life.	
Member and family support:	
1) Do you provide Member and Family Support that is contingent on effective communication with member, family, guardian, other support persons, or caregivers?	Y/N
2) Do you provide Member and Family Support that involves accommodations related to culture, disability, language, race, socio-economic background, and non-traditional family relationships?	Y/N
3) Do you provide Member and Family Support that promotes engagement of members, family/support persons and guardians?	Y/N
4) Do you provide Member and Family Support that promotes self-management capabilities of members?	Y/N
5) Do you provide Member and Family Support that involves ability to determine when members, families/support persons, and guardians are ready to receive and act upon information provided, and assist them with making informed choices?	Y/N
6) Do you provide Member and Family Support that involves an awareness of complexities of family dynamics, and an ability to respond to member needs when complex relationships come into play?	Y/N
Do you/will you subcontract for this service?	Answer: Select
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Member and Family Support. (0-10 with 10 being a high level of readiness) What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?) Click here to enter text.	Score: Select
Referral to Community and Social Support Services Referral to community supports and services includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paper work, identifying natural supports if service providers are unavailable in the member's community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible. Community supports and services include long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member.	
Referral to community and social support services involves:	
1) Do you provide Referral to Community and Social Supports thorough knowledge of the medical and non-medical service delivery system within and outside of the member's area?	Y/N
2) Do you provide Referral to Community and Social Supports through engagement with community and social supports?	Y/N
3) Do you provide Referral to Community and Social Supports through establishing	Y/N

and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc.?	
4) Do you provide Referral to Community and Social Supports through fostering communication and collaborating with social supports?	Y/N
5) Do you provide Referral to Community and Social Supports through knowledge of the eligibility criteria for services?	Y/N
6) Do you provide Referral to Community and Social Supports through identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary?	Y/N
Do you/will you subcontract for this service?	Answer: Select
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Referrals to Community and Social Supports. (0-10 with 10 being a high level of readiness) What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?) Click here to enter text.	Score: Select

3) Health Homes Health Information Technology

1. Do you use an interoperable EHR?	Y/N
If answering "No" above, 1) Do you currently have the capacity to submit a plan, within 90 days of contracting as a HHP, to implement the EHR?	Y/N
2) The State expects HHPs to achieve full implementation of the EHR within a timeline approved by the Lead Entity. Provide an estimate of how long it may take you to meet this expectation:	Select
3) The State expects HHPs to have the capacity to connect to one of the certified state HIEs, KHIN or LACIE. Provide an estimate of how long it may take you to meet this expectation:	Select

4) Health Homes Provider Standards

1. Health Homes Providers must meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following. Do you meet these standards?	
• Center for Independent Living	Y/N
• Community Developmental Disability Organization	Y/N
• Community Mental Health Center	Y/N
• Community Service Provider – for people with intellectual / developmental disabilities (I/DD)	Y/N
• Federally Qualified Health Center/Primary Care Safety Net Clinic	Y/N

• Home Health Agency	Y/N
• Hospital – based Physician Group	Y/N
• Local Health Department	Y/N
• Physician – based Clinic	Y/N
• Physician or Physician Practice	Y/N
• Rural Health Clinics	Y/N
• Substance Use Disorder Provider	Y/N
2. Health Homes Partners must enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements.	
• Are you enrolled in the KanCare Program?	Y/N
• Do you agree to comply with all KanCare program requirements?	Y/N
***3.* Health Homes Partners must have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls**	
• Does your leadership fit the description above? Please provide some brief examples: Click here to enter text.	Y/N
4. Health Homes Partners must provide appropriate and timely in-person care coordination activities. Alternative communication methods in addition to in-person such as telemedicine or telephonic contacts may also be utilized if culturally appropriate and accessible for the enrollee to enhance access to services for members and families where geographic or other barriers exist	
• Do you provide appropriate and timely in-person care coordination activities?	Y/N
• Do you utilize alternative communication methods?	Y/N
5. Health Homes Partners must have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals	
• Do you have the capacity to accompany enrollees to critical appointments?	Y/N
***6.* Health Homes Partners must agree to accept any eligible enrollees, except for reasons published in the Kansas Health Homes Program Manual**	
• Do you agree to accept any eligible enrollees except for reasons published in the Kansas Health Homes Program Manual?	Y/N
7. Health Homes Partners must demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers to collaborate with the HHP on care coordination and hospital / ER notification	

• Do you demonstrate such engagement and cooperation? Please provide some brief examples: Click here to enter text.	Y/N

5) Health Homes Partner and Lead Entity Joint Standards

The following questions pertain to services that either the Health Homes Partner or the Lead Entity must perform. Even though the Lead Entity may take responsibility for some of these services, potential HHPs should consider whether or not they could do them as well.

1. The Lead Entity and the Health Homes Partner jointly must provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees	
• Do you have staff and procedures in place to ensure this availability?	Y/N
2. **The Lead Entity and the Health Homes Partner jointly must ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay**	
1) Do you have staff and procedures in place to ensure that enrollees will be seen within seven days of an acute care or psychiatric inpatient stay? 2) Do you have staff and procedures in place to ensure that enrollees will be seen again within 30 days of an acute care or psychiatric inpatient stay? Please provide some brief examples: Click here to enter text.	Y/N Y/N
3. The Lead Entity and the Health Homes Partner jointly must ensure person and family-centered and integrated health action planning that coordinates and integrates all his or her clinical and non-clinical health care related needs and services	
1) Do you have staff and procedures in place to ensure that this health action planning will be achieved?	Y/N
4. The Lead Entity and the Health Homes Partner jointly must provide quality-driven, cost-effective Health Homes services in a culturally competent manner that addresses health disparities and improves health literacy	
1) Do you have staff and procedures in place to ensure that quality-driven services are provided to address health disparities? 2) Do you have staff and procedures in place to ensure that quality-driven services are provided to address and improve	Y/N Y/N

health literacy?	
3) Do you have staff and procedures in place to ensure that cost-effective services are provided to address and improve health literacy?	Y/N
4) Do you have staff and procedures in place to ensure that culturally competent services are provided to address health disparities?	Y/N
5) Do you have staff and procedures in place to ensure that culturally competent services are provided to address and improve health literacy?	Y/N
5. The Lead Entity and the Health Homes Partner jointly must establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers	
1) Have you established such a data-sharing agreement?	Y/N
***6.* The Lead Entity and the Health Homes Partner jointly must demonstrate their ability to perform each of the following functional requirements. Can you do the following? Please provide a brief example to support your answer to each. If you respond "No", please explain where you are in your process and describe your current abilities.**	
a. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines?	Y/N
b. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders?	Y/N
c. Coordinate and provide access to mental health and substance abuse services?	Y/N
d. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families?	Y/N
e. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate?	Y/N
f. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level?	Y/N
7. The Lead Entity and the Health Homes Partner jointly must demonstrate the ability to report required data for both state and federal monitoring of the program	

a. Do you have the staff and procedures in place to report this required data?	Y/N

Kansas Health Homes Referral Form

Directions: Please complete sections 1 through 5 and send via fax, email, or standard mail to:		
Amerigroup 9225 Indian Creek Pkwy, Ste. 400 Overland Park, KS 66210 Member Services: 1-800-600-4441 Fax: 1-877-820-9028	Sunflower State Health Plan 8325 Lenexa Dr. Lenexa, KS 66214 Member Services: 1-877-644-4623 Fax: 1-888-453-4316	United Health Care 10895 Grandview Drive Suite 200 Overland Park, KS 66210 Member Services: 1-877-542-9238 Fax: 1-855-252-9324
Current MCO assignment: Choose an item.		Medicaid ID#:
Section 1: Member Information		
Date of referral: Click here to enter a date. Name of individual being referred: Date of Birth: Address: Phone: Email:		
Name of Referring Organization: Name/Position or Title of Individual submitting the referral: Address: Phone: Email:		
Section 2: Has your patient/client/consumer been diagnosed with any of the following chronic conditions? (check all that apply)		
☐ Schizophrenia		Enter ICD-10 Code:
☐ Bipolar disorder & major depression disorders		Enter ICD-10 Code:
☐ Delusional disorders		Enter ICD-10 Code:
☐ Other nonorganic psychoses		Enter ICD-10 Code:
☐ Obsessive-compulsive disorder		Enter ICD-10 Code:
☐ Obsessive-compulsive personality disorder		Enter ICD-10 Code:
☐ Paranoid Personality disorder		Enter ICD-10 Code:
☐ Schizoid Personality disorder		Enter ICD-10 Code:
☐ Schizotypal Personality disorder		Enter ICD-10 Code:
☐ Borderline Personality disorder		Enter ICD-10 Code:
☐ Post-traumatic stress disorder		Enter ICD-10 Code:

Kansas Health Homes Referral Form (cont.)

TO BE COMPLETED BY MCO	
Section 3: Eligibility Criteria	
☐ Medicaid Eligible (KMAP) ☐ Member has at least one Serious Mental Illness (SMI HH) ☐ Member does not meet eligibility criteria. Reason for ineligibility:	
Section 4: MCO Follow-up	
Date referral received: Click here to enter a date. Date referral reviewed: Click here to enter a date. Name of health home partner (HHP): HHP Contact Name: HHP accepts referral: ☐ Yes ☐ No HHP start date: Click here to enter a date. Date response letters mailed: Click here to enter a date.	MCO Representative name: Title: Phone number: Corresponding follow up letters: ☐ Health Home Member Welcome Letter ☐ Health Home Partner Welcome Letter ☐ Health Home Referral Letter (if other than HHP)

Expedited Health Homes Referral Form (for completion by contracted HHPs)

Directions: Please complete sections 1 through 5 and send via fax, email, or standard mail to:		
Amerigroup 9225 Indian Creek Pkwy, Ste. 400 Overland Park, KS 66210 Member Services: 1-800-600-4441 Fax: 1-877-820-9028	Sunflower State Health Plan 8325 Lenexa Dr. Lenexa, KS 66214 Member Services: 1-877-644-4623 Fax: 1-888-453-4316	United Health Care 10895 Grandview Drive Suite 200 Overland Park, KS 66210 Member Services: 1-877-542-9238 Fax: 1-855-252-9324
Current MCO assignment: Choose an item.		Medicaid ID#:

Section 1: Member Information

Date of referral: Click here to enter a date.
Name of individual being referred:
Date of Birth:
Address:
Phone:
Email:

By signing below, you indicate that you are willing to be placed immediately into the Health Homes Program:

_____ _____
Name Date

Name of Referring Organization:
Name/Position or Title of Individual submitting the referral:
Address:
Phone:
Email:

By signing below, you indicate that you are willing to accept this member immediately into your Health Homes Program and that you believe that the member in question is eligible for the Health Home program:

_____ _____
Name Date

Section 2: Has your patient/client/consumer been diagnosed with any of the following chronic conditions? (check all that apply)

☐ Schizophrenia	Enter ICD-10 Code:
☐ Bipolar disorder & major depression disorders	Enter ICD-10 Code:
☐ Delusional disorders	Enter ICD-10 Code:
☐ Other nonorganic psychoses	Enter ICD-10 Code:
☐ Obsessive-compulsive disorder	Enter ICD-10 Code:
☐ Obsessive-compulsive personality disorder	Enter ICD-10 Code:
☐ Paranoid Personality disorder	Enter ICD-10 Code:

☐ Schizoid Personality disorder	Enter ICD-10 Code:
☐ Schizotypal Personality disorder	Enter ICD-10 Code:
☐ Borderline Personality disorder	Enter ICD-10 Code:
☐ Post-traumatic stress disorder	Enter ICD-10 Code:

TO BE COMPLETED BY MCO

Section 3: Eligibility Criteria

☐ Medicaid Eligible (KMAP)
☐ Member has at least one Serious Mental Illness (SMI HH)
☐ Member does not meet eligibility criteria. Reason for ineligibility:

Section 4: MCO Follow-up

Date referral received: Click here to enter a date. Date referral reviewed: Click here to enter a date. Name of health home partner (HHP): HHP Contact Name: HHP accepts referral: ☐ Yes ☐ No HHP start date: Click here to enter a date. Date response letters mailed: Click here to enter a date.	MCO Representative name: Title: Phone number: Corresponding follow up letters: ☐ Health Home Member Welcome Letter ☐ Health Home Partner Welcome Letter ☐ Health Home Referral Letter (if other than HHP)

Sample Assignment Letter

{System date} **{Member information}**

Welcome to the KanCare Health Home program! Starting **{start date}** you will have the chance to get some new Health Homes services. These services are in addition to what you already get in KanCare and won't change your eligibility for the KanCare program. The new Health Home services will be provided by **{MCO name}** and a community Health Home Partner, **{HHP name}.**

You are eligible for Health Home services because you have one or more of these chronic conditions:

- Asthma
- Diabetes
- Serious mental illness

What is a Health Home? A Health Home is not a place. It is a way to make sure you can be as healthy as possible by giving you some special services. These services include:

- Someone helping you develop a health action plan to guide you and your doctors and other providers.
- Someone meeting with you to help to make sure you get the right services at the right time.
- Help to learn about your conditions and how you can help yourself be healthier.
- Help when you come out of the hospital to make sure you can get to important follow-up visits to doctors or other providers.
- Understanding how your family or other helpers support you to reach your health goals.
- Making sure you get other services and supports you need to stay in your home.

Why a Health Home? There are many benefits to being in a Health Home, including:

- All the people who provide your care work together to give you quality health care. **{MCO NAME}** would be part of your Health Home.
- You get a special person who will coordinate all your care among your providers
- That person will ensure you get what you need when you need it
- That person will help you stay healthy, out of the emergency room and out of the hospital, and in the community
- You will have one point of contact for your health care if you have questions or problems

Your Health Home Partner: {HHP name}

You've been placed with a Health Home Partner that seems best for you, but you have a choice of Health Home Partners. If you want information about other Health Home partners available in your area, please call **{MCO phone number}.**

Health Home services will help you manage conditions you have, and help you meet your health goals. You should get the right services, at the right time, in the right place, and get better coordination among all your health care providers.

How does this change what you have right now?

- Your full Medicare and Medicaid benefits do not change, including appeal rights.
- Health Homes services are additional benefits.
- You keep your choice of providers.
- Joining a Health Homes is voluntary.

How can you get more information about Health Homes?

- Go to the Health Homes link http://www.kancare.ks.gov/health_home.htm.
- Call 785-296-3981.
- Call {**Plan name and phone number}.**

If you don't want to be in a Health Home right now, you may:

- Complete the enclosed Health Homes Opt Out Form and mail it in the postage paid envelope.
- Call the phone number listed on the enclosed Health Homes Opt Out Form.

If you decide to be in a Health Home later:

- It will not change your eligibility to receive other KanCare services.
- You can decide later to be in a Health Homes, but you must call this phone number **{MCO number}.**
- You can keep seeing any of the providers in **{Health Plan name}**'s network.

Discharge & Refusal Forms Instructions

If HHP is Unable to Contact Members:
We expect the HHP to make good-faith efforts to contact the member. To establish good-faith, we require the HHP to document all outreach efforts. If the provider cannot reach the member by phone or mail using their established contact information, the MCOs will attempt to identify updated contact information via claims or other informational resources/data. If there is no alternate contact information in our system, or the information does not resolve the situation, the HHP may visit the member's address. If the HHP is still unsuccessful in contacting the member, the HHP will submit a Refusal Form. The MCO will process the Refusal Form and contact HP to opt the member out of the Health Home program. This is done through the monthly file update. HP will process the opt-out and remove the member from HH. If the member is subsequently contacted; the member may opt back into HH. These good faith efforts will be reimbursed so that the provider is compensated for their efforts to engage the member.

If Members Refuse Services:
If the member refuses Health Home services after two outreach attempts, the HHP will submit a Refusal Form to the MCO. The HHP must specify a reason for all refusals. The MCO will not accept or process any Refusal Forms that do not have a reason specified. If the member refuses services twice and also refuses to officially opt-out, the MCO will process the Refusal Form and contact HP to opt the member out of the Health Home program. This is done through the monthly file update. HP will process the opt-out and remove the member from HH. In each case, the MCO will report the HHP Refusal Form submission on the KKMAR Report.

Choosing the Correct Form:

Member has lost HH eligibility and/or is experiencing a catastrophic illness or event that makes is unlikely the member will continue to participate in or benefit from Health Homes	Discharge Form
Member has been previously discharged by the HHP with applicable notice in writing provided	Discharge Form
Member poses a danger to him/herself or to the HHP staff	Refusal Form
Member resides outside of the geographic area served by the HHP	Refusal Form
Member's age does not fit within the parameters established by the HHP, e.g. a pediatrician is not required to serve adults	Refusal Form
The HHP has reached its capacity to provide HH services	Refusal Form
The HHP wishes to limit its panel	Refusal Form
Member has refused Health Home services after at least two documented attempts to make contact with the member within a month	Refusal Form

When members refuse HH services and also refuse to complete the Opt Out process, the Refusal Form should be used. This will lead to the member dis-enrolled by the MCO. In cases where the member is deemed to pose a threat the same policy will also be used.

HHP Member Assignment Refusal Form

Directions: Please complete sections 1 through 3 and send via fax, email, or standard mail to:

Amerigroup 9225 Indian Creek Pkwy, Ste. 400 Overland Park, KS 66210 Member Services: 1-800-600-4441 Fax: 1-877-820-9028	Sunflower State Health Plan 8325 Lenexa Dr. Lenexa, KS 66214 Member Services: 1-877-644-4623 Fax: 1-888-453-4316	United Health Care 9900 W. 109th St. #200 Overland Park, KS 66210 Member Services: 1-877-542-9238 Fax: 1-855-252-9324

Current MCO assignment: Choose an item. Medicaid ID#:

Section 1: Member Information

Date of refusal: Click here to enter a date.
Name of member:
Date of Birth:
Address:
Phone:
Email:

Section 2: Health Home Partner Information

Name of health home partner:
Name/Position or Title of Individual submitting the refusal:
Address:
Phone:
Email:

Section 3: Reason Member Assignment is Refused

- ☐ The member poses a danger to himself or herself, or to the HHP staff
- ☐ The member resides outside the geographic range served by the HHP, e.g. a Community Mental Health Center
- ☐ The member is outside the age range parameters established by the HHP, e.g. a pediatrician is not required to serve adults
- ☐ The HHP has reached its capacity to provide HH services
- ☐ The HHP is a Tribal 638/Indian Health Facility and wished to limit its HH activities to Native Americans
- ☐ The HHP is a provider of services to people with intellectual or developmental disabilities (I/DD) and wished to limit its HH activities to those with I/DD
- ☐ The member has refused Health Homes services. The assigned HHP has documented at least two attempts to contact the member within a month.
- ☐ Other:

TO BE COMPLETED BY MCO

Date refusal received: Click here to enter a date. MCO Representative name: Title: Phone number: Name of alternate HHP: HHP Contact Name: HHP accepts referral: ☐ Yes ☐ No HHP start date: Click here to enter a date.	Corresponding follow up letters: ☐ Member Change of Health Home Letter ☐ HHP Notification of Enrollment Letter (Alternate HHP) ☐ HHP Disenrollment Letter (First HHP) ☐ Health Home Member Disenrollment Letter ☐ Health Home Not Available Letter Date response letters mailed: Click here to enter a date.

Health Homes Member Discharge Form

Directions: Please complete sections 1 through 3 and send via fax, email, or standard mail to:		
Amerigroup 9225 Indian Creek Pkwy, Ste. 400 Overland Park, KS 66210 Member Services: 1-800-600-4441 Fax: 1-877-820-9028	Sunflower State Health Plan 8325 Lenexa Dr. Lenexa, KS 66214 Member Services: 1-877-644-4623 Fax: 1-888-453-4316	United Health Care 10895 Grandview Dr., Suite #200 Overland Park, KS 66210 Member Services: 1-877-542-9238 Fax: 1-855-252-9324
Current MCO assignment: Choose an item.	Medicaid ID#:	

Section 1: Health Homes Member Information

Date of request: Click here to enter a date.
Health Homes Member Name:
Member Medicaid ID #:
Member Address:
Member Phone:

Section 2: Health Homes Partner Information

Health Homes Partner Name:
Health Homes Partner Address:
Health Homes Partner Phone:
Health Homes Partner Email:

Section 3: Discharge Request

Reason for Member Discharge Request:

☐ The member is experiencing or has experienced a catastrophic illness or event that makes it unlikely the member will continue to participate in or benefit from Health Homes
☐ The member poses a danger to himself or herself, or to HHP staff
☐ The member has moved outside the geographic range served by the Health Homes Partner
☐ The member's age makes him or her no longer within the age range parameters established by the Health Homes Partner
☐ Other reason:

TO BE COMPLETED BY MCO

Section 4: Discharge Determination

Notice is hereby provided that the Health Homes Partner's Request to Discharge the member named above is:

☐ Approved
☐ Denied (reason)
Reason for discharge denial:

Section 5: MCO Follow-up

Date discharge received: Click here to enter a date. Date discharge reviewed: Click here to enter a date. Name of Health Homes partner (HHP): HHP Contact Name: HHP discharge request granted: ☐ Yes ☐ No Discharge date: Click here to enter a date. Date response letters mailed: Click here to enter a date.	MCO Representative name: Title: Phone number: Corresponding follow up letters: ☐ Health Homes Member Discharge Notice of Action ☐ Health Homes Partner Discharge Request Response Letter

APPENDIX C: Kansas Health Homes Quality Goals and Measures

(CMS Core Measures in Yellow)

Service Goal	Measure	Numerator	Denominator
1. Reduce utilization associated with inpatient stays	Decrease in Institutional Care Utilization	The number of members that were admitted to an inpatient psychiatric facility as a result of mental health inpatient screen performed by CMHC Staff. An inpatient psychiatric facility includes any state-operated or state-contracted psychiatric inpatient facilities, local/regional inpatient psychiatric facilities, local/regional medical facilities providing psychiatric services, and psychiatric residential treatment facilities (excluding nursing homes for mental health.)	The number of members that were assigned to the MCO on the last day of the measurement period and continuously assigned during the measurement period (allowing one gap of up to 14 days in duration.)
	Inpatient Utilization—General hospital/Acute	HEDIS specifications	HEDIS specifications
	Plan- All Cause Re-admission	Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination	Count the number of Index Hospital Stays for each age, gender, and total combination
	Ambulatory Care-Sensitive Condition Admission	Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years	Total mid-year population under age 75
2. Improve Management of Chronic Conditions	HBa1C Testing	An HbA1c test performed during the measurement year as identified by claim/encounter or automated laboratory data.	The eligible population
	LDL-C Screening	An LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data.	The eligible population

Service Goal	Measure	Numerator	Denominator
	Follow-up after Hospitalization for Mental Illness	An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between July 1 and June 30 of the SPA measurement year
	Adult Body Mass Index (BMI) Assessment	Body mass index documented during the measurement year or the year prior to the measurement year	Members 18-74 of age who had an outpatient visit
	Screening for Clinical Depression and Follow-up Plan	Total number of patients from the denominator who have follow-up documentation	All patients 18 years and older screened for clinical depression using a standardized tool
	Controlling High Blood Pressure	The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.	Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.
3. Improve Care Coordination	Increased Integration of Care	The number of members who reported, through the survey tool, a moderate or high level of clinical integration of care between their case manager and other service providers.	The number of Health Homes members continuously enrolled in a Health Home with the same MCO for > or = to 180 days.
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	"Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive	Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period,

Service Goal	Measure	Numerator	Denominator
		outpatient encounter, or partial hospitalization within 14 days of diagnosis.	reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.
	Tobacco Use Assessment Percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months (measure at intervals of 6 months; 12 months; 18 months; and 24 months)	Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit **OR** within 24 months of the most recent visit.	Number of patients who were 13 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least *two* medical visits in the last three years ,**OR** a sample of these patients (FYI—this means a random sample of 70 performed using their rules). For measurement year 2012, this includes patients with a date of birth on or before December 31, 1994.
4. Improve transitions of care among primary care and community providers and inpatient facilities	Inpatient Utilization—General hospital/Acute Care (HEDIS)	HEDIS specifications	HEDIS specifications
	Care Transition- Transition Record Transmitted to Health Care Professional	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care

Service Goal	Measure	Numerator	Denominator
	Follow-up after Hospitalization for Mental Illness	An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between July 1 and June 30 of the SPA measurement year

APPENDIX D: Resources

Kansas Health Homes Web Page
This web page contains much information about the Kansas Health Homes Program and has information for providers and consumers, as well as frequently asked questions, informational materials for providers and educational materials for consumers and other stakeholders.

http://www.kancare.ks.gov/health_home.htm

Centers for Medicare and Medicaid Services Health Homes Web Page
CMS provides much general information and guidance about Health Homes at:
http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

SAMHSA/HRSA Integrated Care Website
The Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration have created a joint website with a great deal of integrated care information and resources available at:
http://www.integration.samhsa.gov/

Health Homes Herald – Sign Up Information
KDHE publishes a monthly e-newsletter that provides updates about the Health Homes program and includes news for both providers and consumers. You can sign up for the newsletter, by e-mailing a request to this address: healthhomes@kdheks.gov .

NOTES