



Health Homes Webinar Series
Targeted Case Management
Questions & Answers
June 17, 2014

Staff Roles

Q1: Can the Health Home Coordinator and the Targeted Case Manager (TCM) be the same person?

A1: Yes, but they don't have to be.

Q2: If the TCM is the Care Coordinator, can they work with individuals who do not have Intellectual/Developmental Disabilities (I/DD)?

A2: Yes, if the agency they work for is a contracted Health Home Provider that chooses to serve a wider population.

Q3: What is the role of the physician in relationship to the Case Managers within a Health Home?

A3: It depends on which physician you are talking about. Each type of Health Home, SMI or Chronic Conditions, has to have a physician consultant who is part of the Health Home. Then a member may also have a different physician who is their primary care physician (PCP). In some cases, it may be the same physician, but not always. The physician consultant, (if he or she is not the primary care physician) will be involved in the development of the Health Action Plan and will be available for consultation on particular issues that might arise. The PCP will continue his or her role as the primary care physician, but they will be included in communication through the Health Home Care Coordinator. This means that the PCP will receive information about other issues that are going on that they may not know now as the primary care physician. Both the consulting physician and the primary care physician should be involved in the development of the Health Action Plan. This may occur in person for the consulting physician, but in the case of the primary care physician, this may be done electronically. The Care Coordinator will share the HAP and any challenges or progress being made.

Q4: Does the physician consultant have to be licensed in Kansas?

A4: Yes.

Q5: What is the role of the Nurse Care Coordinator?

A5: A Health Home Partner can use both the Nurse Care Coordinator and the social worker to do care coordination activities. The Nurse Care Coordinator has a clinical background, so he or she is going to have a stronger role related to either the physical health care or behavioral health care of the individual. The Social Worker Care Coordinator has the background for community supports and services and making referrals to services. So both of them are going to play similar roles and they will, as the Health Home Partners get set up, determine who's going to which tasks for the caseload. Care Coordinators will have the



larger caseload, for example, than Targeted Case Managers now carry. So there will be a need for both the Nurse Care Coordinator and the Social Worker Care Coordinator to do specific things for the same individual.

- Q6: What will the Health Home Case Manager need to do in relationship with the HCBS Waiver Services and KDADS licensing?
- A6: TCM Providers will continue to have to meet the requirements that are determined by the Kansas Department on Aging and Disability Services (KDADS) for the Home and Community Based Services (HCBS) Waivers. There are specific requirements the Centers for Medicaid and Medicare Services (CMS) have laid out for all of our HCBS Waivers, so those will have to continue to be met, either by the TCM within the Health Home or the TCM provider outside of the Health Home.
- Q7: For I/DD TCM providers, who will be responsible for doing the Health Action Plan? Will the Health Action Plan be led by the Targeted Case Manager or by the Health Home Partner? Some combination?
- A7: That is negotiated at the time that you develop your contracts with the MCOs or subcontracts with Health Home Providers. If an I/DD agency is the Health Home Partner and some of the Targeted Case Managers work for that agency, then it would probably make sense for the Targeted Case Managers there to develop the Health Action Plan. But we want clinical involvement in that development, as well, because we are looking at health goals. It will be negotiated in terms of who's going to take the lead on that, but everyone on the team will be involved in developing the Plan.
- Q8: One of the slides in this presentation indicated that the Care Coordinator will be going to medical appointments – is that a requirement or only if needed by the client?
- A8: It's not a requirement to attend every appointment. However, we do require that Health Home Partners must have the capacity to accompany members to appointments when deemed necessary. The accompanying person could be the Care Coordinator, TCM, or other member of the team, such as a Peer Support Specialist.
- Q9: Will case managers be required to transport, or just meet, the client at the medical appointment?
- A9: That will be up to each TCM agency and their policies. A HHP cannot require a subcontracting TCM provider to transport a member in their personal vehicle; however, a TCM provider may need to accompany a member in a non-emergency medical transportation (NEMT) vehicle. This would only occur if it was necessary for the TCM provider to be with the member at a specific medical appointment.



Q10: Is it the expectation that scheduling and attending appointments is going to be completed by the Health Home Partner or will they follow up with the residential provider regarding who is making and keeping the appointments?

A10: It's going to depend on the individual and where they're living and how they are supported. As providers enter into contracts with Health Home Partners, this will need to be outlined and then for each individual, there's going to have to be some flexibility.

Q11: For residential facilities, the RN and Nursing Office currently perform many of these functions - how will that translate to Health Home Partners? How does the work that's already getting done get coordinated with the new Health Home Partner that might be outside the provider's agency?

A11: It is the responsibility of the Health Home Partner (HHP) to know everybody who's involved in providing service to an individual. First, the HHP would need to know that the RN at the facility is doing some of that work. Then, the Health Home Partner is going to be ultimately responsible for care coordination and for the outcome. So the HHP may decide that they want to take on some of that work directly. Or they may continue to have the RN at the agency do it and coordinate the other way, so that the RN is letting the Health Home Partner know who set up this appointment, and at what time, so that the Health Home Partner can note the information and follow up to see what happened after the appointment.

Q12: Does the Health Home Partner have to have both a Nurse Care Coordinator and a Social Worker Care Coordinator?

A12: Yes.

Process

Q13: What would an agency need to do to begin the contracting process with a Health Home Provider?

A13: Contact the Community Mental Health Center in their area, the Federally Qualified Health Clinic, the CDDOs who might be in their areas, etc., and ask if they are planning to become Health Home Partners. These conversations should start today. Agencies can also reach out to the MCOs to ask who they are working with to become contracted as Health Home Partners.

Q14: Can a Targeted Case Management provider contract with more than one Health Home?

A14: Yes, and should because it is likely that consumers in your organization will not all be assigned to the same Health Home Partner.

Q15: When will the client find out that they have been invited to participate in a Health Home and how might the TCM be notified that their clients are being sent letters?

A15: Assignment letters will be received sometime in the first week of July 2014. These will go to the consumer or whoever is listed as the responsible party in our eligibility system. The MCOs will also send a letter to whoever has been



assigned as the Health Home Partner. It is the responsibility of the MCOs, the Health Home Partner, and whoever receives the letter for the individual to communicate to make sure that everybody else knows what's happening for that individual. The Health Home Provider should notify the TCM provider of those members who are on their list.

Q16: Is there anywhere on the MCO sites that can tell the TCM if the member has been assigned to a Health Home?

A16: Providers will be able to look the member up at the KMAP site and see the member is assigned to a Health Home.

Q17: Can a Health Home member begin services in the middle of the month?

A17: Assignments will always begin at the first of the month.

Q18: If a member is eligible for Health Homes but does not want to join the Health Home, what happens? Do they lose the Health Home or does the TCM have to become part of the Health Home?

A18: If the member doesn't want to be part of the Health Home, he or she opts out. The member will simply return the opt out form that comes with their notification letter or call Hewlett Packard (HP) and tell them they want to opt out. The member will continue receiving their services from the TCM provider and won't receive any Health Home services. They do have the option to opt back in at a later time, if they wish to do so.

Q19: If the I/DD TCM Provider chooses to not subcontract with the Lead Entity or HHP and the individual wants to participate in the Health Home, does the individual need to choose another TCM that will subcontract?

A19: Yes, if the member wants to have a TCM provider as part of the Health Home.

Q20: What if an independent Case Manager refuses to contract for Health Home services with a Health Home Partner and then requires that their clients make that choice?

A20: Notify the MCO and KDHE immediately as this is considered to be unethical practice. Anyone serving as a Targeted Case Manager should not coerce someone to remain with the provider versus participating in a Health Home.

Q21: Will Health Home members have the choice of case managers within the Health Home similar to the current TCM process?

A21: I/DD members who have a TCM provider prior to entering a Health Home will continue to have a choice of I/DD TCM providers as long as the TCM providers are willing to contract with the member's Health Home Partner.

Q22: Is the expectation that the Health Action Plan will be written and ready to be go by 8/1?

A22: No. The expectation is that Coordinators will be begin meeting with clients to develop these in August.



Training

- Q23: Will there be formalized training for these Health Home specific services like there is training for Mental Health Case Management?
- A23: The State will not be providing that training. The Center for Community Support and Research at Wichita State University (WSU CCSR) has received a grant from the Kansas Health Foundation to provide training to Care Coordinators on how to write quality Health Action Plans. The Managed Care Organizations (MCOs) will be providing some training. The Health Home Partners may also be accessing or developing trainings on their own.
- Q24: Will the state be implementing a Health Home Learning Collaborative?
- A24: Yes, staff from contracted Health Home Partners will be participating in peer-to-peer learning experiences both in person and online beginning in the fall of 2014. For more information on participation expectations, please consult the Health Home Policy Manuals for each target population.

HIT/Documentation

- Q25: Will Health Home Care Coordinators have access to each MCO's Health Information System to enter required information/data?
- A25: Each of the MCOs has a data portal. At this time, only the UHC portal will allow certain information to be entered.
- Q26: What kind of documentation is required? Note requirements?
- A26: Documentation requirements are laid out in the program manuals located here: http://www.kancare.ks.gov/health_home/providers_materials.htm .

Payment

- Q27: Is the minimum payment listed in the presentation a guaranteed minimum for the Health Home Partner or is that a guaranteed minimum to the MCO?
- A27: It is a guaranteed minimum per member/per month (PMPM) to be paid to the TCM Provider from either the MCO or the HHP, dependent on who you are contracted/subcontract with. For additional information about Health Home rate calculations and payment, please visit http://www.kancare.ks.gov/health_home/download/KanCare_Health_Homes_Payment.pdf.
- Q28: Is this I/DD TCM payment paid to the MCOs for Waiver users only?
- A28: No, it is any individual with I/DD in the Health Homes program who receives Targeted Case Management.
- Q29: When is the first date that an agency can bill for Health Home services?
- A29: August, if a service is provided that month. July will primarily be a time when members will learn of their assignment and of the option to opt out of Health Home services. Once it is confirmed the member plans to participate, service will begin – this will likely be in August.



- Q30: Can the TCM agencies continue to bill TCM until the Health Home is actually started?
- A30: Yes. Additionally, for members who are in unmet “spend down” status, TCM may continue. TCM may be used to help the member meet “spend down” status. Once the member meets their “spend down” requirement, TCM payment ends and Health Home payment begins. Providers will need to monitor spend down status closely as it changes quickly.
- Q31: Can the Health Home Partner take a percentage of the payment as processing before paying a subcontractor?
- A31: No. The HHP must pay the minimum PMPM payment to a subcontracting TCM provider.
- Q32: Is the 12% Administration fee included in the published rate or in addition to it?
- A32: It is included in the calculated rate that was published.
- Q33: Will the I/DD TCM provider continue to bill in the same manner or will this be specifically sent under the Health Home code?
- A33: This will depend on whether the TCM Provider is a Health Home Partner that is contracted with an MCO or a subcontractor with a Health Home Partner. If contracted with a MCO, Health Home services will be billed by filing a claim with the MCO using the Health Homes codes. If you are subcontracting, how you bill for services will be arranged through contract negotiations with the HHP.
- Q34: Can the Health Home Partner bill for the services provided by a Registered Nurse who visits a patient in a residential setting and provides teaching on disease management or does an assessment onsite?
- A34: They could, but if that service is already part of the residential service that gets paid for through the HCBS Residential Service, they probably shouldn't, because that's going to be considered duplication.