



Health Homes Webinar Series
A Primer for Primary Care Providers
Questions & Answers
June 24, 2014

Q1: Slide 40 of today's presentation references "10 days" for MCOs to schedule conversations with HHPs. When you say "10 days", is that 10 *business* days or *calendar* days?

A1: Ten (10) *calendar* days.

Q2: How are levels of care determined?

A2: Currently, when the State pays KanCare rates to the MCOs, we have over 50 rate cell categories developed by our actuaries to organize people into sub-populations and some of that relates to their Medicaid eligibility category. These "rate cells" are pretty complicated, but there is a crosswalk table in each of the Health Homes Program Manuals. You can find that in the Payment section and see all of the rate cell categories and how we rolled those into the four levels. Those folks, by virtue of being in a particular eligibility category, tend to use services in a similar way. Although we aren't dividing folks up by acuity, in a sense they are sort of falling into acuity-based levels because of the eligibility group that they are in. These categories are determined by the State, not the MCO or Health Home Provider and cannot be influenced by either entity. Therefore, Health Home Partners will receive notice of the level of payment eligibility from the MCO when a member is assigned.

Q3: Are Health Home services in addition to those services we're already providing?

A3: Yes. If I'm a member participating in a Health Home, I would still see my doctor if I needed a physical or if I was having an upper respiratory complaint, I would go to my Primary Care Physician. If he or she was *not* my assigned Health Home Partner, I would still be getting Health Home services from my Health Home Partner...they would be coordinating care, they would know, or find out, that I had seen my PCP and they would include that information in my record. They will share information back to the PCP. If my PCP *is* my Health Home, I would still see him or her for the acute-care services, but they would also be able to bill for Health Home services that they are providing me – any of those six services that are listed in the presentation.

Q4: Will there ever be a deadline to apply to become a Health Home Partner?

A4: No. Anyone who is interested in becoming a Health Home Partner or subcontractor may submit their Preparedness and Planning Tool (PPT) to KDHE at any time and they will then be forwarded to the MCOs you are interested in working with to begin the process.



- Q5: Will patients with mental health issues be automatically assigned to a mental health provider and then possibly subcontracted back to their PCP?
- A5: If the person with SMI (Serious Mental Illness) has an existing relationship with their Community Mental Health Center (CMHC), then, in all likelihood, they will be assigned to the CMHC as the Health Home Partner. That same member would continue to see their PCP and the PCP would continue to bill for their regular services and the CMHC would act as the Health Home. So, they would have a Care Coordinator who's working with the Primary Care Provider to make sure that information is shared back and forth. Some CMHCs are entering into contractual relationships with Primary Care Providers to serve as physician consultants for the Health Home. If the member is eligible for both types of Health Homes, they could conceivably be assigned to a Chronic Conditions Health Home that may be a Primary Care Clinic or a Primary Care Provider. This is dependent on what the member relationships are and what the MCO is seeing in terms of their needs and services are the member is using most. For instance, if the member is in and out of the hospital a lot for their diabetes and their mental illness is pretty well managed and they just receiving medication checks, the member would probably be assigned to a Chronic Conditions Health Home.
- Q6: Can individual Providers sign up or does it have to be the entire practice?
- A6: An individual Provider can sign up, but he or she must be able to provide the six services or subcontract with somebody to help provide them and must have the constellation of professionals that we lay out in the Program Manual. That provider must also be licensed to practice in the State of Kansas.
- Q7: Have the contracts have been reviewed for all three of the MCOs and are they available? And then, are they reaching out to practices or is it the other way around?
- A7: We have reviewed the contracts for all three MCOs and we did share them with some Associations for review and the MCOs should all be reaching out to practices. Because we (KDHE) require the PPT comes into us, that's who they are starting with. So, if you have not done a Planning and Preparedness Tool, you are encouraged to get that in as quickly as possible. Practices can still reach out to the MCOs and they can start working with you, but we want that Tool in just so we have that on file and we can make sure that the MCOs are being responsive to you.
- Q8: If we have contacted the MCO with questions or negotiations about the contract amendment we were sent and have not yet received a response or come to an agreement with the MCO, does the 10 day rule still apply?
- A8: No - if you're talking about the 10 day rule to get a contract signed. We wanted to make sure that practices weren't holding up the process unnecessarily, but we understand that it sometimes takes some time to work out and negotiate rates.



- Q9: As a Primary Care Provider, how will we interact with a Health Home Partner whose member presents to us with an already developed Health Action Plan?
- A9: Hopefully, you would have been involved in the development of the Health Action Plan. If you were already the Primary Care Provider for that person, you should have been involved, at least to the point of it being shared with you for your review. If you are becoming the Primary Care Provider for somebody who enters a Health Home and doesn't have a Primary Care Provider, you can certainly weigh in on that Health Action Plan. You can contact the Care Coordinator and talk with the individual themselves about a need for adding a health goal or modifying a health goal. The Health Action Plan is not something that is going to be static, we fully expect the Health Home Partner and the Care Coordinator there to make sure that it's a workable plan and that it's going to meet the individual's needs and that as goals are met, new goals are added, or if goals need to be modified, they are modified. Everybody who's part of the team, including the Primary Care Provider and Specialty Providers, can weigh in on that and make recommendations.
- Q10: Will the Learning Collaborative that you spoke of that is going to be facilitated by Wichita State going to be open to anyone, or is that only for folks that are designated Health Home Partners?
- A10: It's going to be open to Health Home Partners. We are allowing Association Membership because we know that, particularly for Primary Care Providers, it's going to be tough sometimes for you to be able to attend them all the time, particularly in person. In order to manage the size, we won't be including all the subcontracting partners. We've had some conversations with Wichita State about as new Health Home Partners are identified or Providers are starting to begin the process to become a Health Home Partner, we might need to have a...sort of a two separate tracks, so kind of the ongoing process of – I'm a new Health Home Partner or I'm trying to be a Health Home Partner and I need some assistance with that versus the existing Health Home Partners who are already up and running and the Learning Collaborative is really around identifying issues and areas for improvement and developing continuous quality improvement processes.