



Health Homes Regional Tour  
April 2-9, 2014  
Questions & Answers  
May 2, 2014

The Kansas Department of Health & Environment (KDHE) Division of Health Care Finance hosted six (6) regional meetings across the State of Kansas on April 2-9, 2014 to increase awareness and education related to the upcoming Health Homes initiative. At each of these meetings, participants were given several opportunities to ask questions of the staff from KDHE and MCOs (Managed Care Organization). These questions have been themed and consolidated to reduce duplication and increase clarity.

Health Home Basics

Q1: How is the Health Homes program funded?

A1: They are funded with Medicaid funds since it is a Medicaid program. For the first two years the Federal government will pay 90% of the costs and the State will pay 10%. Thereafter, the Federal share will be about 60% and the State share will be about 40% - as most Medicaid services are.

Q2: Is the Health Homes program for adults and children?

A2: Yes, if they meet the target population criteria, both adults and children are included, but only children who are Medicaid (Title XIX) eligible. Children in the Children's Health Insurance Program (CHIP – Title XXI) are not eligible since Health Homes is a Medicaid program.

Q3: Medicaid patients often use Hospital Emergency Departments because they are unable to quickly access services in the community. How do you see the Health Homes program helping with access to primary care (medical) and mental health services (i.e. medication appointments, psychiatric services, case management)?

A3: Our hope is that Health Homes will work to help build more collaborative relationships among community health care providers that will result in Health Home members having primary care that is more accessible.

Q4: Please explain the relationships and delineation of "Lead Entity", "Health Home Partner/Provider", and "Subcontractor".

A4: The Lead Entity is one of the three KanCare managed care organizations (MCOs). It is responsible for developing a network of Health Home Partners – HHPs - (who are community providers, e.g. physicians, clinics, Community Mental Health Centers) who can provide some or all of the six core Health Home services. The HHPs can subcontract with one or more agencies/people to provide one or more of the six core services. The HHP must contract with Lead Entity and must meet the requirements specified in the State Plan Amendment and the Program Manual (found here:



[http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm)). Any subcontractor would work with the HHP and would not necessarily have to meet all the requirements, but if they were providing a specific core service, would need to meet the professional requirements for the service.

Q5: How do we all fit together to form a Health Home?

A5: That will vary, depending upon whether the Lead Entity is providing some of the six core services. If the Lead Entity does none of the six services, they would identify and assign the member and then the HHP would be responsible for the six core services, either directly or through a subcontractor. Whoever is responsible for comprehensive care manage would work with the member, the members' providers and family to develop a Health Action Plan. The care coordinator, most likely at the HHP if the Lead Entity is not performing any HH services, would then manage and monitor the HAP to make sure all assigned parties are working toward the goals laid out. Whoever is doing Health Promotion would work to make sure the member is getting education about their chronic conditions and what they can do to better manage them and be healthier. Each service is defined in great detail in the State Plan Amendment and Program Manual, found here:

[http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm) .

Q6: Will there be more than one Health Home in a community?

A6: There must be a choice of Health Homes in an area. The MCOs/Lead Entities and their Health Home Partners (HHPs) will determine what an "area" is.

Q7: What is the "threshold" to initiate Health Homes in Kansas? Is there a certain number of Health Home Partners (HHP) required?

A7: We intend to launch the program July 1, 2014. There is not a specific number of HHPs required. The network must be sufficient to serve the number of people who are assigned and don't opt out.

Q8: If there is only one partner in the area who wants to be a HHP, how will other gaps get filled?

A8: The Lead Entity will either need to recruit another HHP or be ready to provide the Health Homes services directly.

Q9: Who will be responsible, in July, to explain to Medicaid beneficiaries what a health home is, answer their questions, and assist them in determining if they want to be a part of this program or opt out?

A9: Everyone who knows about Health Homes and encounters a consumer who has a question- case managers, community providers, MCOs, advocates and State staff.



### Preparedness and Planning Tool (PPT)

Q10: Is there flexibility in the timeline to get applications in?

A10: Yes. Though agencies interested in becoming a HHP were encouraged to submit the Tool by April 1<sup>st</sup>, we will continue to accept Tools.

Q11: What if we have additional information to add or clarify on our previously submitted Preparedness Tool?

A11: Please contact Samantha Ferencik at [sferencik@kdheks.gov](mailto:sferencik@kdheks.gov) to discuss your desired changes/additions.

Q12: Are agencies who want to subcontract for services expected to complete the PPT?

A12: Yes. All agencies who hope to provide any of the six Core Services should complete the Tool.

Q13: How much of the Tool would a subcontracting Targeted Case Management (TCM) provider (I/DD) complete?

A13: TCM providers are not required to complete the Tool. However, if you choose to complete the Tool, you only need to complete the portions that are specific to the Core Services you intend to provide.

Q14: Can the language line be used to meet the requirements/accommodations related to culture, disability, language etc.?

A14: Maybe. Please feel free to include as much detail as you desire. The MCOs will assess your explanations to determine if the requirements are met in full or in part.

### Member Assignment & Referral

#### *Eligibility*

Q15: Please clarify the date that members become eligible for the Health Home program.

A15: For the launch, everyone identified by the MCOs/Lead Entities as eligible will receive assignment letters the first part of July 2014. If they don't opt out, their services will begin August 1. (They can opt any time, even after August 1.) Thereafter, the Lead Entities will mine their data monthly and take referral information, sending out assignment letters monthly to newly identified members. Services will start in the month following the assignment letter.

Q16: Is a patient eligible for Health Homes when Medicaid is secondary?

A16: Yes.

Q17: Are veterans or those who have services through the Veteran's Administration eligible for Health Homes?

A17: Only if they also eligible for Medicaid.



Q18: Can these services be provided in long term care facilities?

A18: No.

Q19: What does “QMB” stand for? Are these members eligible for Health Homes?

A19: A Qualified Medicare Beneficiary is someone who has Medicare coverage and qualifies for Medicaid to pay for their Medicare premiums and co-pays. They are not eligible for Health Homes.

Q20: Are youth in the Home Community Based Service (HCBS) Waiver for Severe Emotional Disturbances (SED) also eligible for Health Homes?

A20: Yes, because being on the waiver makes them eligible for Medicaid, but they still must meet the Health Home eligibility criteria.

Q21: Does the Health Homes model apply to Work Opportunities Reward Kansas (WORK) participants? If so, will Independent Living counselors be included as partners?

A21: Yes, WORK participants can be eligible for Health Homes if they meet the target population criteria. ILCs will continue to provide the same services to WORK participants who are also in Health Homes.

Q22: Could eligibility criteria include a physical condition and Serious Mental Illness diagnosis such as diabetes and depression?

A22: The eligibility criteria for both Health Homes are described in the numerous documents found here:

[http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm).

Q23: Is there or will there be a list of qualifying diagnostic or DSM-5 codes?

A23: Yes. They are found here:

[http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm).

Q24: Is COPD considered an asthma related complication?

A24: It might be, depending upon what other clinical indicators there were.

Q25: When we receive a referral, will we know the level?

A25: As members are assigned to Health Home Partners (HHPs), the Lead Entities/MCOs will also indicate the reimbursement level for each.

Q26: Can a consumer’s level change during the month?

A26: Not usually, unless there was an error in eligibility that is corrected and usually those take effect the next month.

Q27: Is there an appeals process if we disagree with the level?

A27: No. The level is directly related to the member’s eligibility category and age. If you believe there is a mistake in eligibility, you should notify the Lead Entity/MCO who will work with the state’s enrollment broker and State eligibility staff to see if there needs to be a correction.



*Provider Limitations for Service Populations*

Q28: How large will the HHP capacity have to be? Are there limits?

A28: It needs to be large enough to be financially sustainable.

Q29: Can services be provided “in house” or to community as a whole?

A29: If you mean that you, as a Health Home Partner would only provide Health Home services to people who you already provide other KanCare services to, you can specify that limit when you contract with the Lead Entity, but you may not have enough Health Home members to sustain your HHP business. In addition the Lead Entities want to work with HHPs who will have capacity to take new members.

Q30: If we become a HHP, could we be assigned a consumer outside of our “waiver services?”

A30: You can limit your membership to people whom you are already serving in other KanCare services, but please see the caveats listed in A 29.

*Assignment*

Q31: Will the Lead Entities make HHP assignments according to their diagnosis?

A31: Yes, that is how the Health Home target population is determined.

Q32: Do the claim forms/info that MCOs receive include all diagnoses or just primary? If just primary, do all patients with a qualifying SMI secondary diagnosis need to be referred to a Health Home?

A32: KanCare claims contain 10 diagnoses code fields. Any that have been populated by the billing provider will be in the Lead Entities’ data and will be used.

Q33: What happens if an individual who qualifies for both the Serious Mental Illness & Chronic Condition Target Populations?

A33: That person would be able to choose between the two types of Health Homes, although the Lead Entity will default assign them to the type they believe best meets their needs.

Q34: What happens if an individual has three current providers and all are HHPs? How is the assignment chosen?

A34: The Lead Entity/MCO will look at all the claims and determine the best HHP from the information they have. The member can always select a different HHP.

Q35: If an assignment of Health Home is in place for someone and then they are determined I/DD, will an I/DD agency become a choice for care coordination services?

A35: The Lead Entity/MCO will likely not change the HHP assignment unless the member requests it. The member can request an I/DD target case manager (TCM) provider become part of the Health Home team and the HHP would have to contract with the TCM provider the member chooses.



Q36: What happens if the member “fired” the service provider, does that automatically impact the health home assignment?

A36: If the service provider is also the HHP, the member would have to select another HHP and work through the Lead Entity/MCO to do so.

Q37: When will members receive their health home assignment letter?

A37: For those who will be in the July 2014 launch, they will see a letter sometime in the first week of July.

Q38: Who are the HHP assignment letters being sent to?

A38: The KanCare member.

Q39: Once the Lead Entity identifies members who qualify for Health Homes and sends them a letter, will they also notify that member’s current providers (including the TCM provider, Parent/Guardian, Behavioral Health, etc.)?

A39: The Health Home Partner will receive notification from the MCO of all members assigned to them. It is the responsibility of the Health Home Partner to engage other providers as needed to participate in the coordination of care and services. The member (parent/guardian for children) will receive an assignment letter from the MCO.

Q40: Some individuals with intellectual/developmental disabilities may not be able to fully understand the content of an assignment letter. If a guardian is not in place, who decides if they go into a Health Home?

A40: The member still must make the decision, by federal regulation. People who support that member – family, friends, service providers can help them understand their choices.

Q41: Will those assigned to a HHP be listed as such on the Kansas Medical Assistance Program system?

A41: Yes.

Q42: If members choose to change their Health Home, will this be done at the 1<sup>st</sup> of the month?

A42: Yes.

#### *“Opt Out” Option*

Q43: Will the benefits of participating in Health Homes and the “opt out” option be clearly explained to members?

A43: Assignment letters and other consumer information is all crafted at the 6<sup>th</sup> grade reading level, by Federal requirement, but everyone who works with or supports or interacts with members has an obligation to help them understand the information.

Q44: Do you have an anticipated opt out rate of members?

A44: 25%



Q45: Can the HHP apply a waiting period to re-enroll members who opt in and out frequently?

A45: No. CMS has been clear that we cannot restrict members in these choices.

#### *Referral*

Q46: Who is eligible to refer to Health Homes?

A46: Anyone who interacts with a member and has some knowledge about their conditions. The Lead Entities may ask for supporting documentation once a referral is received.

Q47: When would a hospital or other entity make referral to a Health Home?

A47: Any time they see a person who they believe meets the criteria. They should ask the member and look them up in the KMAP system to determine if they are already in a Health Home.

Q48: How do we differentiate with patients if they are opting out of a health home?

A48: The Lead Entity/MCO will let you know who has opted out.

#### *Reasons for Refusal*

Q49: Do the reasons for refusal of member assignment also pertain to subcontractors?

A49: Not necessarily. The Health Home Partner may extend them to subcontractors as part of their agreement with the subcontractors.

Q50: Would the following be an example of refusing an individual? A Managed Care Organization attempts to relocate an individual from the Kansas Neurological Institute back into the community. This individual has respirator and is a brittle diabetic. Could the Community Service Provider for I/DD choose to close or not accept the individual?

A50: If the CSP is a HHP for the Chronic Conditions Health Home, they could not. If the referral is for I/DD waiver services that is a separate issue from Health Homes and would be governed by KDADS.

#### *Enrollment/Disenrollment*

Q51: Regarding, "members who have been previously discharged with applicable notice in writing", does this include folks written out prior to KanCare?

A51: The Lead Entity/MCO will make the determination based upon what information the HHP provides about the reason for discharge.

Q52: Why not have automatic discharge option with catastrophic event?

A52: Each event is an individual situation and sometimes the member may benefit from remaining in the Health Home.



### Payment/Billing

- Q53: Does Lead Entity get the Per Member/Per Month (PMPM) payment if the HHP doesn't provide a service during the month?
- A53: No, unless the Lead Entity provides a service directly to the member. Payments will be issued by the state to the Lead Entity (MCO) once a service has been utilized. If no service has been delivered to a Health Home member, no payment will be issued to the Lead Entity.
- Q54: Will the Administrative costs that are built into the rate structures be the amount the Lead Entity will keep?
- A54: Each Lead Entity's Health Home program and payment structure is unique. A Health Home Partner's Per Member Per Month payment from the Lead Entity will be dependent upon many factors, including but not limited to how many of the six core services the Health Home Partner will deliver, or subcontract to deliver.
- Q55: Will all waiver services (i.e. waiver facilitation for youth on the SED waiver) be billable?
- A55: Yes, with the exception of Targeted Case Management. The Centers for Medicare and Medicaid Services has determined Health Home Services and Targeted Case Management Services are duplicative. Target Case Managers for Health Home members on the I/DD waiver are guaranteed a minimum Per Member Per Month Payment, if the member chooses to maintain the relationship with the Targeted Case Manager, and the Targeted Case Manager provides some or all of the six core Health Home services. For more information regarding TCM and Health Homes, please see the KDHE's Health Home's Program Manuals: [http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm)
- Q56: How would a provider monitor an individual's spenddown status?
- A56: The Lead Entity (MCO) and the Kansas Medical Assistance Program (KMAP) website are the tools a provider uses to monitor a KanCare member's spenddown status. The KMAP website: <https://www.kmap-state-ks.us/>.
- Q57: Is your first face to face billable?
- A57: The delivery of one or more of the six core Health Home services is billable.
- Q58: Is "timely filing" involved?
- A58: Yes, the same timely filing requirements for all other KanCare services will apply to the Health Homes program. The details of timely filing requirements are outlined in a provider's current contracts with the MCOs and will be outlined in the provider's contract amendment with the MCOs for Health Homes.
- Q59: What is the professional licensing required for providing care coordination to qualify as a billable service?
- A59: The Health Home service of care coordination should be provided by the Nurse Care Coordinator and the Social Worker and/or Care Coordinator professionals. The Nurse Care Coordinator is an RN, APRN, BSN, or LPN actively licensed to



practice in Kansas. The Social Worker/Care Coordinator must be a BSW actively licensed in Kansas, a BS/BA in a related field, a Mental Health Targeted Case Manager, an I/DD Targeted Case Manager, or a Substance Use Disorder person centered Case Manager. Case Managers must meet the requirements specified in the Kansas Medicaid State Plan and Health Home Provider Manuals and can either be employed or directly contracted with the Health Home Partner.

Q60: Does the contracted physician bill independently of the HHP or does the HHP bill for them and then reimburse the physician?

A60: Generally, the Health Home Partner (HHP) will bill the Lead Entity for Health Home Services it provides or subcontracts to be provided to its enrolled Health Home members. Health Home Services are not billed or paid by the Lead Entity on a fee for services basis. The Health Homes rate is a bundled payment for a bundled set of services, and does not replace any existing KanCare or waiver services, with the exception of Targeted Case Management. More information about Targeted Case Management in Health Homes can be found in the Health Homes Program Manuals:

[http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm)

Q61: How is the cost of signing on with the Electronic Health Record covered? Can it be negotiated in the reimbursement rate?

A61: The non-medical loading component of the Health Homes rates includes Information Technology costs associated with Electronic Health Records. Some providers may be eligible for meaningful use funding. More information about meaningful use funding can be found on KDHE's meaningful use website:

[http://www.kdheks.gov/epi/meaningful\\_use.htm](http://www.kdheks.gov/epi/meaningful_use.htm). Additional resources regarding Health Information Technology for Health Homes can be found on KDHE's Health Home's website:

[http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm)

Q62: Will there be funding for reimbursement for travel to and from appointments?

A62: The Health Home rates are a Per Member Per Month bundled rate for delivering one or more of the six core Health Home Services. If travel to and from appointments is part of delivering one or more of the six core Health Home services, it could be a component of eligible billing to the Lead Entity (MCO). This will be negotiated in the contract and payment between the Health Home Partner and the Lead Entity (MCO). Transportation services provided to KanCare members for medical appointments will not change if the member is in a Health Home.

#### Contracting and Subcontracting

Q63: Do you have to be an established company before you can contract as a HHP or can you be a brand new provider?

A63: You must meet the requirements outlined in the documents found here:

[http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm) .



- Q64: Is there a contracting template available?  
A64: Once the Lead Entities/MCOs share those with the State, they will be shared with the various provider associations for their feedback.
- Q65: Are Health Homes Partners responsible for finding partners to subcontract with?  
A65: You should be working on that now in your community, but the Lead Entities/MCOs can also help you learn who is willing to subcontract in your area.
- Q66: Do you have to be enrolled in KanCare as a provider to be a subcontractor?  
A66: Not necessarily. It depends upon what service you want to sub-contract for and whether the HHP requires it.
- Q67: What if all of the organizations in a service area only express an interest in subcontracting and no one is interested in leading the effort?  
A67: The Lead Entities are responsible for making sure Health Homes are available statewide. They will work with providers to ensure that some can be HHPs.
- Q68: As a subcontractor, would an agency contract with Home Health Partners or with Lead Entities?  
A68: You would contract with the HHP.
- Q69: Under what circumstances does “partnering” involve the exchange of money vs. the “service” being an already existing natural or established resource?  
A69: Certainly, if you can access some services that already occur in your community, without having to subcontract and pay for them, that is great. An example might be just offering space at your facility for a chronic disease self-management (CDSM) class that is open to the public and you can send some of your consumers to it.
- Q70: Which of the core services would be most appropriate for a type of provider to subcontract?  
A70: Comprehensive care management and care coordination are the two least likely to be subcontracted since they are core to Health Homes. Health promotion and referral to community and social supports services are probably the two services that lend themselves most readily to subcontracting.
- Q71: If you’re a Health Home Partner, can you also subcontract for other HHPs who don’t provide your services for their consumers who did not choose your health home?  
A71: Yes.
- Q72: How does subcontracting work for a Local Health Department where we already work under a physician? Does the physician need to start the process first?  
A72: That is going to depend upon who has authority for your LHD to enter into contracts.



Q73: Will a Business Associate Agreement with an agency cover the Affordable Care Act HIPAA requirements? (subcontractors, other providers, etc.)

A73: Yes.

#### Health Action Plan (HAP)

Q74: What is the protocol for setting up a HAP?

A74: The HAP is developed following a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs. The HAP is developed 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 Home partner (HHP), member, family/support persons/guardian, and health services and social service staff.

Q75: Are all service providers participating in developing the HAP?

A75: Ideally, all entities that will be involved with the implementation of the member's HAP should participate, either by participating during the actual development of the HAP, or at least weighing in on what might be included.

Q76: Will training be available to providers on how to develop a quality HAP?

A76: Offering training may be possible if providers are having problems developing HAPs.

Q77: It was noted that HAPs require physician oversight, what is an example of what is expected?

A77: While a physician may be a part of the member's Health Home team, and may provide services that contribute to a member's goals, the physician does not have "oversight" of the HAP. The HAP is a tool to document the member's

- Health Home goals
- strategies to achieve goals
- progress towards achieving goals
- member and providers specific responsibilities related to Health Home goals

It is the responsibility of the partner providing Comprehensive Care Management to ensure that a HAP is developed, and the responsibility of the partner providing Care Coordination to assist the member to implement the strategies listed on the HAP, as well as document progress toward meeting goals.

#### Health Information Technology (HIT)

Q78: How do you define "interoperable" Electronic Health Record (EHR)?

A78: Please refer to this link for an easily understandable definition of interoperability and how that fits with Health Information Exchanges (HIEs):

<http://www.healthit.gov/buzz-blog/meaningful-use/interoperability-health-information-exchange-setting-record-straight/>



Q79: Is it a process and quality outcomes database?

A79: An EHR is not just a database. It is a patient record which allows staff to enter and retrieve relevant health information, as well as to share it with other, appropriate partners and a Health Information Exchange.

Q80: What does it take to connect to Health Information Exchange (HIE), Kansas Health Information Network (KHIN) & Lewis and Clark Information Exchange (LACIE)?

A80: Please contact either or both of these exchanges for the answer to this question: <http://www.khinonline.org/> and/or <http://www.lacie-hie.com/>

Q81: Does an EHR have to connect directly to KHIN or LACIE to be accepted/approved?

A81: Not initially, but you should have a plan to connect.

Q82: Will the Lead Entities prefer HHPs to use the EHRs they already have in place?

A82: If your agency already has an interoperable EHR, you already meet the requirement, but you will still need a plan to connect to one of the certified HIEs, KHIN or LACIE.

Q83: Do you have to have an EHR if you are subcontracting?

A83: That is going to depend upon what you're sub-contracting for, but in most cases, you may not need one.

Q84: What EHR can link to provide Points of Contact (POC)?

A84: For an answer to this, we suggest you ask your POC vendor.

Q85: If a guardian "opts out" on the use of Information Technology, is there somewhere to require electronic Information Exchange participation by the client?

A85: No.

#### Data and Documentation

Q86: Will there be a universal data collection tool created for use to meet all Lead Entity needs?

A86: No.

Q87: How does an organization know what data will be expected to be completed for each individual monthly?

A87: There is a documentation requirements table in the Program Manual (found here: [http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm) ) that lays out what the Lead Entities expect in the way of documentation for each Health Home service.



Q88: When will the State/MCO's make the transition to DSM-5 and ICD10 to capture the correct diagnosis for SMI?

A88: A crosswalk to the DSM-5 for the SMI diagnoses can be found here: [http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm) . We plan to transition to ICD-10 prior to the CMS deadline.

Q89: What if a provider within the service team refuses to collect and/or share information related to the tracking measures for the HAP (i.e. Health Care Provider, Child Welfare Community Based Service Provider, etc.)?

A89: Assuming these providers all contract with the Lead Entity/MCO for those services, you can enlist the Lead Entity's help, but we hope Health Home Partners will approach all providers in a spirit of collaboration and by helping everyone understand the importance of sharing information to best coordinate care and determine outcomes.

### Consumer Issues

Q90: What is the penalty to the member for ongoing noncompliance?

A90: There are none. Participation in Health Homes is voluntary. We expect the Health Home to work with the consumer to help them understand the need for cooperation. It may be that Health Action Plan goals need to be very small at first to encourage cooperation and allow the member to see progress.

Q91: Is there a penalty to the member if they "opt out"?

A91: No.

Q92: If a member opts in for a Health Home and goes to a non-health home partner, will the member be responsible for charges (i.e. penalty)? Is this a similar structure to a lock-in provider?

A92: No. Health Homes are not lock-in providers, which are used when a member is abusing medications. Remember that the six Health Home services are **in addition** to any other KanCare services the person receives. A member cannot receive Health Home services from anyone but their Health Home Partner, Lead Entity or a subcontractor of the HHP, unless the member asks to switch to a new HHP.

Q93: Is there a minimal amount of contact that the individual must have in order to continue qualify for a health home?

A93: The member must receive at least one of the six core Health Home services in a month in order for the State to pay the Lead Entity/MCO and for the Lead Entity to pay the Health Home Partner.

Q94: What if the provider is unable to make contact with a member to provide a service (comprehensive assessment, HAP, etc.) after several attempts to do so?

A94: That should be documented and the HHP should enlist the aid of the Lead Entity to help engage the member. We expect the HHP to go beyond phone calls in their attempts to contact the member.



### Managed Care Organization Processes

Q95: When will the Lead Entities contact potential HHPs regarding their submission of the PPT?

A95: 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.

Q96: If you intend to work with all three Lead Entities, would there be an in-person or over the phone follow up discussion with all three Lead Entities?

A96: Please see A96 above. Each MCO will contact you separately.

Q97: Are Lead Entities wanting to retain specific core services, or intending to contract for all/almost all core services?

A97: This varies among the Lead Entities. Please refer to their presentations contained in the PowerPoint from the regional provider meetings, found here: [http://www.kancare.ks.gov/health\\_home/provider\\_regional\\_meetings.htm](http://www.kancare.ks.gov/health_home/provider_regional_meetings.htm).

Q98: How will the Lead Entities fill in service gaps?

A98: They must provide the missing Health Home service directly, if they cannot find a HHP (with or without a subcontractor) who can provide the service in a specific area.

Q99: Do all Lead Entities have the same payment structure to HHPs? What are they?

A99: No, each will develop payment structures depending upon what each Health Home Partner agrees to do.

Q100: How does Comprehensive Care Coordination and Care Management interface with the MCO Care Coordinator? Are they the same?

A100: They are not the same. MCO Care Coordinators primarily work telephonically with some limited face-to-face interaction. The MCO Service Coordinator will continue to perform the same level of service for our members as they currently do. The intent of the Health Homes program is for local providers to engage in face-to-face interactions with the member to help them manage their health. The MCOs may elect to maintain and continue the work of their Care Coordinators. We expect the Health Home Partner to collaborate with the MCO Care Coordinator in the coordination activities performed by the Health Home Partner since they are considered part of the care team.



Q101: Will all Lead Entities have regional staff?

A101: The Lead Entities will have staff located in certain areas of the state to support providers on an ongoing basis based upon member enrollment and Health Home Partner network development. Location, area of responsibility, and scope of work are still to be determined, but this support would be available to all Health Home Partners.

Q102: Who is assessing to assure Lead Entity staff meet Health Home qualifications?

A102: The State. We will actually be conducting readiness reviews of the Lead Entities May 20-22.

Q103: Are the Lead Entities also concerned about subcontractors and their qualifications?

A103: Health Home Partners that subcontract any service must assure that the subcontractor meets the applicable requirements for the services performed and that the subcontract is compliant with KDHE subcontractor agreement requirements. Health Home Partners must work to ensure that quality services will be delivered. This may also be a focus of the ongoing monitoring undertaken by the Lead Entities.

Q104: Will Health Home payments arrive separately from other KanCare payments?

A104: No, Health Home payments will be remitted via our standard process.

Q105: How will Lead Entities audit providers to ensure they are doing what they are supposed to?

A105: Just as the State audits the Lead Entities, by reviewing a random sample of files.

Q106: How quickly will the Lead Entity notify the HHP of a client that is on a spend down?

A106: The HHP will need to check the KMAP website ( <https://www.kmap-state-ks.us/> ) to determine whether the member has met their spend down.

Q107: If a person moves from one Lead Entity to another, will information/records flow from one to the other?

A107: Yes, much like any other transition of a member from one MCO to another MCO, there is a process established for sharing any relevant member information. This requirement to share information is outlined in the State's Health Home Program Manuals.

Q108: Will the "opt out" call-in number go to a person or a voicemail?

A108: The number is the State's enrollment broker, HP, and is answered by live people.



## Targeted Case Management (TCM) for Individuals with Intellectual/Developmental Disabilities (I/DD)

Q109: Is TCM available to a person in a Health Home?

A109: Not as TCM. CMS has told us that they will not pay for TCM and Health Home services for the same person, so we have established this requirement for Health Home members who are I/DD: Every Health Home must include the targeted case management (TCM) provider for any Health Home member who has an intellectual or developmental disability (I/DD). The Lead Entity or the HHP must 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.

Q110: If a TCM provider chooses to not become a HHP will we lose the clients that want to be in the Health Homes program?

A110: No. As long as you are willing to subcontract with HHPs to provide TCM-like services to members who are in Health Homes, you will receive a guaranteed monthly payment for those members of no less than \$137.32 for I/DD Health Home members in the SMI Health Home and no less than \$208.75 for I/DD members in the CC Health Home.

Q111: Does this affect services to individuals with I/DD who are not eligible for Health Homes?

A111: No.

Q112: Will the TCM agency be notified of who is included in the Health Homes? How?

A112: If the TCM agency is a HHP, they will be notified if members are assigned to their Health Home. Members they serve will receive the Health Home assignment letter. If TCM agencies are not the Health Home Partner, we expect that the Health Home Partner will reach out to the TCM agency to determine if they are interested in participating. The TCM will need to have a process for coordinating with the consumers they serve to determine which of their consumers have been assigned to a Health Home so they can assist the consumer in accessing/contacting/working with the Health Home Partner.

Q113: Does the Health Homes program require the Targeted Case Manager to perform non-TCM type duties?

A113: Health Home services allow more flexibility than does TCM, so the Targeted Case Manager may be able to do some things they couldn't do and be reimbursed for under TCM. Generally, the tasks will be the same things a case manager would do under TCM.

Q114: What happens if the individual wants to keep their TCM services but change to another TCM provider?

A114: They can do that and the new TCM provider would receive the guaranteed payment.



### Provider Roles & Core Services

Q115: How do the different entities such as rural clinics, health departments, and pharmacies fit into the Health Home picture?

A115: Any provider who is serving someone in the Health Home will be involved in that member's care. The Health Home will coordinate all the providers. Rural Health Clinics and Local Health Departments could also become HHPs if they meet all the requirements. Almost any type of provider could also subcontract with the HHP to provide one or more Health Home service.

Q116: Who is going to "market" the Health Homes program to Doctors, hospitals, etc.?

A116: We have had representatives from the Kansas Medical Society and the Kansas Hospital Association on our stakeholder group for well over a year. We have also sent out information through those associations. We will continue to engage and educate all provider groups as we move into implementation and beyond.

Q117: Will Health Promotion activities have to be provided by a licensed health professional?

A117: No.

Q118: Will a HHP need to subcontract 24 hour emergency access care or would our staff be on call?

A118: The requirement you're referring to is a joint Lead Entity/HHP requirement and can be met with the Lead Entity's 24-hour nurse line. There are a number of other ways to meet the requirement without having staff on call. The requirement is for availability of information and emergency consultation services to enrollees.

Q119: How is the care provided by a physician as a fee-for-service activity distinguished from the physician's role in the service provided in the HH?

A119: Let's say the member's PCP is also their consulting physician in the Health Home. The physician would participate in the development of the Health Action Plan. The Health Home member might see the PCP for a physical exam. During that exam, the PCP may refer the member for diabetes education. The PCP would bill for their evaluation and management code. The Health Home would set the individual up with the diabetes education class and bill for a Health Home service (health promotion). In a follow up visit the PCP might provide the member some information about the relationship between diabetes and depression. This could be billed as an E&M code or as a Health Home service (health promotion). Later, the care coordinator may have a question about how the member is reacting to a medication. The care coordinator could consult with the PCP and discuss whether or not the medication needs to be changed. The member was not present so this would not be billed by the PCP, but could be billed as a Health Home service (care management).



Q120: How are RN's already employed by CSP's going to be utilized and reimbursed?

A120: If the Community Service Provider is a HHP then the RN can be a care coordinator and the HHP would be reimbursed through regular Health Home services. If the CSP is not a HHP the RN would be paid for as s/he already is.

Q121: How do foster care homes serving children on the I/DD waiver fit into the Health Home delivery system?

A121: If these children are eligible for Health Home services they will be subject to the IDD TCM guarantees noted in A110 and A111 above. The state child welfare contractors responsible for the placement of the children would be responsible for the choice of HHPs for these children.

Q122: How will peer support be implemented or used within this model?

A122: Peer Support professionals are a required part of the SMI Health Home team and are associated with several services. Please refer to the draft SMI Health Home State Plan Amendment and the SMI Health Home Program Manual, both located here: [http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm).