



WICHITA STATE  
UNIVERSITY

*CENTER FOR COMMUNITY SUPPORT  
AND RESEARCH*

# Health Homes Regional Meeting

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WELCOME!!

# Purposes of the Day

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- Provide information regarding the tools and processes available to potential Health Home Partners
- Discuss how MCOs will connect and engage with potential HHPs
- Provide opportunities for potential partners to learn from and connect with key staff from KDHE, MCOs, and other service systems



# Introduction to Health Homes

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- Health Homes are an option which states can choose to offer Medicaid consumers.
- A Health Home is not a building. It is a comprehensive and intense system of care coordination. Health Homes integrate and coordinate all services and supports for people with complex chronic conditions
- Health Homes will not disrupt current provider relationships with members

# Introduction to Health Homes

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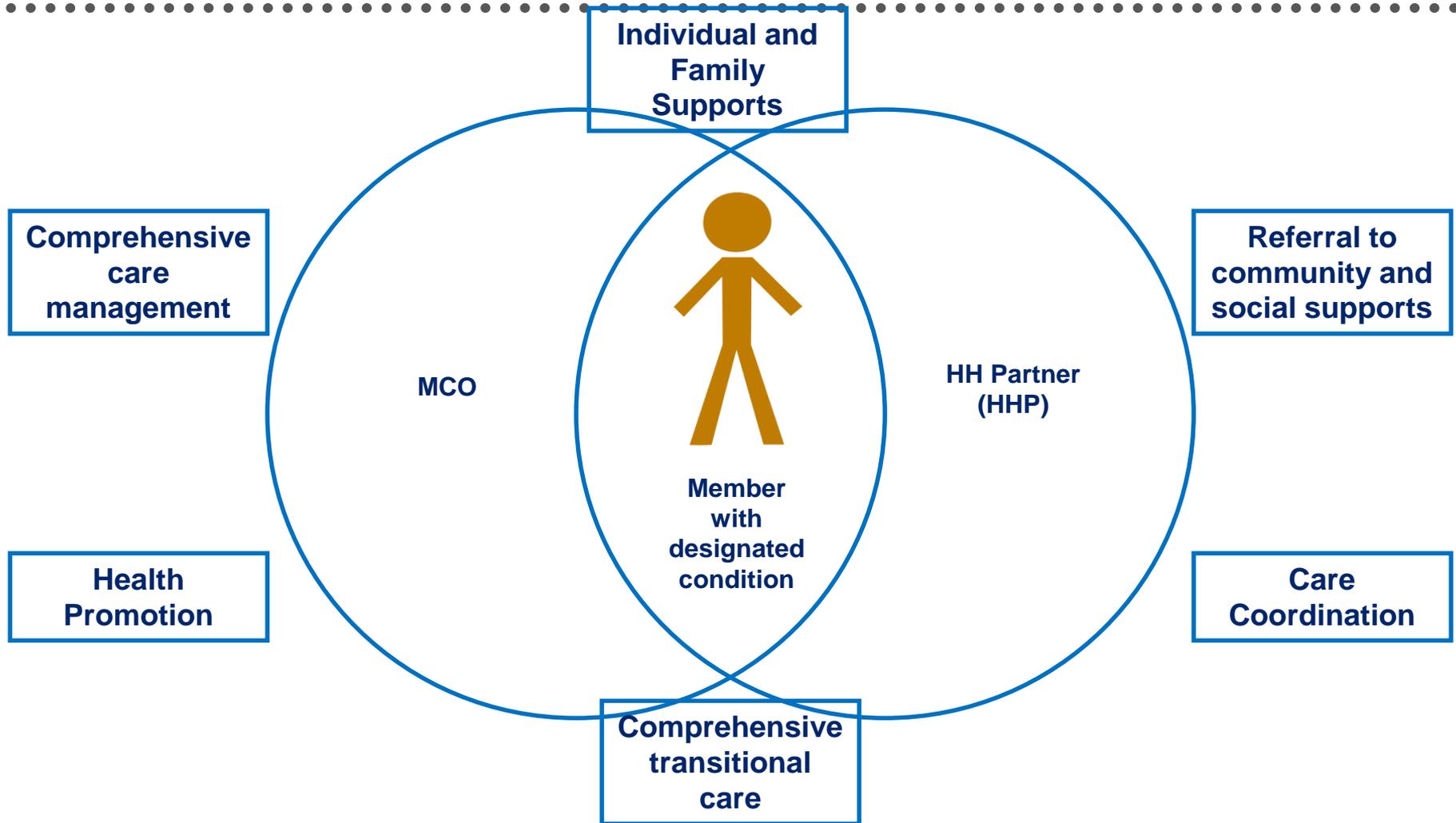
- Health Homes are for people with certain chronic conditions, like serious mental illness or diabetes or asthma.
- Health Homes do not replace care already being received, like doctor visits, medicine, hospital care, therapies, etc.
- Health Homes are in addition to the services already being provided to individuals.
- Providers may continue to provide services as they currently are AND provide additional Health Homes services.

# Health Homes Six Core Services

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- Comprehensive Care Management
  - Care Coordination
  - Health Promotion
  - Comprehensive Transitional Care
  - Individual & Family Supports
  - Referral to Community & Social Support Services
- Remember, these are in addition to the services that individuals already receive!

# Health Homes Service Structure



# Who Decides When a Person Needs Health Homes?

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

# How Can I Learn More About Health Homes?

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- Website
  - [http://www.kancare.ks.gov/health\\_home.htm](http://www.kancare.ks.gov/health_home.htm)
- Newsletter
  - - Health Homes Herald
  - [http://www.kancare.ks.gov/health\\_home/news\\_herald.htm](http://www.kancare.ks.gov/health_home/news_herald.htm)
- E-mail box on web

# Preparedness & Planning Tool

# Preparedness & Planning Tool

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- Completed by all potential Health Home Partners (HHP)
- Submitted to KDHE by April 1 for July 1 launch date
- To follow review of the actual form, visit [http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm)

# KanCare Website

**KanCare**  
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**Latest News – Upcoming Events**  
Meetings for Members with Serious Health Conditions  
I/DD Waiver Services' Incorporation into KanCare  
Open Enrollment for Members with Jan. 1 Anniversary  
Important message for Members (Video)

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Medicaid for Kansas

KanCare Consumer Assistance: 1-866-305-5147

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Events  
Frequently Asked Questions  
...More

**Providers**  
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Frequently Asked Questions  
Events  
KanCare Health Plan Information  
Pharmacy  
Provider Billing Information

**Policies & Reports**  
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KanCare Quality Measurement  
**Health Homes in KanCare**  
Readiness Activities  
Delivery System Reform Incentive  
Annual and Quarterly Reports

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Kansas Medicaid Reform  
Sect. 1115 Waiver and Comments  
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# KanCare Website

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# KanCare Website



Medicaid for Kansas

## Health Home in KanCare

### Providers

**Informational Materials for Providers:**

<b>Health Home</b>	
<b>Provider Regional Meetings</b>	
<b>Approaches to Health Homes</b>	
<b>Payment Principles and Parameters:</b>	
<b>Services</b>	
<b>Informational Materials for Providers:</b>	
<b>Stakeholder Meetings</b>	
<b>Health Homes Webinar Series</b>	
<b>Contacts</b>	

**Serious Mental Illness (SMI)**

- SMI State Plan Amendment
- KanCare Health Homes Program Manual – SMI
- SMI Health Homes Provider Requirements
- SMI Health Homes Services and Professional Requirements
- Target Population Estimates

**Chronic Conditions (CC)**

- CC State Plan Amendment
- CC Health Homes Provider Requirements
- CC Health Homes Services and Professional Requirements
- Kansas CC Health Homes Target Population
- Target Population Estimates (.xlsx)

**Health Action Plan**

- Health Action Plan Instructions
- Health Action Plan

# KanCare Website

## Health Homes in KanCare

### News & Events

#### Providers, You're Invited! Health Homes Regional Meetings April 2-9, 2014

##### Health Home

[Health Homes Regional Meeting Presentation](#)

##### Provider Regional Meetings

Health Homes are an innovative new model for improving health care management services for individuals who live with serious mental illness or specific chronic conditions and are eligible for Medicaid. The Kansas Department of Health and Environment plans to implement Health Homes in Kansas beginning July 1, 2014.

##### Health Homes Consumer Tour

##### Health Homes Herald

##### State Forums

##### Focus Group

##### Webinar with Dr. Moser

**You are invited to attend a regional meeting regarding the upcoming Health Homes initiative April 2-9 in locations across the State.** These meetings will give potential Health Home Partners and potential sub-contracting agencies an opportunity to learn more, get on board, and get prepared through information sharing and conversation.

##### Contacts

These full-day meetings will be held:

- April 2 – Hays (Fort Hays State University – Robbins Center)
- April 3 – Dodge City (Dodge House Hotel & Convention Center)
- April 4 – Wichita (WSU Hughes Metroplex)
- April 7 – Chanute (Memorial Building – Alliance Room)
- April 8 – Bonner Springs, KS (George Meyn Community Center)
- April 9 – Topeka (Ramada Inn)

# Purpose of the Tool: For Providers

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

# Purpose of the Tool: For MCOs

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

# How to Use the Tool

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

# Understanding your Population

## 1. General Population

**1. Most prevalent (top five) diagnoses:**

- 1.
- 2.
- 3.
- 4.
- 5.

**2. Total number of individuals seen in past 12 months:**

**3. Total number of visits to the whole organization in past 12 months:**

**4. Where individuals who are served by the organization live (i.e. counties, cities/towns, areas within a city):**

**5. Based on the physical health information available to you, percentage of your population with multiple chronic conditions (MCC)? 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?**

**7. Do you know the total number of individuals seen in your organization who visited the emergency department within the last year? If so, how many? What was the total number of visits?**

# Kansas Health Homes Service Definitions

- Comprehensive Care Management

**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?	Yes/No
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?	Yes/No
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.?	Yes/No
4. Do you provide Comprehensive Care Management through monitoring and follow-up to ensure that needed care and services are offered and accessed?	Yes/No
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?	Yes/No

# Kansas Health Homes Service Definitions

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- Comprehensive Care Management

Do you/will you subcontract for this service?	Answer:
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)	Score:
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?)	

# Kansas Health Homes Service Definitions

- Care Coordination

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?	Yes/No
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?	Yes/No
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?	Yes/No
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?	Yes/No
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?	Yes/No
6) Do you provide Care Coordination that creates and promotes linkages to other agencies, services, and supports?	Yes/No

# Kansas Health Homes Service Definitions

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- Care Coordination

Do you/will you subcontract for this service?	Answer:
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)	Score:
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?)	

# Kansas Health Homes Service Definitions

- Health Promotion

**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?	Yes/No
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?	Yes/No
3) Do you provide Health Promotion that ensures all health action goals are included in person centered care plans?	Yes/No
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?	Yes/No
5) Do you provide Health Promotion that offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations?	Yes/No

# Kansas Health Homes Service Definitions

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- Health Promotion

Do you/will you subcontract for this service?	Answer:
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)	Score:
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?)	

# Kansas Health Homes Service Definitions

- Comprehensive Transitional Care

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?	Yes/No
2) Do you provide Comprehensive Transitional Care follow-up appointment information?	Yes/No
3) Do you provide Comprehensive Transitional Care medication information to allow providers to reconcile medications and make informed decisions about care?	Yes/No
4) Do you provide Comprehensive Transitional Care medication education?	Yes/No
5) Do you provide Comprehensive Transitional Care therapy needs, e.g., occupational, physical, speech, etc.?	Yes/No
6) Do you provide Comprehensive Transitional Care transportation needs?	Yes/No
7) Do you provide Comprehensive Transitional Care community supports needed post-discharge?	Yes/No
8) Do you provide Comprehensive Transitional Care determination of environmental (home, community, workplace) safety?	Yes/No

# Kansas Health Homes Service Definitions

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- Comprehensive Transitional Care

Do you/will you subcontract for this service?	Answer:
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)	Score:
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?)	

# Kansas Health Homes Service Definitions

- Member and Family Support

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?	Yes/No
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?	Yes/No
3) Do you provide Member and Family Support that promotes engagement of members, family/support persons and guardians?	Yes/No
4) Do you provide Member and Family Support that promotes self-management capabilities of members?	Yes/No
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?	Yes/No
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?	Yes/No

# Kansas Health Homes Service Definitions

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- Member and Family Support

Do you/will you subcontract for this service?	Answer:
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)	Score:
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?)	

# Kansas Health Homes Service Definitions

- Referral to Community & Social Support Services

**Referral to community and social support services involves:**

1) Do you provide Referral to Community and Social Supports through knowledge of the medical and non-medical service delivery system within and outside of the member's area?	Yes/No
2) Do you provide Referral to Community and Social Supports through engagement with community and social supports?	Yes/No
3) Do you provide Referral to Community and Social Supports through 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.?	Yes/No
4) Do you provide Referral to Community and Social Supports through fostering communication and collaborating with social supports?	Yes/No
5) Do you provide Referral to Community and Social Supports through knowledge of the eligibility criteria for services?	Yes/No
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?	Yes/No

# Kansas Health Homes Service Definitions

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- Referral to Community & Social Support Services

Do you/will you subcontract for this service?	Answer:
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Referral to Community and Social Support Services. (0-10 with 10 being a high level of readiness)	Score:
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?)	

# Health Homes Health Information Technology

1. Do you use an interoperable EHR?	Yes/No
<p>If answering "No" above,</p> <p>1) Do you <u>currently</u> have the capacity to submit a plan, within 90 days of contracting as a HHP, to implement the EHR?</p> <p>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:</p> <p>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:</p>	<p>Yes/No</p> <p>12 months/ 18 months/ 24 months</p> <p>12 months/ 18 months/ 24 months</p>

# Health Homes Provider Standards

**1. Health Home Providers must meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following. Do you meet these standards?**

- |  |        |
|--|--------|
| 1) Center for Independent Living   | Yes/No |
| 2) Community Developmental Disability Organization   | Yes/No |
| 3) Community Mental Health Center  | Yes/No |
| 4) Community Service Provider – for people with intellectual / developmental disabilities (I/DD) | Yes/No |
| 5) Federally Qualified Health Center/Primary Care Safety Net Clinic                              | Yes/No |
| 6) Home Health Agency  | Yes/No |
| 7) Hospital – based Physician Group  | Yes/No |
| 8) Local Health Department   | Yes/No |
| 9) Physician – based Clinic  | Yes/No |
| 10) Physician or Physician Practice  | Yes/No |
| 11) Rural Health Clinics   | Yes/No |
| 12) Substance Use Disorder Provider  | Yes/No |

# Health Homes Provider Standards

<b>2. Health Homes Partners must enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements.</b>	
1) Are you enrolled in the KanCare Program?	Yes/No
2) Do you agree to comply with all KanCare program requirements?	Yes/No
<b>3. Health Home Partners must have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls.</b>	
1) Does your leadership fit the description above? Please provide some brief examples:	Yes/No
<b>4. Health Home 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.</b>	
1) Do you provide appropriate and timely in-person care coordination activities?	Yes/No
2) Do you utilize alternative communication methods?	Yes/No

# Health Homes Provider Standards

**5. Health Home Partners must have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals.**

1) Do you have the capacity to accompany enrollees to critical appointments?

Yes/No

**6. Health Home Partners must agree to accept any eligible enrollees, except for reasons published in the Kansas Health Homes Program Manual.**

1) Do you agree to accept any eligible enrollees except for reasons published in the Kansas Health Homes Program Manual?

Yes/No

**7. Health Home 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.**

1) Do you demonstrate such engagement and cooperation?  
Please provide some brief examples:

Yes/No

# Health Homes Partner and Lead Entity Joint Standards

<b>1. The Lead Entity and the Health Home Partner jointly must provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees.</b>	
1) Do you have staff and procedures in place to ensure this availability?	Yes/No
<b>2. The Lead Entity and the Health Home 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.</b>	
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?	Yes/No
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?	Yes/No
Please provide some brief examples:	
<b>3. The Lead Entity and the Health Home 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.</b>	
1) Do you have staff and procedures in place to ensure that this health action planning will be achieved?	Yes/No

# Health Homes Partner and Lead Entity Joint Standards

<b>4. The Lead Entity and the Health Home Partner jointly must provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy.</b>	
1) Do you have staff and procedures in place to ensure that quality-driven services are provided to address health disparities?	Yes/No
2) Do you have staff and procedures in place to ensure that quality-driven services are provided to address and improve health literacy?	Yes/No
3) Do you have staff and procedures in place to ensure that quality-driven services are provided to address health disparities?	Yes/No
4) Do you have staff and procedures in place to ensure that cost-effective services are provided to address and improve health literacy?	Yes/No
5) Do you have staff and procedures in place to ensure that culturally competent services are provided to address health disparities?	Yes/No
6) Do you have staff and procedures in place to ensure that culturally competent services are provided to address and improve health literacy?	Yes/No

<b>5. The Lead Entity and the Health Home Partner jointly must establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers.</b>	
1) Have you established such a data-sharing agreement?	Yes/No

# Health Homes Partner and Lead Entity Joint Standards

**6. The Lead Entity and the Health Home 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.**

- |   |        |
|---|--------|
| 1) Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines?  | Yes/No |
| 2) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders?   | Yes/No |
| 3) Coordinate and provide access to mental health and substance abuse services?   | Yes/No |
| 4) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families?  | Yes/No |
| 5) 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?  | Yes/No |
| 6) 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? | Yes/No |

# Health Homes Partner and Lead Entity Joint Standards

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**7. The Lead Entity and the Health Home Partner jointly must demonstrate the ability to report required data for both state and federal monitoring of the program.**

1) Do you have the staff and procedures in place to report this required data?

Yes/No



# Program Manual & Documents List

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Becky Ross

Medicaid Initiatives Coordinator,  
KDHE Division of Health Care Finance

# Overview

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- Two State Plan Amendments – Serious Mental Illness (SPA 1) & Chronic Conditions (SPA 2)
- Each has own program manual – each in draft form until CMS approval
- What's different?
  - How the target populations are defined
  - Professional requirements for Health Home Providers (HHPs)
  - Payment

# Overview

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- What's the same?
  - Six Health Home services
  - Health Home Provider requirements
  - Assignment and enrollment process
  - Referral process
  - Forms
  - Claims submission
  - Grievances and appeals
  - Health Information Technology (HIT) requirements
  - Quality goals & measures

# **Health Homes Program Manual (Serious Mental Illness) (DRAFT)**

# Health Homes Program Manual (SMI)

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- This draft focused on State Plan Amendment 1 (SPA 1) for Serious Mental Illness (SMI)
- SPA 2 Manual for Chronic Conditions (CC) still pending
- Will not discuss every section – addressed in future webinars
- To follow review of the actual document, visit [http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm)

# Health Homes Program Manual (SMI)

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- Section 1 review of the Health Homes Model
- Introduction video available on KanCare website
- Includes outline of Health Home services and professional requirements

# Section 2 - Provider Requirements for SMI Health Home Participation

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## Lead Entity Requirements

- For all KanCare Health Homes target populations, the requirements for the Lead Entities are the same.

# Section 2 - Provider Requirements for SMI Health Home Participation

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## Health Home Partner Requirements

- The requirements for Health Home Partners vary, depending upon the target population served by the Health Home; however, 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).

# Section 2 - Provider Requirements for SMI Health Home Participation

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## Lead Entity and Health Home Partner Joint Requirements

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

# Section 3- Lead Entity Contracts with Health Home Partners

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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 Home, 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 Home services.

# Section 7 - Claims Submission and Billing

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- A Health Home 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.
- HHP must provide the member with at least one Health Home service during the month for which the claim is submitted.

# Section 7 - Claims Submission and Billing

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- Services should be documented per the information provided in the Section 11: Health Home Documentation Requirements of this manual and as required by the Lead Entity-HHP contract.
- The billing code for any and all Health Home services is **S0281**.
- Information specific to each Lead Entity regarding provider billing is available on the KanCare website at [http://www.kancare.ks.gov/provider\\_billing\\_information.htm](http://www.kancare.ks.gov/provider_billing_information.htm).

# Section 11- Health Home Documentation Requirements

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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 Home services.

# Section 11- Health Home Documentation Requirements

Service	Documentation	Examples of HIT
<b>Comprehensive Care Management</b>	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 Home 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
<b>Care Coordination</b>	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.
<b>Health Promotion</b>	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.

# Section 11- Health Home Documentation Requirements

Service	Documentation	Examples of HIT
<b>Comprehensive Transitional Care</b>	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.
<b>Individual and Family Support</b>	Documentation of the assessment of psychosocial 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.
<b>Referral to Community and Social Support Services</b>	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.

# Appendices

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**APPENDIX A: Contact Information**

**APPENDIX B: Forms (also via [www.kancare.ks.gov](http://www.kancare.ks.gov))**

**APPENDIX C: Kansas Health Homes Quality Goals and Measures**

**APPENDIX D: Resources**



WICHITA STATE  
UNIVERSITY

# Member Assignment & Referral Process

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Rebecca Ross

Medicaid Initiatives Coordinator,  
KDHE Division of Health Care  
Finance

# Target Populations

# State Plan Amendment #1

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## Target Population:

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

# State Plan Amendment #2

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## Target Population:

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

OR...

# State Plan Amendment #2

---



- Current smoker or exposure to second-hand smoke
- Environmental exposures
- Missed quality of care indicator:
  - No evidence of inhaled steroid prescription in last 12 months
  - Evidence of more than one rescue medication in the prior 6 months
- One or more ER visit for asthma or asthma-related complication in the prior 12 months
- One or more hospital admission for asthma or asthma-related complication in the prior 12 months
- In the top 25th percentile of Lead Entity's risk stratification for persons with primary condition

# State Plan Amendment #2

---



- Current smoker or exposure to secondhand smoke
- Uncontrolled diabetes (as demonstrated by HbA1c or glucose tests)
- Missed quality of care indicator:
  - No HbA1c, LDL cholesterol, or HDL/Triglyceride level in the prior 12 mo.
- One or more ER visit for diabetes or diabetes-related complication in the prior 12 months
- One or more hospital admission for diabetes or diabetes-related complication in the prior 12 months
- In the top 25th percentile of Lead Entity's risk stratification for persons with primary condition
- Non-compliance in taking medication regularly

# Member Assignment

# How are Members assigned?

---

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

OR

- Referral by a provider in the community
- Based on:
  - Target population
  - Available HHPs in the geographic area
  - Existing relationships with HHPs

# How are Members assigned?

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Members always have the right to choose!

# How are Members assigned?

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- When a Health Homes member is identified, the Lead Entity will send an assignment letter 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
- Sent on 1<sup>st</sup> day of each month
  - Referred members receive letter the 1<sup>st</sup> day of the following month

# How are Members assigned?

---

- 'Opt out'
  - Can be done at any time after initial assignment letter is received
  - Members who 'opt out' will be reassessed annually by the MCO
  - Can opt back in at any time
  - Hewlett Packard (HP) Enterprises receive information and verify with Lead Entity files

# How are Members assigned?

---

- Children in Foster Care:
  - Assignment letter sent to foster family
  - Requests to ‘opt out’ or changes in HHP completed by the DCF Child Welfare Community Based Service (CWCBS) Contractor
  - CWCBS Contractor will coordinate with Lead Entity if child moves outside of assigned HHP service area to reduce service disruption

# 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 Home services, except for limited reasons
- Reasons include (but are not limited to):
  - Member has been previously discharged by the HHP with applicable notice in writing
  - Member resides outside the HHP service area
  - Member is outside the age range parameters set by the HHP
  - HHP has reached capacity
  - HHP is a Tribal 638/Indian Health Facility & wishes to limit services to Native Americans
  - HHP is an I/DD provider and wishes to limit activities to that population

# Refusal of Member Assignment

---

- All other reasons for refusing to serve a potential Health Home member must be approved by the State Health Homes Manager & the Lead Entity
- HHP Member Assignment Refusal Form will be available on the KanCare website
- Details also included in contracts between Lead Entities and HHPs

# Enrollment/Disenrollment

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- Lead Entity notifies HHP of member assignment – this triggers Health Action Plan process
- Lead Entity processes requests for change in HHP assignment at any time during eligibility
- Lead Entity coordinates transfer of information when Health Home members change KanCare MCOs
- HHP can remain the same if partnered with both MCOs

# Enrollment/Disenrollment

---

- Reasons for discharge or disenrollment:
  - Member chose to ‘opt out’
  - Member has a catastrophic illness or event that makes it unlikely the member will continue to benefit from Health Homes
  - Member poses a danger to himself or herself, or to HHP staff
- To officially discharge or disenroll a member, the HHP must submit a completed Health Home Discharge Form to the Lead Entity and send a copy to the State Health Homes Manager.
- Members losing Medicaid eligibility due to unmet spend down will not require a HH Discharge form but must be informed that they must meet spend down requirement prior to reinstatement

# Member Referral

# Member Referral Process

---

## Hospitals

- Mandated by ACA to refer individuals with chronic conditions who see or need treatment in an emergency department

## Other Medicaid Providers

- May refer Medicaid members through their MCO if they meet Health Home requirements

## Kansas Health Homes Referral Form:

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

# Kansas Health Home Referral Form

## Kansas Health Home Referral Form



<b>Directions: Please complete sections 1 through 5 and send via fax, email, or standard mail to:</b>		
Amerigroup 9225 Indian Creek Pkwy, Ste. 400 Overland Park, KS 66102 Member Services: 1-800-600-4441 Fax: TBD	Sunflower State Health Plan 8325 Lenexa Dr. Lenexa, KS 66214 Member Services: 1-877-644-4623 Fax: TBD	United Health Care 9900 W. 109 <sup>th</sup> St. #200 Overland Park, KS 66210 Member Services: 1-877-542-9238 Fax TBD:
<b>Current MCO assignment:</b> <small>MCO Assignment</small> Choose an item. ▾	<b>MCO Member ID#:</b> [REDACTED]	
<b>Section 1: Member Information</b>		
Date of referral: <a href="#">Click here to enter a date.</a>		
Medicaid ID# of individual being referred: [REDACTED]		
* If none, please refer individual for Medicaid eligibility determination		
Name of individual being referred: [REDACTED]		
Date of Birth: [REDACTED]		
Address: [REDACTED]		
Phone: [REDACTED]		
Email: [REDACTED]		
Name of Referring Organization: [REDACTED]		
Name of Individual submitting the referral: [REDACTED]		
Address: [REDACTED]		
Phone: [REDACTED]		
Email: [REDACTED]		

# Kansas Health Home Referral Form

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

- 295.xx : Schizophrenia
- 296.xx : Bipolar disorder and major depression disorders
- 297.xx : Delusional disorders
- 298.xx : Other nonorganic psychoses
- 300.3 : Obsessive-compulsive disorder
- 301.4 : Obsessive-compulsive personality disorder
- 301.0 : Paranoid Personality disorder
- 301.2 : Schizoid Personality disorder
- 301.22 : Schizotypal Personality disorder
- 301.83 : Borderline Personality disorder
- 309.81 : Post-traumatic stress disorder
- 250.xx : Diabetes
- 790.29 : Pre-diabetes/ Other abnormal glucose
- 648.00 : Diabetes mellitus complicating pregnancy childbirth
- 648.8 : Abnormal glucose tolerance/gestational diabetes
- 277.7 : Dysmetabolic syndrome
- 493.xx : Asthma

# Kansas Health Home Referral Form

<b>Section 3: Clinically Documented Risk Factors in the last 24 months</b>	
<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Overweight
<input type="checkbox"/>	Substance Use
<input type="checkbox"/>	Coronary Artery Disease (CAD)
<input type="checkbox"/>	Tobacco Use Disorder
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Second Hand Tobacco Smoke
<input type="checkbox"/>	Uncontrolled Diabetes
<input type="checkbox"/>	Environmental Exposure to one or more of the following: Air pollution, industrial/chemical toxins, dust mites, pets, mold, pollen
<b>Section 4: Hospital Utilization</b>	<input type="checkbox"/> Hospital utilization information not available
<b>Emergency Department Visits:</b>	<b>Inpatient Admissions:</b>
<input type="checkbox"/> > 1 ED visit for asthma or related complication within the past 12 months	<input type="checkbox"/> > 1 asthma admission or related complication within the past 12 months
<input type="checkbox"/> > 1 ED visit for diabetes or related complication within the past 12 months	<input type="checkbox"/> > 1 diabetes admission or related complication within the past 12 months
<b>Section 5: Quality of Care Indicators</b>	<input type="checkbox"/> Quality of Care Indicator information not available
<input type="checkbox"/>	No evidence of inhaled steroid prescription in last 12 months
<input type="checkbox"/>	Evidence of < 1 rescue medication prescription in the prior 6 months
<input type="checkbox"/>	No HbA1c in the prior 12 months
<input type="checkbox"/>	No LDL Cholesterol test in the prior 12 months
<input type="checkbox"/>	No HDL/Triglyceride cholesterol test in the prior 12 months
<input type="checkbox"/>	Top 25 % of Lead Entity risk score for primary condition
<input type="checkbox"/>	Non adherence to medication regimen

# Kansas Health Home Referral Form

TO BE COMPLETED BY MCO

## Section 6: Eligibility Criteria

- Medicaid Eligible (KMAP)
- Member has two chronic conditions or has one chronic condition and at risk for another (CC HH)
- Member has at least one Serious Mental Illness (SMI HH)
- Member does not meet eligibility criteria.

Reason for ineligibility:

## Section 7: 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)



# Payment Structure – SPA 1 & 2

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Melissa Warfield

KDHE Division of Health Care Finance

# Basic Payment Structure & Payment Principles

# Basic Payment Structure

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

# Basic Payment Structure

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

# Payment Principles

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1. State Health Home payments to MCOs are structured to be adequate in ensuring quality services are sustainable.
2. MCO payments to HHPs will be structured to be adequate in ensuring quality services are sustainable.
3. State Health Home payments to the MCOs are actuarially sound as defined by the American Academy of Actuaries.

# Rate Development Process

---

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

# **Serious Mental Illness Health Home Rates**

# SMI Health Home Rates

---

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

# Professional Costs (SMI)

---

Centered around  
staffing of the Home  
Health Team:

- Physician
- Psychiatrist
- Nurse Care Coordinator
- Social Worker
- Peer Support Specialist



# SMI Health Home Staffing Cost

---

## Consulting Physician/Psychiatrist (Behavioral Health Professional):

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

# SMI Health Home Staffing Cost

## Nurse Care Coordinator, Social Worker and Peer Support Specialists:

Professional	Salary	Burden Rate	Total Compensation
Nurse Care Coordinators	\$ 80,720	28.00%	\$ 112,111
Social Workers	\$ 54,890	28.00%	\$ 76,236
Peer Support Specialist	\$ 15,080	28.00%	\$ 20,944

# Service Utilization

---

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

# Non-medical Loading (Administrative Costs)

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

<b>SMI Health Home Rate Level</b>	<b>Non Medical %</b>	<b>Non Medical PMPM</b>
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 Home PMPM Rate (7/1/14)

Level	SMI HH Rate	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	\$ 171.79	

# Chronic Conditions Health Home Rates

# CC Health Home Rates

---

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

# Professional Costs (CC)

---

Centered around  
staffing of the Home  
Health Team:

- Physician
- Nurse Care Coordinator
- Social Worker



# CC Health Home Staffing Cost

---

## Consulting Physician

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

# CC Health Home Staffing Cost

---

## Nurse Care Coordinator and Social Worker

Professional	Salary	Burden Rate	Total Compensation
Nurse Care Coordinators	\$ 80,720	28.00%	\$ 112,111
Social Workers	\$ 54,890	28.00%	\$ 76,236

# Service Utilization

---

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

# Non-medical Loading (Administrative Costs)

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

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

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

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

# I/DD Target Case Management Providers

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- The Centers for Medicare and Medicaid Services (CMS) prohibit the provision of Targeted Case Management services to people in Health Homes.
- KDHE requires all HHPs who serve I/DD members **must** contract with the TCM providers for those members who **want** to maintain a relationship with their current Targeted Case Managers.
- Member choice is key.

# I/DD Target Case Management Providers

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- The TCM performs some of the six core Health Home services
- The specific activities will be determined in the contracting process.
- The TCM provider will be paid a guaranteed per member per month payment.

# I/DD Target Case Management Providers

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- **Minimum TCM Payments:**
- Minimum PMPM payment of **\$137.32** to TCM providers serving I/DD Health Home members in the **SMI Health Home**.
- Minimum PMPM payment of **\$208.75** to TCM providers serving I/DD members in the **CC Health Home**.

# CC Health Home Rate Review

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- The State and its actuaries will review the Health Home 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.



Leslie Banning  
Health Homes Manager  
[KSHealthHome@amerigroup.com](mailto:KSHealthHome@amerigroup.com)



# Enrollment

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## Automatic assignment with opt-out

- a. Amerigroup will auto-enroll Medicaid eligible members using claims data to determine those members with a qualifying diagnosis
- b. Amerigroup assigns members to Health Home Partner while considering:
  - 1) Geographic area of residence
  - 2) Current Health Service Providers
  - 3) Availability of a Health Home Partner
- c. Amerigroup mails assignment/enrollment letters to members and providers
- d. Members can choose to opt-out of Health Home participation, accept Health Home assignment, decline and/or request a different Health Home



# Health Home Referrals

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- **Providers or community partners can complete a KanCare Health Home Referral Form**

Referral Forms include:

- Member information
  - Diagnosis of a qualifying condition
  - Presence of other health risk factors
  - History of high health service utilization
  - Quality of Care Indicators
  - Provider contact information
- **Members can self-refer by calling 1-800-600-4441**



# Health Home Delivery System (Financial)

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- Defines four levels with a Case Rate
- MCO may provide some of the health home services for certain waiver populations
- Health Home Partners strongly encouraged to provide the following Health Home core services: Care Coordination, Comprehensive Transitions in Care and Health Promotion
- HHP uses Code S 0281 to submit a Health Home service. Payment is provided for each enrollee who received at least one of the six core services by the HHP (PMPM)

# Health Action Plan

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- Meet with enrollee
- Complete a comprehensive assessment including reconciliation of medications
- Identify unmet needs from a holistic prospective— physical health, mental health, substance use, social, financial, spiritual and cultural
- Establish Health Action Plan goals and action steps
- Ensure collaboration/integration of care between all providers of care and/or support

# Program Activities: Roles and Responsibilities

Health Home	MCO
Outreach and engagement	Identify members from data files for health home
Biopsychosocial assessment, establish personal health plan inclusive of safety, advanced directive	Benchmarks, expected outcomes
Outpatient physical and behavioral health services — assessment and health plan	Provide sample clinical guidelines — pathways to manage members with chronic conditions
Wellness visits and health promotion	Monitor health screenings completed
Chronic condition management: acute episodes of care, education and self-management (chronic care)	Monitor care for chronic conditions, duplication of test and procedures, ER/inpatient admissions
Case management; refer to community/social supports	Comprehensive care management — communicate with health home on social supports
Individual and family support	Respite services, value-added benefits
Care coordination between physical health and behavioral health; primary care and specialists	Vendor services Ancillary services
Facilitate transitions in care	Utilization management
Monitor members over time — registries to track	QA/QI reporting

# HIT: Member 360

George >

Currently Enrolled ● Alerts Exist ● No OHI ●

Provider: QA  
WELLPOINT

Member Care Summary | **Claims** | Utilization | Care Management | Episodic Viewer | Lab Reports

Date Range: Mar 12, 2012 to Sep 12, 2014

[Update](#)

Active Alerts		
Source	Description	Type
HEDIS	Diabetes- HbA1c Testing - Pending	Alert
HEDIS	Diabetes- LDL Screening - Pending	Alert
HEDIS	Diabetes- HbA1c > 9 - Pending	Alert
HEDIS	Diabetes- HbA1c between 8-9 - Pend...	Alert
HEDIS	Diabetes- LDL < 100 - Pending	Alert
HEDIS	Diabetes- Medical Attention for Neph...	Alert

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Immunizations & Preventive Health		
Date	Service	Provider
07/19/2013	Pneumococcal polysacchari...	Jersey City Medical Ctr

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Lab Results				
Date	Type	Value	Acuity	
07/05/2013 12:33	Hemoglobin A1C	6	No lab acuity p...	
07/05/2013 12:33	LDL	157	No lab acuity p...	
07/05/2013 12:33	HDL	65	No lab acuity p...	
07/05/2013 12:33	Total Cholesterol	241	No lab acuity p...	
07/05/2013 12:33	Blood creatinine	0.7	No lab acuity p...	
05/21/2013 00:00	T4, FREE	1.3	Normal	
05/21/2013 00:00	PROTEIN, TOTAL	6.2	Normal	

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Inpatient			
Admit Date	Discharge Date	Facility Name	Primary Diag
08/07/2013	08/12/2013	Jersey City Medical Ctr	Chronic airway obstruct...
08/07/2013	08/08/2013	Jersey City Medical Ctr	Chronic airway obstruct...
07/19/2013	07/24/2013	Jersey City Medical Ctr	Chronic bronchitis with...
06/08/2013	06/10/2013	Jersey City Medical Ctr	Other dyspnea and res...
06/08/2013	06/10/2013	Jersey City Medical Ctr	Chronic obstructive ast...
04/29/2013	05/01/2013	Jersey City Medical Ctr	Obstructive chronic bro...
02/19/2013	02/21/2013	Jersey City Medical Ctr	Chronic airway obstruct...

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Emergency Department			
Date	Facility Name	Primary Diagnosis	
06/08/2013	Liberty Emergency Medical As...	Other dyspnea and respirator...	
04/29/2013	Liberty Emergency Medical As...	Obstructive chronic bronchitis...	
02/19/2013	Liberty Emergency Medical As...	Chronic airway obstruction, n...	

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Pharmacy		
Date	Medication/Strength	Prescriber
01/01/2014	FOLIC ACID TAB 1MG	Elamir, Mazhar
12/30/2013	METOCLOPRAM TAB 10MG	Elamir, Mazhar
12/30/2013	LACTULOSE SOL 10GM/15	Salah-eldin, Alaa
12/30/2013	ALFUZOSIN HCL ER 10 MG...	Elamir, Mazhar
12/30/2013	MINTOX SUS	Elamir, Mazhar
12/30/2013	OMEPRAZOLE CAP 20MG	Elamir, Mazhar
12/30/2013	IPRATROPIUM SOL 0.02%I...	Elamir, Mazhar

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Authorizations						
Auth Number	Start Date	End Date	Place of Service	Referred To Provider	Status	
C01228606	08/07/2013	08/12/2013	Inpatient Hospital	Jersey City Medical Ctr	Discharged	
C01228191	08/07/2013	08/08/2013	Inpatient Hospital	Jersey City Medical Ctr	Void	
103658934	07/19/2013	01/18/2014	Outpatient Hospital	Senior Spirit Of Jersey City Adult Medic...	Complete	
C01191978	07/19/2013	07/24/2013	Inpatient Hospital	Jersey City Medical Ctr	Discharged	
103647282	07/16/2013	07/16/2013	Patient's Home	Loving Care Agency	Complete	
103629058	07/03/2013	08/03/2013	Ambulance-Land	Ostrich Medical Transportation	Complete	
C01110310	06/08/2013	06/10/2013	Inpatient Hospital	Jersey City Medical Ctr	Disallowed	

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Office Visits		
Date	Provider	Primary Diagnosis
07/15/2013	Raginsky, Boris	Other peripheral vascular...
07/03/2013	Elamir, Mazhar E	Shortness of breath
06/19/2013	Elamir, Mazhar E	Essential hypertension, be...
06/14/2013	Salah-eldin, Alaa A	Acute gastritis without men...
05/20/2013	Lala, Vinod R	Diabetes mellitus without...
04/26/2013	Fatah, Nail A	Asthma, unspecified with st...
04/17/2013	Elamir, Mazhar E	Cough

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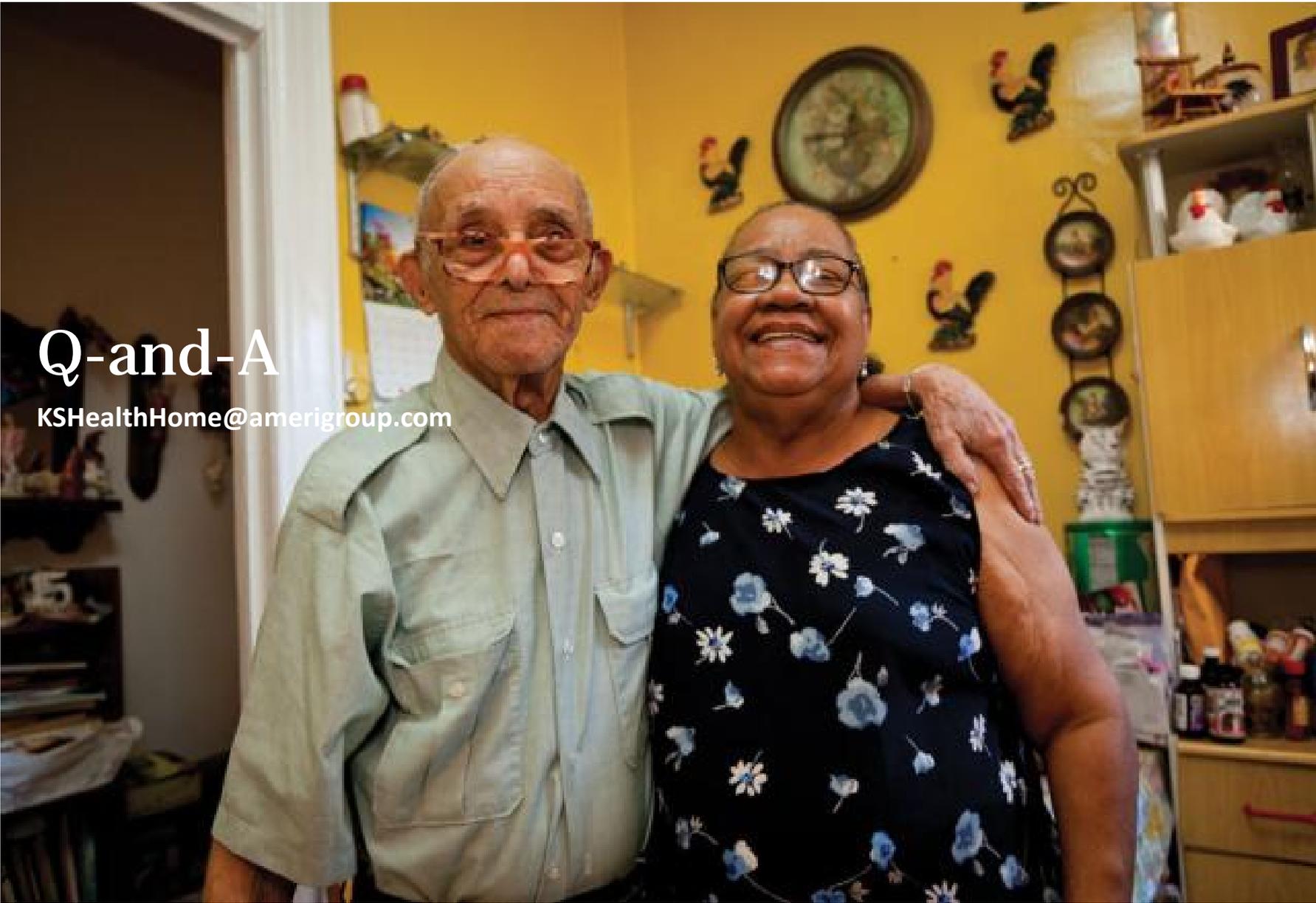
Home Mods and Equipment Claims		
Date	Provider	Service

Other Claims		
Date	Provider	Service
08/08/2013	Quality Home Care Providers	O2 conc 1 del port 85%>0...
07/30/2013	Senior Spirit Of Jersey City	Day Care Services Adult P...

Local intranet | Protected Mode: Off

100%





# Q-and-A

[KSHealthHome@amerigroup.com](mailto:KSHealthHome@amerigroup.com)



# United Healthcare – Health Homes Update

March 21, 2014

# How to Engage UHC on Health Homes

## E-Mail

Health Homes Mailbox

UHC KS Health Homes - [uhckshealthhomes@uhc.com](mailto:uhckshealthhomes@uhc.com)

## Preparedness and Planning Tool

Complete the Preparedness and Planning Tool – UHC will respond after receipt of the tool from the state.

# KS Health Homes Program Key Features

1. MCO Integration into Health Home model
  - The MCOs serve as advisors and SMEs in Care Management
  - Assist in HIT development
  - Payment pass-through from state
  - MCO Determine Eligibility and HH Assignment within some guidelines
  
2. MCO mandate to provide services
  - MCO must provide 6 core services in the absence of a Health Home Partner
  
3. Mandated TCM participation in Health Homes
  - Guarantee of revenue to TCM participating in Health Homes
  
4. Reimbursement
  - Single code for all 6 services
  - Per Member Per Month(PMPM) Payment to Health Home Partners
  - Payment to MCO in arrears based upon encounter activity

## Timeline

**3-21-2014** Stakeholder Meeting

**4-1-2014** Preparedness and Planning Tool “Due Date”

**7-1-2014** Go Live

**July 2014** Letters mailed to members, HH assignments made, opt out letters received.

**8-1-2014** Health Home Services Begin

**Post 8-1-2014** Ongoing support, education, development activities for Health Home Partners that are not ready on day 1.

## What Do We Already Know?

UHC has experience in many states with Health Homes already

We work in WA, NY, and TN on similar programs

Simple is Good – Is there any way to reduce the administrative burden?

UHC performs many of the 6 core services, or services like them today

UHC has dedicated training staff for our internal care management teams

We have more capacity to absorb risk than individual provider practices

We, the MCOs, will be paid after the fact based upon an encounter

# How Do We Best Support Providers?

Category	Provider Concern	UHC Goals for Provider Support
<b>Member</b>	<i>Health Outcomes</i>	<i>Help members live healthier lives</i>
	<i>Existing Relationship</i>	<i>Make smart matches to Health Homes by identifying existing relationships</i>
	<i>Benefit</i>	<i>Help educate members on why Health Homes make sense for them</i>
<b>Revenue</b>	<i>Reimbursement Level</i>	<i>Sustainability</i>
	<i>Membership</i>	<i>Member Choice - Multiple Health Home Options</i>
	<i>Up Front Investment</i>	<i>Risk Reduction</i>
<b>Change</b>	<i>New Program, Systems, Process</i>	<i>Create Tools for Provider Use</i>
	<i>Fatigue - KanCare and DD Implementation</i>	<i>Help promote consistent, current, and timely payment to providers</i>
	<i>New Staff</i>	<i>Demonstrate what the job is.</i>
<b>Operations</b>	<i>Capacity</i>	<i>Ensure Member Access and Provider Capability - Support a Range Health Home Providers</i>
	<i>Claims</i>	<i>Simplify and Streamline Payment Process</i>
	<i>3 MCOs to Work With</i>	<i>Make it Easy to Work With Us</i>

# UHC Proposed Model

## All In Model –

You have the training, tools, capacity, and capability to perform all 6 services on day 1

- Data and application training support from UHC
- Includes models where the Health Home Partner subcontracts with other providers for services
- PMPM Payment –**MAX**

## Partial Service Model –

You can perform at least 3 services on day 1

- Comprehensive Care Management, Care Coordination and Comprehensive Transitional Care
- Data and application training support from UHC
- Does not allow for subcontract models
- UHC assistance in identification of potential subcontractor partners
- PMPM Payment –**MIX**

## Demonstration Model –

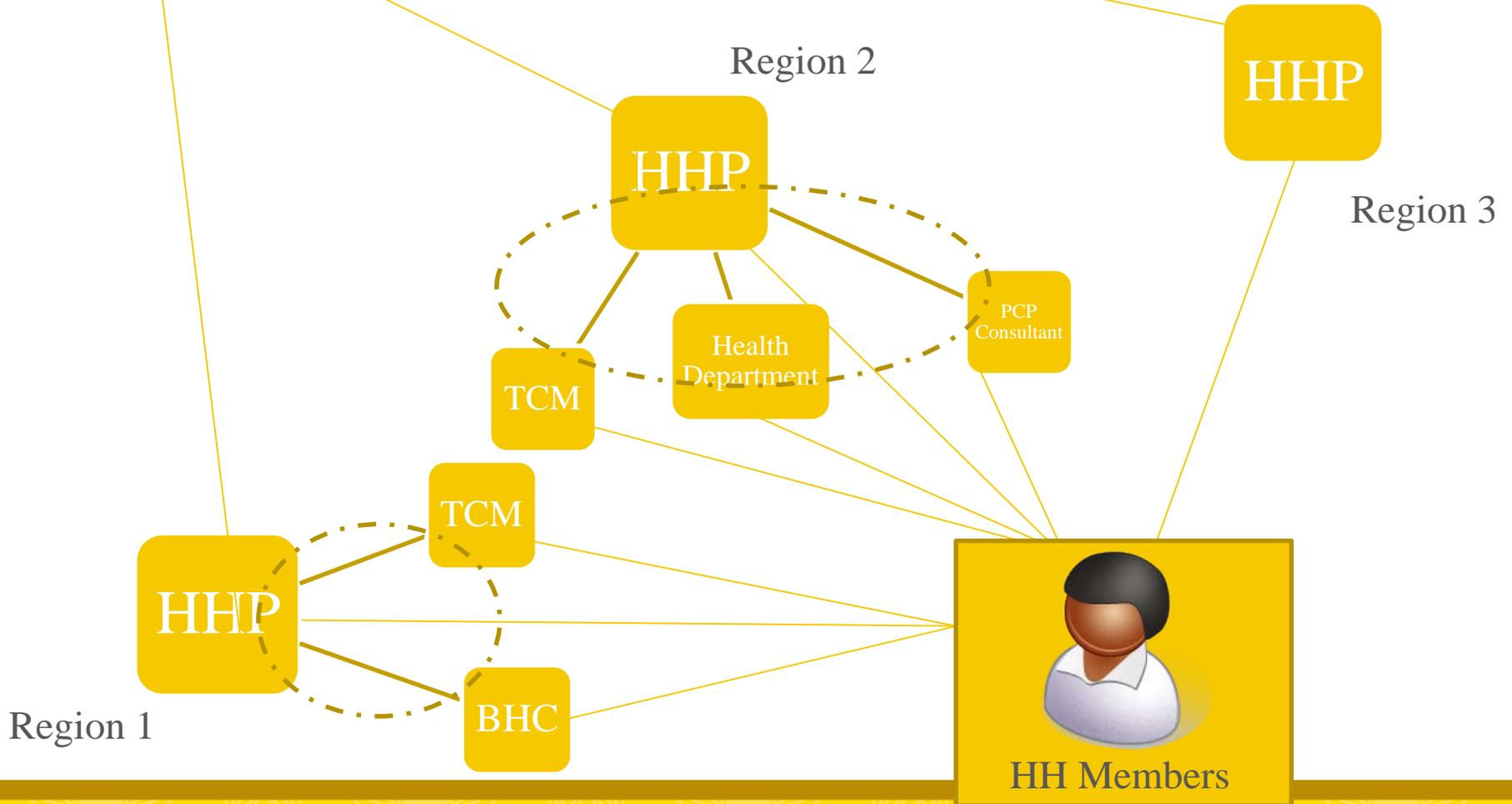
You are a health home provider, but UHC covers staffing, admin, and day to day work

- Members assigned to your practice
- No initial up front staffing cost
- UHC demonstrates scope of work, systems, processes etc.
- Data and application training support from UHC when ready to take over services
- PMPM Payment – **NOMINAL**

# Sunflower Health Plan

## Health Home Program

- Enrolled in KanCare program & agree to comply with KanCare program
- Must meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following:
  - Center for Independent Living, Community Developmental Disability Organization, Community Mental Health Center, Community Service Provider- for people with I/DD, Federally Qualified Health Center/Primary Care Safety Net Clinic, Home Health Agency, Hospital-based Physician Group, Local Health Department, Physician-based clinic, Physician or Physician Practice, Rural Health Clinics or Substance Use Disorder Provider
- Leadership Commitment to Continuous Process Improvement & Patient Centeredness
- Provide 6 core services
  - Directly or through contracted providers



- **Team of Professionals**

- **Physician:** MD/DO (minimum 1)
- **Nurse Care Coordinators:** RN, APRN, BSN or LPN (minimum 1)
- **Care Coordinator (SW):** (minimum 1)
  - BSW or BS/BA in a related field or MH TCM or an IDD TCM or a substance use disorder person centered CM
- **Behavioral Health Professionals:** psychiatrist (must employ or contract)
  - Other Behavioral Health Professional: “May be a licensed clinical psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, licensed clinical additions counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing and is employed by, or under contract with the HHP.”

- Comprehensive Case Management
  - Health Action Plan [http://www.kancare.ks.gov/health\\_home/download/Health\\_Home\\_Action\\_Plan.doc](http://www.kancare.ks.gov/health_home/download/Health_Home_Action_Plan.doc)
- Care Coordination
  - Dedicated care coordinator responsible for overall management of HAP
- Health Promotion
- Comprehensive Transitional Care
  - Facilitate transition of treatment plans among service providers and facilities
- Individual & family support
- Referral to community & social support services

# Lead Entities

- Evaluate, select & support providers
- Provide infrastructure & tools to support HHP
  - Portal
  - Health Home Program team
- Sharing member level data
  - Gaps in care, medications, ER/IP utilization
- Develop & offer learning activities
- Assure HHP commits to the use of an interoperable HER through the following:
  - Submission of a plan to the LE, within 90 days of contracting as a HHP, to implement the EHR
  - Full implementation of the HER within a timeframe approved by the Lead Entity
  - Connection to one of the certified state HIE, KHIN or LACIE, within a timeframe approved by the Lead Entity
- Audits & Data Analysis to facilitate the HHP transformation
  - HAP evaluation
  - Review of PDSA
  - Utilization of Portal

# Provider Portal



SunFlower State Health | Currently sharing | Give Control | Stop Sharing

https://support.sunflowerstatehealth.com/careconnect/memberDetails?displayMedicaidId=

File Edit View Favorites Tools Help

SunFlower State Health Provider Tools

Coordination of Benefits

Claims

Age [Redacted] Phone Number [Redacted]

Member # [Redacted]

Address [Redacted]

**Eligibility History**

Start Date	End Date	Product Name
Mar 1, 2014	Dec 31, 9999	TANF
Aug 1, 2013	Feb 28, 2014	TANF

[more](#)

[View PCP History](#)

Name	Start Date	End Date
[Redacted]	Mar 1, 2014	Dec 31, 9999
[Redacted]	Aug 1, 2013	Feb 28, 2014
[Redacted]	Apr 13, 2013	Jul 31, 2013
[Redacted]	Apr 1, 2013	Apr 12, 2013

[Care Gaps](#)

Due for blood lead test on or before 2nd birthday

[Allergies](#)

None On File

[View Clinical Information](#)

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https://support.sunflowerstatehealth.com/careconnect/memberDetails?displayMedicaidId=...

SunFlower State Health Provider Tools

[View Clinical Information](#)

**Three Most Recent ER Visits**

Primary Diagnosis	Date	Facility/Provider
<a href="#">DIAPER OR NAPKIN RASH</a>	09/16/2013	THE UNIVERSITY OF KANSAS HOSPITAL
<a href="#">FEVER NOS</a>	08/28/2013	THE CHILDRENS MERCY HOSPITAL MO
<a href="#">FEVER NOS</a>	07/28/2013	THE CHILDRENS MERCY HOSPITAL MO

**Top 5 Most Occurring Diagnosis**

- ROUTINE INFANT/CHILD HEALTH CHECK
- FEVER NOS
- OTH SPEC CONDS ORIG PERINTL PERIOD
- SINGLE LIVEBORN HOSP W/O C-SEC
- NB FEEDING PROBLEMS

**Recent Pharmacy Activity**

- FLUCONAZOLE SUS 10MG/ML
- MAPAP LIQ 160/5ML
- MUPIROCIN OIN 2%

**Three Most Recent Inpatient Admissions**

None On File

**Three Most Recent Office Visits**

Primary Diagnosis	Date	Facility/Provider
<a href="#">ROUTINE INFANT/CHILD HEALTH CHECK</a>	01/16/2014	[REDACTED]
<a href="#">ROUTINE</a>	01/16/2014	[REDACTED]
<a href="#">ROUTINE</a>	01/16/2014	[REDACTED]

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# Provider Portal



Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Coordination of Benefits

Claims

Visits Medications Immunizations Labs Allergies

Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy
10/08/2013	FLUCONAZOLE SUS 10MG/ML	10 MG/ML	35	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
10/08/2013	MAPAP LIQ 160/5ML	160 MG/5ML	118	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
10/08/2013	MUPIROCIN OIN 2%	2 %	22	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
09/17/2013	NYSTATIN CRE 100000	100000 UNIT/GM	30	WALGREENS #7550
09/17/2013	NYSTATIN SUS 100000	100000 UNIT/ML	60	WALGREENS #7550
06/10/2013	DEEP SEA SPR 0.65%	0 %	44	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
06/10/2013	MAPAP LIQ 160/5ML	160 MG/5ML	118	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
05/03/2013	SIMETHICONE DRO 40/0.6ML	40 MG/0.6ML	30	CHILDRENS MERCY WEST PHARMACY/THE CORDEL

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- Preparedness & Planning Tool

- [http://www.kancare.ks.gov/health\\_home/download/Preparedness\\_and\\_Planning\\_Tool.doc](http://www.kancare.ks.gov/health_home/download/Preparedness_and_Planning_Tool.doc)
- Key Elements of Tool
  - The population you serve
  - 6 core services you provide
  - Presence of EHR & HIT use
  - Provider standards
  - KanCare Participation
  - Organizational leadership
  - Open panel
  - Community coordination
  - Health Home Partner standards

# What Comes Next?



- Provider tool acknowledgement letter/fax
- SHP Health Home Program team reviews
  - Available health home partners
  - Regional characteristics
- Provider Regional Meetings in 4/2014
- Association outreach- ongoing
- SHP HHP regional calls scheduled after 4/30/2014
- Health home member letter sent on 7/1/2014
- Health home program begins 8/1/2014

- Sunflower Health Home Correspondence:
  - E-mail: [LEN\\_SFSHPHOMEHEALTH@centene.com](mailto:LEN_SFSHPHOMEHEALTH@centene.com)
  - Phone: 913-333-4612
  - Fax: 866-241-6416
- Leadership Team:
  - Health Home Clinical Project Manager: Dorothy Keller, RN
  - Health Home Operational Project Manager: Jeanine Meiers
  - Provider Relations: Bryan Swan

# Provider Relations



A dedicated Sunflower Health Plan Provider Relations Representative can provide:

- ✓ Health Home core services information
- ✓ Health Home rate cell information
- ✓ Demographic information updates
- ✓ New practitioner credentialing information
- ✓ Policy and procedures clarification
- ✓ Contract clarification
- ✓ Membership roster information
- ✓ Claims dispute and resolution information

**Contact Provider Relations at 877-644-4623**



# Provider Relations



Providers can contact Sunflower Health Plan through:

Secure web portal – [www.SunflowerStateHealth.com](http://www.SunflowerStateHealth.com)

Phone – 877-644-4623

Fax – 888-453-4316

**Thank you for  
participating!**