

Health Home State Plan Amendment

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Transmittal Number: KS-14-0015 Supersedes Transmittal Number: KS-14-0015 Proposed Effective Date: Jul 1, 2014 Approval Date:
Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

Supersedes Transmittal Number:

Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

- The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program:

State Information

State/Territory name:

Medicaid agency:

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Proposed Effective Date

07/01/2014 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:

The Health Homes model in Kansas takes the form of a partnership between the Lead Entity and another entity (Health Home Partner) that is appropriate for each consumer.

This model of a team of health professionals appears to offer the greatest flexibility for providing health home services within a managed care delivery system. Such flexibility will be important since Kansas is a largely rural state, with a few well-defined urban areas, and familiar community providers, such as community mental health centers are important. Such providers could be Health Home Partners with the Lead Entities, assuming they meet the provider qualifications, can provide some of the six core services and are willing to contract with the Lead Entities.

Health Homes should be connected to other community based providers as well to effectively manage the full breadth of beneficiary needs. Kansas has four high level goals to assess the effectiveness of our health home program - 1) Reduce utilization associated with avoidable (preventable) inpatient stays; 2) Improve management of chronic conditions; 3) Improve care coordination; 4) Improve transitions of care between primary care providers and inpatient facilities.

Federal Budget Impact

Federal Fiscal Year		Amount
First Year	2014	\$ 8375388.00
Second Year	2015	\$ 33501553.00

Federal Statute/Regulation Citation

Section 2703 of the PPACA

Governor's Office Review

No comment.

Comments received.

Describe:

No response within 45 days.

Other.

Describe:

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Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- Public notice was not required and comment was not solicited**
- Public notice was not required, but comment was solicited**
- Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

Newspaper Announcement

- Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication:

04/24/2014 (mm/dd/yyyy)

- Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:

(mm/dd/yyyy)

Description:

[Empty text area for description]

- Website Notice**

Select the type of website:

- Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

(mm/dd/yyyy)

Website URL:

[Empty text area for website URL]

- Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

[Empty text area for website URL]

- Other

- Public Hearing or Meeting**

- Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

- Access**

Summarize Comments

[Empty text area for summarizing comments]

Summarize Response

[Empty text area for summarizing response]

- Quality**

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

Service Delivery

Summarize Comments

Summarize Response

Other Issue

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Submission - Tribal Input

- One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**
 - This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**
 - The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

Indian Tribes

Indian Tribes	
Name of Indian Tribe:	
Iowa Tribe of Kansas & Nebraska	
Date of consultation:	
02/27/2014 (mm/dd/yyyy)	
Method/Location of consultation:	

Indian Tribes	
Email notice and KDHE holds a monthly meeting with Indian Tribes, Indian Health Programs and Urban Indican Organizations. Health Hoems were discussed at the March 4 and April 8, 2014 meetings. No e-mail comments were received.	
Name of Indian Tribe: Kickapoo Nation	
Date of consultation: 02/27/2014 (mm/dd/yyyy)	
Method/Location of consultation: Email notice and KDHE holds a monthly meeting with Indian Tribes, Indian Health Programs and Urban Indican Organizations. Health Hoems were discussed at the March 4 and April 8, 2014 meetings. No e-mail comments were received.	
Name of Indian Tribe: Prairie Band Potawatomi Nation	
Date of consultation: 02/27/2014 (mm/dd/yyyy)	
Method/Location of consultation: Email notice and KDHE holds a monthly meeting with Indian Tribes, Indian Health Programs and Urban Indican Organizations. Health Hoems were discussed at the March 4 and April 8, 2014 meetings. No e-mail comments were received.	
Name of Indian Tribe: Sac & Fox Nation of Missouri	
Date of consultation: 02/27/2014 (mm/dd/yyyy)	
Method/Location of consultation: Email notice and KDHE holds a monthly meeting with Indian Tribes, Indian Health Programs and Urban Indican Organizations. Health Hoems were discussed at the March 4 and April 8, 2014 meetings. No e-mail comments were received.	

Indian Health Programs

Indian Health Programs	
Name of Indian Health Programs: Haskell Health Center	
Date of consultation: 02/27/2014 (mm/dd/yyyy)	
Method/Location of consultation: Email notice and KDHE holds a monthly meeting with Indian Tribes, Indian Health Programs and Urban Indican Organizations. Health Hoems were discussed at the March 4 and April 8, 2014 meetings. No e-mail comments were received.	
Name of Indian Health Programs: White Cloud Health Station	
Date of consultation: 02/27/2014 (mm/dd/yyyy)	
Method/Location of consultation: Email notice and KDHE holds a monthly meeting with Indian Tribes, Indian Health Programs and Urban Indican Organizations. Health Hoems were discussed at the March 4 and April 8, 2014 meetings. No e-mail comments were received.	

Urban Indian Organization

Urban Indian Organizations	
Name of Urban Indian Organization: Hunter Health Clinic	
Date of consultation:	

Urban Indian Organizations	
02/27/2014	(mm/dd/yyyy)
Method/Location of consultation: Email notice and KDHE holds a monthly meeting with Indian Tribes, Indian Health Programs and Urban Indian Organizations. Health Hoems were discussed at the March 4 and April 8, 2014 meetings. No e-mail comments were received.	

Indicate the key issues raised in Indian consultative activities:

Access

Summarize Comments

Summarize Response

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Asked at 4/8/14 Tribal Technical Assistance Group where to find Planning and Preparedness Tool. Asked at 4/8/14 Tribal Technical Assistance Group how SUD would be identified in the Health Home model.

Summarize Response

E-mailed information on where to find tool. E-mailed information about newly implemented SBIRT policy.

Benefits

Summarize Comments

Summarize Response

Service delivery

Summarize Comments

Summarize Response

Other Issue

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Submission - SAMHSA Consultation

- The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation:	
03/20/2014	(mm/dd/yyyy)

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Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

- Two or more chronic conditions**

Specify the conditions included:

- Mental Health Condition**
 Substance Abuse Disorder
 Asthma
 Diabetes
 Heart Disease
 BMI over 25

Other Chronic Conditions	
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- One chronic condition and the risk of developing another**

Specify the conditions included:

- Mental Health Condition**
 Substance Abuse Disorder
 Asthma
 Diabetes
 Heart Disease
 BMI over 25

Other Chronic Conditions	
---------------------------------	--

Specify the criteria for at risk of developing another chronic condition:

Clinical or claims-based information indicating:

Hypertension

Coronary artery disease

Depression

Substance Use Disorder

Non-compliance in taking medication regularly
in top 25th percentile of Lead Entity's risk stratification.

Tobacco use or exposure to second hand smoke

Missed quality of care indicators (no HbA1c or LDL or HDL/Tryglyceride levels in prior 12 months)

One or more serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

Health Homes services will be available statewide

If no, specify the geographic limitations:

By county

Specify which counties:

By region

Specify which regions and the make-up of each region:

By city/municipality

Specify which cities/municipalities:

Other geographic area

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

- Opt-In to Health Homes provider**

Describe the process used:

- Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

The Health Home Lead Entities will automatically enroll eligible members, using the State-determined, CMS-approved criteria. The Lead Entities will assign enrolled members to one of the LEs contracted Health Home Partners (HHP) and notify the member by a letter sent via United States Postal Service. Along with the letter, which will explain how members can opt out of health homes, will be a form to return if the member chooses to opt out. Members may also opt out by calling the State's Enrollment Broker.

- The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

- Other**

Describe:

- The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
- The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes**

Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.

- The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

- Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

- Physicians**

Describe the Provider Qualifications and Standards:

- Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

- Rural Health Clinics**

Describe the Provider Qualifications and Standards:

- Community Health Centers**

Describe the Provider Qualifications and Standards:

- Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

Home Health Agencies

Describe the Provider Qualifications and Standards:

 Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:
 Case Management Agencies

Describe the Provider Qualifications and Standards:

 Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards:

 Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards:

 Other (Specify)
 Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

 Physicians

Describe the Provider Qualifications and Standards:

The Lead Entity must ensure the HHP has at least one MD/DO on staff or contracted to support the Health Home in meeting the Provider Standards. The MD/DO must be actively licensed to practice medicine in Kansas. For children, pediatricians are preferred. A Physicians Assistant (PA) or Advanced Practice Registered Nurse (APRN) may be substituted in rural areas if the HHP can demonstrate the PA or APRN is employed by the HHP and the signed protocol from the supervising physician covers provision of Health Home services by the PA or APRN. The PA or APRN must be licensed to practice in Kansas.

Nurse Care Coordinators

Describe the Provider Qualifications and Standards:

The Lead Entity must ensure the HHP has at least one RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards.

Nutritionists

Describe the Provider Qualifications and Standards:

Social Workers

Describe the Provider Qualifications and Standards:

Care Coordinator

The Lead Entity must ensure the HHP has a Care Coordinator to support the health home in meeting the provider standards and deliver health home services to enrollees. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.

Behavioral Health Professionals

Describe the Provider Qualifications and Standards:

Other (Specify)

Provider	
Name: <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Provider Qualifications and Standards: <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>	
Name: Health Home Partner (HHP) Provider Qualifications and Standards: The HHP must: Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements. 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 Centre Community Service Provider for people with intellectual / developmental disabilities (I/DD) Federally Qualified Health Center/Primary Care Safety Net Clinic	

Provider	
Home Health Agency Hospital based Physician Group Local Health Department Physician based Clinic Physician or Physician Practice Rural Health Clinics Substance Use Disorder Provider	
Name: Lead Entity Provider Qualifications and Standards: The Lead Entity must: 1. Maintain a valid certificate of authority as a Health Maintenance Organization from the Kansas Insurance Department 2. Have NCQA accreditation for its Medicaid managed care plan 3. Must have authority to access Kansas Medicaid claims data for the population served. 4. Must have a statewide network of providers to service member with CC. The Lead Entity must maintain a network of providers to support the enrollees Health Care team based upon the individual enrollees health care needs, including but not limited to Nutritionists, Pharmacists, Dietitians, licensed addictions Counselor, LTSS Provider or a Parent Support Specialist who has a child with a mental illness or substance use disorder, etc. The provider must meet Kansas Licensing requirements as appropriate. 5. Must have the capacity to evaluate, select and support providers who meet the standards for HHPs, including: Identification of providers who meet the HHP standards Provision of infrastructure and tools to support HHPs in care coordination Gathering and sharing member-level information regarding health care utilization, gaps in care and medications Providing outcome tools and measurement protocols to assess HHP effectiveness Developing and offering learning activities that will support HHPs in effective delivery of HH services	

Health Teams

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

Medical Specialists

Describe the Provider Qualifications and Standards:

Nurses

Describe the Provider Qualifications and Standards:

Pharmacists

Describe the Provider Qualifications and Standards:

Nutritionists

Describe the Provider Qualifications and Standards:

Dieticians

Describe the Provider Qualifications and Standards:

Social Workers

Describe the Provider Qualifications and Standards:

Behavioral Health Specialists

Describe the Provider Qualifications and Standards:

Doctors of Chiropractic

Describe the Provider Qualifications and Standards:

Licensed Complementary and Alternative Medicine Practitioners

Describe the Provider Qualifications and Standards:

Physicians' Assistants

Describe the Provider Qualifications and Standards:



Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

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

Description:

Kansas will support providers of HH services concerning the above listed components by:

1. Requiring Lead Entities to have statewide networks of providers; evaluate, select and support providers who meet the HHP standards; developing and offering learning opportunities to HHPs; and reviewing and approving plans by HHPs to implement EHRs and connect to HIEs.
2. Supporting the initiation of a Learning Collaborative that will assist providers to become HHPs and to participate in quality improvement activities designed to improve performance of the HHPs and outcomes for the HH members. This Learning Collaborative will consist of a combination of statewide and regional meetings, webinars, teleconferences, a monthly newsletter and the States Health Homes webpage.
3. Development of a Health Homes Program Manual to provide clear guidance to both LEs and HHPs about expectations for both.
4. Holding provider training webinars twice each month from February through June 2014.
5. Holding regional provider training meetings in six cities April 2-9, 2014.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

The State elects to use the team of health professionals model for health homes. The Lead Entities (LE), will be responsible for providing health homes in partnership with a variety of providers (Health Home Partners HHP). The Lead Entities already contract with for Medicaid services.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

The KanCare Health Home Lead Entity must:

1. Must maintain a valid certificate of authority from the Kansas Insurance Department
2. Must have authority to access Kansas Medicaid claims data for the population served
3. Must obtain NCQA accreditation by June 2014 for its Medicaid managed care plan
4. Must have a statewide network of providers to service members with Chronic Conditions
5. Must have the capacity to evaluate, select and support providers who meet the standards for HHPs, including:

- a. Identification of providers who meet the HHP standards
- b. Provision of infrastructure and tools to support HHPs in care coordination
- c. Gathering and sharing member-level information regarding health care utilization, gaps in care and medications
- d. Providing outcome tools and measurement protocols to assess HHP effectiveness
- e. Developing and offering learning activities that will support HHPs in effective delivery of HH services
- f. Reviewing and approving plans for HHPs to implement EHRs and connect to a certified, HIE state.

The KanCare Health Home Partner must:

6. Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements
7. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls
8. 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
9. Have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals
10. Agree to accept any eligible enrollees, except for reasons published in the Kansas Health Homes Program manual
11. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the HHP on care coordination and hospital / ER notification
12. Commit to the use of an interoperable EHR through the following:
 - a. Submission of a plan to the Lead Entity, within 90 days of contracting as a HHP, to implement the EHR
 - b. Full implementation of the EHR within a timeframe approved by the Lead Entity
 - c. Connection to one of the certified state HIE, KHIN or LACIE, within a timeframe approved by the Lead Entity

The Lead Entity and the Health Home Partner jointly must:

13. Provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees
14. 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
15. 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
16. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy
17. Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers
18. Demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner.
 - a. Coordinate and provide the six core services outlined in Section 2703 of the Affordable Care Act
 - b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines
 - c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
 - d. Coordinate and provide access to mental health and substance abuse services
 - e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
 - f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
 - g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level
19. Demonstrate the ability to report required data for both state and federal monitoring of the program

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Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

Fee for Service

PCCM

PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.

The PCCMs will be a designated provider or part of a team of health care professionals.

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

Fee for Service

Alternative Model of Payment (describe in Payment Methodology section)

Other

Description:

Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.

If yes, describe how requirements will be different:

Risk Based Managed Care

The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:

The current capitation rate will be reduced.

The State will impose additional contract requirements on the plans for Health Homes enrollees.

Provide a summary of the contract language for the additional requirements:

Other

Describe:

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

The contract amendment describes these requirements for the Lead Entities:

Providing a statewide network of HHs in partnership with community health care provider types identified by the State to assure that all six core HH services are provided to HH members and that there is a choice of at least two HHPs covering each county Identifying and assigning members to HH, including receiving and evaluating referrals from community providers Handling requests to opt back in to HHs and requests to change HHPs Sending assignment lists to HHPs and indicating which payment level the HH member is in Recruiting and training HHPs, assuring that they meet the HHP and joint Lead Entity and HHP requirements detailed in the State Plan and HH Program Manual Providing bidirectional methods for data sharing between the Lead Entity and HHPs, including clinical care alerts and population management tools Collecting quality information and reporting on HH quality measures to the State Paying HHPs for HH services out of the PMPM the Lead Entities are paid by the State Dedicating no less than one FTE to HH management, to serve as a State contact and participate in regular meetings with the State and stakeholders Meeting all Lead Entity and joint LE and HHP Requirements Participating in the HH Learning Collaborative to promote best practices and process improvement in HHs Submitting encounters to the State through its fiscal intermediary in order to receive a HH PMPM for each HH member monthly; the PMPM will only be made if a HH service was provided by either the Lead Entity or HHP Following all federal and State requirements for HHs described in the Kansas Medicaid State Plan and relevant federal statutes

The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

The State intends to include the Health Homes payments in the Health Plan capitation rate.

Yes

The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**

- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.

The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.

No

Indicate which payment methodology the State will use to pay its plans:

Fee for Service

Alternative Model of Payment (describe in Payment Methodology section)

Other

Description:

Other Service Delivery System:

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

Fee for Service

Fee for Service Rates based on:

Severity of each individual's chronic conditions

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

Capabilities of the team of health care professionals, designated provider, or health team.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

Other: Describe below.

Rate Development Process

In developing the Health Home rates for Kansas, we relied on multiple actuarial assumptions. These assumptions were estimates of the impacts of various components of the rate development methodology. Multiple sources of program-specific information, industry information, were relied upon to ensure that these assumptions were well-informed, unbiased, and as accurate as possible. We also reviewed the rates of other states already implementing Health Homes to benchmark the overall reasonableness of the assumptions and the resulting final rates.

The following outlines the steps in developing the Health Home rates:

• Target Population

• Professional Costs

• Service Utilization for the following set of core benefits:

o Comprehensive Care Management

o Care Coordination

o Health Promotion

o Comprehensive Transitional Care

o Individual and Family Support

o Referral to Community and Support Services

• Non-Medical Loading

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to

determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Target Population

The target populations outlined in this methodology letter for the Kansas Health Home program are members with diabetes and/or asthma and who are at risk of developing one or more of the following chronic conditions based on clinical or claims-based information:

- o Hypertension
- o Coronary artery disease
- o Depression
- o Substance Use Disorder
- o Non-compliance in taking medication regularly
- o Top 25th percentile of Lead Entity's risk stratifications
- o Tobacco use or exposure to second hand smoke
- o Missed quality of care indicators (no HbA1c or LDL or HDL/Tryglyceride levels in prior 12 months)

The state used a four-leveled approach to capture the different levels of need in this population. These levels of need will differ by service and are discussed below in service utilization.

Professional Costs

The costs associated with providing Health Home services surrounds the staffing of the Health Home, and involves the three following professionals: physician, nurse care coordinator, and social worker. For determination of salary costs, the state utilized the Occupational Employment Statistics database from the Bureau of Labor Statistics, which outlines the Kansas specific annual salary for these professionals. The cost associated with physicians is on a per visit basis for the services they provide. All other professional costs are based on an annual salary with a burden rate for additional costs associated with payroll taxes, worker's compensation and health insurance, paid time off, training and travel expenses, vacation and sick leave, pension contributions and other benefits.

After determination of professional costs, the state determined the appropriate mix of staffing professionals required to provide each of the core services. This was accomplished to calculate an average hourly rate which would then be utilized to determine total costs of providing the service based on utilization.

Service Utilization

The Health Home rates are developed under the assumption that a payment will only be made once a service is utilized, and will be paid once per month regardless of how many services are provided in that month.

For the services provided by the physician, a per visit rate was used to determine overall costs. Members with a higher level of need may require additional visits with this professional. For example, a member assigned to level 1 may require 1 visit per month while a member assigned to level 3 may require 1.5 visits per month.

For those services provided by nurse care coordinators and social workers, the previously determined staff hourly rate as well as a projected number of hours per month was used to determine overall costs. For example a member assigned to level 1 may require only .75 hours per month while a member assigned to level 3 may require 1.25 hours per month.

The total cost for each of the core services, for each level, includes the visits with the physician at the per/visit cost and the number of hours/month spent with each of the other professionals at the hourly rate.

Non-Medical Loading

The non-medical load measures the dollars associated with components such as administration, profit, IT, costs associated with electronic health records (EHR), and telephone calls and is expressed as a percentage of the Health Home rate.

Conclusion

The Health Home program has been developed to implement better coordination of care for members with chronic health conditions. There are six core services included in the Health Home: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, Referral to Community and Support Services. These six core services will be provided by the following health care professionals: Physician, Nurse Care Coordinator, and Social Worker.

Health Homes Rates may also be found at:

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

Per Member, Per Month Rates

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Incentive payment reimbursement

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

PCCM Managed Care (description included in Service Delivery section)

Risk Based Managed Care (description included in Service Delivery section)

Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)

Tiered Rates based on:

Severity of each individual's chronic conditions

Capabilities of the team of health care professionals, designated provider, or health team.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

Rate only reimbursement

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

If a member in the HH receives case management through TCM in the State Plan, the member can choose between the TCM or the HH. HHs will provide services equivalent to TCM. HHPs will be expected to contract with or hire staff who meet Kansas qualifications for I/DD TCM.

- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**
- The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Attachment 3.1-H Page Number:*

Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

- Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:

Comprehensive care management involves Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from a HH, and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the members physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), Health Home partner (HHP), member, family/support persons/guardian, and health services and social service staff. Critical components of comprehensive care management include

Knowledge of the medical and non-medical service delivery system within and outside of the members area

Effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers Ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc.

Monitoring and follow-up to ensure that needed care and services are offered and accessed

Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances

These services are more robust and do not duplicate what is currently offered by Lead Entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

Both the Lead Entities and the HHPs will utilize certified health information exchange (HIE) networks including the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE) to share patient health information across various health home provider settings. MCO and HHPs must meet this HIT standard within 18 months to participate in health homes. A portion of potential HHPs currently do not use EHRs. These organizations will be required to develop a plan to implement EHRs within the specified time frames outlined in provider standards.

Details of the health action plan will be documented in the EHR to facilitate the sharing of patient needs across health home providers.

The use of HIT via established networks will ensure that providers are updated on changes to patients' health action plans and care requirements. HIT will allow for the continuous monitoring of patient outcomes and the appropriate changes in care and follow up.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurse Care Coordinators from the Lead Entity or HHPs

Nurses

Description

Medical Specialists

Description

Physicians

Description

MD/DO at Lead Entity or HHP

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Care Coordinator at HHP

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners
Description

 Dieticians
Description

 Nutritionists
Description

 Other (specify):
Name

Description

Care Coordination
Definition:

Care coordination is the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a members progress towards achievement of goals, and revising the HAP as necessary to reflect the

members needs. Care coordination
 Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the members goals
 Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care
 Involves coordination and collaboration with other providers to monitor the members conditions, health status, and medications and side effects
 Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports
 Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact
 Creates and promotes linkages to other agencies, services, and supports
 These services are more robust than, and do not duplicate, what is currently offered by Lead Entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

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

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurse Care Coordinators at the Lead Entity or the HHP

Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Care Coordinators at the HHP

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists
Description

 Other (specify):
Name

Description

Health Promotion

Definition:

Health promotion involves engaging members in HH care by phone, letter, HIT and community in reach and outreach, assessing members understanding of health condition/health literacy and motivation to engage in self-management, e.g., how important is the persons health status to the member, how confident the member feels to change health behaviors, etc., assisting members in the development of recovery plans, including self-management and/or relapse prevention plans, linking members to resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on member needs and preferences, and assisting members to develop the skills and confidence that will enable them to independently identify, seek out and access resources that will assist in managing and mitigating their conditions, and in preventing the development of secondary or other chronic conditions. Health promotion Encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health Places a strong emphasis on self-direction and skills development, engaging members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment Ensures all health action goals are included in person centered care plans provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions based upon the members preference Offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations.

These services are more robust than, and do not duplicate, what is currently offered by Lead Entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

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

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurse Care Coordinators at the Lead Entity or HHP.

Nurses

Description

Medical Specialists

Description

Physicians

Description

MD/DO at the Lead Entity or HHP.

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Care Coordinators at the HHP.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Health Homes Services (2 of 2)

Category of Individuals CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:

Comprehensive transitional care is specialized care coordination designed to facilitate transition of treatment plans from hospitals, ED, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. It may also involve identifying members not participating who could benefit from a HH. Comprehensive transitional care involves developing a transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. For each HH member transferred from one caregiver or site of care to another, the HH coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation. Comprehensive transitional care involves collaboration, communication and coordination with members, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers. It is designed to ease transition by addressing the members understanding of rehab activities, LTSS, self-management, and medications. It includes scheduling appointments scheduling and reaching out if appointments are missed. It may also include evaluating the need to revise the HAP. The transition/discharge plan includes, but is not limited to, the following elements timeframes related to appointments and discharge paperwork follow-up appointment information medication information to allow providers to reconcile medications and make informed decisions about care medication education therapy needs, e.g., occupational, physical, speech, etc. transportation needs community supports needed post-discharge determination of environmental (home, community, workplace) safety These services are more robust than, and do not duplicate, what is currently offered by the Lead Entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

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

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Care Coordinators at the HHP.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Lead Entity

Description

Network of other supporting providers.

Individual and family support, which includes authorized representatives

Definition:

Member(mbr)& family support involves identifying supports needed for mbrs, family/support persons/guardians need to manage mbrs conditions & assisting them to access these supports. It includes assessing strengths & needs of mbrs, family/support persons/guardians, identifying barriers to mbrs highest level of health & success, locating resources to eliminate these barriers,& advocating on behalf of mbrs, family/support persons/ guardians, to ensure that they have supports necessary for improved health. Included in this service is assistance to complete paperwork, provision of information & assistance to access self-help & peer support services,& consideration of the family/support persons/guardians need for services such as respite care. To promote inclusion,consideration is given to accommodating work schedules of families,providing flexibility in terms of hours of service,& teleconferencing. The goal of providing member & family support is to Increase mbrs,family/support persons & guardians understanding of effect(s)of the condition on the mbrs life,& improve adherence to an agreed upon treatment plan, with the ultimate goal of improved overall health & quality of life. Mbr & family support Is contingent on effective communication with mbr, family, guardian, other support persons, or caregivers Involves accommodations related to culture, disability, language, race, socio-economic background,& non-traditional family relationships Promotes engagement of mbrs,family/support persons & guardians Promotes self-management capabilities of mbrs Involves ability to determine when mbrs, families/support persons,& guardians are ready to receive & act upon information provided,& assist them with making informed choices Involves an awareness of complexities of family dynamics,& an ability to respond to mbr needs when complex relationships come into play These services are more robust than,& do not duplicate, what is currently offered by the Lead Entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

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

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurse Care Coordinators at the Lead Entity or HHP.

Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Care Coordinators at the HHP.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Referral to community and social support services, if relevant

Definition:

Referral to community supports and services includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paper work, identifying natural supports if services providers are unavailable in the members community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible. Community supports and services include long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. Referral to community and social support services involves

A thorough knowledge of the medical and non-medical service delivery system within and outside of the members area

Engagement with community and social supports

Establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc.

Fostering communication and collaborating with social supports

Knowledge of the eligibility criteria for services

Identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.

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

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurse Care Coordinators at the Lead Entity or HHP.

Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

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Pharmacists

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Care Coordinators at the HHP.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
To be provided separately.

Medically Needy eligibility groups

- All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
 - All Medically Needy receive the same services.**
 - There is more than one benefit structure for Medically Needy eligibility groups.**

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Attachment 3.1-H Page Number:*

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

The State will use Lead Entity claims/encounter data to track the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days; may include analysis of condition-specific readmissions.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

Year 1 (YR1) PMPM savings calculation: The average PMPM over YR1 for members who utilized a HH for at least 4 continuous months, or a minimum of 5 months in the first year. This will be called Actual YR1 HH PMPM & will be calculated separately by eligibility group, Chronic Condition (CC) & region. The average PMPM over YR1 will be calculated for members who didn't participate in a HH for the minimum of 4 continuous months, including those who opted out. This will be called the Actual YR1 Non-HH PMPM & will

be calculated separately by eligibility group, CC & region similar to the Actual YR1 HH PMPM. The difference of (Actual YR1 Non-HH PMPM Actual YR1 HH PMPM) is the PMPM savings. This PMPM will be adjusted to account for changes in the PMPM not due to participation. A trend analysis on 18 months of experience under KanCare, before the implementation of HHs will be performed for members in the Actual YR1 HH PMPM & for members in the Actual YR1 Non-HH PMPM. These analyses will be used to project what the average PMPM over YR1 would have been for both groups had HHs not been implemented & will be split within each group by eligibility, CC & region. These will be called Projected YR1 HH PMPM & Projected YR1 Non-HH PMPM. The difference of (Projected YR1 Non-HH PMPM Projected YR1 HH PMPM) will account for savings or costs in the PMPM savings calculation not due to implementing HH's. The final YR1 PMPM savings calculation: (Actual YR1 Non-HH PMPM Actual YR1 HH PMPM) (Projected YR1 Non-HH PMPM Projected YR1 HH PMPM). A positive PMPM indicates achieved PMPM savings. Because of the lack of data for members new to both HH's & Medicaid, the PMPM savings calculation for these members will be the difference between those who didn't enroll in HH's & those who did: (Actual YR1 Non-HH PMPM Actual YR1 HH PMPM). Significant savings won't be realized until YR3 due to time needed to get systems in place, stabilize utilization & continue to identify HH target populations.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The Lead Entity will provide IT infrastructure and program tools to the Health Home Partners in order to facilitate collaboration. These capabilities include, but are not limited to, patient screening and risk stratification, and a web-based profile that integrates Medicaid claims, patient self-reported information, and clinical documentation. The Lead Entity will be responsible for sharing health utilization and claims data with the Health Home Partner network to facilitate care coordination and prescription monitoring for members receiving health home services. Each Lead Entity will have a member website available to health home enrollees, their families and supports. It will contain evidence-based information on conditions, health promotion and wellness information, and links to resources.

Lead Entities Must:

- 1) Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers
- 2) 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

Health Home Partners Must:

- 1) Commit to the use of an interoperable EHR through the following:
 - a. Submission of a plan, within 90 days of contracting as a HHP, to implement the EHR
 - b. Full implementation of the EHR within a timeframe approved by the Lead Entity
 - c. Connection to one of the certified state HIE, KHIN or LACIE, a timeframe approved by the Lead Entity.
- 2) Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers
- 3) 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

Quality Measurement

- The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**
- The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

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Evaluations

- The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure: Hospital Admissions Measure Specification, including a description of the numerator and denominator. HEDIS specifications (Inpatient General Hospital/Acute Care) Data Sources: Claims Frequency of Data Collection: <input type="radio"/> Monthly <input type="radio"/> Quarterly <input checked="" type="radio"/> Annually <input type="radio"/> Continuously <input type="radio"/> Other <input style="width: 100%;" type="text"/>	
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Emergency Room Visits

Measure: Emergency Room Visits Measure Specification, including a description of the numerator and denominator. Visits/1000 Cost/Visit N = Avoidable ED visits, defined as ED visits for Ambulatory Care Sensitive Conditions (CMS Definition: ACSC conditions are medical conditions for which physicians broadly concur that a substantial proportion of cases should not advance to the point where hospitalization is needed if they are treated in a timely fashion with adequate primary care and managed properly on an outpatient basis.) Data Sources: Claims Frequency of Data Collection: <input type="radio"/> Monthly <input type="radio"/> Quarterly <input checked="" type="radio"/> Annually <input type="radio"/> Continuously <input type="radio"/> Other <input style="width: 100%;" type="text"/>	
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Skilled Nursing Facility Admissions

Measure: Skilled Nursing Facility Admissions	
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<p>Measure Specification, including a description of the numerator and denominator.</p> <p>Numerator Number of nursing admissions for each of the MCOs prior to the implementation of health homes</p> <p>Denominator Total number of Medicaid members meeting the health home criteria for each of the MCOs</p> <p>Numerator Number of nursing admissions for each of the MCOs after the implementation of health homes</p> <p>Denominator Total number of Medicaid members meeting the health home criteria for each of the MCOs</p> <p>Data Sources: State and MCO claims data</p> <p>Frequency of Data Collection:</p> <p><input type="radio"/> Monthly</p> <p><input type="radio"/> Quarterly</p> <p><input checked="" type="radio"/> Annually</p> <p><input type="radio"/> Continuously</p> <p><input type="radio"/> Other</p>	
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Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates

Medicaid claims and encounter data will be assimilated to determine hospital admission rates in categories established through NCQA HEDIS specifications. Rates and costs will be compared for the pre- and post-program period for enrollees in a Health Home and those not in Health Home.

Chronic Disease Management

The state will use a combination of claims, administrative, and qualitative data to calculate performance measures consistent with best practice to monitor the management of chronic diseases/conditions.

The measures may include the following quality measures as proposed elsewhere in the SPA:

- HbA1C testing
- LDL-C screening
- BMI assessment
- Blood pressure control
- Tobacco use screening
- Inpatient admissions
- 30-day readmissions
- Ambulatory care sensitive admissions
- Medication management

Coordination of Care for Individuals with Chronic Conditions

Care coordination is the implementation of a single, integrated health action plan (with active client involvement) through appropriate linkages, referrals, coordination, collaboration, and follow-up to needed services and supports. Care coordination should assist in the attainment of the individuals goals and improvement of chronic conditions. It should be provided timely, and address needs agreed upon with the individual.

Care Coordination for individuals with chronic conditions will be assessed through the Health Homes quality goals and measures identified in this SPA. This may include evaluation of the level of clinical integration of care, utilization of services, and assessment of identified metrics for clinical outcomes for Health Homes participants.

Assessment of Program Implementation

Implementation will be monitored through processes developed by the State Medicaid Agency, Lead Health Home Entities, and Health Home Partners. These processes will incorporate review by the previously established Health Home Focus Group, comprised of State representatives, managed care entities, direct service providers and various interested stakeholders. Initial program implementation activities to be monitored include: agreements established

between community based organizations and Lead Entities, data source is the reported number of agreements by type of community based organization (CMHC, FQHC, etc.), and geographic coverage area. Additional process measures may include: the number of individuals enrolled in Health Homes, number of core health home encounters; health service encounters by type of provider; and number of Health Home enrolled individuals with recorded data on core health status indicators. An engagement rate is proposed to be the number of individuals with at least one Health Home service encounter in the month in comparison to all individuals enrolled in health homes. Additionally, the State will obtain stakeholder feedback through a variety of survey methods and utilize data reporting and evidence-based decision making to assess implementation of the program. An evaluation plan will include these findings as well as a comprehensive implementation strategy and applied modifications necessary to execute the program.

Processes and Lessons Learned

An evaluation that includes provider and patient input on the Health Home program will inform the state on ways to improve the process. This evaluation may include focus groups and targeted consumer and provider surveys. As more successful Health Homes are identified using clinical and claims data, implementation guidelines and suggestions will be documented and used for training additional Health Home providers to further promote success statewide. The State will meet at least quarterly with participating Health Home Partners, and other stakeholders as needed, to gather input on the programs success and challenges. A Learning Collaborative will be convened and will be utilized as necessary to glean feedback and lessons learned from a broad array of interested parties.

Assessment of Quality Improvements and Clinical Outcomes

To assess quality improvements and clinical outcomes, the State will collect clinical and quality of care data for the CMS Core Set of Measures and state-specific quality goals. This assessment may include a combination of claims, administrative, and qualitative data. Where possible, Kansas will utilize metrics where benchmark data is available, such as HEDIS (Healthcare Effectiveness Data and Information Set). Data are to be compared to state and regional benchmarks and collected through defined quality processes.

Estimates of Cost Savings

The State will use the same method as that described in the Monitoring section.

If no, describe how cost-savings will be estimated.

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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.