

Health Homes Webinar  
February 25, 2014  
Program Manual & Documents List

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Moderator: Sonja Armbruster – Public Health Initiatives Coordinator, WSU Center for Community Support & Research

Sonja:

(In progress)...last two Tuesdays of each month through the spring and are intended to highlight tools and resources that are available for all potential Health Home Partners. Just a few quick housekeeping items. We are recording this webinar to be posted on the KDHE website for later viewing, so please assure that your phone is on mute and that you do not place us on hold at any time during the presentation. The webinar is available from last week on the KDHE/KanCare website. So, if you would like to see the webinar, if you would like to see the slides, if you would like to read a transcript, all of those things are available on the Health Homes website on the KanCare website. So, you are welcome to find those there. I’d like to encourage you to take a look in the right hand corner of your screen...there’s a red arrow that maybe you need to click on, you will then have a column box out to the right. There’s a question box that appears on your desktop and this is the method that we will be using for asking questions during the presentation. You may type in your questions related to today’s discussion at any time and our staff will theme these and ask them of the panelists. I really encourage you to ask questions as soon as they come up so that, for you, so that we can be sure to get those questions asked during the conversation. Again, I would encourage you to mute your line, especially whoever just joined...thank you. Because of the large people...large number of people participating in the call, we will not be taking questions over the phone so your phones should remain on mute for the duration of the presentation.

Today’s presentation is given by Becky Ross, the Medicaid Initiatives Coordinator at KDHE’s Division of Health Care Finance. You can see that...(background noise)...so, there is someone talking who would benefit from muting their line. Thank you for that. And we are...hmmm...not advancing to the next slide. Hold on just a moment. (Caller comment & staff discussion regarding technical difficulty). Ok! So, welcome! Today’s agenda is to highlight the draft Health Homes Program Manual related to Serious Mental Illness and that same program manual will be very similar to the Chronic Disease SPA, for those of you who are interested in that. These two elements are very similar. And then, we will look at the documentation requirements from Section 11 and we will have time for Questions and Answers with Becky and with the MCO representatives. So, I’ll pass to you, Becky, and thank you so much!

Becky:

Thanks, Sonja. So, today we have several purposes. We really want you all to become familiar with the draft program manual and we’ll talk about why it’s “draft” until it’s actually published. We want you to increase your understanding about the Lead Entity role, the Health Home Partner, and the joint requirements for both of those. We also hope that you’ll learn about some of the requirements that we’re imposing upon the Lead Entities as they contract with the Health Home Partners. We’ll talk a little about basic claim submission and billing and, as Sonja mentioned, we’ll go over the documentation requirements table that is also in the manual. Next slide please:

## **Overview**

So, as Sonja mentioned we actually are doing two State Plan Amendments or 'SPAs' for the acute Health Home Population. We will have Health Homes for people with Serious Mental Illness and Health Homes for people with chronic conditions. And, they will each have their own Program Manual because there are some differences between the two programs. And they will each be in 'Draft' form until CMS finally approves our State Plan Amendment. But, we wanted to get them out there for you to begin working with. We are holding off on the Chronic Conditions (background noise)...

Sonja:

I'm sorry. Whoever's just joined please mute your line. Thank you!

Becky:

So we will have the Chronic Conditions manual out in draft form as soon as we have the payment information available for that. We really didn't want to put that out until we had some payment information. So, the differences between the two manuals...Basically, the target populations are different in how we define them, of course. There are some differences in professional requirements and there will be some differences in payment. But, as Sonja mentioned, there is a lot similarities. Next slide please.

So, things that are the same...there's a lot...there's a lot of stuff. The services that are defined are the same across the manuals. Health Home Provider or Partner requirements are the same. The assignment and enrollment process...and we're going to have a separate webinar about that at our next webinar. The referral process...which we will also talk about at the next webinar. Forms are the same across the two populations. Claims submission will be essentially the same. Grievances and appeals are the same and our HIT requirements and quality measures are the same. Next slide.

So, let's take a look at this draft manual for the SMI population. As I mentioned, we'll have the second manual out for Chronic Conditions as soon as we have some payment information that we can put in there. We are not going to talk about every section. In part, because some of those will be addressed at future webinars...like payment and assignment and referrals. If you want to follow the actual document, you can obtain that at the website listed there. Next slide.

So, just a couple of slides here to show you our website because we have added a lot to it, we've reorganized it, and hopefully, it is...it is useful to you all. If you go to the KanCare website and click where the red box is, you will get to the Health Homes page. Next slide.

And this is the front page for Health Homes. The box there for 'Providers', click there, and you should go to this next page that has been reorganized to list materials more easily for providers. So, if you click on 'Informational Materials for Providers', you'll get the various items that you can retrieve from that page. And, this is where we'll put all of our finished forms and other documents that providers need to be aware of. So, hopefully, you'll become familiar with this page and know where to go to get (cough). Next slide.

## **Section 1**

So, Section 1 is really review of the Health Homes model. It talks about information that you can sort of get a summary of related to the Federal requirements for Health Homes. We have some introductory material that's available on the website that will give you more information and then we'll...we also talk about the Health Home Services and Professional Requirements at a high level at that point. Next slide.

## Section 2

So, Section 2 lays out the specific requirements for the Lead Entities, the Health Homes Partner, and requirements that they both have to meet. So, Lead Entities, if you are not familiar with our Health Homes Model, are the Managed Care Organizations. (Cough) So, Amerigroup, Sunflower, and United are the three 'Lead Entities' for Health Homes. And, these requirements that you see on the screen are the ones that they specifically have to meet. So, we require them to have a valid certificate of authority; they are going to have to be NCQA accredited by the end of June of this year; they have the authority to access our Kansas Medicaid claims data for the population served - they have historical data that we've provided and, of course, since they pay claims, they have claims data that they collect. They also have to have a statewide network of providers which we require as a part of KanCare and they will certainly need that for Health Homes. Next slide please.

So, here we have laid out some things that we expect of the Lead Entity in terms of evaluating, selecting and supporting providers who will become Health Home Partners. So, we expect the Lead Entities to be able to identify providers who meet the standards; that they will help provide infrastructure and tools to support those Health Home Partners – and by that we mean, training, HIT support, a wide...sharing data...so, a wide variety of ways that the Lead Entities will support those Health Home Partners to be able to participate in care coordination; data gathering and sharing data at the member level is going to be critical so we expect the Lead Entities to be able to do that so that Health Home Partners can identify gaps. You know, track medications and other critical health information as their performing care coordination activities. We expect the Lead Entities to provide some tools for Health Home Partners to be able to report and measure their success, and, in turn, allow the Lead Entities to measure that success and report that to the State. I mentioned training activities, so...we...we will be working with WSU to launch a Learning Collaborative once Health Homes are implemented in July. We expect the Lead Entities to participate in that and to support Health Home Partners in that effort as well. We also expect the Lead Entities to provide other kinds of learning activities for the Health Home Partners. Next slide please.

Sonja:

This is Sonja, I'm just going to interrupt as we transition here. This is one last call to please mute your line to be sure that all can hear the presenter. Thank you.

Becky:

So, now the manual starts talking about Health Home Partner requirements and we've laid out a number of those as well. So, they...they're going to vary a bit between the SMI population and the Chronic Conditions population, but for the most part, they are going to be very similar. And, whether or not we are talking about the SMI population or the Chronic Conditions population, there are some specific requirements related to Targeted Case Management for any Health Home member who has an intellectual or developmental disability. And, essentially, that requirement is that if a person with I/DD wants to be in a Health Home, and they want to continue to have their current Targeted Case Management provider, the Health Home Partner must contract with their Targeted Case Management provider to provide similar services within the Health Home. (Background noise) Next slide please.

So, here we just talk about the various types of providers who can essentially be Health Home Partners. Being one of these providers doesn't guarantee that you could be a Health Home Partner but you start here. Basically, you meet the State licensing standards or Medicaid provider certification and enrollment requirements to be one of these many different providers. Next slide please.

So, you can see there is a long list of providers. You should know what group you fall into...some of you may fall into more than one group...and these are sort of standard Medicaid groupings, so you should know whether or not you're licensed to be one of these providers or you're enrolled as a Medicaid provider type as one of these providers. Next slide please.

So, in addition to being one of those many providers listed there, you have to enroll or be enrolled in the KanCare program and agree to comply with the KanCare program requirements because the Health Homes are going to be operated within the KanCare program. We also ask that you have engaged leadership who are willing to participate in the learning activities that I mentioned through the Learning Collaborative. And, this can include in person learning opportunities or calls that are regularly scheduled. It's also that Health Home Partners will be able to provide timely in-person care coordination. We do not expect Health Homes to simply do care coordination through the telephone. So, there is an expectation that actually, when necessary, meet with the individuals who are in the Health Home. Next slide please.

Health Home Partners will also have to be able to accompany Health Home members to critical appointments, when necessary. We don't expect that you would accompany everybody, every time. But there may be specific instances...for example, if you have somebody who comes into your Health Home as a new Health Home member and they don't have an established Primary Care Physician or provider, it might be appropriate for you to arrange an appointment for them with a PCP and accompany them to that first appointment so they understand how to interact with the provider, what questions they need to ask. You know, the provider may have some information that makes it difficult for the person to understand and they might need someone there with them. So, there are going to be cases where it is important for the member to actually have somebody from the Health Home accompany them. But, by no means, do we expect this to happen every time and for everybody. We also expect Health Home partners to agree to accept any eligible enrollees, except for reasons that we have outlined in Section 4 of this manual and for those of you who have the manual and might be following along, that starts on page 25 where we talk about refusal of member assignment and we've lined out some few specific reasons. For example, if I'm a pediatrician, I should be able to refuse an adult Health Home member. I don't serve adults, so it doesn't make sense for me to have one as a Health Home member. If I've reached capacity...maybe I can only serve 250 Health Home members and I'm at that capacity...I should be able to refuse. (Background noise). We will also allow Health Home Partners to refuse for other reasons but they are going to have to submit a refusal form that we are finalizing, and we'll talk about that at a future webinar, but, essentially the Health Home Partner would have to submit a refusal form when they refuse somebody that Lead Entity/MCO has assigned them. We also ask that Health Home Partners demonstrate some engagement and cooperation with hospitals in their area, and other core providers. So, if you are a Community Mental Health Center, we want to see that you are collaborating with hospitals and primary care practices...that you've reached out to them and helped them understand that you are planning to be a Health Home Partner and that you need to cooperate. You know, this could extend into having some formal agreement. We are not requiring that but there are, you know, some requirements for hospitals in particular, related to Health Homes, so it is important that the hospitals are aware of who the Health Home Partners are, who is wanting to become a Health Home Partner, so that they know who they need to be sharing information with. Next slide please.

Sonja:

Thank you, and as we transition this is another invitation to mute your line if you haven't already, thank you so much!

Becky:

So, now we get to some Health Information Technology requirements and (background noise) the State is really thinking of Health Homes in a number of ways, but, one of them is a way to transform the health care systems and one of the ways that we would like to transform the system is to get people moving toward a more robust use of Health Information Technology. So, to become a Health Home Partner, you must commit to the use of an interoperable Electronic Health Record. That simply means that your Electronic Record has to be able to connect to a Health Information Exchange or to share information to another entity. (Background noise) So, if it just resides on your server for your agency and it's not able to share information outside your agency, then it wouldn't be considered 'interoperable'. You'll notice there that we have some sub-requirements. Essentially, to start with, we expect you to have a plan within 90 days of contracting to become a Health Home Partner to implement an Electronic Health Record. And then, there are a couple of timelines after that. But, you would work with the Lead Entity, submit your plan, and say, as part of the plan, we are going to have full implementation of an Electronic Health Record by 'x' date – the Lead Entity will have to approve and agree to that. Same thing with connecting to the Health Information Exchange. We know this is a process, and we know that people are at different points in the process, so we want to allow some flexibility there. But, we also want people to understand that the ultimate goal is that our Health Homes will all be connected. That, eventually, they will all have interoperable EHRs and they will all be connected to the Health Information Exchange. Next slide please.

So, now we come to the joint requirements and these are requirements that we expect the Lead Entity and the Health Home Partner to meet and they can meet them at different times. So, for example, a Health Home Partner might not be able to meet one of these requirements, but as long as the Lead Entity can meet it at that point in time, that's acceptable. And, as I go through them, we'll pull out some examples to demonstrate that. Next slide please.

So, there's a whole list of things that I'm not going to go through all of them, but, the first one here – 24 hour, seven days a week availability – is a classic example of where the Lead Entity might be able to meet that and the Health Home Partner might not be. So, this could be the nurse line that MCOs all have. They all have 24 hour/seven day a week nurse lines that can provide information and assist members when they have an issue after hours. Some practices, some mental health centers, have 'crisis' lines; it can be an after-hours voice mail that directs people to another place for information or direct them to an urgent care clinic for emergency services or something similar. So, it could be a variety of things and these might, you know, be things that the Health Home Partner could do but, certainly the MCOs can do. Next slide please.

So, again, the more requirements that could be met by both or either at any given time. But, you'll note there, we expect integrated health action planning, person and family-centeredness, that's a thread that runs through all of the different requirements for Health Homes. Next slide please.

The data sharing agreement is going to be very important. So, it needs to be compliant, obviously, with all the Federal and State laws. But, sharing of information is critical to be able to coordinate care effectively. Next slide.

And I'm not going to go through...this is a long, long list and I think it's this slide, and the next slide, and maybe another one after it...but, these are requirements that come directly from CMS in the State Medicaid Director's letter for Health Homes. And, these are requirements that CMS expects all Health Homes to be able to meet, no matter what state the program is in. Next slide please.

And, so finally we get down to demonstrating an ability to report required data. Obviously, that's important. We have a lot of things that we have to report to CMS. We want the Lead Entities, the MCOs, to report things to us. We have to be able to measure effectiveness and the way to do that is to collect data. Next slide please.

### **Section 3**

Ok, so these are some things that we've outlined that we expect to see in contracts between the Lead Entities and the Health Home Partners. I've talked about limiting panels and this applies a lot to physician practices. They...they can serve, you know, so many thousands of people and they limit within that number to a certain number of Medicaid, a certain number of Blue Cross, or whatever...that's acceptable. We want the Lead Entities to note that in their agreements with you that you can limit it by panel size or to members that you are already serving – either one of those would be acceptable. Note, there in the second bullet, we're expecting that Health Home Partners should be able to provide those three things, or be very close to doing that at that time that they enter into contract agreements with the Lead Entities. We think those are important components of Health Home services. So, Care Coordination is key. Comprehensive Transitional Care is that working with people as they're coming out of the hospital and into the community and we think that capability for HIT is critical as well. Next slide.

### **Section 7**

(Background noise)

Sonja:

So, this is a good time to interrupt again...I'm sorry...just a moment...if everyone could mute their line, that could be very helpful for all, thanks! (Background noise)

Becky:

So, Health Homes is a bundled service. We talk about six services but, providing Health Homes services to people...we consider that a bundle. So, each service is not going to be provided...be billed for...like you're used to for other services in KanCare. So, it's important that you understand that concept and that will be in the agreement between the MCO and the Health Home Partner. The payment that the State makes to the MCO, or 'Lead Entity', will be a per member/per month payment and unless it's preapproved by the State, we expect that the payment to the Health Home Partner from the Lead Entity will also be a PM/PM. But...that final bullet applies as well. CMS expects that...that we will not pay for Health Home services unless at least one service has been provided during the month. So, you'll get a bundled payment, but you'll have to provide at least one service during the month to every member in order to receive that payment. Next slide.

So, we get to Section 7 of the manual, and here's where we talk about documentation...and we'll get to the table in a minute...but, note there in the bullet the billing code. That is the Health Home Service billing code that the State expects to see. So, as I mentioned, it'll be a bundled set of services – so, it doesn't matter whether you provided Health Promotion to John in the month of August, or you provided Care Coordination to John, or you provided all of the services. You would just bill for that one code and received that bundled payment. I've noted that you can go on the KanCare website, which will give you links to each of the three Lead Entity websites and you can get more information about billing. And, as they are working with you on the contract, they'll talk more about how they want you to bill or help them. Next slide.

## **Section 11**

So, again, as the Lead Entities are working with you, they'll lay out their expectations in their contracts, they'll have Provider Manuals, they'll have more specific information...but, they did work together to develop this table that lays out some things that they would expect to see as documentation that you provided that's specific Health Home services. Next slide please.

So, we've got the first three of the six services here and you can see we...there's some brief information there talking about what the MCOs will be looking for, generally, to see that you provided that service. For example, Health Promotion. They want to see some documentation that you've engaged the member in their care. You know, did you outreach? Did you send an email? Did you have a phone call? Did you have a meeting with them and share some information? That's going to be the evidence that they're looking for to demonstrate that you provided Health Promotion. Then that last column lays out the ways that they're going to try to assess that you're (background noise) using HIT to link services. So, you know, I mentioned email. Do you have documentation that you send a secure email to an individual and gave them some information about, you know, diabetes management. You know, for Care Coordination, do you have entries in your system – whether its patient notes, or whatever, distributed the Health Action Plan. You know, ways that you are using HIT to, you know, link Care Coordination to the other activities. Next slide.

And these are the next three services. It's the same layout. So, the middle column just gives you some general examples of documentation that the MCOs would be looking for. And, the far right hand column lays out some examples of what they would expect to see for Health Information Technology in terms of linking your services. So, again, Comprehensive Transitional Care...they're going to expect to see how this gets reflected in the Health Action Plan or Individual and Family Support, they want to see some assessment of the need, recommendations. So, they're going to want to see things in your record – both paper and electronic – to document that performed each of these services. Next slide.

## **Appendices**

So, finally, I just want to point out that we have four appendices to the manual, so far. Appendix A is still sketchy because we need to get some more specific contact information in there for each of three MCOs and we are hoping to hire a Health Homes manager here at the State level and we would put that contact information in there. We have given you in the draft manual some State contacts that you can contact for specific questions and so, we have laid out those areas. Appendix B will have all of our forms. I would encourage you, though, to access the forms directly from the website to get forms that are going to be fillable. You know, the manual is in .pdf and so the forms are not going to work if you try to fill them out electronically. We tried to make all of our forms fillable documents. Appendix C is a table that lays out all of our goals and measures for quality. And, then Appendix D has some resources – mostly websites – that we're sharing with you. And, I think that's it.

## **Questions**

Sonja:

Ok. Excellent! Thank you, Becky Ross, for a walk through of some of the important elements of the Program Manual and some of the many resources that folks might want to access. With the time that we have remaining, we would like to be able to provide answers to some questions that you all might have. This is a wonderful opportunity for you to have access to a number of experts who want to answer your questions. So, we encourage you to submit them to...to the 'Question' box on your screen through the webinar software.

So, we have two questions about the 'panel'. One is, "What is a panel? This was discussed in the section discussing the Lead Entity contracts with the Health Home Partner." So, what does the word, 'panel', refer to? Becky?

Becky:

Well, 'panel', it's really more of a term for...on the physical health side. So, if I'm a physician...I'm a primary care doc and I can serve, you know, based on my time and how my office works, I can serve, you know...I don't know...12,000 patients. That's my total panel. But then I generally break that up into 'I can serve so many Medicare, so many Medicaid, so many Blue Cross'...you know, by insurer/major insurer type. I may limit my Medicaid panel to 3,000 of that 12,000. So, when we talk about a Health Home Partner can limit their Health Home membership to a 'panel', I could say 'I only serve 3,000 Medicaid patients, so I don't want my Health Home membership to go above that.' I could also say, 'I just want to serve a thousand Health Home members because they are going to take more time and I just don't have all the resources to do more than that.' So, it really applies to the...for the physical health care providers. But, the same sort of thing can happen on, for example, the community mental health center side. They have a certain number of resources that they know can serve a certain number of clients. So, they could also limit the number of Health Home members that they want to serve. And, as the MCOs or 'Lead Entities' are reaching out to you and you are having those discussions, that's going to be very important. They're going to want to know how many you think you can serve. What your capacity is. Not just necessarily today, but as we move towards July 1<sup>st</sup>, how many do you think you can serve?

Sonja:

Ok. So, that links to two of the other questions that have been raised. One of them was related to the Preparedness and Planning Tool and it relates to what you were just answering there, Becky. It was, "Should we answer that tool...should we answer those questions based on our current clients, the projected number of clients that we know are eligible in our area, or the number we believe the PM/PM will support?"

Becky:

Well. (Laughter) I think you could answer it with all three. I mean, I think we're going to be flexible on the tool. You know, the MCOs are going to want to know what you can do now, but, they also to want to know what your capacity is. So...and I think as agency heads, you have a fiscal responsibility...so, you need to think about what the payment will support as well.

Sonja:

And that relates to another question related to the 'panel', which was, "Is it accurate to state that a Health Home Partner could be a sole source provider in terms of limiting their panel to only the individuals they currently serve?"

Becky:

That is a possibility. However, if you serve a small number of consumers, it may be unlikely that the Lead Entity would be interested in contracting with you because we're requiring them to have a statewide network and to be able to serve, essentially, maximum 75,000 people between the two populations. But, I do know that the MCOs are not...are not completely averse to working with providers who want to serve a particular population.

Sonja:

Ok. We have several questions coming in – which is great. And, we have several folks on the line who can help assist with answering some of these questions. One is very specific to a numbered slide, which asks, “On page 17 of the slides, where do the CMHCs fall?” Becky, do you need us to go back to that page or do you have that handy?

Becky:

Is that the list of...yeah, you might need to go back.

Sonja:

Yeah, we’ll go back.

Becky:

Go up one more slide and I think that you will see where they fall. (Pause) They’re right there, ‘Community Mental Health Center’.

Sonja:

Ok. So, it was just a...that was an easy one...

Becky:

So, as a Community Mental Health Center, you would fall under that list.

Sonja:

Great. “Please clarify, ‘Health Home eligibility’ for KanCare members with dual mental health and substance use disorders.” “Does it matter which diagnosis is considered primary for placement in a Health Home?”

Becky:

No. No. So, there will be people who will have both diagnoses and for those diagnoses, it doesn’t matter whether the SMI diagnosis is first or second.

Sonja:

Also, “If a member qualifies for both SMI and the Chronic Disease Health Home, which one will be the defaulted one for enrollment?” And, is that a question for this call?

Becky:

(Background noise) Basically, the MCOs, as they mine their data and they see all the issues that the person has and the providers that they’re seeing, the MCOs will make the call. They will default the person to one or other of the Health Homes. However, CMS has made it very clear that people can choose – not only their Health Home Partner, but they can choose which type of Health Home –either SMI or Chronic Conditions – that they want to be in. But the MCOs will make their assignments based on the data that they have and using that data to see...to determine what they think is the most appropriate assignment. But, the member has the right to choose the different Health Homes.

Sonja:

Thank you very much. A couple of more questions. One is, “Do we have specific diagnoses that will be served with the Chronic Conditions Health Plan?” So, what are the chronic conditions included in the second SPA?

Becky:

Well, those are outlined on the website and I encourage you all to go out and get the draft State Plan Amendments that are out there. I know they're kind of difficult to wade through because they're in an electronic format but...that CMS requires us to use...but that contains all the information to date that we have determined for the SPA. But, there's also specific information about each target population out there. So, for the Chronic Conditions SPA, those are people who have asthma or diabetes, AND are at risk for one of several other chronic conditions. And I'm going to do this off the top of my head... So, they might be a smoker or live with a smoker. They might have a substance use disorder. They might have hypertension. They might have coronary artery disease. And, then we also have some clinical indicators. So, somebody could have diabetes but it's not very well controlled. So, they're not getting the blood work done or they're not getting their eyes checked or, you know, many of those indicators that we look for in diabetes. Same thing with asthma. They have asthma, but it's not well controlled, so there's some clinical indicators that indicate that the asthma's not well controlled. And, I should also say, for diabetes, we're also including pre-diabetes and metabolic syndrome, because we think that it's important to reach people early.

Sonja:

Thank you, Becky, for that answer. There's another question that I think relates to the Planning and Preparedness Tool. The question is, "Thank you for the presentation. Will the Lead Entities be reaching out to providers already in their network to serve as Health Home Providers? Or is it the responsibility on the location (I guess, the provider) who wants to be a Health Home Provider?"

Becky:

Well, I know that the Lead Entities have been having some discussions with some providers in their networks. And, in some cases, they reached out and in other cases, it was the provider. I would encourage you to just reach out to the MCO directly. As you know from the webinar last week, we're collecting the tool and they will be forwarded on to the MCOs that you indicate you want to work with. And that will trigger interaction with the MCOs. But, certainly, feel free to contact your provider representative or anyone else at the MCO that you're used to working with, and let them know that you're interested and they'll share that information within their agency. (Background noise)

Sonja:

So, for you who are considering becoming a Health Home, you might mute your line. There are about four more questions that we have here. One is related to, "Will the role of the subcontractor (or the subcontracting roles) be explained in the manual or will that be explained in documentation from the MCOs?"

Becky:

Well. Let me see if I understand the question. When we talk about 'subcontractors', we talk about somebody who is contracting with the Health Home Partner. Who, in turn, then contracts with the MCO. So, if you are meaning somebody that subcontracts with a Health Home Partner, we're really not going to lay out specifics in the manual. That's going to be between the Health Home Partner and the subcontractor. The only...the only thing we've touched on there is the special relationship between the Targeted Case Management providers for people with I/DD. And, only there to say that they must be contracted with a Health Home Partner if the person wants to retain their Targeted Case Management Provider. And, there's also some information around payment that will be talked about at the payment webinar. But, the relationship between the Health Home Partner and the subcontractor is just that. It's between those two and we're not going to spell out any specifics in the manual.

Sonja:

Ok. This next question might be for the two MCOs that are on the line...and maybe all three are on and I'll invite you all to weigh in. The question is, "When will MCOs share their expectations of the Health Home Partners? For example, will there be specific assessment tools to be used?" (Pause) So, are there different expectations that the MCOs have of Health Home Partners that Health Home Partners don't already have access to, I think is the question.

Ben:

Well, this is Ben Pierce from United and I think I'll answer first if it's ok with everybody.

Sonja:

Yes, thanks Ben!

Ben:

I think, right now, we're still working to resolve a couple questions surrounding some of the reporting and some of the NCQA implications for some of that reporting and oversight. So, I will say that there may be some additional information coming on that. But I think the basic structure of the program, the use of the HIT...I know each of the MCOs has solutions and assistance to provide in that arena. I'm not anticipating a whole lot of additional requirements beyond what's been outlined in the Preparedness and Planning Tool – as far as information goes. The completion of the Health Action Plan...we believe will be pretty seamless so I'm not anticipating too much additional work there. (Background noise)

Sonja:

Ok. Thank you! Leslie, did you want to weigh in as well?

Leslie:

Absolutely. Yeah, so, the vast majority of the required paperwork is most likely going to be provided on the State website and so we would encourage people to always refer back to the KanCare Health Homes website for any required paperwork or forms. And, much along the lines of United HealthCare's response, the vast majority of the information and function around Health Homes is going to be very similar across all MCOs and we'll all have Health Information Technology resources available to help facilitate all of those activities.

Sonja:

Thank you for those answers. A couple of questions have come in related to payment and we have another webinar focused on that. So, those questions will be captured and shared with KDHE but we're not going to address those during the call right now as this is focused on the manual and some of the understanding about eligibility. We have a question about, "Can members choose between Health Homes if they don't have a diagnosis or qualification for both? Such as, a member with a chronic condition and no SMI, could they choose to be in the SMI Health Home?"

Becky:

No. They have to...they would have to meet the target population definition for the specific Health Home. They can, however, choose between different Health Home Partners within the Chronic Condition Health Homes.

Sonja:

And...we have a question about, "Where can we access the information for the MCOs?" You want to put that slide back for us? Right there, you should be able to see on the screen, we have the contact information for the MCOs available there on the screen. Another question, "Is April 1<sup>st</sup> still the planning date for submission for the Planning and Preparedness Tool?"

Becky:

Yes.

Sonja:

Ok. And, there is another question related to member assignment but I'm going to just acknowledge that we see that question and that is the topic of the next webinar. And we'll make the answer to that as soon as possible. "Are any of the MCOs planning to provide any of the six core services themselves? Or can the partner provide all six?" is one of the questions. So, let me read that again and maybe tag team for the answer. "Are any of the MCOs planning to provide the six core services themselves? Or can a partner, a Health Home Partner provide all six?"

Ben:

This is Ben Pierce from United and I'll go ahead and lead things off again. There are some, what we would consider 'core business functions' that we are going to always hold on to. So, the assessment of our own members...doing health risk assessments, those types of things...we'll always retain. But, really, we do envision that some Health Home Partners will be able to do all six. There's not going to be a restriction and United HealthCare would not say, "We'll retain this service across the board and five would be the max for providers to do". Really, we're hoping that everybody out in the community can perform all six eventually.

Sonja:

Ok. Thank you. I'll pass to Leslie. Could a Health Home Partner provide all six? Or will one or more of those be something the MCO might focus on?

Leslie:

Right. Ben did a fantastic job of summarizing. All the MCOs agree that there are those three core services that Health Home Partners should be prepared to deliver, but really, it's more focused on partnership between the Lead Entity and the Health Home Partner. So, it's really...it's really much more important to understand that if a Health Home Partner is unable to provide one of the services, the Lead Entity should and would be able to help provide those services.

Sonja:

We have another questions related the two kinds of SPAs which is asking, "Could a Community Mental Health Center be a Chronic Conditions Health Home? That is, serve a person with a chronic condition, but who has no SMI diagnosis?"

Becky:

Potentially, yes. If they can meet the requirements on the Chronic Conditions side and they would have the professionals available that are spelled out in that SPA, presumably they could become a Health Home Partner for both types of SPAs.

Sonja:

Ok. Excellent. Well, we have a few more questions but they are not all specific to the Program Manual and the topic outline for today. They are captured and you can ask those questions and we will seek to answer those and have them placed on the KanCare website. So all questions have been captured and we look forward to providing the Q&A answers. If you are looking for the Q&A from last week, you can see those on the KanCare website now, along with the webinar from last week, and we'll work to get this webinar...the slides from this webinar and the Q&A made available to everyone in the coming week. Thank you all for participating in today's webinar and we look forward to talking with you all in a few weeks. Thanks so much!