

# MINUTES

## Health Homes Stakeholder Meeting

### Looking Back—Looking Forward

January 21, 2014 9:30-3:30 pm

Topeka & Shawnee County Public Library

1515 SW 10th Ave | Topeka, Kansas 66604-1374

- 9:30 Welcome, Introductions and Purpose of Meeting – CCSR
- 9:45 **Progress to Date** – Becky Ross
- Completing the 2<sup>nd</sup> year of planning, which began March 2012. SRS original conveners. Applied and received \$500,000 federal planning money.
  - Established a webpage
  - 2 state plan amendments with 2 target population definitions
  - Learning Collaboratives research
  - Health Homes Herald
  - Consumer education materials developed
  - Need to finalize the payment methodology, publish program manuals, hold consumer meetings
- 10:00 **Learning Collaborative: Lessons Learned** – CCSR
- Provided executive summary of learning collaborative report, and the full report is available on the KanCare website.
  - Key Findings: Stay focused on the purpose, Relationship with other components of health home implementation, Learning Collaborative participation, Topic Selection, Learning Collaborative Format
  - Decision Points: Design Team Development, Components, Format/Structure and Frequency, Who attends, Consumer Engagement
- 10:10 **Payment Methodology** – Mike Randol, KDHE
- The actuaries included a 28% burden rate – work comp, insurance, etc., and a 12% administrative rate
  - Draft rates were provided with two scenarios: Higher estimate – higher salary, Low Estimate – lower salary, median salary
  - Steering committee needs to approve the rates and CMS needs to approve the rates before they can be published.
  - A four tier pricing plan was described based services utilization by diagnosis type.
- 11:05 **Moving Forward: Plans for January - June 2014** – Becky Ross and Samantha Ferencik
- Several materials were shared that will be available as soon as they're finalized on the KanCare Health Homes website. These materials included:
- **Preparedness and Planning Tool:** The Preparedness and Planning Tool will be used for two distinct purposes. The first purpose is to help providers determine their understanding

of Health Homes services and requirements and serve as a roadmap for providers looking to become Health Home Partners (HHPs). The second purpose is to provide the MCOs some information to help them in their discussion with interested providers.

- The tool itself is 11 pages and guides potential health home partners in a self-assessment of readiness to provide the six core services that are essential elements of Health Homes.
- Agencies who want to be a Health Home provider beginning July 1, 2014, need to completed the Preparedness and Planning Tool by April 1.
- **Requirements:** The KanCare SMI Health Homes Services (description of all six requirements) and Professional Requirements (description of qualified practitioners) were provided and discussed. Additionally, the KanCare SMI Health Homes Provider Requirements, a form that outlines the roles and requirements of the Lead Entity (MCOs) and Health Home Partners, were presented and reviewed.
- **Health Action Plan:** The form itself and instructions on how to use the form were reviewed and discussed.

1:45 **MCO Coordination Efforts** – Bob Spadaccini, Amerigroup (representing all three MCOs)

- All 3 MCOs met with KDHE and developed a 15 page design document.
- The purpose is to assure coordinated efforts for the enrollment process, change of a HH, integration for long term service support, delivery of services, etc.
- 6 core services – MCO may be providing some of the services or a HHP may be providing all services
- Outcome of document – 20 or 30 decisions still needed to be made after report was completed.
- Operations workgroup and technical workgroup were developed to continue the coordination work.

2:30 Post July 1, 2014: SPA 2: Focusing on Asthma and Diabetes – Theresa Shireman, KDHE

- Slides were presented and are available
- 14,000 children have asthma on Medicaid
- 4,000 adults have asthma on Medicaid
- 1,000 children have diabetes on Medicaid
- 18,000 adults have diabetes on Medicaid
  - at least 1/3 are overweight
- 35-40% of Medicaid households have a smoker – or secondhand smoke – this will be the primary driver to place the consumer in a HH

3:00 Post July 1, 2014: Learning Collaborative – CCSR

- Most states formalize the learning collaborative after the launch
- CCSR would appreciate individuals to join the LC design team – meet virtually and by phone

**Discussion Notes:** Participants were invited to use flipcharts in small group discussions to capture questions and comments about all presentations. These follow, with some theming. If answers were provided in the course of discussion, those answers are provided.

- **Looking Back – Initial Questions**

- **Consumer Education**

- Options education- How is that being handled? And who is handling this? Time frame? Opt out rule?
  - There will be consumer meetings
  - Brochure is developed on KanCare website
  - State is working on a booklet
  - There are printed material for the consumer education meetings
  - Consumer will receive a letter who is their HH but have the opportunity switch
  - Members can opt out at any time
- Ensuring consumer education is done in a conflict free manner.
- Consumer education – when will this begin?

- **Rate/PMPM**

- More clarification on tiers, high plus low.
- How do service limits impact the placement in the 4 tiers?
- Salary: How was CPS calculated related to all TCM case managers?
- Are peer support services still allowed to be billed outside HH/PMPM?
- How would a provider determine if the MCO offered PMPM rate is actuarially sound?
  - Rate MCO pays to provide is negotiated with the HHP.
  - The KDHE requirement is that the rate from the MCO to the HHP be reasonable, not necessarily actuarially sound.
- What kind of guidance is the MCO's receiving regarding the PMPM rate?
- How rate calculation relates to staffing patterns.
- How does PMPM relate to cost-based accounting for FQHCs?
- Can we use billing codes and HH for medical providers?
- How do tier rates equate to 6 core services?
- Which cohort in each tier?
- Why such difference between tier 3/ 4?
- Is there a draft for the PMPM for both SPA's
- How was the salary for the peer support workers captured?

- **Other**

- Learning Collaborative – confused on the next steps of the learning collaborative. Feels like this is a crucial piece and need more clarification
- Need tight deadlines
- Which cohorts (of the 54) not included?
  - CHIP, Autism
- Will there be any additional credentialing requirements?
- How many partners do the MCO plan to have per area?
- Can HH partners contract out portions of the services?
  - Yes
- What is the potential number of HH providers?

- In terms of a team within the HH partner agency – is there any thought who facilitates the process?
  - Care coordinator would perform that function within the HH partner
- With medical services – does the HH structure limit the billing codes?
- **What do you like about the Health Action Plan and process?**
  - Seems clear and like that its electronic.
  - Electronic Tool
  - HAP like short plan with drop down boxes.
  - Data we already collect
- **What idea do you have for improving the Health Action Plan and process?**
  - How does this relate to other assessments? So we don't duplicate other assessments.
  - Is this document required? What if we have an existing tool that hits all these requirements?
  - HAP Instructions- Will the guardian of the child be involved in the HAP.
  - Frequency of review of HAP?
  - How do sign an electronic document?
  - Section 3: When it says select provider is that who is filling it out?
  - Section 3: What's that line to the right? Name of provider?
  - Section 4: Existing "waiver" plan?
  - Should specify member signature required?
  - DX "history" r/t just "DX" but SBIRT could be done by CM= section 3 ok hybrid-need clarification.
  - Which of 6 core services do MCO's want to provide?
  - Clarity- All MCO's will contract with providers even if they don't do /arrange for all 6 services-depending on needs of area of state.
  - Is HAP to be submitted in paper form or electronic format?
  - Would documentation of completion of the HAP be sufficient?
  - How involved are psychiatrist/dr. involved in the development HAP?
  - Would a dr. be involved each time. Don't understand about dr. role.
  - Where is it housed? Part of EHR?
  - Does physician include PA/Mid-level providers?
  - How and who defines area of choice?
  - Getting confused – care coordinators taking the lead how do you get input from other providers?
- **What questions do you have about the Preparedness and Planning Tool?**
  - Doesn't encourage honesty
  - If you answer yes, how? Need more clarification
  - Indicate services that are not available in your area.
  - What is your current capacity?
  - What support would you need to build capacity?
  - KHIN- What about participants/members who opt out? Can a member opt out of the HIE?

- HIT/EHR- What will be needed? Just have one or will there be some Health Homes specific reporting?
  - Page 12 – HH Provider Standards – Can we dig deeper into this section?
  - Will all the MCO's contract with providers that don't meet all the 6 services?
  - Page 6 of the PPT tool – opening paragraph has a few mistakes
  - Is the PPT only completed by the HHP and not the sub-contractors?
  - Under electronic MR discussion – if you don't have this what types of support do you need to complete this?
- **What questions do you have about the SMI Health Home Provider Requirements?**
    - What is the “interoperability” requirement for the EHR?
    - How will this apply to practices who limit their panel?
    - How do you define population from CDDO- we don't provide treatment
    - #6 – how will this be limited to practices who count?
    - Could an LMHT provide the role of the nurse care manager?
  - **What else do we need to be ready for July 1, 2014?**

#### **Consumer Items**

- Educational meetings need to be close within 1 hour radius to have consumers and families attend.
- Need to explain what a HH is to consumers, community

#### **Rates/PMPM**

- Chronic Disease SPA rates
- Service model information used by actuaries to determine rates (how much provided by what providers per month).
- Methodology for billing services codes by/for service? (bill by facility code or provider)?
- Confirm the rate

#### **Training/Documentation/Education for providers/HIT**

- Education regarding the eligible population in each county?
- Outcomes to be achieved by the HH?
- Training on MCO software?
- 6 core service provider training
- Need additional clarity on HIT- from, state but mostly from MCO's.
- Need to explain to providers sooner rather than later. (Print materials)
- Education- cm, self advocates, KDADS
- Send out potential HH prep tools out
- Need comprehensive manual that is updated frequently.
- Recording and documentation training

#### **Other**

- Assignment by MCO?
- Role of PA in Health Homes?
- Any out of state providers willing to offer advice or guidance?
- Increased involvement of P.C.

- Provider plus MCO on the ground interaction.
  - Discussion Re Quality outcome requirements.
  - CMS approval timeline
  - Opportunity to discuss contracting and negotiation between MCO and HHP's to include fiscal.
  - Names of MCO contacts (and contact) information who will negotiate contracts?
  - Can HHP limit who served by tier or just overall?
  - Updated data on population by county
  - Health outcomes expected in aggregate.
  - Determine incentives for exceptional performance.
  - Clarify difference between PCMH and HH participation.
  - In CC SPA assignment of HHP may dictate a change in PCP. How do we address this potential conflict?
  - MCO's need to decide if there will be minimum services HHP's provide.
  - How is this communicated with KDADS
  - Develop/ prepare HH network
  - Clarification MCO need to develop their model and let potential partners know expectations.
  - Need to address potential duplication FFS vs. Health Home.
  - Need to consider if providers in Oklahoma, Missouri can be HH's.
  - Start assessing for the need for state wide capacity
  - Get the providers to complete the PPT and turned in by April 1
  - HHP sub-contracting and/or networking for affiliate providers
  - Operational issues – how to submit a claim? What is an encounter?
  - What are the remedies for disagreements? Appeal process?
  - What is the HHP role in disagreements?
- **How can we best use the time when we meet again to prepare during this next six months?**
    - Like small group discussions
    - Ongoing feedback
    - MCO's vision
    - Split by service population type specific= KDHE MCO
    - Room per group and answer specific questions.
    - Definite answers and policies in place
    - Clarity of the MCO decisions and the state decisions
    - What can the HHP decide, MCO decide and state, and what does the member themselves decide
    - Specific timelines and due dates
    - Share the workflow and workplans – before the next meeting
    - Clearly define boundaries for services
    - How many HHP partners have completed the PPT?
    - Are the lead entities ready to launch?
    - Can they present the workplan before the next meeting?