OneCare Kansas (OCK) Program Manual

A Program of KanCare, Kansas Medicaid

Kansas Department of Health and Environment

January 16, 2024

Version 2024 - 1

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Preface

The purpose of this Manual is to provide Medicaid policy and billing guidance to providers participating in the KanCare OneCare Kansas (OCK) Program. It is intended to provide:

- Instructions about how to become a OneCare Kansas Partner (OCKP)
- Guidance about OCK services
- Information relating to billing procedures
- Links to additional information

Policy statements and requirements governing the OCK Program are included. The Manual is formatted to incorporate changes as additional information and periodic clarifications are necessary.

Before rendering service to a consumer, providers are responsible for familiarizing themselves with all KanCare procedures and regulations, currently in effect and those issued going forward, for the OCK Program. The OCK Program is an optional service under the Kansas Medicaid State Plan.

*Note: Although every effort has been made to keep this program manual updated, the information provided is subject to change. Medicaid program policy concerning OCK may be found on the OCK page of the **KanCare website**.*

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Introduction

Statutory Authority of OCK

The goal of OCK is to improve care and health outcomes, lower Medicaid costs, and reduce preventable hospitalizations, emergency room visits and unnecessary care for Medicaid members.

Health Homes (called OneCare Kansas in our state) is an option afforded to States under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 allows states under the state plan option or through a waiver, the authority to implement health homes effective January 1, 2011. The purpose of Health Homes is to provide the opportunity to States to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness. States approved to implement Health Homes will be eligible for 90 percent Federal match for health home services for the first eight (8) fiscal quarters that a health home state plan amendment is in effect.

State Medicaid Director Letter: Health Homes for Members with Chronic Conditions

State Medicaid Director Letter (SMDL), #10-024, Health Homes for Enrollees with Chronic Conditions, provides preliminary guidance to States on the implementation of Section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Members with Chronic Conditions." For additional information, please refer to the **State Medicaid Director's letter**.

On _____, 2019 the US Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) approved Kansas' State Plan Amendments (SPA) #____ for individuals with serious mental illness (SMI).

As of November 15, 2019, the State of Kansas announced a launch date of April 1, 2020, for the OneCare Kansas program.

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Section 1: The OCK Service Model

1.1 Overview of the OCK Model

OCK is a care management service model where all the professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all the services a member requires to optimize member health. It is anticipated that the provision of appropriate care management will reduce avoidable emergency department visits and inpatient stays and improve health outcomes. With the member's consent, health records will be shared among providers to ensure that the member receives needed unduplicated services.

The OCK model of care differs from a Patient-Centered Medical Home (PCMH). The PCMH is a model of care provided by physician-led practices. The physician-led care team is responsible for coordinating all the individual's health care needs and arranging for appropriate care with other qualified physicians and support service providers. The Federal Patient Protection and Affordable Care Act anticipates that the OCK model of service delivery will expand on the traditional medical home model to build linkages to other community and social supports and to enhance coordination of medical and behavioral health care, with the focus on the needs of persons with multiple chronic illnesses.

1.2 Federal OCK Population Criteria

OCK services are provided to a subset of the Medicaid population with complex chronic health and/or behavioral health needs whose care is often fragmented, uncoordinated, and duplicative.

This population includes categorically, and medically needy beneficiaries served by Medicaid managed care or fee-for-service and Medicare/Medicaid dually eligible beneficiaries who meet Health Home criteria. Individuals served in a Health Home must have at least two chronic conditions; or one qualifying chronic condition and be at risk of developing another; or one serious mental illness. The chronic conditions described in Section 1945(h)(2) of the Social Security Act include, but are not limited to, the following:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Overweight as evidenced by a body mass index (BMI) of 25
- HIV/AIDS
- Other Chronic Conditions

Note: As of November 2012, Health and Human Services (HHS) announced HIV/AIDS as an additional diagnosis to the list of qualifying chronic conditions.

1.3 Federal Core Health Homes Services

The OCK service delivery model is designed to provide cost-effective services that facilitate access to a multidisciplinary array of medical care, behavioral health care and community-based social services and supports for individuals with chronic medical and/or behavioral health conditions. OCK services support the

provision of coordinated comprehensive medical and behavioral health services through care coordination and integration. The goal of these core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT), and avoid duplicative or unnecessary care.

Section 1945(h)(4) of the Social Security Act defines Health Home (called OneCare Kansas in our state) services as "comprehensive and timely high-quality services" and includes six services to be provided by designated Health Home (OneCare Kansas in our state) providers. Services include:

1. Comprehensive care management.
2. Care coordination.
3. Health promotion.
4. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
5. Individual and family support, which includes authorized representatives; and
6. Referral to community and social support services if relevant.

1.4 Federal OCK Partner (OCKP) Functional Requirements

The OCK model of service delivery supports the provision of timely, comprehensive, high-quality OCK services that operate under a whole person approach to care. The whole-person approach to care addresses all the clinical and non-clinical care needs of the individual. Section 1945(b) of the Social Security Act requires providers of OCK services to address/provide the following functional components.

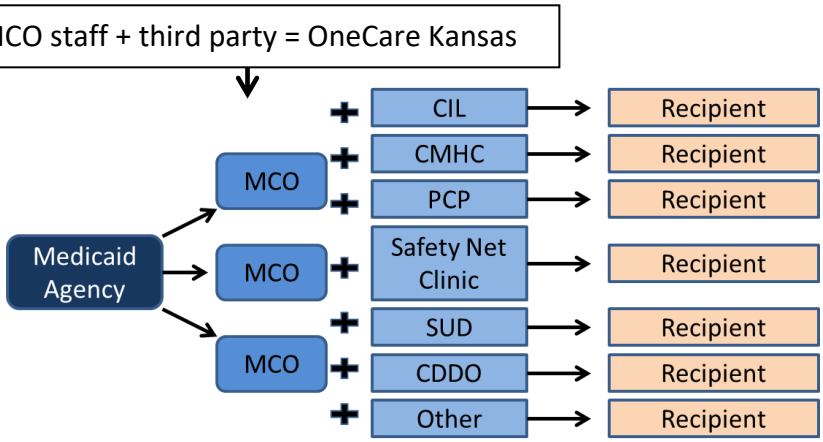
1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered OCK services.
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
3. Coordinate and provide access to preventive and health promotion 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 everyone that coordinates and integrates all 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; and

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.

Additional information regarding Federal Functional Requirements may be accessed **here**.

1.5 OCK Model

The Kansas model is a partnership between the managed care organization (MCO) and another entity (OCKP) that is appropriate for the consumer as in this diagram, modified from a similar one published by the Center for Health Care Strategies in the brief *Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System* by Dianne Hasselman and Deborah Bachrach (June 2011):



This model offers the greatest flexibility for providing OCK services within the KanCare managed care framework, while still supporting existing relationships between members and the community providers they may have experience with and preferences for. Such flexibility is 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.

In this model, the three KanCare managed care organizations (MCOs) will serve as the Lead Entities (LEs) for OCK and will contract with community providers to be OCKPs. The OCKPs will provide all OCK services and the MCO will not provide any direct services in this model. The contracts between the LEs and the OCKPs will spell out service and quality reporting expectations as well as payment.

1.6 Target Population for OCK

The Kansas legislature issued a proviso in January 2019 that tasked KDHE with reinstating a Health Homes program in Kansas. Though the details of the proviso are subject to change should the legislature choose to make such changes, the following language served to initiate the program's launch as well as place parameters around the programs scope and approach. The text of the proviso has been condensed for clarity below:

> Expenditures shall be in an amount not to exceed $2.5 million from the State General Fund…to reinstate a program implementing state Medicaid services for health homes. [During the fiscal year ending June 30, 2019].
>
> Provided that participation in such program shall be:
>
> - On an opt-in basis and not based on automatic enrollment
> - Open to youth and adults

- Structured to ensure that individuals with a behavioral health diagnosis or chronic physical health condition are served
- Designed to allow any managed care organization providing the above services…to claim an administrative claiming rate no higher than 10%

To meet the expectations set forth by the legislature, the OCK population will include individuals who have:

- Schizophrenia, Bipolar Disorder, and/or Major Depressive Disorder
- Or individuals who have Asthma that also are at risk for developing:
  - Diabetes
  - Hypertension
  - Kidney Disease (not including Chronic Kidney Disease Stage 4 and ESRD)
  - Cardiovascular Disease
  - COPD
  - Metabolic Syndrome
  - Mental Illness (not including Schizophrenia, Bipolar Disorder, and Major Depressive Disorder)
  - Substance Use Disorder
  - Morbid Obesity (body weight 100lbs over normal body weight, BMI greater than 40, or BMI over 30 with obesity-related health problems)
  - Tobacco Use or exposure to secondhand smoke

A complete list of ICD-10 codes can be accessed on the OCK website at the provided link. The State hopes to add additional target populations to the OCK SPA in the future. Providers will be notified in various ways about these additions (i.e., provider bulletins, e-mail, OneCare Kansas web page).

1.7 Kansas Services and Professional Qualifications for OCK

The following table lays out the OCK staffing requirements listed on the OneCare Kansas Partner Application, which is available on the OCK website at the provided **link**. A link to the application can also be found in **Appendix B** of this manual.

Title	Currently on Staff	Hire Before Launch [a.]	Intend to Contract [c.]
Physician/Psychiatrist [b.]	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mid-level Practitioner (APRN or PA)	☐ Yes ☐ No	☐ Yes ☐ No	*Disqualifies Applicant*
Nurse Care Coordinator	☐ Yes ☐ No	☐ Yes ☐ No	*Disqualifies Applicant*
Social Worker/Care Coordinator	☐ Yes ☐ No	☐ Yes ☐ No	*Disqualifies Applicant*
Peer Support Specialist	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Peer Mentor	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Notes:

[a.] Required prior to MCO contract.

[b.] Having a physician or psychiatrist on staff satisfies the requirement for having a Nurse Practitioner or PA.

[c.] Select 'Currently on Staff' if a physician or psychiatrist is under contract and is physically on-site at least part-time.

The table on the subsequent pages contains the definitions of the six core services for the OCK program, along with the professional requirements associated with these six services.

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OneCare Kansas Services and Professional Qualifications

Service	Description	Professional Qualifications
Comprehensive Care Management	Identifies high-risk members who may benefit from OCK and coordinate their care with all team members. This includes conducting a comprehensive health needs assessment to determine the member's physical, behavioral health, and social needs, and developing a health action plan (HAP) with input from the member, family members, guardians, and service providers. The HAP includes member goals and clarifies the roles and responsibilities of all involved parties. Critical components include: • Having knowledge of both local and non-local medical and non-medical service delivery systems. • Practicing effective cultural, linguistic, and disability-appropriate communication with the member, family members, guardians, and service providers. • Addressing barriers to success, such as low income, housing, transportation, and social supports. • Monitoring and following up to ensure that needed care and services are offered and accessed. • Regular reviewing and updating of the HAP to reflect the member's current needs, the effectiveness of services in improving or maintaining health status, and other changes.	**Physician**: Must be actively licensed to practice medicine in Kansas. May be employed directly or contracted with the OCKP. See notes in Section V of the application for more information on contracting requirements. **Psychiatrist:** Must be actively licensed to practice psychiatry in Kansas. May be employed directly or contracted with the OCKP. See notes in Section V of the application for more information on contracting requirements. **Nurse Care Coordinator:** To meet the provider standards, the OCKP must directly employ at least one registered nurse (RN), advanced practice registered nurse (APRN), or licensed practical nurse (LPN) who is actively licensed to practice in Kansas. **Social Worker/Care Coordinator:** Care Coordinators must be employed directly by an OCKP and adhere to the requirements outlined in the Kansas Medicaid State Plan and Provider Manuals avalible on the OCK website. To meeting provider standards and serve OCK members, Care Coordinators must meet the following criteria: • Hold an active social work license (BSW) in Kansas; or • Have a bachelor's degree (BS/BA) in a related field; or • Serve as a Targeted Case Manager (TCM) specializing in mental health (MH) or intellectual and developmental disabilities (I/DD); or • Work as a substance use disorder person-centered case manager. **Physician Assistant (PA):** Must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner. **Advanced Practice Registered Nurse (APRN):** Must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner.

Service	Description	Professional Qualifications
Care Coordination	Implements the members HAP through various linkages, referrals, coordination, collaboration, and follow-up for the delivery of necessary services and supports. A designated Care Coordinator takes responsibility for managing the member's HAP, which includes referring, scheduling appointments, sharing information with all parties involved (including the member), monitoring Emergency Department (ED) and in-patient admissions for coordinated care transitions, communication during transitions of care and hospital discharge, referrals for Long-Term Services and Supports (LTSS), sourcing non-Medicaid resources, tracking the member's progress toward goal achievement, and adjusting the HAP as necessary to meet the member's needs. Care Coordination: • Ensures timely attention to member needs, improves chronic condition management, and supports goal achievement. • Encourages members to adhere to treatment recommendations, engage in self-care for chronic conditions, and stay engaged in OCK services. • Involves coordinating and collaborating with other providers to monitor the member's conditions, health status, and medication side effects. • Engages members and their family/guardians in decision-making, including decisions related to pain management, palliative care, and end-of-life decisions and supports. • Manages the HAP by assessing quality metrics, survey results, and service utilization, allowing for the evaluation of intervention effectiveness. • Creates and promotes connections to other agencies, services, and support resources.	**Nurse Care Coordinator:** To meet the provider standards, the OCKP must directly employ at least one registered nurse (RN), advanced practice registered nurse (APRN), or licensed practical nurse (LPN) who is actively licensed to practice in Kansas. **Social Worker/Care Coordinator:** Care Coordinators must be employed directly by an OCKP and adhere to the requirements outlined in the Kansas Medicaid State Plan and Provider Manuals avalible on the **OCK website**. To meeting provider standards and serve OCK members, Care Coordinators must meet the following criteria: • Hold an active social work license (BSW) in Kansas; or • Have a bachelor's degree (BS/BA) in a related field; or • Serve as a Targeted Case Manager (TCM) specializing in mental health (MH) or intellectual and developmental disabilities (I/DD); or • Work as a substance use disorder person-centered case manager.
Health Promotion	Engages members with chronic conditions through phone, letters, health information technology (HIT), and community in-reach/outreach. It assesses their understanding of their conditions, health literacy, and motivation for self-management, considering their health status and confidence in changing behaviors. Health promotion also helps members develop recovery plans, including self-management and relapse prevention. It connects members with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery, and other services based on their needs and preferences. Ultimately, health promotion	**Physician**: Must be actively licensed to practice medicine in Kansas. May be employed directly or contracted with the OCKP. See notes in Section V of the application for more information on contracting requirements. **Psychiatrist:** Must be actively licensed to practice psychiatry in Kansas. May be employed directly or contracted with the OCKP. See notes in Section V of the application for more information on contracting requirements.

Service	Description	Professional Qualifications
	empowers members to learn the skills and confidence they need to independently manage and prevent chronic conditions. Health promotion: • Encourages healthy behaviors to help members monitor and manage their health successfully. • Focuses on self-direction and skills development, involving members and family members/guardians in healthcare decisions. • Ensures all health action goals are part of person-centered care plans. • Provides health education and coaching on chronic conditions based on member preferences. • Offers prevention education on proper nutrition, health screening, and immunizations to members and family members/guardians.	**Nurse Care Coordinator:** To meet the provider standards, the OCKP must directly employ at least one registered nurse (RN), advanced practice registered nurse (APRN), or licensed practical nurse (LPN) who is actively licensed to practice in Kansas. **Social Worker/Care Coordinator:** Care Coordinators must be employed directly by an OCKP and adhere to the requirements outlined in the Kansas Medicaid State Plan and Provider Manuals avalible on the **OCK website**. To meeting provider standards and serve OCK members, Care Coordinators must meet the following criteria: • Hold an active social work license (BSW) in Kansas; or • Have a bachelor's degree (BS/BA) in a related field; or • Serve as a Targeted Case Manager (TCM) specializing in mental health (MH) or intellectual and developmental disabilities (I/DD); or • Work as a substance use disorder person-centered case manager. **Physician Assistant (PA):** Must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner. **Advanced Practice Registered Nurse (APRN):** Must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner.
Comprehensive Transitional Care	Helps members transition from hospitals, EDs, and inpatient units to their homes, LTSS providers, rehabilitation facilities, and other healthcare facilities. This process streamlines patient care, reduces frequent ED visits, and avoids unnecessary hospital stays. It may also involve identifying non-participating members who could benefit from this care. This includes the development of a transition plan in collaboration with the member, their family/ guardians, and other providers. This plan is then shared with all relevant parties. When transferring a member from one caregiver or care site to another, coordination is vital to ensure smooth transitions, timely follow-up care, and the accurate sharing of medication information. This approach involves effective collaboration, communication, and coordination among a diverse group of individuals involved in the member's care. The goal is to enhance members' comprehension of	**Physician**: Must be actively licensed to practice medicine in Kansas. May be employed directly or contracted with the OCKP. See notes in Section V of the application for more information on contracting requirements. **Psychiatrist:** Must be actively licensed to practice psychiatry in Kansas. May be employed directly or contracted with the OCKP. See notes in Section V of the application for more information on contracting requirements. **Nurse Care Coordinator:** To meet the provider standards, the OCKP must directly employ at least one registered nurse (RN), advanced practice registered nurse (APRN), or licensed practical nurse (LPN) who is actively licensed to practice in Kansas.

Service	Description	Professional Qualifications
	rehabilitation activities, LTSS, self-management, and medications. Additionally, this service involves managing appointments and evaluating the need for adjustments to the members HAP. The transition/discharge plan encompasses elements such as: • Timeframes for appointments and discharge paperwork. • Information about follow-up appointments. • Medication details for medication reconciliation and informed decision-making. • Medication education. • Therapy needs (e.g., occupational, physical, speech). • Transportation requirements. • Post-discharge community support. • Assessment of environmental (home, community, workplace) safety.	**Social Worker/Care Coordinator:** Care Coordinators must be employed directly by an OCKP and adhere to the requirements outlined in the Kansas Medicaid State Plan and Provider Manuals avalible on the **OCK website**. To meeting provider standards and serve OCK members, Care Coordinators must meet the following criteria: • Hold an active social work license (BSW) in Kansas; or • Have a bachelor's degree (BS/BA) in a related field; or • Serve as a Targeted Case Manager (TCM) specializing in mental health (MH) or intellectual and developmental disabilities (I/DD); or • Work as a substance use disorder person-centered case manager. **Physician Assistant (PA):** Must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner. **Advanced Practice Registered Nurse (APRN):** Must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner.
Member and Family Support	Identifies the necessary assistance for members and their family/guardians to manage the member's conditions and aiding them in accessing these supports. This involves evaluating the strengths and needs of members and their families, recognizing barriers to the member's health and success, finding resources to remove these obstacles, and advocating on their behalf to secure the essential support for improved health. This service also includes assistance with paperwork, providing information, access to self-help and peer support services, and considering the need for services like respite care. To promote inclusion, flexibility is provided in terms of scheduling, hours of service, and teleconferencing. The goal is to enhance the understanding of how the condition affects the member's life, improve adherence to treatment plans, and ultimately enhance overall health and quality of life for members, their families, and guardians. Member and family support: • Requires effective communication with members, families, guardians, and caregivers.	**Nurse Care Coordinator:** To meet the provider standards, the OCKP must directly employ at least one registered nurse (RN), advanced practice registered nurse (APRN), or licensed practical nurse (LPN) who is actively licensed to practice in Kansas. **Social Worker/Care Coordinator:** Care Coordinators must be employed directly by an OCKP and adhere to the requirements outlined in the Kansas Medicaid State Plan and Provider Manuals avalible on the **OCK website**. To meeting provider standards and serve OCK members, Care Coordinators must meet the following criteria: • Hold an active social work license (BSW) in Kansas; or • Have a bachelor's degree (BS/BA) in a related field; or • Serve as a Targeted Case Manager (TCM) specializing in mental health (MH) or intellectual and developmental disabilities (I/DD); or • Work as a substance use disorder person-centered case manager.

Service	Description	Professional Qualifications
	• Includes accommodations related to culture, disability, language, race, socioeconomic background, and non-traditional family relationships. • Encouragement of member and family/ guardian engagement. • Fosters self-management capabilities in members. • Assesses the readiness of members and families/guardians to receive and act on information and support informed choices. • Considers the complexities of family dynamics and responds to member needs when complex relationships come into play.	**Peer Support Specialist/Peer Mentor:** The Peer Support (PS) Specialist must comply with the specified KDADS Behavioral Health criteria for either mental illness or substance use disorder (SUD). For mental illness, the PS Specialist must meet the following requirements: • Be employed by a licensed Mental Health provider. • Satisfy age requirements. • Successfully complete state-approved training through a state contractor and undergo background checks. • Self-identify as a present or former primary recipient of Mental Health Services. For SUD, the PS Mentor must adhere to the following criteria: • Work for a licensed or certified SUD provider. • Meet age, training, and supervision requirements. • Self-identify as actively in recovery from alcohol and/or illicit substances for at least one year. If the PS Specialist is employed in the agency where the PS Specialist services are received, they must also fulfill discharge requirements, which entail having been discharged by that agency for a minimum of six months.
Referral to Community Supports and Services	Helps members identify the services they need to achieve their best possible outcomes. Find available community resources and assist members in accessing care. Aid in paperwork completion and identify natural supports if necessary. Ensure members have access to needed services and consider the preferences of family, support persons, and guardians when possible. These services encompass long-term care, mental health, substance use services, housing, transportation, and other community and social services required by the member. Referral to community and social support services involves: • Familiarity with local and regional service delivery systems. • Engagement with community and social supports. • Building and maintaining relationships with service providers, such as Home and Community Based Services (HCBS) providers, the Aging	**Nurse Care Coordinator:** To meet the provider standards, the OCKP must directly employ at least one registered nurse (RN), advanced practice registered nurse (APRN), or licensed practical nurse (LPN) who is actively licensed to practice in Kansas. **Social Worker/Care Coordinator:** Care Coordinators must be employed directly by an OCKP and adhere to the requirements outlined in the Kansas Medicaid State Plan and Provider Manuals avalible on the **OCK website**. To meeting provider standards and serve OCK members, Care Coordinators must meet the following criteria: • Hold an active social work license (BSW) in Kansas; or • Have a bachelor's degree (BS/BA) in a related field; or

Service	Description	Professional Qualifications
	& Disability Resource Center (ADRC), faith-based organizations, and others. • Collaborating with social supports and fostering communication. • Understanding eligibility criteria for services. • Identifying comprehensive resource guides or creating one if needed.	• Serve as a Targeted Case Manager (TCM) specializing in mental health (MH) or intellectual and developmental disabilities (I/DD); or • Work as a substance use disorder person-centered case manager. **Peer Support Specialist/Peer Mentor:** The Peer Support (PS) Specialist must comply with the specified KDADS Behavioral Health criteria for either mental illness or substance use disorder (SUD). For mental illness, the PS Specialist must meet the following requirements: • Be employed by a licensed Mental Health provider. • Satisfy age requirements. • Successfully complete state-approved training through a state contractor and undergo background checks. • Self-identify as a present or former primary recipient of Mental Health Services. For SUD, the PS Mentor must adhere to the following criteria: • Work for a licensed or certified SUD provider. • Meet age, training, and supervision requirements. • Self-identify as actively in recovery from alcohol and/or illicit substances for at least one year. If the PS Specialist is employed in the agency where the PS Specialist services are received, they must also fulfill discharge requirements, which entail having been discharged by that agency for a minimum of six months.

For specific health information technology (HIT) requirements related to each of the six core OCK services, please refer to Section 10 of this manual.

Certified Nursing Assistants (CNAs) and/or Medical Assistants (MAs)

The state will allow OCKPs to hire Certified Nursing Assistants (CNAs) and/or Medical Assistants (MAs) as support staff who would be under the direct supervision of a Nurse Care Coordinator (NCC). However, the CNAs and/or MAs cannot fill or replace the role(s) of any required OCK professionals. CNAs and/or MAs will only act as support/administrative type staff to the required Nurse Care Coordinator. CNAs and MAs will be able to perform certain tasks and duties in support of the NCC at the OCKP, but CNAs and/or MAs will not be allowed to bill in OCK since they are not an OCKP professional. Refer to Appendix G for more details on the tasks CNAs and/or MAs can and cannot perform.

1.8 OneCare Kansas Partner Team Meeting (OCKPTM)

OneCare Kansas partners need to have a documented policy/procedure in place for a OneCare Kansas partner team meeting (OCKPTM) that occurs on a regular basis; this meeting must occur quarterly at minimum. The purpose of this meeting is to discuss OCK members and program related issues, processes, and topics (i.e., rounds, case reviews, team huddle, the HAP, etc.). The OCKPTM will consist of OCK staff from multiple disciplines including, but not limited to, the nurse care coordinator (NCC) and the care coordinator (CC). Additionally, the OCKP must have and maintain documentation that demonstrates and supports the quarterly occurrences of the meeting. Examples of documentation must include, but are not limited to, meeting minutes and meeting agendas detailing meeting dates and times, meeting topics, as well as the first names, last names, and official roles of all meeting attendees.

Section 2: Provider Requirements for OCK Participation

2.1 Lead Entity Requirements

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 members of the target population; and
5. Must have the capacity to evaluate, select and support providers who meet the standards for OCKPs, including:
    a. Identification of providers who meet the OCKP standards.
    b. Provision of infrastructure and tools to support OCKPs 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 OCKP effectiveness; and,
    e. Developing and offering learning activities that will support OCKPs in effective delivery of OCK services.

2.2 OCKP Requirements

The licensing requirements for OCKPs vary, depending upon which category below they fall into. For OCK members, the OCKP must:

1. Meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following:
    a. Center for Independent Living
    b. Community Developmental Disability Organization
    c. Community Mental Health Center
    d. Clubhouses providing community mental health services
    e. Community Service Provider – for people with intellectual / developmental disabilities (I/DD)
    f. Federally Qualified Health Center/Primary Care Safety Net Clinic
    g. Home Health Agency
    h. Hospital – based Physician Group
    i. Local Health Department
    j. Physician – based Clinic
    k. Physician or Physician Practice
    l. Rural Health Clinics
    m. Substance Use Disorder Provider.
2. Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements.
3. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls.
4. Provide appropriate and timely in-person care coordination activities. Alternative communication methods in addition to in-person such as telemedicine, 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. Tele-video may also be used if a secure platform is being utilized. For more information please refer to **KMAP General Bulletin 20047** or **https://www.kmap-state-ks.us/Documents/Content/Provider/COVID-19.pdf**;
5. Have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals.
6. Agree to accept any eligible enrollees, except for reasons published in Section 4 of this Manual.
7. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the OCKP on care coordination and hospital / ER notification and be using an electronic health record.
8. Assist in identifying actionable health goals for the entire community based on current needs through collaboration(s) with other community providers.

2.3 OCKP Staff Roles and Responsibilities

OneCare Partners are encouraged to utilize existing staff to the degree appropriate, dependent on their caseload, within the OneCare framework. To illustrate how roles and responsibilities may be delegated to staff, please refer to **Appendix E** or the **OneCare Kansas Partner Professional Process Flow document** available on the OCK website.

OCKPs must have a documented policy/procedure in place for filing new and open positions, as well as a documented policy/procedure for covering the duties of any open positions; this includes any supervisory changes. OCKPs must ensure that staff are aware of the procedures and plans that are in place.

OCKPs must have a documented policy/procedure in place for regular performance evaluations. These evaluations must be completed for each staff member. OCKPs must ensure that staff are aware of the policies and procedures that are in place.

2.4 Lead Entity and OCKP Joint Requirements

For OCK, the Lead Entity and the OCKP must jointly meet several requirements. This means that one or the other must be able to meet the requirement at any one time.

The Lead Entity and the OCKP must jointly:

1. Provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees.
2. 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.
3. Ensure person and family-centered and integrated health action planning that coordinate and integrate all his or her clinical and non-clinical health care related needs and services.
4. Provide quality driven, cost-effective OCK services in a culturally competent manner that addresses health disparities and improves health literacy.
5. Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers.
6. 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; and,

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.

7. Demonstrate the ability to report required data for both state and federal monitoring of the program.

OCKP needs to communicate effectively, openly, and often with the MCO(s) regarding the program requirements. Therefore, if concerns arise, MCO(s) should be the first point of contact. OCKP needs to have a documented policy/procedure for when and how concerns are communicated to the MCO(s); policy/procedure should outline and explain how the organization will communicate with MCO(s). Contact with the MCO(s) could be done either telephonically or through e-mail. The document regarding the policy/procedure could include telephone numbers and/or e-mails of MCO contacts designated specifically for OneCare Kansas.

2.5 OCKP Application

Each potential OCKP must complete the OCKP Application and submit it to KDHE. The application is available on the OCK website at the provided **link**. A direct link to the application can also be found in **Appendix B** of this manual.

Within 21 calendar days of receiving State-approved Application, the MCOs must schedule a follow-up call with each interested OCK Provider and provide a written evaluation of their application. Not all applicants who submit the Application will be able to immediately become an OCK Provider. The written evaluation will indicate the MCO's assessment of the Application. After the follow-up call, the MCOs will have 10 days to provide potential OCK Providers with a contract amendment.

The potential OCK Providers will then have another 10 days to sign and return the contract amendment to the MCO. If at any point in this process the MCO or the applicant fails to meet a prescribed deadline as outlined above a 15-day grace period will take effect. If a final contract is not made within those 15 days, the provider will need to reapply.

Section 3: Lead Entity Contracts with OCKPs

3.1 State Requirements for Lead Entity Contracts with OCKPs

KDHE will require that contracts between the Lead Entities and OCKPs contain the following provisions:

- OCKPs can limit panels by the number of people they wish to serve in the OCK program, or to KanCare members already being served or in the provider's panel.
- The MCO will not retain more than 10% of the PMPM payment and will pass at least 90% to the OCKP.

KDHE will review the templates for contracts between the Lead Entities and the OCKPs. If a Lead Entity proposes a contract that employs a payment method other than a PMPM to the OCKP, KDHE will not only review the contract, but must approve it as well.

Within 21 calendar days of receiving State-approved Application, the MCOs must schedule a follow-up call with each interested OCK Provider and provide a written evaluation of their application. Not all applicants who submit the Application will be able to immediately become an OCK Provider. The written evaluation will indicate the MCO's assessment of the Application. After the follow-up call, the MCOs will have 10 days to provide potential OCK Providers with a contract amendment.

The potential OCK Providers will then have another 10 days to sign and return the contract amendment to the MCO. If at any point in this process the MCO or the applicant fails to meet a prescribed deadline as outlined above a 15-day grace period will take effect. If a final contract is not made within those 15 days, the provider will need to reapply.

3.2 Indicators of OCKPs Underperformance

The Lead Entities (MCOs) have jointly developed a list of situations that would signal to them an OCKP might be underperforming either in an OCK process or quality area. Each of the Lead Entities will also have specific performance indicators they may look at.

OCKP Underperformance Criteria - OCK Processes
Failure to maintain required staffing
Failure to provide services
Inadequate documentation on file for service delivery
Failure to submit timely and accurate claim for OCK service
Non-compliance with contract
Failure to implement an Electronic Health Record (EHR) at any stage
Failure to maintain OCK enrollee membership
No contact with enrolled members
Inadequate collaboration with other providers and/or Lead Entity (MCO)
Failure to submit data/reports as required
Failure to participate in training/meetings as required

OCKP Underperformance Criteria - OCK Quality
Poor or minimal documentation
Inadequate use of evidence-based guidelines or care guidelines
Care not provided in timely manner
Enrollee/member complaints
Lack of use of health information technology as provided by the Lead Entities (MCOs)
Insufficient evidence supporting holistic care (addressing all member needs)
Failure to targeted improvements on OCK Quality Goals (?)
Inadequate response to clinical needs of assigned members
Inadequate supports provided to member and/or providers during periods of transition of care

3.3 Member Transition Guidance upon Partner Contract Termination

To ensure uninterrupted service delivery upon the termination of an OCKPs contract, providers are encouraged to follow the steps outlined in the "OneCare Kansas Partner Termination Guidance: Managing Member Transitions for Continued Care" document. Below is a summarized version of these guidelines:

1. Provide advanced notice to both MCOs and affected members regarding the decision and effective date for terminating OCK services.
2. Communicate directly with members to discuss the upcoming changes and their options for continued care:
   - CCBHC Providers:
     - Reassignment to a new OCK provider with CCBHC services.
     - Reassignment to a new OCK provider without CCBHC services.
     - Opting out of OCK for CCBHC care coordination only.
     - Ensuring coordination for all referrals.
   - Other Providers:
     - Reassignment to a new OCK provider.
     - Opting out of OCK and exploring alternative care options.
     - Ensuring coordination for all referrals.
3. Collaborate with MCOs for transition, sharing relevant member information and facilitating referrals.
4. Coordinate with the new OCK provider for seamless care transition.

Providers should tailor the transition process to align with the specific needs and preferences of each member while maintaining consistent communication with all parties throughout the transition period. For more detailed guidance, please consult the **full document** available on the OCK website.

Section 4: Member Assignment, Enrollment and Disenrollment

4.1 Medicaid Eligibility Determination for OCK Members

To be eligible for OCK, a person must first be eligible for Medicaid. OCK is not available to children in the Children's Health Program (CHIP) portion of KanCare because OCK services are a State Medicaid Plan service. Eligibility for Medicaid is determined by state staff at either the KanCare Eligibility Clearinghouse or at Department of Children and Families (DCF)- for children in state custody.

Medically Needy Medicaid beneficiaries are eligible for OCK services only if the members spend down amounts are met for the applicable spend down periods.

4.2 Member Invitations & Opt-In

KanCare members who are determined eligible for Medicaid are notified of their eligibility for OCK by their MCO (OCK Lead Entity), based on information the Lead Entity already has from claims and other data, or because of a referral by a provider in the community. Members will have a choice of OCK Partners, but this choice may be limited by the member's geographic area and what existing relationship the member may already have with any OCKPs in their area. Members have the right to choose from among available OCKPs in their area, with certain limits.

When an OCK member is identified, the Lead Entity will send an invitation letter explaining:

- OCK and its benefits
- Why the member is eligible
- How to opt in to OCK

Opting in to OCK will be accomplished through completing and mailing in the Opt-In Form included with the assignment letter. If the letter is not returned, the Lead Entity will assume the person is not an OCK member. Members will be able to opt out at any time after the initial Opt-In Form is received.

Members who choose not to opt in to OCK will be reassessed annually by their MCO and another invitation letter will be sent at that time. If a member does not opt in to OCK, but later wants to join or one of their providers submits a referral form, the MCO will send another invitation letter whether or not a year has passed since the member originally was invited.

Any referrals from providers that result in identification of additional OCK members will result in invitation letters being sent the following month.

4.3 Member Invitations for Children in Foster Care

The decision to opt in to OCK will be the responsibility of the Department on Children and Families (DCF) foster care contractor who has been assigned the child's foster care case. Lead Entities will not accept opt in information provided by foster families. Lead Entities will also not accept requests for OCKP changes from foster families.

For foster care members who relocate, the MCOs will maintain existing OneCare Kansas member assignments until members have demonstrated stability in placement for at least six months. After six months of stable placement, youth in foster care will be reassigned to a local OneCare Kansas provider. All members will retain the right of choice--meaning, they may, after reassignment, ask for a different local OneCare Kansas provider through their foster care contractor.

Minimizing OneCare Kansas member reassignments while encouraging telephonic delivery will ensure stability and flexibility, enhancing our OneCare Kansas partners' ability to deliver OneCare Kansas services to some of our most vulnerable members. If any OneCare Kansas provider is unable and/or unwilling to deliver these services as described above, then the MCO will reassign the impacted member(s) to another OneCare Kansas partner who will meet the service delivery requirements.

4.4 OCKP Refusal of Member Assignment

An OCKP may not refuse to accept a member assigned by any Lead Entity with which the OCKP contracts for OCK services, except for some limited reasons. These reasons include:

- The member has been previously refused by the OCKP with applicable notice in writing provided.
- The member has not participated for two consecutive quarters.
- The member resides outside the geographic range served by the OCKP, e.g., a Community Mental Health Center.
- The member is outside the age range parameters established by the OCKP, e.g., a pediatrician is not required to serve adults.
- The OCKP has reached its capacity to provide OCK services.
- The member poses a danger to himself or herself, or to OCKP staff – the member will be assigned to a new OCKP.
- The OCKP is a Tribal 638/Indian Health facility and wishes to limit its OCK activities to Native Americans.

In cases where the Refusal Form is used for any of the above reasons, the Refusal Form shall be sent to the appropriate MCO. However, if an OCKP chooses to refuse a member for any other reason, not listed above,

the refusal must be approved by both the State OCK Manager and the Lead Entity. The OCKP must submit the reason for refusal on the OCKP Member Assignment Refusal Form to the State OCK Manager, copying the appropriate Lead Entity staff. The Refusal Form is available on the OCK website at the provided **link**. A link to the form can also be found in **Appendix B** of this manual.

Lead Entities must outline provisions for refusal to serve OCK members in their contracts with OCKPs and in their OCK provider manuals. These provisions must align with the information in this manual.

4.5 OCK Enrollment and Disenrollment

For operational purposes the Lead Entity may establish an internal timeline during which opt in information is expected to be returned; however, all parties need to be aware that opt in information can be submitted at any time. The Lead Entity will be responsible for informing OCKPs of the members assigned to each OCKP. This will be the signal to initiate contact with the member and begin the Health Action Plan process.

The Lead Entity will be responsible for handling any requests for a change of OCKP assignment at any time during the member's eligibility for OCK. A member must choose from available OCKPs in the Lead Entity's network which serve the area where the member lives.

Lead Entities are responsible for coordinating transfers of information when OCK members change KanCare MCOs, either during regular choice periods or due to good cause reasons. When members transfer MCOs, the MCOs will exchange member information including the Medicaid number, OCK chronic condition, OCK start date, provider name, provider start date, and diagnosis code. This information will be forwarded to the new MCO before the 1st of the following month.

If the OCKP is contracted with both the receiving and transferring MCO, there is no need for the member to select another OCKP. If the member's current OCKP is not contracted with the receiving MCO, the MCO should either work to contract with the current OCKP or help the member choose a different OCKP.

There will be reasons some OCK members are discharged from OCK. This includes the member having a catastrophic illness or event, like end stage renal disease that makes it unlikely the member will continue to benefit from OCK – the member will be ineligible for OCK services.

The Lead Entity will establish procedures it and the contracting OCKPs will follow when any of these situations occur so that the OCK member receives timely and clear communication, is dealt with equitably and is notified of any applicable appeal rights.

To officially request a discharge or disenrollment for a member from the OCK program, the OCKP must submit a completed OCK Discharge Form to the Lead Entity and send a copy to the State OCK Manager. The OCK Discharge Form is available on the OCK website at the provided **link**. A link to the form can also be found in **Appendix B** of this manual.

A member losing Medicaid eligibility due to an unmet spend down amount, will not require completion of an OCK Discharge Form; however, the OCKP must ensure that the member has met their designated spend down to receive OCK services. OCK Partners should ensure that spend downs have been met by checking the member's status in either KMAP or through the MCO portal.

Section 5: Health Action Plan (HAP)

The Health Action Plan is a tool developed by the member, Lead Entity, OCKP, and others who will be involved, to document goals the member will pursue within OCK, and the progress toward meeting those goals. Each OCK member is required to have a HAP. The HAP is developed by the member with the assistance of the OCK

Care Coordinator, with input from others who are involved in the member's care, including those people the member chooses to include in the process.

The HAP is developed in a face-to-face or telehealth meeting with the member, care coordinator and any others who are involved in the member's care. The initial HAP meeting must be face-to-face. There will be a one-time only payment per lifetime per member for completion of the HAP. To receive the bonus payment, the HAP must be completed and uploaded to the HAP Portal within 90 days from the first day the member is eligible to receive services. If an OCK member is treated in an institution during this initial 90 days, such as an acute hospitalization (medical or psychiatric) or receive treatment in a Psychiatric Residential Treatment Facility (PRTF), the 90-day clock for the HAP bonus will restart. The HAP may be updated as often as necessary; however, the ***HAP must be submitted through the portal a minimum of every 90 days after the previous HAP submission***.

OCK services have been promoted as an intensive care coordination effort which will result in improved health and quality of life, as well as reduced health care costs. A face-to-face meeting between the member and care coordinator are warranted for the following reasons:

- OCK care coordination involves a relationship that engages members in their self-care and encourages and supports adherence to a treatment plan. This type of relationship involves more interaction with the member, including more face-to-face visits than might typically occur in a traditional care coordination model.
- If the traditional care coordination model was effective, it is likely that fewer people who receive case management would need OCK services. Given that claims and payment data indicate that several of them would benefit from OCK, the need to try a more "hands on" care coordination approach is warranted.
- Care coordinators within OCK can provide direct services if necessary, such as providing transportation for medical visits, working with the member to understand medical information, etc., which typically involves face-to-face contact, therefore contact a minimum of every 90 days should not be a hardship.
- Problems with physical or behavioral health, in the member's environment, may be more apparent during a face-to-face encounter, versus over the telephone.

The Health Action Plan is not intended to replace any specific treatment plans or person-centered support plans already required. It is designed to capture some minimal critical information that can be shared with all providers involved with the member. Additionally, it is necessary to assign specific responsibilities to providers and the member related to health goals. The Health Action Plan includes:

- Demographic information
- Contact information
- Physical and behavioral health information
- Whether there is a Home and Community Based Services waiver plan in place, and the type of waiver plan
- Whether the member has an Advanced Directive, and where it is located
- OCK goals, steps to achieve each goal, strengths and needs, measurable outcomes, start date, progress
- Signatures

The Health Action Plan portal can be accessed **here**. The Health Action Plan Manual Form and instructions are available on the OCK website at the provided **link**. Links to these resources can also be found in **Appendix B** of this manual.

Section 6: Member Referral Process

6.1 Hospital Requirements

Section 2703 of the Affordable Care Act requires that hospitals participating under the state Medicaid Plan or waiver of such plan must refer individuals with chronic conditions who seek or need treatment in an emergency department to a health home, called OneCare Kansas in our state. Such a referral must be made using the OCK Referral Form, which is available on the OCK website at the provided **link**. A link to the form can also be found in **Appendix B** of this manual.

6.2 Referrals from Other Providers

Other providers may refer Medicaid members to OCK through their MCO, based on the criteria outlined in **Section 1.6** of this manual. Such a referral must be made using the OCK Referral Form, which is available on the OCK website at the provided **link**. A link to the form can also be found in **Appendix B** of this manual.

Section 7: Claims Submission and Billing

OCK is considered a bundled service, so individual core services provided within any month will not be billed for as fee-for-service. Payment to the Lead Entity, from the State, is a per member per month (PMPM) payment made retrospectively each month and, unless pre-approved by the State, payment to the OCKP will be a PMPM. For an OCKP to receive the OCK PMPM payment agreed upon between the Lead Entity and the OCKP, the OCKP must provide the member with at least one OCK service during the month for which the claim is submitted. Services should be documented per the information provided in the Section 11: OCK Documentation Requirements of this manual and as required by the Lead Entity-OCKP contract. The billing codes and modifiers for OCK services are outlined in the table below.

Service	Code	Notes
Comprehensive Care Management	S0280 U1	Completion of the HAP one-time only.
Comprehensive Care Management	S0281 U1	
Care Coordination	S0311 U1	
Health Promotion	G9148 U1	
Comprehensive Transitional Care	G9149 U1	
Patient and Family Support	G9150 U1	
Referral to Community and Social Supports	S0221 U1	
Specific Identifying Modifier for SUD. Add this modifier to OCK service codes for tracking purposes.	HF Modifier	Identifies members with a diagnosis of substance use disorder. Does not have to be the primary diagnosis.

There will be one per member per month payment (PMPM) for each of the OCK services, this is paid once a service is utilized. The one rate will be regardless of the number of services provided. There also will be a one-time only payment for completion of the Health Action Plan (HAP) which is a comprehensive care management service. The MCOs are allowed no more than a 10% administrative claiming rate. The MCOs will

not be able to provide any direct OCK services to members unless there is an extreme circumstance which must be approved by the State.

HF – This modifier is currently defined as substance abuse program. The Substance Use Disorder diagnosis does not have to be the primary diagnosis.

Medicare and other third-party liability (TPL) edits will be bypassed for OCK services.

For clarification on billing for Health Promotion:

- The following are examples that do not constitute a billable service for Health Promotion, because the action cannot be verified that the intended member received the service:
  - Sending out a flyer, newsletter, or educational information as a mailer, this is considered one-way communication
  - Initial calls to members to engage in initial OCK services are not allowed, because this is considered administrative services of the program.
  - Calling and leaving health information on a voice message
- The following are examples that do constitute a billable service for Health Promotion, because the action can be verified that the intended member received the information:
  - Having a conversation with the member where you give the member information.
- Overall, the service needs to be interactive with the member.

Please consult with each Lead Entity (MCO) for more specific information about their billing instructions.

Section 8: Rate Calculation and Methodology

When developing the OCK rates, the state outlined the following payment structure and principles:

Basic Payment Structure

1. The State will pay each MCO a retrospective per member per month (PMPM) payment for each member enrolled in OCK, once a service is delivered. The MCO will be paid the PMPM payment regardless of the number of services delivered to a member in a month. If no OCK services are delivered in a month, the PMPM payment will not be issued by the state to the MCO.
2. The MCO will contract with OCKPs to provide all the six core services. Most often, the MCO will pay the OCKP an agreed-upon PMPM, but other arrangements (e.g., shared savings model, incentive payments for outcomes) may be negotiated. The State will review and approve such non-PMPM payment arrangements.
3. There will be a one-time only payment per member for completion of the Health Action Plan (HAP). The initial HAP must be completed within 90 days of assignment to claim the bonus payment. The HAP is a comprehensive care management service.

Payment Principles

1. State OCK payments to the MCOs are structured to be adequate in ensuring quality OCK services are sustainable.
2. State OCK payments to the MCOs are actuarially sound.
3. The MCO will not retain more than 10% of the PMPM payment and will pass at least 90% to the OCKP.

Rate Development Process

The state's actuary will develop a single rate to be paid per member per month according to the basic payment structure guidelines for OneCare core services, and an additional single rate for completion of the Health Action Plan (HAP). The following was also examined in developing the rates:

- Target population criteria
- Professional costs for physicians, psychiatrists, nurse care coordinators, social workers, and peer support specialists
- Service utilization
- Non-medical loading, or administrative costs

Section 9: Grievances and Appeals

Providers

OCKPs have the same grievance and appeal rights as permitted providers under KanCare. The OCKP must file its OCK grievance or appeal, including payment issues, with the Lead Entity (MCO) involved. Each MCO has established processes that must meet federal regulations and are described in their contract with the OCKP or in their provider manual. OCKPs can generally appeal to the State after exhausting the MCO process. For definitive information on grievances and appeals, please refer to the agreement established with the Lead Entity. For information concerning Kansas Medicaid Fair Hearings, please refer to the Kansas Administrative Procedures Act, K.S.A. 77-501 et seq., and K.A.R. 30-7-64 et seq.

Members

OCKPs must have a documented policy/procedure in place to address member grievances. The policy/procedure must include the following: a process for communicating grievance rights, a process for communicating the steps to file a grievance, and a method for tracking and following up on member and/or member representative complaints. OCKPs must ensure staff are aware of the policies and procedures that is in place.

Section 10: Health Information Technology

Implementation of an Electronic Health Record (EHR) will be required of all Lead Entities and OCKPs to facilitate the sharing of patient information across health settings. EHRs are a necessary component to the success of OCK. Each of the six core services in the OCK program also has specific health information technology requirements outlined below:

Comprehensive Care Management

Details of the Health Action Plan will be documented in the EHR to facilitate the sharing of patient needs across OCK 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.

Care Coordination

The use of HIT will facilitate access to patient information across health care settings which will allow for ongoing care coordination. Lead Entities and OCKPs use of HIT will allow for documentation, execution, continuous monitoring, and updates to the health care plan that will impact patient outcomes, treatment options, and follow-up.

Health Promotion

Lead Entities and OCKPs 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.

Comprehensive Transitional Planning

Electronic and telephonic 24/7 notifications of hospitalizations to the Lead Entities will be shared through secured e-mail or other secure electronic means with OCKPs. OCKPs will use secure portals of Lead Entities websites to assist in developing transition plans.

Individual and Family Support

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. OCKPs will use their existing websites and secure e-mail to share information with members.

Referral to Community and Social Support Services

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

Section 11: OCK Documentation Requirements

Each Lead Entity will have some specific requirements, spelled out in their contracts with OCKPs, but all three have agreed to some basic documentation requirements that are designed to demonstrate OCKPs have provided specific core OCK services. The following table describes these requirements.

Service	Documentation	Examples of HIT
Comprehensive Care Management	Health Action Plan (HAP) in the patient record; notes in the patient record with date and time (including duration), discussion points with the member or other practitioners, indication that the Plan was shared with all other treating practitioners and others involved in providing or supporting care.	Data or reports used to identify participants assigned to the Health Home by the MCO, used to develop or recommend the Health Action Plan; evidence of sharing the HAP with the participant, other practitioners or the MCO via electronic means.
Care Coordination	Patient record entries with date, time, practitioner providing the service, referral, follow-up, or coordination activity with the member, treating practitioners and others involved in providing or supporting care. Patient record note could denote an ER visit, hospital admission, phoning member with lab results, discussing a consult with another treating practitioner, etc.	System entries including patient notes; distribution of the HAP or other notes to the MCO; sharing of lab or other results; retrieving information from the MCO to track hospital, ER, and other utilization.

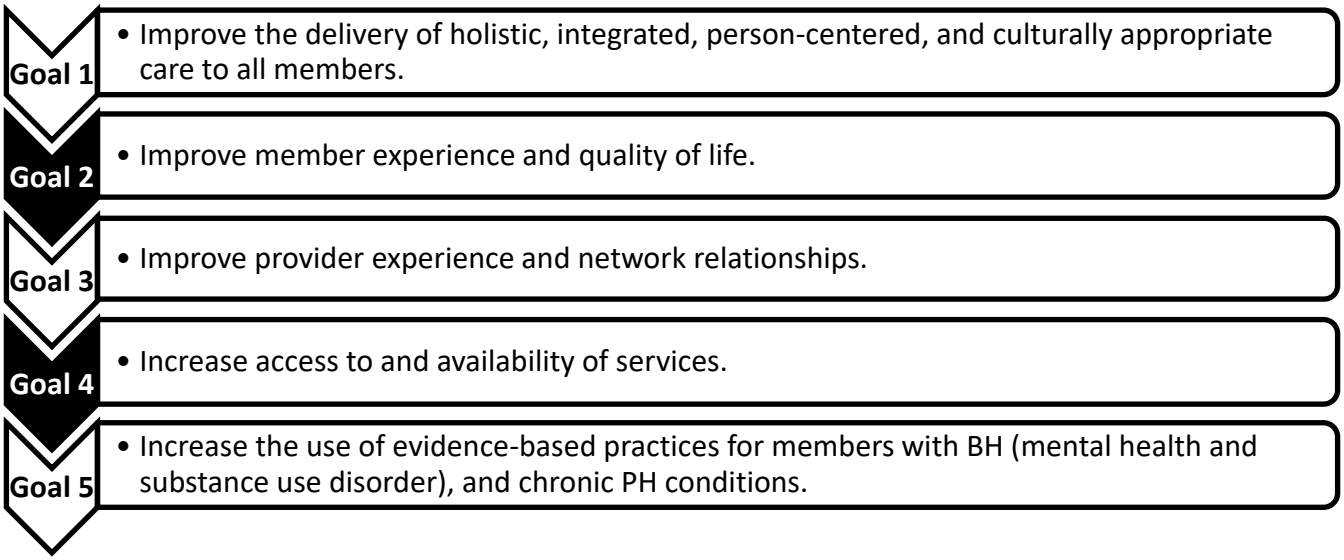
Service	Documentation	Examples of HIT
Health Promotion	Health promotion activities document activities to engage member in care, including outreach, assessment of member's health literacy, summary of health education and resources provided.	Evidence of the use of data pulled from the system to identify participant health promotion needs; notes of health promotion interactions; resources to which the participant is directed to address educational and health literacy needs.
Comprehensive Transitional Care	Documentation in the patient record as to medication reconciliation and other key treatments or services with other health systems/places of service. Documentation should include date, time, practitioner from the HHP and what specific elements of the Health Action Plan, or the Plan itself, were shared and with what other health system or place of service and to achieve which specific Health Action Plan goal. Attention to the appropriate providers to address the follow-up care is extremely important, e.g., transmission of the Health Action Plan to a physical therapist who will be treating a member post knee replacement.	Use of the system to identify admissions, discharge needs, to update HAP based on revised needs, document the scheduling and notification to participants of follow-up appointments.
Individual and Family Support	Documentation of the assessment of psycho-social or community support needs including the identified gaps and recommended resources or resolutions to address the gaps. Date, time, practitioner, service recommendations and discussion with the member, family (or other support persons), and/or guardian should all be included.	Use of the system to share assessment of community support or psychosocial assessments; update of the HAP as applicable to address same; patient record entries; collaboration with other practitioners as to resource information provided or recommended.
Referral to Community and Social Support Services	Documentation in the member record of the date, time and contact at a referral source and/or the date and time that a referral follow through, or discussion was convened to address the gaps from the Individual and Family Support assessment process.	Use of the system to share assessment of community support or psychosocial assessments; update of the HAP as applicable to address same; patient record entries; collaboration with other practitioners as to resource information provided or recommended.

Section 12: Quality Goals and Measures

KDHE, in cooperation with varied stakeholders and representatives from KDADS, MCOs and KUMC partners and advised by Kansas Foundation for Medical Care, the External Quality Review Organization of Kansas, formed a quality sub-group to develop quality goals and measures to assess the OCK delivery model. The purpose of quality goals and measures in OCK is to promote coordination of care, accountability, and responsiveness through a rapid-cycle improvement process for planning, implementation, monitoring, and decision-making to drive continuous quality improvement in the OneCare program.

12.1 Measurement

OneCare Core Set Measures correlate to KanCare 1115 waiver goals and KanCare Quality Management Strategy. The Kansas QMS was revised on July 2, 2018, to reflect the Medicaid Managed Care Final Rule. OneCare program metrics will be aligned with high-level goals in the Quality Management Strategy to clearly link program measures to the 1115 quality strategy.

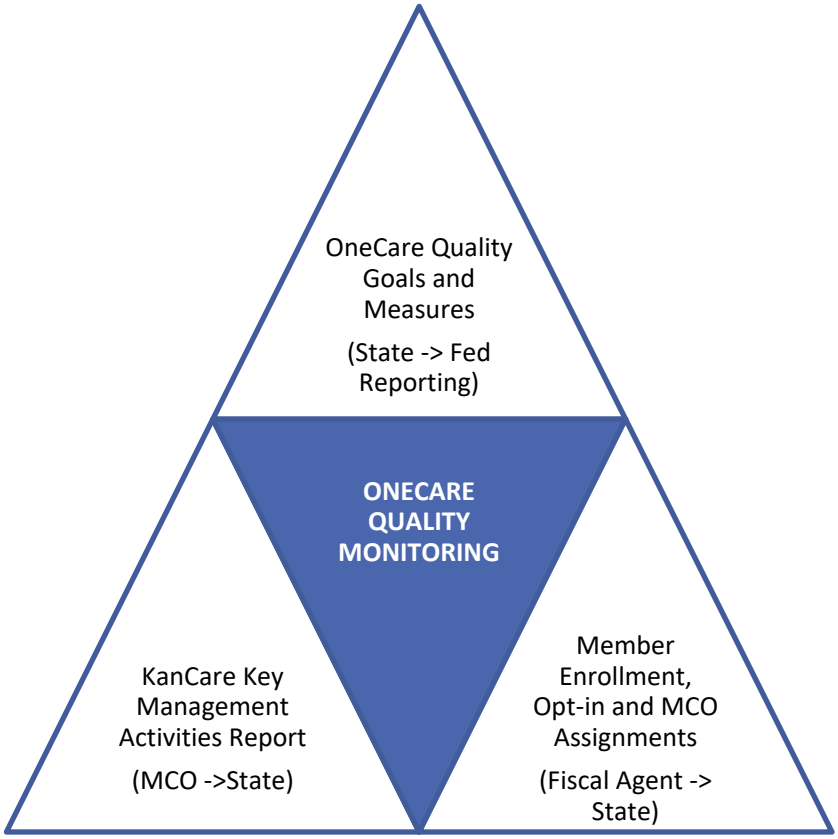


The model drives change by tying goals to actionable activities, inputs, and outcomes to produce results. The OCK quality program incorporates federally required reporting for eight mandated areas comprised of hospital admission, chronic disease management, coordination of care, program implementation, processes and lessons learned, quality and clinical outcomes, cost savings and admissions to skilled nursing facilities.

The OneCare quality program will include both prospective and retrospective monitoring to ensure an early warning system and a comprehensive look-back system to stimulate quality improvement processes for quality reporting, monitoring, and compliance. The OneCare quality monitoring design will provide a structure for regular and systemic monitoring, evaluation and improvement of program provider networks and service delivery to members. This work will be accomplished through development of clear expectations, comprehensive policies and procedures and well-defined on-site and desk review criteria and tools. A quality monitoring approach will be constructed for lead entities to ensure partner support and accountability for program and member outcomes.

Two teams will be critical to this work: the quality sub-group and the data and reporting sub-group. These teams agreed the OneCare Quality Goals and Measures will reside with the quality sub-group and the fiscal agent report will reside with the data and reporting sub-group.

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 utilizes metrics where benchmark data is currently available and collected, such as HEDIS (Healthcare Effectiveness Data and Information Set). Data for each goal and measure will be collected through defined quality processes aligned to state and regional benchmarks as defined in the Kansas OCK Quality Goals and Measures included in **Appendix C**.



To further assess the OCK program, KDHE will be conducting a member survey in 2021. This survey will be a useful tool for measuring our progress on the quality goals listed on page 31.

12.2 Reporting Specifications

KDHE, in cooperation with stakeholders and representatives from KDADS, MCOs and KUMC partners and advised by the External Quality Review Organization will develop quality goals and measures to assess Health Homes delivery model. Centers for Medicare and Medicaid Services (CMS) published the 2019 Health Home Core Set of required measures. Core Set measures will be combined with state-specific measures to assess quality improvements and clinical outcomes and may include a combination of claims, administrative, and qualitative data. Where possible, Kansas utilizes metrics with available benchmark data and collection specifications, such as HEDIS (Healthcare Effectiveness Data and Information Set). The embedded table includes all Federally required reporting measures and specifications. For more information on OCK Quality Core Measures, please refer to **Appendix C**.

12.3 Audits

Newly Contracted OCKPs

Audits of newly contracted OneCare Kansas partners will take place during the sixth month following the effective date of the last contracting MCO. For example, OCKP A contracts with all three MCOs. These MCOs execute contracts with OCKP A dated December 1st, December 3rd, and January 1st. In this scenario, the audit will occur six months after January 1st.

Annual Audits of All OCKPs

Annual audits of OCKPs are performed on a rolling basis. The OCKP network is divided into three audit groups, each with a fixed audit timeline that will remain the same each year. The MCOs will assign each OCKP to one of these groups and inform them of their audit timeline. Appendix F contains more details on the audit timeline for each group.

Annual Audit Results

The MCOs will meet with the OCKPs within 90 days of receiving the audit results to review the findings and provide feedback on areas of strength and areas that require improvement. The MCOs will maintain regular communication with the OCKPs, following up at least quarterly.

OCKPs who receive partially met (PM) or not met (NM) audit scores will be monitored by the MCOs for two quarters to evaluate their improvement in these areas only. OCKPs that do not show progress within this timeframe will be subject to further corrective actions as outlined in the next section.

Additional Corrective Actions

The MCOs will communicate with the State prior to initiating any of the following additional corrective actions:

1. Initiation of the Process Improvement Plan (PIP):
    - After two quarters of no improvement in performance, the MCO will direct the OCKP to develop a PIP.
    - The PIP is a written plan that will be implemented by the OCKP to improve their processes and performance.
2. Monitoring of OCKP under the PIP
    - The MCOs will monitor the OCKP's progress under of PIP for a duration of three months.
    - If the OCKP does not complete the objectives of the PIP within three months, the MCOs will consult to determine the need for placing an OCKP on a Corrective Action Plan (CAP).
3. Initiation of the Corrective Action Plan (CAP):
    - Once the MCOs have agreed to move forward with the implementation of a CAP, the following would apply:
        - The written CAP will be developed and implemented, which will address deficiencies, OCKP action steps, and consequences up to and including termination as an OCK program partner.
        - Deadlines will be set for making progress in addressing each deficiency.
        - Failure to complete the CAP may result in termination from the OCK program partnership.

For more information, please refer to the **OneCare Kansas Audit Result Policy and Procedures** document on the OCK website.

12.4 Member Satisfaction

OCKPs should use a survey tool that measures member satisfaction. The purpose of this tool is to gain better insight into how the partner's program is being implemented from a service perspective, determine whether member goals and objectives are being met, as well as identify successes and possible improvements.

For the first audit, OCKPs must have a documented policy/procedure in place outlining their survey tool utilization process. For the second and subsequent audits, OCKPs must be able to demonstrate implementation of the documented policy/procedure and how it is utilized for program evaluation and improvement.

Section 13: OCK Learning Collaborative

A Learning Collaborative will be convened and will include multiple program components to support provider implementation of OCK. A design team of interested organizational partners, including representatives from KDHE, MCOs, OCKPs, and Association partners, will identify evolving learning needs as well as ways to address those needs. This team and all Learning Collaborative activities will be facilitated by an organization selected by KDHE to provide coordination and support for the Collaborative.

Learning Collaborative activities will be made available to staff of contracting OCKPs, MCOs, and KDHE in a variety of formats, including in person and electronically. Organizational leadership agree to participate in learning activities, including in-person sessions and regularly scheduled calls and participate in peer-to-peer learning that will allow continual quality improvement of the OCK system. Ongoing training and education for staff and potential consumers about OCK will be provided by system partners and will inform, but not replace, Learning Collaborative activities.

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Appendix A: Contact Information

Providers seeking assistance or information can reach out to the designated state staff as follows:

OCKP applications, program manual, or general inquiries:
Email: OneCareKansas@ks.gov

Payment methodology questions:
Mark Heim
Email: Mark.S.Heim@ks.gov

Quality goals and measures questions:
Shaune Parker
Email: Shaune.Parker@ks.gov

Behavioral health questions:
Cissy McKinzie
Email: Tamberly.McKinzie@ks.gov

Providers can also contact the MCOs for further assistance:

Aetna Better Health of Kansas
Attention: Member Services
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
Email: ABHKSOneCare@aetna.com
Fax: 959-282-8852
Phone: 1-855-221-5656

Sunflower Health Plan
8325 Lenexa Drive, Ste. 200
Lenexa, KS 66214
Email: SFHPOneCare@sunflowerhealthplan.com
Fax: 1-888-453-4317
Phone: 1-877-644-4623

United Health Care
United Health Care OneCare Kansas
6860 W 115th St.
Mail Route: KS015-M400
Overland Park, KS, 66211
Email: uhckshealthhomes@uhc.com
Fax: 1-855-252-9324
Phone: 1-877-542-9238

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Appendix B: Forms

All program forms are avalible on the OCK website through the following links:

- Portal Health Action Plan Instructions
- Manual Health Action Plan Instructions
- Manual Health Action Plan
- OCK HAP Medication Reconciliation Form
- OCK Partner Application
- Sample OCK Invitation Letter (For MCO Use Only)
- OCK Refusal Form
- OCK Member Discharge Notification Form
- OCK Referral Form
- OCK Member Opt-Out Form

The table below captures the most common instances for using each OCK program form, but it is not an all-inclusive list.

OCK Forms	
Member chooses to opt-out of the program	Opt-Out Form
Organization refers KanCare member to program	Referral Form
Member is terminally ill, in an institution, a hospital, or long-term care facility	Discharge Form
Member has lost KanCare eligibility	Discharge Form
Member is deceased	Discharge Form
Member is incarcerated	Discharge Form
Member has been previously refused by the OCKP	Refusal Form
The member has not engaged in services for two (2) consecutive quarters *Note: Program Disenrollment is at the discretion of the MCO and member*	Refusal Form
Member resides outside the geographic range established by the OCKP	Refusal Form
OCK partner does not serve the member's age group	Refusal Form
OCKP has reached its capacity to provide OCK services	Refusal Form
Member poses a danger to themselves, or to OCKP staff	Refusal Form
OCKP is a Tribal 638/Indian Health facility and wishes to limit its OCK activities to Native Americans	Refusal Form

Appendix C: OCK Quality Goals and Measures

Core Set Measure	Service Goal	Measure	Measure Category	Source	Numerator	Denominator
PCR-HH	1.1 Reduce utilization associated with inpatient stays	Plan- All Cause Re-admission	Quality of Care	HH Core Measure PCR-HH-Admin - Pg. 40 of CMS Core Measures Tech Specs)	Count the number of Index Hospital Stays with a readmission within 30 days. Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. Determine if there was a planned hospital stay within 30 days after the acute inpatient discharge. To identify planned hospital stays: identify all acute inpatient discharges on or between January 3 and December 31 of the measurement year.	The denominator for this measure is based on discharges, not Health Home enrollees. Include all acute inpatient discharges for Health Home enrollees who had one or more discharges on or between January 1 and December 1 of the measurement year.
PQI 92-HH	1.2 Reduce utilization associated with inpatient stays	Ambulatory Care-Sensitive Chronic Conditions Composite	Quality of Care	HH Core Measure PQI92-HH CC Composite- Admin- (Pg. 48 of CMS Core Measures Tech Specs)	Discharges for patients ages 18 and older, who meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQIs): • PQI 01: Diabetes Short-Term Complications Admission Rate • PQI 03: Diabetes Long-Term Complications Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 07: Hypertension Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 13: Angina without Procedure Admission Rate • PQI 14: Uncontrolled Diabetes Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate • PQI 16: Lower-Extremity Amputations Among Patients with Diabetes Rate Include paid claims only.	The total number of months of Health Home enrollment for enrollees aged 18 and older during the measurement year.
AMB-HH	1.3 Reduce utilization associated with inpatient stays	Emergency Department Visits	Quality of Care	HH Core Measure, AMB-HH-Admin- (Pg. 57 of CMS Core Measures Tech Specs)	Number of ED visits: Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Do not include ED visits that result in an inpatient stay. Report age as of the date of service.	Number of enrollee months.
	2.1 Improve Management of Chronic Conditions	HBa1C Testing	Clinical Outcomes	HEDIS Code CDC-Admin	HEDIS Specifications	HEDIS Specifications

Core Set Measure	Service Goal	Measure	Measure Category	Source	Numerator	Denominator
	2.2 Improve Management of Chronic Conditions	LDL-C Screening	Clinical Outcomes	HEDIS Code CDC (diabetes)	HEDIS Specifications An LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data.	HEDIS Specifications
FUH-HH	2.3 Improve Management of Chronic Conditions	Follow-up after Hospitalization for Mental Illness	Quality of Care	HH Core Measure, FUH-HH- Admin- (Pg. 27 of CMS Core Measures Tech Specs)	7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge. 30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge. The 30-day follow up rate should be greater than (or equal to) the 7-day follow-up rate.	The eligible population. The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
ABA-HH	2.4 Improve Management of Chronic Conditions	Adult Body Mass Index (BMI) Assessment	Clinical Outcomes	HH Core Measure ABA-HH Administrative or Hybrid-(Pg. 11 of CMS Core Measures Tech Specs)	HEDIS Specifications	HEDIS Specifications
CDF-HH	2.5 Improve Management of Chronic Conditions	Screening for Clinical Depression and Follow-up Plan	Quality of Care	HH Core Measure CDF-HH Hybrid or EHR (Pg. 22 of CMS Core Measures Tech Specs)	HEDIS Specifications Hybrid: Enrollees screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. EHR: Patients screened for depression on the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.	HEDIS Specifications Hybrid: The eligible population with an outpatient visit during the measurement year. EHR: All eligible enrollees aged 12 and older before the beginning of the measurement period, with at least one eligible encounter during the measurement period.

Core Set Measure	Service Goal	Measure	Measure Category	Source	Numerator	Denominator
CBP-HH	2.6 Improve Management of Chronic Conditions	Controlling High Blood Pressure	Clinical Outcomes	HH Core Measure CBP-HH-Hybrid - EHR (Pg. 14 of CMS Core Measures Tech Specs)	HEDIS Specifications Hybrid: The number of Health Home enrollees in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria: Health Home enrollees ages 18 to 59 as of December 31 of the measurement year whose BP was <140/90 mm Hg. Health Home enrollees ages 60 to 85 as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg. Health Home enrollees ages 60 to 85 as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg. To determine if an enrollee's BP is adequately controlled, the representative BP must be identified. EHR: Patients whose blood pressure at the most recent visit is adequately controlled (systolic <140 mmHg; diastolic <90 mmHg) during the measurement period.	HEDIS Specifications Hybrid: A systematic sample drawn from the eligible population. Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For this measure, NCQA recommends that states use an oversample of 10 to 15 percent to ensure enough confirmed cases of hypertension. EHR: Patients ages 18 to 85 who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period. Exclusions: Patients with evidence of end stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.
	3.1 Improve Care Coordination	Increased Integration of Care	Quality of Care	Member Survey	The number of members who reported, through the survey tool, a moderate or high level of clinical integration of care between their case manager and other service providers.	The number of Health Homes members continuously enrolled in a Health Home with the same MCO for > or = to 180 days.
IET-HH	3.2 Improve Care Coordination	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Quality of Care	HH Core Measure IET-HH-Admin-(Pg. 31 of CMS Core Measures Tech Specs)	Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of AOD Treatment: If a Health Home enrollee is compliant for multiple cohorts, only count the enrollee once for the Total Engagement numerator. The Total Column is not the sum of the diagnosis columns. The time frame for engagement, which includes the initiation event, is 34 total days.	Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators. Administrative Specification: Denominator: Exclude Health Home enrollees from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Core Set Measure	Service Goal	Measure	Measure Category	Source	Numerator	Denominator
	3.3 Improve Care Coordination	Tobacco Use Assessment Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user	Quality of Care	HRSA Specifications	Numerator Statement: Population 1: Patients who were screened for tobacco use at least once within 24 months Population 2: Patients who received tobacco cessation intervention Population 3: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit OR within 24 months of the most recent visit.	Initial Patient Population: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period Denominator Statement: Population 1: Equals Initial Population info-icon Population 2: Equals Initial Population who were screened for tobacco use and identified as a tobacco user Population 3: Equals Initial Population Denominator Exceptions: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)
IU-HH	4.1 Improve transitions of care among primary care and community providers and inpatient facilities	Inpatient Utilization—General hospital/Acute Care (HEDIS)	Clinical Outcomes	HH Core Measure IU-HH Administrative-(Pg. 60 of CMS Core Measures Tech Specs)	Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year. Length of Stay (LOS): All approved days from admission to discharge. The last day of the stay is not counted unless the admission and discharge date are the same. (LOS = discharge date - admit date - denied days)	Number of enrollee months
FUH-HH	4.2 Improve transitions of care among primary care and community providers and inpatient facilities	Follow-up after Hospitalization for Mental Illness	Quality of Care	HH Core Measure, FUH-HH-Admin- (Pg. 27 of CMS Core Measures Tech Specs)	7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge. 30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge. The 30-day follow up rate should be greater than (or equal to) the 7-day follow-up rate.	The eligible population. The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
AIF-HH	4.3 Improve transitions of care among primary care and community providers and inpatient facilities	Admission to an Institution from the Community	Quality of Care	HH Core Measure AIF-HH For the 2019 Health Home Core Set, Nursing Facility Utilization (NFU-HH) was revised and renamed Admission to an Institution from the Community (AIF HH).	HEDIS Specifications	HEDIS Specifications

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Appendix D: Resources

OCK Website

This page encompasses comprehensive information about the OCK Program, for both providers and members. It includes frequently asked questions, informational materials for providers, and educational resources for members and other stakeholders. Access the OCK website through the provided **link**.

CMS Health Homes Webpage

CMS provides general information and guidance about Health Homes on their **Health Home Information Resource Center** webpage.

SAMHSA/HRSA Integrated Care Website

The Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration have created a joint website with information and resources focused on integrated care. The SAMHSA/HRSA Integrated Care Website is available at the provided **link**.

OCK Newsletter Subscriptions

A monthly GovDelivery newsletter is published by the state, offering updates on the OCK program, and featuring news relevant to both providers and members. To subscribe and manage preferences, individuals can use this direct **GovDelivery subscription link**. This link is also avalible on both the OCK section of the **KanCare homepage** and the **OCK Newsletter Library page**. Those requiring further assistance with newsletter subscriptions may reach out to the **OCK state team** by email.

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Appendix E: OCKP Professional Process Flow

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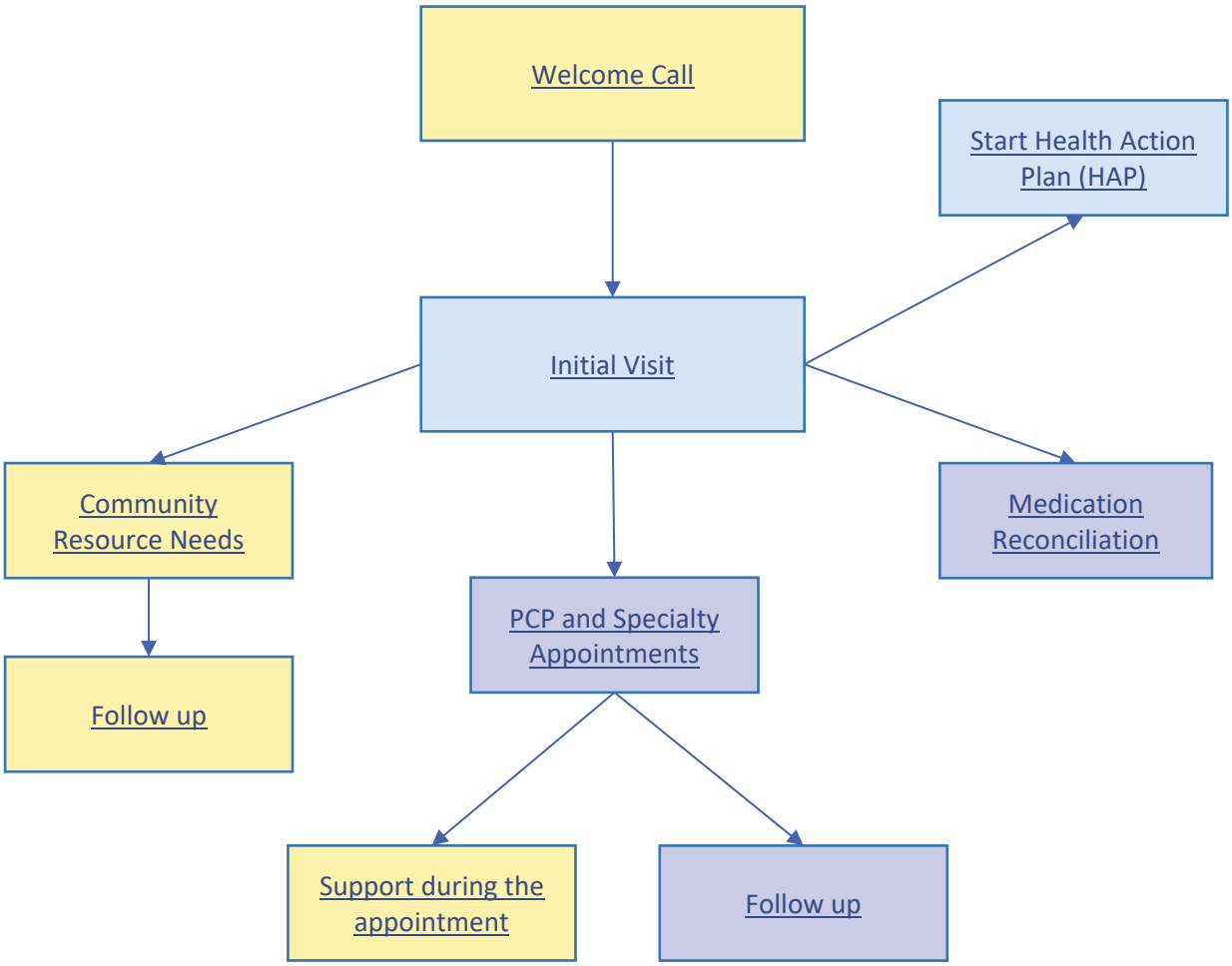
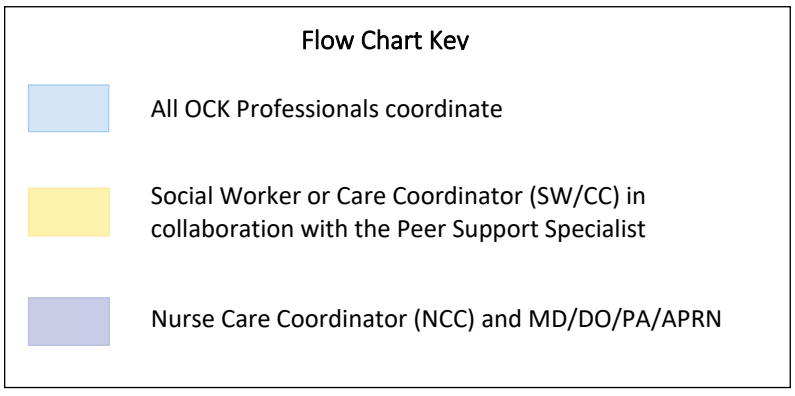
Newly Assigned Members

The member has opted into OneCare Kansas (OCK) and is assigned to the OCK Partner. The diagram below outlines the possible delegation of activities to each professional within the OCK Partner. By clicking any of the links below, you can access more information on the topics.





Welcome Calls

Social Worker, Care Coordinator, Peer Support Specialist, or Nurse Care Coordinator

- Calls the newly assigned member to introduce them to the OCK Partner.
- Coordinates with the member and the NCC to schedule the Initial Visit
    - If needed, 2 separate appointments are made: one for the member to meet with the Social Worker and one to meet with the Nurse Care Coordinator and Physician/Mid-level.
- Discusses the HAP and the process for it to be completed.

  Welcome calls can also be completed by the receptionist of the facility.

Initial Visits

Introducing the member to the OCK Partner's team of professionals and starting the HAP are the critical components of the Initial Visit. Also, a brief overview of the services offered through the OCK program may be needed.

Social Worker or Care Coordinator

- Identifies social needs of the member (such as food security, housing, etc.)
- Coordinates with Nurse Care Coordinator to complete **Health Action Plan (HAP)**

Peer Support Specialist

- Coordinates with the Social Worker to identify any Community Resource needs

Nurse Care Coordinator

- Starts the **Health Action Plan (HAP)** and coordinate with the Social Worker/CC to address all the components of the HAP
- Identifies health needs of the member (such as wellness visit or vaccine schedule needs)
- Completes the **Medication Reconciliation Form** for the member
- Identifies appointments already scheduled with PCP or Specialties Physicians

Physician, PA or APRN

- Identifies any health concerns that may need follow-up

Return to Newly Assigned Member Chart

Health Action Plan

Social Worker or Care Coordinator

- Downloads the **Health Action Plan (HAP) Document** and instructions from the OCK Website or the OCK HAP Portal
- Compiles information for the following sections of the HAP, in coordination with NCC:
    - Section I: Demographic Information
    - Section II: Additional Contact Information
    - Section VI: Goals and Steps to Achieve
    - Section VII: Signatures
- Submits completed HAP, as well as any updates, to the OCK HAP Portal
    - The initial HAP is due no later than 90 days after the member is enrolled into OneCare Kansas
- Coordinates with the NCC to monitors the HAP for the required quarterly updates or as needed for the following reasons:
    - Changes in health status
    - Hospitalizations
    - Emergency Room use
    - Milestones reached with the Member's goals

Nurse Care Coordinator

- Completes the following sections of the HAP, in coordination with the SW/CC and MD/PA/APRN:
    - Section III: Physical, Behavioral Health
    - Section IV: Existing HCBS Waiver Plan of Care (If applicable)
    - Section V: Advanced Directives
    - Section VI: Goals and Steps to Achieve
    - Section VII: Signatures
- Updates the HAP quarterly, or as needed for any of the following reasons:
    - Changes in health status
    - Hospitalizations
    - Emergency Room use
    - Milestones reached with the Member's goals

Physician, PA or APRN

- Reviews the HAP
- Signs the Section VII: Signatures Section of the HAP

Return to Newly Assigned Member Chart

Return to Discharge from Hospital or Nursing Home

Identifying Appointments

Nurse Care Coordinator

- Asks the member for a list of upcoming medical appointments and document in chart.
- Coordinates with SW/CC for any needs for appointment such as transportation, attendance, etc.
- Asks the member who their Primary Care Physician (PCP) is and when their last Wellness check was. Schedule as needed.
- Follows up with the provider's office after each appointment for any changes in care and/or medications.
- Follows up with the member for any questions related to the appointment to ensure that the member understands all instructions given.
- Updates the Medication Reconciliation Form, as needed.

Social Worker or Care Coordinator

- Schedule transportation, if needed for the member.
- Attends any appointment with the member, as needed.
- Helps the member formulate questions to ask the provider prior to each appointment.
- Follows up with the member after each appointment to assess for any questions and understanding of instructions from the provider.

Peer Support Specialist

- Coordinates with the SW/CC to help schedule transportation to appointments for the member.
- Attends appointments with the member, as needed.

Physician, PA or APRN

- If any health concerns are identified, refer to PCP or specialists, as needed. Coordinate with NCC or SW/CC to schedule appointments.
- Peer-to-Peer communication and coordination with member's other providers, as needed.

Return to Newly Assigned Member Chart

Medication Reconciliation

Nurse Care Coordinator

- Asks the member, at each appointment, for their medication list, including supplements.
    - Document on the **Medication Reconciliation Form** on the OCK website.
    - Update the Medication Reconciliation Form with any changes to the member's medications.
- Submits the Medication Reconciliation Form onto the OCK HAP Portal.

Physician, PA or APRN

- Reviews the Medication Reconciliation Form and assess for any interactions.
    - If potential interactions are identified, contact prescribing provider to discuss.

Return to Newly Assigned Member Chart

Return to Discharge from Hospital or Nursing Home

Community Resource Needs

Social Worker or Care Coordinator

- Identifies any Social Determinants of Health and Independence issues and resources in the community that could help the member address them. The **Aunt Bertha** website can be used to help find resources for the member. This could include:
    - Housing
    - Food Security
    - Transportation issues
    - Counseling needs
- Follow up with the member and community partners to ensure that the member understood the instructions.

Peer Support Specialist

- Works with the SW/CC with linking the member with Community Recourses to address SDOH/I needs that could include:
    - Housing
    - Food Security
    - Transportation issues
    - Counseling needs
- Works with the SW/CC to follow-up with the member

Return to Newly Assigned Member Chart

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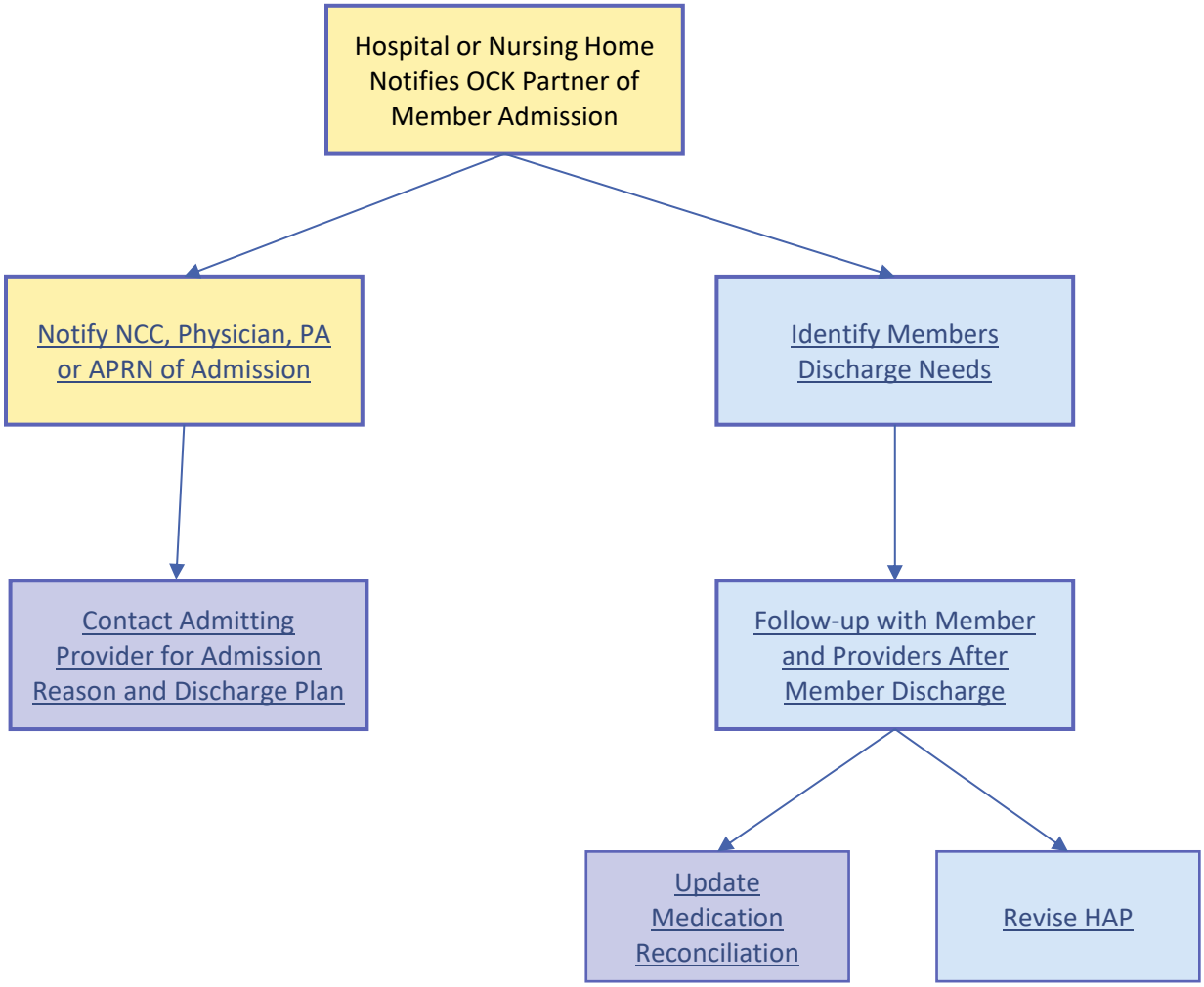
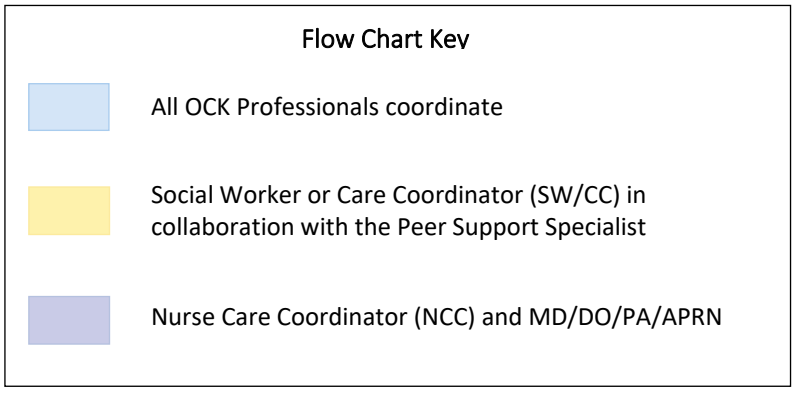
Discharge from Hospital or Nursing Home

The OCK member is admitted to the hospital or nursing home. The SW/CC is listed as the OCK Partner main point of contact for community partners. Transitional Care is a Core Service in OneCare Kansas. This scenario is meant to be an example, but not all inclusive. Transitional Care may be appropriately billed for any transition out of intuitions back to the community.





After a Hospital or Nursing Home Admission

Social Worker or Care Coordinator

- Receives notification from the facility and/or the member that member has been admitted
- Coordinates with the NCC for discharge needs
- Visits the member in the facility to assess for any needs while hospitalized
- Identifies any needs after discharge, such as:
    - Meal delivery services
    - Transportation needs
- Coordinates with NCC to revise the HAP, as needed, and submit to OCK HAP Portal

Peer Support Specialist

- Coordinates with the SW/CC to determine member and family support needs as well as Community resources that the member needs after discharge.

Nurse Care Coordinator

- Coordinates with SW/CC for discharge needs.
- Identifies needs after discharge, including discharge orders, such as:
    - Follow-up appointments
    - Referrals made to Home Health care
    - Medication changes
- Coordinates with the SW/CC to revise the HAP, as needed
- Revises the Medication Reconciliation as needed
- Schedules appointment for member to meet with OCK Team, as needed

Physician, PA or APRN

- Reviews member's chart, as needed, for any healthcare needs

Return to Discharge from Hospital or Nursing Home

Follow-up After Discharge with Member and Providers

Social Worker or Care Coordinator

- Contacts the member to ensure that discharge instructions are understood and followed
- Identifies any Community Resource needs and refer as appropriate
- Coordinates with NCC for any changes to HAP
- Submits revised HAP to OCK HAP Portal, as needed

Peer Support Specialist

- Works with the SW/CC to identify any Community Resources needs and help connect the member to those resources.

Nurse Care Coordinator

- Follows up with Member to ensure that discharge instructions were understood
- Updates the member's Medication Reconciliation

Return to Discharge from Hospital or Nursing Home

Return to Appendix E TOC

OneCare Kansas Partner Team Meeting (OCKPTM)

- OCKPs must have a documented policy/procedure in place that supports the regular, quarterly occurrence of the meeting.
- OCKPTM members will discuss:
    - OCK members
    - Program related issues, processes, and topics
- The OCKPTM will consist of OCK staff from multiple disciplines including, but not limited to:
    - The nurse care coordinator (NCC)
    - The care coordinator (CC)

OneCare Kansas Team Meeting Documentation

- Examples of OCKPTM documentation must include, but are not limited to:
    - Meeting minutes
    - Meeting agendas
- OCKPTM documentation must detail:
    - Meeting dates and times
    - Meeting topics
    - First names, last names, and official roles of all meeting attendees.

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Appendix F: Audit Timeline Schedule

OCK Annual Audit Timeline

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Group 1				**Document Submission**	**Audit**		**Results to OCKPs**					
Group 2						**Document Submission**	**Audit**		**Results to OCKPs**			
Group 3								**Document Submission**	**Audit**		**Results to OCKPs**	

Group	Full Audit	Audit Timeframe
1	May - June	April 1 - March 31
2	July - August	June 1 - May 31
3	September - October	August 1 - July 31

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Appendix G: CNAs and MAs as OCK Support Staff

CNAs and/or MAs will only act as support/administrative type staff under supervision of a NCC in OCK. Therefore, CNAs and/or MAs will not be allowed to bill for services in OCK since they are not an OCK professional. However, CNAs and/or MAs can assist the NCC with certain duties.

Description of Duties CNAs and/or MAs can handle:

- Assist primary care providers in determining identification of high-risk patients or chronically ill patients that may qualify for OneCare Kansas Program.
- Create and promote adherence to a patient specific care plan, developed in coordination with the patient, primary care provider and family/caregiver(s).
- Provide and/or coordinate at least monthly telephonic services to OneCare Kansas member related to setting up transportation, keeping members engaged, etc.
- Work with patients and healthcare providers to provide continuity of care and to provide support to follow the treatment plan; may also assist with scheduling appointments.
- Assist patients in self-management of health and other skills that appear in the member's existing HAP.
- Assess the patients' unmet psychosocial needs and connect with community and organizational resources.

Description of Duties CNAs and/or MAs cannot handle:

- Completing initial in-person Health Action Plan within ninety (90) days of member's assignment to the OneCare Kansas Program.
- Updating Health Action Plan at least quarterly and on an as needed basis and may be done in-person or by Telehealth.
- Assist patients in setting goals for their HAP.
- Provide medication reconciliation and education on medication management.

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Glossary

Term	Definition
Attribution List	A list of members who have been identified by the MCO as eligible for the OneCare Kansas program and have attributed claims with OneCare Kansas partners but have not enrolled in the program. The list is provided monthly by the MCO as a courtesy to the attributed partner. The OCK Partner may use the list to engage members.
Care Coordination	Implementation of a single integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports.
Claims	OCK providers should not submit billing with the individual rendering practitioner on the claim. Meaning the nurse would not be listed in 24j of the claim. Bill for the OCK HAP and OCK services being completed within 180 days from the date of service. The HAP bonus and a regular OCK service can be provided and paid for within the same month. OCK services can be provided and billed for prior to the initial HAP completion. To receive the HAP bonus, the HAP must be completed within 90 days of the member being in the OCK program. The diagnosis that made the member eligible for the OCK program does not need to be on the claim when the provider bills for OCK services.
Comprehensive Care Management	Involves identifying members with high risk environmental and/or medical factors and complex health care needs who may benefit from OCK and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication.
Comprehensive Transitional Care	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.
Health Action Plan (HAP)	This is a tool to document goals that the member will pursue within the OCK program. The HAP also documents the proposed process for achieving these goals, as well as progress made in achieving the goals. The HAP is developed during a face-to-face meeting with the member and Care Coordinator with input from others who are participating in the OCK program of services. HAPs are to be updated and submitted every 90 days in a face-to-face setting with at least the Care Coordinator and the member being present.
Health Promotion	Involves engaging members in OCK 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.
Individual and Family Support	Documentation of the assessment of psycho-social or community support needs including the identified gaps and recommended resources or resolutions to address the gaps. Date, time, practitioner,

Term	Definition
	service recommendations and discussion with the member, family, or other support persons, and/or guardian should all be included.
Managed Care Organization (MCO)	Aetna Better Health, UnitedHealthcare, Sunflower Health Plan
Member and Family Support	Involves identifying supports needed for members, family/support persons/guardians needed to manage member's conditions and assisting them to access these supports. It includes assessing strengths and needs of members, family/support persons/guardians, identifying barriers to member's highest levels of health and success, locating resources to eliminate barriers.
OneCare Kansas (OCK)	Comprehensive and intense method of care coordination. OCK integrates and coordinates all services and supports to treat the "whole person" across the life span.
Opt-In	Member meets both Kancare eligibility requirements and OCK eligibility diagnosis. The Member then actively choses to participate in the program by following current opt-in processes with their MCO.
Referral Form	A form that can be used by organizations to refer Medicaid members for the OneCare Kansas program. Completed forms are to be sent to the assigned MCO and processed. The MCO responds to the referring organization and the member with OCK program eligibility findings.
Referral to Community and Social Support Services	Determining the services needed for the member to achieve the most successful outcomes, identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paperwork, identifying natural supports if service providers are unavailable in the member's community, following through until the member has access to needed services and considering the family/support person/guardian preferences when possible.
Roster: Opt-In to Roster Timeframe	Rosters are created by the MCOs and sent to OCK Partners monthly on the 18th of each month. Members who opt in on or before the 9th of the month will be on the roster the next month. Members who opt in after the 9th of the month will be on the roster the month following the next month.
Severe Mental Illness (SMI)	Defined as a mental behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.
State Plan Amendment (SPA)	The document that grants Kansas the authority to provide OCK services.
Trauma Informed Care (TIC)	An approach based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff.

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Notes