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Preface

The purpose of this Manual is to provide Medicaid policy and billing guidance to providers participating in the KanCare Health Homes Program. It is intended to provide:

- Instructions about how to become a health homes provider
- Guidance about health home services
- Information relating to billing procedures
- Links to additional information

Policy statements and requirements governing the Health Homes 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 Health Homes Program. The Health Homes Program is an optional service under the Kansas State 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 this Health Homes initiative may be found on the Health Homes page of the KanCare website listed below.

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

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Introduction

Statutory Authority of Health Homes

The goal of Health Homes 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 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." A link to the State Medicaid Director's letter has been provided below for additional information:
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

On _____, 2014 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) and #____ for individuals with chronic conditions.

(Link to approved SPAs)

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Section 1: The Health Homes Service Model

1.1 Overview of the Health Homes Model

Health Homes is a care management service model where all of 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 of the services a member requires in order to facilitate optimum member health status. 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 Health Homes 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 of 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 Health Homes 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 main focus on the needs of persons with multiple chronic illnesses.

1.2 Federal Health Home Population Criteria

Health Home 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 Homes 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 Health Homes 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

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behavioral health conditions. Health Home 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 unnecessary care.

Section 1945(h)(4) of the Social Security Act defines Health Home services as "comprehensive and timely high quality services" and includes six Health Home services to be provided by designated Health Home providers.

Health Home 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 Health Home Provider Functional Requirements

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

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

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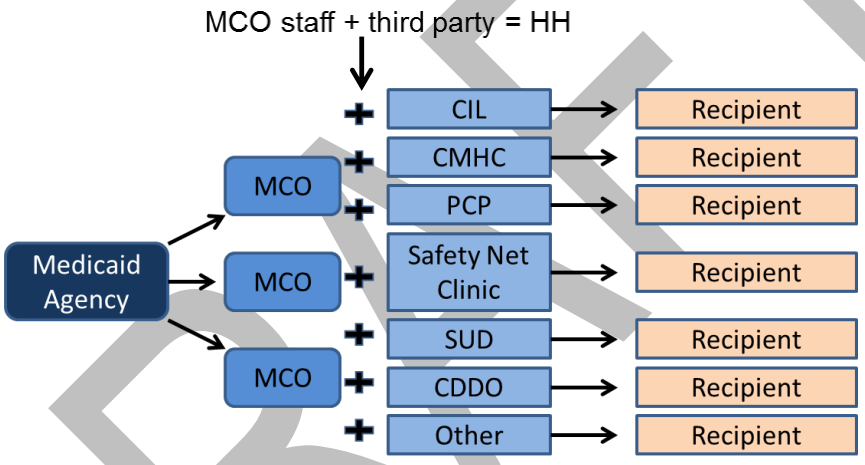
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Additional information regarding Federal Health Homes Functional Requirements may be found at:
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

1.5 Kansas Health Homes Model

The Kansas model for Health Homes is a partnership between the managed care organization (MCO) and another entity (Health Home Partner) 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 Health Home 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 Health Homes and will contract with community providers to be Health Home Partners (HHPs). Together, they will provide the six core services and share the payment provided by the State. The contracts between the LEs and the HHPs will spell out which entity is providing each of the core services and how the payment will be divided. The diagram below illustrates how the two entities, together, form the Health Homes.

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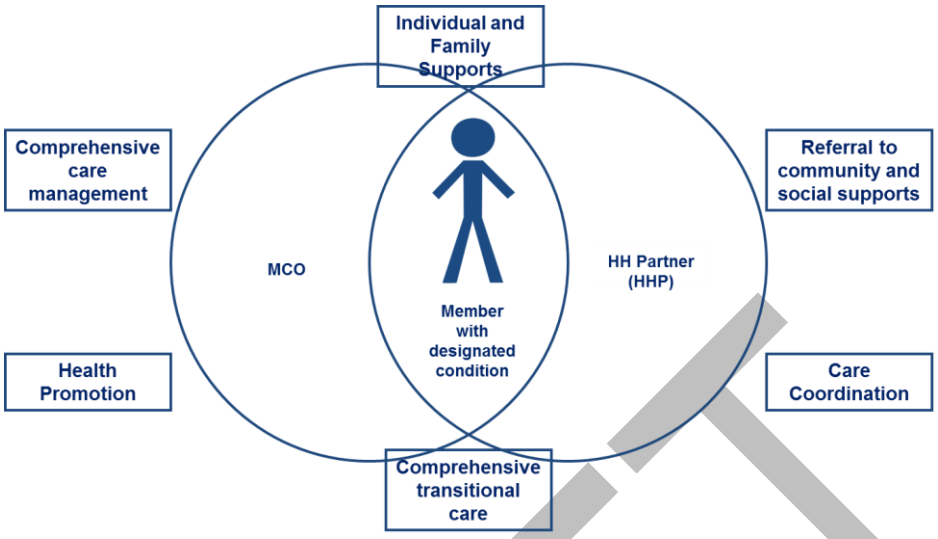

NOTE: The placement of the six services is random and for illustrative purposes only.

1.6 Target Populations for KanCare Health Homes

The first two target populations Kansas has chosen to receive Health Home services are people with serious mental illness (SMI) and people with chronic conditions (CC).

The SMI population is defined as anyone with a primary diagnosis of one or more of the following, unless the person has a co-occurring substance use disorder (SUD):

- Schizophrenia
- Bipolar and major depression
- Child disintegrative disorder
- Delusional disorders
- Personality disorders
- Psychosis not otherwise specified
- Obsessive-compulsive disorder
- Post-traumatic stress disorder

The CC population is defined as anyone_____

If a person qualifies for both target populations, he or she may only receive services from one type of Health Home. A person who qualifies for both target populations must choose which type of Health Home he or she wishes to receive service from.

The State will be adding target populations to the Health Homes SPAs in the future. Providers will be notified in various ways about these additions (i.e., provider bulletins, e-mail, Health Homes web page).

1.7 Kansas Services and Professional Qualifications for Health Homes

Health Homes' requirements differ, depending upon which population a Health Home is designed to serve.

SMI Health Homes Services and Professional Qualifications

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The following table lays out the definitions of the six core services for the KanCare SMI Health Homes program, along with the professional requirements associated with the six services.

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KanCare SMI Health Homes Services and Professional Requirements

Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
Comprehensive care management involves Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from a HH, and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), Health Home partner (HHP), member, family/support persons/guardian, and health services and social service staff. Critical components of comprehensive care management include: • Knowledge of the medical and non-medical service delivery system within and outside of the member's area • Effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers • Ability to address other barriers to success,	Psychiatrist Nurse Care Coordinator Physician Social Worker/Care Coordinator	LE or HHP LE or HHP LE or HHP HHP	Licensed to practice psychiatry in Kansas RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. MD/DO must be actively licensed to practice medicine in Kansas. For children, pediatricians are preferred. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc. • Monitoring and follow-up to ensure that needed care and services are offered and accessed • Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances			
Care coordination is the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a member's progress towards achievement of goals, and revising the HAP as necessary to reflect the member's needs. Care coordination:	Nurse Care Coordinator Social Worker/Care Coordinator	LE or HHP HHP	RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
• Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals • Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care • Involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects • Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports • Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact • Creates and promotes linkages to other agencies, services, and supports			
Health promotion involves engaging members in HH care by phone, letter, HIT and community "in reach" and outreach, assessing members understanding of health condition/health literacy and motivation to engage in self-management, e.g., how important is the person's health status to the member, how confident the member feels to change health behaviors, etc., assisting members in the development of recovery plans, including self-management and/or relapse	Psychiatrist Nurse Care Coordinator Physician	LE or HHP LE or HHP LE or HHP	Licensed to practice psychiatry in Kansas RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. MD/DO must be actively licensed to practice medicine in

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
prevention plans, linking members to resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on member needs and preferences, and assisting members to develop the skills and confidence that will enable them to independently identify, seek out and access resources that will assist in managing and mitigating their conditions, and in preventing the development of secondary or other chronic conditions. Health promotion: • Encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health • Places a strong emphasis on self-direction and skills development, engaging members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment • Ensures all health action goals are included in person centered care plans • Provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions based upon the member's preference • Offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations.	Social Worker/Care Coordinator	HHP	Kansas. For children, pediatricians are preferred. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
Comprehensive transitional care is specialized care coordination designed to facilitate transition of treatment plans from hospitals, ED, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. It may also involve identifying members not participating who could benefit from a HH. Comprehensive transitional care involves developing a transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. For each HH member transferred from one caregiver or site of care to another, the HH coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation. Comprehensive transitional care involves collaboration, communication and coordination with members, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers. It is designed to ease transition by addressing the members understanding of rehab activities, LTSS, self-management, and medications. It includes scheduling appointments scheduling and reaching out if appointments are missed. It may also include evaluating the need to revise	Psychiatrist Nurse Care Coordinator Physician Social Worker/Care Coordinator	LE or HHP LE or HHP LE or HHP HHP	Licensed to practice psychiatry in Kansas RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. MD/DO must be actively licensed to practice medicine in Kansas. For children, pediatricians are preferred. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP.

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
the HAP. The transition/discharge plan includes, but is not limited to, the following elements: • timeframes related to appointments and discharge paperwork • follow-up appointment information • medication information to allow providers to reconcile medications and make informed decisions about care • medication education • therapy needs, e.g., occupational, physical, speech, etc. • transportation needs • community supports needed post-discharge • determination of environmental (home, community, workplace) safety			
Member and family support involves identifying supports needed for members, family/support persons/guardians need 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 level of health and success, locating resources to eliminate these barriers, and advocating on behalf of members, family/support persons/ guardians, to ensure that they have supports necessary for improved health. Included in this service is assistance to complete paperwork, provision of information and assistance to access self-help and peer	Nurse Care Coordinator Social Worker/Care Coordinator	LE or HHP HHP	RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
support services, and consideration of the family/support persons/guardians need for services such as respite care. To promote inclusion, consideration is given to accommodating work schedules of families, providing flexibility in terms of hours of service, and teleconferencing. The goal of providing member and family support is to Increase member's, family/support persons and guardians understanding of effect(s) of the condition on the member's life, and improve adherence to an agreed upon treatment plan, with the ultimate goal of improved overall health and quality of life. Member and family support: • Is contingent on effective communication with member, family, guardian, other support persons, or caregivers • Involves accommodations related to culture, disability, language, race, socio-economic background, and non-traditional family relationships • Promotes engagement of members, family/support persons and guardians • Promotes self-management capabilities of members • Involves ability to determine when members, families/support persons, and guardians are ready to receive and act upon information provided, and assist them with making informed choices • Involves an awareness of complexities of family dynamics, and an ability to respond to	Peer Support Specialist/Peer Mentor/Recovery Advocate	HHP	and Provider Manuals, and can either be employed directly or contracted with the HHP. The Certified Peer Support Specialist (mental illness) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for mental Illness, be employed by a licensed mental health provider, meet education and age requirements, pass state-approved training through a state contractor and complete criminal, state abuse/neglect registry, and professional background checks. Additionally, the Certified Peer Support Specialist must self-identify as active in stable recovery and be a present or former primary recipient of mental health services. The Certified Peer Mentor (Substance Use Disorder) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for substance use disorder, be employed by a licensed or certified Substance Use Disorder provider; meet age, training, and supervision requirements, and self-identify as active in stable recovery from alcohol and/or illicit substance use for at least one year. If employed in the same agency in which the individual received services, the Certified Peer Mentor must have completed services at that agency for a minimum of six months. The Recovery Advocate must meet the defined KDADS Behavioral Health requirements for mental illness and/or substance use disorder, meet age, training, and supervision requirements, and self-identify as active in stable recovery for a minimum of one year.

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
member needs when complex relationships come into play			
Referral to community supports and services includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paper work, identifying natural supports if services providers are unavailable in the member's community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible. Community supports and services include long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. Referral to community and social support services involves: • A thorough knowledge of the medical and non-medical service delivery system within and outside of the member's area • Engagement with community and social supports • Establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc. • Fostering communication and collaborating	Nurse Care Coordinator Social Worker/Care Coordinator Peer Support Specialist/Peer Mentor/Recovery Advocate	LE or HHP HHP HHP	RN, APRN, BSN or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider Standards. Although the preference is for the HHP to have an RN, APRN, BSN or LPN, some HHPs in rural areas may need to rely on the Lead Entity to provide a nurse care coordinator. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals, and can either be employed directly or contracted with the HHP. The Certified Peer Support Specialist (mental illness) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for mental Illness, be employed by a licensed mental health provider, meet education and age requirements, pass state-approved training through a state contractor and complete criminal, state abuse/neglect registry, and professional background checks. Additionally, the Certified Peer Support Specialist must self-identify as active in stable recovery and be a present or former

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Service	Professional(s)	Lead Entity (LE) or Health Home Partner (HHP)?	Professional Qualifications
with social supports • Knowledge of the eligibility criteria for services • Identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary			primary recipient of mental health services. The Certified Peer Mentor (Substance Use Disorder) must meet the defined Kansas Department for Aging and Disability Services Behavioral Health requirements for substance use disorder, be employed by a licensed or certified Substance Use Disorder provider; meet age, training, and supervision requirements, and self-identify as active in stable recovery from alcohol and/or illicit substance use for at least one year. If employed in the same agency in which the individual received services, the Certified Peer Mentor must have completed services at that agency for a minimum of six months. The Recovery Advocate must meet the defined KDADS Behavioral Health requirements for mental illness and/or substance use disorder, meet age, training, and supervision requirements, and self-identify as active in stable recovery for a minimum of one year.

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Each of the six core services in the SMI Health Homes program also has specific health information technology requirements outlined below:

Comprehensive Care Management
Both the MCOs and the HHPs will utilize certified health information exchange (HIE) networks including the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE) to share patient health information across various health home provider settings. HHPs must meet this HIT standard within a timeframe agreed to by the Lead Entity in order to participate in health homes. A portion of potential HHPs currently do not use EHRs. These organizations will be required to develop a plan to implement EHRs within the specified time frames outlined in provider standards. Details of the health action plan will be documented in the EHR to facilitate the sharing of patient needs across health home providers. The use of HIT via established networks will ensure that providers are updated on changes to patients' health action plans and care requirements. HIT will allow for the continuous monitoring of patient outcomes and the appropriate changes in care and follow up.

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

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

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

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

Referral to Community and Social Support Services
The health home member portal managed by the Lead Entities and accessible to members will include information and links to community and social support resources. HHPs will use their existing websites and secure e-mail to share information with members.

Chronic Conditions Health Homes Services and Professional Qualifications

(Text will be added)

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Section 2: Requirements for Health Homes Participation

2.1 Lead Entity Requirements for all Target Populations

For all KanCare Health Homes target populations, the requirements for the Lead Entities are the same. 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 with SMI.
5. Must have the capacity to evaluate, select and support providers who meet the standards for HHPs, including:
    a. Identification of providers who meet the HHP standards
    b. Provision of infrastructure and tools to support HHPs in care coordination
    c. Gathering and sharing member-level information regarding health care utilization, gaps in care and medications
    d. Providing outcome tools and measurement protocols to assess HHP effectiveness
    e. Developing and offering learning activities that will support HHPs in effective delivery of HH services

2.2 Health Home Partner Requirements

The requirements for Health Home Partners vary, depending upon the target population served by the Health Home; however, every Health Home must include the targeted case management (TCM) provider for any Health Home member who has an intellectual or developmental disability (I/DD). The Lead Entity or the HHP must contract with the TCM provider if the I/DD member wishes to continue the relationship with that provider. The TCM provider will be responsible for various components of the six core Health Homes services and these will be determined at the time the Health Action Plan is developed.

Requirements for SMI Health Homes Partners

For Health Home members with SMI, the Health Home Partner 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. Community Service Provider – for people with intellectual / developmental disabilities (I/DD)
    e. Federally Qualified Health Center/Primary Care Safety Net Clinic
    f. Home Health Agency
    g. Hospital – based Physician Group
    h. Local Health Department
    i. Physician – based Clinic
    j. Physician or Physician Practice
    k. Rural Health Clinics

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    l. 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 or telephonic contacts may also be utilized if culturally appropriate and accessible for the enrollee to enhance access to services for members and families where geographic or other barriers exist
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 the Kansas Health Homes Program Manual
7. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the HHP on care coordination and hospital / ER notification
8. Commit to the use of an interoperable EHR through the following:
    a. Submission of a plan, within 90 days of contracting as a HHP, to implement the EHR
    b. Full implementation of the EHR within a timeline approved by the Lead Entity
    c. Connection to one of the certified state HIE, KHIN or LACIE, within a timeline approved by the Lead Entity

Requirements for Chronic Conditions Health Homes Partners

(Text will be added)

2.3 Lead Entity and Health Home Partner Joint Requirements

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

Joint Requirements for SMI Health Homes

For Health Home members who are SMI, the lead Entity and the Health Home Partner 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 coordinates and integrates all his or her clinical and non-clinical health care related needs and services
4. Provide quality-driven, cost-effective health home 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

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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
    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

Joint Requirements Chronic Conditions Health Homes
(Text will be added)

Preparedness and Planning Tool
Each potential HHP must complete the Kansas Health Homes Preparedness and Planning Tool (PPT) and submit it to KDHE. The tool can be found at: _____ or in Appendix ___ of this manual. Once the completed tool is received, copies will be sent, electronically, to the MCOs with which the HHP indicates it would like to contract. The selected MCOs will have ____ days within which to respond to the potential HHP.

The PPT is designed to help the potential HHP make a realistic examination of its ability to provide Health Home services and determine where its strengths and areas for transformation are. Ultimately, the MCOs will make the decision about contracting with potential HHPs, but KDHE has directed that they must offer providers feedback on the completed PPT and allow providers additional opportunities to complete the tool and request to contract.

Section 3: Lead Entity Contracts with Health Home Partners
(Text will be added)

Section 4: Member Assignment, Enrollment and Disenrollment

4.1 Medicaid Eligibility Determination for Health Home Members
To be eligible for Health Homes, a person must first be eligible for Medicaid. Health Homes are not available to children in the Children's Health Program (CHIP) portion of KanCare because

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Health Homes 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) offices throughout the state.

4.2 Member Assignment

KanCare members who are determined eligible for Medicaid are assigned to Health Homes by their MCO, based on information the MCO already has from claims and other data, or as a result of a referral by a provider in the community. The assignment will be made based upon which target population the member is in, which HHPS are available in their geographic area and what existing relationship they may already have with any HHPs in their area. Members have the right to choose from among available HHPs in their area, with certain limits.

When a Health Homes member is identified, the MCO will send an assignment letter explaining:

- Health Homes and their benefits
- Why the member is eligible
- Which HHP the member has been assigned
- How to choose a different HHP
- How to opt out of Health Homes

A sample letter can be found here: _____ or in Appendix ___ of this manual.

Members who opt out of Health Homes will be reassessed annually by their MCO and another assignment letter will be sent at that time. If a member opts out of Health Homes, but later wants to join a Health Home or one of their providers submits a referral form, the MCO will send another assignment letter whether or not a year has passed since the member originally opted out.

(Insert specific assignment requirements for foster care children here)

Section 5: Health Action Plan

The Health Action Plan is a tool developed by the member, Lead Entity, HHP, and others who will be involved, to document goals the member will pursue within the Health Home, and the progress toward meeting those goals. Each Health Home member is required to have a Health Action Plan. The Health Action Plan is developed by the member with the assistance of the Care Manager or Care Coordinator, with input from others who are participating in the Health Home, including those people the member chooses to include in the process.

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
- Health Home goals, steps to achieve each goal, strengths and needs measureable outcomes, start date, progress
- Signatures

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The Health Action Plan and instructions may found here: _____ and in Appendix ___ 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 such plan must refer individuals with chronic conditions who seek or need treatment in an emergency department to a health home. Such a referral must be made using the Kansas Health Homes Referral Form, found here: _____ or in Appendix ____ of this manual.

6.2 Referrals from Other Providers

Other providers may refer Medicaid members to Health Homes through their MCO, based on the criteria outlined in Section 1.6 of this manual. Such a referral must be made using the Kansas Health Homes Referral Form, found here: _____ or in Appendix ____ of this manual.

Section 7: Claims Submission and Billing

Health Homes is considered a bundled service, so individual core services provided within any month will not be billed for as fee-for-service. Payment to the Lead Entity, from the State, is a per member per month (PMPM) payment made retrospectively each month and unless pre-approved by the State, payment to the HHP will be a PMPM. In order for a HHP to receive the Health Home PMPM payment agreed upon between the Lead Entity and the HHP, the HHP must provide the member with at least one Health Home service during the month for which the claim is submitted. Services should be documented per the information provided in the Section 11: Health Home Documentation Requirements of this manual.

The billing code for Health Home services is **S0281**.

Information specific to each Lead Entity regarding provider billing is available on the KanCare website at http://www.kancare.ks.gov/provider_billing_information.htm.

Section 8: Rate Calculation and Methodology

(Text will be added)

Section 9: Grievances and Appeals

HHPs have the same grievance and appeal rights as permitted providers under KanCare. The HHP must file its Health Home 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 HHP or in their provider manual. HHPs can generally appeal to the State after exhausting the MCO process. For definitive information on grievances and appeals, please refer to your agreement with the Lead Entity. For

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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.

Section 10: Health Information Technology

(Text will be added)

Section 11: Health Home Documentation Requirements

Each Lead Entity will have some specific requirements, spelled out in their contracts with HHPs, but all three have agreed to some basic documentation requirements that are designed to demonstrate HHPs have provided specific core Health Home services. The following table describes these requirements. (Table will be inserted.)

Section 12: Health Home Learning Collaborative

A Learning Collaborative will be convened and will include multiple program components to support provider implementation of Health Homes.
(Text will be added)

Glossary

Contact Information

Forms

List of Resources?

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