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State/Territory Name: KS

State Plan Amendment (SPA) #: 20-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
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- 3) Approved SPA Pages

KS - Submission Package - KS2019MS0005O - (KS-20-0004) - Health Homes

Summary Reviewable Units Versions Correspondence Log Analyst Notes Review Assessment Report **Approval Letter** Transaction Logs

News Related Actions

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group, Division of Program Operations
601 E. 12th Street
Room 355
Kansas City, MO 64106



Center for Medicaid & CHIP Services

July 16, 2020

Christiane Swartz
Interim Medicaid Director
Kansas Department of Health and Environment, Division of Health Care Finance
900 SW Jackson, Suite 900 N
Topeka, KS
Topeka, KS 66612

Re: Approval of State Plan Amendment KS-20-0004 OneCare Kansas - SMI (Serious Mental Illness)

Dear Christiane Swartz:

On April 20, 2020, the Centers for Medicare and Medicaid Services (CMS) received Kansas State Plan Amendment (SPA) KS-20-0004 for OneCare Kansas - SMI (Serious Mental Illness) to provide selected Medicaid members with a new set of six services. OneCare Kansas services will be provided through a partnership between KanCare managed care organizations (MCOs) (lead entities) and community providers (OneCare Kansas Partners — OCKP). The six new services will be provided in addition to the other services that members receive in Medicaid. These new services will be available to members with Serious Mental Illness (SMI).

We approve Kansas State Plan Amendment (SPA) KS-20-0004 on July 16, 2020 with an effective date(s) of April 01, 2020.

No enhanced match is available for services provided in this approval letter with respect to OneCare Kansas - SMI because Kansas has received eight quarters of enhanced match in a previous SMI health home program.

This SPA is being approved concurrent with SPA KS-20-0005, which establishes a similar Health Homes program for Medicaid members with Asthma who are at risk of developing another chronic condition; and SPA KS-20-0013, which adds the six Health Homes services to the Working Healthy Alternative Benefit Plan service package. These two SPAs are also effective April 1, 2020.

Name	Date Created	
No items available		

If you have any questions regarding this amendment, please contact Michala Walker at michala.walker@cms.hhs.gov.

Sincerely,
James G. Scott, Division Director
Division of Program Operations
Center for Medicaid & CHIP Services

KS - Submission Package - KS2019MS0005O - (KS-20-0004) - Health Homes

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

CMS-10434 OMB 0938-1188

Package Header

Package ID	KS2019MS0005O	SPA ID	KS-20-0004
Submission Type	Official	Initial Submission Date	4/20/2020
Approval Date	07/16/2020	Effective Date	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Kansas	Medicaid Agency Name:	Kansas Department of Health and Environment, Division of Health Care Finance
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Submission Component

- ☒ State Plan Amendment
- ☒ Medicaid
- ☐ CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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SPA ID and Effective Date

SPA ID KS-20-0004

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	4/1/2020	new
Health Homes Geographic Limitations	4/1/2020	new
Health Homes Population and Enrollment Criteria	4/1/2020	new
Health Homes Providers	4/1/2020	new
Health Homes Service Delivery Systems	4/1/2020	new
Health Homes Payment Methodologies	4/1/2020	new
Health Homes Services	4/1/2020	new
Health Homes Monitoring, Quality Measurement and Evaluation	4/1/2020	new

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

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Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives The Health Homes model in Kansas takes the form of a Partnership between the Lead Entity and another entity, a Health Home (OneCare Kansas (OCK)) Partner, that is appropriate for each member.

This model of a team of health professionals appears to offer the greatest flexibility for providing health home services within a managed care delivery system. Such flexibility will be important since Kansas is a largely rural state, with well-defined urban, areas, and familiar community providers, such as community mental health centers are important. Such providers can be OCK Partners with the Lead Entities, assuming they meet the provider qualifications, can provide all the six core services, and are willing to contract with the Lead Entities. OCK Partners are expected to provide face-to-face services. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

OCK Partners should be connected to other community-based providers as well to effectively manage the full breadth of member needs. Kansas has 5 high-level goals to assess the effectiveness of our Health Home program and to align with the KanCare Quality Management Strategy: 1) Improve the delivery of holistic, integrated, person-centered, and culturally appropriate care to all members; 2) Improve member experience and quality of life; 3) Improve provider experience and network relationships; 4) Increase access to and availability of services; 5) Increase the use of evidence-based practices for members with behavioral health (mental health and substance use disorder) and chronic physical health conditions.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2020	\$249461
Second	2021	\$748747

Federal Statute / Regulation Citation

Section 2703 of the PPACA

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

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Governor's Office Review

- ☒ No comment
- ☐ Comments received
- ☐ No response within 45 days
- ☐ Other

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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Program Authority

1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

OneCare Kansas - SMI (Serious Mental Illness)

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The Health Homes model in Kansas takes the form of a Partnership between the Lead Entity and another entity, a Health Home (OneCare Kansas (OCK)) Partner, that is appropriate for each member.

This model of a team of health professionals appears to offer the greatest flexibility for providing health home services within a managed care delivery system. Such flexibility will be important since Kansas is a largely rural state, with well-defined urban, areas, and familiar community providers, such as community mental health centers are important. Such providers can be OCK Partners with the Lead Entities, assuming they meet the provider qualifications, can provide all the six core services, and are willing to contract with the Lead Entities. OneCare Kansas (Health Home) providers should have “face to face” in-person assessments and visits while encouraging the use of technology to engage members. In the event that in-person communication is not possible, due to a public health emergency or a natural disaster, alternative communication methods should be used. This would include telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication that assure the health, safety, and continuity of care for members.

OCK Partners should be connected to other community-based providers as well to effectively manage the full breadth of member needs. Kansas has 5 high-level goals to assess the effectiveness of our Health Home program and to align with the KanCare Quality Management Strategy: 1) Improve the delivery of holistic, integrated, person-centered, and culturally appropriate care to all members; 2) Improve member experience and quality of life; 3) Improve provider experience and network relationships; 4) Increase access to and availability of services; 5) Increase the use of evidence-based practices for members with behavioral health (mental health and substance use disorder) and chronic physical health conditions.

General Assurances

- ✓ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ✓ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ✓ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ✓ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ✓ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ✓ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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	User-Entered		

- ☒ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☐ Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- ☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

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Population Criteria

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

- ☐ Two or more chronic conditions
- ☐ One chronic condition and the risk of developing another
- ☒ One serious and persistent mental health condition

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

1 serious and persistent mental illness, defined as having at least one of the following diagnoses:
Paranoid Schizophrenia
Severe Bipolar Disorder

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

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

- ☒ Opt-In to Health Homes provider
- ☐ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

Describe the process used:

The OCK Lead Entities (LE) will identify eligible members through claims, using the State-determined, CMS-approved criteria. The Lead Entities will assign enrolled members to one of the LEs contracted OCK Partners and notify the member, by letter, sent via United States Postal Service. Along with the letter, which will explain how members can opt-in to OCK, will be a consent to participate form. To comply with 42 CFR, consent must be obtained in writing and returned to the LE via e-mail, fax or mail. Members may also receive information about their options for OCK Partners by calling their OCK LE.

OneCare Kansas members are able to choose to participate in the program (opt-in), but they are not required to participate. In addition, they also have a choice of OneCare Kansas Partners. Our OneCare Kansas network of providers continues to grow allowing for choice among at least two OneCare Partners in every area of our state. One method to ensure choice is the fact that the State continues to remind the providers, MCOs and the members themselves that the usual catchment areas do not apply to OneCare Kansas. This is also published in the OneCare Kansas Manual. The invitation letter specifies that the member may ask for another OneCare Kansas Partner and all published member materials make clear that members may opt-out or select another OneCare Kansas Partner at any time. We have developed specific training that is posted on the OneCare Kansas website that outlines the timelines associated with the processing of opt-ins and opt-outs. Opt-ins/outs can be requested at any time and these timelines explain the internal, behind the scenes timeframes and processes that lead to updated rosters, new enrollment of members, etc. Finally, the State has developed and delivered training and also documented in our OneCare Kansas Manual how OneCare Kansas services are always in addition to other Medicaid benefits that a member may already be receiving.

Health Homes Providers

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Types of Health Homes Providers

- ☐ Designated Providers
- ☒ Teams of Health Care Professionals

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

- ☒ Physicians

Describe the Provider Qualifications and Standards

The LE must ensure the OCK Partner has at least one MD/DO to support the Health Home in meeting the Provider Standards. The MD/DO must be actively licensed to practice medicine in Kansas. For children, pediatricians are preferred. The MD/DO can either be employed directly or contracted with the OCK Partner if a Mid-level practitioner is employed by the OCK Partner.

✓ Nurse Practitioners

Describe the Provider Qualifications and Standards

The Lead Entity must ensure that the OCK Partner has a Mid-level practitioner on staff, if the OCK Partner's physician is contracted to support the Health Home in meeting the Provider Standards. The Mid-level practitioner must be actively licensed to practice in Kansas.

Professional requirements for all staff providing OneCare Kansas services are that they must be licensed to practice in the State of Kansas. Our contracted providers have experience serving complex needs of the population identified in OneCare Kansas. OneCare Kansas team members are expected to provide services through a Trauma-Informed approach and are required to complete the CDC's online Adverse Childhood Experiences (ACEs)-focused Introductory Training Modules 1 and 2.

The staff of the OCK partners are expected to have experience and a proven ability to effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions. The State will provide opportunities for staff education and development to aid OCK partners with the resources needed to provide quality care. In addition, the Lead Entities will include staff training as a component of their audits thereby ensuring that all OCK partners employ trained staff for the program.

The Lead Entity and OCK partner must jointly provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees. All OCK partners must demonstrate their capacity to meet this requirement prior to being awarded a contract to serve as an OCK partner. The OCK partner staff will have a variety of tools available to ensure safe care transitions occur. 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. Prior to being awarded contracts as OCK partners, all providers interested in serving as OCK partners were required to submit to the state evidence of their existing relationships with both hospitals and other community based providers. Evidence of these relationships was mandatory for a provider to move ahead in the contracting process.

All OCK partner staff are expected to participate in quality improvement. A requirement in OCK partners' contract is that they participate monthly in a Learning Collaborative where among other topics, quality takes center stage. To assess quality improvements and clinical outcomes, the State will collect clinical and quality of care data for the CMS Core Set of Measures. Each of the Lead Entities will also have specific performance indicators they may look at. The Lead Entities will audit the OCKP on a biannual basis through the use of a standardized audit tool, OneCare Kansas Partner Auditing Tool.

✓ Nurse Care Coordinators

Describe the Provider Qualifications and Standards

The LE must ensure the OCK Partner has at least one RN, APRN, or LPN actively licensed to practice in Kansas to support the Health Home in meeting the Provider standards.

Professional requirements for all staff providing OneCare Kansas services are that they must be licensed to practice in the State of Kansas. Our contracted providers have experience serving complex needs of the population identified in OneCare Kansas. OneCare Kansas team members are expected to provide services through a Trauma-Informed approach and are required to complete the CDC's online Adverse Childhood Experiences (ACEs)-focused Introductory Training Modules 1 and 2.

The staff of the OCK partners are expected to have experience and a proven ability to effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions. The State will provide opportunities for staff education and development to aid OCK partners with the resources needed to provide quality care. In addition, the Lead Entities will include staff training as a component of their audits thereby ensuring that all OCK partners employ trained staff for the program.

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partners were required to submit to the state evidence of their existing relationships with both hospitals and other community based providers. Evidence of these relationships was mandatory for a provider to move ahead in the contracting process.

☐ Nutritionists

☒ Social Workers

Describe the Provider Qualifications and Standards

Care Coordinator. The LE must ensure the OCK Partner has a Care Coordinator to support the health home in meeting the provider standards and deliver health home services to enrollees. The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) TCM or a Substance Use Disorder (SUD) person centered case manager to support the health home in meeting the provider standards and deliver health home services to enrollees. MH and I/DD TCMs must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals.

OCKPs have experience serving the complex needs of the OneCare Kansas population. OCKP staff members are expected to provide services through a Trauma-Informed approach and are required to complete the CDC's online Adverse Childhood Experiences (ACEs)-focused Introductory Training Modules 1 and 2.

OCKP staff have experience and a proven ability to coordinate the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions. The State provides opportunities for education and development to aid OCKPs with the resources needed to provide quality care. LEs will include staff training as a component of their audits thereby ensuring that all OCKPs employ trained staff for the program.

The CCs facilitate the development and maintenance of the Health Action Plan (HAP). The HAP is developed in a face-to-face or telehealth meeting with the member, the CC and any other individual(s) who are involved in the member's care. The HAP itself is designed to include an emphasis on allowing the member to set their own goals as well as an approach to meeting those goals that the member is comfortable with. The HAP is the centerpiece for the program around which all services are delivered. The HAP does not replace any specific treatment plans or person-centered support plans already required. The HAP assigns specific responsibilities to providers and the member related to health goals. Information collected in the HAP along with OCKP data collected through their EHR will allow data to be used for a holistic care approach.

Eligible members are invited to participate in OCK. The invitation and consent letter is sent to all eligible members to facilitate the Opt-In process. This process is designed to ensure member's right to privacy. The member is educated that participation is voluntary, free of charge, and members may opt-in, opt-out and request a different OCKP at any time.

The Lead Entity and OCKPs must jointly provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees. Coordination with other providers is an expectation for OCKPs. Prior to being awarded a contract as an OCKP, interested providers were required to provide evidence of existing formal relationships with key area providers (i.e. hospitals, community-based services, etc.) Providers who could not demonstrate such existing relationships and protocols were not awarded contracts to serve as OCKPs.

OCKP staff will have a variety of tools available to ensure safe care transitions occur. 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 the LE's secure portals and websites to assist in developing transition plans.

The CCs as well as other OCKP staff will use health information technology (HIT) to facilitate access to patient information across health care settings which will allow for ongoing care coordination. Lead Entities and OCKP's 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.

☐ Behavioral Health Professionals

☒ Other (Specify)

Provider Type	Description
Peer Support Specialist/Mentor/Advocate	<p>The OCK Partner may employ a Peer Support Specialist/Mentor/Advocate to support the Health Home in delivering OCK Services</p> <ul style="list-style-type: none"> 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 the 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.
Mid-level Practitioner - Physician Assistant (PA)	<p>The Lead Entity must ensure that the OCK Partner has a Mid-level practitioner on staff, if the OCK Partner's physician is contracted to support the Health Home in meeting the Provider Standards. The Mid-level practitioner must be actively licensed to practice in Kansas.</p>
Lead Entity	<p>The Lead Entity must:</p> <ol style="list-style-type: none"> Maintain a valid certificate of authority as a Health Maintenance Organization from the Kansas Insurance Department Have a NCQA accreditation for its Medicaid managed care plan Must have authority to access Kansas Medicaid claims data for the population served Must have a statewide network

Provider Type	Description
	<p>of providers to service member with SMI and chronic conditions. The Lead Entity must maintain a network of providers to support the enrollees health Care team based upon the individual enrollees health care needs, including but not limited to Nutritionist, Pharmacists, Dietitians, licensed addictions Counselor, LTSS Provider or a Parent Support Specialist who has a child with a mental illness or substance use disorder, etc. The provider must meet Kansas Licensing requirements as appropriate</p> <p>5. Must have the capacity to evaluate, select and support providers who meet the standards for OCK Partners, including:</p> <p>identification of providers who meet the OCK Partner standards</p> <p>a. Provision of infrastructure and tools to support OCK Partners in care coordination</p> <p>b. Gathering and sharing member-level information regarding health care utilization, gaps in care and medications</p> <p>c. Providing outcome tools and measurement protocols to assess OCK PARTNER effectiveness</p> <p>d. Developing and offering learning activities that will support OCK Partners in effective delivery of OCK services</p>
OneCare Kansas Partner (OCKP)	<p>The OCK Partner must:</p> <p>1. Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements.</p> <p>2. Must meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following:</p> <p>a. Center for Independent Living</p> <p>b. Community Developmental Disability Organization</p> <p>c. Community Mental health Center</p> <p>d. Community Service Provider for people with intellectual/developmental disabilities (I/DD)</p> <p>e. Federally Qualified health Center/Primary Care Safety net Clinic</p> <p>f. Home Health Agency</p> <p>g. Hospital based Physician Group</p> <p>h. Local Health Department</p> <p>i. Physician based Clinic</p> <p>j. Physician or Physician Practice</p> <p>k. Rural Health Clinics</p> <p>l. Substance Use Disorder Provider</p>

Health Homes Providers

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☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

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

1. The Lead Entity/OCK partner team structure will ensure the provision of quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services. The team structure is ideal because it allows for the OCK partner to deliver the hands-on care our members need, relying on their knowledge of local resources and community partnerships. The Lead Entity is able to provide education to the OCK partners where needed and can fill any gaps that may exist in some of our small rural communities that otherwise would not have access to some of the resources more commonly found in the urban areas of our state.
2. The Lead Entity/OCK partner team structure allows for coordination and provides access to high quality health care services informed by evidence-based clinical practice guidelines. Development of a Health Action Plan (HAP) is required for each member. OCK partners are expected to complete the HAP within 90 days of a member being assigned to them. The HAP itself is infused with evidence-based clinical practice guidelines and the State provides ongoing training to OCK partners to ensure that such guidelines are followed and incorporated as they deliver the six core services. OCK partner participation in this training is monitored and completion of some training such as Trauma Informed Care is required in order for OCK partners to remain in good standing.
3. The Lead Entity/OCK partner team structure allows for coordination and provides access to preventive and health promotion services, including prevention of mental illness and substance use disorders. In the Kansas model, all six core services are delivered at the local level. However, the Lead Entity is expected to support the OCK partner by providing training and resources, including assisting local OCK partners by providing ongoing training on a variety of health-related topics. These trainings focus on sharing best-practices, strategies for success and include a heavy emphasis on health promotion and prevention. The delivery of these trainings is monitored by the State to ensure that the Lead Entity is continuously providing support to the OCK partners.
4. The Lead Entity/OCK partner team structure allows for coordination and provides access to mental health and substance abuse services. In the Kansas model, all six core services are delivered at the local level. However, the Lead Entity is expected to support the OCK partner by providing training and resources, including assisting local OCK partners with locating other providers to whom referrals may be needed for services beyond the six core services delivered under the OCK program.
5. The Lead Entity/OCK partner team structure ensures coordination and provides 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. In the Kansas model, all six core services are delivered at the local level. OCK partners who are familiar with local community providers, resources and supports will work to ensure that members are connected to the services that they need and that communication between various providers is intact. Facilitating transitions of care and subsequent follow-ups is the responsibility of the OCK partners. OCK partners will be responsible for assisting in the development of transition plans when members leave hospital or other in-patient settings. Though the OCK partners are responsible for these duties, the Lead Entity is expected to support the OCK partner by providing training and resources, including assisting local OCK partners when members move from one area of the state to another.
6. The Lead Entity/OCK partner team structure ensures coordination and provides access to chronic disease management, including self-management support to individuals and their families. In the Kansas model, all six core services are delivered at the local level by the OCK partner. As part of the development of the Health Action Plan (HAP) the OCK partner takes account of not only the needs of the member, but also the needs of the member's support system, including their families. HAP goals should address both behavioral health as well as physical health concerns and provide a path for improvement. An emphasis on helping members and their families understand their diagnoses and what they can do to help themselves or their loved ones be healthier is a focus of the HAP as well as the program as a whole. Though the OCK partners are responsible for these duties, the Lead Entity is expected to support the OCK partner by providing training and resources to aid the OCK partner.
7. The Lead Entity/OCK partner team structure allows for coordination and provides access to individual and family supports, including referral to community, social support, and recovery services. In the Kansas model, all six core services are delivered at the local level. However, the Lead Entity is expected to support the OCK partner by providing training and resources, including assisting local OCK partners with locating other providers to whom referrals may be needed for services beyond the six core services delivered under the OCK program. Prior to being awarded a contract as an OCK partner, interested providers were required to submit evidence of their existing relationships with community partners. The state reviewed all interested providers to ensure that all OCK partners have a strong knowledge of local resources and supports and had existing, formal relationships with key community partners.
8. The Lead Entity/OCK partner team structure allows for coordination and provides access to long-term care supports and services. In the Kansas model, all six core services are delivered at the local level. However, the Lead Entity is expected to support the OCK partner by providing knowledge of, and assistance with, connecting OCK members with the long-term care supports and services that they may need.
9. The Lead Entity/OCK partner team structure ensures the development of 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. This plan is called the Health Action Plan (HAP). The HAP clarifies roles and responsibilities of the Lead Entity (LE), OneCare Kansas partner (OCKP), member, family/support persons/guardian, and health services and social service staff.
10. The Lead Entity/OCK partner team structure ensures a robust 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. OCK partner staff will use health information technology to facilitate access to patient information across health care settings which will allow for ongoing care coordination. Lead Entities and OCK partner's use of health information technology will allow for documentation, execution, continuous monitoring, and updates to the health care plan that will impact patient outcomes, treatment options, and follow-up.
11. The Lead Entity/OCK partner team structure establishes 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. All members of the OCK partner staff are expected to participate in quality improvement. A requirement in OCK partners' contract is that they participate monthly in a Learning Collaborative where among other topics, quality takes center stage. To assess quality improvements and clinical outcomes, the State will collect clinical and quality of care data for the CMS Core Set of Measures. 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. 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 of OneCare Kansas Draft Manual. Regarding OCK partner performance and service delivery, the Lead Entities have jointly developed a list of situations that would signal to them an OCK partner 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. The Lead Entities will audit the OCKP on a biannual bases through the use of a standardized audit tool, OneCare Kansas Partner Auditing Tool.

OCK members may need services beyond those available through the OneCare Kansas Providers (OCKP). Such services may include: Housing assistance, vocational rehabilitation, financial counseling, etc. Such providers would not be allowed to serve as OCKPs but member may still need referrals to such providers at times.

Supports for Health Homes Providers

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

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

Description

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

1. Requiring Lead Entities to have statewide networks of providers; evaluate, select and support providers who meet the OCK Partner standards and who have been approved by the State; developing and offering learning opportunities to OCK Partners; and reviewing OCK Partner's EHRs and connection to HIEs.
2. Supporting the initiation of a Learning Collaborative that will assist providers to become OCK Partners and to participate in quality improvement activities designed to improve performance of the OCK Partners and outcomes for the HH members. This Learning Collaborative will consist of a combination of statewide and regional meetings, webinars, teleconferences, a monthly newsletter and the State's OneCare Kansas webpage.
3. Development of a OneCare Kansas Program Manual to provide clear guidance to both LEs and OCK Partners about expectations for both.
4. Holding provider training webinars once each month from March 2019 through March 2020.
5. Holding regional provider training meetings in 3 cities in February 2020.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

The KanCare Health Home Lead Entity must:

1. Must maintain a valid certificate of authority from the Kansas Insurance Department.
2. Must have authority to access Kansas Medicaid claims data for the population served.
3. Must obtain NCQA accreditation for its Medicaid managed care plan.
4. Must have a statewide network of providers to service members with Chronic Conditions and SMI.
5. Must have the capacity to evaluate, select and support providers who meet the standards for OCK Partners, including:
 - a. Identification of providers who meet the OCK standards;
 - b. Provision of infrastructure and tools to support OCK Partners 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 OCK Partners effectiveness;
 - e. Developing and offering learning activities that will support OCK Partners in effective delivery of HH services;
 - f. Reviewing OCK Partners EHRs.

The KanCare OCK Partner must:

1. Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements.
2. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls
3. 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
4. Have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals
5. Agree to accept any eligible enrollees, except for reasons published in the Kansas Health Homes Program Manual
6. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the OCK PARTNER on care coordination and hospital/ER notification
7. Use an interoperable EHR
8. OCK Partners are expected to provide face-to-face services. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

The Lead Entity and the OCK Partner jointly must:

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
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

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

Package Header

Package ID	KS2019MS0005O	SPA ID	KS-20-0004
Submission Type	Official	Initial Submission Date	4/20/2020
Approval Date	07/16/2020	Effective Date	4/1/2020
Superseded SPA ID	new		
	User-Entered		

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

- ☐ Fee for Service
- ☐ PCCM
- ☒ Risk Based Managed Care

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


- ☒ Yes
- ☐ No

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

The contract amendment describes these requirements for the Lead Entities:

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

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

Name	Date Created	
Amendment 10	4/13/2020 9:30 PM EDT	

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

- ☐ Yes
- ☒ No

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

- ☒ Fee for Service (describe in Payment Methodology section)

☐ Other Service Delivery System

☐ Alternative Model of Payment
(describe in Payment Methodology
section)

☐ Other

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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Payment Methodology

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

☒ Fee for Service

☐ Individual Rates Per Service

☒ Per Member, Per Month Rates

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

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

☒ Other

Describe below

PMPM

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

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

There will be one per member, per month payment for the OCK services provided. There will also be a one-time bonus payment that is for timely completion of the Health Action Plan (HAP). This one-time bonus payment will be once per lifetime of the member regardless of OCK Partner. Timely completion is defined by the OCK Partner completing the HAP and submitting it to the HAP Portal within the first 90 days of enrollment of the member into the OCK Program. The partner will submit a claim for the one-time bonus payment and it will be verified by the Lead entities through the HAP Portal as well as during audits of the partners.
The PMPM is paid out less services rendered. It's paid out retrospectively based on the number of members served that received at least one service during the month.

☐ PCCM (description included in Service Delivery section)

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

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

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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Agency Rates

Describe the rates used

- ☒ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☐ The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS00050 | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

Package Header

Package ID	KS2019MS00050	SPA ID	KS-20-0004
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Approval Date	07/16/2020	Effective Date	4/1/2020
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	User-Entered		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description 1. The state's actuary firm, Optumas, reviewed and developed the rates to ensure the actual Health Home expenditure and cost trend support one comprehensive rate. In developing the OneCare Kansas (OCK) rates, Optumas relied on multiple actuarial assumptions. These assumptions were estimates of the impacts of various components of the rate development methodology and were used to calculate a practitioner component as well as a staff component. The Practitioner component and the Staff component were estimated to be a monthly per member per month (PMPM) cost. Multiple sources of program-specific information, industry information and in-house clinicians with 35+ years of experience were relied upon to ensure that these assumptions were well-informed, unbiased, and as accurate as possible.

2. The reimbursable units are the six (6) core services of Health Homes: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, Referral to Community and Supports Services.

3. Payment will only be made once a service is delivered. At least one of the six (6) core services must be utilized in a month to receive payment for that month. The first claim that is received in a month will trigger the payment to the OCK Partner. Additional claims received for that member in the same month will be billed as \$0 claims. The HAP bonus payment will be available to OCK Partners who complete the initial HAP within 90 days of the members enrollment in the OCK program. This is a one-time only payment. Completion of subsequent HAPs for a given member are not eligible for the HAP bonus payment.

4. Kansas requires all OCK Partners to submit completed Health Action Plans (HAP) into a HAP Portal. Also, OCK Partners are to document OCK services in their Electronic Health Record (EHR). The Lead Entities are required to complete yearly audits, at a minimum, of the OCK Partners to ensure that the services are being documented and completed as defined by the OCK Program Manual and the State Plan.

5.a. The State will revisit the OCK rates annually for rebasing and other adjustments.

b. The key factors that will be reviewed are the utilization assumptions by service, as those are the primary drivers of the rates. Additionally, costs for professionals will be reviewed for more recent information, as will the sufficiency of the non-medical components. Emerging data will be summarized and compared to the rates to determine if the rates are economic, efficient, and sufficient to ensure quality services.

The current rates are published on the OCK website and can be found here: https://www.kancare.ks.gov/docs/default-source/providers/ock/ock-rate-announcement.pdf?sfvrsn=fb44f1b_8.

Health Homes Payment Methodologies

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Assurances

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

The OCK FFS PMPM from the State to the MCOs will be net of other duplicative Medicaid payments and services. This will ensure non-duplication of payment is achieved. Services similar to OCK services that are offered/covered under KanCare capitation and other statutory authorities will not be duplicated.

TCM services and reimbursement will not be duplicated with OCK services.

☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).
- ## Optional Supporting Material Upload
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Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

Package Header

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Service Definitions

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

Comprehensive Care Management

Definition

Comprehensive care management involves Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from a HH, and coordinating and collaborating with all team members to promote continuity and consistency of care to minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the members physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), OCK Partner, member, family/support persons/guardian, and health services and social service staff. Critical components of comprehensive care management include: Knowledge of the medical and non-medical service delivery system within and outside of the members' area. Comprehensive care management is expected to be provided as a face-to-face service. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

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

Comprehensive care management includes: Monitoring and follow-up to ensure that needed care and services are offered and accessed.

Comprehensive care management includes: Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances.

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

Under the OneCare Kansas model, the HAP must be updated at least quarterly.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Lead Entities and OCK Partners are required to implement an electronic health record (EHR) to facilitate collaboration and sharing of patient information across health care settings. The use of Health Information Technology (HIT) through established networks will allow for continuous monitoring of patient outcomes and notification of appropriate changes in care and follow up. Lead Entities and OCK Partners shall exchange data, as permitted by state and federal laws.

Lead Entities and OCK Partners are required to use or modify existing member portals, websites, and/or secure e-mail as a communication tool to share information with members and family/supports. The information outlined will be relating to evidence-based treatment options, links to local and national support resources, and health promotion activities.

The State has designated a data hub for all Health Action Plans (HAP), which is a tool to document information such as demographics, physical and behavioral information, member goals, and measurable outcomes. The HAP data will be accessible by Lead Entities, OCK Partners, and State staff for ongoing monitoring and evaluation purposes.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☒ Nurse Practitioner

Description

APRNs at the OCK Partner

☒ Nurse Care Coordinators

Description

Nurse Care Coordinators at the OCK Partner

☐ Nurses

☐ Medical Specialists

☒ Physicians

Description

MD/DO at the OCK Partner

☒ Physician's Assistants

Description

PA at the OCK Partner

☐ Pharmacists

☒ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

Description

Care Coordinator at the OCK Partner

Provider Type	Description
OCK Partner	Nurse Coordinators at the OCK Partner, or Care Coordinators at the OCK Partner will be responsible for delivery of this service.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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Care Coordination

Definition

Care coordination is the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. Care coordination is expected to be provided as a face-to-face service. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

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 members needs.

Care coordination:

- Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the members goals
- Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in the OCK program
- Involves coordination and collaboration with other providers to monitor the members conditions, health status, and medications and side effects.
- Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports.
- Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact.
- Creates and promotes linkages to other agencies, services, and supports.

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

The HAP must be reviewed and updated regularly, at intervals no greater than 90 days. The State requires that the member participate in the development of the HAP and the HAP itself is designed to include a heavy emphasis on allowing the member to set their own goals as well as an approach to meeting those goals that the member is comfortable with.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Lead Entities and OCK Partners are required to implement an electronic health record (EHR) to facilitate collaboration and sharing of patient information across health care settings. The use of Health Information Technology (HIT) through established networks will allow for continuous monitoring of patient outcomes and notification of appropriate changes in care and follow up. Lead Entities and OCK Partners shall exchange data, as permitted by state and federal laws.

Lead Entities and OCK Partners are required to use or modify existing member portals, websites, and/or secure e-mail as a communication tool to share information with members and family/supports. The information outlined will be relating to evidence-based treatment options, links to local and national support resources, and health promotion activities.

The State has designated a data hub for all Health Action Plans (HAP), which is a tool to document information such as demographics, physical and behavioral information, member goals, and measurable outcomes. The HAP data will be accessible by Lead Entities, OCK Partners, and State staff for ongoing monitoring and evaluation purposes.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

Nurse Care Coordinators at the OCK Partner which may be an LPN, RN, or APRN

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☒ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☒ Other (specify)

Description

Care Coordinator at the OCK Partner

Provider Type	Description
OCK PARTNER	Nurse Coordinators at the OCK Partner, or Care Coordinators at the OCK Partner will be responsible for delivery of this service.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

Package Header

Package ID	KS2019MS0005O	SPA ID	KS-20-0004
Submission Type	Official	Initial Submission Date	4/20/2020
Approval Date	07/16/2020	Effective Date	4/1/2020
Superseded SPA ID	new		
	User-Entered		

Health Promotion

Definition

Health promotion involves engaging members in the OCK program, by phone, letter, HIT and community in reach and outreach, assessing members understanding of health condition/health literacy and motivation to engage in self-management, e.g., how important is the persons health status to the member, how confident the member feels to change health behaviors, etc., assisting members in the development of recovery plans, including self-management and/or relapse prevention plans, linking members to resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on member needs and preferences, and assisting members to develop the skills and confidence that will enable them to independently identify, seek out and access resources that will assist in managing and mitigating their conditions, and in preventing the development of secondary or other chronic conditions. Health promotion encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health. Health promotion 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.

Health promotion ensures all health action goals are included in person centered care plans. Health promotion provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions based upon the members preference. Health promotion offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations. Health promotion is expected to be provided as a face-to-face service. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Lead Entities and OCK Partners 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.

All Lead Entities and OCK Partners are required to implement an electronic health record (EHR) to facilitate collaboration and sharing of patient information across health care settings. The use of Health Information Technology (HIT) through established networks will allow for continuous monitoring of patient outcomes and notification of appropriate changes in care and follow up. Lead Entities and OCK Partners shall exchange data, as permitted by state and federal laws.

Lead Entities and OCK Partners are required to use or modify existing member portals, websites, and/or secure e-mail as a communication tool to share information with members and family/supports. The information outlined will be relating to evidence-based treatment options, links to local and national support resources, and health promotion activities.

The State has designated a data hub for all Health Action Plans (HAP), which is a tool to document information such as demographics, physical and behavioral information, member goals, and measurable outcomes. The HAP data will be accessible by Lead Entities, OCK Partners, and State staff for ongoing monitoring and evaluation purposes.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☒ Nurse Practitioner

Description

APRNs at the OCK Partner

☒ Nurse Care Coordinators

Description

Nurse Care Coordinators at the OCK Partner which may be an LPN, RN, or APRN

☐ Nurses

☐ Medical Specialists

☒ Physicians

Description

MD/DO at the OCK Partner

☒ Physician's Assistants

Description

PA at the OCK Partner

☐ Pharmacists

☒ Social Workers

Description

Care Coordinator at the OCK Partner

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
OCK PARTNER	Peer Support Specialist at the OCK Partner

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care is specialized care coordination designed to facilitate transition of treatment plans from hospitals, ED, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. It may also involve identifying members not participating who could benefit from a HH. Comprehensive transitional care involves developing a transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. For each HH member transferred from one caregiver or site of care to another, the HH coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation. Comprehensive transitional care involves collaboration, communication and coordination with members, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers. It is designed to ease transition by addressing the members understanding of rehab activities, LTSS, self-management, and medications. It includes scheduling appointments scheduling and reaching out if appointments are missed. It may also include evaluating the need to revise the HAP. Comprehensive transitional care is expected to be provided as a face-to-face service. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

The transition/discharge plan includes, but is not limited to, the following elements:

- Establishing timeframes related to appointments and discharge paperwork
- Providing follow-up appointment information
- Providing medication information to allow providers to reconcile medications and make informed decisions about care
- Ensuring medication education
- Assessing therapy needs, e.g., occupational, physical, speech, etc.
- Arranging transportation needs community supports needed post-discharge determination of environmental (home, community, workplace) safety.

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

Comprehensive transitional care involves developing a written transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. This written protocol will specify the care transition process with hospitals as well as other facilities where a member may be discharging from.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

All Lead Entities and OCK Partners are required to implement an electronic health record (EHR) to facilitate collaboration and sharing of patient information across health care settings. The use of Health Information Technology (HIT) through established networks will allow for continuous monitoring of patient outcomes and notification of appropriate changes in care and follow up. Lead Entities and OCK Partners shall exchange data, as permitted by state and federal laws.

Lead Entities and OCK Partners are required to use or modify existing member portals, websites, and/or secure e-mail as a communication tool to share information with members and family/supports. The information outlined will be relating to evidence-based treatment options, links to local and national support resources, and health promotion activities.

The State has designated a data hub for all Health Action Plans (HAP), which is a tool to document information such as demographics, physical and behavioral information, member goals, and measurable outcomes. The HAP data will be accessible by Lead Entities, OCK Partners, and State staff for ongoing monitoring and evaluation purposes.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☒ Nurse Practitioner

Description

APRNs at the OCK Partner

☒ Nurse Care Coordinators

Description

Nurse Care Coordinators at the OCK Partner which may be an LPN, RN, or APRN

☐ Nurses

☐ Medical Specialists

☒ Physicians

Description

MD/DO at the OCK Partner

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Description

PA at the OCK Partner

Description

Care Coordinator at the OCK Partner

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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Individual and Family Support (which includes authorized representatives)

Definition

Member and family support involves identifying supports needed for members, family/support persons/guardians need to manage members conditions and assisting them to access these supports. It includes assessing strengths and needs of members, family/support persons/guardians, identifying barriers to members 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, assistance to access self-help, peer 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 members, family/support persons and guardians understanding of effect(s) of the condition on the members 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. Individual and family support involves accommodations related to culture, disability, language, race, socio-economic background, and non-traditional family relationships.

Individual and family support promotes engagement of members, family/support persons and guardians. Individual and family support promotes self-management capabilities of members. Individual and family support involves ability to determine when members, families/support persons, and guardians are ready to receive and act upon information provided, assist them with making informed choices Involves an awareness of complexities of family dynamics, and an ability to respond to member needs when complex relationships come into play. Individual and family support is expected to be provided as a face-to-face service. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Lead Entities 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. OCK Partners will use their existing websites and secure email to share information with members.

All Lead Entities and OCK Partners are required to implement an electronic health record (EHR) to facilitate collaboration and sharing of patient information across health care settings. The use of Health Information Technology (HIT) through established networks will allow for continuous monitoring of patient outcomes and notification of appropriate changes in care and follow up. Lead Entities and OCK Partners shall exchange data, as permitted by state and federal laws.

Lead Entities and OCK Partners are required to use or modify existing member portals, websites, and/or secure e-mail as a communication tool to share information with members and family/supports. The information outlined will be relating to evidence-based treatment options, links to local and national support resources, and health promotion activities.

The State has designated a data hub for all Health Action Plans (HAP), which is a tool to document information such as demographics, physical and behavioral information, member goals, and measurable outcomes. The HAP data will be accessible by Lead Entities, OCK Partners, and State staff for ongoing monitoring and evaluation purposes.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☒ Social Workers

Description

Nurse Care Coordinators at the OCK Partner which may be an LPN, RN, or APRN

Description

Care Coordinator at the OCK Partner

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
OCK PARTNER	Peer Support Specialist at the OCK Partner

Health Homes Services

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Referral to Community and Social Support Services

Definition

Referral to community supports and services includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paper work, identifying natural supports if services providers are unavailable in the members community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible. Community supports, and services include long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. Referral to community and social support services involves a thorough knowledge of the medical and non-medical service delivery system. This service includes engagement with community and social supports including establishment and maintenance of relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc. This service includes fostering communication and collaboration with social supports through knowledge of the eligibility criteria for services. This service includes identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary. Referral to community and social support services is expected to be provided as a face-to-face service. In the event that in-person communication is not possible, alternative communication methods should be used to maintain continuity of care until face-to-face service delivery can safely be resumed. These alternative methods can include: telehealth, virtual assessments, telephonic monitoring and any other remote forms of communication.

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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

All Lead Entities and OCK Partners are required to implement an electronic health record (EHR) to facilitate collaboration and sharing of patient information across health care settings. The use of Health Information Technology (HIT) through established networks will allow for continuous monitoring of patient outcomes and notification of appropriate changes in care and follow up. Lead Entities and OCK Partners shall exchange data, as permitted by state and federal laws.

Lead Entities and OCK Partners are required to use or modify existing member portals, websites, and/or secure e-mail as a communication tool to share information with members and family/supports. The information outlined will be relating to evidence-based treatment options, links to local and national support resources, and health promotion activities.

The State has designated a data hub for all Health Action Plans (HAP), which is a tool to document information such as demographics, physical and behavioral information, member goals, and measurable outcomes. The HAP data will be accessible by Lead Entities, OCK Partners, and State staff for ongoing monitoring and evaluation purposes.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

Nurse Care Coordinators at the OCK Partner which may be an LPN, RN, or ARNP

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☒ Social Workers

Description

Care Coordinator at the OCK Partner

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☒ Other (specify)

Provider Type	Description
OCK PARTNER	Peer Support Specialist at the OCK Partner

Health Homes Services

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

OCK Enrollment Diagram

Name	Date Created	
OCK Enrollment Diagrams 19-07-18	1/23/2020 1:48 PM EST	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | KS2019MS0005O | KS-20-0004 | OneCare Kansas - SMI (Serious Mental Illness)

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

Year 1 (YR1) PMPM savings calculation: The average PMPM over YR1 for members who utilized a HH for at least 4 continuous months, or a minimum of 5 months in the first year. This will be called Actual YR1 HH PMPM and will be calculated separately by eligibility group, Chronic Condition (CC) and region. The average PMPM over YR1 will be calculated for members who didn't participate in a HH for the minimum of 4 continuous months, including those who opted out. This will be called the Actual YR1 Non-HH PMPM and will be calculated separately by eligibility group, CC and region similar to the Actual YR1 HH PMPM. The difference of (Actual YR1 Non-HH PMPM Actual YR1 HH PMPM) is the PMPM savings. This PMPM will be adjusted to account for changes in the PMPM not due to participation. A trend analysis on 18 months of experience under KanCare, before the implementation of HHs will be performed for members in the Actual YR1 HH PMPM & for members in the Actual YR1 Non-HH PMPM. These analyses will be used to project what the average PMPM over YR1 would have been for both groups had HHs not been implemented & will be split within each group by eligibility, CC & region. These will be called Projected YR1 HH PMPM and Projected YR1 Non-HH PMPM. The difference of (Projected YR1 Non-HH PMPM Projected YR1 HH PMPM) will account for savings or costs in the PMPM savings calculation not due to implementing HHs. The final YR1 PMPM savings calculation: (Actual YR1 Non-HH PMPM Actual YR1 HH PMPM) (Projected YR1 Non-HH PMPM Projected YR1 HH PMPM). A positive PMPM indicates achieved PMPM savings. Because of the lack of data for members new to both HHs and Medicaid, the PMPM savings calculation for these members will be the difference between those who didn't enroll in HHs and those who did: (Actual YR1 Non-HH PMPM Actual YR1 HH PMPM). Dual eligible information is included to the extent a dual eligible member is involved in the OCK program. Significant savings aren't anticipated to be realized until YR3 due to time needed to get systems in place, stabilize utilization and continue to identify HH target populations.

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

All Lead Entities and OCK Partners are required to implement an electronic health record (EHR) to facilitate collaboration and sharing of patient information across health care settings. The use of Health Information Technology (HIT) through established networks will allow for continuous monitoring of patient outcomes and notification of appropriate changes in care and follow up. Lead Entities and OCK Partners shall exchange data, as permitted by state and federal laws.

Lead Entities and OCK Partners are required to use or modify existing member portals, websites, and/or secure e-mail as a communication tool to share information with members and family/supports. The information outlined will be relating to evidence-based treatment options, links to local and national support resources, and health promotion activities.

The State has designated a data hub for all Health Action Plans (HAP), which is a tool to document information such as demographics, physical and behavioral information, member goals, and measurable outcomes. The HAP data will be accessible by Lead Entities, OCK Partners, and State staff for ongoing monitoring and evaluation purposes.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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