Exploring Medicaid Health Homes
Managed Care Plans as the Health Home Lead Entity: The Kansas Model

November 19, 2014; 1:00 – 2:00PM (ET)

For audio, dial: 1-800-273-7043; Attendee code: 596413

An audio archive will be posted on http://www.medicaid.gov

For more information or technical assistance in developing health homes, visit http://www.Medicaid.gov.

Exploring Medicaid Health Homes

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Health Home Information Resource Center

- Established by CMS to help states develop health home models for beneficiaries with complex needs
- Technical assistance includes:
  - One-on-one technical support to states
  - Group discussions and learning activities
  - Webinars
  - Online library of hands-on tools and resources, including:
    - Map of state health home activity
    - SPA template
    - Core quality measures

    http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

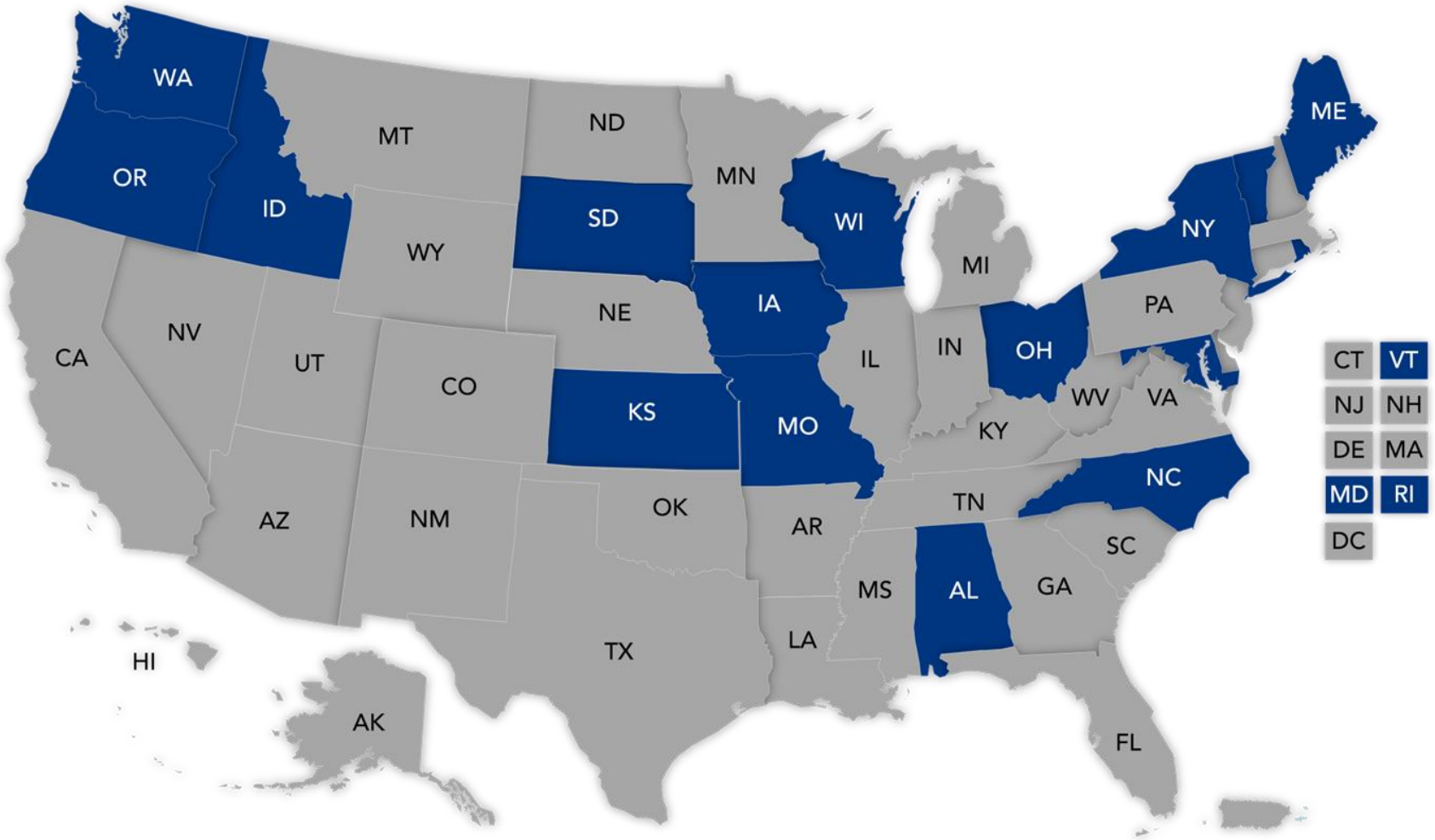
Exploring Medicaid Health Homes Webinar Series

- Provides a forum for states to share models, elements of their SPAs, and successes or challenges in their development process
- Creates an opportunity for CMS to engage in conversation with states considering and/or designing health home programs
- Disseminates existing knowledge useful to health home planning
- Open to any state considering or pursuing health homes

National Landscape to Date

- 16 states have approved health home State Plan Amendments (SPA): AL, IA, ID, KS, MD, ME, MO, NY, NC, OH, OR, RI, SD, VT, WA and WI
- Over 1 million health home enrollees
- Number of states in discussion with CMS
- Many other states exploring the opportunity to develop health homes

State Health Home Activity



States with Approved Health Home SPAs (number of approved SPAs)	Alabama, Idaho, Iowa (6), Kansas, Maine (2), Maryland, Missouri (2), New York (4), North Carolina, Ohio, Oregon, Rhode Island (3), South Dakota, Vermont (2), Washington (2), Wisconsin

Presenters

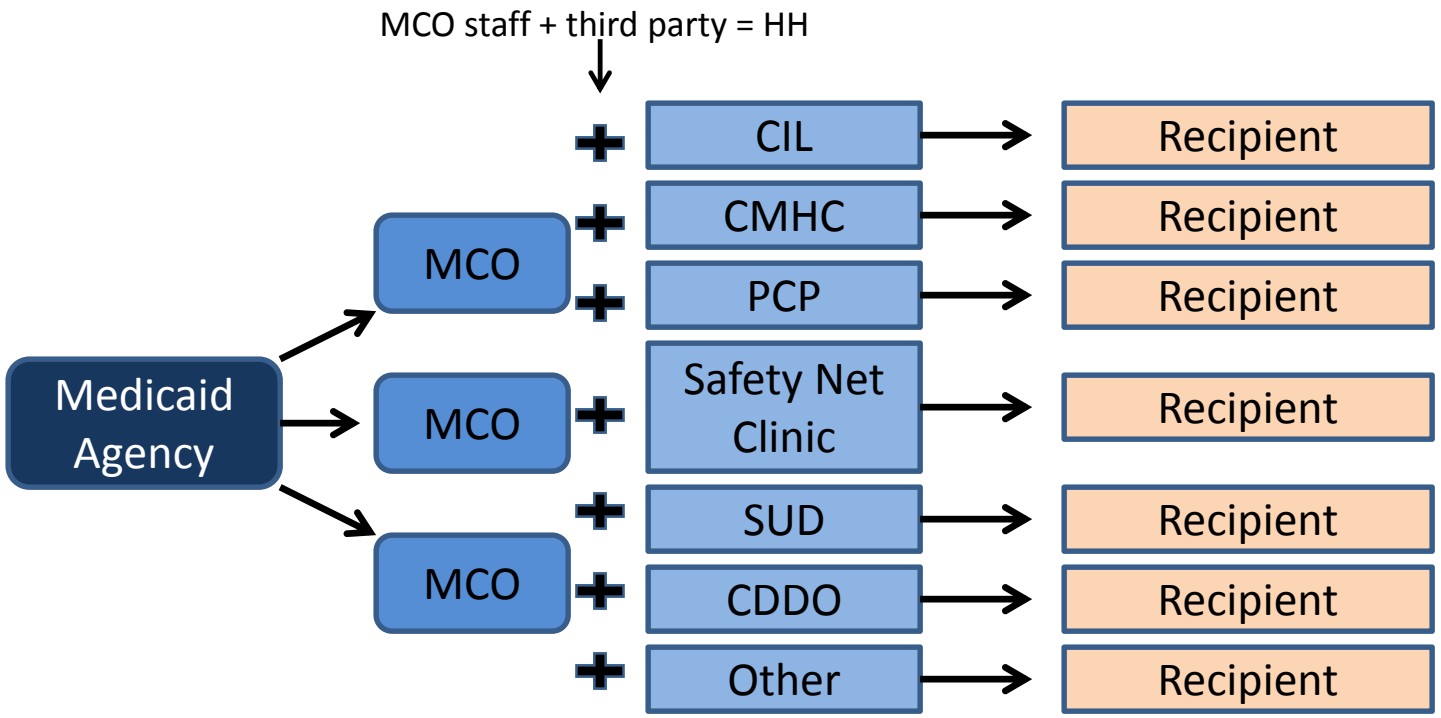
- Becky Ross, Medicaid Initiatives Coordinator, Kansas Department of Health and Environment
- Ben Pierce, Director of Operations, UnitedHealthcare Community Plan of Kansas
- Scott Wituk, Executive Director, Wichita State University - Center for Community Support and Research

Health Homes in Kansas

Overview of KanCare

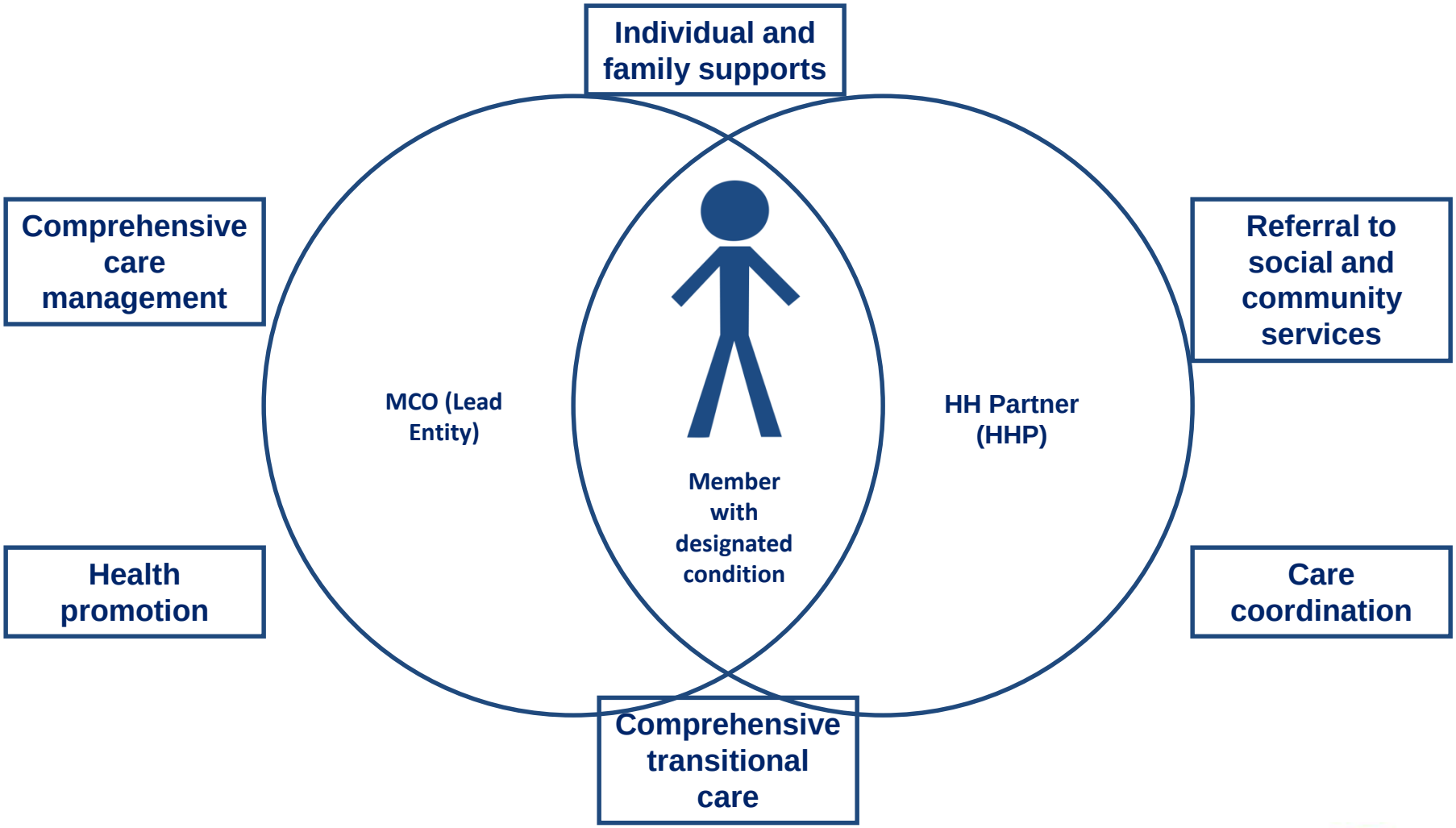
- 404,546 served monthly in SFY 2015 (Medicaid and CHIP)
- All physical and behavioral health care and LTSS included in capitated risk-based managed care (beginning 1/1/2013)
- 3 statewide health plans
  - > Amerigroup
  - > Sunflower (Centene)
  - > United Healthcare

Kan Health Home Model



This diagram has been modified from a similar one published by the Center for Health Care Strategies in the brief *Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System* by Dianne Hasselman and Deborah Bachrach (June 2011)

Kansas Health Homes Model



First Target Population

People (children and adults) with serious mental illness (SMI)

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

Enrollment and Assignment

- Passive enrollment with opt out
- MCOs data mine to identify members and assign a Health Home Partner (HHP)
- Opt out information (form or call) goes to state enrollment broker
- Member can choose different HHP by calling MCO
- Opted out members can opt back in by calling MCO

Project Milestones

- November 2011 – included in KanCare RFP
- April 2012 – formed project team and stakeholder group
- April and July 2013 – Stakeholder forums
- August 2013 – SAMHSA consultation; began monthly calls with CMS
- February 2014 – Twice-monthly provider webinars
- March 2014 – Consumer tour
- April 2014 – Provider training
- July 2014 – Implemented SMI Health Home

KanCare

Stakeholder Engagement

- Stakeholder Group – began April 2012
- Two forums – April and July 2013
- Numerous presentations
- Contracted partners
  - > Hewlett Packard Enterprises (HP)
  - > MCOs
  - > University of Kansas Medical School
  - > Wichita State University Center for Community Support and Research (CCSR)
  - > Kansas Foundation for Medical Care (KFMC)

Becoming a Health Home Partner

- Preparedness and Planning Tool (PPT) – no application
- Must contract with one or more MCOs
- Must employ or contract with required team of professionals
  - > Psychiatrist
  - > Non-psychiatrist physician
  - > Nurse care coordinator
  - > Social worker
  - > Peer support specialist/mentor

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Payment

- Not part of MCO capitated rate
- Four levels of HH PMPM to MCOs
- MCOs pay HHPs a negotiated PMPM
- Payment only triggered to MCOs if a HH service is provided
  - > Use a combination of two codes and some modifiers so individual services can be billed (although $0 claims, after first one in each month) so we can track utilization

Implementation

- July 1 – assignment letters went out
- August 1 – services began
- Weekly implementation calls
- Ongoing learning activities managed by WSU CCSR
- # in HHs (11/1/2014) – 25,630
- Opt out rate - 18%

United Healthcare Community Plan of Kansas Health Homes

November 19, 2014

UnitedHealthcare®
COMMUNITY & STATE

Goals – What are we trying to achieve?

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State Goals:

1. Reduce utilization associated with avoidable (preventable) inpatient stays
2. Improve management of chronic conditions
3. Improve care coordination
4. Improve transitions of care between primary care providers and inpatient facilities

Our Goals (In addition to KDHE goals):

1. Sustainability – Ensure that the program is intelligently designed and staffed to allow for success among our provider partners
2. Practice Transformation – Alignment PCMH and Clinical Best Practices
3. Relationship Building – Build our relationship with our provider partners and build the relationship between local care coordinators and members

Who do we serve through Health Homes?

Today: The Serious Mental Illness (SMI) state Plan Amendment (SPA) is live today.

Eligibility Criteria: Members with a primary diagnosis of one or more of the following:

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

This target population will also include anyone who may have a substance use disorder who also has one of the above-listed diagnoses.

Member Numbers:
Currently Assigned Members: **7,554**
I/DD Waiver Members: **417**
I/DD Service Non-Waiver Members(Waitlist and non-Qualifying): **182**

Managed Care Organization (MCO) Perspective

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Program Development:
What considerations and design decisions were made when we developing the program?

What do Health Home Partners and members need?

What reporting and data considerations are there?

Health Home Partner Support:
How we are working to engage with our contracted providers and provide them with the tools to deliver high quality services?

Member Engagement:
How do we develop a relationship between members and Care Coordinators that will serve as a foundation for the delivery of the 6 Core Services?

Performance Monitoring and Interventions:
How do we determine if the program is successful and if members are being positively impacted?

Program Development: Understanding the Environment

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1. Collaboration Between MCOs and State Partners: Collaborate during program development to determine what insight and recommendations each partner might have. No one has a monopoly on good ideas!

2. Network Development: Consider the unique needs of member sub populations within Health Homes. Target practices with experience serving members with Intellectual and Developmental Disabilities (I/DD) and Foster Care Children to improve continuity of care and member engagement. Ensure choice, but consider oversaturation to improve practice sustainability.

3. Reimbursement and Contracting

Create simple, easy to understand contract amendments. Align these with existing contracts as amendments to allow for rapid and seamless network development.

4. Information: Ensure that there are tools available to connect practices with the data that MCOs have. Empower practices to fully understand member behavior to improve support.

5. Community Based Care Coordination Tool (CBCCT) Flexibility

Do not mandate the use of a specific application for activity tracking. When working with up to three MCOs providers may experience fatigue and confusion. As a result we allow practices the flexibility to build their own solution or use ours so long as the activity is tracked, aligns with the data standards, and is reportable.

Health Home Partner Support

1. Monthly Eligibility Files

Full demographic information on members, qualifying diagnosis, member level, reimbursement rate, information on status changes and assigned United Healthcare Care Coordinators if available.

2. United Support Staff

- An RN Care Manager to train and support the provider's office-based care coordinators
- A Consultant analyst to provide measurement analytics and reporting to support practice transformation

3. Community Care Platform: A web based community health record that allows interactive access to all assigned members by anyone on the patient's care team for full transparency to the plan of care. This is NOT duplicative of data in the electronic medical record

4. Population Registry: A web based tool that gives a health home provider access to two years of health care utilization history and known gaps in care for the patient panel – eliminating the knowledge silos and fragmentation of the current health care system

5. Monthly Joint Operating Committees: A fully developed model of clinical care coordination based on evidence-based best practices and Collaboration with support for the management of very complex and vulnerable patients in the panel.

Member Engagement:
What should our members expect?

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1. Assignment Letter: When a Health Homes member is identified, United (the Lead Entity) will send an assignment letter explaining:

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

2. Outreach from the Health Home Partner: Our contracted Health Home Partners actively engaging members via letter, phone calls, and visits to the member's home. The Health Home Partner is expected to complete a full behavioral, medical, and social assessment within 30 days of assignment to the Health Home Partner

3. Relationship Growth between Care Coordinators and Members: Through consistent interaction and supported the Health Home Partner's Care Coordinator build a rapport and trust with the member. A motivational interviewing style of engagement is strongly encouraged to realize the best outcomes.

4. Satisfaction and Support: The member commits to making positive change in the management of their chronic condition and understands that support and resources are available.

Health Home Partner Support and Member Engagement: Refrigerator Magnet

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Health Homes Information

My Health Home: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Main Telephone Number: _____

My Primary Care Provider: _____

My Behavioral Health Provider: _____

Other Provider Names: _____

_____

_____

UnitedHealthcare Community Plan Information

My Care Coordinator: _____

Phone Number: _____

Member Services
Toll Free Phone:
1-877-542-9238

TTY Line: 711

24/7 NurseLine:
1-855-575-0136

Website: myUHC.com

Transportation Requests:
1-877-796-5847

Where's My Ride?:
1-877-796-5848

KanCare | UnitedHealthcare Community Plan

Additional Support and Engagement

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Create tools to identify Health Home members for other community providers:

1. Supplemental ID Card

UnitedHealthcare Community Plan KanCare

Health Home Member
UnitedHealthcare Community Plan of Kansas
Please contact the member's Health Home Provider listed on the back of this card.

Kansas Health Home Member
UnitedHealthcare Community Plan of Kansas

<Health Home Name>
<Care Coordinator Name>
<Provider Address>
<Provider Phone>
<Provider Hours>
953-CST6209 10/14

2. Indicator on Standard ID Card

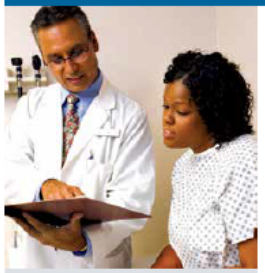
KS Health Home Member
Please ask for details.

3. Card Case

4. Partner Brief

UnitedHealthcare Community Plan
Kansas Health Home

Partner Brief



UnitedHealthcare Community Plan of Kansas Health Homes Membership is a program that provides eligible members with additional benefits and access to extra support.

- The Health Home Card is an identification card intended to supplement the member's current member ID card.
- The Health Home card will let community providers know that the member is eligible for additional benefits and access to additional support.
- The card contains contact information for the member's Health Home Partner.
- We will be training our network providers and office staff to be on the lookout for these cards. We will ask them to notify and coordinate care with you to make sure that you are aware of the services the member is accessing.

These steps will help you to coordinate with the member on their care.

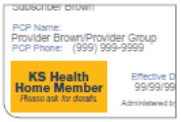
Thank you for all you do to support our members.

Helping Health Home Members Understand Their Cards

The Health Home card, sleeve and sticker should be provided to the member during a face to face visit for Health Home Services. Please follow this check list during the visit.

☐ Confirm the member has their Medicaid ID card from UnitedHealthcare Community Plan of Kansas.

▶ **If yes:** Attach the Health Home sticker to the lower left front corner of the card.



▶ **If no:** Help the member call Member Services to request a new ID Card. Make sure the member provides their correct address and confirms that the PCP they are currently assigned to is correct.

UnitedHealthcare Community Plan of Kansas
Member Services: **1-877-542-9238**

☐ Give the member their Health Home card.

☐ Provide the member with the plastic card holder, and place both cards inside.
- Place their member ID card (with Health Home sticker), and Health Home card in the plastic card holder.
- Remind the member to keep their cards together in the sleeve and to present both cards whenever they visit a health care provider (This includes visits to their PCP, ER, Urgent Care, Mental Health Facility or other).

☐ Every time a member visits, confirm that they have both cards.

For additional card supplies, or to make changes to the existing card, please contact **uhckshealthhomes@uhc.com**

Performance Monitoring and Joint Operating Committee (JOC)

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6 Core Service	Example Requirements	Expectations	Measure
Comp. Care Management	Member assessment for complex care needs and development of Health Action Plan; indication that plan was shared with multidisciplinary care team.	Assessments performed on all Health Home members within 30 days of enrollment and annually.	% members assessed within req. time frame % of patients with a face-to-face encounter with a care coordinator in last 30 days
Care Coordination	Facilitate completion of activities between and among members of the community based care team assuring interactive participation with whole person plan of care.	PCP visits q 90 days for members. Behavioral health visits q 90 with leading behavioral health condition.	% members with no PCP visits % PCP visits every 90 days % behavioral health visits every 90 days
Health Promotion	Documented assessment of health promotion needs and addition of problems to health action plan including obesity, health literacy assessment, educational discussions	All members will have their BMI recorded at least annually, All members receive information on health promotion including gaps in care for chronic illness.	% members with BMI on record % members with preventive measures complete (no gaps in care)
Comprehensive Transitional Care	Coordination of services across various providers, with a transition of place or level of care. Ensure PCP visit within 7 days of inpatient or emergency room visits	PCP visit is provided within 7 days of any discharge from ED or inpatient service.	% PCP follow up visit within 7 days of ER visit % PCP follow-up within 7 days of inpatient discharge
Individual & Family Support	Assessment of individual and family psych-social or community support needs including gap identification and plan development; documentation regarding services for member of family	Document HAP for all members including goals w/ time frames Individuals name a primary caregiver.	% of patients who have goals with timeframes % of patients with substance abuse disorders in active treatment programs % patients who identified a primary caregiver
Referral to Comm / Social Support Services	Management of referrals including transparency of tracking when referrals are made, completed, reported and changes to plan of care resulting from referrals.	All referrals are tracked for completion of visit, completion of referral report or CDC and follow-up up by PCP visit.	% referrals completed by evidence of report tracking
Use of HIT	Documentation and information sharing through community based health information exchange – required for all services above	Use of UnitedHealth Care or similar tools for care coordination.	If using an independent system must provide access to United to that system and provide data field extracts.

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Kansas Health Homes Collaborative Learning

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Peer Learning Opportunities

Learning Collaborative:

- For administrative staff
- Share what works and what doesn't
- Learn best practices to improve the system

Health Action Plan Training & Community of Practice:

- For line staff
- Share what works and what doesn't
- Learn best practices to support individual health outcomes

Learning Collaborative Research

- CCSR conducted interviews with 7 States and 22 Kansas Stakeholders
  - Stay focused on the purpose – peer-to-peer learning
  - Relationship with other components of Health Homes implementation
  - Participation
  - Topic selection
  - Format

Learning Collaborative in Kansas

- Learning Collaborative is required for contracted HHPs
- Funding support from two Kansas Health Care Foundations
- Includes webinars, conference calls, and statewide in-person meetings
- Guided by Design Team of 15 stakeholder agencies
- Topics:
  - Lessons learned from similar programs
  - Member/Provider engagement strategies
  - Health Risk Assessment Tools
  - Quality Goals and Performance Measures

Healthy Living Grant

- Funded by Kansas Health Foundation for two years
- Training for Care Coordinators/Managers on how to write effective Health Action Plans
- Focused on Physical Activity, Nutrition, and Tobacco Control
- Four-part interactive webinar series, repeated three times
  - Writing SMART Goals
  - Motivational Interviewing
  - The 5 "A"s of Smoking Cessation
  - Health Literacy
- Community of Practice – currently monthly online

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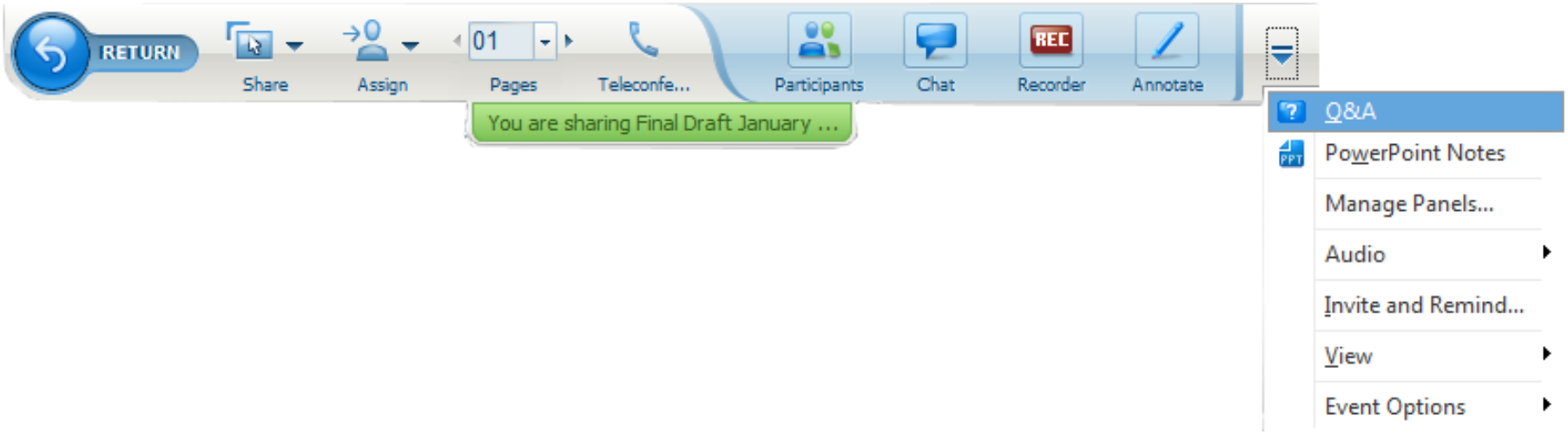
Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to Health Home Information Resource Center staff and the panelists.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.



For More Information

- Download practical resources to improve the quality and cost-effectiveness of Medicaid services.
- Subscribe to e-mail updates to learn about new programs and resources.
- Learn about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

healthhomes@cms.hhs.gov