OneCare Kansas Legislative Update

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Helping people live healthier lives by integrating and coordinating services and supports to treat the "whole-person" across the lifespan.

Introduction to OneCare Kansas

What is a “Health Home”?

- An expansion of the “patient centered medical home” model to include links to community and social supports for eligible Medicaid Members
- It is NOT a place, but a way to provide coordination of physical and behavioral health care with long term supports and services for people with certain chronic conditions
- Health Homes focus on the whole person and their needs to help that person be as healthy as possible.

OneCare Kansas
a program of KanCare, Kansas Medicaid

What is a “Health Home”?

OneCare Kansas (Health Home) members are eligible to receive six core services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual & Family Supports
- Referral to Community & Social Support Services

These services are <u>in addition</u> to the services that members currently receive from their physical and behavioral health providers under Medicaid.

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Health Homes TIMELINE

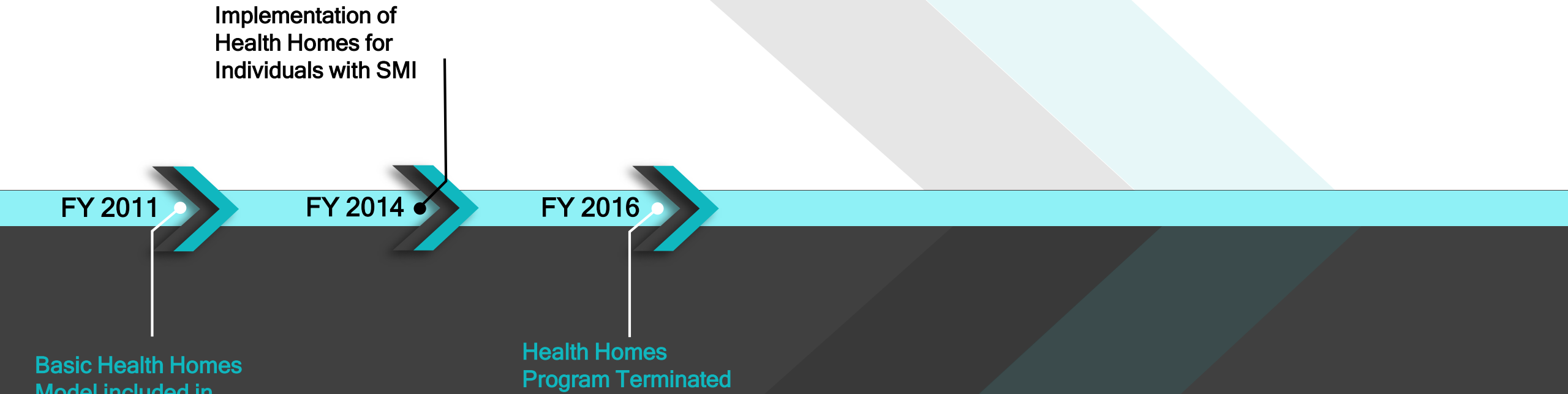
2014

- Held weekly implementation calls with stakeholders
- Implemented program on July 1
- Launched Learning Collaborative for Health Home Partners.

2015

- Collected feedback from partners via surveys and listening tours
- Health Homes Conference
- Continuous quality improvement efforts

Health Homes TIMELINE



Lessons Learned: *Design*

- Focusing on a more narrow population may have allowed earlier demonstration of cost savings
- Developing quality goals and measures early made program design easier
- Allowing enrollment (opt-out and opt-in changes) to occur closer to real time

Lessons Learned: *Stakeholder engagement*

- Robust stakeholder involvement from the beginning increases success
- More frequent stakeholder calls in the first 30 days may have reduced early issues
- More robust engagement of sister State agencies (like DCF) might have reduced challenges

Lessons Learned: *Training/Education*

- An application process (that includes required attendance at trainings) may have helped the program launch more smoothly
- More training was needed of all state agency staff who were not involved in project planning
- More education of primary care providers and hospitals was needed to help prepare them for their roles
- Increased education of consumers prior to implementation and in early days of implementation
- Being "planful" and working *alongside* community partners – rather than *for* them – makes for a better learning process

Lessons Learned: *Quality of Care/Collaboration*

- Much of the work was not necessarily physical or behavioral health care – more social, environmental, and safety needs
- Many HH members were more willing to address difficult health and social issues when given sufficient support
- Some behavioral health providers indicated that the model helped them be more aware of looking at the whole person than in the past
- Some providers, particularly I/DD, indicated that HH helped them to build more community partnerships

What HHPs had to say…

26 Health Home Partner Surveys received:

- 46% CMHCs
- 31% CSP-IDD Providers

When asked if HHs were beneficial to their clients (Scale = 1-10):

- 88.5% rated the program at an “8” or higher
- 46.2% rated the program at a “10”
- Only one respondent rated the program below a “5”

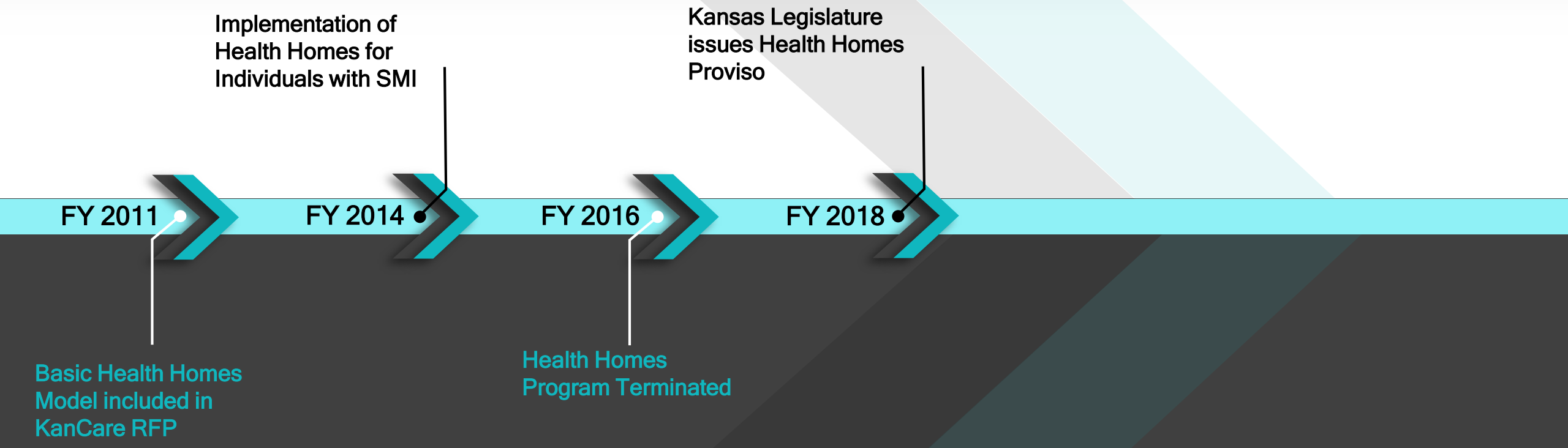
When asked if they would be willing to serve as an HHP should this population ever be reinstated into HHs:

84.6% of respondents reported they would serve as an HHP again.

When asked if they would be willing to serve as an HHP for other populations focused on primary care conditions such as diabetes:

88.5% of respondents reported that they would be willing to serve as an HHP.

Health Homes TIMELINE



Legislative Proviso for Fiscal Year 2019

2018

The current language states:

Expenditures shall be…in an amount not to exceed $2.5 million from the State General Fund…to reinstate a program implementing state Medicaid services for health homes. [During the fiscal year ending June 30, 2019]

Provided that participation in such program shall be:

- On an **opt-in basis** and not on the basis of automatic enrollment
- Open to **youth and adults**
- Structured to ensure that individuals with a **behavioral health diagnosis or chronic physical health condition** are served

Further, the agency shall not:

- Allow any managed care organization providing the above services…to claim an administrative claiming rate **higher than 10%**

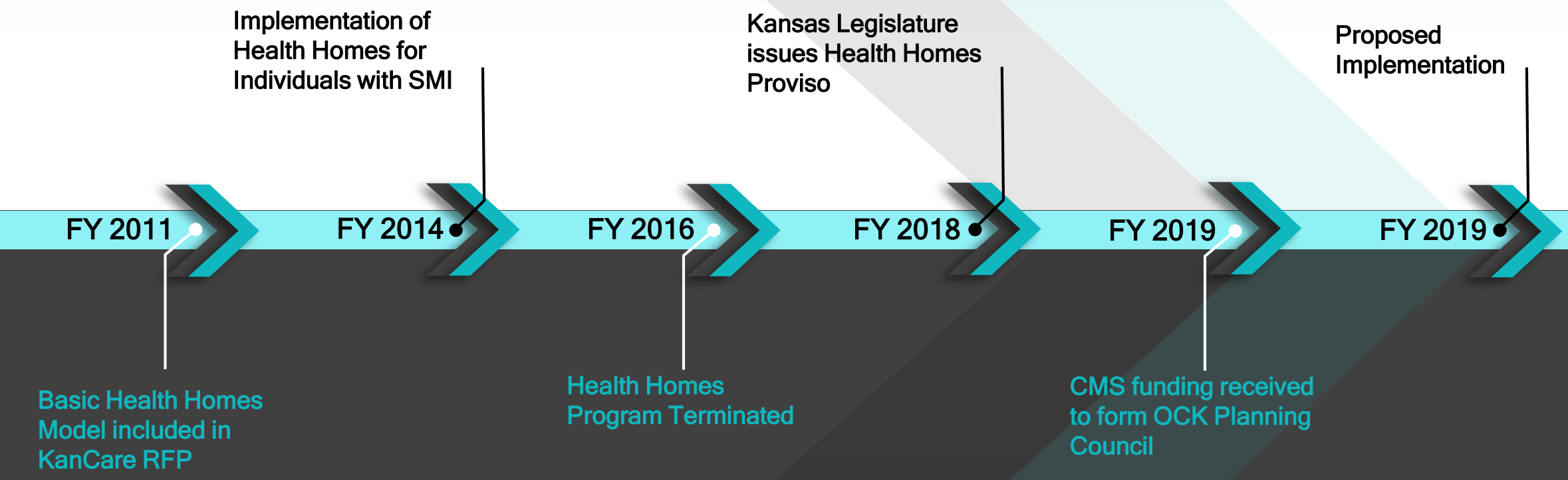
What we know so far…

- Program will be called “OneCare Kansas”
- Six core services and documentation requirements will remain the same
- MCOs will once again serve as the “Lead Entity” but will not be allowed to provide direct services
- Program will be limited in population but have a statewide scope
- Potential provider partners will apply to participate

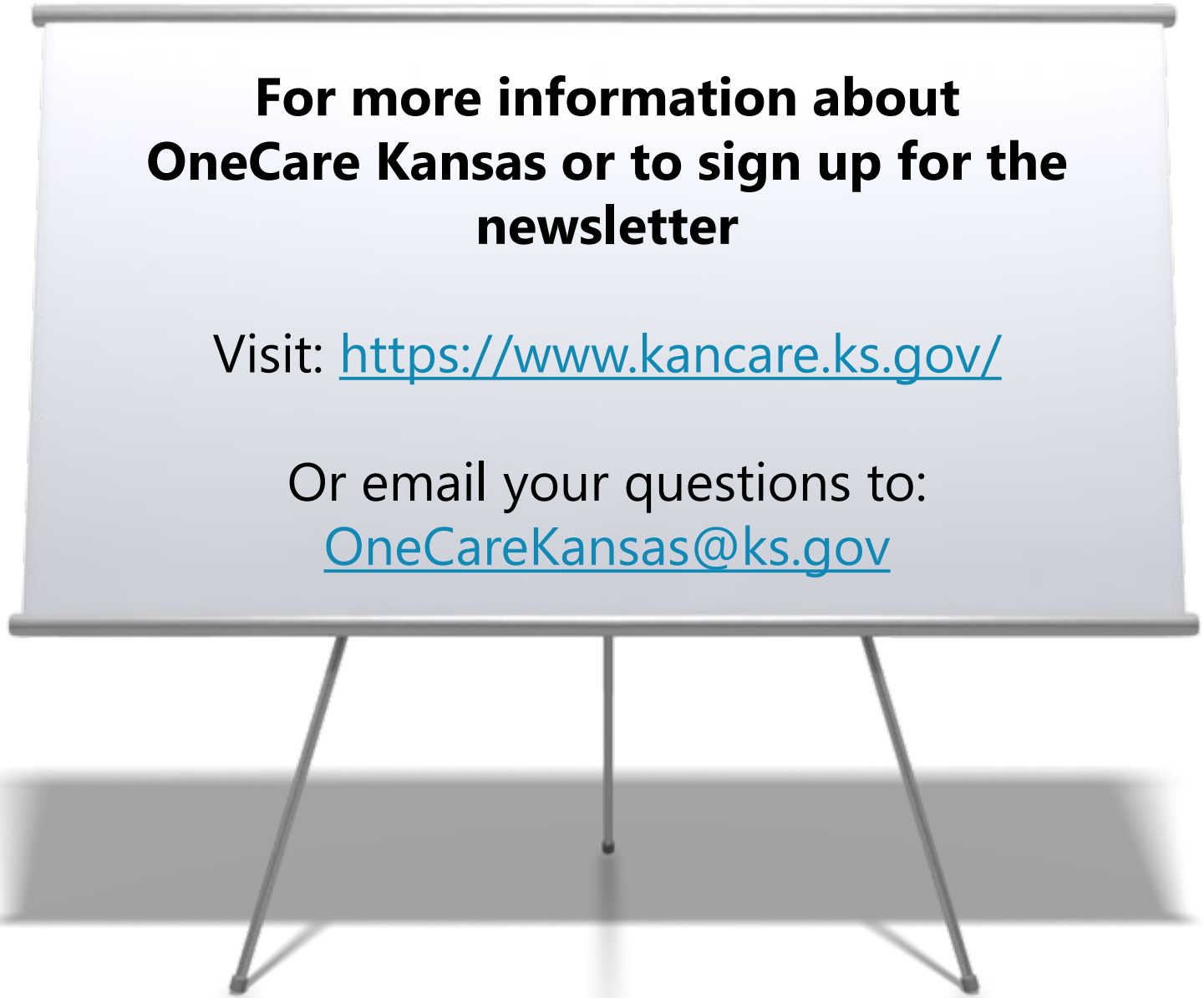
What's in development…

- Population to be served
- Payment rates and structure
- Provider application requirements and process
- Provider team requirements

Health Homes TIMELINE



Questions?



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