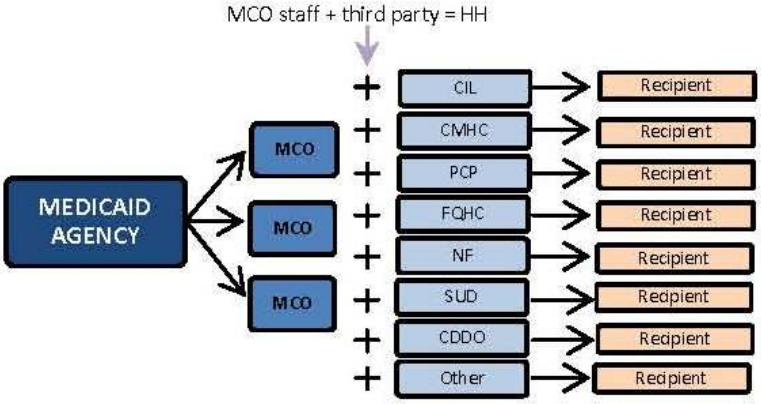
ATTACHMENT I
Kansas Health Homes (HHs) Model

The diagram[1] below illustrates the relationship between the Managed Care Organization (MCO) and various other providers who will form HHs for members with chronic conditions identified in the Center for Medicare and Medicaid Services (CMS) State Medicaid Directors Letter # 10-024.



The MCO must develop a detailed description of how it will provide HHs, including how it will address the following components:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HH services;
- Coordinate and provide access to high-quality healthcare services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders (SUD);
- Coordinate and provide access to mental health (MH) and SUD services;
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient (IP) and community based residential or other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care (LTC) supports and services;
- Develop a person-centered care plan for each individual that coordinates and integrates all of his/her clinical and non-clinical health-care related needs and services;
- Demonstrate a capacity to use health information technology (HIT) 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;
- 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; and
- Clearly delineate what the CONTRACTORS' responsibilities vs. providers, members and family members responsibilities are in this model.

  In addition the description should include what activities and tasks are needed from Kansas Department of Health and Environment (KDHE)/DHCF or other State agencies to successfully provide a HH.

[1]Adapted from Hasselman, Dianne and Bachrach, Deborah. (June 2011). Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System. Center for Health Care Strategies, Inc.