Defining and Managing the Boundaries of Medically Necessary Home Health Care: The Multi-Year Story of an MCO's Efforts and Initiatives

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I. Executive Summary

Health Services for Children with Special Needs (HSCSN) is a Medicaid care coordination plan that serves approximately 5,000 SSI and SSI eligible children with disabilities in the District of Columbia. Home health care services currently represent approximately 17 percent of HSCSN's total health care costs and grew by 120 percent from 2005-2010.[1] More than 50 enrollees received at least $100,000 in home health care services during calendar year 2010. HSCSN has launched a focused, multi-year effort designed to accomplish the following:

- Establish sound criteria for medical necessity with regard to highly intensive and long-term home health cases applicable to a range of chronic conditions and disabilities in children and young adults.
- Educate physicians about these criteria and processes, and simplify their workload in providing care to children with special needs, in an effort to eliminate the initial "over-authorization" of home health services to the greatest feasible extent going forward.
- Utilize a "rounds" process to fully discuss the dynamics surrounding each case, and to help the health plan's utilization management staff make appropriate determinations as to the level of home health services warranting authorization.
- Where reductions and denials of existing services occur, work closely with the provider and family to create a successful transition to the lower level of services being made available (and, where appropriate, to help identify alternative services).

Significant savings occur when the above efforts are focused on persons receiving rather massive levels of home health services. The financial impacts of the actions taken by HSCSN were measured by conducting a pre-versus-post-intervention assessment of costs. These analyses found that home health costs for those patients receiving a reduction or denial determination decreased by 30% post-intervention. Due to the magnitude of the baseline (pre-intervention) costs, these actions created an average savings of more than $3,000 per month per case in home health expenditures, and an average savings of roughly $5,000 per month per case in total medical expenditures. (The fact that the costs for other covered services *decreased* after the home health care reduction actions were taken is encouraging evidence that the plan has been successful in eliminating only services that were not medically necessary.) After taking into consideration the offsetting costs for added administrative efforts, appeals, etc., annual net Medicaid savings of approximately $1.1 million were estimated across the 25 cases where interventions occurred (roughly $45,000 per case).

[1] This extraordinarily high proportion is indicative of the specialized population HSCSN serves. While all Medicaid programs experience these types of cases, HSCSN is the only healthcare coordination plan in the nation that exclusively enrolls SSI children. Thus, HSCSN's high-cost home health cases were a particularly visible contributor to the health plan's overall expenditures.

II. Introduction

Health Services for Children with Special Needs (HSCSN) is a Medicaid managed care plan, specializing in care coordination, serving children with disabilities in the District of Columbia. Home health care services are an important component of the covered services provided to persons with disabilities by the District's Medicaid program and HSCSN. These services often represent a cost-effective substitute for inpatient care in acute situations, as well as a means for maintaining many high-need children in their homes in lieu of long-term institutionalization. HSCSN and its parent entity's commitment to home health care is embodied in the creation of a non-profit sister entity, HSC Home Care, which directly provides home health services to children with disabilities in the District of Columbia.

Over the past few years, HSCSN focused its attention on the challenges of assuring cost-effectiveness for home health services to its members. While less costly than institutional services, home health services can nonetheless accumulate to very large amounts for individual high risk enrollees and families who have high support needs. For example, HSCSN paid more than $100,000 in home health care services on behalf of 35 different enrollees during 2008, 45 enrollees during 2009, and 51 enrollees during 2010. Home health care is *not* a cost-effective substitute for non-medical day care or other forms of child care; nor is it cost effective when the needed medical intensity warrants institutional care. So for children and adolescent patients who have intense needs requiring home health, cost-effectiveness is a matter of appropriately defining medical necessity, which includes the amount of services needed and the goals of home care for chronic conditions. For patients with less intense needs, cost-effectiveness is most often linked to assisting families identify community-based support, appropriate treatments and to move toward self-care and greater independence.

The lines of demarcation as to what constitutes medically necessary home health care in medical practice have not always been clear. Specifically, the lack of national standardized definitions, criteria and policies for home care determinations for children with chronic conditions made medical necessity unclear and denial of services problematic, even when medical necessity was not substantiated. Many of the home health services being requested by physicians are sometimes non-specific, open-ended or are not solely based on clinical need, leading to questionable medical necessity for those services. In addition, since children are entitled to benefits based upon the EPSDT (Early Periodic Screening Diagnosis and Treatment) benefit, the definition of medical necessity can become particularly vague. Under EPSDT a benefit is "medically necessary" if it ameliorates a condition. This definition is less rigorous than the Medicare definition which requires that covered services be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member".[2]

[2] Title XVIII of the Social Security Act, section 1862 (a)(1)(a).

The following dynamics create an environment where physician authorization of intensive home health services is quite likely to occur:

- **<u>Members and Member Families:</u>** Frequently from a member's and family's perspective, more home health care is generally deemed to be better. The greater the involvement of home health personnel, the fewer burdens on the family. Taken to the extreme, families may desire to have home health personnel provide very expensive social-support services that do not meet the Medicare definition of medical necessity and are more than is required under the EPSDT standard, but are nonetheless deemed important to the family.

- **<u>Physicians:</u>** From a physician's perspective, the substantial grey area regarding what constitutes medical necessity for home health services (an area physicians are not well-equipped to navigate) is coupled with the parents' often adamant demands for this support and with the physicians' fundamental desire to be helpful to their patients and their families. Physicians rightfully do not want to be the administrator of the Plan's benefits. Without assistance from the plan, including specific clear-cut guidelines and benefit limits, they are often not comfortable reducing services. Rather, their inclination is typically in the direction of approving and authorizing requests for additional home health services.

- **<u>Home Health Care Providers:</u>** From a typical home health agency's perspective, their organization's revenue is enhanced to the extent the boundary lines of medical necessity (and insurance coverage) can be pushed outward. In general, agencies have little incentive to resist the wishes of the family to use home health services liberally, nor to challenge the medical necessity of authorizations being given by the physician community.

HSCSN's home health care costs increased by 120 percent from 2005 – 2010, a timeframe during which the number of home health users increased by 79 percent and when overall enrollment increased by only 19 percent. Home health care now represents approximately one-fifth of all HSCSN's medical claims costs.

At the end of 2005, the HSCSN contract with the District of Columbia was modified to include up to 1,040 hours of personal care aide (PCA) services as a benefit annually, however, more hours could be approved when *medically necessary*. Rising utilization was also spurned by demands from legal disability advocates that PCA care for children be used to support families and that minimal utilization review occur to parallel use of PCA in the adult population. In 2007, HSCSN began a process of closely examining claims data of all home care service utilizers in the plan to determine what services and populations were driving the increasing expenditures and to critically evaluate all components of the home care utilization process.

In 2007, HSCSN became NCQA certified in Utilization Management and began investing additional resources in the development of the UM program. Over the next two years, Quality and UM teams worked extensively to identify and address barriers to cost containment in home care utilization. In 2009, after multiple pilots and revisions by the UM Team, criteria were adopted for skilled nursing and PCA services that could be applied to HSCSN enrollee. During the second half of CY2010, HSCSN began implementing the new criteria to the highest utilizers of home care, resulting in numerous reductions in the level or hours of home health care that had been previously approved.

This report conveys the process HSCSN has undertaken, as similar issues, related challenges and cost savings opportunities could exist within Medicaid throughout the nation. The report includes estimates of the net savings HSCSN has achieved, based on comparisons between pre-intervention and post-intervention costs for persons who received notification that their home health service levels would be reduced or denied. This report hopefully offers a useful case study as to how a Medicaid health plan can achieve substantial cost savings in a sensitive and difficult area without abandoning its commitment to help members and their families optimize the health care and community support systems.

A. Overview of HSCSN

HSCSN was incorporated in 1994 to manage the care of and improve access to services for children and young adults with special health care needs. HSCSN was established as a demonstration project under a District of Columbia Department of Health Care Finance 1115 waiver; the plan now coordinates health, social and educational services for the District's pediatric Supplemental Security Income (SSI) and SSI-eligible populations. The plan has evolved and grown over the past 17 years; HSCSN now serves nearly 5,000 children and receives more than $100 million in annual revenue.

HSCSN is a subsidiary of The HSC Foundation. The mission of The HSC Foundation is to facilitate access to health care services for children and young adults with special needs and their families in the Washington, DC metropolitan area. In addition, the Foundation conducts regional and national projects with governmental, private and philanthropic organizations. As part of the HSC Health Care System, HSCSN offers a comprehensive approach to caring, serving, and empowering individuals with disabilities.

HSCSN's mission is fourfold:

- Ensure access to health care and services through development, support, and partnership with a committed network of community-based providers and services.

- Facilitate members' appropriate, timely usage of services with a focus on disease prevention, restoration to optimal health, adaptation to chronic illness or disease, health promotion and palliation at the end of life.

- Collaborate with public and private organizations, agencies, caregivers and members to jointly identify and creatively remedy situations and circumstances that threaten the optimal health of children and youth with special needs, their families and communities.

- Maximize the effectiveness of monies allocated for the health care and services of children and youth with special needs.

All HSCSN enrollees are care managed by licensed or non-licensed staff. Each receives an assessment on enrollment and at least annually thereafter to document their medical, safety, and behavioral needs. This assessment allows HSCSN staff to personalize each individual's care coordination plan.

Benefits to members and their families include traditional Medicaid benefits plus expanded health services including:

- Individualized care management
- 24-hour access to care coordination
- Outreach services
- Respite care
- Medically necessary home modifications

Fiscal Situation in the District of Columbia

The District of Columbia's fiscal situation is challenging and similar to what many other state governments are experiencing, and the magnitude and duration of this fiscal crisis is unprecedented for the District's elected officials and broader policymaking community. Given this situation, it is critical that the District and its care coordination contractors search aggressively for all opportunities to achieve Medicaid cost savings that are not clinically detrimental to the beneficiary population. The District has reduced the PCA benefit for adults from 1,040 to 520 hours per year as a part of its own cost cutting strategy. Due to the EPSDT challenges and opposition by legal advocates and other stakeholders, HSCSN abandoned efforts to strictly enforce the limit of PCA services to 1,040 hours/year for children ages 0-22 years and to focus on medical necessity review. There are simply greater needs than there are resources. HSCSN's efforts to identify home health services that are not medically necessary (then seek to reduce such services or identify alternatives) represent a challenging undertaking. But these efforts are important in the context of the fiscal situation the District faces.

B. HSCSN's Home Health Care Cost Trends

Because HSCSN's member population is comprised of many of the most high-need children in the District of Columbia, it has historically experienced far higher per member inpatient costs than traditional Medicaid MCOs. In its earlier years of operations, many HSCSN enrollees had inpatient stays of one year or longer; many others required multiple hospitalizations across a

relatively limited timeframe. The cost of these patterns was challenging on all dimensions -- financially for the plan, clinically for the member, and socially for the family.

When the District's Medicaid program added PCA services to HSCSN 's contract in 2005, physicians began prescribing PCA home health services more frequently and for conditions not generally treated with PCA, such as for management of behavioral health and developmental issues. Parents and advocates also began requesting the PCA service, often as a replacement for, or in addition to, the respite benefit (which has limited benefit hours) that was being provided. Many requests for services were for the purpose of addressing the psychosocial issues of the caregiver. HSCSN's home health costs have grown sharply since 2007 as shown in Table 1. From 2005-2010, annual home health care expenditures rose by 120%, increasing from $7.3 million to $16.0 million - an average annual increase of 17%. The increased home health costs were not caused simply by increased enrollment. HSCSN's enrollment increased by a significantly smaller amount during this timeframe, averaging 3.5% per year. The sharpest single-year growth in home health care expenditures occurred from 2008-2009 (28%).

Table 1 also shows a steadily increasing number of HSCSN members utilizing home health care services. From 2005 to 2010, the number increased by 79%. During the six-year timeframe 2005-2010, 1,030 different members obtained home health care, 499 of whom received home health care services during CY2010 alone. The largest growth in the number of users occurred between 2006 and 2007 (23%).

From 2005 to 2010, HSCSN spent a total of $64.3 million on home health care; 20% of HSCSN's overall medical expenditures. While this is somewhat indicative of the nature of the special needs population HSCSN serves, it also serves as a call to action to analyze utilization patterns and investigate how cost savings might be achieved.

Table 1. HSCSN Home Health Care Expenditures 2005 - 2010

Year	Home Health Care Costs	Percentage Increase Over Prior Year	Number of Home Health Users	Average Home Health Care Costs Per User
2005	$7,271,761		278	$26,157
2006	$8,081,239	11%	283	$28,556
2007	$9,525,808	18%	348	$27,373
2008	$10,287,534	8%	380	$27,072
2009	$13,126,272	28%	445	$29,497
2010	$16,004,213	22%	499	$32,073
Total	**$64,296,827**	**Total % Change 2005 – 2010: 120%**	**1,030 (unduplicated total)**	**Costs Per Unduplicated User: $62,424**

Home health costs were heavily concentrated in a small number of individual cases. For example, during 2007 the 35 enrollees with $100,000 or more in home health expenditures represented only 10 percent of HSCSN's home health care users but accounted for 63% of the health plan's home health care spending. These 35 persons' home health expenditures represented more than 10% of *total* HSCSN health care costs during 2007. Information on members with >$100,000 in annual home health costs is presented in Table 2; similar information on members with >$200,000 in annual home health costs is shown in Table 3.

Table 2. Individuals with > $100,000 of Home Health Care Expenditures

Year	Number of Members With Home Health Care Costs >$100,000	Total Home Health Costs for These Persons	These Members' Share of Total HSCSN Home Health Care Expenditures
2005	25	$4,112,164	57%
2006	27	$4,427,286	55%
2007	35	$5,987,776	63%
2008	35	$5,905,306	57%
2009	45	$7,328,159	56%
2010	51	$8,771,444	55%

Table 3. Individuals with > $200,000 of Home Health Care Expenditures

Year	Number of Members With Home Health Care Costs >$200,000	Total Home Health Costs for These Persons	These Members' Share of Total HSCSN Home Health Care Expenditures
2005	4	$996,509	14%
2006	6	$1,451,762	18%
2007	11	$2,569,175	27%
2008	9	$2,151,607	21%
2009	11	$2,662,405	20%
2010	12	$3,133,509	20%

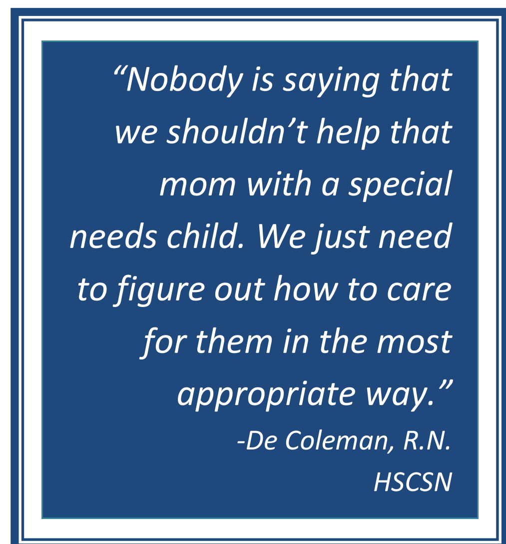
III. Action Plan to Evaluate High-Cost Home Health Cases

Given the magnitude of the costs and the sharp home health cost escalation trends for a small number of enrollees, HSCSN launched a concerted effort to assess opportunities for cost savings in 2006.

A. The HSCSN Quality Improvement Workgroup

In 2006, HSCSN developed a Quality Improvement Work Group (QI Work Group) to examine claims data of all service utilizers in the plan to determine what services were driving the increasing expenditures. HSCSN began by using NCQA's "Quality Improvement Activity" process and format to examine the potential drivers of home care utilization, including clinical data, referral practice trends and utilization review processes.

Through the examination of the home health care request review process, the QI Work Group found that there was not a rigorous enough policy or process for physicians writing home health care referrals. HSCSN staff found that physicians were unclear on the criteria for medical necessity for home health services, and that the process of writing detailed medical necessity letters was burdensome. Additionally, though physicians were required to sign off on the patient's care plan every forty five (45) days, there was no "ownership" by the physician for developing the home care treatment plan, for monitoring the progress of the plan for continued of home care services or for discussing goals, including potential weaning of services, with the enrollee or family. Furthermore, the physician community understandably had no desire to take away existing services valued by the member and family by issuing a determination that the services were not medically necessary. Confusion around the degree of parental support to be provided through home care services, and the role of the parent in providing care to their child, led to a significant increase in the allocation of home health care services in many cases.



HSCSN determined that more streamlined and specified processes for physician referrals, including the ongoing assessment by physicians following initial authorization, were required for preventing the overutilization and inappropriate use of home health services.

Given that home health agencies were at the frontline of interacting with members, HSCSN attempted to work with these agencies to include a clinical assessment of the needed level of home health services for their members. The QI Work Group examined strategies around how to work with home health agencies to improve care giver involvement. The hope was that the home health agency would work with the families and patients to develop the assessments, caregiver

education and goals for subsequent treatment plans in order to move towards a more appropriate level of home health services. However, the home health agency staff did not always feel comfortable performing the assessments that could potentially reduce their own involvement with their patients, were often overwhelmed by caregiver resistance, and many of these agencies had a financial incentive to maintain the amount of home health services members were receiving.

Physicians and HSCSN utilization review staff were struggling to make informed decisions regarding the medical necessity of skilled nursing and PCA home care services given the issues around criteria for a population with a broad range of chronic medical, behavioral and developmental conditions. As the organization began preparing for NCQA certification in Utilization Management in 2006, additional resources were committed to implement a UM Program to meet accreditation standards. The plan began moving beyond the existing model of care coordination, which was primarily driven by what an ordering physician had approved as medically necessary. The Plan sought to develop specific written criteria as to what circumstances do and do not constitute medical necessity with regard to the number of hours of home health care services and to identify the most appropriate evidence-based treatment for the conditions being managed, often inappropriately managed through home care. Later in 2007, HSCSN obtained a license to use McKesson InterQual criteria for Home Care. However, the application of these criteria resulted in determinations of limited number of nursing visits only, whereas HSCSN's issues primarily involved the use of much more extensive shift nursing used in home health care. In addition, InterQual did not have PCA criteria that could be applied for children.

The QI Workgroup initiated a search for decision support tools that had been successfully implemented in other States or health plans for similar populations. In 2008, the health plan leadership met with representatives from a Medicaid health plan that had been successful in implementing home health care standards and criteria. The QI Work Group adapted and expanded those criteria and lessons learned to ensure they met the special needs of HSCSN's member population.

B. HSCSN Home Care Utilization Management Team

Examination of Home Health Care Staffing Needs

In 2008, only one staff person was designated to review all home health requests, but the sheer volume of incoming requests had become overwhelming. The volume and often complex nature of these requests, and the fact that there were not rigorous criteria in place to guide decisions, resulted in the majority of home health care cases being approved.

As a part of the home health initiative, HSCSN expanded its UM department by hiring more staff experts, including home health nurses, a DME reviewer, and a dedicated utilization management physician to work closely with the home care UR nurses. These new staff worked with care managers, providers and home health agencies to review the increasing number of home health care requests. However, even with these additional resources, due to the lack of

detailed clarity of the home health care criteria, this process proved to be frustrating. There were additional staff members to review the requests, but, again, it was challenging to deny requests without clear enough standardized criteria.

Physician Involvement

Extensive and productive interaction with physicians became a critical component of HSCSN's action plan. HSCSN worked in a collaborative fashion in developing the criteria with key medical clinicians who are leaders in the area of pediatric special needs. Consulting with the specialist providers and educating the provider network as to what constituted medical necessity for home health was essential to ensuring that HSCSN's members were receiving the appropriate level of home care services.

To ease the burden on the physician, as well as to create a clear standard for home health medical necessity, the UM Team developed a new referral form for physicians to use when ordering home health care services. Physicians could now use this form, which outlined components of the criteria that are assessed to determine eligibility for home health, instead of writing lengthy letters of medical necessity. As a part of the process, HSCSN staff met with a group of physicians at Children's National Medical center as a small focus group to aid in the development of the home health care criteria. These physicians weighed in on the new criteria and on the overall process.

C. Implementation of Skilled Nursing and PCA Criteria

By the end of 2009, the UM Team had finalized the skilled nursing and PCA criteria that would address chronic conditions and determine the appropriate level and hours of home care to meet the needs of the child versus the number of hours parents, and ultimately physicians, were requesting. Once a robust and relevant clinical guideline was established and accepted, HSCSN then began actively educating network physicians.

During the second half of 2009, HSCSN conducted three pilots using the adapted criteria, using each pilot as a learning opportunity to further focus the criteria so they met the needs of the plan and the members. In early 2010, the UM team developed a point rating system based on the acuity of the child's condition/s and several psychosocial factors to enhance the criteria. This system attached points to certain aspects of the child's condition such as ventilator dependence, feeding tube, paraplegic or quadriplegic. This point system allowed the UM team to develop solid decision tools for determining the appropriate number of hours that would be approved.

D. 2010 Home Care Utilization Management Goal

In 2010, an organizational UM goal for HSCSN was a focused examination of members using high numbers of home health care hours. HSCSN UM Team initially focused on 350 members with the highest overall health care costs. Over three months, the UM Team and CM staff reviewed these 350 members' medical records and claims data and found home care to be the primary driver of 200 of these enrollees' overall health care expenditures. Over a 5 month

period, the UM Team and Care Management staff conducted meetings involving case-by-case presentations to review the details of these 200 cases.

Case-Specific "Rounds"

In July 2010, HSCSN care managers and utilization reviewers began to meet for weekly reviews of cases from the list of the top 100 home health users using the new criteria and point allocation system. Each care manager was required to report to the Home Care UM Team on each of their enrollees describing: 1) the enrollees' medical or behavioral diagnosis and condition; 2) the utilization of medical and behavioral services by the member; and 3) the psychosocial profile of the member and family. The Home Care Review Nurse would provide information on whether that member was receiving the appropriate level of home health services. These "home health rounds" were conducted to review the children's cases and to look at their overall well-being, including their current health and social conditions. During the home health rounds, care managers, UM staff, home health nurses and a physician reviewed all facets of the child's current status to determine whether it was appropriate to maintain, reduce or deny the existing level of home care.

If the level of home care was in question, the care manager had conferences with providers to review and discuss the care plan and frequently met with the families to discuss what they thought the children and parent needed to maintain the child in the home.

The UM Team also instituted a process whereby HSCSN proactively sends a letter to physicians with patients receiving home health who met criteria for a reduction. This letter outlined the current services and the potential reduction and reason; the physician then had ten days to respond to discuss that child's case with the Home Care UR nurse, before the reduction letter would be issued. Once the decision has been made, a reduction or denial letter is sent out to the families and provider notifying them that these services will be reduced effective in 20 days.

Home Health Rounds

Each participant in home health rounds has a specific role. The care managers present the cases of their members, outlining the member's condition, level of acuity, and any background information on the child and family. Based on the child's condition/s, the UM team determines how much home health services the child qualifies for based on HSCSN's point criteria system. The UM physician then takes all aspects of the child's situation into account before making the decision whether to maintain, reduce or deny services.

In many instances, if the decision is made to reduce or deny, the member's services will be reduced incrementally until the level of services are at the appropriate level. This incremental step-down of services places fewer burdens on the families, and allows for transition planning and an adjustment period.

The review of the 200 home health care cases resulted in two major findings. First, many of the PCA services that had begun prior to the development of criteria were for a variety of safety and behavioral issues and were not specifically for ADL assistance. Second, many of the skilled

nursing and PCA cases exceeded the maximum hours expected for the condition, and that reductions would have to be carefully managed to achieve the UM goal for home care.

Alternative Care Options Provided to Members

Many of the children HSCSN serves have extensive special needs, and staff found that navigating medical necessity was often complicated. Staff members also found that instead of medical and medical home care needs, the children's needs were best met by treatment, social, or educational interventions. The challenge for HSCSN staff was finding the most appropriate way to address the specific needs of each individual child and, ultimately, involving caregivers and providers in the discussions and transition planning.

As home health services are reduced or denied for the members examined in the home health initiative, the care managers work with the members and the families to find appropriate care alternatives that best fit the needs of the child. Care managers found some children needed physical or occupational therapy and worked to have the child once again enrolled in school so he/she could receive those therapies. Others needed current pediatric sub-specialty evaluations or behavioral therapies and, subsequently, referrals were obtained from the primary care provider when needed. The care managers and home care staff work simultaneously to ensure members experience a smooth transition to new available care options.

IV. Estimated Savings Created by Home Health Care Cost Reduction Initiative

HSCSN's initial cost savings are associated with the following five-step process:

- Identify the enrollees for whom utilization management determinations were made to reduce or discontinue home health care services (removing individuals with special circumstances that we believe would distort the analysis).
- Compare the selected individuals' pre-intervention costs with post-intervention costs, both for home health services and for all covered services.
- Calculate the average monthly savings in home health and total costs for these individuals.
- Factor in offsetting administrative costs associated with implementing the initiative.
- Consider other factors that might contribute to additional savings and/or offsetting costs.

Each of these areas is discussed below.

A. Enrollee Identification

After identifying the 100 enrollees with the largest home health care expenditures, discussing each case in detail at rounds with HSCSN's medical management team, and applying the plan's criteria regarding medical necessity, 25 persons received notification that their home health care benefit would either be reduced (22 persons) or curtailed altogether (3 persons). Monthly home health care and total HSCSN medical costs for each of these individuals were reviewed. After looking at the monthly cost patterns, two people were removed from the cost savings calculation due to their home health care costs being highly inconsistent and suggestive of fluctuating health status. These persons were presumed to no longer be enrolled in HSCSN from the point their monthly costs dropped from being consistently quite high to $0. (Keeping these persons in the sample would result in over-estimating the savings, as the post-intervention costs of $0 for these persons are likely not attributable to HSCSN's care coordination and medical cost management activities.)

Concerns existed that savings could be over-estimated for persons receiving extensive home health care, to the extent that they were experiencing a significant but time-limited health problem. For such persons, the home health costs (and total medical costs) would drop off – arguably unrelated to HSCSN's medical management efforts -- once these persons' health crises had been successfully addressed. The 23 persons we retained for purposes of estimating cost savings as a group did not appear to be experiencing a temporary health crisis. Many of these persons were enrolled in HSCSN throughout 2009 and 2010 and had significant home health care costs during both years. Fifteen of the 23 persons had more than $50,000 in home health care costs in both 2009 and 2010. Additional statistics on the identified subgroup's home health care costs are summarized in Table 4.

Table 4. CY2009 and CY2010 Home Health Care Costs of Persons Included in Cost Savings Calculation

	2009	2010
Number of Enrollees Receiving Home Health Care Services (and who are included in cost savings calculation)	21	23
Total Home Health Care Cost for these Persons	$2,113,628	$2,935,889
Average Home Health Costs Per Person	$100,649	$127,647
# Persons with > $50,000 in Home Health Costs During Year	$15	$22
# Persons with > $100,000 in Home Health Costs During Year	9	12

Based on the consistently high home health care costs of the 23 persons retained in our cost savings assessment, we felt confident that the derived savings are predominantly attributable to the care coordination and cost management interventions HSCSN implemented.

B. Pre-Intervention versus Post-Intervention Comparisons

Between March and December of 2010, each of the 23 enrollees received a notification letter that their home health care services would either be reduced or denied altogether going forward, based on the application of HSCSN's medical necessity criteria and direct engagement by the physicians who had approved the home health care. For each of the 23 persons, their "notification month" served as the center point for comparing pre-intervention and post-intervention costs. The savings achieved through the HSCSN interventions were quantified in four ways:

a) Comparing the 23 persons' average monthly *home health* costs during the *three months* before the notification month with the *three months* immediately following the notification month. These average costs are shown in Table 5.

b) Comparing the 23 persons' average monthly *home health* costs during *all CY2010 months* before the notification month with *all available months* immediately following the notification month. These average costs are also shown in Table 6. Note that due to claims lag distortions, the post-intervention period assessed extended only through January 2011. All known costs incurred during the months of January 2010 through January 2011 were increased based on average claims completion factors.

c) Comparing the 23 persons' average monthly *total costs for all covered services* during the *three months* before the notification month with the *three months* immediately following the notification month. These average costs are shown in Table 6.

d) Comparing the 23 persons' average monthly *total costs for all covered services* during *all CY2010 months* before the notification month with *all available months* immediately following the notification month. These average costs are also shown in Table 7.

Table 5. Average Monthly Cost Comparison, 3 Month Analysis

Average Monthly Home Health Costs Per Member		Average Monthly Cost of All Services Per Member	
3 Months Before Notification	3 Months After Notification	3 Months Before Notification	3 Months After Notification
$11,348	$8,190	$17,499	$12,818

Table 6. Average Monthly Cost Comparison, All Available Months

Average Monthly Home Health Costs Per Member		Average Monthly Cost of All Services Per Member	
All Months Before Notification	All Months After Notification	All Months Before Notification	All Months After Notification
$11,362	$7,858	$18,576	$13,523

C. Medical Cost Savings

Based on the information tabulated to create Tables 5 and 6, considerable savings occurred in home health care expenditures and some additional savings occurred in total HSCSN expenditures. These savings are summarized in Table 7.

Table 7. Monthly Cost Reductions

	Average Monthly Cost Before Notification	Average Monthly Cost After Notification	Average Monthly Savings Per Person	Total Monthly Savings (23 Persons)	Total Annualized Savings
Home Health Costs					
3 Months Pre vs. 3 Months Post	$11,348	$8,190	$3,158	$72,621	$871,452
All Months Pre vs. All Months Post	$11,362	$7,858	$3,504	$80,598	$967,176
Total Medical Costs					
3 Months Pre vs. 3 Months Post	$17,499	$12,818	$4,681	$107,654	$1,291,848
All Months Pre vs. All Months Post	$18,576	$13,523	$5,053	$116,218	$1,394,616

The reductions in the 23 persons' home health care costs averaged $3,158 - $3,504 per month (reductions of 28% - 31%) depending on the timeframe used for the pre-post comparison. These savings total $73,000 - $81,000 per month across all 23 persons, and annual home health expenditure reductions of approximately $870,000 to $970,000. It is also worth noting that considerable home health costs continued to occur for these 23 persons after the reductions and denials. Despite the cost reduction of approximately 30%, home health care expenditures for these persons averaged roughly $8,000 per month after the interventions.

While home health care services represented the majority of their total medical costs (60% - 65% in the "pre-intervention period"), the 23 individuals did have considerable monthly costs for other covered services (DME and medical supplies in particular). These persons' monthly costs for other services (in addition to their home health care) averaged approximately $6,000 - $7,000 during the pre-intervention months. An encouraging finding is that these other costs did not go up during the post intervention period. Thus, there is no evidence that the reduction in home health care services led to a clinical decline that required greater use of other services. On the contrary, average monthly costs for services other than home health *decreased* by approximately $1,500 during the post-intervention period. Total annualized savings for the 23 targeted cases are estimated at $1.3 million to $1.4 million, combining the home health care cost reductions with the reductions that also occurred across the remainder of these persons' medical expenditures.

We also assessed whether the savings being quantified were largely attributable to a very small number of potential "outlier" cases. We found that the savings were dispersed widely across the 23 cases, although there was a wide range of savings per case with some of the individuals having higher costs in their post-intervention months than in the pre-intervention months. Some statistics related to this assessment are shared below:

- The person with the largest reduction in monthly home health services had a reduction of $11,890 (comparing the three pre-intervention months with the three post-intervention months). This person accounted for 16% of total monthly home health cost savings across the 23 person subgroup.
- Of the 23 persons, seven had a monthly reduction of home health services costs of $5,000 or more in the three post-intervention months (relative to the three pre-intervention months). 13 persons had a reduction of $1 - $4,999 in their monthly home health care costs, and three persons experienced higher home health costs in the post-intervention months.
- The person with the largest reduction in total monthly claims costs (for all covered services) had a monthly reduction of $24,093 (comparing the three pre-intervention months with the three post-intervention months). This person accounted for 22% of total monthly medical cost savings across the 23 person subgroup.
- Of the 23 persons, 10 had a monthly reduction of total claims costs of $5,000 or more in the three post-intervention months (relative to the three pre-intervention months). Nine persons had a reduction of $1 - $4,999 in their total monthly claims costs, and four persons experienced higher overall claims costs in the post-intervention months.

Cost Savings Offsets

HSCSN made considerable time, staffing and capital investments to achieve the above-described medical cost reductions. The costs associated with these investments are estimated at approximately $150,000 - $200,000 annually, comprised of the following components.

- **Increased utilization management staffing levels:** Through the multi-year process, the number of utilization review staff focused on home health services has expanded from one person to 3.5 full time equivalents (FTE). We believe that the case volume would have expanded to two persons without adopting and applying tailored medical necessity criteria (due to enrollment growth and increased use of home health care services); thus the added staffing impact of the new initiative includes 1.5 FTEs. While the savings that have occurred are predominantly attributable to just 23 enrollees, the administrative efforts associated with the home health care quality and cost initiative, including phone calls to providers and home health agencies, reviewing clinical records, time spent in rounds, writing provider memos and reduction or denial letters, involved more than 200 cases.

- **Increased care coordinator workload:** The Care Manager workload was impacted by time spent in obtaining, documenting and summarizing the clinical and psychosocial issues required for utilization review and home care rounds presentations and ongoing follow-up for many cases. Once HSCSN's utilization management team has sent out a notification letter regarding reductions and denials of home health care services, the member's Care Manager calls and works with the family to identify community and other

resources to help address the non-medical needs. These additional efforts to assist the members are estimated to collectively require one full-time equivalent Care Manager (although this added workload is spread across all Care Manager who have members whose home health care benefits were reduced or denied).

- **Fair Hearings & Appeals:** The estimated offsets to savings include the costs associated with addressing fair hearing requests and appeals requested by enrollees for whom HSCSN has sought to reduce the level of authorized home health care services. Over the past year, HSCSN has seen its annual appeals costs increase, in part due to increased action regarding the home health cases.

Taking these offsets into consideration, the annual net savings from HSCSN's home health care quality and cost initiative are estimated to be approximately $1.1 million. The derivation of this estimate is summarized in Table 8.

Table 8. Net Savings Estimates

	Annual Savings Estimate, Low End of Range	Annual Savings Estimate, High End of Range
Home Health Cost Reduction	$871, 452	$967,176
Cost Reduction in All Other Medical Services	$420,396	$427,440
Total Medical Cost Reduction	$1,291,848	$1,394,616
Marginal Administrative Costs Associated with Home Health Cost Reduction Initiative	$200,000	$150,000
Net Savings	$1,091,840	$1,144,000

Other Factors to Consider

We have identified some additional issues that should contribute to additional savings and/or offsetting costs. While these issues have not been factored into a specific cost savings estimate, they are identified and discussed below.

- **Population Impacted Will Slowly Evolve:** We anticipate that for the majority of the 23 persons identified herein, the cost savings achieved will continue to occur over time as they remain enrolled and their circumstances do not fundamentally change. Many of them will likely transition to rehabilitative or disability services. However, some of these persons will leave or age out of the plan, or have their health needs evolve in a manner (e.g., institutional care) that negates further home health savings. Conversely, new

members with significant needs will join HSCSN, and some existing enrollees' needs will evolve such that extensive home health care services become either necessary or at least worthy of consideration. We therefore expect that the cost reduction process will yield ongoing savings on home health and total medical costs, rather than a "one-time" savings on 23 specific individuals. However, for the reasons described below, it is expected that the annual savings will increase over time from the figures derived above in this section of the Report. Further, as the population ages, those who no longer meet the "EPSDT" medical necessity criteria can have their level of care adjusted to meet the adult "medical necessity" standard.

- **Medical Cost Reductions Should Be Larger Than Above Estimates:** Prior to the HSCSN efforts described, the home health benefit was functioning with an inefficient "brake pedal." Physicians were not well-positioned to assess the medical necessity of the home health care services, and were much more inclined to order than not to order these services when asked by the member's family. Due to HSCSN's development of clearer criteria around medical necessity, and the health plan's efforts to educate its physicians about these criteria, it can be reasonably expected that physicians will not order as much home health care going forward as had previously been occurring and will, likely, become more involved in the assessment and monitoring of home care services. Physicians now have much more solid criteria and experience interacting with the health plan nurses and physicians to better discern a medical need from a social need.

- **Administrative Offsets Should Be Smaller:** Going forward operationally, it is expected that there will be less marginal administrative costs than occurred in the initial year of the home health care quality and cost initiative. This is because initially more than 100 cases were reviewed and assessed. The ongoing stream of new home health cases warranting close involvement will be much smaller.

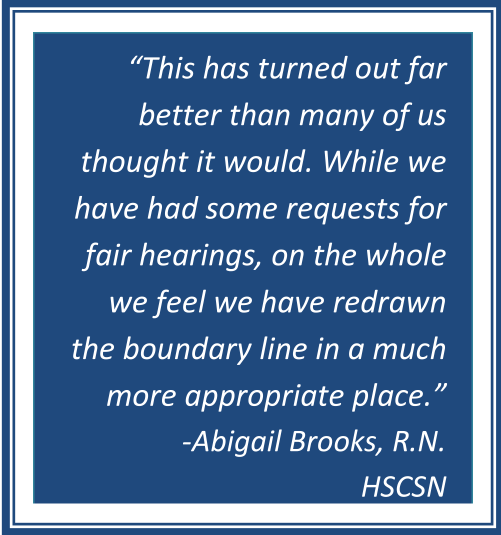
Cost Savings Summary

The net savings the home health care quality and cost initiative has achieved are estimated to be approximately $750,000 per year for home health services, and approximately $1.1 million per year given the reductions in total health care expenditures that has occurred. These savings are expected to grow over time due to greater awareness and practice on the part of the physician community as to what constitutes "medical necessity" with regard to home health care, and HSCSN's application of its carefully developed criteria.

V. Reactions to Initiative

Staff Perspective

From the inception of the home health care initiative, HSCSN staff members were keenly aware of the difficulty in changing existing services for members and their families. Staff had reservations around reducing and potentially denying services for several reasons. First and foremost, at the core of HSCSN's mission is a passion for helping special needs children and supporting the family caregivers. The idea of reducing or denying services for members initially was inherently unpleasant. A fundamental culture change and education at the staff level was critical to the progression of the home health care initiative.



Second, staff members were wary of the new operational processes around changing levels of care. New policies and procedures for denials as well as the documentation necessary to conduct home health rounds, involved an increase in paperwork volume for staff. Simply put, it took much more work to change levels of services than to approve and maintain them.

Finally, staff members knew a focused review of home care was going to be challenging and were wary of the potential backlash against HSCSN. While initially, the process was challenging, after one year of the initiative, staff members generally feel that the process was much less daunting than expected. While there have been several appeals and requests for fair hearings, the push-back from the initiative has not been large-scale. Additionally, staff has become more comfortable with the new policies and procedures for home health care reviews, allowing for a better flow in the review process and creating more efficiencies. Staff members also acknowledge that with the new criteria and review process in place, the line for medical necessity is now clearly drawn in a more reasonable and appropriate way.

Caregiver and Families' Perspective

Caregiver and family reaction to the home health quality and cost initiative varied from case to case. It was a difficult task to reduce or deny services which families and members had come to rely upon; as noted earlier, HSCSN staff expected a certain amount of push-back from families. Because many of the caregivers and families impacted by the reductions had received these services for such an extended period of time, they retained a sense of expectation for the home care services. Many caregivers and families were upset by the reductions or denials; but care managers and providers worked with the families to ease the transition to fewer or more appropriate services.

Physician Reaction

Physicians in HSCSN's network were involved in the development and implementation of the PCA and skilled nursing home health criteria and were more receptive to instituting the new processes and procedures that accompanied the new criteria. Physicians welcomed a more structured method of prescribing home care services, finding the newly developed home care referral form required less time to complete and included the specific detail needed by the health plan. In addition, the enhanced communication and coordination with the health plan, including the home care memo and discussions with the nurses and physicians, assisted them in making a more informed decision around medical necessity. While provider education is an ongoing process, both HSCSN and the providers regard the development and implementation of the nursing and PCA home care criteria as a significant step in determining medical necessity and improving the overall process of prescribing and reviewing home care services.

Appeal Implications

Members have the right to appeal any decision made by HSCSN and, as home care services began to be reduced or denied, some caregivers and families chose to appeal the decisions. The majority of those members who chose to contest reduction decisions tended to be high utilizers of care; they are receiving more services and are dependent to a greater degree on those services. If there is some basis and evidence of medical necessity, HSCSN attempted to work with the members to find a resolution that satisfies all parties. In resolution talks, many times members and families are offered alternatives to home care, if home care was not deemed medically necessary.

VI. Lessons Learned

While the home health quality and cost initiative has undoubtedly resulted in substantial cost savings for HSCSN, there are some larger, overall lessons learned that the health plan has taken away from the process as a whole.

Develop Criteria with an Objective Scoring System to Determine Hours of Service

One of the most important take away messages from this process came from learning firsthand the difficulty in changing levels of members' home health care, particularly after they had become accustomed to and dependent on those services. Developing criteria that use a scoring system to determine hours to be used in the home care request review is critical to ensuring members are receiving and using home health care services appropriately. To remain objective and consistent in medical necessity determinations, the health plan criteria and scoring must be based on the child's current condition and home care needs, which may need to be assessed and must be well documented by the physician or the home health agency.

Fundamental Process Change Takes Time – And May be Uncomfortable

To institute real change in the processes that lead to high utilization of home health services, HSCSN focused to ensure that any quality and cost initiative was done thoughtfully and with the member's well-being in mind. Internally, there were hurdles in the implementation of the initiatives, including educating staff on the new policies and procedures, as well as acclimating to the additional work processes associated with denying or reducing care. All of those individuals involved at HSCSN, from the plan Medical Director to the care managers, stated that the process was difficult and at times uncomfortable; but overall the consensus was that the process was beneficial. The successful implementation and adoption of the interventions was a multi-year process. HSCSN continues to move forward with the interventions in a more proactive manner.

Conduct an In-depth Review of Each Patient

HSCSN staff involved in the interventions found it crucial to tell the story of each patient during the home health rounds so that staff had proper context for making better quality decisions. The process of reviewing and possibly subsequently reducing home care services requires a complete picture of the patient, including medical, familial and socio-economic factors. Additionally, learning *how* to tell a complete story of a patient is a learning process. Those directly involved in the development of the initiative and interventions must understand the process, the inner workings of a health plan, and the availability of community resources and most importantly, must closely interact with the populations served.

Providers and Parents are the Front Line

Because every home health care request must be accompanied by a physician's referral, it was essential that providers knew how to determine whether a patient needed home care services, and if so, the process through which the request should be made. Physicians feel comfortable using the new home health care request form because it eliminates the previous ambiguity surrounding qualifications for home health care. As a result of better educated providers, HSCSN has seen a decrease in the open-ended requests for home health care. The physicians are the frontline decision makers and prefer that nursing assessments are performed to determine the specific hours needed and the parent teaching that is indicated.

HSCSN care managers worked with providers and home care agencies to identify strategies for empowering parents and caregivers who were capable of taking care of their children. (I removed preceding sentence – redundant). HSCSN's philosophy is that home care shall neither replace the parent/guardian as primary caregiver nor provide all of the care that an enrollee requires to live at home. Educating the caregivers and families is critical to improving confidence and independence.

Renewed Focus on Care Management

For care managers, this process reinforced the Care Manager's critical role of interacting with members and the importance of comprehensive assessment of the member's condition, the care needs, family functioning, utilization of services and community resources needed to help support family. The initiative also improved care managers' communication skills with their members, and has likely improved the overall relationship between care managers and members.

VII. Policy Implications

While much of HSCSN's initial involvement surrounded the reduction in home health services for a targeted group of individuals, the key and lasting impacts of the initiative involve better defining the boundaries of home health services from a clinical perspective. Going forward, HSCSN is positioned to take an earlier, more proactive approach in distinguishing clinical versus non-clinical services and identifying services that are more of a custodial care nature. Deploying clear and agreed-upon "medical necessity" criteria at the outset, including agreement by local and state Medicaid agencies, circumvent a need to deny inappropriate home care services later. It is also very important that all stakeholders understand that home care reductions will typically occur over time as patients/enrollees clinically improve and as families and patients learn to adapt to chronic conditions that do not require high levels of skilled nursing care.

The criteria development and intervention processes HSCSN has undertaken may be of value to other payers (particularly Medicaid agencies and health plans) facing similar circumstances. The benefits are two-fold: (1) achieving appropriate costs reductions for persons receiving home health services that are not medically necessary, and (2) avoiding authorizations (and subsequently reductions and appeals) for such services in the future. In the end, more enrollees

will receive more appropriate levels of care to enhance quality and costs to the payer/taxpayer will be reduced.

Children with similar needs to HSCSN's enrollees reside throughout the nation. While those with extremely high home care expenditures are particularly important to HSCSN due to the plan's unique enrollment mix, the challenges HSCSN has confronted likely exist on a much larger scale in most states. The overall coordinated care model HSCSN employs, as well as the specific interventions conducted in regards to home health, may be important for Medicaid policy makers around the nation to be aware of as they develop tailored solutions for their own unique populations.