

Chapter 5: Home Health Benefits

Executive Summary

Description

Home health services include skilled nursing care, home health aide service, and other therapeutic skilled services. Home health services are provided at a patient's place of residence. An average of 145 agencies provide home health services to approximately 5,000 Kansas Medicaid beneficiaries. Due to increased program scrutiny and management since 2004, the number of consumers receiving home health services has declined. Expenditures also have decreased through FY 2007, and preliminary data for FY 2008 indicates further declines in total home health spending.

Analysis of expenditures for FY 2005 to FY 2007, based on the top 10 diagnoses for home health services, indicates that unspecified essential hypertension was the most frequently billed diagnosis with expenditures exceeding \$4 million. During FY 2005 to FY 2007 Medicaid paid home health agencies a little over \$14 million for diabetic management services. During that same period, expenditures for beneficiaries with diagnoses related to mental health were almost \$9 million.

Key Points

- In an effort to improve efficiency many states have established limits on the number of visits a beneficiary may receive in a year. Many states allow only 50 to 100 visits per year, compared to limits of 730 visits per year in Kansas. Prior authorization for home health services is currently only required for individuals receiving services through waivers and beneficiaries requiring multiple visits per day.
- A number of concerns regarding home health services were identified in this year's comprehensive program review:
 - Provision of multiple skilled nursing visits per day for oral medications administered for beneficiaries with psychiatric conditions that could receive this service through the community mental health centers
 - Extended duration of services with a lack of evidence of attempts to promote beneficiary/family independence
 - Providers billing Medicaid for daily home health aide visits that may include services like housekeeping that are not considered to be home health care for purposes of Medicaid reimbursement
- Given the high-level of routine interaction between providers and patients, there may be significant opportunities to implement core elements of a medical home in the context of home health services.

KHPA Staff Recommendations

- In light of the recent launch by Kansas Department of Health and Environment (KDHE) of a five-year state diabetes plan, the KHPA will consider sponsoring a forum to address home health diabetic services, and consider applying the medical home concept by developing a tool for Medicaid home health providers to address best practices in the care of other chronic disease processes.
- Limit home health aide visits to two per week, with additional visits through prior authorization to demonstrate medical necessity.
- Develop separate acute and long-term home health care benefits with differential rates that reflect the changing intensity of services over time.
- Increase some acute home health reimbursement rates for skilled nursing visits to reflect increasing costs.
- Work with the Department of Social and Rehabilitation Services to improve coordination of services with community mental health centers.

Projected fiscal impact:

	FY 09	FY 10	FY 11	FY 12	FY 13	5 Year Total
State General Fund (SGF)		\$-200,000	\$-220,000	\$-230,000	\$-240,000	\$-890,000
Total		\$-500,000	\$-530,000	\$-560,000	\$-590,000	\$-2,180,000

Program Overview

Program Description

Home health agencies provide skilled nursing care, home health aide services and other therapeutic skilled services to beneficiaries in the home following illness or debilitation. Home health services are provided in accordance with Medicare requirements in the Code of Federal Regulations (CFR), 42 CFR 440.70. Services available under a home health plan of care include skilled nursing services in combination with at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; or home health aide services).

Home health services are available on a visiting basis in the patient's place of residence. A place of residence is defined as where the person regularly makes his or her home, for example, a house or apartment. It does not include nursing facilities, hospitals, or intermediate care facilities for mental retardation (ICF/MRs).

Skilled nursing services must be provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Skilled nursing services are those services requiring the substantial and specialized knowledge and skill of a licensed professional nurse. Skilled nursing services require a physician's order. The home health agency care team communicates with the physician in an effort to coordinate appropriate, adequate, effective and efficient care for the consumer.

Home health aide services must be performed by a home health aide under the supervision of a registered nurse.

A nursing care plan outlining specific duties of the aide is required. These plans are also returned to the physicians for their approval. Home health aide services need not be related to skilled nursing visits. A supervisory visit of a home health aide is required at least every two weeks when the patient is under a skilled service plan of care.

Home health services are reimbursed fee-for-service through Kansas Medicaid and are not provided through HealthWave, nor through the home and community based service (HCBS) waivers with the exception of the Technology Assisted (TA) waiver for medically fragile children. HCBS waivers that serve other targeted populations are designed to supplement fee for service options such as home health. Providers are reimbursed a specified payment for home health visits. The payment is based upon the service provided and the amount of time typically required to complete the tasks. Medicaid reimburses home health agencies in 15 minute increments for nursing services. Rehabilitative therapy services are reimbursed per visit.

Definitions

A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable the agency must be licensed under state or local law, or be approved by the state or local licensing agency as meeting the licensing conditions of participation.

A home health visit is an episode of personal contact with the beneficiary by staff of the home health agency or others under arrangements with the home health agency, for the purpose of providing a covered service.

A home telehealth visit is made via interactive audio and video telecommunications systems by a registered nurse or licensed practical nurse. Home telehealth services are delivered as a supplement to enhance home health services, and not as a substitute for face-to-face visits.

Program Management

In an effort to improve the efficiency of their home health programs, many states have established limitations on the number of home health aide visits, skilled nursing visits and rehabilitative therapy visits that a beneficiary may receive per year. The Kaiser Family Foundation compiled a state comparison of limitations to the home health benefit. This reference is available at web site: <http://www.kff.org/medicaid/benefits/service.jsp?yr=2&cat=1&nt=on&sv=12&so=0&tg=0>.

Many states allow a total of 50 to 100 visits per year for home health services including skilled nursing visits, home health aide visits and therapy visits. The state of Kansas allows a maximum total of at least 730 visits per year for these services without prior authorization. The Kansas Medicaid home health benefit has comparatively few limitations on the provision of home health services. For example, Kansas allows one home health aide visit per day and one skilled nursing visit per day without prior authorization. Currently prior authorization for home health services is only required for individuals on waivers and for those who receive multiple skilled nursing visits per day. The implementation of prior authorization for these two populations has allowed Medicaid to more closely monitor services rendered. There remains a large group of individuals who received home health visits daily without a method in place (other than post pay reviews) to ensure that these visits are necessary and appropriate. The analysis below suggests the need to consider limitations to the home health benefit to monitor those services that do not currently require prior authorization.

Service Utilization and Expenditures

When data for the past seven years was reviewed it was apparent that the total expenditures on home health services and average expenditure per beneficiary both decreased significantly (over 50% in both cases). Table 1 illustrates this information.

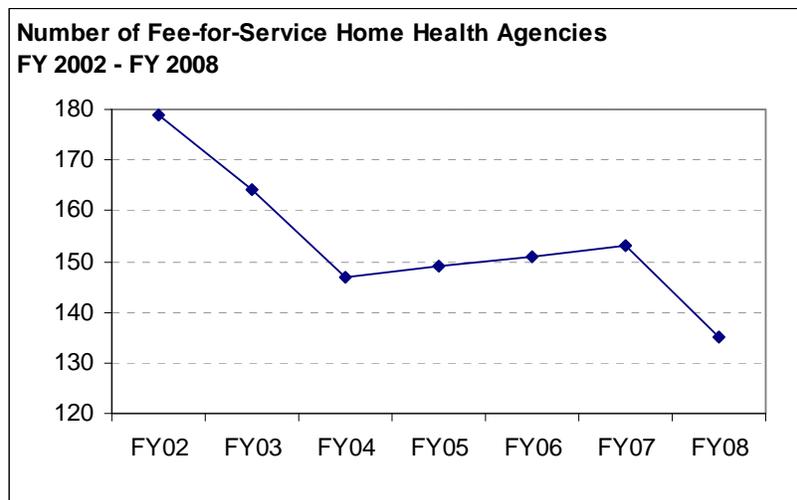
*Table 1
Trends in Home Health Services*

FY	# Home Health Agencies	# Unduplicated Beneficiaries	Total Medicaid Reimbursed	Average Expenditure per Beneficiary
2008	135	4145	\$12,085,293	\$2,916
2007	153	4888	\$14,790,240	\$3,026
2006	151	5364	\$16,359,837	\$3,049
2005	149	5865	\$16,570,270	\$2,825
2004	147	4922	\$13,277,138	\$2,698
2003	164	4750	\$16,077,318	\$3,385
2002	179	5227	\$28,220,999	\$5,399

Total Home Health Expenditures

As shown in Figure 1, during fiscal years 2005-2007, there was a slight increase in the number of home health agencies enrolled to participate in Medicaid fee-for-service. An average of 145 agencies provided home health services for Medicaid beneficiaries during this time frame.

Figure 1



During that same time period, however, the number of beneficiaries and the total home health expenditures decreased as noted in Figures 2 and 3. The number of unduplicated home health beneficiaries decreased from a high of approximately 6,000 in 2005 to a low of approximately 4,000 in 2008. With respect to total expenditures, the decrease cannot be totally attributed to fewer beneficiaries served by the program.

Figure 2

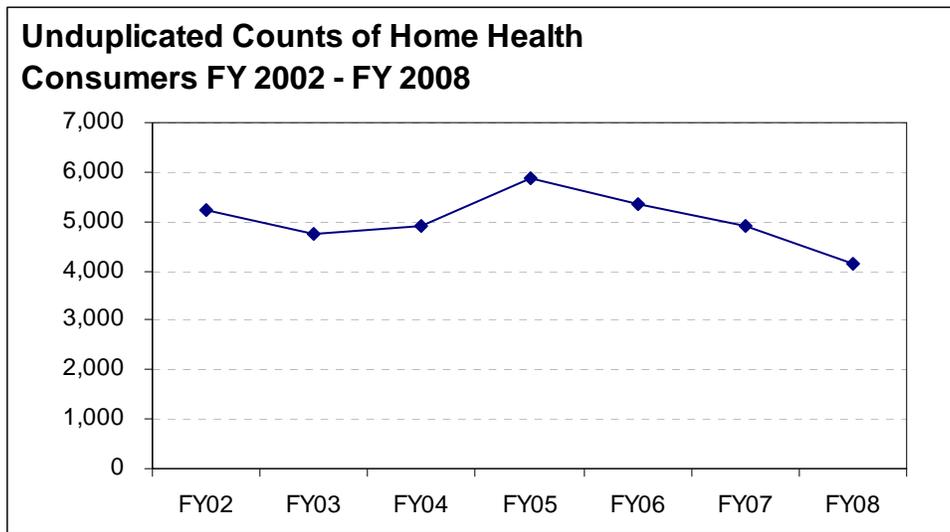
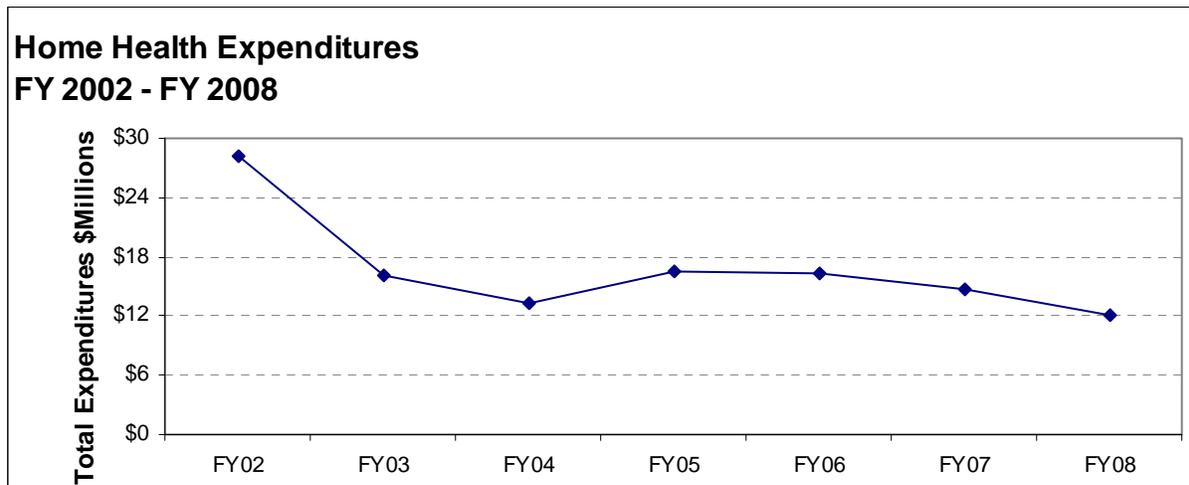
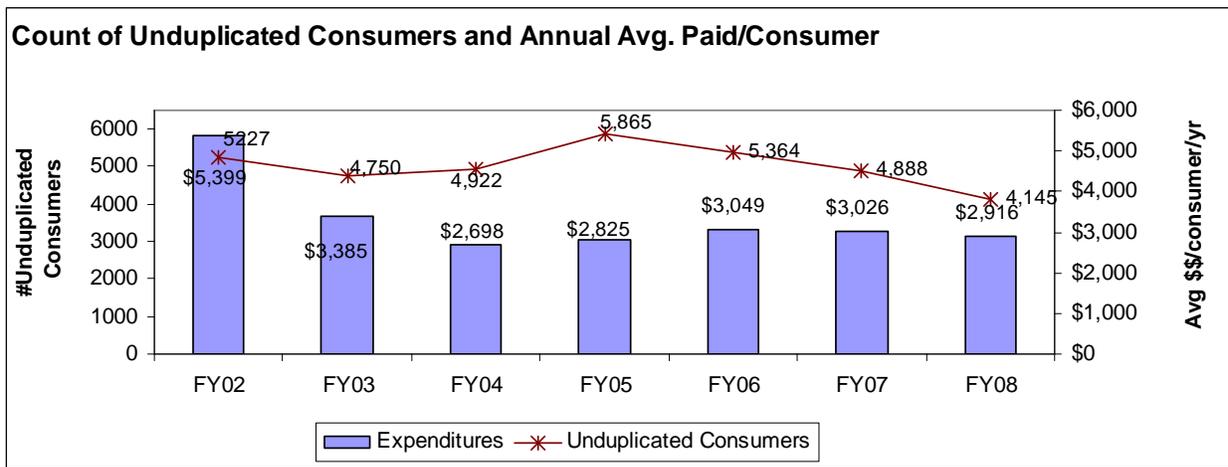


Figure 3



The number of unduplicated home health beneficiaries decreased from a high of approximately 6,000 in 2005 to a low of approximately 4,000 in 2008. However, the corresponding decline in total expenditures cannot be totally attributed to fewer beneficiaries served by the program. The data indicate a slight decline in expenditures per beneficiary per year during the last two fiscal years, as indicated in Figure 4. This reduction coincides with closer reviews of prior authorization requests for home health services which began in 2005. The reduction in expenditures may also be attributed to exploration and utilization of other community resources to meet the needs of high cost beneficiaries. A slight reduction can be attributed to HCBS waiver beneficiaries that self direct their care. For some of the most expensive cases, a few providers were able to obtain assistance from the primary caregivers of self directed beneficiaries, and thereby decrease the frequency of skilled nursing visits provided by home health agencies. For example, the cost of four skilled nursing visits per day is \$43,800 per year per beneficiary. If a self directed caregiver is able to provide two of the visits as allowed by K.S.A. 65-6201 for HCBS beneficiaries, this would reduce the fee for service cost to \$21,900 per beneficiary per year.

Figure 4

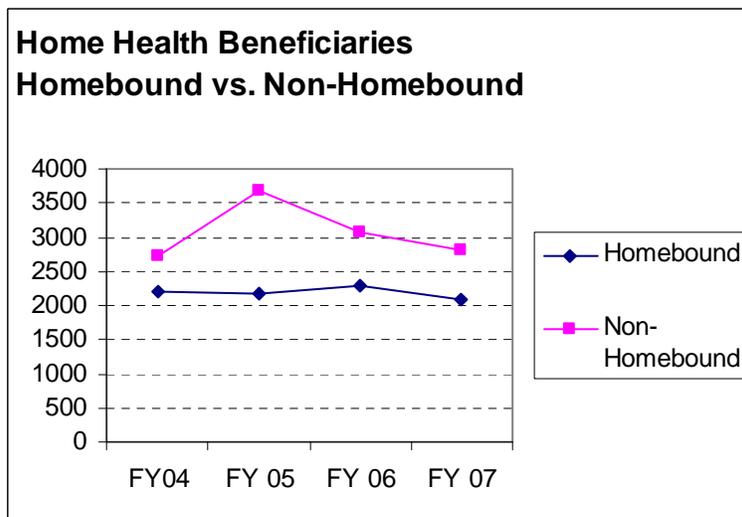


Homebound vs. Non-Homebound Recipients

Figure 5 illustrates the number of home health beneficiaries who were homebound versus those beneficiaries who were not homebound. The number of beneficiaries who were not homebound revealed a sharp increase from fiscal year 2004 through fiscal year 2005. In fiscal years 2006 and 2007 the number of homebound beneficiaries has shown a decline. According to Medicare requirements, homebound status is granted for beneficiaries when leaving home requires taxing effort and the beneficiary is normally unable to leave home unassisted either by a person or an assistive device. Medicare does allow beneficiaries to maintain this status even if they leave home to receive medical care, to attend religious services or attend adult day care. Homebound status is not a requirement for Medicaid home health services, but is required for Medicare covered services.

The decline in the number of homebound Medicaid beneficiaries is reflective of Medicare trends, as the homebound status requirement is not as stringently enforced by Medicare; provided the individual's condition requires intermittent skilled services. However, analysis of homebound status could prove useful in exploring the possibility of substituting a home health visit with alternative community services, depending on the beneficiaries' ability to access those services. An example of this would be using Community Mental Health Centers for medication administration and medication management for individuals with mental health diagnoses.

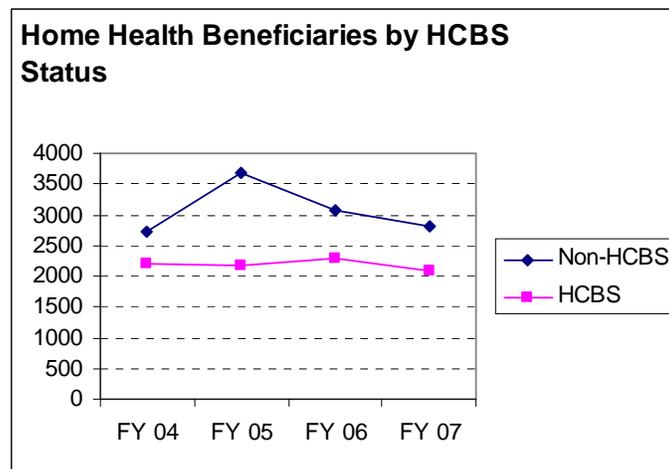
Figure 5



HCBS Compared to Non-HCBS Recipients

Figure 6 compares the number of beneficiaries who received home health services in addition to Home and Community Based Services (HCBS) waiver program services with the number of non-HCBS beneficiaries who receive home health services. As mentioned previously, prior authorization is required for home health services provided to individuals on an HCBS waiver. This requirement promotes effective utilization of home health expenditures, and decreases the potential for duplication of services. Beneficiaries who are not on an HCBS waiver are limited to one skilled nursing visit and one home health aide visit per day without prior authorization. The number of HCBS waiver beneficiaries who receive home health services has remained relatively stable, which demonstrates consistent management or a stable HCBS population and reflects the fact that these individuals' medical conditions require skilled nursing services in the home to remain in the community. HCBS waiver services and fee for service home health expenditures complement each other to serve the needs of long-term care beneficiaries living independently in the community.

Figure 6

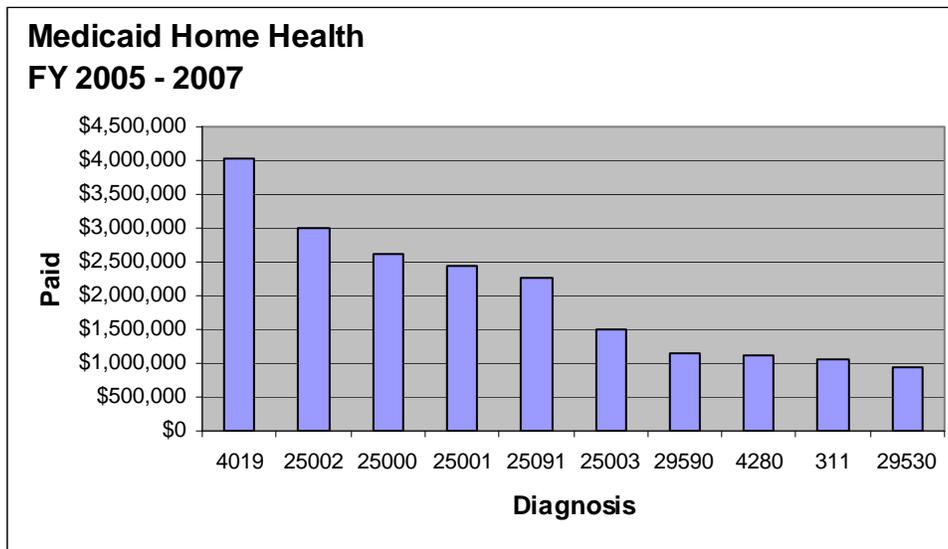


The decline in the number of non-HCBS beneficiaries has been a consistent trend over the last two years. This decline could be attributed to home health program changes that were implemented as a result of the home health special project completed several years ago. The results of that project revealed that 83% of the skilled nursing visits reviewed were not medically necessary for a skilled nurse to provide. The prior authorization process has also been a contributing factor in the decline in the number of home health beneficiaries. The prior authorization criterion was published in the home health manual to provide guidance for home health agencies regarding skilled level of care and program expectations. Attributing the decline in home health service reimbursements since 2002 to a lack of medical necessity is consistent with the intent of the program changes, and appears validated by the lack of consumer complaints and coverage appeals since the program changes (and service declines) occurred.

Recipient Diagnoses

Figure 7 represents the top 10 primary diagnoses for home health beneficiaries (by expenditures) for combined fiscal years 2005 -2007, representing about half of all home health expenditures over this period. Unspecified essential hypertension was the most frequently billed diagnosis, which resulted in an expenditure of more than \$4,043,665. During this same reporting period, diabetes related diagnoses ranked 2nd through 6th among the top 10 home health primary diagnoses, with expenditures of more than \$11,839,376. The prevalence of diabetes is increasing both on the state level and nationally and appears to be headed for epidemic proportions.

Figure 7



Diagnosis Code Description

4019	- Unspecified essential hypertension
25002	- Diabetes Mellitus without mention of complication, TYPE II OR UNSPECIFIED TYPE, Uncontrolled
25000	- Diabetes Mellitus without mention of complication, TYPE II OR UNSPECIFIED TYPE, Not stated as uncontrolled
25001	- Diabetes Mellitus without mention of complication, TYPE I (JUVENILE TYPE), Not stated as uncontrolled
25091	- Diabetes with Unspecified Complication, TYPE I (JUVENILE TYPE), Not stated as uncontrolled
25003	- Diabetes Mellitus without Mention of Complication, TYPE I (JUVENILE TYPE), Uncontrolled
29590	- Unspecified schizophrenia, unspecified condition
4280	- Congestive heart failure, unspecified
311	- Depressive disorder, not elsewhere classified
29530	- Paranoid schizophrenia, unspecified condition

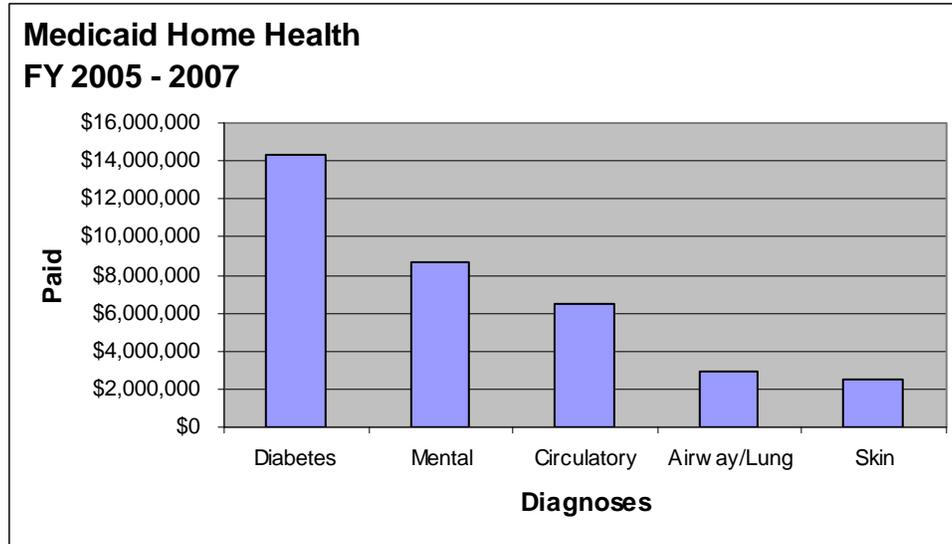
Congestive heart failure ranked 8th in the top 10 most frequently billed primary diagnoses for home health services, and represents an expenditure of more than \$1,113,569.

Mental health diagnoses which include unspecified schizophrenia, depressive disorder, and paranoid schizophrenia ranked 7th, 9th and 10th of the top 10 most frequently billed primary home health diagnoses. The expenditure for these three mental health diagnoses was more than \$3,140,273 during this reporting period.

Aggregating specific diagnoses into larger groups helps to explain the primary medical needs for the home health population. Figure 8 represents the top five diagnostic groups for home health services, representing about three quarters of spending in this period. The data collection involved review of ICD-9 (International Classification of Diseases, ninth edition) groupings. During fiscal years 2005-2007, Kansas Medicaid paid home health agencies fee for service \$14,303,883.00 for diabetic management services. This represents an average per year expenditure of \$4,767,791 for diabetic management. The expenditures for 2005-2007 for beneficiaries with diagnoses related to mental health were \$8,694,177. This represents an average expenditure of \$2,898,059 per year.

Conditions of the circulatory system including hypertension and cardiac related illnesses representing an expenditure of \$6,432,929. The diagnostic group of respiratory or airway conditions represent an expenditure of \$2,923,314. Number five of the top five home health diagnostic groups represents diagnoses related to skin ulcerations and wounds. The expenditure for beneficiaries with skin/wound care was \$2,507,366.

Figure 8



ICD - 9 Diagnostic Groupings

Diabetes	Diabetes (ICD 250-25093 and Insulin V5867)
Mental	Mental Disorders (ICD 290-319)
Circulatory	Hypertension/cardiology (ICD 3911-4599)
Air/Lung	Airway/lungs (ICD 4610-5199)
Skin	Skin ulcers/wounds (ICD 707-7099 8737-8917)

Figure 9 represents the number of home health beneficiaries with diagnoses of diabetes and diagnoses related to mental health, or with both diagnoses, two of the most frequently billed home health diagnoses. It is quite likely that a beneficiary could be counted in both categories for mental health and diabetes, as there are a number of beneficiaries with mental illness who also have a diagnosis of diabetes. These individuals are often prescribed multiple psychoactive medications to manage their mental illness. Potential adverse reactions or side effects of some of the medications used to treat mental illness include weight gain and an increase in blood glucose levels. Skilled nursing visits may be indicated for these individuals with both diabetes and a mental health diagnosis as they may have a limited ability to manage their diabetes due to their mental illness. Further, multiple skilled nursing visits are more likely to be approved for diabetic management visits compared to visits for administration of oral psychoactive medications. Oral medication administration does not require the skill of a licensed nurse and as a stand alone task does not meet medical necessity for skilled nursing services.

Figure 9

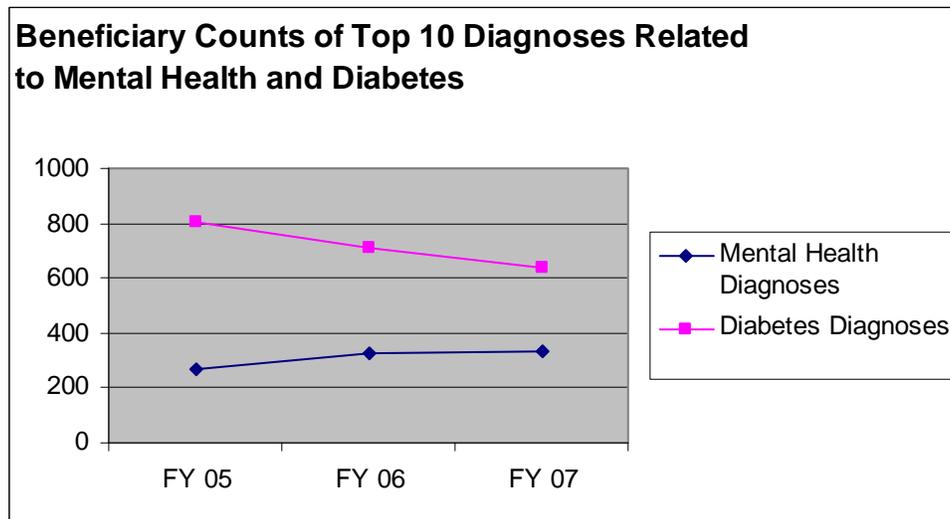
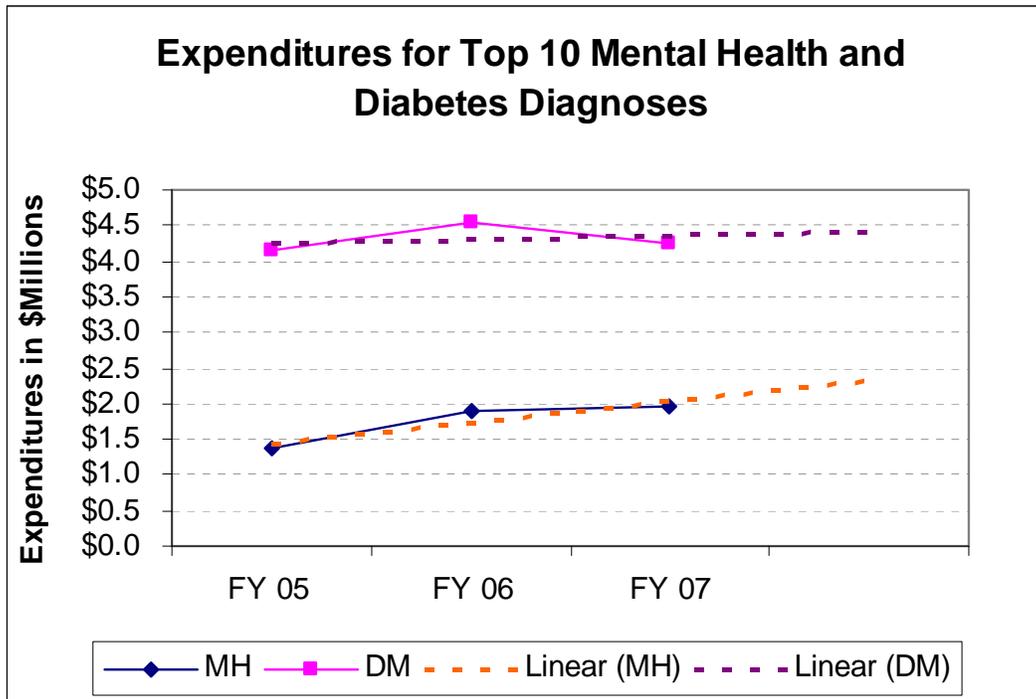


Figure 10 represents expenditures for the most frequently billed home health diabetes diagnoses. In 2005, a total of \$4,147,714 was spent for diabetic management in the home health setting. The cost of serving diabetic clients peaked in 2006, with a total expenditure of \$4,531,344, although close to 100 fewer beneficiaries were served. An explanation for this finding could be that many providers obtained prior authorization for multiple daily visits for diabetic management instead of billing the daily limitation, which is \$45 more per day per beneficiary. This information is of significance, as these individuals often require multiple skilled nursing visits each day for blood glucose monitoring and insulin administration. The expenditures for diabetes management decreased in 2007, as only \$4,243,244 was reimbursed for the top diabetes diagnoses. This decline coincides with the initiation of reviews by the Home Health Program Manager of home health prior authorization requests on a weekly basis. Many of the requests are for multiple daily visits for blood glucose monitoring and insulin administration.

The data for mental health diagnoses show that there has been a steady increase in expenditures for management of mental illness in the home health setting during the past three fiscal years. In fiscal year 2007, \$1,955,110 was reimbursed for beneficiaries with a primary mental health diagnosis. This amount has increased from \$1,367,797 paid in fiscal year 2005. KHPA will continue to monitor trends and expenditures of home health services to assist Medicaid beneficiaries with mental health diagnoses. A straight line projection suggests the cost of serving these individuals will continue to rise. Further, many of these individuals are so chronically mentally ill that the home health benefit is one of the few non-institutional options available to meet their needs. The Pre-paid Ambulatory Health Plan (PAHP) was implemented on July 1, 2007 (the beginning of FY 2008), but it is likely that those individuals served by home health agencies will not seek assistance through the Community Mental Health Centers, as their needs are being met through the home health agencies.

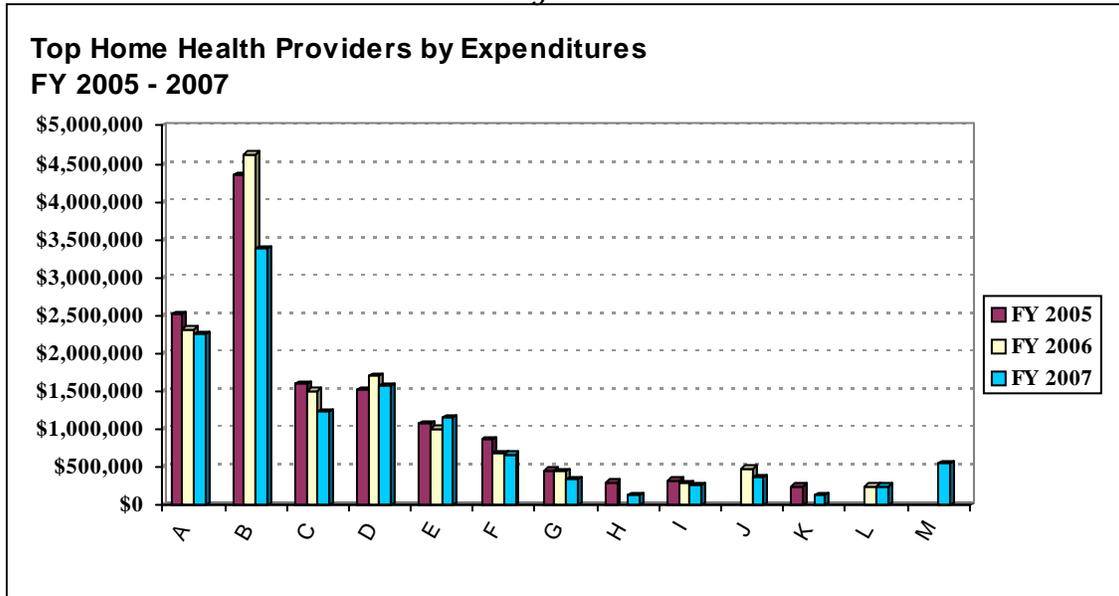
Figure 10



Home Health Providers

Figure 11 represents the top home health providers by expenditures and shows that most providers maximized home health expenditures in fiscal year 2005, and remained fairly stable or had a slight decline in Medicaid revenue in fiscal year 2006. Home Health Agency B surpassed all other providers of home care services, and continued to experience an increase in Medicaid revenue in 2006. Kansas Medicaid will conduct utilization reviews of home health agencies that are outpacing other home health agencies in the provision of services. In fiscal year 2007, most of the top home health providers by expenditure experienced some decline in Medicaid revenue. The decline in home health expenditures is likely the result of state program manager review of prior authorization requests for beneficiaries who have received home health services for an extended period of time. These requests were once approved every six months without question regarding medical necessity or appropriateness for continuation of services. There has also been close review of prior authorization requests for beneficiaries on HCBS waivers to ensure that services that should be provided through the waiver are not provided through home health fee for service. This further decreases the potential of duplication of services for those health maintenance tasks that are self directed.

Figure 11



Telehealth

Figure 12 represents expenditures for home telehealth services for fiscal years 2005-2008. Telehealth visits are provided via interactive audio and video telecommunications systems by a registered nurse or licensed practical nurse located at the home health agency while the beneficiary remains in his or her home. These visits were previously provided to assist beneficiaries in the home setting to monitor medications, vital signs, and consumer administered injections. Program changes were implemented on November 1, 2007, and telehealth visits are now used only to monitor beneficiaries for significant changes in health status, provide timely assessment of chronic conditions and provide other skilled nursing services. The changes have already resulted in a cost savings.

Figure 12

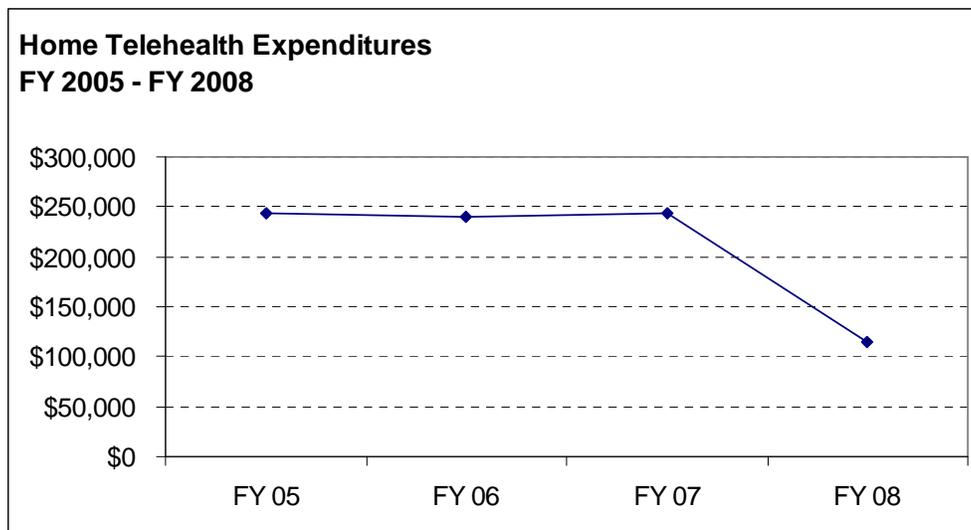
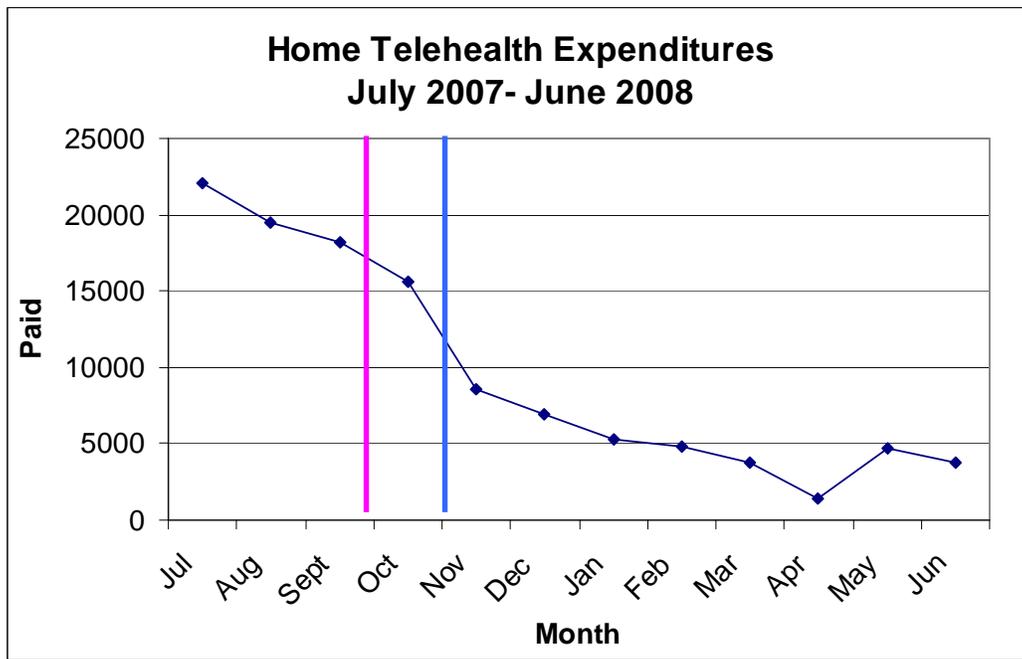


Figure 13 represents monthly expenditures for home telehealth visits for fiscal year 2008. The figure shows a significant decline in expenditures with the implementation of the program changes. The changes were implemented to ensure that telehealth visits provide a skilled service or provide frequent monitoring of unstable chronic conditions. The home telehealth policy was implemented on November 1, 2007. Figure 13 reveals a decline of telehealth expenditures during the month prior to the policy change. Before November, prior authorization was not a requirement for home telehealth services. In anticipation of program changes the provider re-evaluated telehealth clients to ensure that services rendered met the prior authorization requirement for skilled nursing services. The provider discontinued home telehealth services for several beneficiaries as some of the visits were not medically necessary. Home telehealth expenditures continued to decline as the documentation submitted with prior authorization requests did not support the need for skilled telehealth visits.

Figure 13



Program Evaluation

A number of opportunities for potential savings or more efficient use of home health services have been identified, including:

1. *Address the provision of multiple skilled nursing visits per day for oral medication administration for beneficiaries with a psychiatric illness as the primary diagnosis.* Often the physician orders specify that medications should be stored in a locked box and administered by the home health agency. Many of these beneficiaries are not homebound and could be served by Community Mental Health Centers, rather than home health skilled nurses. The home health program manager met with the KHPA Mental Health Liaison and SRS mental health managers to discuss this specified population of beneficiaries and how they may be served through the PAHP and Community Mental Health Centers. During FY 2009 KHPA and SRS will conduct extensive reviews of beneficiary data, including diagnoses, geographic location, and involve other agencies and organizations as appropriate to most effectively and efficiently meet the needs of these

beneficiaries in the community setting without a duplication of services.

2. *Address the provision of intensive home health services for an excessive duration, with lack of evidence of attempts to promote beneficiary/family independence.* In many cases, home health services should be of limited duration and intensity, and should empower and educate beneficiaries and caregivers to be more active participants in their care. Many states limit the intensity of home health services by regulating the total number of visits in a year. Medicare utilizes a PPS (prospective payment system) reimbursement methodology to provide incentives for the provision of only necessary services. Under the prospective payment, Medicare pays home health agencies (HHAs) a predetermined base payment. The payment is adjusted for the health condition and care needs of the beneficiary. The payment is also adjusted for the geographic differences in wages for HHAs across the country. The adjustment for the health condition, or clinical characteristics, and service needs of the beneficiary is referred to as the case-mix adjustment. The home health PPS provides HHAs with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin; there are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. Each episode is adjusted to reflect the beneficiary's health condition and needs - which acts as a kind of pre-authorization or screening criteria for continuing benefits each 60 days. A special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The home health PPS is composed of six main features:

- Payment for the 60-day episode
- Case-mix adjustment - Adjusting payment for a beneficiary's condition and needs
- Outlier payments - Paying more for the care of the costliest beneficiaries
- Adjusting for beneficiaries who require only a few visits during the 60-day episode
- Adjusting for beneficiaries who experience a significant change in their condition
- Adjustment for the beneficiaries who change HHAs

For details, go to web site <http://www.cms.hhs.gov/HomeHealthPPS/>.

KHPA will continue to review the effectiveness of the Medicare pre-payment and periodic review methodology, but recommends interim steps below to address the concerns raised regarding provision of indefinite and intensive home health services.

3. *Address the provision of services through home health agencies that are considered content of service for HCBS waiver recipients, including health maintenance tasks such as blood glucose monitoring, insulin administration, administration tube feedings, and simple dressing changes.* The program manager will continue to monitor home health prior authorizations for HCBS beneficiaries to ensure that services are appropriate and that beneficiaries' needs are met through the appropriate provider and without duplication. There are instances in which an HCBS waiver beneficiary's condition would require intermittent skilled nursing visits. HCBS beneficiaries are entitled to Medicaid state plan services that are not duplicative of services offered through the waiver. Further, special allowances have been made through the waiver programs that allow self directed personal care attendants to perform health maintenance tasks that may be considered outside of the scope of practice for home health aides or agency directed personal care attendants. The program manager has on-going contact with SRS HCBS program managers as needed regarding home health prior authorization requests for waiver beneficiaries. Beneficiary choice regarding self direction of care is respected, but exploration of other resources available to assist with health maintenance activities is considered on a

case by case basis.

4. *Provision of multiple visits per day for the sole purpose of blood glucose monitoring and insulin administration.* Diabetic management and insulin administration are tasks that many diabetic clients are able to safely perform themselves with proper training and diabetic education. In keeping with KHPA's vision principles of promoting health and wellness, education and engagement, identification of methods to encourage appropriate self-management of diabetic conditions will continue to be a priority.
5. *On-going review of the home health plans of care and assessments required for prior authorizations suggest opportunities for diabetic management services to more comprehensively address beneficiaries' needs and associated co-morbidities.* Currently Medicaid does not reimburse for DSMT (Diabetic Self Management Training). Instead, Medicaid approves 15 minute visits for diabetic management, which includes blood glucose monitoring and insulin administration. Emphasis could be placed on training and education to facilitate beneficiary and caregiver empowerment, participation and independence.
6. *Provision of excessive home health aide services for beneficiaries that are not on an HCBS waiver.* The current limitation allows a one hour home health aide visit per day without prior authorization. Home health aide tasks include but are not limited to the following: personal hygiene, linen change, maintenance exercises, medication assistance, vital signs, bowel/bladder procedures, and non-sterile dressing changes. On-going review of records has revealed that some providers are billing Medicaid for daily home health aide visits for the provision of home maker services which include housekeeping and meal preparation. These are not home health aide tasks and are consistent with homemaker and chore services which fall under HCBS waivers.

Recent Changes

The following changes have been implemented recently in the home health program to address identified concerns regarding skilled nursing visits for HCBS waiver recipients, home telehealth services, and home health plans of care. Close monitoring of home health services and the prior authorization process has resulted in significant decreases in overall home health expenditures over the past five years.

1. In October 2007 the state program manager and prior authorization nurses began requesting additional information upon receipt of prior authorization requests for HCBS beneficiaries. This process provided the opportunity for home health agencies to identify beneficiary supports and explore ways by which to decrease beneficiary dependence on home health services. The prior authorization request form was modified in January 2008 to include information regarding HCBS waiver services and the beneficiary's choice of self directed or agency directed personal care attendant services. This change resulted in home health agencies having a greater awareness of other more appropriate resources available to recipients of home health services. Self direction of care permits the beneficiary or caregiver to make important decisions regarding his or her care and delivery of services. Self directed HCBS beneficiaries are able to choose who they would like to provide their attendant care service which has the potential to increase continuity of care. The option of self direction of HCBS services is also a potential area of cost savings, as the self directed caregivers are able to provide an expanded range of services that agency directed caregivers cannot provide. K.S.A 65-6201 permits self directed caregivers to perform health maintenance activities that the beneficiaries could safely perform for them-

selves if not for their disability. Utilization of self directed caregivers according to K.S.A 65-6201 has the potential to decrease the need for skilled nursing visits to perform these tasks.

2. A telehealth policy was implemented in November 2007 that requires prior authorization of home telehealth visits for HCBS beneficiaries, and for non-HCBS beneficiaries who receive more than two telehealth visits per week. The policy included the assignment of a new provider type and specialty for home telehealth providers and the use of procedure codes that are specific to nursing services. The reimbursement for this service was decreased to the equivalent reimbursement of a 15 minute in home skilled nursing visit. Plans of care are reviewed by the program manager and only those that require a skilled level of care or warrant more frequent monitoring of an unstable chronic condition are approved. This change has resulted in a significant reduction of expenditures for home telehealth services as noted by Figure 12 and Figure 13. Home telehealth visits are no longer approved for non-skilled services. Review of home telehealth data pre- and post- policy implementation revealed that there has not been an increase in hospitalizations or reports of adverse outcomes for this population. With the implementation of the telehealth policy in November 2007, prior authorizations were requested for 18 beneficiaries. Only two of these beneficiaries required hospitalizations during the period of January to November 2007. Only 1 beneficiary of the 18 has had a hospitalization since the implementation of the telehealth changes in November of 2007.
3. In May 2007 the state program manager and prior authorization nurses began more closely monitoring prior authorization requests for services of an excessive duration that had minimal to no changes in the associated plans of care or level of service. The prior authorization nurses requested additional information regarding beneficiary need, health status and resources available to promote beneficiary and caregiver independence. This change provided opportunities for home health agencies to evaluate the plans of care to ensure that home health services are appropriate, adequate, effective and efficient. Program management has identified and prevented unnecessary and inappropriate utilization of home health services, and has contributed to a decline in the overall use and expenditures in fiscal year 2008.

Conclusions

More careful review of home health prior authorization requests for both HCBS and non-HCBS beneficiaries has resulted in a decrease in overall expenditures for fiscal years 2007 and 2008. While we do not anticipate that this trend will continue indefinitely, we may see continued decreases in expenditures with the increased examination of prior authorization requests. The combination of proposed changes described below is expected to result in modest additional savings in home health expenditures. Realignment benefits to more appropriately align greater payments for more intensive, short-term benefits, and providing incentives and support for beneficiaries to transition to self-care is expected to offset the recommended rate increases intended to maintain access for beneficiaries.

Recommendations

1. The expenditures for home health beneficiaries with a diagnosis of diabetes represent a large portion of the home health budget. This issue will be addressed through a diabetic management forum. A home health provider survey was developed to establish a consistent and comprehensive method of determining the needs of beneficiaries with diabetes. The survey was

shared with board members of the Kansas Home Care Association. The data obtained through the survey results will be analyzed and then used to develop a comprehensive diabetic management program to educate and encourage beneficiary and caregiver participation in self care. The preliminary goals for the diabetic management forum are to:

- a. Develop a tool to assess the beneficiary's knowledge of their disease and provide education and training to increase knowledge and independence.
- b. Assess what is currently the best practices in the care of beneficiaries with diabetes in the home health setting, and provide a comprehensive assessment of the beneficiary's strengths and needs.
- c. Address quality indicators to be completed by physicians who refer diabetic beneficiaries to home health for diabetic management services. This tool will require evaluation of the beneficiary's Hemoglobin A1C, LDL (low density lipoprotein), blood pressure and associated co-morbidities.

2. Implement mechanisms limiting overuse of home health services and distinguishing between intense acute and long-term maintenance and support needs of home health consumers.

Proposals include:

- a. **Implement prior authorization for all home health services.** Currently only HCBS and other selected services are reviewed in advance to ensure medical necessity. In conjunction with the creation of separate acute and long-term home health benefits, KHPA plans to implement universal prior authorization for home health benefits. Prior authorization will be required for all waiver and non-waiver beneficiaries needing acute care home health services and criteria will be developed to determine if skilled nursing visits are truly for an acute condition. Prior authorization will also be required for long-term care home health services in accordance with criteria that identify the service as health maintenance and provide evidence that other resources have been explored and exhausted.
- b. **Limit acute care home health services to 120 visits.** Should beneficiaries require home health services beyond 120 visits; they will receive services through a long-term care benefit. Consultation with other state Medicaid agencies revealed a variety of mechanisms to distinguish between acute and long term home health benefits. Colorado utilizes revenue codes to reimburse home health services and multiple daily visits are paid descending rates. Several states utilize disease management or chronic care management programs. Iowa Medicaid coverage of home health is similar to Kansas Medicaid coverage, but Iowa is also exploring avenues by which to more efficiently meet the needs of diabetic beneficiaries.
- c. **Place a limit on acute care home health aide visits.** Currently Medicaid beneficiaries may receive up to 365 home health aide visits and 365 skilled nursing visits per year without prior authorization for those individuals not on an HCBS waiver. Beneficiaries will be allowed only two home health aide visits per week without express prior authorization. Home Health aide visits are for the purpose of assisting with activities of daily living such as bathing, toileting and grooming. It does not include homemaker tasks such as house keeping and meal preparation. Implementation of this program change could result in a cost savings, as services will require prior authorization which will address medical necessity, frequency of visits and duration of home health episodes of care.
- d. **Reimburse acute home health benefits at a higher rate than the long-term care home health benefit.** Providers will bill acute care services utilizing the G codes and T codes currently used for skilled nursing visits. The long-term care benefit will re-

imburse at a lower rate and providers will utilize a code to be designated for the long-term care home health benefit. The long-term care benefit would address the needs of beneficiaries with chronic diagnoses that require more frequent monitoring or skilled nursing assistance for health maintenance activities that the beneficiaries and care givers cannot perform themselves. This will allow the beneficiaries to receive supportive services to remain in their homes instead of placement in an institution.

- e. **Work with stakeholders.** KHPA will work with stakeholders and our sister agencies to establish needed criteria for the long-term care home health benefit and to review the proposed transition to an acute care and long-term care (health maintenance) home health Medicaid benefit.
3. Develop comprehensive tools to address the best practices in the care of other chronic disease processes. These tools will address education and training that will facilitate increased beneficiary participation in self monitoring and self care. The goal is to empower beneficiaries to obtain a knowledge base that facilitates management of their chronic illness and knowledge of changes that warrant notification of their health care provider. The home health provider will become an extension of the primary care medical home. The home health skilled nursing visit is a perfect opportunity to address the on-going education and training needs of home health beneficiaries, as the providers are frequently in the homes. Since the medical provider may not be able to visit the beneficiaries in their homes, the home health visit becomes an opportunity to reinforce and evaluate training efforts that may be prescribed by the provider. Other disease processes for which comprehensive tools will be established include but are not limited to congestive heart failure, chronic obstructive pulmonary disease, and asthma.
 4. The Medical Home Model emphasizes coordination of care throughout the health care continuum. KHPA is convening a group of stakeholders to define medical home in state statute. This definition will be incorporated into the management and administration of Medicaid. Home health providers will be an integral part of the patient centered medical home. Home health providers will serve as an extension of the medical home that seeks to keep the beneficiary at the most cost effective level of care by assessing the beneficiary in their home, educating them on their medical disease and maintaining close contact with the primary care provider. This will be especially important as we develop the medical home model for our beneficiaries with chronic diseases.
 5. Expenditures for home health beneficiaries with a mental health diagnosis represent a significant proportion of the home health budget. Improved coordination of services through the Community Mental Health Centers has the potential to benefit home health recipients, facilitating contact with outside resources, decreasing dependency on home health services, and promoting participation in groups and therapeutic activities, and increasing the beneficiaries' quality of life in many ways. KHPA will work with SRS to identify ways to better coordinate services for these beneficiaries. Reports have been generated to identify beneficiaries who receive home health services that have a SPMI (Severe and Persistent Mental Illness). The data will be analyzed to explore how PAHP (Prepaid Ambulatory Health Plan) services might be utilized to serve these beneficiaries. These beneficiaries could also be served through an ECM (Enhanced Care Management) assignment where available. If these efforts are successful, the beneficiaries will have assistance not only to manage their mental health diagnosis, but will have somewhat of a medical home to address other needs and concerns.

6. There has not been a rate increase in Medicaid reimbursement for home health services since program changes were implemented in 2002. Providers have expressed that low Medicaid reimbursement has made it difficult to stay in business. Some have expressed that they cannot afford to continue serving Medicaid beneficiaries. Increasing gasoline prices are putting additional cost pressure on home health providers. In conjunction with the cost-control measures described above, including the added distinction of acute and long-term home health benefits, KHPA proposes to increase Medicaid reimbursement for the first 15-minute code of the acute home health visit (G0154) from \$30 to \$35.