COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 10, 2019

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Jennifer S. Lee, MD

SUBJECT: Report on Community-Based Nursing Transformation in the Medicaid Program

Item TTT of the 2018 Appropriations Act states, "1. The Department of Medical Assistance Services shall work with stakeholders to review and adjust medical necessity criteria for Medicaid-funded nursing services including private duty nursing, skilled nursing, and home health. The department shall adjust the medical necessity criteria to reflect advances in medical treatment, new technologies, and use of integrated care models including behavioral supports. The department shall have the authority to amend the necessary waiver(s) and the State Plan under Titles XIX and XXI of the Social Security Act to include changes to services covered, provider qualifications, medical necessity criteria, and rates and rate methodologies for private duty nursing. The adjustments to these services shall meet the needs of members and maintain budget neutrality by not requiring any additional expenditure of general fund beyond the current projected appropriation for such nursing services.

2. The department shall have authority to implement these changes to be effective July 1, 2019. The department shall also have the authority to promulgate any emergency regulations required to implement these necessary changes within 280 days or less from the enactment dated of this act. The department shall submit a report and estimates of any projected cost savings to the Chairman of the House Appropriations and Senate Finance Committees 30 days prior to implementation of such changes.

3. The department shall work with stakeholders to review changes to services covered, provider qualifications, rates and rate methodologies for private duty nursing services, and make recommendations to the Chairmen of the House Appropriations and Senate Finance Committees by December 15, 2018."

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

JSL/

Enclosure

pc: The Honorable Daniel Carey, MD, Secretary of Health and Human Resources

Community-Based Nursing Transformation in the Medicaid Program

A Report to the Virginia General Assembly *December 15, 2018*

Report Mandate:

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Executive Summary

Nursing is an important component of a continuum of supports designed to allow eligible Medicaid recipients to live within their communities. "Skilled nursing" is a level of care that includes services that can only be performed safely and properly by either a registered nurse (RN) or a licensed practical nurse (LPN). Medicaid currently covers several skilled nursing services (dependent on eligibility), including Home Health, Skilled Nursing (SN), and Private Duty Nursing (PDN). PDN services are skilled nursing services for eligible individuals with complex medical needs who require more individual and continuous care than is available from an intermittent visiting nurse, such as those available in the Home Health and Skilled Nursing services.

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high-quality and cost-effective health care.

Medicaid plays a critical role in the lives of more than a million Virginians. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long-term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

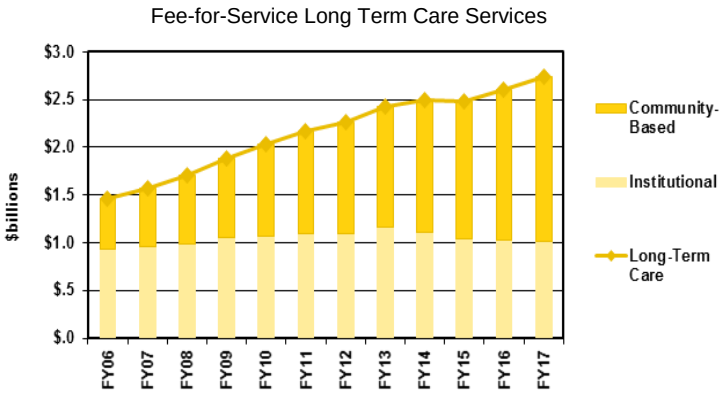
Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Per the direction of the 2018 Appropriations Act, the Department of Medical Assistance Services (DMAS) is conducting a review of the complicated system for provision of nursing services to Medicaid recipients. This delivery system has not been reviewed in upwards of 15 years, and it has not kept up with changes in the practice of medicine and in demand for services.

This report details the work already completed and an initial set of recommendations for the further transformation of these services. Among the recommendations updates to the medical necessity criteria used to determine the amount of services that are appropriate to meet recipients' clinical needs and a simplification of the billing codes and rates for these services. DMAS also recommends a new methodology for reimbursement of these services that will allow CNAs to function as nurse-extenders in a team-based approach to care delivery. Doing so would simultaneously address workforce concerns through the use of assistive personnel, allow higher-level skilled professionals to practice at the top of their licenses and provide a *de facto* rate increase for community-based nursing providers without a formal rate increase with budgetary impacts.

Background

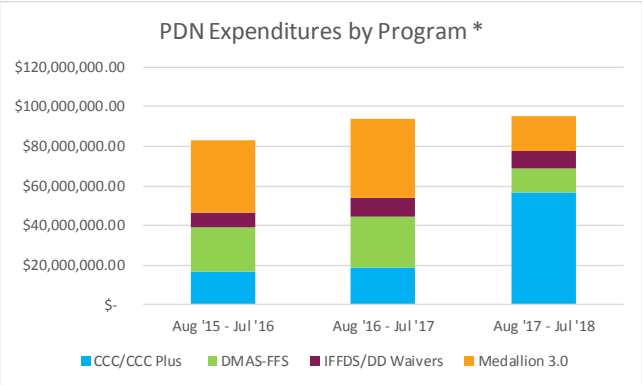
Nursing agencies (defined as Home Health Agencies in state regulations) report that they struggle to recruit and retain nurses to staff all of the medically authorized hours of Medicaid members, sometimes striving to staff more than 50 percent of hours authorized for Medicaid members. These gaps are evident in the service authorization and billing data. While a 2017 US Health Resources and Services Administration report estimated that Virginia will see an excess of roughly 23,000 nurses by 2030, the 2017 Occupational Employment data from the Bureau of Labor Statistics (BLS) estimates that only 10 percent of the RNs and LPNs practicing in the Commonwealth do so in a Home Health setting. The discrepancy between hours authorized and hours staffed may be partially attributable to the increasing demand for services in the community setting due to state and national "rebalancing" efforts, with a concurrent shortage of nurses working in these settings.



Nursing agencies must often consider expensive administrative costs in order to recruit and retain nurses. Combine staffing needs with Medicaid reimbursement rates hovering at roughly 70 percent of the BLS benchmark in Virginia, and many nursing agencies struggle to pay nurses competitive salaries, which leads to challenges with recruitment and high turnover rates. The agencies may have very limited financial resources to prioritize investments that could ultimately lead to improved patient outcomes (for example, extra trainings and technological advancements like electronic charting).

Determination of a clear baseline for this work is difficult – throughout 2017 and 2018 populations have shifted, services previously in DMAS's Fee-for-Service (FFS) program were rolled into Managed Care contracts. However, the graph below demonstrates that the majority of expenditures for private duty nursing services are increasingly in the Commonwealth Coordinated Care Plus (CCC Plus) Program. This is ideal because individuals with medical complexities who need community-based nursing services may also benefit from the additional services and enhanced care management offered under the CCC Plus Program. This graph also shows that the spending on these services is slowly increasing. While it is too early to determine if the shift is permanent or due to the work outlined below,

service utilization grew at a rate of 13 percent in FY'16, and only 2 percent in FY'17.



**** For consistency, eligibility categories were grouped according to their current operational program affiliation.***

In the summer of 2017, DMAS undertook a limited process improvement effort focused on a review of the medical necessity criteria to determine service authorization levels for PDN (particularly for services provided through the Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit). DMAS increased collaboration and stakeholder engagement through the formation of a "Private Duty Nursing Workgroup." In addition, all authorizations for EPSDT PDN for all Medicaid FFS members - with the exception of those for participants in the Developmental Disabilities (DD) Waiver, administered by the Department of Behavioral Health and Developmental Services (DBHDS) - were transitioned from the KEPRO service authorization vendor to the DMAS Medical Support Unit (under the Office of the Chief Medical Officer).

The pending merge between the Technology-Assisted Waiver and the Elderly or Disabled with Consumer Direction (EDCD) Waiver into the CCC Plus Waiver required that DMAS review the respective medical necessity forms which determined authorization for these two former waivers. There were similarities, but they had not been reviewed in over a decade and so had not kept pace with current medical practice. Limited updates and clarifications were made, including the requirement that supplemental clinical documentation (such as provider visit notes) be submitted with the authorization request. However, research from other states (Ohio, North Carolina, Texas, West Virginia, Michigan and Indiana) indicates the prevalence of stricter medical necessity criteria, as well as disproportionate utilization of these services in Virginia. DMAS therefore believes further updates to the medical necessity criteria are required.

DMAS convened the "Private Duty Nursing Workgroup" comprised of clinician representatives from each of the six Medicaid Managed Care Organizations (MCOs) and several of the largest nursing agencies in the Commonwealth. This group provided a forum for open communication about system-level opportunities and challenges, with the goal of improving outcomes for the recipients of these services, who are among the state's most vulnerable citizens.

Over the next year, DMAS worked with this group to review a new medical necessity framework (based on other states' service authorization criteria). The group validated that the form captured the full spectrum of clinical interventions performed by nurses in community-based settings. The DMAS Medical Support Unit (under the Office of the Chief Medical Officer) and the MCOs then concurrently completed (or "shadow scored") the new form in tandem with their official authorization reviews using the current DMAS EPSDT PDN authorization criteria (DMAS-62), and entered the information into a secure REDcap database. Roughly 400 individual EPSDT authorizations were entered over a 6-month period, creating data representing the nursing interventions each individual required. The nursing agencies were also asked to "assign" each of these interventions to an RN, LPN or Certified Nursing Assistant (CNA), using current Virginia Department of Health Professions scope of practice regulations (18VAC90-19-240 through 18VAC90-19-280) as the standard for safe delegation.

Both the MCOs and nursing agencies have been active partners in these conversations, and have co-presented on cases in which they effectively collaborated in order to ensure that the patient's needs were met. Both groups have provided valuable insight into the financial, operational and clinical considerations of a potential transformation of these services.

Recommendations

Medical Necessity Criteria

DMAS recommends adoption of a medical necessity authorization form based on the skilled nursing interventions that the individual requires, rather than one based upon specific diagnoses. This format follows other states' criteria and forms, and allows for more flexibility to accommodate medical advancements. For example, the presence of a tracheostomy does not in and of itself

mean that skilled nursing is appropriate; instead, skilled nursing is required when the specialized judgment, knowledge, and skills of a nurse are necessary for the services to be safely and effectively provided – such as when the tracheostomy is still considered "unstable".

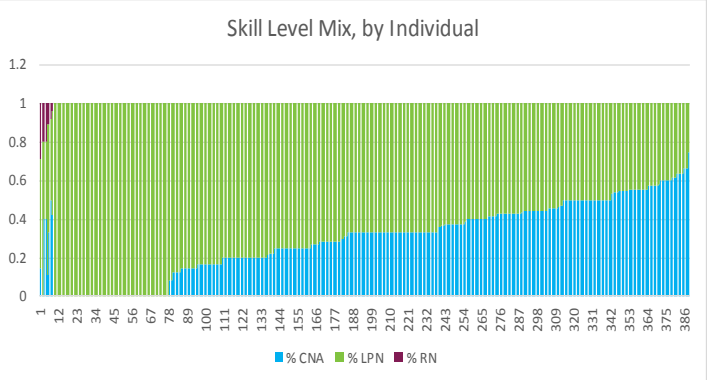
The primary goal of updating medical necessity criteria is to ensure that those who need skilled nursing services receive them, at the appropriate level, and that those whose clinical condition does not warrant receipt are redirected to other, more clinically appropriate support services, such as personal care, specific home-based therapies and/or evidence-based behavioral health services. Basing authorization determinations on expanded criteria - and supplemental clinical documentation – will also allow for a more robust and individual review, as is required under federal EPSDT regulations from the Centers for Medicare and Medicaid services.

Updating these new criteria after so many years is likely to cause a contraction of services for some individuals, whose clinical complexity does not warrant provision of a skilled nursing level of care. The first step in increasing the efficiency of the system is therefore to reduce unnecessary services. However, because there is unmet demand in those who medically require the services, the expected result is a reallocation of services rather than a reduction. Those with significant needs will more often have their needs fully met, while those with a lesser degree of medical support needs will receive less medically intensive services. The net result will be that budget neutrality is maintained.

Rates/Rate Methodologies

The "shadow data" produced by the Private Duty Nursing Workgroup members demonstrates that these clinical needs can be met with lower skill sets, justifying the use of CNAs in the continuum of care. The inclusion of these individuals would assist in solving several complex challenges in the current PDN delivery system.

The "shadow data" indicates that those requiring direct care by an RN are rare outliers; for the average recipient of these services, 70 percent could be performed by LPNs, the other 30 percent by CNAs, below.



CNAs have a similar scope of practice to other "assistive" personnel, including Personal Care Assistants and Home Health Aides. However, they are required to complete training programs and take a certification exam, both of which are regulated by the Department of Health Professions in Virginia, and their training is more heavily focused on working in care teams under the oversight of nurses. They are often therefore employed in hospitals and nursing facilities (roughly 13 percent currently work in the Home Health setting); currently, DMAS does not allow for the billing of CNAs, except when included in a bundled daily charge within these settings, or when working as a personal care aide.

According to BLS data, there are an estimated 37,000 CNAs in Virginia, 13 percent of whom are employed in the Home Health setting. CNAs can be more quickly trained than licensed or registered nurses can, so the supply could more quickly catch up to an increase in demand. In addition, CNAs are compensated at lower levels than LPNs or RNs. For the 30 percent of the skills that could be delegated, allowing a CNA to perform this work increases the efficiency of the system, allows clinicians to more effectively practice at the top of their licenses and increases the "value" of the services to the taxpayer.

Despite an increase in 2016, Medicaid rates for PDN sit consistently below 75 percent of the benchmark established by an independent third party using a CMS-approved methodology. LPN rates are at a higher percentage of the benchmark than those for RNs, exacerbating the shortage at the top of the delegation chain.

	Current hourly rate*	Benchmark Rate	Percent of Benchmark
LPN - NOVA	31.97	44.08	73%
LPN – ROS	26.37	35.83	74%
RN – NOVA	36.88	60.80	61%
RN – ROS	30.37	48.12	63%

**Current rate in CCC Plus waiver and EPSDT*

There are currently around ten primary billing codes used for PDN, with many variations and as many rates. DMAS therefore recommends a simplification of the services to include only four codes, aligned with standard Healthcare Common Procedure Coding System (HCPCS) definitions, as set out below. This simplified alignment will not only reduce provider confusion and the administrative burden related to billing, but will also allow Virginia Medicaid to compare itself more easily to other states' policies and utilization patterns. Limiting billing options to the four "T-codes" below, when possible, is preferable, because these codes are designed specifically for state Medicaid use.

HCPCS Code	HCPCS definition	DMAS Use
Option 1:		
T1000	Private duty/individual nursing service – licensed, up to 15 minutes	NEW Blended LPN/CNA rate
T1001	Nursing assessment and evaluation	NEW Used for RN oversight: plan of care updates, supervisory visits and live or telephonic clinical consultations
Option 2:		
T1002	RN services, up to 15 minutes	Traditional rate
T1003	LPN services, up to 15 minutes	Traditional rate

The vast majority of PDN services are currently billed to two general PDN codes and two EPSDT-specific PDN codes. Due to recent guidance from CMS, EPSDT criteria must be used to assess and fully meet needs in lieu of waiver services. Therefore, DMAS recommends removal of the EPSDT PDN codes (S9123 and S9124), and that all PDN services provided for individuals under the age of 21 be automatically considered EPSDT. In addition, there is a group of waiver-specific PDN codes that are billed with much less frequency; for simplification, DMAS recommends that these be absorbed into the four T-codes noted above, with limited modifiers when necessary for rate adjustments (such as for congregate nursing). With this change, waiver individuals would continue to have access to waiver services, such as Respite nursing, to meet eligibility requirements.

In order to protect this vulnerable population from potential contraction in the availability of providers due to these aggressive delivery system reforms, DMAS proposes that the traditional system of billing for an RN or LPN remain intact for the present. Nursing agencies will need to pick between the options above, billing for *either* the traditional RN and LPN codes (T1002 and T1003) *or* for the new model, including CNAs and LPNs under the delegation authority of the RN supervisor (T1000 and T1001). Keeping T1002 and T1003 as active codes will allow nursing agencies to decide if they would like to continue with the old model or "opt into" the new payment model during the piloting phase, described below. This choice gives providers autonomy and allows for flexibility in testing the financial impact of the new model. However, after piloting and proving the concept of Option 1, with the new blended rate, the intent is to remove the Option 2 (T1002 and T1003) to incentivize provider adoption of the new model.

In addition to the direct financial incentives associated with these efficiencies, thoughtfully designing the incentives built into the system could have positive qualitative and quantitative downstream effects in the longer-term. Recipients will more consistently receive the services that they need, but will also benefit from a system of care which incentivizes increased use of RNs for oversight rather than the rare need for direct care. Currently, reimbursement rates for T1002 and T1003 take into account "administrative costs", including oversight by an RN for tasks such as the DMAS-required plan of care updates every 30 days. By requiring separate billing for RN services under the code T1001, DMAS hopes to allow for transparency into how often these services are used. In fact, access to RNs has been demonstrated to improve patient safety and outcomes in both acute care and long-term care settings. This methodology therefore also provides a structure to incentivize future measurement of patient quality of care outcomes, such as emergency room utilization and readmission rates, with this critical component of the delivery system.

Unnecessary Emergency Department visits, unplanned admissions and readmissions are more likely to occur when home care staff feel that they are isolated and lack confidence in the availability of escalation pathways to higher levels of clinical support. Creation of a full continuum for delivery of nursing care in the community would likely lead to increased quality of life, and potentially a reduction in these costly events. For those who rely on assistive personnel as well as nursing, integrating these services into a single, team-based

approach to care delivery may have the additional benefit of increasing caregiver continuity in patient-provider relationships. *Home Care Pulse's* Home Care Benchmarking Study found that the median non-nurse caregiver (personal care attendants, companion or homemaker providers, etc.) turnover rate hit 66.7 percent in 2017, with 57 percent doing so in the first three months of employment. Along with compensation, the challenging work environment – including isolating environments and little support - is often a reason for dissatisfaction among home care workers. Creating a payment structure that provides an incentive for providers to facilitate team-based care will likely have a positive effect on patient outcomes, especially when processes, strategies and tools are put in place to ensure that delegation corresponds with professional and practical nursing practice.

In addition, a recent study in *Pediatrics* found that 68.5 percent of new pediatric patients with medical complexity experienced discharge delays, of which 94.1 percent of delayed hospital discharge days were due to shortages in pediatric home care nurses. Existing patients were less likely to experience delays (9.2 percent), but 71.3 percent of delayed discharge days for were due to the same reason. According to the Children's Hospital Association, medically complex children account for one-third of pediatric healthcare expenditures, and 80 percent of these costs are attributable to hospitalizations. These delays can therefore have huge systemic impacts on costs, as well as quality of life for the children and families who are waiting to return home.

Implementation Approach

The transformation of PDN services in the Commonwealth is exceptionally complex, due in part to the high stakeholder engagement and the medical fragility of the individuals who receive services. DMAS therefore recommends a phased approach to implementation beginning by July 1, 2019. The first phase would include extensive outreach to gather feedback and provide education and training. It would also include piloting the proposed system changes and additional data collection efforts. This would provide a clear, limited scope to the initial work and directly engage stakeholders in solution development, which would ensure the development of the best result, minimize unintended consequences and ensure maximum support through the full implementation process, projected to begin in early 2020.

It is also important to note that while the language mandating this transformation was included in the 2018 Appropriations Act, the General Assembly required this report so they could review the proposed changes and provide any further input or direction during the 2019 session. This phased approach will therefore allow DMAS to adjust its approach, if/as necessary to meet any additional requirements from the Governor's Office and General Assembly.

Phase I

Because of the scale of any changes to the delivery system for community-based nursing, DMAS proposes that the scope for the first phase of work be limited exclusively to changes to the PDN service. Changes within this service are likely to have effects on other services, such as "Home Health" and "Skilled Nursing", which should be considered while under development.

The initial phase should ideally involve a significant focus on education, training, and stakeholder engagement. Diverse input on operational considerations proved to be valuable in making adjustments to medical necessity forms; that same diversity would be equally valuable in fostering creative solutions to this significant challenge. DMAS therefore recommends the expansion of the Private Duty Nursing Workgroup described above.

This group has already validated the completeness of the clinical skills included in the proposed medical necessity criteria, and could be tasked with developing the weighting of the skills into a "clinical complexity index" with which to determine authorization levels. The participants in this workgroup also have great insight into what will be required of DMAS's provider and MCO partners when operationalizing these system changes.

In addition, this first phase should include additional data collection for those populations excluded from the original data analysis described above. This would include limited data on adults and those who receive services through the Community Living and Family & Individual Supports waivers (two of the 3 elements of the DD Waivers). As of the fall of 2018, DBHDS has partnered with DMAS to perform "shadow scoring" as described above for these populations. Since the majority of adults receiving skilled nursing services do so through these waivers, this data capture will simultaneously provide information about adjustments inherent to the unique DD system as well as the adult population.

Specific rates for the new blended option are not included in this report because they are dependent on the lessons learned in this pilot phase. For example,

updates to the medical necessity criteria are likely to have effects on the distribution of PDN hours to recipients, which may in turn have effects on how these codes will be billed. Data collected early in the pilot will inform the modeling method used for rate development, which will be completed within this first phase.

Phase II

The second phase of work would include a full implementation of the PDN solutions developed and piloted by MCO and nursing agency partners. This would include the use of the new, indexed medical necessity criteria for PDN. It would also include termination of the traditional, separate T1002 and T1003 RN and LPN billing codes, with a shift to billing for the new, blended LPN/CAN and RN evaluation codes (T1000 and T1001) only. Implementation would include the DD waiver population, albeit with any necessary adjustments to account for the participants' unique needs. Lastly, this phase may include changes to the "Home Health" and "Skilled Nursing" services, to ensure that these linked services form a complete continuum of community-based nursing care.

DMAS proposes that this phase commence in early 2020 to provide ample time to make adjustments and effectively communicate the changes to various stakeholders. In addition, this timeline also allows DMAS the needed space to collect and respond to data, in order to ensure that the goals of the system transformation (including budget neutrality) will be met.

This timeline would also allow DMAS to implement any required system changes in the new Medicaid Enterprise System, avoiding duplication of work effort by requiring system changes to the current VA-MMIS, as well.

There is much work to be done to ensure that this important delivery system effectively balances the needs of the various stakeholders involved. However, DMAS is confident that creative problem solving with a focus on system-level process improvements, a strong working relationship with stakeholders and a proactive approach to data-driven decision-making will ensure that this system works more effectively for all involved.