Nursing Services Data Report

NURSING HOURS UTILIZATION III.D.I

Six Month Review of FY20

February 2021

INDICATOR

III.D.1

6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018. The utilization rate is defined by whether the hours for the service are identified as a need in an individual's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.

INTRODUCTION

The Office of Integrated Health (OIH) in collaboration with Data Analysts within DBHDS performed a review of the first six months of FY20 data for Nursing Services within the Commonwealth. This time period covers 7/1/19 – 12/31/19. The service authorizations pulled for this review included all authorizations that ran through FY20 including those beginning in FY19 and concluding in FY20 or beginning in FY20 and concluding in FY21.

OVERVIEW OF DATA

DBHDS found 643 unique ID/D individuals (1309 total authorizations) in DMAS service authorization files with a valid nursing service authorization (i.e. G0493, S9123, S9124, T1002, T1003) open within FY20 (July 1, 2019 – June 30, 2020).

In addition, DBHDS found a total of 35 unique ID/D individuals (57 total authorizations) with new service authorizations that began in FY20.

REPORTING

Timeliness of Service – Individuals with New Authorizations within FY20

GOAL: 70%

There were a total of 35 EPSDT and Waiver recipients combined with new service authorizations that began in FY20. Of that number, a total of 30 individuals had their first service delivered within 30 days of the date the need was identified in their ISP. The rate of those receiving service within 30 days was 85.71%, which compares to the goal of 70%.

- 35 Total Individuals Identified with first time authorizations
- 30 Total Individuals received first service within 30 days

EPSDT Recipient Breakdown

GOAL: 70%

There were a total of 8 EPSDT individuals with new service authorizations within FY20. Of that number, 7 EPSDT individuals had their first service delivered within 30 days of the date the need was identified in their ISP. The rate of those receiving service within 30 days was 87.5%, which compares to the goal of 70%.

These 8 EPSDT individuals had a total of 13 authorizations within FY20. Of that number, 10 had service delivered within 30 days of the date the need was identified in their ISP. The rate of these services starting within 30 days was 76.92%.

- 8 EPSDT Individuals Identified
- 7 EPSDT Individuals received first service within 30 days

Waiver Recipient Breakdown

GOAL: 70%

There were a total of 27 Waiver individuals with new service authorizations within FY20. Of that number, 23 Waiver individuals had their first services delivered within 30 days of the date the need was identified in their ISP. The rate of those receiving service within 30 days was 85.19%, which compares to the goal of 70%.

These 27 Waiver individuals had a total of 44 authorizations within FY20. Of that number, 33 had services delivered within 30 days of the date the need was identified in their ISP. The rate of these services starting within 30 days was 75%.

- 27 Waiver Individuals Identified
- 23 Waiver Individuals received first service within 30 days

NURSING UTILIZATION

ESPDT Recipients Overview

Of the 643 unique individuals identified within the first six months of FY20, 113 individuals were EPSDT recipients. Of the 113 recipients, 67 recipients received 80% or more of their allotted hours.

- 643 Individuals Identified
- 113 Total ESPDT Recipients
- 67 recipients received 80% or more of their allotted hours

Waiver Recipients Overview

Of the 643 unique individuals identified within the first six months review of FY20, 530 individuals were Waiver recipients. Of the 530 recipients, 358 recipients received 80% or more of their allotted hours.

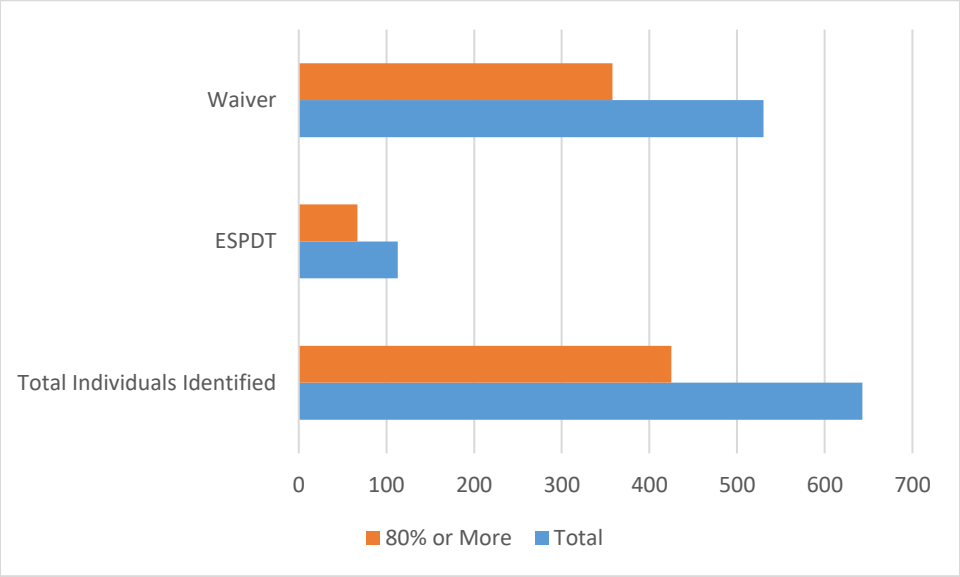
- 643 Individuals Identified
- 530 Total Waiver Recipients
- 358 recipients received 80% or more of their allotted hours

EPSDT and Waiver Recipients Total Utilization

Of the 643 unique individuals identified within the first six months of FY20, 425 unique individuals received 80% or more of their allotted hours.

66.1% unique individuals of both EPSDT and Waiver recipients received 80% or more of their allotted hours.

- 643 Individuals Identified
- 425 Individuals received 80% or more of their allotted hours
- 66.1% received 80% or more of their allotted hours



RESULTS/ANALYSIS

As part of this mid-year review of waiver nursing services, a deeper analysis was begun to determine what barriers are causing the underutilization of authorized nursing hours. The first step was to identify the waiver nursing providers (total 69) and then to call each of them and conduct a phone interview. The second step was to code the responses captured to complete a deeper dive regarding these barriers.

In Step One, Registered Nurse Care Consultants (RNCC) from the Office of Integrated Health, called 69 Waiver/EPSDT nursing providers who were authorized to provide Skilled Nursing (SN), Private Duty Nursing (PDN) and nursing under Waiver/EPSDT. All 69 providers were found in the billing records from the Department of Medicaid Assistance (DMAS) to either be behind in the goal of providing 80% of authorized nursing hours and/or may not have started the service within 30 days of the identified need. The RNCCs were able to make contact with 42 of the 69 Waiver/EPSDT providers.

When interviewed by phone, Waiver/EPSDT nursing providers reported the following top reasons that most individuals did not either begin their nursing service within 30 days of the date the need was identified in their ISP and/or utilize 80% of their authorized hours (Table 1).

- Loss of Waiver level of care
- Staffing issues
- Family choice
- Individual's death
- Individual was hospitalized
- Private insurance was billed
- Authorization process is too complicated

The same seven reasons were also the top reasons that most authorizations, in total, did not begin their nursing service within 30 days of the date the need was identified in the ISP and/or utilize 80% of their authorized hours (Table 2).

As can be seen in Table 1 below, it was reported that four individuals experienced challenges to accessing nursing services because of their location, for example, a provider who only provides nursing services in the day support program; therefore, utilization of authorized hours is dependent upon attendance within the program. Table 2, shows that location impacted four specific nursing authorizations.

Table 1.

	Unique Individuals
Individual lost waiver level of care	18
Staffing Issues	18
Family Choice	16
Individual died prior to Authorization end	10
Individual was hospitalized	10
Billing Private Insurance	8
Authorization process is too complicated	4
Location	4
Individual lost Medicaid Eligibility	3
Individual utilized one service over the other	3
Provider provided and billed services	3
Dual Agency	2
Agency Unaware of SA	1
Couldn't bill RN	1
Discharged early due to difficult family	1
Individual moved	1
Provider only provided nursing in the day program	1
Requested more hours than were needed	1
Shows services were utilized	1
Unsure	1

**Definitions for above on Pages 10-11*

As can be seen in Table 2 below, loss of Medicaid eligibility impacted four total authorizations, which resulted in roughly 5,931 total authorized hours to not be able to be provided. An individual can lose Medicaid eligibility if they move into a nursing facility or intermediate care facility. If they lose Medicaid eligibility, they are no longer able to access waiver services. In these cases, waiver funded nursing services would end immediately. Table 1 above shows that three unique individuals lost Medicaid eligibility and therefore their waiver funder nursing services ended. This impacted four specific authorizations for nursing hours.

Table 2.

Reason	Auths
Staffing Issues	34
Family Choice	28
Individual lost waiver level of care	18
Billing Private Insurance	15
Individual died prior to Authorization end	15
Individual hospitalized	11
Authorization process is too complicated	4
Individual lost Medicaid Eligibility	4
Location	4
Provider provided and billed services	4
Dual Agency	3
Individual utilized one service over the other	3
Agency Unaware of SA	2
Couldn't bill RN	1
Discharged early due to difficult family	1
Individual moved	1
Provider only did nursing in the day program	1
Requested more hours than needed	1
Shows services were utilized	1
Unsure	1

**Definitions for above on Pages 10-11*

The results of both tables identified that the authorization process as well as issues around billing and staffing presented significant challenges in delivery of authorized nursing hours in many cases. Some specifics in each area as reported by Waiver/EPSDT nursing providers are below:

Authorization Process

- *Agency unaware of the service authorization*
- *Authorization process being too complicated*
- *Issues with the plan of care*

Staffing Issues & Agency Viability

- *Staffing in the specific home*
- *Staffing in general*
- *Retention and inability to keep an RN to maintain the service*

Billing Issues

- *Billing private insurance instead of waiver*
- *Couldn't bill RN service*
- *Provider record shows they provided Authorized service and billed for services*
- *Requested more hours than were needed*
- *They were told they could only bill for one service*
- *Provider never got paid*
- *Uses LPN therefore unable to bill the RN authorized hours*

In Step Two, the narrative recorded by the RNCCs during the phone calls with Waiver/EPSDT nursing providers was coded to provide another view and a deeper dive regarding these barriers. The table below (Table 3) reflects the category the narrative falls into and the number of times providers reported the specific narrative.

Table 3.

	Unique Individuals	# of Authorizations	Number of Responses in Narrative
Authorization Issues	5	6	0
Billing Issues	13	21	5
Factors Affecting/Relating to the Individual	45	52	23
Family Related Factors/Issues	17	29	1
Location Related Issues	5	5	0
Staffing Issues	18	34	17
Unsure	1	1	1
Agency Viability	0	0	1
Issues with Plan of Care (not sure who had issues)	0	1	0
Other Issues	0	0	4

It is significant that Waiver/EPSDT nursing providers reported that the 45 unique individuals with Waiver and EPSDT nursing authorizations in FY20 experienced barriers to utilization in the category of "factors affecting/relating to the individual."

A sample of responses that were captured in the narratives is as follows:

- "The individual died prior to authorization end date"
- "The individual was hospitalized"
- "The individual lost Medicaid eligibility"
- "The individual lost waiver level of care"
- "The individual moved"
- "The individual utilized one service over the other"
- "The individual attends school and does not utilize services during those hours individual scheduled"
- "The individual declined services most days"
- "The individual was discharged prior to the end of the authorization"
- "The MD discontinued services"
- "The mother is an RN and preferred to provide most of the care. Only utilized a nurse a few days per week."
- "The individual no longer needed nursing supports"
- "The individual only accepted services on Saturdays"
- "The individual only used services on weekdays."
- "The individual chose to utilize nursing on weekdays and used less hours."
- "The individual chose other help in the home."

NEXT STEPS

The RNCCs are continuing to follow up with the identified providers to gather further results as to the barriers recognized in this midyear review. The Office of Integrated Health will continue to document these results to enhance our final FY20 review. In addition, this midyear review of FY20 nursing utilization will be repeated when the full FY20 utilization data is available (June 2021). The results of this review will be provided to the Nursing Services Work Group to be included in their development of interventions to target the expansion and access to Waiver and EPSDT nursing services.

DEFINITIONS FOR TABLE 1 & 2

Staffing Issues – Provider unable to staff or retain staff for a position with appropriate nursing personnel

Family Choice – Family only utilized services on select days; Family declined services; Individual has other help in the home

Individual lost waiver level of care – DMAS identified in the billing as moved into Nursing Facilities or ICFs; Medicaid denied services; No longer met criteria for Waiver nursing per DMAS regulations

Billing Private Insurance – Nursing provided by and paid for by Individual's MCO provider

Individual died prior to Authorization end – Individual passed away prior to the end of their authorization and authorization was not closed in a timely manner

Individual hospitalized – Individual was hospitalized during authorization period

Authorization process is too complicated – Service authorization process considered overwhelming and/or confusing for Provider agency to submit/re-submit service authorizations for nursing

Individual lost Medicaid eligibility – Individual no longer a candidate for Waiver nursing services.

Location – Staffing with appropriate nursing personnel difficult due to geographical location

Provider provided and billed services – Provider staffed service with appropriate nursing personnel but failed to bill for those services

Dual Agency – Multiple providers are providing the same individual the same services during the same authorization period

Individual utilized one service over the other – Individual with one or more active Waiver nursing service authorizations but utilized one Waiver service over another *(Ex: Individual has approved services for both Skilled Nursing – RN (S9123) and Skilled Nursing – LPN (S9124) but mainly utilizes Skilled Nursing – LPN (S9124) services)*

Agency unaware of SA – Agency was unaware of the service authorization

Couldn't bill RN – Agency provided RN support and oversight but unable to bill for those services since the Individual had an active LPN authorization for the same service

Discharged early due to difficult family – Family preference made staffing service difficult

Individual moved – Individual relocated to an area where provider agency was unable to staff service

Provider only did nursing in the day program – Waiver nursing services were only provided during Day Program and not in residential setting

Requested more hours than needed – Individual requested more hours than necessary *(Ex: Individual may receive nursing services at school but requests additional hours in case the individual is unable to attend school)*

Shows services were utilized – Agency is showing that an individual utilized their hours on their end, unsure why it is not showing in our data

Unsure – Agency was unsure as to why an individual did not utilize all of their hours

PROCEDURE CODES

Skilled Nursing	
Code	**Description**
G0493	Skilled Services of a Registered Nurse (RN) for the observation and assessment of the patient's condition; up to 15 min
S9123	Nursing care; in the home; by registered nurse (RN); per hour
S9124	Nursing care; in the home; by Licensed Practical Nurse (LPN); per hour
Private Duty	
Code	**Description**
T1002	Registered Nurse (RN) services; up to 15 min
T1003	Licensed Practical Nurse (LPN)/Licensed Vocation Nurse (LVN); up to 15 min