ALPP
THE ACADEMY OF
Lactation Policy
and Practice

September 30, 2019

Health Care Administrative Rules 4.239 – In-home Lactation Consultation Services

Vermont Agency of Human Services

This comment is being submitted on behalf of the Academy of Lactation Policy and Practice ("ALPP"), a division of the Healthy Children Project, Inc. ("Healthy Children)." ALPP operates the Certified Lactation Counselor® ("CLC"®) certification program. The CLC certification program "identifies a professional in lactation counseling who has demonstrated the necessary skills, knowledge, and attitudes to provide clinical breastfeeding counseling and management support to families who are thinking about breastfeeding or who have questions or problems during the course of breastfeeding/lactation".[1]

ALPP recognizes that the proposed Health Care Administrative Rule 4.239 does not make any changes to the Medicaid policy for in-home lactation consultation services. Attachment 3.1-A page 3d(4) of Vermont's Medicaid State Plan requires that, "Providers must be licensed and enrolled Medicaid providers and hold an International Board-Certified Lactation Consultant certificate" to be reimbursed for in-home lactation consultant services. In order to enroll in Vermont Medicaid, a licensure is required. All Medicaid-enrolled IBCLCs hold clinical licensure in Vermont (e.g. Registered Nurses; Registered Dieticians; etc.). The IBCLC certificate alone is not recognized as a clinical license. The Vermont Medicaid State plan is a statewide document rather than a federal document.

Prior to the adoption of the Affordable Care Act, certain preventative services listed by the USPSTF when provided by non-licensed practitioners were not covered by Medicaid due to regulatory requirements limiting practitioners of preventative services to either physicians or licensed professionals. Section 1905(a)(13) of the Act indicates that for services to be eligible for reimbursement, those services must be "recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law..." According to the Centers for Medicare and Medicaid Services (CMS), the former version of 42 CFR 440.130(c) indicated that, "Preventive services means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice..." **CMS amended 42 CFR 440.130(c) to accurately reflect the statutory language that physicians or other licensed practitioners recommend these services but that preventive services may be provided, at state option, by practitioners other than physicians or other licensed practitioners.** This rule change became effective on January 1, 2014 and applies to preventive services, including preventive services furnished pursuant to section 2713 of the Affordable Care Act, which includes lactation counseling services.[2]

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[1] Academy of Lactation Policy and Practice, *Certifications*, available at: https://www.alpp.org/certifications/certifications-clc

[2] Department of Health & Human Services; Centers for Medicare & Medicaid Services, *Update on Preventive Services Initiative, available at:* https://www.medicaid.gov/federal-policy-guidance/downloads/cib-11-27-2013-prevention.pdf

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There are currently 141 CLCs[3] in Vermont and 84 IBCLCs.[4] If the language of Rule 4.239 and the greater Vermont Medicaid State Plan is not amended, 63% of the state's qualified lactation care providers would be excluded from providing in-home lactation consultation services because of the lack of reimbursement by Medicaid. We believe that expectant, nursing mothers, and babies are best served when lactation care options are expanded, rather than restricted.

Our suggested amendment is consistent with the *Model Policy Payer Coverage of Breastfeeding Support and Counseling Services, Pumps and Supplies* ("*Model Policy*")[5] developed by the United States Breastfeeding Committee (USBC) and the National Breastfeeding Center (NBfC) to provide guidance regarding reimbursement under the Affordable Care Act ("ACA").[6] The aim of the *Model Policy* is "to provide clear recommendations for federal and state agencies (that oversee delivery of health care services to eligible low-income families through Medicaid or similar programs) and for private insurers (that reimburse health care services through plans offered by employers or purchased by individuals)". The *Model Policy* recommends that "approved lactation care providers" be eligible for reimbursement and defines "approved lactation care providers" to include CLCs and IBCLCs.

Since the new CMS regulations do not require licensure of lactation providers, we would like to suggest that the Vermont Medicaid State Plan *and* Rule 4.239 be amended to: set forth the criteria for Medicaid coverage and reimbursement for in-home lactation consultation services under Vermont's Medicaid Program, which would allow for qualified lactation support providers, as recognized by the Centers for Disease Control and Prevention (CDC), USBC, and NBfC as CLCs and IBCLCs,[7] to receive reimbursement for lactation consultation services.

Thank you for your time and consideration. We look forward to working with the Vermont Agency of Human Services and the Director of Medicaid Policy to ensure that all Vermont families have access to high-quality and affordable in-home lactation care and services.

Sincerely,

Ellie MacGregor, MPH, CLC

Director, Academy of Lactation Policy and Practice

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[3] Academy of Lactation Policy and Practice, *Statistical Report: Breakdown of current CLCs in the U.S. & Territories, July 1, 2019, available at:* https://www.alpp.org/pdf/Statistical-Report-CLCs.pdf

[4] International Board of Lactation Consultant Examiners, *Statistical report: Breakdown of Certified IBCLCs in the U.S. & Territories for 2019, February 8, 2019, available at:* https://10301dl.com/wp-content/uploads/2019/04/Statistical-Report-IBCLCs-in-AMS-2019.pdf

[5] National Breastfeeding Center, *Model Policy Payer Coverage of Breastfeeding Support and Counseling Services, Pumps and Supplies*, 3rd rev. ed. (2016) available at: http://www.nbfcenter.com/model-payer-policy.html

[6] USBC is "an independent nonprofit coalition of more than 50 nationally influential professional, educational, and governmental organizations that share a common mission to drive collaborative efforts for policy and practices that create a landscape of breastfeeding support across the United States." USBC, http://www.usbreastfeeding.org/. Healthy Children and the IBCLE, which certifies IBCLCs, are members of the USBC.

[7] Centers for Disease Control & Prevention, Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, *2016 Breastfeeding Report Card, available at*: www.cdc.gov/breastfeeding/data/reportcard.htm.

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October 1, 2019

Submitted Electronically to: AHS.MedicaidPolicy@vermont.gov
Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671

In re: GCR-19-058 PROPOSED Health Care Administrative Rules Updated Rule 4.232

Dear Medicaid Policy Unit:

Thank you for the opportunity to submit comments on the proposed Medically Complex Nursing Services rule.

Once again, we appreciate the work that the agency has committed to do to improve the program for individuals with medically complex nursing needs, and look forward to continuing that work.

We also appreciate the change in the title, as we believe it is more accurate.

Vermont Legal Aid submits the following comments in response to the proposed changes to the rule:

4.232.1 Definitions
(a) "Medically complex nursing services". This term needs to be defined to explain what the Department considers to be "medically complex nursing services." In the past it has been "skilled nursing care" which is a term of art.

Is "Medically complex nursing services" intended to mean something other than skilled nursing care? In the past, it has been the same as "skilled nursing care", but it has been provided at greater frequency, or for greater duration than traditional home health nursing care.

The Home Health Services rule, 4.231 does not define nursing services, nor does the Services Covered in a Nursing Facility (7603) (other than to exclude services covered under this rule).

Under Medicare regulations, the term "skilled nursing services" is defined through a long list of examples that include observation and assessment, IV injections or feeding, trach aspirations, etc. See 42 C.F.R. 409.33(a)-(b). https://www.law.cornell.edu/cfr/text/42/409.33

We recommend that the Medically Complex Nursing Services rule define what services fit this definition. If it is the same definition as skilled nursing care, as it has been in the past, we recommend that this be made clear.

4.232.3 Eligibility for Care

(a)(1) Involvement and Oversight of the Treating Physician. We appreciate that language was returned to the rule that services are provided under the direction of a physician in a treating relationship with the beneficiary. However, it is important that this language be amended to ensure *approval* of the allocation and care plan for individuals in this program, just as physicians are required to approve the allocation and care of other home health services. Excluding physicians from the determination of service needs is medically dangerous and problematic. We propose that this subsection be revised to state:

> *Services are provided under the direction, and approval of a plan of care, by a physician in a treating relationship with the beneficiary.*

In addition, we recommend subsection (a)(2) be amended to include a requirement that the allocation resulting from the eligibility tool be reviewed by the primary care provider and most important specialist for the individual, and that physician have an opportunity to express concerns about the allocation.

(a)(2) The State-Authorized clinical provider who assesses initial and ongoing eligibility should be required by the rule to meet with the applicant and caregiver, and have a phone conversation with, at a minimum, the applicant's primary care provider and most important specialist. Information from these treating providers are essential for an accurate assessment of the individual's need for medical care, and moreover, is consistent with the need to have physician involvement to ensure a medically safe allocation of hours and plan of care. This consultation is similar to the Face-to-Face visit requirement for home health services, a requirement CMS established to ensure that care is provided under the direction of a physician with current knowledge of the patient's clinical condition.

We propose that the language read:

> *The individual undergoes a needs assessment by a State-Authorized clinical provider to determine eligibly for services. This includes meeting with the applicant and caregiver, and having a phone conversation with, at a minimum, the applicant's primary care provider and most important specialist.*

(a)(4) Subsequent assessments must also be available upon request of the beneficiary or parent or guardian *when necessitated by is a life-changing event for the beneficiary*, for example, loss of an unpaid family caregiver or a change in a particular housing arrangement. This is important because lack of timely reassessment following, or in anticipation of, a life-changing event places beneficiaries at unnecessary risk of institutionalization in violation of the ADA, not because the medical needs have changed, but because other circumstances. The Assessment tools asks for information about the availability of caregivers, so it is clear the State considers this a factor.

4.232.5 Conditions for Coverage

(b) The carry forward limitation should be amended to clarify the timeframe for the ability to carry forward unused hours. Unused units should be able to be carried through the benefit year (rather than within a pay period or a month or some other more limited time period). This is especially important for families who may "save" hours for a respite week or weekend, school break, or unpaid caregiver illness, within the annual program year. Without the flexibility to expend unused service units where most needed within the annual program year, breaks for family may become non-existent, and the self-management option may become unusable.

Additional Provisions

(1) Nurse Case Management. Nurse case management has always been a service available, and desperately needed, by families. There is no explanation for the elimination of this service from the rule, and it should continue to be included. We propose adding to section 4.232.2 a section (b) that states "Nursing case management" and retaining the previous language: *"Nursing case management shall be provided by a Registered Nurse or Licensed Practical Nurse who is employed by a Medicaid contracted home health agency or visiting nurse association."*
There are families who are benefiting from case management in other programs. However, Nurse Case Management is different, it is medical case management, and families need this medical management.

(2) Self-Management Option. We proposed adding a section 4.232.7 "Self-Management Option" which is adapted from the self-management language in the Developmental Disabilities regulations at section 7.100(5), and would state:

> *Individuals receiving services, or a family member of an individual receiving services, can manage the services instead of having the services managed by an agency. Individuals may manage their services either independently or with the help of their families. Self/Family-management is a service option that is designed to provide choice and control to an individual or family. Self-Family-management is a service option that can include some, but not all, Medically Complex Nursing Services.*
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> *Individuals who select the self-management option must have their registered nurses or licensed practical nurses enroll as Medicaid providers.*

(3) Escape Valve. We propose adding a section 4.232.8 which would allow for families who have had less than 60 percent of hours filled for more than one month, or less than 80 percent of hours filled for more than two months, regardless of whether they family-manage or self-manage care, to:

a. receive direct case management and nurse recruitment from the Department of Health, and
b. receive authorization for a nurse pay increase of up to 40 percent above the RN/LPN rate, and

c. allow the family to combine High Tech, Personal Care or Developmental Services funds to hire staff (including hiring a parent as a paid caregiver through a combination of funds), and
d. to propose another alternative to the Department of Health the family believes will assist in solving the service delivery problem.

Thank you for your consideration, and for your ongoing important work.

Sincerely,

Barb Prine
Staff Attorney

Rachel Seelig
Staff Attorney