Private Duty Nursing (PDN) Rule Review

Stakeholder Engagement Meeting #3

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HCBS Division Director

June 29, 2023

Purpose

The purpose of the Private Duty Nursing Rule Review stakeholder meeting is for advocates, providers, members, case managers, and other interested stakeholders to collaborate with and advise the Department as it reviews regulations pertaining to the Private Duty Nursing benefit.

10 CCR 2505-10 Section 8.540

Agenda

- HCPF Introductions
- Complete Attendance Form
- Meeting Guidelines
- Rule Revision Presentation
- Discussion
- Next Steps

Housekeeping

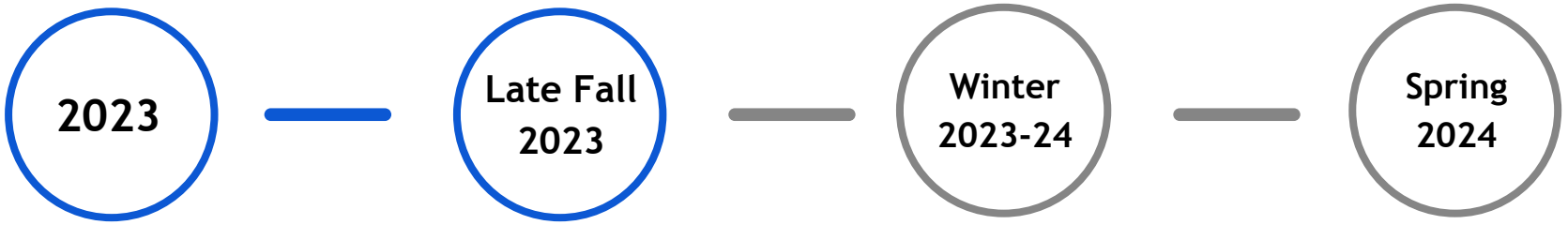
- Please mute when not speaking
- Raise hand and unmute yourself for questions, comments, or suggestions
- Use the Chat Box to enter questions, comments, or suggestions
- Please do not disclose Protected Health Information (PHI). We are unable to discuss specific cases during this meeting.

The team will answer questions and concerns as we are able but will need to take back some for deliberation. Thank you for your patience!

Send Further Questions, Comments, and Suggestions to: homehealth@state.co.us

Look for the webinar recording and other posted materials here: hcpf.colorado.gov/private-duty-nursing

Rule Revision Process



Rule Revision Meetings

Bimonthly meetings to review prospective changes and updates to the rules.

Clearance Process

The Department will formally review the proposed rules.

Medical Services Board

The Department will present the proposed rule to the Medical Services Board for adoption.

Effective Date

The adopted rules are effective.

hcpf.colorado.gov/medical-services-board

Revision Goals

- Conduct a thorough review and update of the Private Duty Nursing (PDN) regulations by Spring 2024.
- In collaboration with stakeholders, we will revise language that is outdated or unclear. We will identify areas that need edits, rephrasing, clarification, removal, or restructuring.

  For example:

  - Adding relevant definitions to PDN rules
  - Use best practices to clarify the process

Overview of PDN Rules

PDN rules can be found at the Colorado Secretary of State's Code of Colorado Regulations for the Department: 10 C.C.R. 2505-10, Section 8.540

1. Definitions
2. Benefits
3. Benefit Limitations
4. Eligibility
5. Application Procedures
6. **Provider Requirements**
7. *Prior Authorization Procedures* *-reviewed Meeting #1 and #1*
8. *Reimbursement* *- reviewed Meeting #2*

Overview of PDN Rules

Each meeting will address a section of the rule or a topic.

- ➔ In February 2023, we reviewed Section 8.540.7 - Prior Authorization Procedures, focusing on the documentation requirements.

- ➔ In April 2023 we will be focused on the remaining PAR components which included a description of the PAR submission process and 3rd party Utilization Management (UM) Contractor utilization review process. We will also reviewed Section 8.540.8 on reimbursement.

- ➔ For June 2023 we will be reviewing the Provider Requirements section of the PDN Rule. This section is focused on the provider agency responsibilities when providing Private Duty Nursing services.

General Considerations

As we review the rules, please remember:

- Language and concepts discussed are ***not*** final
- We are documenting your feedback and ideas
- Certain words will be changed throughout the document (i.e. *client* will change to *member*)
- In some cases, we will propose reorganizing sections to improve readability and clarity
- We will add definitions for common terms and spell out acronyms in the first instance of use
- We look forward to your feedback and participation!

Suggestions that remain under review/consideration…..

- PDN-specific timelines incorporated in rule
- Language: continued versus continuous
- Include process to transfer a PAR between agencies
- Change the timelines for PAR appeals to 60 days
- Documentation requirements
- General definitions in rule
- Clarify PAR expiration dates
- Review and discuss options for group ratios
- Clarify language about additional members in the home
- Separate rules for adult vs peds

8.540.6 Provider Requirements

The suggested revisions remove outdated language and reorganize provider requirements into 6 distinct sections.

A. Provider Eligibility
B. Provider Agency Requirements
C. Provider Responsibilities
D. Family/In-Home Caregiver Responsibilities
E. Environmental Requirements
F. Physician/Authorized Provider Role

Key to proposed changes:

Underlined = added language

Highlighted = renumbered or reorganized

Red lettering = removed

The following two (2) sections (8.540.6.A and 8.540.6.B) were added to directly align with the LTHH Provider Requirements. See 8.520.3.

PROPOSED NEW SECTION

8.540.6.A. Provider Eligibility

1. Services must be provided by a Medicare and Medicaid-certified Home Health Agency.

2. All Home Health Agency providers shall comply with the rules and regulations set forth by the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Regulatory Agencies, the Centers for Medicare and Medicaid Services, and the Colorado Department of Labor and Employment.

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PROPOSED NEW SECTION

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8.540.6.B Provider Agency Requirements

1. A Home Health Agency must:

   a. Be certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act;

   b. Be a Colorado Medicaid enrolled provider;

   c. Maintain liability insurance for the minimum amount set annually as outlined in 6 CCR 1011-1 Chapter 26; and

   d. Be licensed by the State of Colorado as a Class A Home Care Agency in good standing.

2. Home Health Agencies which perform procedures in the member's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee.

3. Home Health Agencies must comply with the Medicaid rules, 10 CCR 2505-10. The Home Health Agency shall make access to these rules available to all staff and all members on service.

4. A Home Health Agency cannot discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal. The Home Health Agency must provide notice of at least thirty days to the member, or the member's legal guardian.

5. In the event a Home Health Agency is ceasing operations, provider agencies must notify the Department within 30 calendar days. The notification must be submitted through the Provider Portal as a maintenance application for the disenrollment request. The provider must also email the Department the notice at the designated Home Health email inbox.

HOW THIS SECTION IS CURRENTLY WRITTEN

8.540.6.A.(moving to 8.540.6.C) - Part 1

8.540.6.A. A certified Home Health Agency may be authorized to provide PDN services if the agency meets all of the following:

1. Employs nursing staff currently licensed in Colorado with experience in providing PDN or care to Technology-Dependent persons.

2. Employs nursing personnel with documented skills appropriate for the client's care.

3. Employs staff with experience or training, in providing services to the client's particular demographic or cultural group.

4. Coordinates services with a supplemental certified Home Health Agency, if necessary, to meet the staffing needs of the client.

5. Requires the primary nurse and other personnel to spend time in the hospital prior to the initial hospital discharge or after Re-Hospitalization, to refine skills and learn individualized care requirements.

6. Provides appropriate nursing skills orientation and on going in-service education to nursing staff to meet the client’s specific nursing care needs.

7. Requires nursing staff to complete cardio pulmonary resuscitation (CPR) instruction and certification at least every two years.

8. Provides adequate supervision and training for all nursing staff.

PROPOSED CHANGES - 8.540.6.C - Part 1

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8.540.6.C. Provider Responsibilities

A certified Home Health Agency may be authorized to that provides PDN services if the agency shall meet all of the following:

1. Employs nursing staff currently licensed in Colorado that possess the education and experience in providing care to Technology Dependent high acuity, medically complex persons in the home in accordance with Home Health Agency policy, state practice acts, and professional standards of practice.

   a. Employs nursing personnel with documented skills, training and/or experience appropriate for the client's member's individualized care requirements.

   b. Provides appropriate nursing skills orientation and ongoing in-service education to nursing staff to meet the client's member's specific nursing care needs.

   c. Requires nursing staff to complete cardiopulmonary resuscitation (CPR) instruction and certification at least every two years.

   d. Provides adequate supervision and training for all nursing staff as required by the agencies listed in 8.540.6.A.2.

   e. Requires the primary nurse and other personnel to receive training in the hospital prior to the initial hospital discharge or after re-hospitalization, to refine skills and learn individualized care requirements, as needed.

HOW THIS SECTION IS CURRENTLY WRITTEN

8.540.6.A.(moving to 8.540.6.C) - Part 2

8.540.6.A.9. Designates a case coordinator who is responsible for the management of home care which includes the following:

a. Assists with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician regarding the home care plan.

b. Assesses the home prior to the initial hospital discharge and on an ongoing basis for safety compliance.

c. Submits an application for PDN to the URC if the client is not in the hospital at the time services are requested.

d. Refers the client or the client's designated representative to the appropriate agency for Medicaid eligibility determination, if needed.

e. Ensures that a completed PAR is submitted to the URC prior to the start of care and before the previous PAR expires.

f. Provides overall coordination of home services and service providers.

g. Involves the client and Family/In Home Caregiver in the plan for home care and the provision of home care.

h. Assists the client to reach maximum independence.

i. Communicates changes in the case status with the attending physician and the URC on a timely basis, including changes in medical conditions and/or psychological/social situations that may affect safety and home care needs.

PROPOSED CHANGES - 8.540.6.C. - Part 2

8.540.6.C. Provider Responsibilities

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2. Coordinates services with a supplemental certified Home Health Agency, if necessary, to meet the staffing needs of the client member.

3. Designates a case coordinator who is responsible for the management of private duty nursing services for the client member, which includes the following:

a. Assists with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician/authorized provider regarding the home care plan.

b. Assesses the home prior to the initial hospital discharge and on an ongoing basis for safety compliance.

c. Involves the member and Family/In Home Caregiver in the plan for home care and the provision of home care.

d. Assists the member to reach maximum independence.

e. Communicates changes in the case status with the attending physician/authorized provider and the URC on a timely basis, including changes in medical conditions and/or psychological/social situations that may affect safety and home care needs. A revision to the prior authorization request may be warranted.

HOW THIS SECTION IS CURRENTLY WRITTEN

8.540.6.A.(moving to 8.540.6.C) - Part 3

8.540.6.A.9 (continued)

j. Assists with communication and coordination between the service providers supplementing the primary Home Health Agency, the primary care physician, specialists and the primary Home Health Agency as needed.

k. Makes regular on-site visits to monitor the safety and quality of home care, and makes appropriate referrals to other agencies for care as necessary.

l. Ensures that complete and current care plans and nursing charts are in the client's home at all times. Charts shall include interim physician orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the times indicated on the care plans.

m. Communicates with Single Entry Point or other case managers as needed regarding service planning and coordination.

10. Makes and documents the efforts made to resolve any situation that triggers a discontinuation or refusal to provide services prior to discontinuation or refusal to provide services.

PROPOSED CHANGES - 8.540.6.C. - Part 3

8.540.6.C. Provider Responsibilities

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f. Assists with communication and coordination between the service providers supplementing the primary Home Health Agency, the primary care physician, specialists and the primary Home Health Agency as needed.

g. Makes regular on-site visits to monitor the safety and quality of home care according to Home Health Agency policies and procedures and professional standards of practice to monitor the safety and quality of home care, and makes appropriate referrals to other agencies for care as necessary.

h. Ensures that complete and current care plans, no older than 60 days, and nursing charts are in the client's member's home at all times. Charts shall include interim physician orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the times indicated on the care plans.

i. Communicates with Single Entry Point or other case managers Case Management Agency and/or Regional Accountability Entity as needed regarding service planning and coordination.

4. Makes and documents the efforts made to resolve any situation that triggers a discontinuation or refusal to provide services prior to discontinuation or refusal to provide services.

HOW THIS SECTION IS CURRENTLY WRITTEN

8.540.6.A.11. Documents that the Family/In-Home Caregiver:

a. Is able to assume some portion of the client's care.

b. Has the specific skills necessary to care for the client.

c. Has completed CPR instruction or certification and/or training specific to the client's emergency needs prior to providing PDN services.

d. Is able to maintain a home environment that allows for safe home care, including a plan for emergency situations.

e. Participates in the planning, implementation and evaluation of PDN services.

f. Communicates changes in care needs and any problems to health care providers and physicians as needed.

g. Works toward the client’s maximum independence, including finding and using alternative resources as appropriate.

h. Has notified power companies, fire departments and other pertinent agencies, of the presence of a special needs person in the household.

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PROPOSED CHANGES

8.540.6.D. Documents that the Family/In-Home Caregiver Responsibilities:

The Home Health Agency must inform the member and their family/in-home caregiver of the following responsibilities for PDN services and ensure the caregiver:

1. Is able to assume some portion of the client's member's care.
2. Has the specific skills necessary to care for the client member.
3. Has completed CPR instruction or certification and/or training specific to the client's member's emergency needs prior to providing PDN services.
4. Is able to maintain a home environment that allows for safe home care, including a plan for emergency situations.
5. Participates in the planning, implementation and evaluation of PDN services.
6. Communicates changes in care needs and any problems to health care providers and physicians as needed.
7. Works toward the client's member's maximum independence, including finding and using alternative resources as appropriate.
8. Has notified power companies, fire departments and other pertinent agencies, of the presence of a special needs person in the household.

HOW THIS SECTION IS CURRENTLY WRITTEN

8.540.6.A.12. Performs an in-home assessment and documents that the home meets the following safety requirements:

a. Adequate electrical power including a back up power system.

b. Adequate space for equipment and supplies.

c. Adequate fire safety and adequate exits for medical and other emergencies.

d. A clean environment to the extent that the client's life or health is not at risk.

e. A working telephone available 24 hours a day.

PROPOSED CHANGES

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8.540.6.E Environmental Requirements

The Home Health Agency performs an in-home assessment and documents that the home meets the following safety requirements:

1. Adequate electrical power including a backup power system.
2. Adequate space and ventilation for equipment and supplies.
3. Adequate fire safety and adequate exits for medical and other emergencies.
4. A clean environment to the extent that the client's member's life or health is not at risk.
5. A working telephone is available 24 hours a day.

HOW THIS SECTION IS CURRENTLY WRITTEN

8.540.6.B.

The Home Health Agency shall coordinate with the client's attending physician to:

1. Determine that the client is medically stable, except for acute episodes that can be managed under PDN, and that the client can be safely served under the requirements and limitations of the PDN benefit.

2. Cooperate with the URC in establishing medical eligibility.

3. Prescribe a plan of care at least every 60 days.

4. Coordinate with any other physicians who are treating the client.

5. Communicate with the Home Health Agency about changes in the client's medical condition and care, especially upon discharge from the hospital.

6. Empower the client and the Family/In-Home Caregiver by working with them and the Home Health Agency to maximize the client's independence.

PROPOSED CHANGES

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8.540.6.F. Physician/Authorized Provider Role

The Home Health Agency shall coordinate with the client's member's attending physician/authorized provider to:

1. Determine that the client member is medically stable, except for acute episodes that can be managed under PDN, and that the client member can be safely served under the requirements and limitations of the PDN benefit.

2. Cooperate with the URC in establishing medical eligibility.

3. Prescribe a plan of care at least every 60 calendar days.

4. Coordinate with any other physicians/authorized providers who are treating the client member.

5. Communicate with the Home Health Agency about changes in the client's member's medical condition and care, especially upon discharge from the hospital.

6. Empower the client member and the Family/In-Home Caregiver by working with them and the Home Health Agency to maximize the client's member's independence.

Next Steps

- Future Engagement Opportunities and Meetings
- Meeting documents and recordings available here: Private Duty Nursing Webpage
- How to submit feedback and comments
  - PDN Rule Comments Google Form
  - Email HomeHealth@state.co.us - subject “PDN Rule Comments”
  - Call 303-866-5349 and leave a message with your name, phone number, and comments

Ways to Provide Public Comment

Email

HomeHealth@state.co.us

PDN Rule Review Feedback Google Form

FAX

303-866-2786
ATTN: PDN Rule Comments

Letter

Department of Health Care Policy and Financing
ATTN: PDN Rule Comments
1570 Grant Street
Denver, CO 80203

hcpf.colorado.gov/private-duty-nursing

Questions?

Contact Information

Home Health Inbox

HomeHealth@state.co.us

Thank you!