| Private Duty Nursing (PDN) Stakeholder Listening Log | | | | | | |
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| Please email any additional comments you would like to add to homehealth@state.co.us | | | | | | |
| **Source** | **Topic** | **Stakeholder(s)** | **Section of Rules** | **Date/Meeting Minutes** | **Comment** | **HCPF Response** |
| Question- Chat | Submission of Information | Vicky | | 02-23-23, 00:10:50 | Will we still be able to backdate 10 days? | Thank you for your question. This will specifically be addressed in the April 27, 2023 meeting which will review section 8.540.7.D. Providers must submit requests for prior authorization directly to the URC within 10 business days of starting PDN services. |
| Question- Chat | Language/wording | Katie Wallat | | 02-23-23, 00:10:56 | Does this proposed language change the timeliness provision in the prior language? Receiving the PAR in time for the PDN services to begin has been a big issue. I'm concerned about removing the timeliness requirement, which I don't see in the proposed language. | Thank you for your question. As stated verbally in the meeting on February 23, 2023, timelines were not on the agenda for discussion. The Department intends to review timelines at the April 27, 2023 meeting. |
| Question- Phone | Rules/Regulations | Pam R. | 8.540.7.A. | 02-23-23, 00:11:08 | How do CO rules/requirements compare to federal requirements? | Thank you for your question regarding alignment with federal requirements. As stated in the meeting on February 23, 2023, Colorado rules must also comply with state and federal laws. |
| Comment- Phone | Language/wording | Claire Dickson | 8.540.7.A. | 02-23-23, 00:12:56 | Suggestion from stakeholder regarding language/wording on continued vs continuous. | Thank you for your suggestion regarding continued versus continuous. The current regulations do include this word in various sections, including the definition of Private Duty Nursing at Section 8.540.1. The Department will review this definition further along in the rulemaking process. |
| Comment- Phone | Language/wording | Jennifer Gilchriest | 8.540.7.A. | 02-23-23, 00:13:55 | Concern acknowledged re: continued vs continuous. | Thank you for sharing your concerns about continued and continuous nursing definitions. The current regulations do include this word in various sections, including the definition of Private Duty Nursing at Section 8.540.1. The Department will review this definition further along in the rulemaking process. |
| Question- Chat | Rules/Regulations | Scott Salmans | | 02-23-23, 00:17:19 | Where in the PDN or DD waiver regulations does it say that individuals cannot access Home Health CNA services especially when an individual medically qualified for CNA services prior to turning 18. | Thank you for your question regarding waiver regulations. As stated in the meeting on February 23, 2023, the Developmental Disabilities Waiver is governed by a different section of rules and will not be reviewed during Private Duty Nursing regulations. If there are member/stakeholder questions regarding specific cases of PDN needed on DD waiver recipients, please email the inbox at homehealth@state.co.us. |
| Question- Phone | Language/wording | Pam R. | 8.540.7.A. | 02-23-23, 00:19:09 | Stakeholder asked about the PDN definition and how and where it should be defined. | Thank you for your feedback regarding the Private Duty Nursing definition. As stated verbally in the February 23, 2023 meeting, the definitions part of the rule will be reviewed further along in the rulemaking process. The definition is currently available at Section 8.540.1. |
| Comment- Phone | Language/wording | Galia Spychalska | 8.540.7.A. | 02-23-23, 00:21:43 | Reported concerns regarding the validity of the rule wording "continuous." | Thank you for sharing your concerns about the validity of the word continuous in the regulations. The current regulations do include this word in various sections, including the definition of Private Duty Nursing at Section 8.540.1. The Department will review this definition further along in the rulemaking process. |

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| Question- Phone | Language/wording | Galia Spychalska | 8.540.7.A. | 02-23-23, 00:22:52 | Asked for explanation re: "additional members in the home do not impact the individual member needs." | Thank you for your question. This language is intended to explain that each member is reviewed based on their medical needs and individual circumstances. The Department will take the request for further clarification under advisement. |
| Comment- Phone | Language/wording | Galia Spychalska | 8.540.7.B. | 02-23-23, 00:27:53 | Stakeholder states that the language is in "violation of federal EPSDT law in every shape and form." | Thank you for your concern that the proposed language violates the federal Early Periodic Screening Diagnosis and Treatment (EPSDT) law. As stated verbally in the meeting on February 23, 2023, the proposed language stating a prior authorization can be a minimum of six months and up to one year does not conflict with or violate EPSDT law. Per CMS "A state may establish tentative limits on the amount of a treatment service a child can receive... Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually." H.R. Rep. No. 101-247 at 399, reprinted in U.S.C.C.A.N. 1906, 2125. |
| Comment- Chat | Language/wording | Maureen Welch | 8.540.7.B. | 02-23-23, 00:28.49 | They should be separated in rule. separate pediatric and adult in rule please criteria different | Thank you for your suggestion that adults and children have separate rules for the Private Duty Nursing Benefit. Given the fact this is one benefit with small differences for a members age, the Department will not be establishing separate sections for adults and children. The Department will ensure that rules where there may be differences due to age are closely reviewed and discussed with stakeholders. |
| Request- Chat | Stakeholder Request | Maureen Welch | | 02-23-23, 00:28:06 | Can we can please have the slide show shared or posted on website before these future group meetings? those on phone requesting them so they can see the slides. Thank you. | Thank you for providing feedback about meeting materials. As stated in the February 23, 2023 meeting, the Department agrees to post the agenda, presentation, and draft rules on the Private Duty Nursing website before each rule review meeting. In addition, the video recordings of meetings are available to stakeholders following each meeting. |
| Comment- Phone | Language/wording | Colby Kostur | 8.540.7.B. | 02-23-23, 00:31:52 | Feedback regarding the language around PAR approval time (up to one year) | Thank you for providing feedback regarding this language. The current process is that new PDN members can request an initial PAR for up to six months, and subsequent PARs can be requested for up to a year. The Department will clarify language regarding the length of prior authorization requests. |

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| Comment- Chat | Language/wording | Scott Salmans | 8.540.7.B. | 02-23-23, 00:30:30 | This seems to be limiting the PAR to 1 year if the individual doesn't make progress at the end of that year. | Thank you for your feedback regarding PAR expiration dates. As stated in the February 23, 2023 meeting, the Department agreed to clarify language regarding the authorization of PARs. The current process is that new PDN members can request an initial PAR for up to six months, and subsequent PARs can be requested for up to a year. The maximum length of a prior authorization request is limited to one year. The annual review helps to ensure that the services meet the current medical needs of the member. The Department will work to have language clarified surrounding this topic. |
| Question- Phone | Language/wording | Pam R. | 8.540.7.C.2. | 02-23-23, 00:36:08 | Question about additional information required when submitting a PAR | Thank you for your feedback regarding PAR expiration dates. As stated in the February 23, 2023 meeting, the Department agreed to clarify language regarding the additional information required when submitting PARs. |
| Question- Chat | Formatting | Katie Wallat | 8.540.7.C.2. | 02-23-23, 00:36:31 | Could (a) be separated into each requirement instead of having a long list with commas? | Thank you for your suggestion. This will be incorporated in the rule. |
| Question- Phone | Submission of Information | Karen Leh | 8.540.7.C. | 02-23-23, 00:37:15 | Concern acknowledged that HH agencies may not be uploading all of the relevant information required. Is it possible for families to have more transparency in this process? Can supplemental information be uploaded or added after all documentation has been provided? | Thank you for your concern about home health agencies submitting the necessary documentation for PDN requests. As stated verbally in the meeting on February 23, 2023, members have a choice of providers and if they are unsatisfied with services provided by a home health agency, they may change agencies. In addition, the Department is available for questions, concerns, or feedback via the Home Health Inbox (HomeHealth@state.co.us). |
| Comment- Chat | Submission of Information | Maureen Welch | 8.540.7.C. | 02-23-23, 00:42:13 | can they have portal access to hCPF. and ability to supplement | Thank you for your suggestion to allow parents have access to the Kepro portal and the ability to supplement information. The Kepro portal is not available to members or their representatives. However, if a member or family member wishes to provide supplemental information to substantiate service needs, this should be shared with the Home Health agency, which can then be provided to Kepro via the PAR submission process. |
| Comment- Chat | Submission of Information | Scott Salmans | 8.540.7.C.2. | 02-23-23, 00:42:22 | No one knows these patients better than the parents, and switching agencies is not that simple. Many kiddos wait months in order to get services because there just aren't enough nurses. There needs to be some flexibility to allow "supplemental" documentation. Medical status is always changing. | Thank you for your statements. The Department agrees that workforce shortages are a significant challenge for many members and providers. Regarding supplemental documentation outlined in the draft rule, the Department intends this to be a list of items that can help substantiate or support a member's level of care needs. Reconsideration or PAR revisions can be requested if new/supplemental documentation shows a change of condition. |
| Comment- Chat | Language/wording | Katie Wallat | 8.540.7.C. | 02-23-23, 00:44:40 | If a verbal order is allowed, as Christine Merriman just stated, that should be indicated--the language in the rule here says only "physician signed plan of care" | Thank you for your feedback. The proposed rule change includes language stating orders must be "signed by the physician or allowed practitioner or has a documented verbal order" in reference to the POC/485. |

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| Comment- Phone | Submission of Information | Eduard (Irina) Gorovoy | | 02-23-23, 00:46:45 | Stakeholder stated that other medical practitioners besides MDs were able to sign HH orders. | Thank you for your comment. The proposed rule change now includes "physician or allowed practitioner." |
| Comment- Chat | Submission of Information | jdrobinson1963 | 8.540.7.C.3. | 02-23-23, 00:47:27 | I think that it is critical to accurately define the criteria by which Kepro is utilizing the information submitted with the PAR in order to determine the need for PDN services (and the amount of those services. If the criteria is just "continuous technology dependence," why not just require that limited information. If the criteria is not so limited, what is the criteria? | Thank you for your comment and question. This particular section being reviewed does not cover eligibility for PDN; that section is not being revised at this time. Your comments/suggestions will be taken into consideration when that section of the rule will be reviewed. |
| Question- Phone | Documentation | Pam R. | 8.540.7.C.3. | 02-23-23, 00:50:28 | Stakeholder shared concern regarding supportive documentation and the apparent vague language in the proposed rule. The stakeholder then stated that visit notes are not being created after every communication and that a "paper trail" is not created due of this lack of documentation | Thank you for your feedback. As stated verbally in the February 23, 2023 meeting, the goal of supporting documentation is to ensure the member is approved for services appropriate for their level of care needs. To help outline some options for documentation, the Department has drafted a list of potential options at 8.540.7.C.6. |
| Comment- Chat | Documentation | Galia Spychalska | 8.540.7.C.3. | 02-23-23, 00:50:49 | Rule instead of all documentation allow for supplementation and put needed documentation instead. Also huge issue problem with changing home health agencies I don't think HCPF realizes the current barriers to changing agencies - you have to discharge from one and admit to new one and then do an entire brand new PAR submission and admission which can affect PDN hours or risk of losing PDN totally - there should be a rule in addition to switch agencies where PAR is transferred with the child | Thank you for your feedback. The Department understands the difficulties with and administrative burden of changing providers during the span of a PAR cycle. The transferring of a PAR from one agency to another is something the Department is exploring for future state of PDN, but is not something we are able to implement during the current revision process. We appreciate your thoughtful feedback. |
| Request- Chat | Stakeholder Request | Katie Wallat | | 02-23-23, 00:51:23 | Would it be possible to send the proposed language prior to these meetings? It's difficult to read each individual slide, without being able to see the rest of the section, and provide feedback in real time. | Thank you for providing feedback about meeting materials. As stated in the February 23, 2023 meeting, the Department agrees to post the agenda, presentation, and draft rules on the Private Duty Nursing website before each rule review meeting. In addition, the video recordings of meetings are available to stakeholders following each meeting. |
| Question- Chat | Language/wording | Erica Eisenlauer Drury | | 02-23-23, 0:54:34 | Will the language outlining the discretion of the use of the LPN exist in another section? | Thank you for your feedback. As stated verbally in the February 23, 2023 meeting, the Department has moved this language to another section. The Private Duty Nursing benefit will continue to allow LPNs as well as RNs to provide services. |
| Question- Chat | Rules/Regulations | Galia Spychalska | | 02-23-23, 00:58:37 | Can we add transfer of PAR for PDN under PAR submission rule? | Thank you for this question. The Department has a process for members who wish to change providers. The PAR itself cannot be transferred between providers, but a Change of Provider form can be utilized for most members and situations. |

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| Question- Phone | Documentation | Scott (Tracy) Salmans | 8.540.7.C.6. | 02-23-23, 01:00:55 | Stakeholder has concerns that the documentation requirements are and would continue to be "over cumbersome." Further concerns that the documentation being asked for by the HH agency may not be "a realistic expectation of those of us with our feet on the ground." | Thank you for sharing concerns about the proposed documentation requirements. We appreciate your perspective on how these might impact a member, their family, the nurse, and the agency. As stated in the meeting on February 23, 2023, a certain level of documentation is necessary to meet state and federal requirements. We appreciate your perspective and welcome suggestions and examples during the rule review process that ensure the documentation requirements follow medical Standards of Care. |
| Comment- Chat | Documentation | Galia Spychalska | 8.540.7.C.6. | 02-23-23, 01:01:37 | I think putting examples in a regulation is not necessary - this is too specific the amount of documentation outlined this is ridiculous | Thank you for your feedback. The proposed regulation 8.540.7.C.6. states "Further documentation to support the continuous nature of the request may include but is not limited to, the following...". The Department intends to provide a list of required and optional supplemental documentation to help support the members' level of care needs. By providing a specific list, all stakeholders (members, family members, advocates, providers, and vendors) will have access to and use the same information. |
| Comment- Chat | Documentation | Galia Spychalska | 8.540.7.C.6. | 02-23-23, 01:02:15 | Documentation should be PAR 485 nursing interventions MD orders and supplemental documentation as needed | Thank you for this suggestion. The draft rule proposes that the Plan of Care / 485 includes "A signed nursing assessment, a current clinical summary or 60-day summary of care, physician or allowed practitioner signed plan of care, including orders for all disciplines and treatments, and goals of care/rehabilitation potential". This aligns with the federal guidelines. Supplemental documentation is optional. |
| Question- Chat | Submission of Information | Callie Blake | | 02-23-23, 01:05:21 | Is there going to be a more universal system of how the assigned person reviews this documentation? We have had approval for PDN services one submission and submission of the exact same information or more documentation the next time for the same member and received an RFI or reduction of services. It is very frustrating with this inconsistency with how people review the submitted documentation. | Thank you for your feedback about the documentation review. While required and optional supplemental documentation is proposed in the rule, the Department does not intend to outline the review process or contractor expectations in the rule, as this is outlined in the contract with the vendor. The Department works closely with the URC and the goal is to ensure consistency in the review process, basing request outcomes on the needs of the member and submitted documentation. We thank you for sharing your perspective. |
| Comment- Chat | Submission of Information | Cierra Tracy | 8.540.7.C.6. | 02-23-23, 01:07:42 | To Tracy's point of gathering documentation - When an agency is submitting supporting documentation, such as seizure logs, we are only able to provide a snapshot of the severity and number of times they needed rescue medications based on the amount of nursing services we're currently providing. It does not capture the number of seizures or need for rescue medications when other caregivers are providing care. How can we possibly prove when the need for intervention will arise? | Thank you for your feedback and examples of how nursing services are documented. Each prior authorization request should be specific to the member's level of care needs and may include supplemental documentation to help support the request. Together, documents provided should paint a picture of what the member needs and how nursing support ensures the member's safety in the home and community. |

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| Comment- Phone | Documentation | Karen Leh | 8.540.7.C.6. | 02-23-23, 01:08:14 | Stakeholder agrees about the "cumbersomeness" of the documentation and stated specific definitions for what is expected. Feedback acknowledged. | Thank you for your comment about required and supplemental documentation. We appreciate your perspective and suggestions, and will take unnecessary cumbersomeness under consideration as we continue with the rule review process. |
| Comment- Phone | Documentation | Pam R. | 8.540.7.C.6. | 02-23-23, 01:09:17 | Stakeholder provides feedback that current and proposed documentation would lead to "[spending] more time charting than I would taking care of my children." Suggests that documentation should be charting by "exception." | Thank you for your comment about charting in the role of nursing. The proposed rule reviewed in the meeting on February 23, 2023, provided a list of supplemental documentation that could be provided to the Department for a prior authorization request. All charting and documentation should be performed in accordance with medical Standards of Practice. |
| Comment- Chat | Language/wording | Galia Spychalska | 8.540.7.C.6. | 02-23-23, 01:09:24 | Current slide E should not be defined this way - RN assessment for intervention is key to my sons life and medical care this is in full violation of the state nurse practice act as well | Thank you for your comment about RN assessment and the definition proposed in this section of the rule; further clarification is likely needed and will be addressed during this stakeholder process. |
| Question- Chat | Submission of Information | Katie Wallat | | 02-23-23, 01:10:27 | Will there be a standard or curricula to indicate how these documents should be reviewed, and applied to what standard to determine if someone qualifies? Here we have examples of documentation that could be provided, but haven't yet seen an articulation of what the rubric will be (beyond the "tech dependence" language in the adult rule). | Thank you for your question about documentation review. The Department intends to provide examples of required and optional supplemental documentation to help support the members' level of care needs. By providing specific examples, all stakeholders (members, family members, advocates, providers, and vendors) will have access to and use the same information. Following any changes to the rule, there will be supplemental information developed to guide stakeholders. Each case is reviewed individually and all documentation is viewed to fully assess the member's needs. |
| Comment- Chat | Documentation | Scott Salmans | 8.540.7.C.6. | 02-23-23, 01:10:03 | Nursing care is the most important. When we are charting, we are not able to provide care. | Thank you for your comment about charting in the role of nursing. The proposed rule reviewed in the meeting on February 23, 2023, provided a list of optional supplemental documentation that could be provided to the Department for a prior authorization request. The goal of the list of optional supplemental documentation is not to take away from care provided, but to help show ways the provided care can be documented. |
| Request- Chat | Stakeholder Request | Galia Spychalska | 8.540.7.C.8. | 02-23-23, 01:17:58 | Again I would like to request to have the the Colorado state board of nursing present at all meetings moving forward so that we are not violating the CO state Nurse Practice Act doing these regulation changes by HCPF because it is apparent to me that this is happening | Thank you for your suggestion. The Department has outreached the Department of Regulatory Agencies and the Board of Nursing, requesting an attendee for future meetings. |
| Comment- Phone | Language/wording | Christine Russell | 8.540.7.C.6. | 02-23-23, 01:19:43 | Suggestion made by stakeholder to combine details of what necessitates need for continued skill nursing. | Thank you for your suggestion to combine information to support a need for continued skilled nursing. We will keep this as part of our notes as we work collaboratively with stakeholders in the rulemaking process. |

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| Request- Chat | Stakeholder Request | Katie Wallat | | 02-23-23, 01:20:09 | Will you please create a process that documents the feedback you get and what was done with that feedback, to be shared publicly? The CMRD webinars use an ongoing, public google doc that outlines specifically what was said, by whom, and how the department responded to each request. This level of transparency really builds trust and lets us know that you are in fact taking in all of the feedback and responding to it. | Thank you for your suggestion about stakeholder feedback. We have developed a listening log with specific comments, who shared the comment, and a Department response. The log will be posted publicly on the Private Nursing website. |
| Comment- Chat | Rules/Regulations | Galia Spychalska | 8.540.7.C.6. | 02-23-23, 01:22:29 | Also nurse practice guidelines and research needs to be identified for all rule changes which is not shown at all | Thank you for your comment. In the regulatory process the proposed rules will be reviewed by various parties to ensure there is no conflict with other regulations at the state and federal level. |
| Comment- Email | Documentation | Traci Anderson | 8.540.7.C.6. | 02-23-23, N/A | Stakeholder is responding to a comment made previously in the meeting regarding documentation. It is the stakeholder’s opinion that providers ask for the “exception” and “don’t have time to read through all of the details” specially regarding suctioning a member’s trach. The stakeholder provides multiple examples of detailed documentation vs “minimal” documentation. | Thank you for sharing concerns about the proposed documentation requirements. We appreciate your perspective and the examples provided. As stated in the meeting on February 23, 2023, a certain level of documentation is necessary to meet state and federal requirements. We appreciate your perspective and welcome suggestions and examples during the rule review process that ensure the documentation requirements follow medical Standards of Care. |
| Feedback Form | Documentation | Colby Kostur | | 02-23-23, N/A | Documentation Requirements- I don't think we should be so granular in policy. With PDN billing guidelines (https://hcpf.colorado.gov/pdn-manual) and the the par website (https://hcpf.colorado.gov/par) I think that it covers to allow for the department to request what they're needing. I think this is more of an educational expectation that needs to be reviewed with UM vendor. | Thank you for your comments regarding documentation requirements. The Department aims to detail requirements as well as supplemental documentation in the rule so that all stakeholders (members, family members, advocates, providers, and vendors) are accessing and using the same information. The billing manual and PAR website will be updated to align with the rules following adoption. |
| Feedback Form | Stakeholder Request | Katie Wallat | | 02-23-23, N/A | Please send us the proposed language in full prior to the meeting that is set to discuss it. It is difficult to read a short section of a rule on a slide, which often doesn't include the whole list of items within that section, and respond in real time. We need the context of the rest of the rules around the proposed language, and we need time to read, digest, and provide valuable feedback.<br><br>Secondly, please create a process that documents the feedback you get and what was done with that feedback. The CMRD webinars use a google doc pointing out specifically what was said, by whom, and how the department responded to each request. | Thank you for providing feedback about meeting materials. As stated in the February 23, 2023 meeting, the Department agrees to post the agenda, presentation, and draft rules on the Private Duty Nursing website before each rule review meeting. In addition, the video recordings of meetings are available to stakeholders following each meeting. Regarding your suggestion about stakeholder feedback, we have developed a listening log with specific comments, who shared the comment, and a Department response. The log will be posted publicly on the Private Nursing website. |

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| Feedback Form | Documentation | Jennifer Gilchriest | | 02-23-23, N/A | Hi! Just commenting on the Documentation Regulations... I think it looks good and fair. If a patient has medical necessity, it should be no problem to justify. I think the comments we heard here today reflect a larger problem of nursing shortages, caregiver burnout, lagging technology such as streamlined documentation (PDN agency), and lacking community supports. Thanks for your time guys! | Thank you for your review of the documentation requirements and supplemental information. We appreciate your perspective and participation. |
| Comment- Chat | Meeting format | Galia Spychalska | | 04-27-23, 0:02:43 | I would like the meeting to start with prior meeting minutes changes and updates and the last 30 minutes where there were lots of questions and no answers | Thank you for your comment and suggestion. After each meeting, all public comments are posted on the PDN website with the Department's response. Additionally, there will be a final meeting to go over all proposed changes made by all stakeholders before any permanent changes are enacted. |
| Question- Chat | Language/Wording | Galia Spychalska | | 04-27-23, 0:04:10 | Was Pediatric and Adult PDN Policy changes separated? | Thank you for your question regarding separating rules for adults and children in the Private Duty Nursing Benefit. Given the fact this is one benefit with small differences for a member's age, the Department will not be establishing separate sections for adults and children. The Department will ensure that rules, where there may be differences due to age, are closely reviewed and discussed with stakeholders through the engagement process. |
| Comment- Chat | Language/Wording | Galia Spychalska | 8.540.7.A. | 04-27-23, 0:08:15 | Last meeting on rule 8.540.7.A. HCPF stated that it will delete the phrase “continuous” nursing services because that implies only 24/7 nursing and that was not corrected or deleted | Thank you for sharing your concerns about continued and continuous nursing definitions. There was extensive discussion regarding this terminology during the meeting. The Department continues to receive public comments regarding this topic and is conducting research on all suggestions. The Department will hold a final meeting to go over all proposed changes by all stakeholders before any final decisions are made. |
| Question- Chat | Comment | Galia Spychalska | | 04-27-23, 0:15:18 | For the PDN Policy Rule stakeholder meetings, has HCPF and OCL also included inpatient physicians, paediatricians, experts on level of nursing care, members of board of nursing, medical nursing policy experts, who has HCPF engaged in this process | Thank you for your question. Stakeholder meetings are open to the public and the Department has extended invitations to the Board of Nursing along with numerous clinical partners. As part of the rule revision process, the Department reviews all suggested changes with legal and clinical experts in the field. |
| Comment- Chat | Language/Wording | Galia Spychalska | 8.540.7.A. | 04-27-23, 0:16:16 | Please explain your discussions and evidenced based practice to base decision not to delete continuous nursing services | Thank you for your comment about continued and continuous nursing definitions. The Department is currently gathering research and consulting with experts in the field to review suggestions from feedback. All proposed changes to the terminology will be reviewed with stakeholders before final decisions are made. |
| Comment- Chat | Rules/Regulations | Galia Spychalska | 8.540.7.D. | 04-27-23, 0:17:32 | If you are reviewing with URC and put contract in PDN rule then the actual contract has to be accessible to public | Thank you for your comment. The Department's contract with Kepro is a public record for stakeholders to review and can be requested through the Home Health Inbox. The Department is still reviewing if URC timelines should be within the regulations. |

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| Comment- Phone | Language/Wording | Katie Wallat | 8.540.7.D. | 04-27-23, 0:17:34 | *[Stakeholder comment in response to contract language.]* I had a couple concerns about putting all of that in the contract and I wanted to sort of outline them. One piece is certainly anything related to what, how we're determining what's medically necessary has to have this ascertainable standard, right from the federal law? So I appreciate that. There may be some deliverables or reports or timeliness that you're saying needs to be in the contract as opposed to in the rule. But I would definitely want to add in language here that says that this contract has to be consistent with federal and state law regarding the medical criteria. So I would definitely add that in. But I also think there are three concerns that come up when we are taking language from the rules and putting it in the contract, because this, the edit here takes out a lot of the language and I think the idea is to put it in the contract to make it easier, which I appreciate. But there's no stakeholder engagement in the creation of that contract. Like we might be able to see the RFP, but then the contract is negotiated between HCPF's lawyers and then the URC's lawyers sort of behind closed doors and so we have no way of sort of being involved in that. | Thank you for your feedback on the proposed language in the proposed Utilization Review section of rule. The Department intends to ensure that all stakeholders (members, family members, advocates, providers, and vendors) have access to and use the same information. We will take your suggestions under advisement as we continue in the rule review process. |
| Comment- Phone | Rules/Regulations | Katie Wallat | 8.540.7.D. | 04-27-23, 0:18:46 | I think the second piece is enforcement right? How do you enforce the contract? The only way to enforce a contract is, is one party suing the other party, right? And so again like, unlike a rule where we have these enforceability provisions about sort of the application of those rules, there's no enforcement mechanism if the URC doesn't do what the contract says. | Thank you for your comment on contract enforcement. As stated verbally in the meeting on 04/27/2023, the Department has a variety of methods of enforcing contracts. The rules governing benefits like Private Duty Nursing do not specifically outline contract remedies. |
| Question- Phone | Rules/Regulations | Katie Wallat | 8.540.7.D. | 04-27-23, 0:19:08 | And then the third piece is, I'm curious about how the ALJs are going to handle that. Contracts can change mid-year, change year by year, and ALJ meaning Administrative Law Judge in the Office of Administrative Courts the OAC. I'm just concerned about how the judges will know what's in that contract, which can change year to year. And again, it doesn't go through the same stakeholder engagement and long process that rules do. So I'm really concerned about sort of the impact of this last piece without it being clear, why we're taking certain things out of rule and putting it on a contract, which again is sort of more behind closed doors. | Thank you for your feedback about Administrative Law Judge (ALJ) hearings and how the Office of Administrative Courts (OAC) would know the contents of a vendor's contract. The Department intends to ensure that all stakeholders (members, family members, advocates, providers, and vendors) have access to and use the same information. We will take your suggestions under advisement as we continue in the rule review process. |
| Comment- Chat | Comment | Galia Spychalska | 8.540.7.D. | 04-27-23, 0:18:15 | If you are choosing with putting URC contract in the PDN Rule then you have to provide a copy of the specific contract and the outlines and criteria used by that URC | Thank you for your question. The Department's contract with Kepro is a public record for stakeholders to review and can be requested through the Home Health Inbox. The Department is still reviewing if URC timelines and requirements should be within the regulations. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Chat | Timeline | Galia Spychalska | 8.540.7.D.1. | 04-27-23, 0:22:11 | Paediatric PDN PARs have not had a 10 day turnaround time currently | Thank you for your comment. The 10-day turnaround time is currently in rule, section 8.540.5.G.3. The Department does not intend to change this part of the regulation; we have proposed moving it to section 8.540.7.D.1. The Department will take concerns about this timeline under consideration as we continue with rulemaking. |
| Comment- Chat | Timeline | Galia Spychalska | 8.540.7.D.1. | 04-27-23, 0:24:03 | 10 day turnaround time in PDN PARs needs to be in PDN rule not anything that is in the contract that wording is very vague and public has no access to this contracts so it can't be in the file | Thank you for your suggestion. The 10-day turnaround time requirement is currently in rule, section 8.540.5.G.3. The Department does not intend to change or remove this part of the regulation; we have proposed moving it to section 8.540.7.D.1. Any Department contract with a vendor is a public record for stakeholders to review and can be requested through the Colorado Open Records Act or by requesting it through the Home Health Inbox. The Department is still reviewing if URC timelines and requirements should be within the regulations. |
| Comment- Phone | Rules/Regulations | Katie Wallat | 8.540.7.D.2. | 04-27-23, 0:25:46 | I really appreciate your response Michelle, and I appreciate the Department's efforts to make sure that the contracts are public. It's too bad that you have to request them, but I understand that's a totally different regulation that you can't change. I think my concern with this language for number two is that it's just so broad. It doesn't say what you shared verbally that this will not include the medical criteria and is only about the timing. With it being so broad, it's hard to know how it will be applied 20 years down the road. I also really appreciate hearing what your team does in terms of enforcement of the contract. My point was only that the public and the members have no role in that. And unlike with the rulemaking where here we are in this meeting having a stakeholder process, the contract is hammered out between the parties and then there's no way for us to know. A member going to an appeal can't say, "Here's what the regulation says, and the URC isn't following it". That's my concern. I just want to make sure that this is really clear that we're only talking about these specific things. Contracts change year to year, change mid-year - how is that actually going to work? | Thank you for your detailed feedback and dialogue in the 04/27/2023 meeting. We appreciate your participation and contributions. |
| Question- Chat | Meeting format | Galia Spychalska | | 04-27-23, 0:27:35 | Is there an AG representative at this meeting to guide this legal wording? | Thank you for your comment. A representative from the AG's office was not at the meeting, nor is that typical practice for stakeholder engagement. However, we continue to receive input and guidance from our legal team regarding language not only used in regulations, but in all letters and communications distributed by the Department. |

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| Question- Chat | Stakeholder request | Pam R. | 8.540.7.D. | 04-27-23, 0:27:52 | KEPROs contract with HCPF is currently 141 pages. Can you identify sections of the contract that are applicable to each section of regulation being addressed relating to the URC contract? | Thank you for your question. The Department's contracts, including KEPRO's, cite regulations. We are focusing efforts on revising the regulations. Once a rule is officially revised, we will work on updating citations in any applicable vendor contract. Vendors are also required to follow all Department regulations. |
| Comment- Chat | Timeline | Galia Spychalska | 8.540.7.D.6. | 04-27-23, 0:31:00 | 15 days is not ok it's too short amount of time 60 days is what it has been in the past | Thank you for your comment and concern that the timeline established following a notice of denial or reduction letter is insufficient. We appreciate your participation in this meeting. While the current time limit is 15 days, the Department is still reviewing appropriate timelines and will take your suggestions under advisement. |
| Question- Chat | Stakeholder request | Pam R. | | 04-27-23, 0:31:33 | Can you please post a link to HCPFs current ORG Chart? | Thank you for your comment. The current organizational chart for HCPF can be found here: https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20Organizational%20Chart%20-%205-2023.pdf |
| Comment- Chat | Timeline | Galia Spychalska | 8.540.7.D.6. | 04-27-23, 0:31:51 | 15 days from the start of the letter this has been a huge problem in the past with batch mailings, no postmarks, families did not receive PDN PAR denials until after the dates. | Thank you for your comment and concern that the timeline established following a notice of denial or reduction letter is insufficient. We appreciate your participation in this meeting. While the current time limit is 15 days, the Department is still reviewing appropriate timelines and will take your suggestions under advisement. |
| Comment- Chat | Timeline | Donna Floyd | 8.540.7.D.6. | 04-27-23, 0:31:53 | I agree, 15 days from date on letter is not a functional timeframe | Thank you for your comment. We appreciate your participation in this meeting and your insight on notice timeframes. While the current time limit is 15 days, the Department is still reviewing appropriate timelines and will take your suggestions under advisement. |
| Comment- Phone | Language/Wording | Katie Wallat | 8.540.7.D.3. | 04-27-23, 0:31:59 | Thank you. Going back to the third, its number three, provider should only request services allowed or covered. I have some concerns about that because my understanding is that providers are not required to know what is allowed or covered under the PDN benefit. I'm also thinking a lot about EPSDT, which is Early Periodic Screening, Diagnostic, and Treatment for kids who are 21 and younger, 20 and younger. The whole point of EPSDT is the department even has a campaign where they're saying, Just Ask, right? Ask for the care that you need because there's the standard within EPSDT that it's not just to treat and diagnose, it's also to ameliorate. And so I'm concerned that putting language in here that says providers can only request what they think is allowed could actually restrict the options that may be available particularly when you do the analysis under EPSDT. | Thank you for your perspective and feedback. The intention of the proposed regulation 8.540.7.D.3. was to address instances of providers including multiple non-PDN services on a PAR. The Department has observed this happening regularly among providers, which can result in a technical denial of the PAR. The Department welcomes suggestions on how best to manage this issue in or outside of regulation. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | Rules/Regulations | Katie Wallat | 8.540.7.D.7-9. | 04-27-23, 0:32:56 | I was actually curious with the stuff that was taken out and deleted. I'm not sure now, what's happening with it. So, like one question, number seven was deleted. In number seven was notifying the department of all extraordinary PDN services approved of an EPSDT screen. I'm wondering will the department still be tracking approvals of PDN services based on EPSDT when they don't meet tech-dependent requirements? I would love to see that be a requirement within the rule. | Thank you for your comment and suggestion. The Department will take this feedback into consideration as the rulemaking process continues. Eligibility requirements will be reviewed at a future meeting. |
| Question- Phone | Rules/Regulations | Katie Wallat | 8.540.7.D.9. | 04-27-23, 0:33:25 | And then also, what's going to happen with expedited PARs? That's not in, if you're taking it out, I don't see added anywhere else. And so it's just brings up questions of why we're taking things out, because then we don't know what you know what's going to happen with those. And I will stop now. | Thank you for your suggestion. We agree that there should be a standard solution for expedited PARs. We will work to clarify this as we continue with the rulemaking process. |
| Comment- Chat | Language/Wording | Christy Blakely | 8.540.7.D. | 04-27-23, 0:32:59 | What about the ability to request continued benefit after a denial. that isn't clear | Thank you for your question. There are no changes to the ability to request a continuation of benefits. |
| Question- Chat | Language/Wording | Christy Blakely | 8.540.7.D. | 04-27-23, 0:35:33 | On this rule it uses medical necessary, are we using the EPSDT definition or the HCPF definition? | Thank you for your question. The Department's definition of medical necessity is described in 10 C.C.R. 2505-10, Section 8.540.7 and Section 8.076.1.8. Additionally, If this request is for a member 20 years of age or younger, medical necessity is evaluated under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations at 10 C.C.R. 2505-10, Section 8.280.4.E. |
| Comment- Chat | PAR | Katie Wallat | 8.540.7.D.9. | 04-27-23, 0:36:26 | So the expedited PAR is an example where the contract language will be used, instead of rule language. And as I mentioned, we have no stakeholder process in how those contracts are negotiated, or how they're enforced. | Thank you for your comment. The Department will provide specific language in the rule rather than referencing a vendor contract. |
| Question- Chat | Timeline | Galia Spychalska | 8.540.7.D.1. and 8.540.7.D.6. | 04-27-23, 0:36:31 | 10 days of turnaround time for PARs is not being done and 15 days after date to cancel PDN services? What are these families supposed to do for care for their kids? Who do they turn to? It should be 60 days like it has been that is not a viable timeline at all | Thank you for your comments on timelines. The 60-day language in rule was specific to PAR denials or reductions between November 2021 and August 2022. The current timeline is 15 days. The Department will review this and other suggestions from stakeholders about the timelines in rule. |

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| Comment- Phone | Timeline | Pam R. | 8.540.7.D.6. | 04-27-23, 0:36:33 | I wanted to comment on the change from the 15 days. On calendar days. I think that's way too short. I currently have a letter that was issued by Kepro on the 20th. It's the 27th and I haven't received a letter. I only know that because my agency forwarded the letter that was given to them in Atrezzo. However even if you, even if let's say, the decision is issued on a Friday and maybe the company doesn't pick it up until Monday afternoon. That's already three calendar days out of 15. And, then we've got as a consumer, we have to be able to then find an attorney. We have to be able to speak to the attorney. We have to be able to get all the documentations to the attorney. Like, you don't just file, an appeal overnight, right? And these are not children that you can just find a new daycare for. And so, 15 calendar days seems a little short when previously it was 60. | Thank you for your comment regarding calendar versus business days, and for your suggestion to allow denied or reduced services to continue for 60 days. The 60-day language in rule was specific to PAR denials or reductions between November 2021 and August 2022. The current timeline is 15 days. The Department will review this and other suggestions from stakeholders about the timelines in rule. |
| Comment- Phone | Reimbursement/Ratios | Pam R. | 8.540.7.D. | 04-27-23, 0:38:10 | Well, there's somewhere else when it talks about reimbursement. So, these two things kind of contradict each other. Because when you talk about reimbursement, it talks about reimbursing for services up to 60 days after that. I'm trying to find it here because I remember seeing it and it was crossed out. Now, I can't find it of course. | Thank you for your comment. We appreciate your participation in this meeting. The 60-day language in rule was specific to PAR denials or reductions between November 2021 and August 2022. The current timeline is 15 days. |
| Question- Chat | Rules/Regulations | Chris Russell | 8.540.7.D.6. | 04-27-23, 0:38:19 | Does this change at 8.540.7.D.6 eliminate the peer-to-peer review opportunity? | Thank you for your question. There is no suggested change to the process of requesting peer-to-peer reviews. |
| Comment- Phone | Timeline | Pam R. | 8.540.7.D. | 04-27-23, 0:38:51 | I feel like 30 days would be the absolute minimum. Because we're not even getting these letters for seven plus days. Like in the mail we're not, we're not getting them. So you're writing the letter, like the letter that I should have in my hand, was dated the 20th. It's now the 27th. I don't have it. So that's seven business days already that's gone and that's assuming I check my mail every single day.. And so somebody that doesn't check their mail, but once week because they can't physically get to their mailbox because it's down the street and now it took you a week to mail it and then it took you a week to pick it up in your mailbox. And now you're, you're 15 days is already gone and you haven't even made a single phone call. So that's as a consumer that's all I'm saying is that just seems a little short to try to start a legal process in. | Thank you for providing additional context about how the current timeline impacts you. We appreciate your perspective and will work to clarify timelines in rule. |
| Question- Chat | Language/Wording | Holly Fast | 8.540.7.D. | 04-27-23, 0:39:16 | I'm curious about the language that claims "may" be paid during the time between when request is submitted and a decision is rendered. Is there criteria to determine when those claims would be paid and when they would not? | Thank you for your question. The Department cannot guarantee payment. If there are submission errors or omissions on claims that may delay or prevent payment processing. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Chat | Meeting format | Galia Spychalska | | 04-27-23, 0:39:25 | Is there an AG representative present at this meeting and part of this process? | Thank you for your comment. A representative from the AG's office was not at the meeting. However, we continue to receive input and guidance from our legal team regarding language not only used in regulations, but in all letters and communications distributed by the Department. |
| Comment- Chat | Timeline | Donna Floyd | 8.540.7.D. | 04-27-23, 0:41:17 | Filing time should be 60- in addition to other issues mentioned the time to gather information from physician and other involve providers, developing legal documents etc | Thank you for your suggestion to change the rule to 60 days. The Department will review this as well as other suggestions from stakeholders about the current timeline. |
| Question- Phone | Timeline | Pam R. | 8.540.7.D. | 04-27-23, 0:41:21 | And Candace, just one more question. Does that 15 days account for the potentiality of asking for a redetermination or a peer to peer? Like is that listed somewhere else in the process? Does that stop that 15 days if you initiate another process? | Thank you for your question. The 15 days allowance would start over once the reconsideration or Peer to Peer is submitted. The case would be moved back into a pending status during the reconsideration process and benefits would continue 15 days past the notification of final PAR determination. |
| Question- Chat | PAR | Chris Russell | 8.540.7.D. | 04-27-23, 0:41:40 | Does this mean that the "step-down' PAR is no longer going to happen? | Thank you for your question. The step-down process will continue and information about this process is currently posted on the Private Duty Nursing website. |
| Question- Phone | Language/Wording | Katie Wallat | 8.540.7.E. | 04-27-23, 0:45:54 | So when I look at the draft, I don't see it incorporated above unless it's just incorporated in the contract, but I think it's important that, and I use quotes just to say again, you don't have as much access to that as we make rules. When the utilization manager delays its response, the home health agency should not be on the hook for the days of service prior to approval. We know that that's happened. It's happened many times over the past several years. So I don't really quite understand why this language is being struck and then where it is now. I think it's important that if Kepro is behind which we know happens, that the home health agency isn't on the hook because of their delays which again we know happen. And so I'm just curious like why is this being taken out? And where is it now? | Thank you for your comment and perspective on this matter. The Department will take this issue back and provide clarification regarding the proposed changes to the regulations and timelines. The 15 day allowance would start over once the reconsideration or Peer to Peer is submitted. The case would be moved back into a pending status during the reconsideration process and benefits would continue 15 days past the notification of final PAR determination. The proposed changes would reimburse agencies for care provided to members while waiting for the determination of the PAR request. The Department is still reviewing if URC timelines and requirements should be within the regulations, but your point and rationale for inclusion is well taken. |
| Comment- Chat | Meeting format | Galia Spychalska | | 04-27-23, 0:47:03 | An AG rep should be here for these meetings to answer stakeholder specific legal questions to be used as a resource if they have reviewed all of these rule changes Again continuous nursing services in the last meeting was severely objected by stakeholders and additional discussions and no sharing of those discussions HCPF has chosen to leave that wording in and this should be addressed by the AG and they should be present at all meetings this is not appropriate | Thank you for your comment. A representative from the AG's office was not at the meeting. However, we continue to receive input and guidance from our legal team regarding language not only used in regulations, but in all letters and communications distributed by the Department. |

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| Question- Phone | Rules/Regulations | Chris Russell | 8.540.7.E. | 04-27-23, 0:47:22 | Real short, Candace. On a previous slide you talked about, this is from 8.540.7.D. 1 and 2, you said providers must submit requests for their prior authorization of PDN services directly to URC within 10 business days of starting the PDN. But then this one that just was going to be that got moved past it, but the one that you're going to strike entirely just said that no dates will be paid prior to the date that the URC receives the um PAR request. So, I'm confused, they don't seem compatible to me. I'm not understanding something. Within 10 business days, but you don't get paid for those 10 business days? | Thank you for your comment and question. We will review and further clarify timelines for PAR submission. The proposed changes would reimburse agencies for care provided to members while waiting for the determination of PAR. |
| Comment- Phone | PAR | Chris Russell | 8.540.7.D. | 04-27-23, 0:48:35 | So, Candace yes, I think so. It's a lot of changes actually. Let me just state this simply and see if I've got it right. So an agency has 10 business days from the start of their PDN care to get the PAR in. And, then we'll be able to bill if everything is approved back to when they started the services, not when they get it in. So that's something brand new. That's kind of huge it seems to me. | Thank you for your comment. Home health agencies have always had 10 days to submit PARs. We hope that the discussion provided made this clearer. The proposed change is that agencies will be able to be reimbursed during the time span that they services are started and the determination of the PAR. |
| Comment- Chat | Language/Wording | Donna Floyd | 8.540.7.E. | 04-27-23, 0:48:18 | Language being struck because it is noted in another location should have a citation listing where HCPF believes that language is | Thank you for your suggestion. The Department will take this idea back and see about implementing citation listings in the revised rules to make it easier to follow where things are moving to. |
| Comment- Chat | Reimbursement/Ratios | Galia Spychalska | 8.540.7.E. | 04-27-23, 0:49:01 | Children’s hospital and hospitals will not get reimbursed for services supposed to be provided medically necessary for discharge but yet not addressed will prevent HHA from accepting patients like this this is a catastrophe | Thank you for your comment. We intend to discuss admission regulations in an upcoming meeting. |
| Question- Chat | Rules/Regulations | Galia Spychalska | 8.540.7.E. | 04-27-23, 0:49:21 | What if the PDN is denied post discharge what happens then do patients go back to inpatient | Thank you for your question. This will be addressed in an upcoming meeting. We appreciate your perspective and contributions. |
| Comment- Chat | Meeting format | Galia Spychalska | | 04-27-23, 0:50:45 | Candace … you keep moving too fast and not answering questions and specific concerns and the comments from previous meetings or this meeting. Perhaps we need to increase back to monthly 2 hour meetings because this is a lot of information and no ability for full discussion or stakeholder input it’s just you reading the slides | Thank you for your comment and concerns regarding the meeting format. All comments and questions from previous meetings as well as this meeting, will be recorded and answered on the PDN website. The presentation and recording of the meeting will be housed on this site for review. Comments and questions can also be made via the Home Health email inbox: HomeHealth@state.co.us |
| Comment- Chat | Language/Wording | Katie Wallat | 8.540.8. | 04-27-23, 0:52:06 | 8.540.8.E (2) and (3) use "client" instead of "member" | Thank you for your comment and for pointing out the necessary language change. We will note this and revise this to read "member." |

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| Comment- Phone | Timeline | Pam R. | 8.540.7.G. | 04-27-23, 0:52:13 | So, we just found that spot, so it's the previous slide that you did 8.5, blah, blah, blah 7.G.1. And then underneath that, it says, when denied or reduced services, shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client, and you struck that. | Thank you for your comment. The language you referenced states, "For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request (PAR) in accordance with the schedule in Sections 8.540.7.G.1-10. When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client... After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client." The language was struck to remove a temporary process that has concluded. The Department will work to clarify timelines in this proposed rule. |
| Comment- Chat | PAR | Donna Floyd | 8.540.7.G. | 04-27-23, 0:53:17 | Payment has historically been denied until date PAR was determined to be received complete. This better aligns with HH PAR submission and payment will be received functionality- no haggling once PAR is approved, payment to start date of requested (which can be 10 days back) | Thank you for your comments regarding submission timelines and reimbursement. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | Meeting format | Galia Spychalska | | 04-27-23, 0:53:52 | This is Galia Spychalska, I'm a RN and FNP and a family parent caretaker and I appreciate everybody's time. I do want to raise some concerns, is that we are not reviewing some of the concerns and input and feedback from the last stakeholder meeting. There is no minutes of prior changes made. When I asked about the continuous, which had a lot of stakeholder objections, you stated to me that discussions were made at HCPF and this was the decision, and there's no information provided for that. I have a really big problem with that because then that means that our attendance as stakeholders and our input is not really taken seriously. You have no evidence-based practice based on not taking continuous out, you did not share what these discussions were. Additionally, I had asked for the Board of Nursing for clinical experts, for the Attorney General to have a representative here to answer specific questions. These are very, very serious policy changes and we need to have an AG representative here to answer some of the legal implications for the wording. And lastly, I am truly appalled that HCPF decided not to separate pediatric and adult PDN and that we're not back on track to some of the things that we were working on at the last stakeholder meeting, because that wasn't even done. It seems that you're just reading the slides, but you're not necessarily taking in the input and then the last meetings minutes and things that we didn't finish doing or discussing or not even brought back to the table. So, I have some really, really huge concerns about input from the stakeholders, about discussions, about timing, about having an expert panel and really doing the work because | Thank you for your comment and concerns regarding the meeting format. As noted at the beginning of this meeting and the last meeting, nothing is final as these are all just proposed changes. The Attorney General's Office (AG) does not attend stakeholder meetings as these meetings are for feedback only. They do not provide legal advice to stakeholders. However, we continue to receive input and guidance from our legal team regarding the language used. We have reached out to the board of nursing to attend these meetings per your prior request, but unfortunately, we do not have anyone at this time. Furthermore, thank you for your comment about continued and continuous nursing definitions. Please note there has not been a final decision made as we are still gathering feedback on the language proposed. |
| Question- Phone | Language/Wording | Christy Blakely | | 04-27-23, 1:03:19 | I'm asking a clarifying question on the definition of medical necessity in this rule. Which one are we using? Are we using EPSDT or we using which one? | Thank you for your question. The Department utilizes both the EPSDT and medical necessity definition described in 10 C.C.R. 2505-10, Section 8.540.7 and Section 8.076.1.8. If a request is for a member 20 years of age or younger, medical necessity is evaluated both under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations at 10 C.C.R. 2505-10, Section 8.280.4.E and Sections 8.540.7 and 8.076.1.8. Please see https://hcpf.colorado.gov/department-program rules-and-regulations for more information. |
| Question- Chat | Meeting format | Galia Spychalska | | 04-27-23, 1:04:14 | Will there be an EPSDT expert part of these meetings as well and who would that be | Thank you for your comment. We have numerous clinical and subject matter experts within the Department who have been and will continue to be present for the rule meetings. |
| Comment- Chat | Language/Wording | Katie Wallat | 8.540.8.E. | 04-27-23, 1:05:29 | This slide--client vs. member | Thank you for your comment and for pointing out the necessary language change. We will note this and revise this to read "member." |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Chat | Acuity scale | Deborah Bowman | | 04-27-23, 1:06:26 | Will the PDN Acuity scale be updated during this review prior to Spring of 2024? Will a pediatric specific tool be considered? | Thank you for your question. As part of an American Rescue Plan Act (ARPA) project, the Department has contracted with a vendor, the University of Massachusetts School of Medicine is working to develop an acuity tool for PDN and LTHH. Because of that work being performed, we will not be reviewing the current acuity scale. |
| Comment- Chat | Rules/Regulations | Galia Spychalska | 8.540.8.E.2-3. | 04-27-23, 1:07:16 | Will there be a part of the PDN rule that addresses the federal mandate that the state has the responsibility to provide medically necessary PDN services? This is not outlined at all, huge concerns in order for CO Medicaid to receive federal funds | Thank you for your feedback. All regulations must comply with federal requirements. Any revisions made will be in compliance with all federal requirements. |
| Comment- Chat | Reimbursement/Ratios | Galia Spychalska | 8.540.8.E.5 | 04-27-23, 1:08:23 | Parameters safe nursing practice is per most hospital outlines - perhaps you should have inpatient nursing administrators to put in on pout I believe most hospital inpatient nursing ratios are 4-6:1 RN | Thank you for your comment. We appreciate your participation in this meeting and your suggestions on potential ratios. We will take your feedback into consideration as we continue with the rule revision process. |
| Comment- Phone | Reimbursement/Ratios | Deborah Bowman | 8.540.8.E.5 | 04-27-23, 1:08:32 | Yes, I've been a pediatric nurse for 20 years and I'm currently the nursing supervisor with All For Kids Home Health. I think certainly that the ratio should be similar to what we would provide in a hospital or facility with similar acuity kids. So, I agree we're probably looking at a maybe 2:1 ratio depending on the acuity of the child, but I think we can look to some of our expertise with some of the ratios that are already established for caring for patients of similar need. | Thank you for your comment. We appreciate your participation in this meeting and your suggestions on potential ratios. We will take your feedback into consideration as we progress with the rule revision process. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | Reimbursement/Ratios | Pam R. | 8.540.8.E.5 | 04-27-23, 1:09:16 | I think that this is an incredibly loaded thing because as you all know in hospitals, they have ratios that are exceeded, probably on a daily basis, based on the number of nurses that they have. If you look at a nursing home, you've got nursing homes that have a ratio of 20, 30, 40 people, it's how it's laid out. And so, I think that to put an exact number is doing the community an incredible disservice because you're not looking at, if you're going to look at this from a perspective of individual needs and all of these children are only going to get approved based on individual needs, like you can't. Currently right now, in my home, I have one nurse to six kids, I also have two teachers and a therapist and a CNA. So to put an exact number on it is going to be incredibly limiting one. And two, you're not going to get it. We don't have the nurses. So when, when you look at a hospital, if they don't have a nurse and their normal ratio is 2:1, but they don't have enough nurses for that, their ratio that day becomes 4:1 or 5:1 or whatever they have to do to take care of that patient. So, I think that with home health being so individualized to put an exacted number on it is going to be incredibly problematic for the kids that are currently in care. Because we're now, are we talking about nurse to adult or nurse to patient? Are we talking about child to adult? I mean, because right now I have probably do have a 2:1 ratio in my house. It's not nurse to child. It's not nurse to patient. It's more adults. I've got two therapists, one nurse, a CNA, and two teachers in my house right now. I don't need three more nurses in my house right now. That would be a waste of resources. | Thank you for your comment and concerns regarding the member ratio and individualized care. The Department will continue to examine what is safe and appropriate when providing care to our members. We appreciate your perspective and participation. |
| Comment- Chat | Reimbursement/Ratios | Megan Bowser | 8.540.8.E.5 | 04-27-23, 1:09:38 | Seems like there should be a differentiation in ratios depending on acuity. Just as ICU and regular hospital floors have different ratios. | Thank you for your suggestion to base provider care on a members acuity rather than a specific member to provider ratio. The Department will continue to examine what is safe and appropriate when providing care to our members. |
| Comment- Chat | Reimbursement/Ratios | Donna Floyd | 8.540.8.E.5 | 04-27-23, 1:10:17 | What, if any, rule making discussion will address the issue of a single RN providing one on one care through Agency #1 and 3 others in the same home under group rate through Agency #2 at the same day/time | Thank you for your question. The discussion of staffing ratios will be continued at subsequent rule review meetings. |
| Comment- Chat | Reimbursement/Ratios | Galia Spychalska | 8.540.8.E.5 | 04-27-23, 1:10:30 | I believe it's 4:1 at kid street but now with nursing shortages and in Pediatric home health only 30% of cases are staffed | Thank you for your comment about member to provider ratio. We are taking feedback into consideration as we continue to discuss this topic in future meetings. |
| Comment- Chat | Reimbursement/Ratios | Deborah Bowman | 8.540.8.E.5 | 04-27-23, 1:11:46 | I agree! It should be based on the acuity of the member. Not an exact ratio. | Thank you for your suggestion to base provider care on a member's acuity rather than a specific member to provider ratio. The Department will continue to examine what is safe and appropriate when providing care to our members. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Chat | Reimbursement/Ratios | Brent Hogue | 8.540.8.E.5 | 04-27-23, 1:11:53 | I work in several States and do not recall seeing more than 1:2 | Thank you for your comment about member to provider ratio. We are taking feedback into consideration as we continue to discuss this topic in future meetings. |
| Comment- Phone | Reimbursement/Ratios | Galia Spychalska | 8.540.8.E.5 | 04-27-23, 1:12:11 | This is Galia Spychalska. I'm a RN, FNP and I just want to say that in my 25 years of experience and probably about 16 of years of it inpatient mostly in the ER I really express a lot of concerns that Colorado state hasn't even done hospital inpatient ratio and legislative work and capping that at 3:1 is quite dangerous because there are multiple barriers to that. We currently have a huge nursing shortage in the pediatric home health and home health arena. And I mean, I haven't had an extra nurse for three years and post pandemic and the ARPA funding was not used for nursing shortages and pediatric home health. And so I worry that capping that would decrease our pool of nurses, decrease our quality of care, decrease our access to nurses and would therefore deny access of safe, nursing care to our kids. Some of whom there's a mixture, if you have more than one client, some are more acute than others and that's all based on most hospitals nursing ratios. In pediatric hospitals, in the state of Colorado, like at Children's Hospital some of their step-down units and regular floor patients are 4 to 6:1 because they don't have the nurses to staff it. I just really have a lot of concerns about putting an actual number on that because there's just not enough nurses to go around to begin with and this would restrict access. Thank you so much. | Thank you for your comments and concerns regarding member to provider ratios. The Department will continue to examine what is safe and appropriate when providing care to our members. The workforce shortage will be taken into consideration when discussing the proposed rule changes. |
| Comment- Chat | Reimbursement/Ratios | Megan Bowser | 8.540.8.E.5 | 04-27-23, 1:14:04 | Maybe setting a max ratio of 4 or 6:1 but adding a recommendation of best practices based on acuity. I don't think it should remain fully open ended to ensure client safety. | Thank you for your suggestion of implementing a 4:1 or a 6:1 ratio in addition to a member's acuity. The Department will continue to examine what is safe and appropriate when providing care. |
| Comment- Phone | Reimbursement/Ratios | Galia Spychalska | 8.540.8.E.5 | 04-27-23, 1:14:27 | I do want to add also is that when we do have more than three patients at home having additional alternative access to different appropriate providers, where a RN can delegate tasks can be intertwined into this rule somehow. But I think it would be an important additional benefit. If you do want to put those numbers, then you can say we can do one RN, one CNA to every five kids but again I think putting out those numbers is really, really destructive to our process which is to really help ameliorate and maintain our kids at home so that they don't have to be inpatient. That's just another thought process. | Thank you for your comments and concerns regarding member to provider ratios. The Department will continue to examine what is safe and appropriate when providing care to our members. The workforce shortage will be taken into consideration when discussing the proposed rule changes. |
| Comment- Chat | Reimbursement/Ratios | Deborah Bowman | 8.540.8.E.5 | 04-27-23, 1:15:35 | The ratio should be pediatric or adult specific. It should be based on the ideal ratio not the sometimes unsafe ratios that have become a reality. | Thank you for your comments and concerns regarding provider ratios. The Department will continue to examine what is safe and appropriate when providing care to our members. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Chat | Language/Wording | Brent Hogue | 8.540.8.E.5 | 04-27-23, 1:15:37 | We shouldn't try to compare Home Care vs Facility Settings. HH staff are often by themselves vs. the other settings that have support that can help in an emergency | Thank you for your comment. We appreciate your perspective and participation. |
| Question- Phone | Language/Wording | Anna Barisi | | 04-27-23, 1:15:51 | Hi. Hi, my name is Anna Barisi. I'm an RN. Parent-child. I just was wondering um if the criteria is going to be clarified? I see on the website it says Technology Dependent and some other bullet points, but is that something you're still working on? the criteria/assessment tool? | Thank you for your comment and participation in the meeting. We will be discussing definitions and eligibility at later meetings. We hope you will participate in the upcoming meetings to share your experiences and perspective. |
| Comment- Chat | | Christy Blakely | | 04-27-23, 1:16:34 | I can not accept any hard limits in this rule like technology dependence. | Thank you for your comment. While the topic for the 4/27/23 meeting was not regarding benefit limitations, we will be discussing these topics in future meetings. The Department looks forward to continued stakeholder participation in this rulemaking process. |
| Comment- Chat | Language/Wording | Christy Blakely | | 04-27-23, 1:17:50 | I think terms like best practices, move with history. but are very mushy related to interpretation. | Thank you for your suggestion. The Department with take this back and try to help clarify the language in the proposed rules changes. |
| Comment- Chat | Stakeholder request | Galia Spychalska | | 04-27-23, 1:17:59 | Please add transfer of HHa and transferring PARs. Currently have to be discharged from one HHa and then admit to new agency | Thank you for this comment. The Department has a process for members who wish to change providers. The PAR itself cannot be transferred between providers, but a Change of Provider form can be utilized for most members and situations. |
| Question- Chat | Reimbursement/Ratios | Sanjanique Irby | 8.540.8.E.5 | 04-27-23, 1:18:42 | If the ratio changes will reimbursement increase so home health can adequately compensate nurses who can make more in other settings? | Thank you for your question regarding nursing reimbursement as it pertains to member-to-provider ratios. The Department will continue to examine what is safe and appropriate when providing care. While provider rates are not a part of the rulemaking process, we take this under consideration as we continue discussions on member-to-provider ratios. |
| Question- Chat | Unknown | Pam R. | | 04-27-23, 1:19:27 | Who decides what is safe? I have had 2 ED visits in 5 years. | Thank you for your comment. We appreciate your perspective and participation. The Department will continue to examine what is safe and appropriate when providing care as we progress with the rulemaking process. |
| Comment- Chat | Reimbursement/Ratios | Christy Blakely | 8.540.8.E.5 | 04-27-23, 1:19:43 | reimbursement is a big issue in lack of workforce. RN's can make more with better benefits in hospital systems. They also stay current with practices and have less isolation | Thank you for your comment about reimbursement. Reimbursement rates are not part of this rule revision. We understand that staffing can be an issue; this is a high priority for the Department. We have several ARPA projects underway to maintain and sustain the Direct Care Workforce that includes home health and nursing services. More information on current projects with the goal of strengthening the direct care workforce can be found at https://hcpf.colorado.gov/arpa/project-directory. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Feedback Form | Reimbursement/Ratios | Katerina Evers | 8.540.8.E.5 | 04-27-23, N/A | my ratio for my children is 1 mom RN to 8 children plus CNAs assistance during the night. During the weekend 2 RNs to 8 children plus parents in the home. During school 1 RN per 2 children. This is my home. Over two decades we decided to provide a home for these medically fragile children based on their PDM services. Now you are backtracking and taking their services away and trying to cap children. You really need to think about the impact you are creating on families that have had these services in place for many years. The children depend on these services. The eligible criteria is still not clear. So me kids are getting approved and some completely denied based on very similar criteria. Which is it? I could see if you stated moving forward in 2024 and making a new cap and new rules for the future. I can not see you breaking up families that have been together because their services and placing all those adopted children back into foster care and hospitals because their adoptive families are unable to physically care for them because you took the services away or capped the services. Please think of the impact. Colorado foster care has raised their cap from 8 children in the home to 10 children because they had nowhere to place them. This will do great damage to the children waiting for a family in the hospitals. Thank you Katerina | Thank you for providing this feedback about member-to-provider ratios. We appreciate your perspective and experience. The Department will continue to examine what is safe and appropriate when providing care as we progress with the rulemaking process. We appreciate your ongoing participation. |
| Question- Phone | | Katie Wallat | | 06-29-23 / 16:50 | Thank I just had a couple questions about the new number four. Which is about, home health agency not discontinuing or refusing services. And the two questions I had was how does this section apply when a member has been terminated from PDN services and is it requiring the home health agency to do something in addition to what they're already required? And then the second piece was just more broadly, what does documented efforts mean and to whom do they have to show that, right? Do they have to show that? Do they have to show it to HCPF? I just wasn't clear on that. | Thank you for your questions. The intent of this section is to align with existing rules for Home Health 8.520.11 in regards to denial, termination and reduction of services. The agency processes should include documentation of a good faith effort to assist the member in securing appropriate services and also proper notice if there is a discontinuation. Documentation can take many forms and should follow accepted standards of practice and should be made available for compliance audits. |
| Question- Chat | | Karen Leh | | 06-29-23 / 17:04 | Would you repost the link that shows all the changes/suggested changes you've made so far? | A draft of the proposed revisions to the rule are posted on the PDN webpage. |
| Question- Phone | | Heather Alvarez | | 06-29-23 / 19:18 | Are you able to hear me okay? What about an instances where discharge is related to um you know, safety concerns that we have for our nurses in the home or staff in the home? | Thank you for your question. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the member or staff. Clarification on emergency discharges will be reviewed when finalizing language regarding termination of services. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Heather Alvarez | | 06-29-23 / 20:14 | Yeah, that's more. What I'm thinking of. I mean we had it since a few weeks ago, where a family member assaulted our staff just out of the blue and that's not, that would be an immediate discharge and we wouldn't send staff back to that environment. | Thank you for sharing your experience around this topic. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the member or staff. Clarification on emergency discharges will be reviewed when finalizing language regarding termination of services. |
| Comment- Chat | | Alexandra Koloskus | | 06-29-23 / 19:59 | Recommend aligning this language with 8.520.11.B from the Home Health regulation | Thank you for your suggestion. The goal is to align the PDN rules with the existing Home Health rules and will review this recommendation when finalizing language regarding the termination of services. |
| Question- Phone | | Erica Eisenlauer Drury | | 06-29-23 / 20:22 | Hi, thanks Candace. Can you hear me? Hi, um thank you so much for these and just along the same lines of the comments that Katie made with regard to the documented efforts. I would have the same question about the notice of at least 30 days to the member or the member's legal guardian. Just a little bit more clarity around that, like what the notice looks like, and I know we have a lot of you know, different notice requirements around PDN with you know PARs and things like that. And so just a little bit more clarity around the notice would be helpful, I think of what that means? What it looks like? You know, is it snail mail? Is it an email? Is it, you know, word of mouth? Like what does that notice mean? | Thank you for your question. The intent of this section is to align with existing rules for Home Health as well as align with CDPHE regulations outlined in 10 CCR 1011-1 Chapter 26 5.5. We have clarified the language to include information that the consumer or authorized representative shall be notified, verbally and in writing, of the agency's intent to discharge and the reasons for the discharge. |
| Comment- Chat | | Alexandra Koloskus | | 06-29-23 / 20:22 | 8.520.11.B. Termination of services to Clients still medically eligible for Coverage of Medicaid Home Health Services:1. When a Home Health Agency decides to terminate services to a client who needs and wants continued Home Health Services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the Home Health Agency shall give the client, or the client's designated representative/legal guardian, written advance notice of at least 30 business days. The Ordering | Thank you for your suggestion. The goal is to align the PDN rules with the existing Home Health rules and will review this recommendation when finalizing language regarding the termination of services. |
| Comment- Chat | | Alexandra Koloskus | | 06-29-23 / 21:02 | 5. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the Client, Home Health Agency, staff, or when the Client has begun to receive Home Health Services through a Medicaid HMO. | Thank you for your suggestion. The goal is to align the PDN rules with the existing Home Health rules and will review this recommendation when finalizing language regarding the termination of services. |
| Question- Chat | | Erica Eisenlauer Drury | | 06-29-23 / 24:50 | Also in 4 it states "thirty days" and in 5 it states "thirty calendar days". Is 4 meant to be business days or calendar days? Thanks for clarifying! | Thank you for pointing that out. The language will be corrected to "thirty calendar days" to ensure consistency. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Erica Eisenlauer Drury | | 06-29-23 / 27:26 | So sorry, I had one other question. I was wondering if we're using authorized provider what that meant to be, um, do we have that defined somewhere? I'm confused if the attending physician or authorized provider, um just using that interchangeably or if we define that anywhere. | The PDN rule language currently does not have a definition for authorized provider however, the proposed addition of this term is to match CMS definition of allowed practitioner. This can be found at CMS Pub. 100.2, Ch. 7, sect 30.2.1. We will also follow State conditions of practice while we work to clarify this terminology. |
| Comment- Phone | | Katie Wallat | | 06-29-23 / 28:28 | Thank you. Let's see, I had just a couple questions. One was, I think there's maybe two or three parts in this section that refer to home health agency policy. And I was just curious about what that is? How do members, the public, and advocates understand what that is? And you know, is there a rule or requirement that is shared with the members and that is public and so that I can get it? For example, if I'm representing someone in a hearing um where the home health agency is saying, "This is my policy." And so I was curious about that and then I had just a couple other questions about things that were removed and where they might be. | Thank you for this question. Home Health Agencies have the requirement to provide information regarding a variety of policies including consumer rights, complaint processing, and disclosures of business practices. This requirement is outlined in 10 CCR 1011-1 Chapter 26 licensure regulations for Home Health Agencies. The goal of the PDN rule revision is to directly align with already existing requirements that Agencies must follow. |
| Question- Phone | | Katie Wallat | | 06-29-23 / 30:17 | I do, yeah. Sorry, um I was just curious about some of the things that were removed and just making sure that the rules make clear who's responsible. So like one part that was removed was submitting the PDN application to the URC and doing it on time before the previous PAR expires. Who is ultimately responsible for that and where is that in the rules, since it was removed. And then similarly, there was a section removed about, kind of cultural competency, in terms of employing staff that have training regard to a client's demographic group. And so I just wanted to ask about where those ended up if they're not here anymore. | Thank you for your question. We have suggested to move the responsibilities for PAR submission to the section of the rule on the PAR process and URC responsibility. Language around training and employing staff that are trained and/or have experience individualized to the member is meant to be an all-encompassing statement, however we have made sure to provide clarification around these requirements. |
| Question- Chat | | Alexandra Koloskus | | 06-29-23 / 30:59 | What HCPF regulation requires agencies to make policies available to HCPF vs CDPHE upon survey? | It is the goal of the rule revision to have the PDN rule language align with the Home Health rule language. Under provider compliance in section 8.520.10 it states that "Home Health Agencies shall submit or produce all requested documentation in accordance with 10 C.C.R. 2505-10, Section 8.076". This typically is requested during compliance monitoring of Home Health services that are conducted by state and federal agencies, their contractors and possibly law enforcement agencies. This would include HCPF. |
| Question- Phone | | Jennifer Washington | | 06-29-23 / 31:49 | Hi, I'm just wondering, I don't know if it's further along in the slides as well, but kind of going back a couple slides it talks about changing the language from technology dependent to high acuity. Is high acuity actually defined somewhere as well? | The terminology of high acuity is not currently defined in this rule but we appreciate the suggestion and will work to clarify. We will also review the terminology surrounding technology dependence to ensure we meet current State statutes. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Chat | | Myria Normann | | 06-29-23 / 35:57 | Can you clarify if the working telephone can be a cell phone versus a landline | Thank you for your question. The regulation has been clarified to state that requirement is to have a means of communication in an emergency to call for assistance, which can include a cell phone - it does not have to be a landline. |
| Question- Chat | | Christine Bancroft | | 06-29-23 / 36:40 | Can you clarify if backup power supply is mandatory? | Thank you for your question. Yes, having an emergency backup plan is mandatory. This requirement is not a new revision to the current rule, as all life-sustaining equipment should have an emergency backup plan in place - if the primary source of power for life sustaining equipment is down, how will this be powered in an emergency. This could take the form of a generator, but it does not have to be. Clarification has been incorporated to further outline the need of emergency preparedness in the home. |
| Question- Chat | | Pam R | | 06-29-23 / 37:49 | back up power is defined what? generators are expensive and require storage of gas. is this realistic? | Thank you for your question. The intent of this portion of the rule is to ensure that there is an adequate emergency power source specific to the member situation for any life-sustaining equipment should there be a primary power failure. The rule does not specify the type of power supply to be used, as each member has different needs and different living environments. |
| Question- Phone | | Katie Wallat | | 06-29-23 / 37:58 | Thank you. I just had a quick question about the language for this section. Because it says that this is the physician or authorized provider role, but then the first sentence is that, it sort of seems to put the requirement on the home health agency to coordinate, if that makes sense? So, the first sentence is, a home health agency shall coordinate with the physician. And then if you go to five, it's saying the home health agency shall coordinate with the physician to communicate with the home health agency. And I guess I'm asking, do you understand what I'm saying? It's sort of circular, so it's unclear to me when I read this, whose responsibility it is? Is it that the home health agency needs to coordinate with the physician to communicate with themselves? Do you understand my question? Like it, even though this says it's the physician authorized provider role, its saying the home health agency is required to do these things with the physician. | Thank you for bringing that to our attention. We have clarified the language to demonstrate the goal is to have open and clear communication between the physician/authorized provider and the Home Health Agency. |
| Comment- Chat | | Myria Normann | | 06-29-23 / 39:30 | Agree with Pam. It is worded as though the agency is required to provide a backup power source, which is expense. Educating on charging back up batteries and having an Emergency Evacuation Plan should be an allowed alternative. | Thank you for your comment. At this time the requirement for backup power will remain, but we will ensure language is added about education, training and evacuation plans. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Chat | | Christy Blakely | | 06-29-23 / 39:54 | Pam R there is a program right now purchasing backup generators for clients. if you or you know someone who needs a generator you should apply/ | Thank you for sharing this information. The ARPA project 7.02 for Member Emergency Preparedness program makes grant funds available for members to obtain back-up power supply units. Here is the link to the application. |
| Question- Chat | | Myria Normann | | 06-29-23 / 40:15 | Christy, can you post the link to that program? | Thank you for sharing this information. The ARPA project 7.02 for Member Emergency Preparedness program makes grant funds available for members to obtain back-up power supply units. Here is the link to the application. |
| Comment- Phone | | Katie Wallat | | 06-29-23 / 40:18 | That makes sense and I appreciate that and it sounds like this section is to empower the home health agencies to be able to say, these are your requirements. And I'm just not quite sure the language does that the way it's written now. So maybe we can take a look at that. Thank you. | Thank you. You are correct about the goal of this language. We have revised the language to make that goal clear. |
| Question- Chat | | Pam R | | 06-29-23 / 41:04 | Yes, I forwarded that link. How do you store the gas if you are living in an apartment? | Thank you for your question. The intent of this portion of the rule is to ensure that there is an adequate emergency power source specific to the member situation for any life-sustaining equipment should there be a primary power failure. The rule does not specify the type of power supply to be used, as each member has different needs and different living environments. |
| Question- Chat | | Jennifer Washington | | 06-29-23 / 41:17 | Can language be added to clearly define medically stable? | Thank you for sharing your insights. We appreciate having the agency's viewpoint. We have clarified the terminology used. |
| Comment- Chat | | Heather Alvarez | | 06-29-23 / 44:45 | we evaluate if the pt is appropriate for homecare more than "stable" | Thank you for sharing your insights. We appreciate having the agency's viewpoint. We have clarified the terminology used. |
| Question- Chat | | Christy Blakely | | 06-29-23 / 46:42 | August date?? | The next stakeholder workgroup meeting will be Thursday, August 31, 2023 at 10:00am. The OCL Stakeholder Engagement Calendar is also updated with this information. |
| Question- Chat | | Christy Blakely | | 06-29-23 / 49:58 | Aug 31 do we have a time? | The next stakeholder workgroup meeting will be Thursday, August 31, 2023 at 10:00am. The OCL Stakeholder Engagement Calendar is also updated with this information. |
| Question- Chat | | Heather Akins | | 06-29-23 / 51:21 | Can that email be used for all entities or only HHC agencies | The Home Health Inbox is for all stakeholders to submit inquiries. You may submit questions or comments to homehealth@state.co.us |
| Question- Chat | | Katie Wallat | | 08-31-23 / 06:45 | Will stakeholders have a chance to review a second draft of the rules, in full, prior to their presentation to the MSB? | Hello, thank you for your question. A revised full draft will be shared with stakeholders before the meeting to be held on October 26. No rule will go to MSB before a full and final review with stakeholders. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 08:45 | To clarify, will that full rule packet be a second draft? | Hello, thank you for your question. A revised full draft will be shared with stakeholders before the meeting to be held on October 26. No rule will go to MSB before a full and final review with stakeholders. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Chat | | Katie Wallat | | 08-31-23 / 09:13 | Will that full draft include changes based on these meetings, is what I'm asking? | Hello, thank you for your question. A revised full draft will be shared with stakeholders before the meeting to be held on October 26. No rule will go to MSB prior to a full and final review with stakeholders. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 09:17 | Or just the same draft put together. | Hello, thank you for your question. A revised full draft will be shared with stakeholders before the meeting on October 26. No rule will go to MSB before a full and final review with stakeholders. |
| Question- Phone | | Katie Wallat | | 08-31-23 / 09:31 | Sorry, I'm just trying to understand the process that you're saying. Will the whole packet just be the same draft that we've discussed already? Or will it incorporate the changes from our meetings? That's what I'm trying to get. | Thank you for the clarifying question. The full and final review will incorporate suggested changes and feedback about clarification of items presented at previous draft reviews with stakeholders. |
| Question- Chat | | Katie Wallat | | 08-31-23 / 15:43 | I'm concerned here about what "good cause" means in 8.540.2.A.1, and how that good cause would be different than a change in circumstances. This seems to grant HCPF/URC unnecessary leeway in an ambiguous way. | Thank you for this question. Vague language such as this phrase will be revised throughout the draft. |
| Question- Phone | | Katie Wallat | | 08-31-23 / 16:26 | Thank you, I appreciate it. For the current slide, I did put a comment which I know will be logged, so we don't need to discuss that. I just had questions about what “good cause” meant because it's not defined, and it seems like there's trying to be a separation between a change in circumstances. So I had questions about that. But in this slide that's up here now, I think the language that says here, uh medical necessity criteria identified by HCPF and used by the URC. Medical necessity is not identified by HCPF. It has to be in rule or it's going to be an ascertainable standard, right? We can't just say, HCPF is going to decide what medical necessity criteria is. It should just be referenced in the rule of what that definition is. Go ahead. | Thank you for your comments. Medical Necessity means a Medical Assistance program good or service as defined in Program Integrity rules (10 CCR 2505-10, 8.076.1.8). For children 20 and younger, this is defined in the Early and Periodic Screening, Diagnosis, and Treatment rules (10 C.C.R. 2505-10,8.280.1.) This will be added to the definitions section of the PDN rule under the proposed revision. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Katie Wallat | | 08-31-23 / 17:53 | Okay, thank you. I appreciate that. And I also just wanted to make a sort of a general comment about this draft. I went through and I think I counted like six or seven places where it seems to be um redefining or mentioning areas that I think should be in the PAR section that we did at the very beginning. And I think there's several parts that sort of introduce this level of ambiguity that I think is going to make the rule hard to implement, right? And it's going to require the URC or whoever's doing the PAR to reference, not only the PAR section, but also here. So we reference plans of care repeatedly. We reference a written treatment plan developed in coordination with the home health agency. There's just a bunch of different, and I'm happy to send this via email, but there's just several pieces here where it seems to repeat sections of the PAR that I don't think need to be repeated and that I think introduce this level of ambiguity sort of throughout the role. So again, I'm happy to follow up with an email with that. | Thank you for taking the time to review this draft. Your points are noted and are being addressed as we review and revise the full version of the rule. |
| Question- Chat | | Heather Alvarez | | 08-31-23 / 17:53 | in 8.540.2.e will the PDN provided at school issue be further defined or clarified? | Thank you for this question. There have been no changes to how healthcare services, including PDN services, are provided in schools. The School Health Services team is currently working to review newly issued guidance from CMS on how these services will be delivered in the future. |
| Comment- Phone | | Katie Wallat | | 08-31-23 / 19:23 | Yeah, I also think right on this section in 2D, it says that the home health agency should apply for additional hours. So it sounds like we're asking the home health agency to know when to apply. But I also just wanted to mention the home health agency is not mentioned at all in the PAR section and I think it was in the previous drafts and was taken out. And so I just think that's not very clear. Thanks. | Thank you. We will review the entirety of the rule to ensure clarity and consistency of PAR requirements. |
| Comment- Phone | | Erica Eisenlauer Drury | | 08-31-23 / 20:18 | Yeah, that's okay. I had the same question actually as Katie about the medical necessity and it was referenced or if it was something different that would be outside of the rule. And so I think that clarified it and I think it would make it absolutely more clear if it was um cited within that rule where the medical necessity, you know, is otherwise listed in rule just so it doesn't feel like it's something else other than, you know, just the contents of the rule and it's like totality I guess. And I just want to say thanks for clarifying the ages, that's very helpful. | Thank you for your comments. Medical Necessity means a Medical Assistance program good or service as defined in Program Integrity rules (10 CCR 2505-10, 8.076.1.8). For children 20 and younger, this is defined in the Early and Periodic Screening, Diagnosis, and Treatment rules (10 C.C.R. 2505-10,8.280.1.) This will be added to the definitions section of the PDN rule under the proposed revision. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 20:37 | The new PAR draft posted has removed all mentions of the home health agency, they are crossed out. I did a ctrl + f and couldn't find it. | Thank you. We will review the entirety of the rule to ensure clarity and consistency of PAR requirements. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Chat | | Claire Dickson | | 08-31-23 / 20:38 | How will the new acuity tool play into the medical necessity determination | Thank you for this great question. The new acuity tool, which is actively being developed, will incorporate defined medical necessity requirements with benefit rules for the specific program in a tangible manner to determine the amount and level of appropriate care needed by each member. |
| Question- Phone | | Claire Dickson | | 08-31-23 / 20:59 | Yes, I just wanted to ask how, I know that the department has over many years said that it is going to redo the PDN acuity tool and I believe that, that work may still be in progress. But how does the acuity tool play into the medical necessity definition and all of the benefit limitations and eligibility criteria that are included in the rule? Since you do not have the new acuity tool yet, how do those things come together? | Thank you for this great question. The new acuity tool, which is actively being developed, will incorporate defined medical necessity requirements with benefit rules for the specific program in a tangible manner to determine the amount and level of appropriate care needed by each member. |
| Comment- Phone | | Pam R. | | 08-31-23 / 23:49 | So I just have some concerns around the vagueness of medical necessity and the lack of a criteria tool. I have a kiddo who was approved for 24 hour nursing within the administrative approval process and we transferred agencies and we went from 24 hours to 13 hours. Same kids, same care plan, same everything. So, that to me is just incredibly disconcerting and that there doesn't seem to be continuity in and what you're doing. We had a year PAR, we were only two months into it and all of a sudden we're in appeals for something that we shouldn't be an appeals for. So I guess I'm just incredibly concerned about the interpretation of medical necessity when we are that inconsistent. | Thank you for bringing this issue to our attention. We are sorry to hear about the difficulties and inconsistency you have experienced. Medical necessity is defined and will be added as a definition within the PDN rule. This issue around transferring a PAR to a new provider resulting in a different PAR approval amount has a couple of possible reasons that could have occurred, such as lack of documents submitted, newly identified change of condition, or error. Please email the home health inbox so that we can look into this specific situation. |
| Comment- Chat | | Heather Alvarez | | 08-31-23 / 26:24 | I believe my question was missed. Thank you | This question was answered above on line 158. |
| Question- Chat | | Claire Dickson | | 08-31-23 / 27:13 | What is an "average non medical person"? | Great question. An average non-medical person does not need a clinical license or certification, or does not have to have specialized medical training to perform a service or a task. Oftentimes the term “unskilled” has been used. However, we do not want to imply that the person has no skills and would therefore like to move away from using that term. |
| Question- Chat | | Eliza Schultz | | 08-31-23 / 29:12 | Can you say that instead (referencing "average non medical person") | Thank you for this suggestion. We will review the language and adjust. |
| Comment- Chat | | Erica Eisenlauer Drury | | 08-31-23 / 29:37 | Technical suggestion - it seems "PDN services" "continuous nursing" "skilled nursing" "complex" are used interchangeably and we would suggest making these consistent to the extent it makes sense. Thanks | Thank you for the suggestion. We will revise the language to be consistent throughout the rule. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Katie Wallat | | 08-31-23 / 30:12 | Sorry, thanks. I appreciate that this section, I think, Candace, you mentioned that the goal here is to sort of make things clearer by adding more pieces. I actually think, it actually creates a lot of ambiguity because a lot of these like in the 8.540.3.D. section, a lot of this is already included in the medical necessity definition, is already included in the skilled nursing definition, in other parts of our big HCPF rules. Um and so I'm a little bit concerned that it actually creates more ambiguity. I think like number three, that talks about observation or monitoring that does not require skilled nursing assessment, I'm not sure I know what that means and I'd love like an example of what would be observation and monitoring that doesn't require that, because I'm just not sure I understand what that means and so it's hard for me to imagine understanding how the rule will be implemented. And then going back to that C one, that Claire was mentioning about the sort of average non-medical person, um I really, I sort of object to this, the addition of this, which seems to be trying to remove what is, or limit what is considered a nursing service. I might be able to safely clean someone's g-tube because I've watched a nurse do it over and over and over again. But if it's in the Nurse Practice Act and it's defined as a nursing task, it should still be a nursing service. And so I think that section in particular is saying… | Thank you for your comments. The goal of this section is to specify that activities that do not fall under the scope of skilled nursing tasks are not covered. Tasks that require a higher level of clinical training versus those tasks that do not are the distinctions we are trying to articulate. This section will be revised to remove anything that creates further ambiguity or confusion. |
| Comment- Phone | | Katie Wallat | | 08-31-23 / 32:29 | I totally understand the motivation because we already have a definition of skilled nursing that goes to the Nurse Practice Act. | Thank you for pointing that out. The Nurse Practice Act is directed towards the individual professional license standards. The skilled nursing tasks outlined in the regulation pertain to the specific benefits of the PDN program, not just tasks that can be performed by a nurse. |
| Question- Phone | | Katie Wallat | | 08-31-23 / 32:53 | Then I definitely think this section should reference the Nurse Practice Act and what is included because the way I read this the way it's written now… again if I can safely and effectively do a g-tube why would this section not apply to me? I think the way, I totally appreciate the motivation, what I'm saying is my feedback is the way this is written makes it very… | Thank you. We will review and clarify where where necessary. |
| Comment- Chat | | Claire Dickson | | 08-31-23 / 32:07 | Thanks for the clarification but the rule does not say that now. | Thank you. We will review and clarify where where necessary. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Erica Eisenlauer Drury | | 08-31-23 / 33:59 | I put a technical suggestion in the chat which hopefully will help clarify some of it I think. In looking at this, it seems like there's different ways we talk about PDN services being either continuous, skilled, complex, or just PDN. So hopefully that would be helpful. And then I just had a question, if OCL has these types of sections and other sections of other areas of rules that like do not include if there's like a precedent for that because it wasn't something that I've seen before just in other states rules. So just one throw that out there and I don't know if the answer today and it's okay if you don't, but just wanted to put it out there. Thanks. | Thank you for the suggestion. We will work on revising the language to be consistent throughout the rule and with identified definitions where applicable. |
| Comment- Phone | | Katie Wallat | | 08-31-23 / 39:04 | All right. I'd like to do these two minutes on the first section that I think applies to both, to all members, the kids and the adults. If that's… perfect, yeah, thank you. Um, so I think the first definition of going through to say what the interventions are for to improve health status and delayed skilled nursing-level intervention would result in this deterioration. That isn't accurate when it goes to EPSDT. What is medically necessary under EPSDT is broader than this definition and I think this definition inaccurately and like unlawfully tries to restrict what would be considered eligible, you know considered necessary for EPSDT. | Thank you for this comment. We will review and incorporate EPSDT language throughout where appropriate. |
| Question- Phone | | Katie Wallat | | 08-31-23 / 39:57 | Yeah, so um, it says maintain or improve health status and delayed skilled care would result in a deterioration. And EPSDT says it's a benefit that will, or reasonably expected to prevent, diagnose, cure, correct, reduce, ameliorate the pain and suffering, physical, mental cognitive developmental effects of illness, injury and disability, right? So, that is much broader than just, these will be the negative effects. Um, and again, I'm just not sure why that's on here when we have, as we've said, a medical necessity definition for all members and a medical necessity definition for kids for EPSDT? | Thank you for this comment. We will review and incorporate EPSDT language throughout where appropriate. |
| Question- Phone | | Katie Wallat | | 08-31-23 / 40:49 | I don't right now. I'm happy to think about that and follow up. Yeah, I would strike it. I think the third, the bigger piece for me is that third definition of what continuous is, is incredibly limiting, and I think my reading, okay I had to read the EPSDT definition so I feel like I'm not going to get a chance to say the most important piece here. The way that this seems like it's defined is that it has to be without cease, because the lay definition of continuous is without cease, right? And other states, like, North Carolina, define continuous, and they say, and I'm quoting "nursing assessments requiring interventions that are performed at least two, at least every two or three hours during the…" | Thank you for your follow-up comments. Continuous is used in the State Statute to define Private Duty Nursing so we must use that same terminology in Colorado's rule language. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 08-31-23 / 42:38 | Yeah thanks. And it's from the federal, so I totally appreciate that. My point is only that it seems like the definition using, being used here is the lay definition which means, "without cease." And if that's taken to its, it its um, to the end right, that would mean that there would be no PDN services for anyone not needing it 24 hours because why would I need constant, without cease intervention for only two hours, right? I would need it for the whole time. And all I'm trying to say also, it's that other states define continuous in a much different way, like you know, once every two to three hours and that still counts as the PDN benefit. Thanks. | Thank you for this comment. We are working to define continuous within the regulations to provide clarity about the PDN benefit. |
| Question- Chat | | Erica Eisenlauer Drury | | 08-31-23 / 39:05 | These proposed changes would most certainly have some current PDN patients denied for services. For the patients that will become ineligible for PDN as a result of these rule changes, does the Department expect these clients to move to intermittent nursing? | Thank you for your question; we appreciate the feedback that is seems more restrictive. We have taken a look at this section and revised accordingly. |
| Question- Chat | | Erica Eisenlauer Drury | | 08-31-23 / 41:28 | How about using the EPSDT verbiage? | Thank you for this comment. We will review and incorporate EPSDT language throughout where appropriate. |
| Question- Phone | | Dana Held | | 08-31-23 / 44:41 | Thank you and I'm sorry I have not had a chance, I just have found out about these meetings so I have not had a chance to read through the document and all of that. But I'm a mom of a special needs kid and have been in the private duty program since she was a newborn and I have always had a question around, is it statute that says that we have different criteria for adults and children? You know, again my daughter's care did not change at 21, right? But the benefit changed at 21. And it sounds like in this document we're trying to say so, for pediatrics, there's one set of criteria for what's medical necessity and there's another one for adults and that doesn't make sense to me. But that just may be my ignorance so I apologize. | Thank you for your comments. You are correct, there is different criteria for adults and pediatrics, which is outlined in State Statute. Statute outlines technology-dependence as one of the qualifying criteria for adults. In order to better serve the pediatric population and align with EPSDT requirements, the Department proposes to remove that requirement for members 20 years old and younger. We would like to note that when a member is reviewed for PDN services, the whole person is reviewed, along with changes of condition. The review is not solely based on one criteria such as tech-dependence. The State Statute for Private Duty Nursing is located at C.R.S. 25.5-5-303. |
| Comment- Phone | | Dana Held | | 08-31-23 / 46:15 | But what we consider medical necessity, some of that criteria is going to be different between the two as well. It's not very logical when you're in the thick of taking care of kids that have issues, but yeah. | Thank you for your comment. The goal of providing the specific definitions of medical necessity is that we capture all members and can receive the service. |
| Comment- Chat | | Claire Dickson | | 08-31-23 / 45:33 | There are several terms/phrases in this section that should be defined, or if defined elsewhere in rule referred to, including continuous, intermittent, high intensity, "dependent on technology" , multistep, complex, high acuity. | Thank you for the suggestion. The Department will revise the language to be consistent throughout the rule and with identified definitions. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Chat | | Claire Dickson | | 08-31-23 / 45:45 | There is no federal requirement that Colorado limit the PDN benefit for adults | The Statute says "Private-duty nursing services shall not be provided as twenty-four-hour care" therefore the limit threshold has been set at 23 hours per day. EPSDT is taken into consideration for pediatrics and therefore the limit is related to the number of hours in a day. The State Statute for Private Duty Nursing is located at C.R.S. 25.5-5-303 |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 47:09 | 8.540.A.4. seems to indicate that the provider (licensed physician) is who determines what is medically necessary (it says "requires skill nursing services that . . . are ordered as medically necessary by a licensed physician") | Thank you for your comment. An important consideration in determining medical necessity of a healthcare service is a physician's attestation that a service is medically necessary as well as their certification that the ordered plan of care is an acceptable standard of care. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 49:38 | I don't think the legal term "medical necessity" should be used here in that case, because that refers to something defined elsewhere in the reg--and the doc doesn't determine if it's MN | Thank you for your suggestion. An important consideration is a physician's attestation that a service is medically necessary as well as their certification that the ordered plan of care is an acceptable standard of care. |
| Question- Chat | | Galia Spychalska | | 08-31-23 / 50:06 | I'm sorry continuous nursing … where is that defined? And none of our kids get better and the wording of this slide is in contrast of Colorado State Nurse Practice Act by identifying in such specifics federal law also states ameliorate I just think this is very dangerous | Continuous is used in the State Statute to define Private Duty Nursing therefore that language must be utilized within the rule when defining the service. |
| Question- Phone | | Pam R. | | 08-31-23 / 50:20 | I'm just curious when you, when you talk about tasks, nursing tasks, is there any place in this, I'm trying to read it on my phone. It's not working very well, but um, that nursing assessment is addressed within this continuous definition? | Thank you for this question. Ongoing nursing assessment is part of the Private Duty Nursing definition. |
| Question- Phone | | Pam R. | | 08-31-23 / 51:19 | Right. No, and I guess that's my question because it doesn't seem, when you've got a kid on oxygen or a kid on a ventilator or you have a kid that's being g-tube fed and maybe it's a bolus feed, but they have feeding tolerance difficulties and you're assessing you know, before, during, and after to make sure that they're not aspirating, right? That's an assessment that then goes into their next feed or, you know, they vomit and aspirate and need a neb and a CPT. Like that's not, do you know what I'm saying? I'm just curious if that's going to be adequately identified within this? Because there's a lot of nursing assessment that goes on, even with the kid that's receiving three feeds a day, right? | Thank you for these examples. You have described exactly the nursing duties and ongoing assessment that are the criteria of PDN services. |
| Comment- Phone | | Pam R. | | 08-31-23 / 54:04 | [in response to Michelle Miller's comments] No, I mean it's helpful. I just want to make sure that the word assessment or monitoring or, because that's not a task but it is a task and it is a hundred percent something that may not be delegated. | You are correct. A nurse can only delegate things within the CNA's scope of practice. Thank you for mentioning this. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Chat | | Galia Spychalska | | 08-31-23 / 51:42 | There is no nursing assessment or nurse monitoring and the state specifically outlines in The Colorado State Nurse Practice Act | Thank you for your comment. Nursing assessment and monitoring are inherent nursing tasks under the PDN benefit. The Nurse Practice Act is for the individual professional license, which this rule does not violate. |
| Comment- Chat | | Galia Spychalska | | 08-31-23 / 52:12 | Also a lot of our kids have physician orders and protocols based on RN assessment | Thank you for your feedback. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 52:41 | 540.4.A.8.a. seems to add an additional criteria for people over 21--they have to require nursing services "to sustain life". This is different than what is defined above, at 8.540.4.A.1. | Thank you for this feedback. We have reviewed and revised where necessary. |
| Comment- Chat | | Claire Dickson | | 08-31-23 / 53:13 | Yes. Agree with Katie. And HCPF has said that it is trying to clarify the rule not limit the benefit | Thank you for your feedback. |
| Question- Chat | | Katie Wallat | | 08-31-23 / 53:49 | To Claire's point above, what are "high intensity" nursing services? What is "complex skilled nursing"? These are added terms to the over 21 crowd and seem to limit the benefit, and create ambiguity because these terms are not defined. | Thank you for the suggestion. We have revised the language to be consistent throughout the rule and with identified definitions where applicable. |
| Question- Phone | | Claire Dickson | | 08-31-23 / 55:02 | Thanks. I just wanted to suggest that um there be some reference to a definition of intermittent home health services or explanation of it. Because you know, and I'm speaking particularly about Section 4.A.2. “Requires continuous skilled nursing services that exceed what can be managed with intermittent home health services.” I know individuals who have been approved for 24 hours of PDN for many, many years, and the Department has told them, you can manage with intermittent. So there needs to be some clarification. My understanding of intermittent, it's the task base and that the nurse is sent out and paid in a different way. Sent out to do a particular task and technically is not supposed to be doing something that's not on our task sheet, even if it would, if it is a, if something occurs while the nurse is there that would require skilled nursing intervention. Thanks. | Thank you for this suggestion. The intermittent home health benefit can be reviewed at 8.520 and we will review to add citations of that rule where needed for clarification in the PDN rule language. |
| Question- Chat | | Erica Eisenlauer Drury | | 08-31-23 / 56:03 | Good point, Claire. Many current PDN patients will be denied under these proposed changes. How will HCPF ensure that families don’t fall into a space - below PDN and more than home health (since that benefit is currently limited to 4.5 hr blocks) - where they aren't getting access to services for sufficient care as a result of these proposed changes? | Thank you for your question; we appreciate the feedback that is seems more restrictive. We have taken a look at this section and revised accordingly. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 56:10 | I think there are too many different phrases describing the nursing services. It's really hard to provide feedback on a draft using words that have not yet been defined. | Thank you for the suggestion. We have revised the language to be consistent throughout the rule and with identified definitions where applicable. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 08-31-23 / 56:15 | This is Galia Spychalska. Can you hear me? Hi, I'm a RN, FNP and I'm also a mom to my son. I would really caution you to really look at the wording of the specific slide, because it's very concerning to me. First, definition of continuous versus intermittent nursing, and I think that that is a slippery slope because the only definition that was ever identified was in a federal lawsuit that talked about private duty nursing. And intermittent home health services is task oriented, and that is correct, that Claire pointed that out. And that is not private duty nursing. Private duty nursing is continuous. So, we need to identify what continuous nursing services, or private duty nursing is in a tangible criteria. And uh other thing is, the nursing task thing. I would identify that as, again, task oriented and part of intermittent home health nursing. And so, if you're saying that private duty nursing is only nursing task oriented, it does exclude assessment monitoring. I can tell you that there are many (INAUDIBLE) children that have specific physician orders and protocols, like my son does. If this happens, do this. Based on this assessment, do this. Based on that, do this. And that is all based on RN assessment and so putting it as a nursing task is questionable because a lot of our children that receive private duty nursing services, receive it because those things are interventions and they're based on nursing. So I just wanted to make sure I pointed that out. Thank you. | Thank you for this suggestion. The intermittent home health benefit can be reviewed at 8.520 and we will review to add citations of that rule where needed for clarification in the PDN rule language. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 58:37 | For example, 8.540.4.A.8.a. references "high intensity, continuous nursing services", and then 8.540.4.A.8.a.i refers to "complex skilled nursing" and provides a list, but "complex skilled nursing" is not a phrase used elsewhere. | Thank you for the suggestion. We have revised the language to be consistent throughout the rule and with identified definitions where applicable. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Katie Wallat | | 08-31-23 / 1:00:47 | Thank I put a bunch of comments in the chat already, obviously, but I wanted to comment on the over 21 8.a.ii. the very last one. And just mention the language of “consecutive tasks at a level that cannot be delegated.” I'm sorry I lost my notes in front of me. Basically, my point is just that I wanted to make sure to be clear that it's where professional judgment is required to make the decision to delegate, right? And like, it's only when it can be and is delegated that it doesn't, that it's no longer skilled. Am I making any sense? What I'm trying to say, here's an example, right? Like I'm a nurse, I can delegate this test to the CNA that's present, but I don't feel comfortable delegating that task because the CNA is not prepared to do it because they had a bad day, or I don't feel comfortable because this member is incredibly aggressive and this CNA is not prepared to deal with and, requires more help because this member has a specific need. And so I just want to make sure that anytime we're talking about delegation that the language should be if it can be and is, right, as opposed to whether just can be if that makes sense. | You are correct. A nurse can only delegate things within the CNA's scope of practice. The examples provided explain why Home Health agencies may or may not choose to delegate tasks. We Have reviewed the language to ensure that this is clarified. |
| Comment- Phone | | Galia Spychalska | | 08-31-23 / 1:02:48 | Hi, sorry. Can you hear me now? Okay, again, I just feel like this slide in comparison to the other side um uses different terminology, and the terminology should be fluid within the PDN rule because now you're identifying complex skilled nursing um which is totally different than continuous nursing. And then you're also identifying all of these specific tasks um which are, I understand that you're trying to put in multi-step systems and all that, but that's all identified in the Colorado State Nurse Practice Act. And I just worry that being this specific and this wording and then adding complex skilled nursing as another definition that needs to be identified with specific criteria. You're throwing in too many different words to describe the same thing ina very, very complex way. And again, this is, this is not a Board of Nursing State Practice Act yet. You guys are identifying criteria, like it is. And so if we're going to actually put in specifics like this, then the Board of Nursing needs to be involved because we have a Colorado State Nurse Practice Act that identifies all of this. And this is unnecessary. | Thank you for the suggestion. We have revised the language to be consistent throughout the rule and with identified definitions where applicable. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 08-31-23 / 1:04:40 | Well, and I just think making it so specific is going to actually deny access to needed private duty nursing care for children under the age of 21. And I think that writing it in this specific manner is really not needed. There's no other Colorado, I mean there is no state private duty nursing rules that I've read through, and I've read through about 15 nationally that are this specific. So, I would urge you not to go this route because this is going to be a big fight and then you're going to have to compare the Colorado State Nurse Practice Act and to this, and I would encourage you to make it more broad and not as specific because that's really concerning. | Thank you for your question; we appreciate the feedback that is seems more restrictive. We have taken a look at this section and revised accordingly. |
| Comment- Chat | | Claire Dickson | | 08-31-23 / 1:03:21 | 8.6.a.ii. if taken to its logical conclusion would seem to mean that any member who has a family member who has learned how to provide skilled care (out of necessity) would not be eligible for PDN | Thank you for your comment. The intention of this section is to clarify eligibility criteria and benefit limitations to ensure that members have access to the appropriate level of services. The rule does not limit the eligibility of PDN based on a families' ability to provide services. The language has been revised to ensure this is made clear. |
| Question- Chat | | Claire Dickson | | 08-31-23 / 1:04:45 | What is going to happen to children who are not technology dependent but need PDN services turn 21 ? Under this dichotomy between adults and kids mean those people will not get PDN services. Where are they going to get the services | Thank you for your question. When reviewing for PDN services, the whole person is reviewed and along with changes of condition and not strictly on one criteria such as tech-dependence. |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 1:04:49 | I agree with Claire and want to highlight her point here. I appreciate that the goal here is not to limit the service, but the way this is written does, in fact, do that. | Thank you for this feedback. We have reviewed and clarified the rule where needed. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 08-31-23 / 1:07:21 | Hi, this is Galia's Spychalska again and I am going to reference to Colorado, state statute does not state that private duty nursing patients require to be technology dependent at all times because the state statute and (INAUDIBLE)… let me finish because it's my time I have my two minutes and I would like to say my two minutes. The Colorado state statutes actually identify specific criteria and it's listed and it also states that if it's medically necessary and that there are always exceptions to the rule. So, I've read that Colorado state statute and it's one of the things that's on the criteria. So, to sit there and say that children require private duty nursing have to be technology dependent with continuous nursing services, complex skilled nursing and doing all of these identifications that is not the truth. That is not the truth at all. That is not what the state statute says. And I would tell you that that is going to um legally come up on multiple levels because that is not the truth. My son requires CPR times and life saving interventions and he is not technology dependent and um I can tell you that his private duty nursing since the age of four has saved his life multiple times. And the only reason that this child is alive is because of his private nursing services, the assessment, the monitoring, the medications, his treatments, his physician orders, everything. And so um I would urge to reread the statute because I have. | Thank you for your comments. You are correct that the State Statutes specify certain criteria; however, we outline differences between adults and pediatrics in this revised section of the rule. The technology-dependent language is under the adult criteria and we have proposed removing it from a universal requirement due to EPSDT rules. |
| Question- Chat | | Eliza Schultz | | 08-31-23 / 1:08:14 | What is the CRS that is being referenced on technology dependent? Might be helpful to be working off the same language | Great suggestion. The State Statute for Private Duty Nursing is located at C.R.S. 25.5-5-303 |
| Comment- Chat | | Katie Wallat | | 08-31-23 / 1:08:31 | 8.540.4.A.8.b. introduces new terms to describe the nursing services: "high acuity and high intensity nursing services." Again, it's hard not to see this as further limiting what counts. | Thank you for the suggestion. We will revise the language to be consistent throughout the rule. |
| Comment- Chat | | Dana Held | | 08-31-23 / 1:09:27 | I can say the same thing about my daughter- PDN has saved her life. | Thank you for sharing your personal experiences. It is very helpful to have these type of stories shared to provide additional context. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Katie Wallat | | 08-31-23 / 1:10:01 | Thank you. So for this kids section, I just wanted to bring up a couple points. The first is just that B, that definition I get just nervous anytime we're restricting medical necessity, which again I know that's not the intention, but I feel like this should just say, "Members, age 20 years or younger that demonstrate medical necessity in accordance with EPSDT." That's how I think that it should look, because we're gonna define medical necessity and that's sort of the whole point. I also think, so then there's a new word introduced, which is "constant skilled nursing." Is that different than continuous? Again, just sort of thinking through those definitions. And as we've said a couple times, I think in the chat, there's just a lot of new words put in in various places that make it hard to know what's going to apply. And then I also just wanted to say, I think that number four is just kind of offensive. We're talking about nursing services. There's no world in which age appropriate child care responsibilities are nursing services. So this seems to come from some place like we're assuming that parents are trying to defraud and use this service when they don't need it. And I find it offensive. I think if I were a parent I would find it offensive, it's completely unnecessary because we're talking about nursing services. These are obviously not nursing services. So I absolutely think that should come out. And then I also again think that last piece number five, that the severity makes the services medically necessary to ensure member safety. No, it doesn't have to be member safety under EPSDT. That's just not a requirement. So, again, a lot of these just seem, and | Thank you for your feedback. We have reviewed your suggestions and further clarified the terms. The next section of the rule revision addresses definitions for terminology used in this rule. We will also include EPSDT references where necessary. |
| Question- Phone | | Claire Dickson | | 08-31-23 / 1:11:58 | I had technical difficulties. I just wanted to clarify that, what happens because of this dichotomy between children and adults where children can have comorbidities and get PDN and they don't have to be technology dependent, but adults do for at least part of the day. What's going to happen to those people when they turn 21? Is there a plan by the Department to make sure that those people get service? | Thank you for your question. When determining the level of care and what benefit is utilized for services, the assessment of the member is based on the member's medical needs and not strictly based on tech dependence alone. The statute is not clear in the limitation, but unfortunately when a member turns 21 EPSDT is no longer an option. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Claire Dickson | | 08-31-23 / 1:14:02 | In part. But I want to address something that Candace said. It's like that brings me back to my complete and utter confusion about what you mean by "intermittent." When, if this person needed continuous care under PDN services and now they're going to get intermittent, that's the Department's solution for them. I don't, and I just want to make sure that, you know, it doesn't seem right to me that there is this dichotomy between kids and adults. And that's just my general opinion there. Right? And then the other thing I wanted to mention here was that um, that uh, shoot now I forgot it. Sorry, I'll have to put it in the chat. | The intermittent home health benefit can be reviewed at 8.520.1.M. which defines intermittent nursing as visits that have a distinct start time and stop time and are task-oriented with the goal of meeting a client's specific needs for that visit. This differs from the definition of PDN which uses the term continuous regarding nursing tasks under this benefit. Billing codes for both intermittent LTHH and PDN can be found in the HH and PDN billing manuals respectively. |
| Request- Chat | | Galia Spychalska | | 08-31-23 / 1:13:31 | Can you please provide examples of adult intermittent nursing services? | The intermittent home health benefit can be reviewed at 8.520.1.M. which defines intermittent nursing as visits that have a distinct start time and stop time and are task-oriented with the goal of meeting a client's specific needs for that visit. This differs from the definition of PDN which uses the term continuous regarding nursing tasks under this benefit. Billing codes for both intermittent LTHH and PDN can be found in the HH and PDN billing manuals respectively. |
| Question- Chat | | Galia Spychalska | | 08-31-23 / 1:15:06 | Also again definition of intermittent nursing and continuous nursing - this is very important. And also are there even billing codes for intermittent and continuous in pediatrics? Maybe in adults but this does not apply children are coded with a heart rate of 60 and still alive versus an adult | The intermittent home health benefit can be reviewed at 8.520.1.M. which defines intermittent as visits that have a distinct start time and stop time and are task-oriented with the goal of meeting a client's specific needs for that visit. This differs from the definition of PDN which uses the term continuous regarding nursing tasks under this benefit. Billing codes for both intermittent LTHH and PDN can be found in the HH and PDN billing manuals respectively. |
| Comment- Chat | | Eliza Schultz | | 08-31-23 / 1:15:08 | Statues can be changed :) | You are correct. Thank you for the feedback. |
| Question- Chat | | Stefanie Harris | | 08-31-23 / 1:15:21 | I used to be a manager in our TX offices and they would start that process a year before they turned 21 bc our rules are the same for when they turn 21. They have to get on a new plan or waiver. | Thank you for your insight. |
| Question- Chat | | Claire Dickson | | 08-31-23 / 1:15:37 | Is the Department taking into consideration a person's ability to communicate to their providers in assessing need for PDN care | Thank you for this great question. All of the member's abilities are considered when assessing nursing needs. |
| Request- Chat | | Galia Spychalska | | 08-31-23 / 1:16:39 | Please have Colorado Board of Nursing attend the October meeting | Thank you. We will continue to invite all relevant partners to attend meetings and provide feedback. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-03-23 / 13:25 | Thank you. I just want to alert HCPF that this definition of continuous nursing is in full violation of the Board of Nursing and the Colorado State Nurse Practice Act and the Nurse Aide Practice Act 12-255-104. Again it is in full violation by definition according to the State Nurse Practice Act which states the Practice of professional nursing means the delivery of independent and collaborative nursing care to individuals of all ages, families, groups, and communities, whether sick or well, in all settings. The functions include the initiation and performance of nursing care through health promotion, supportive or restorative care, disease prevention, diagnosis and treatment of human disease, ailment, pain, injury, deformity, and physical or mental condition using specialized knowledge, judgment, and skill involving the application of biological, physical, social, and behavioral science principles required for licensure as a professional nurse pursuant to section 12-255-110. The practice of professional nursing includes the performance of such services as evaluating health status through the collection and assessment of health data, health teaching and health counseling, providing therapy and treatment that is supportive and restorative to life and well-being either directly to the patient or indirectly through consultation with, delegation to, supervision of, or teaching of others, executing delegated medical functions and delegated patient care functions, referring to medical or community agencies those patients who need further evaluation or treatment.. And finally the reviewing and monitoring therapy and treatment plans. Again this is in | Thank you for your comments. As part of the rule revision process, staff from the Board of Nursing, staff from the Attorneys General Office and the Colorado Department of Public Health and Environment will review the regulations. Any suggested changes from these entities will be reviewed and incorporated. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 10-03-23 / 16:14 | Can you hear me? Great. I just want to say I don't think there should not be a definition of continuous nursing in this regulation because PDN does not require continuous nursing. Based on the Federal Regulation as well as our state statute what PDN requires is more continuous nursing than can be provided, in our case through the home health benefit. And so if more than intermittent nursing or more than what's provided in the home health benefit is required then that means it's continuous and that means it's under the PDN. I think this definition whether this is the intent or not really severely limits what would be considered PDN because it's asking for things like a continual basis or a constant basis. That's just not what the fed require, the Federal Regulations require, it is not what our state statute requires and I think the result of having this in here would be to really limit and there would be a bunch of people who would need more than what's provided in the home health benefit who would not be captured under this definition and they are going to be stuck. This definition should be fully scrapped. Thanks. | Thank you for this feedback. The Department has reviewed and based on feedback has determined the need to remove the definition of "continuous". We appreicate your thoughtful engagement. |
| Comment- Phone | | Megan Bowser | | 10-03-23 / 17:54 | Hi. This is Megan Bowser with Family Voices Colorado. Assuming that the definition stays in and Katie and Galia's comments are not followed, my big problem with this is the word "and." In a couple places it says it's requiring ongoing assessment planning and intervention. I think it should be "or" both in that first sentence and in the last one, assessment or nursing interventions. They may not be constantly assessing if they're doing an intervention or they may need constant assessment, but not constant intervention and both should be included versus how it as it's worded now. It sounds like all three of those things have to be happening all the time which is not life in reality. | Thank you for this feedback. The Department has reviewed and based on feedback has determined the need to remove the definition of "continuous". We appreicate your thoughtful engagement. |

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| Comment- Phone | | Erica Eisenlauer Drury | | 10-03-23 / 18:55 | Hi this is Erica Drury with MGA Home Care and I just want to echo the comments of the previous speakers and also just focus on the “on a regular basis” and the word “constant.” I think that those are just dangerous to include and I think maybe a more appropriate word would be “ongoing.” It's very concerning and by this gauge you're quantifying the intervention or care on a constant basis as an ICU or hospital, like an ICU or hospital setting, and that's really an impossible benchmark we feel. Even in a highly acute setting one nurse is assessing and intervening on multiple patients meaning there will be, you know periods that patients don't receive constant assessment and intervention as the previous speaker said and while the other patient needs are met like in the hospital or the ICU setting. So just also wanted to say that a lot of participants for this meeting are having trouble accessing the meeting via Google Meet and are only able to join via phone. Thank you. | Thank you for this feedback. The Department has reviewed and based on feedback has determined the need to remove the definition of "continuous". We appreicate your thoughtful engagement. |
| Comment- Chat | | Amy | | 10-03-23 / 22:00 | Violation of the nurse practice act. Please review in your legal department and change accordingly. | Thank you for your comments. As part of the rule revision process, staff from the Board of Nursing, staff from the Attorneys General Office and the Colorado Department of Public Health and Environment will review the regulations. Any suggested changes from these entities will be reviewed and incorporated. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-03-23 / 24:14 | Hi, can you hear me or should I change speakers? Sorry I'm in the car, so. Okay great. I have a lot of concerns about the identification and determination by the State of Colorado for identifying family and live-in caretaker under this definition. First of all it is against federal guidelines for what a live-in caretaker or family care provider is. That is identified in IRS code 2014-7 and there are also other federal laws that apply to this. Specifically in reference to the wording of this. I truly question why the Department is starting to do this process under a PDN rule stating that family or caregiver, in-home caregiver, can only be identified as number one unpaid and then the wording at the end says either living in the resident's home or living out of the resident's home. I have huge concerns because this is against federal guidelines, federal statutes and current laws. HCPF has also identified what family and live-in caregivers really are and the biggest concern is that you know there there's a lot of repercussions to this including access and denial to additional services that families are able to tap in to. One of them is to be able to tap into the Colorado Legal Services due to their income as a parent or a family caretaker. The other is other services such as LEAP and everything else that is income based and currently under the HCPF memo it's specifically outlines what a family or caretaker or live-in is. I truly question if this is the first step in a process of HCPF actually attacking parent caretakers and trying to take that out of statue completely and if this is the first step to kind of towards that. Currently there's such a shortage of providers period. I | Thank you for your comments. As part of the rule revision process, staff from the Board of Nursing, staff from the Attorneys General Office and the Colorado Department of Public Health and Environment will review the regulations. Any suggested changes from these entities will be reviewed and incorporated. The Department is determining if this definition is helpful and provides additional context or causes confusion. Your feedback is being taken into consideration. |
| Comment- Chat | | Eliza Schultz | | 10-03-23 / 24:47 | The continuous/intermittent definition is very important. Now that more folks are getting online, it might be helpful to revisit | Thank you for your suggestion. |
| Comment- Phone | | Christy Blakely | | 10-03-23 / 28:07 | Thank you John. I am concerned about the unpaid individual because that is looking like we're saying families should not be paid to do, especially children's care, adult care, whatever. So I would, I would like to put in a complaint that that's not where we want to go. Families are paid to be CNAs or whatever and if this is to ebb the tide that's going to happen with Community First Choice and in-home support services and CDASS growth I understand, but folks should be paid to do what they're doing above and beyond a normal parent role. Thank you. | Thank you for your comment. Based on feedback, the Department is removing the word "unpaid" from the definition. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Megan Bowser | | 10-03-23 / 29:32 | Thanks. My question around this, is where is this definition being utilized? So you know we can define this here, but I'm more concerned about where that's being used within the regulations in terms of how concerning it is that it says “unpaid.” But I agree with what everyone has said so far that I don't think we need to define whether it's unpaid or paid because family caregivers do both and we don't want to be putting that at risk. But I would be interested in what context this is being utilized to know how concerning it is. | Thank you for your comment. Based on feedback, the Department is removing the word "unpaid" from the definition. |
| Comment- Phone | | Amy | | 10-03-23 / 30:41 | Yeah hi, thank you. I also have concerns about the unpaid portion of the statute whether it is ongoing or something that you're going to implement, because I know in other states that has been an issue and the state has turned around and used that to not provide PDN services for clients when they're not available. And as we all know that's a big issue right now. PDN is not available for many of the families and I think that needs to be looked at more closely. And I agree with everyone else. And that's all. Thank you. | Thank you for your comment. Based on feedback, the Department is removing the word "unpaid" from the definition. |
| Comment- Phone | | Eduard Gorovoy | | 10-03-23 / 31:28 | (INAUDIBLE) have to use my husband's account (INAUDIBLE) so I think just to sum up the overarching concerns is that because within the PDN field there's so many family members who are registered nurses for licensed (INAUDIBLE) you know CNAs and they are getting paid as part of this program. So maybe instead of focus you know we can focus on unpaid part, but maybe have an addendum to this definition where we can describe when would be the situations when the family members would be paid caregiver when you know somebody said there's a definition already out there when they go above and beyond about expect to go the family. Maybe (INAUDIBLE) here so it comes together (INAUDIBLE) there's no like the talk to everybody to see oh it's unpaid, but I am a registered nurse who is providing services for my family member for example and as such getting paid. So just bringing those two together just to, for clarification and clarity. Thank you. | Thank you for your comment. Based on feedback, the Department is removing the word "unpaid" from the definition. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Megan Bowser | | 10-03-23 / 32:36 | So I'm, I need to go and look at the context more particularly, but I'm guessing that based on the need for this definition that what we're really talking about is care that is provided when a paid caregiver is not available. And so I wonder if we need to keep a definition similar to this in there if it needs to not say family in-home caregiver. It just needs to define an unpaid caregiver as a separate thing and not mention that that could be a family member or anybody else, but just saying that sometimes PDN is not available and an unpaid caregiver will come into them the home or will provide that care at some point to make sure they are staying in the community. But separate family and unpaid so there's not some assumption that every family member is an unpaid caregiver. | Thank you for your comment. Based on feedback, the Department is removing the word "unpaid" from the definition. |
| Question- Phone | | Katie Wallet | | 10-03-23 / 36:00 | Thank you. I wanted to do the Home Health Agency one and then I can do medical necessity once we move on. My main comment was just why are we defining it again? It's already in, what is it? Eight…hang on sorry, it's already in the home health definition. I just lost my notes, I'm sorry. 852.1.J. already defines it. And then in the section that, in our draft section from 8540.6, for provider agency requirements, a lot of this is already listed. So in the draft that we already reviewed it says that the Home Health Agency must be licensed by the state and have a Class A and it has all that information is already in there, in the other draft piece, so I just think there's a lot of repetition that's unnecessary. And again I'm not sure why we can't just refer to the Home Health Agency definition that we already have earlier in the regulation. Thanks. | Thank you for your comments. Definitions are outlined in each section of the rule that they apply. We will look at reducing redundancy and unecessary wording as necessary. |
| Comment- Chat | | Erica Eisenlauer Drury | | 10-03-23 / 36:49 | Thank you for referencing EPSDT for medical necessity for pediatrics - that's very helpful! | Thank you for your comment, so glad to hear you find this helpful. |
| Question- Phone | | Galia Spychalska | | 10-03-23 / 37:59 | Great. I just want to see if we can clarify the first slide when it comes to identifying providing nursing services in a home care setting mostly because, again a lot of our kids may not be getting it in the home and I really worry that making that so specific will then exclude PDN services that are being provided in schools or in any other environment. I would like to echo that the Home Health Agency identification means a provider of home health services and is defined in section 25.5-4-103 and it's specifically certified by the Department of Public Health and Environment. So I generally question why that's in the rule as well. Thank you. | Thank you for your comments. PDN services can be provided in the home or community-based setting. We will correct the language so this is clear. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Eduard Gorovoy | | 10-03-23 / 39:38 | Yes thank you John. Yes if you don't mind putting back up the definition of the group, nursing group rate, I mean group nursing I'm sorry. I think it might be missing because if we, for previous discussion when we talking about the definition of RN group rate or LPN group it said specifically at the same time in the same setting and I think that same setting is missing from that definition that says in a private home setting. So maybe originating from the same side or in the same setting just to make sure that's again more clarity for that. | Thank you for pointing that out. We will work to clarify that the group rate is for nursing care that is provided at the same time and in the same setting. |
| Comment- Phone | | Katie Wallet | | 10-03-23 / 40:22 | Thanks. I was just going to switch over to medical necessity and I just wanted to make sure that my understanding is that for kids, so for children 20 and younger for medical necessity it's both the general definition that's in the program integrity rules 8076.18 which is referred to here, but with the addition of the added flexibility of the EPSDT. So it's not just the EPSDT, but that it includes both. So I just wanted to make sure that that was included in here. | Thank you for that clarification. We will revise language to reflect that the definition for medical necessity includes both references. |
| Question- Chat | | Christy Blakely | | 10-03-23 / 41:07 | So now we have a Medical Necessity for EPSDT, DME and a general definition?? That is 4!? | In regards to the PDN rule, there is the standard definition for medical necessity as well as the EPSDT definition for pediatrics that is being used. |
| Comment- Phone | | Christy Blakely | | 10-03-23 / 42:54 | I was just going to say that I feel like in the medically stable, that's not the same definition you had up a few minutes ago, frequent change because of health issues, I think one of the things that confuses me is we're not using decision making which is part of that the nurse skilled level. And so in medically stable I think we need to talk about clarifying this language a little bit more that the medical needs, not routine or subject to frequent change, but there's a decision making requirement to knowing what to do, using your nurse degree. | Thank you for that comment. We will clarify that the decision making for whether a member is medically stable is determined by the physician or allowed practitioner. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-03-23 / 44:24 | I wanted to raise concern about the medically stable definition because it seems that we're using Google to identify that as a legal definition and it provides the State of Colorado the power to just identify a patient as medically stable based purely on the basis of the criteria of this definition and that is something that is only done by a physician. Even the Colorado DMV has a five-page physician certification. This is identification of a medical condition that requires physician certification for the State of Colorado to define that and to apply that to patients is against the law. Second of all nursing assessment specifically is in full violation of the State Nurse Practice Act 12-255-104. Again, the practice of professional nursing as well as treating means the selection, recommendation, execution, and monitoring of those nursing measures essential to the effective determination and management of actual or potential human health problems and to the execution of the delegated medical functions and delegated patient care functions. The delegated medical functions and delegated patient care functions shall be performed under the responsible direction and supervision of a licensed health care provider. And that is not being done. It is stating that a home health agency staff member where anybody can perform a nursing assessment which is against the Board of Nursing, against the Colorado State Nurse Practice Act, should be totally taken out of this rulemaking because again this is again against the Board of Nursing and our Colorado State Nurse Practice Act. Thank you so much. | Thank you for that comment. We will clarify that the decision making for whether a member is medically stable is determined by the physician or allowed practitioner. |
| Comment- Chat | | Amy | | 10-03-23 / 46:10 | Nursing process and physician assessment is essential in the changing condition of medically stable. Nurse Practice Act violation. | Thank you for your comments. As part of the rule revision process, staff from the Board of Nursing, staff from the Attorneys General Office and the Colorado Department of Public Health and Environment will review the regulations. Any suggested changes from these entities will be reviewed and incorporated. |

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| Comment- Phone | | Eliza Schultz | | 10-03-23 / 46:31 | Yeah, can you hear me? Great, thanks. I also have a couple concerns about the nursing assessment definition as well as the medically stable definition. Both are vague and I worry that they'll be difficult, at least for the previous definition, difficult to determine. You know, home health agencies have a requirement to do regular assessments on their clients and there could be changes that are quote unquote frequent because of those required assessments, but that doesn't mean that the person is not stable. So I think this definition needs some more work and then John could you or whoever is doing the slides go to the nursing assessment. I also agree that this is concerning because it says that a nursing assessment is done by a home health health agency staff person. A nursing assessment should be done by a nurse. And I also worry about this desired outcomes language in there. Not all of the clients under PDN are going to have rehabilitative or discharge plans. This could be just supports to have them have activities of daily living and that they may not quote unquote graduate from the PDN program. So this makes me think that like the purpose of the nursing assessment is to improve conditions in such a way that the person no longer needs PDN and I'm not sure that that accurately reflects the mission of the program. | Thank you for your comments. We will correct the language around who can determine if a member is medically stable as well as clarify that the staff person referred to in the definition of nursing assessment is in fact a nurse. |
| Comment- Phone | | Megan Bowser | | 10-03-23 / 48:56 | Yeah going back to the medically stable definition I agree with what's been said that it is very very vague and needs to have some criteria on who can make that determination and more specifics about what that means because it is such an essential part to receiving services and right, with this it seems like anybody could declare someone medically stable or not medically stable because the definition is so vague. | Thank you for that comment. We will clarify that the decision making for whether a member is medically stable is determined by the physician or allowed practitioner. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Erica Eisenlauer Drury | | 10-03-23 / 49:52 | Sorry I was muted of course. I have two two comments. The first will be brief. It's just a suggestion for the nursing assessment definition where it says home health staff. We feel that it should say home health nurse for obvious reasons. The nurses are doing the assessment and of course their staff of the home health agency, but we do have other staff with the home health agency as well that don't include nurses. So if we could clarify that we would appreciate it. My other comments are around medically stable and our main concern here is the majority of our patients live their lives at home in a stable condition. Of course ICU and ED level intervention by definition cannot occur in a home environment otherwise these patients would need to be hospitalized due to necessary equipment and the physician level of intervention care needed, if care needed, that is elevated at that level. The nursing interventions lead to sustained stability and reduced hospitalization and illness in the home environment as others have kind of reiterated. It seems counterintuitive to claim that the stability in the presence of long-term medical need mitigates the need for further intervention. And so we just feel that this definition could use some additional work as others have said. So those are our comments and thank you so much. | Thank you for your feedback. We will work to clarify that the staff person referred to in the definition of nursing assessment is in fact a nurse. We will also review the use of the term medically stable and revise as necessary. |
| Comment- Chat | | Amy | | 10-03-23 / 50:14 | Home Health agency staff cannot determine the condition of a client. Rehabilitation and improvement is not an obtainable goals for many clients. | Thank you for your comment. We will revise the terminology in this definition to clearly state a nursing assessment is completed by the nurse. |
| Question- Phone | | Claire Dickson | | 10-03-23 / 52:06 | Yeah, I thought that medically stable used to be part of the eligibility criteria for the PDN program. So you had to be medically stable. I just double checked that before, if that's still in the regs. | Thank you for that clarification. We appreciate your verification of this term. |
| Comment- Chat | | Christy Blakely | | 10-03-23 / 54:14 | It is hard to put medical into human language. Acute in a hospital is not stable, but someone on TPN would need a nurse to change the device, but not a full time nurse. | Thank you for your insight and comments. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-03-23 / 55:19 | Hi, thank you. I just had some concerns again in reference to the wording and on the plan of care and the nursing part, it specifically states a home setting and at his or her residence and again a lot of our patients and our kids receive services in multiple environments so I think not making it so specific and especially like school and things like that. And then I would like to also cite the Board of Nursing, our Colorado State Nurse Practice Act 12-255-104. In reference to the plan of care. The delegation of patient care includes aspects of patient care that may be delegated by a licensed health care provider within the scope of the provider's practice and within the provider's professional judgment to a licensed or an unlicensed health care provider within the scope of that provider's practice. When we look at plan of patient care it you know there are specific things within the State Nurse Practice Act that talks about delegation of nursing tasks again and that also talks about the stability of the condition of the patient, the training… no delegation shall be made without the delegating nurse making a determination that in his or her professional judgment the delegated task can be properly and safely performed by the delegate and the delegation is commensurate with the patient safety and welfare and the delegation the delegating nurse shall be solely responsible for determining the required degree of supervision the delegate will need after an evaluation of the appropriate factors which shall include but not be limited to the following… and then it lists the nature of the nursing task being delegated, whether that delegated task has a | Thank you for your comments. PDN services can be provided in the home or community-based setting. This language has been added to the definition. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallet | | 10-03-23 / 57:35 | Thanks. So focusing on the plan of care definition I just wanted to point out, sort of similarly to the home health agency definition, that it's definitely something that's referred to and defined elsewhere in the regulations. And so two specific points, one is just that throughout the draft that we've been given over the past year or so, plan of care is referenced a lot and it will be referenced and then it'll say a specific document that is needed as part of the plan of care and it doesn't seem to be consistent throughout. So I would certainly suggest like when you all are going back, going through the full draft, to like check every part that is mentioned the plan, that mentions the plan of care because I found that they're not consistent and so it can be kind of confusing. And I also wanted to say, and this is probably user error on my fault, I couldn't find 42 C.F.R. 484.18. that's referenced here, my guess is it's that's my mistake not yours, but I did want to point out and sort of make sure that in 42 C.F.R. 484.50. that's a patient's right section, and it makes clear that patients have the right when they're establishing and revising the plan of care, that they have the right to participate in, be informed about, and consent or refuse care in advance of an enduring treatment where appropriate with respect to the plan of care. And so I was just going to suggest that in, that right here what we have is just written in consultation with the member but in fact that there are a lot more rights provided within the fed, from the Federal Regulations, that should also be included. And I'm partly saying that because you know we've had clients come to us saying you know where their home health agency has | Thank you for this insight. The plan of care is also referred to as the form CMS-485 which is a standardized format for HHAs and physicians to communicate orders and treatment plans. The member and their designated representative should be involved in ensuring an accurate and medically necessary plan is developed. The regulation will be updated to ensure it is clear the documents being referenced. |
| Comment- Chat | | Amy | | 10-03-23 / 59:24 | Community involvement is a right of clients and family as determined by physician. Specification of home care for client is against federal law. The least restrictive environment would be more appropriate. | Thank you for your comment. PDN services can be provided in the home and/or community-based setting. We will clarify the language in the definitions to reflect that allowance. |
| Question- Phone | | Pam R. | | 10-03-23 / 59:32 | I guess my question is on your definition of skilled nursing you mentioned finding it in your fee schedule. So are you using that to, because everything that a nurse does in an intervention is a skilled nursing task, so is that what you're what you're getting at? Or are you getting at the different (INAUDIBLE)? Because you're forever calling it intermittent. So now are you calling it skilled? Like what is this referencing, as far as, is this referencing specific things within the PDN or is it referencing what isn't PDN? | Thank you for pointing this out. The references to where terms are used are for sections of the PDN rule and are used in the context of the PDN benefit. |
| Comment- Phone | | Pam R. | | 10-03-23 / 1:00:46 | So what you're using it for here is to define what a skilled nursing task is within the context of PDN? Okay. | Yes that is correct. These definitions are all in context of the PDN benefit. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Claire Dickson | | 10-03-23 / 1:01:07 | Thank you, thank you Katie. So I'm concerned about whether or not this addition of a definition of nursing assessment is adding more work to be done in order for a person to get found eligible for PDN services or the amount of services. I thought that the plan of care was essentially the assessment that helped establish the need for skilled nursing services and helped establish the number of hours when used in conjunction with the PDN Acuity Tool. So I guess my question is this another series of papers that need to be filled out and how are they different from the plan of care? Perhaps the Department could, in the regulations, refer to the actual document or link to the document that they're referring to so that people could see what it is that they're using. Also had a concern, mainly about the definition of private duty nursing, but just wanted to point out that I don't think you should remove the distinction between the type of care that PDN serves and provides against the home health benefit because that really is what makes the PDN service, the service that it is. It isn't the task oriented home health nurse service that is, you know an hour or two hours in scope. And you've taken that out the comparison, you've taken it out of the definition of private duty nursing. Thanks. | For clarification, the plan of care is an existing document often referred to as the form CMS-485. This is not an extra step for eligibility or an additional assessment required. This is the standard form to collect the orders and treatment plan for communication between the HHA and the physician or allowed practitioner. This plan of care outlines the tasks and services to be provided to the PDN member under this service. This will be further outlined in the regulations to ensure this is made clear. |
| Comment- Phone | | Katie Wallat | | 10-03-23 / 1:04:28 | Thank you. I was going to move on to the PDN definition and I've said this before I will say it again, and I appreciate Candace you saying that this definition isn't very different than the old one which is absolutely true, but I think we're all here rewriting these rules because of these sort of ongoing crises that keep popping up and I think a lot of it has to do with this continuous nursing. So what I've said before and we'll say again, PDN does not require continuous nursing, it doesn't. Our state statute makes clear that it requires anything that is more individualized and continuous than the nursing care available under the home health benefit. And the federal definition says that it is more individual and continuous than is available from a visiting nurse. It does not require continuous nursing care and I don't think that should be in the definition. Thanks. | Thank you for sharing your thoughts and sharing these citations. Based on feedback, the Department has revised the definition of PDN to more closely reflect the federal regulation and state statute. We appreicate your throughful engagement throughout the process. |
| Comment- Phone | | Megan Bowser | | 10-03-23 / 1:05:19 | Yes also on the private duty nursing definition, I agree with Katie that that continuous word is a huge problem there and again the word “and” so it should be that list of items intervening “or” evaluation not and evaluation. And then again we have the home setting issue in this one as well. | Thank you for sharing your thoughts and sharing these citations. Based on feedback, the Department has revised the definition of PDN to more closely reflect the federal regulation and state statute. We appreicate your throughful engagement throughout the process. |

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| Comment- Phone | | Galia Spychalska | | 10-03-23 / 1:05:52 | Hi, thank you again. I would like to also raise concerns in reference to the private duty nursing definition in context to intermittent and continuous nursing, because there's no such thing, and it is against a federal statute and it would really really inhibit a physician according to the federal EPSDT law and really ordering what's medically necessary. Again the PDN, sorry I just ran up the stairs, the PDN context that's being used is really really questionable and and I really really worry about the nursing assessment piece because it's saying that it's done by any home health agency staff and if it can, this can be totally taken into out of context and used into practice of delegation of nursing assessment and the wording should be totally scrapped. If you wanted to put nursing assessment in reference to eligibility or criteria or plan of care, then again you put it into the context of plan of care, then a nursing assessment will be performed by a registered nurse or an allowed provider or a physician for for it to be used in that context and I really really worry that now we're looking at delegating you know a nursing assessment which is not appropriate and all of our families and and and members and clients. So I echo a lot of my concerns as the previous ones in reference to identifying location, residence and having the ability to have it be so specific, whereas we have a lot of community settings where our children receive PDN so that they can access their community and that is the whole point of PDN. Thank you. | Thank you for your comments. Terminology will be clarified to reflect that PDN services can be provided in a community-based setting as well as the home setting. We will also revise the definition of the nursing assessment to reflect that a nurse is the one completing that task. We will also incorporate the federal definition of PDN and State statute where needed. |
| Question- Chat | | Erica Eisenlauer Drury | | 10-03-23 / 1:06:32 | could "home setting" simply be changed to include "home or community-based setting"? | Great suggestion. We have incorporated that into the rule language. We very much appreciate your suggested language changes. |
| Comment- Phone | | Claire Dickson | | 10-03-23 / 1:08:00 | Again going back to this this really changes, this change in the definition of private duty nursing is significant and not the way it should be. Your, the whole point of the original definition was to say that the private duty nursing service was somehow different than the nursing service that was provided under the home health benefit. It didn't talk about a home setting, it was compared to the home health benefit or nursing services provided in a hospital or nursing facility. I don't think that that comparison should be taken out, I actually think the language at least with respect to the hospital or nursing facility is in the federal regulation. You shouldn't, there's no point in removing that. It's required under the federal regulation. Thanks. | Thank you for sharing your thoughts and sharing these citations. Based on feedback, the Department has revised the definition of PDN to more closely reflect the federal regulation and state statute. We appreicate your throughful engagement throughout the process. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Pam R. | | 10-03-23 / 1:09:04 | I just, under private duty nursing you have added towards the bottom the statement that says, who is employed by or contracted with a licensed home health agency, I'm just curious if you could give me an example of where it would be appropriate to have a contracted or 1099 nurse participating in in PDN Services? | The relationship between staff and the Home Health Agency is an employment agreement that the Department does not weigh in on. |
| Question- Chat | | Christy Blakely | | 10-03-23 / 1:09:11 | IS HCPF trying to stop PDN in schools and other setting?? Yes or NO | We appreciate you pointing out that the old wording of the home setting needs to be updated, which we will do. The Department is not trying to eliminate or restrict any sort of community-based setting for individuals. There has been no changes to how healthcare services are provided in the school setting. |
| Comment- Chat | | Katie Wallat | | 10-03-23 / 1:09:22 | 42 CFR 44.80 "Private duty nursing services means nursing services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility" | Thank you for including this citation. |
| Comment- Chat | | Katie Wallat | | 10-03-23 / 1:10:05 | Our state statute: 25.5-5-303 “PDN means nursing care that is more individualized and continuous that both the nursing care available under the home health benefit and the nursing care routinely provided in a hospital or nursing facility” | Thank you for this reference. |
| Comment- Phone | | Eliza Schultz | | 10-03-23 / 1:10:37 | Thanks John and thanks HCPF, Candace, and Valerie, and team. I know this has been a heavy lift for you guys and these rules have not been updated in quite some time so I just want to throw that out there as a thank you for these meetings. I will say for the Home Care and Hospice Association of Colorado I am getting significant concern from agencies and the families we serve around this intermittent versus continuous nursing and really worried about the impacts of many families who, depending on how this is applied and implemented, many families could potentially lose critical service that allows their parents to go to work, that allows you know some sort of normalcy for the other kiddos in the home and we just would encourage you, and agree with the comments that have been said before, to not remove the comparison to the other facility types and those types of care. And also to remove the definition of continuous because from my layman's seat here as a lay person, not a clinician, if a person does not get approved for 24-hour care then that is not potentially fits in the definition of continuous and so that is just a concern that that I've heard um from my my folks. Thanks. | Thank you for your comments and for sharing the viewpoint of the Association members. The Department is not wanting to negatively impact members but rather ensure that all members have access to the necessary services in the appropriate manner. We plan to revise regulations to ensure this occurs. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Chris Russell | | 10-03-23 / 1:14:14 | Hi, thank you John. I'm, I don't know for some reason not comfortable with the term “allowed practitioner.” I don't understand why that can't be defined. It's not like there's a bevy of allowed practitioners. Why is it that that hasn't been, I mean if you're talking about a certified nurse assistant that's only one thing that you could put under there perhaps where that could take delegation from a nurse? But I don't, I'm wondering what you're talking about with that term? | The definition was expanded to match CMS terminology of medical professionals who are allowed to order services under the Home Health program, which includes PDN. |
| Question- Phone | | Chris Russell | | 10-03-23 / 1:15:07 | Where is that specifically? Is that defined? Specifically that term? | The definition we are proposing is that a Physician or Allowed Practitioners means a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) who oversees the delivery of skilled care to a member within their scope of practice, in accordance with State law who is actively enrolled with Health First Colorado. |
| Question- Phone | | Chris Russell | | 10-03-23 / 1:15:42 | I thought that this was referring to in the context of the private duty nursing situation, not, I mean, not a physician or a physician assistant in a hospital or something. | This definition is specific to Home Health and PDN to match CMS terminology for who can order the service. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallet | | 10-03-23 / 1:16:36 | Thank you. I have two really quick ones specific to the utilization management. The first piece is that, I don't think it should say anything other than evaluates medical necessity, because that's its job. Nothing can be medically necessary in the definition of medical necessity and not be appropriate. And similarly the definition of medical necessity includes these efficiency concerns, right? Because it says, shouldn't be more costly, other equally effective treatment options, is delivered in the most appropriate setting, etc. So those words are not necessary. Utilization management should only be looking at medical necessity. That's the first piece. And then the second piece is based on my reading of all the different pieces of the draft that we've been given over the past year I'm not sure that the process that is described here is ever actually described in a step-by-step way in this regulation. So I'm not sure it's clear what the home health agency does, what they provide to the utilization management vendor, excuse me, the URC, and then sort of how that goes back to the member and I think that there may be a problem with the administrative procedures act if that process isn't clearly articulated in the regulation because it can be really hard for members to understand what are the steps by which they might be approved or denied and so I would definitely encourage HCPF to go back and sort of make make sure that when they're going through the full draft that these steps are actually articulated in the regulation so that everyone can understand what's going on. Thank you. | Thank you for this feedback. Those items will be taken into consideration as we revise the regulations. Our goal is to ensure the URC process is clear and outlines expectations for members and providers. |
| Comment- Chat | | Erica Eisenlauer Drury | | 10-03-23 / 1:17:51 | I have one more comment for technology, it seems that intermittent feedings would not qualify (ie 4+ feedings via Pump during day, continuous at night)? This has no bearing on the amount of work/intervention needed; in fact, it is more tedious than continuous feeds. Any technology dependence in the example (“adverse health consequences”) is applicable. If the patient has technology dependence, regardless of frequency, it would be “detrimental/adverse” if the technology were not utilized. | Thank you for voicing this concern. The use of technology is evaluated in combination with any co-morbidities that a member may have to determine medical necessity for each individual based on their circumstances. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-03-23 / 1:18:20 | Sorry, thank you. I also echo the concern of the URC just being focused on on medical eligibility and medical necessity rather than other evaluations and I worry that this context or the manner that it's worded could be questionable since then it would give the power of the URC to do a lot more than that and that needs to be defined a little bit better. I also worry about the implications of what these definitions mean as a whole. Again I question the intermittent and continuous nursing as being included in any of these definitions, because that is not within the federal guidelines, it's not according to EPSDT, and I worry that it would limit the access to needed PDN services for children and therefore limits LTSS which under the 1 billion dollars that the State of Colorado is receiving ARPA funding on is not supposed to be limited while the funding is being received by the State of Colorado and I am genuinely questioning how this process is going to increase rather than decrease access to these services. Thank you so much. | Thank you for your feedback and expressing your concerns. This feedback is being taken into consideration as we revise the regulations. |
| Question- Chat | | Katie Wallat | | 10-03-23 / 1:19:48 | Because our next meeting will be the entire rule, how soon before the meeting will we be given the draft? We will certainly need more than a day or two to review it. Also--will the meeting itself be scheduled for longer than an hour and a half with so much to discuss? | Presentation materials are available one week in advance of the meeting however we will provide the full rule draft as soon as we are able to allow for additional review time. |
| Question- Chat | | Christy Blakely | | 10-03-23 / 1:23:50 | From today's comment will you be making changes?? | We will compile all of the suggestions from stakeholders, both internal and external, and incorporate recommendations as necessary. |
| Comment- Chat | | Dr Pamela Knothe | | 10-03-23 / 1:23:51 | Thank you HCPF staff! We appreciate your time and the information | Thank you for joining us today and for providing feedback. |
| Question- Phone | | Galia Spychalska | | 10-26-23 / 00:15:00 | I'm RN, FNP and a parent nurse provider. First of all, I would like to thank you for making all the changes that we had talked about in the last meeting. But I definitely still have some more concerns and I think one of my biggest things, in reference to the concerns that I have, is the definition of private duty nursing, the definition of skilled nursing tasks, and the definition of skilled nursing, and skilled nursing service. And particularly because it's still quite confusing. Are we saying that private duty nursing is a skilled nursing service? Because I feel like those two definitions can be combined into one. And then my other concern is that the identification of skilled nursing tasks is actually in violation of the Board of Nursing Colorado State Nurse Practice Act, which genuinely defines what nursing tasks are. And so I just worry that actually putting this in here is really quite confusing and in violation of the State Nurse Practice Act. Thank you. | Thank you for your comments. The definition of private duty nursing has been updated to reflect the language of the federal and state statute definition of PDN. We will revisit the definitions of skilled nursing and skilled nursing tasks to clarify. The Department of Regulatory Agencies has reviewed the proposed rule changes to ensure there are no conflicts with the Board of Nursing regulations, of which there are none. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-26-23 / 00:17:28 | Okay, and then one more thing I just wanted to add because we had quite extensive conversations when we're talking about private duty nursing and it says "who require more individual and continuous care." Again, I think that wording implicates and basically continuous means 24/7 and I would really urge the Department to change continuous to continuing care or continuing you know nursing care because I think that that creates a more viable definition and there's a big difference between continuing and continuous. So, thank you. | Thank you for sharing your thoughts. The revised definition of private duty nursing was taken directly from the federal and state statute and combine them into one definition. |
| Comment- Phone | | Katie Wallat | | 10-26-23 / 00:18:31 | Hi, good morning. I also wanted to echo what Galia said just in terms of thanking the Department for the changes that were made particularly in the PDN definition and really defining it in terms of by comparison to the home health benefits. So we really appreciate that and sort of how articulating all the changes which makes it easier. The one piece I just wanted to sort of bring up was the skilled nursing and skilled nursing service definition and that end piece about for tasks that cannot be delegated. And just to make sure it's very clear that it's the nurse who ultimately has to make that determination just based on our statute, which I'm happy to quote but don't need to, and the regulations, and because it's the nurse who's ultimately responsible and it's not just task-based, right? It's a task that can be delegated and that the nurse says this should be delegated to this delegatee based on this patient based situation. And so what I would recommend is saying something like, cannot be delegated based on the nurse's judgment or cannot be delegated and is not delegated just to make sure that it's very clear who is ultimately responsible in making that determination. | Thank you for your comments. The Department has received additional feedback that changing the term tasks to care or care that cannot be delegated would clarify that PDN is differentiated from task-based services. This change has been made to the draft regulations. We welcome additional feedback if that provides the clarification we are aiming for. |
| Comment- Phone | | Katie Wallat | | 10-26-23 / 00:20:02 | I think that's helpful. My part is not even the tasks or care, I do think that would be beneficial. I think that that cannot be delegated, just doesn't identify who's making that call. And so I would, even if you did care for care that cannot be delegated based on the nurse's judgment. Again, the point is to identify that it is ultimately the nurse's responsibility. It's not just that this care can or cannot in a vacuum be delegated. Do you understand that distinction? But I do think care makes sense. | Thank you for your additional thoughts on this terminology. We have clarified the use of delegation in this instance. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Pam R. | | 10-26-23 / 00:20:44 | Hey, I just had a question. When you're talking about the skilled nursing and the home health benefit versus the PDN benefit and then you kind of throw in the word intermittent. I guess where I'm confused is none of that matches anything that's really stated in the regulation for home health benefits nor does it match anything on your fee schedule. So is that something that's going to be clarified? Because intermittent is not mentioned on a fee schedule and it's not mentioned, that I'm aware of, in the home health regulation. So we're using a term in this regulation that's not mentioned anywhere else. | Thank you for your question. The term intermittent was used in the eligibility section of the PDN rule, specifically where it describes the benefit as "requires skilled nursing services that exceed what can be managed with intermittent home health services." (8.540.2.A.3) That verbiage aimed to differentiate PDN from the Home Health benefit; however, it seems to have caused more confusion. That term has since been removed from the rule. |
| Question- Phone | | Pam R. | | 10-26-23 / 00:22:28 | Right because I know that on some of the like you know letters that are going out or have gone out in the past right, the word intermittent is used but there's nothing on the fee schedule for a home health, do you know what I'm saying? I feel like we're still a little gray on what the difference between skilled nursing, like even with this definition right? Because you're using like words and letters and then you're using words and regulation. So yeah, like I, like as a consumer I'm just still kind of confused as to what like what that means as far as the home health service and what that means when you're looking at the fee schedule. | Thank you for that context. It can often be difficult to distinguish between PDN and LTHH. The Fee schedule is specific to the procedure codes and units of service. The Department is working to ensure the two services are clear and distinct not only in the rule but also on the web page information and in conversation with stakeholders. The fee schedule is limited to the amount of information that can be displayed due to space constraints on the tables themselves. |
| Comment- Chat | | Galia Spychalska | | 10-26-23 / 00:21:25 | Skilled nursing delegation of nursing tasks in direction violation of Board of nursing Colorado State Nurse Practice Act 12-255-131 delegation of nursing tasks | The proposed rule has been reviewed by the Department of Regulatory Agencies (DORA) for accuracy and to ensure it is not in violation of the Nurse Practice Act. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 00:21:54 | "intermittent" is at 8.540.2.A.3 | Thank you for sharing the reference. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 00:22:13 | and 8.540.2.A.9.d | Thank you for sharing the reference. |
| Comment- Chat | | Galia Spychalska | | 10-26-23 / 00:23:00 | Delegated tasks shall be within the area of responsibility of the delegating nurse and shall not require any delegatee to exercise the judgment required of a nurse | Thank you. We have worked to clarify that terminology as appropriate. |
| Comment- Chat | | Galia Spychalska | | 10-26-23 / 00:23:44 | I think it would be helpful to take out intermittent and define that as home health benefit rather than PDN | Thank you for your comment. The Department has removed that term from the PDN regulations. |
| Question- Chat | | Galia Spychalska | | 10-26-23 / 00:26:12 | Can we discuss definition of PDN as skilled nursing and or combine that rather than keeping these definitions as is? | The proposed revision to the definition of PDN incorporates terminology directly from the federal and state statutes. The Department has revised the definition of skilled nursing to ensure clarity. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 10-26-23 / 00:2719 | Thank you. First just to say again I really appreciate the changes that were made already. I still find a couple problems with the EPSDT standard. So the first section here is for all members including people under 21, and I just have concerns about deterioration of a chronic condition, loss of function, imminent risk to health status, risk of death. None of those things are requirements for kids under 21 because EPSDT cover services that maintain function and address pain. Also later on in the under 21 section, in the B part on the next page there's this "ensuring member safety." And again, that's sort of a more limitation, more limiting of what EPSDT would require. EPSDT based on the Medicaid act correct or ameliorate defects and physical mental illness. So I think that those things should be removed. But I also think over 21, the non-EPSDT folks, I really have a problem with this addition of "sustaining life" because pain mitigation or bed sores or things like that that could require more continuous and more individual services is not about sustaining life, but should still be covered under this benefit. And then again just the A, B, C and D and E underneath the over 21 folks, it just seems like, there's again like there's these additional things of multi-step processes and it's just more, it feels again that it's limiting beyond the more continuous then what we already provide under the home health benefit. And I just don't think that those are necessary. And then the last piece is just similarly with the EPSDT folks for the B, the members aged under age 20, I don't think that they require, EPSDT doesn't require a combination of tech | Thank you for your review of this section. This section aims to outline the subtle differences in eligibility for private duty nursing services depending on age. Your comments bring up valid points and as such we have revised the language within the draft regulation. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-26-23 / 00:29:46 | Thank you. I just to, I have some additional comments as well. And that is that I definitely feel like private duty nursing should encompass the skilled nursing definition. I also have huge concerns about, I'm talking about deterioration of a chronic condition, loss of function, imminent risk because again, it is in violation of federal EPSDT law because a lot of our kids are not going to die, but they do require a certain level of skilled nursing services that can be provided in the home that would keep them out of the hospital. And I also feel that there's there's a lot of questions about the PDN service being considered supplemental to the care because it's not, our kids receive PDN services because it's medically necessary and the severity of a member's clinical condition should not shouldn't even be there. Like that is a decision that is done by a physician that is covered under medical necessity with federal EPSDT law and the severity of the member's clinical condition should not make the service medically necessary and I believe that that should totally be taken out because it's not really appropriate for that to be in there. I do appreciate all of the other changes that the Department was able to make, but I think putting on there that a member's need for skilled nursing be solely (INAUDIBLE). | Thank you for your comments. We have revised the language as appropriate to align more directly with EPSDT |
| Comment- Chat | | Eliza Schultz | | 10-26-23 / 00:30:55 | I still need to review with a fine tooth comb. It would be good to engage with the hospitals before removing that language. I worry the hospitals will think the entire obligation for discharge is on a home health agency. | Thank you for that suggestion. We have left hospital procedures in the rule but have modified to reflect updated processes and language. |
| Comment- Phone | | Galia Spychalska | | 10-26-23 / 00:33:20 | Thanks Candace. I just, I just have two additional comments to the last slide and I'm not sure are you guys on 8.540.2.B? So the criteria for approval of PDN services outlines all of the documentation that's needed, but it's not stated that it is to be provided it by the home health agency and then it also says a member's need for skilled nursing care again, and it's based solely on their unique condition. Again, there's that question of skilled nursing care being the home health care benefit or the private duty nursing benefit. And then I think again the confusion of pediatric EPSDT and then adult, I just worry that this is again getting kind of really questionable about what we're talking about and what it encompasses. Thank you. | Thank you for pointing out that this may be confusing to some folks. The language has been reviewed throughout the rule to ensure that those responsible for certain tasks are properly identified. The EPSDT rules have been clarified where appropriate as well. |
| Comment- Phone | | Galia Spychalska | | 10-26-23 / 00:34:45 | Then also as far as the the member's need for base solely, it should also have medically necessary as medically necessary ordered by a physician in there as well in that definition. | Thank you for that clarification. The regulations will be revised to ensure clarity. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 10-26-23 / 00:35:06 | Hey, sorry, I didn't realize this section was 2, 3, and 4. So in that number 4, the benefit limitations, and this I think is the comment that I feel most strongly about, is the 8.540.4C, when a service can be safely and effectively performed or self-administered without the directing prevention of a registered nurse or licensed practical nurse, the service is not considered a nursing service. Fully disagree. I think this is illegal. And the reason I think it's illegal is because this needs to refer to the Nurse Practice Act. Like what we were talking about before, it is the nurse who ultimately decides. So here it's unclear who is deciding it can be safely or effectively performed. Just because I think I can clean a G-tube doesn't mean that it is no longer a nursing service. It's still a nursing service. And then it has to refer back to the Nurse Practice Act, it has to refer back to the regulations. And again, if a service can be delegated but isn't, because the nurse says, “you know what mom, you're not quite ready to do this” or “you know what mom, your daughter is sort of stressed out and I don't think you should do this right now.” It's still a nursing service. And that is completely up to the nurse, it has to refer back to the law and I feel really strongly that this should not be in here and needs to be changed or removed. Thanks. | Thank you for your comments. All rule revisions have been reviewed by DORA to ensure accuracy and legality of proposed regulations compared to the Board of Nursing Regulations among others. |
| Comment- Chat | | Galia Spychalska | | 10-26-23 / 00:36:28 | I agree 8.540.4.C. Does violate BON nurse practice quoted above | Thank you for your comments. All rule revisions have been reviewed by DORA to ensure accuracy and legality of proposed regulations compared to the Board of Nursing Regulations among others. |
| Question- Phone | | Erica Eisenlauer Drury | | 10-26-23 / 00:36:55 | Thank you, I will unmute myself. Sorry about that. Okay, maybe I'll change locations and come back. Okay. Let's try that. I wanted to comment on Section 8.540.3B., is that in this? So mine is the added language identified by HCPF and used by the URC, and my comment would be if that medical necessity criteria identified by you all and used by the URC isn’t provided, I guess it's a question, isn't provided to the public, I guess is it or is it not? And then the second part of that question would be like if it's not, is that considered an underground regulation and you know trying to basically have us not be aware of what, as a home health agency, then we would not be aware of what that medical necessity criteria is that was developed by you all. So I guess I would just urge that information is a little bit more transparent if it's not already planned to be. | Thank you for providing your thoughts. The intent of this section is to clarify that the Department provides guidance to the utilization review contractor. However, from the comments, it appears that this needs to be adjusted to reflect just medical necessity criteria. Those changes have been made. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Erica Eisenlauer Drury | | 10-26-23 / 00:38:49 | That would be helpful. I think just because then when you read that your mind starts to go, "What is that medical necessity criteria and where is it?" So if it's referring back to another section if you guys could clarify that that would be super helpful. Thank you as just so there's not some question that there's another magical checklist that you know we should be trying to track down. No problem. Thank you. | All tools and criteria are publicly available to ensure fair and equitable care and services. This section has been reviewed for clarity and revised as needed. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 00:37:16 | Also, 8.540.3.A refers to 8.076.7 as the PAR process, but this is an incorrect citation. That is the false claims act and whistleblower section. | Thank you for your comment. Section 8.540.3.A refers to 8.540.7 and not the citation referenced in the chat. |
| Comment- Chat | | Galia Spychalska | | 10-26-23 / 00:37:29 | 8.540.4.D needs to be totally taken out | Thank you for sharing your feedback. Limitations to benefits are standard regulatory language and will remain in the language. |
| Comment- Chat | | Galia Spychalska | | 10-26-23 / 00:38:06 | Limitations identified in this way is unnecessary and offensive please delete | Thank you for sharing your feedback. Limitations to benefits are standard regulatory language and will remain in the language. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 00:38:10 | Yes, Erica--let's just refer back to the regulation's definition of medical necessity. | Thank you. This has been revised. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 00:38:26 | We don't need to add "identified and used by", it's just medical necessity. | Thank you for that clarification. This has been revised. |
| Comment- Phone | | Galia Spychalska | | 10-26-23 / 00:39:23 | Thanks. I just wanted to express concern… are we on 8.540.4.D.? I genuinely believe that this entire thing needs to be deleted. Honestly, it's offensive. It's really absolutely ridiculous that you should actually outline these limitations to the PDN benefit because there's no reason that any patients should be receiving care on the list that you gave. And I just feel like it's unnecessary and it's unbelievable that you would actually put this into a code of regulation. So like, I've never seen anybody not receive, not receive PDN because they genuinely needed it and I just really worry that this is going to be interpreted in other ways. And you know like, they're like my child for instance like I have to be able to have PDN care for him in order to attend school, but in order for him to even do community connector he has to have you know, he has to have PDN in order to access those services. I just really worry that the wording is not only offensive, but it's really not applicable to the population that we're addressing and it's totally out of context. Thank you. | Thank you for sharing your feedback. Limitations to benefits are standard regulatory language and will remain in the language. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 00:40:22 | I think 8.540.4.D. are all already covered in what is considered medical necessity, and what is considered a nursing service. I agree with removing this just because they're unnecessary as these definitions already cover the additions there. | Thank you for sharing your feedback. Limitations to benefits are standard regulatory language and will remain in the language. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Galia Spychalska | | 10-26-23 / 00:43:49 | Thank you again for outlining all this. I think it's very very helpful. I guess in reference to PDN services, it's pretty self-explanatory in reference to the home health agencies, but I know that when a child receives PDN services that there's also a part of federal statutes that, that also states the State is responsible for the nursing staffing levels or providing the staffing to provide those services. And due to current staffing shortages, is there a way to integrate that because there's a lot of families that are not receiving PDN services even though they are approved for it? Clearly because there are no nurses to provide them. And is this part of that or a separate thing or is that something that HCPF is starting to discuss? I just think it’s a huge issue. Like I haven't had a nurse in almost three years post-pandemic and I genuinely believe that there is a federal statute that states that the State has to be held responsible for that. And so how do we incorporate that into this rule so that we can actually get more staffing for our children? Thank you. | Thank you for sharing your concerns. Mandated staffing levels are used for facilities and not within home care services. Workforce issues continue to be a priority for the State. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Katie Wallat | | 10-26-23 / 00:46:28 | Thank you. I just had a couple quick things. The first was about some things that were taken out. It looks like one part was cultural competence was removed and it makes it seem like we don't value cultural competence and that there's no training required for people at home health agencies to have cultural competence. So I was curious about that. And then there were two parts that were taken out that has to do with that, it's the home health agency's responsibility to submit a PAR or to submit the application for PDN. Those were removed between, is that 3.B and C and I don't believe, and I'd be very interested to hear from the people who actually work at home health agencies about this, but I don't think it's identified anywhere in this draft rule who's ultimately responsible for submitting those. So I was curious, you know why those were taken out and then separately the new addition of that purposeful activity. I'm a little bit concerned just because I don't know what a purposeful activity is and I'm wondering like does observation count, right? Like I'm not doing anything or doesn't look like I'm doing anything but I'm doing observation. Does that count? And I was also just curious about the addition of that sentence "staff must be physically able and mentally alert to carry out the duties" feels like if the staff member wasn't, wouldn't the home health agency fire that person? Wouldn't that be against the policies of the home health agency state practice acts and professional standards of practice that are referenced above? So I just wasn't sure about a sort of reason behind that addition. | Thank you for these comments. HHAs are required to train staff specific to each individual, which includes items such as cultural or disability competency. The intention of this section is to clearly outline the rules and regulations that HHAs need to have within their policies in order to effectively hold employees accountable and as such CDPHE can survey on those policies. The PAR submission references were moved to the PAR section of this rule so as not to be redundant or duplicative. |
| Question- Phone | | Katie Wallat | | 10-26-23 / 00:48:21 | Sorry, do you mean it's in home health agency policy? What do you mean by the training of the individual? | To further clarify, each agency is required to train all staff who are providing services in accordance to the needs of that specific individual; this would include cultural competency. |
| Question- Phone | | Katie Wallat | | 10-26-23 / 00:49:52 | Yeah, the only other one was just confusion about what a purposeful activity is and would be and does that include observation? And how do we prove what a purposeful activity is? Just because it seems like a sort of a new phrasing and a new term. | Thank you for this comment. The descriptive word seems to add more confusion than clarify and has since been deleted from the draft. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-26-23 / 00:53:31 | I just wanted to talk about the prior authorization procedures and I know that we had discussed this in the past, but again a lot of our families due to staffing shortages are not able to get nurses and one agency or another, so I'm really really glad that the addition has made that we're able to (INAUDIBLE) home health agencies. And so the biggest problem that I see is that it's not identified in any of this dating that the PAR follows the patient, meaning right now as of right now if I wanted to change agencies to another home health agencies because they have the ability to provide more staffing for me I'm not able to move to another agency without first being discharged from our home health agency and then readmitted and then a brand new PAR authorization process to be submitted and then I have to wait to see if the PDN hours are actually approved. And so I'm just wondering, we had talked about this in the past. So I wanted to make sure that it's definitely included into this rules and regulations because a lot of our families are really suffering, and I know for a fact that like I can't change agencies, even though I haven't had staffing in three years because I risk my PAR not being approved. Thank you. | Thank you for bringing up this topic. A focus of the Department is continuity of care and a process for this has been outlined in the draft that will be discussed in January. |
| Comment- Phone | | Katie Wallat | | 10-26-23 / 00:56:22 | Thank you. I have two significant ones and then one smaller one. The first one is this reference to the PDN tool. That's not identified, It's not provided in the rule which is against the Administrative Procedures Act. You can't just refer to things without providing them or providing them you know in a public way. And I don't know if this refers to the Pediatric Acuity Tool which I'm sure doesn't apply to adults over 21, so that part I just think isn't going to fly just with the APA requirements because I don't believe it's identified and I can't find it. | Thank you for letting us clarify. The PDN Acuity Tool that is mentioned here refers to the current tool that is linked on the PDN webpage. It will also refer to any additional or updated tools that may be developed and used in the future. |
| Comment- Phone | | Katie Wallat | | 10-26-23 / 00:57:21 | Okay, and I would argue that the APA requires it to be put into the rule then. | Thank you for your comment. Attachments and/or tools are not housed within regulations as those tools are subject to change or be utilized in a different manner. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Katie Wallat | | 10-26-23 / 00:57:39 | I don't know what that is. So I would love to see that and certainly make it as accessible as possible. The other part is this concept of providers should only request services allowed or covered under the PDN benefit. I think that providers here means home health agencies. I think this should be that the home health agency should only request PDN services consistent with the plan of care. I don't that we should put, and again I'd love to hear from home health agency staff, but I don't think we should put the onus on them about what is to know what's allowed or covered and I also think it goes against the sort of just ask idea of EPSDT, which is EPSDT covers a lot of stuff, just ask and see if it's covered. And so I think I disagree with putting this in there and sort of putting the onus on providers to know what to ask for instead of just asking for what is consistent with the plan of care, just asking for what the allowed practitioner has said that that person needs. And then the last part just a smaller piece is that there's several mentions in this section into providers and I think that means the home health agency, but it makes it a little bit unclear if we're talking about practitioners or different providers. So I would clarify that and then the last one is there is a timeline in here that says within one business day, but I think the URC has to do something within one business day, but it doesn't say within one business day of what. And I can find that and give you the citation, but I just was wondering like one day of what? It's 8.504.6.D. Utilization Review number seven, "Written notification of all PAR denials including in members appeal rights will | Thank you for your thorough review of this section. The Home Health Agency should only request services for care outlined in the POC and under the PDN benefit. We have updated the language to reflect that. We have clarified HHA where appropriate in place of the term provider as that could be confused with physician. Clarification whas also been made to the URC timelines to indicate that the notice letter will be sent within one business day of the determination. |
| Question- Phone | | Katie Wallat | | 10-26-23 / 00:59:37 | So is there a timeline on when the URC needs to make the determination? Because otherwise that one business day isn't helpful. But we can get number five, ten working days. | Thank you for pointing that out. The timeline has been clarified to show that the notice letter is sent within one day after the determination. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 10-26-23 / 01:00:02 | Hi, thank you so much. And I genuinely really appreciate this revision that you guys have been working on because it genuinely shows that our input and feedback and everything is really taken into account. But I just worry with some of the way that this is categorized in regulation in reference to pediatrics and adults and then mixing them together and then doing it in these categories. I think it would be helpful in order to have one regulation for pediatrics from beginning to end and then another one for adults from beginning to end incorporating all of these and while that might be duplication I also feel like it would really be able to encompass federal EPSDT guidelines a lot more succinctly and I worry that a lot of these definitions clarifications and processes would be then apply to pediatrics inappropriately. So I'm wondering if HCPF is willing to do that so that this process is more seamless and it's identified accurately. Thank you. | Thank you for sharing your thoughts. To reduce duplication, the PDN rule will remain as one rule with differences highlighted in areas that pertain specifically to pediatrics or adults |
| Comment- Chat | | Chris Russell | | 10-26-23 / 01:03:29 | I would really like time to digest this and have another meeting before the MSB. | The goal is to have a finalized draft of changes posted on the PDN webpage end of November for public review and another meeting to be held in January for final stakeholder feedback. |
| Question- Chat | | Katie Wallat | | 10-26-23 / 01:03:33 | We haven't seen any PDN tool in use in our PDN cases, besides the pediatric acuity tool. Is that what is being referenced by "PDN tool", or a different one? | The PDN Acuity Tool that is linked on the PDN web page is a tool that Home Health Agencies utilize to help guide the hours of service they will request and determine what items need supporting documentation. This tool does not guarantee hours, but is a tool that is helpful when submitting a request. |
| Comment- Phone | | Galia Spychalska | | 10-26-23 / 01:03:51 | Hi Candace, I really appreciate you asking that question because I think that there were still some significant concerns that were brought up at this meeting and I would like the Department to consider the input from today and schedule another meeting in one month so that we can finalize some of the input that we had today into a regulation that's finalized and then we can see if there's any input based on the changes and input from today that still needed to be discussed in more detail so that the stakeholder process feels more complete and we all feel comfortable moving forward and I would really appreciate that. And if we can make that like a you know a significant amount of time, but again giving everybody kind of a month to kind of go through all this and kind of review what what the input was on both sides and be able to come back to the table with some really good additional feedback and sometime to really look at it a little bit more closer and in detail. Thank you. | Thank you for those helpful comments. Several stakeholders suggest to reconvene for another meeting after revisions are made to the final draft for review. The Department agrees with this suggestion and are adding another meeting to the schedule in January. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 10-26-23 / 01:05:19 | Oh thanks. I was just gonna sort of say the same thing as Galia and what Chris Russell put, just we'd love to see the next draft and have a little bit more time to process and have another meeting like this one because I just find them very helpful. Thank you. | Thank you for your comments. We plan to have another stakeholder meeting to review any additional changes to the rule, as we, too, find this discussion valuable. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 01:06:25 | Oh--I thought the PDN tool you've provided the link to was a Pilot, as identified. | The current PDN Acuity Tool linked on the PDN webpage is valid and in use by agencies. However, the Department is working to develop a new tool however there is a new tool under through an ARPA project. |
| Comment- Chat | | Deborah Bowman | | 10-26-23 / 01:06:56 | I agree. I would love to see the draft once the changes from today have been added have a chance to review the draft prior to a final review meeting. | The Department will have a final draft to review over a month prior to the scheduled stakeholder meeting to ensure plenty of time to for review. |
| Question- Chat | | Galia Spychalska | | 10-26-23 / 01:07:28 | Can you please provide the PDN tool? If we are going to include in tule was there stakeholders for that? Is it approved? | The PDN Acuity Tool can be found on the PDN webpage and has been used as a tool during PAR submission since 2003. |
| Comment- Chat | | Katie Wallat | | 10-26-23 / 01:07:39 | That pilot tool has been publicly described by HCPF staff for several years as no longer valid. | The PDN Acuity Tool that is linked on the PDN web page is a tool that Home Health Agencies utilize to help guide the hours of service they will request and determine what items need supporting documentation. This tool does not guarantee hours, but is a tool that is helpful when submitting a request. |
| Question- Chat | | Cassandra Keller | | 10-26-23 / 01:07:51 | Would two weeks with the rule for your review be enough, keeping Candace's comments in mind? | After discussing with stakeholders during this meeting and taking a poll, it was decided that the next stakeholder meeting would be held in January and an updated draft would be posted to the PDN website by the end of November for review. |
| Question- Chat | | Katie Wallat | | 10-26-23 / 01:08:05 | Do you mean the next draft, Cassandra? | Yes this will be for the next draft incorporating suggestions and revisions from stakeholders at this meeting. |
| Question- Chat | | Galia Spychalska | | 01-11-24 / 00:06:30 | Question is this PDN rule is totally replacing what is currently in place | Thank you for this comment. The current rule will not be deleted but rather updated with the revisions that are agreed upon through this stakeholder review process. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Galia Spychalska | | 01-11-24 / 00:09:23 | Hi Candace, can you hear me? So um, Candace this is Galia Spychalska I'm a RN FNP and I'm a nurse to my son. And first I just want to thank you wholeheartedly for all of your help. Not only personally for me but really in this entire PDN stakeholder stakeholder meeting process. And I know that there have been some moments of contention and I truly appreciate you taking the feedback seriously and to this current PDN rule because I can totally tell that you guys are actually listening and I just want to commend you. This has been a very hard process and I just think that this rule and the way that it's outlined for this meeting, I just felt like our concerns were heard for the majority. I still do have some questions. But my first question of the day is, are we fully replacing the current PDN rule that's in Colorado statute and deleting all of that and replacing it with just this rule? | Thank you for your engagement in this process. The current rule will not be deleted but rather updated with the revisions that are agreed upon through this stakeholder review process. |
| Comment- Phone | | Katie Wallat | | 01-11-24 / 00:15:54 | Well hello again. I actually had one on the one before, we go back to two on eligibility. And I wanted to start also by echoing what Galia said because I do really appreciate the changes that were made and I do think it's just really great in terms of building trust and we really do feel heard. There were a few sections, I know I mentioned this in an earlier meeting about exactly what you said in terms of bringing this back to EPSDT and sort of making sure you weren't adding pieces. And I think for the most part the changes were really great and were made and there's just a couple in here that I still see that I'm sort of concerned about. And I don't know if it makes sense for me to highlight those specifically? There's, the first one is under the first definition, “A member shall be eligible…” “When a member is…” Those are for like every, those are for pediatric and adults and one of the sections just has these limitations that I feel like wouldn't cover somebody in need of pain medication. For example that requires a skilled nurse because it's only listed as you know without it would result in deterioration of chronic condition loss of function etc., it's number two. And then the other piece was in the section that's just focused on pediatrics. There's this final thing about, “...it has to be necessary to ensure member safety…” and I don't think that that's in line with EPSDT requirements because there are, you know EPSDT includes amelioration and other pieces that have nothing to do with safety, pain management, bed sores, that are not about the member being safe. And so those are the two that I still think should be looked at again. | Thank you for your comments and your engagement through the review process. The Department agrees with ensuring that language is aligned to EPSDT requirements. The language "to ensure member safety" will be removed from the draft revision of the rule. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 01-11-24 / 00:18:54 | Hi, um did you already go through the 8.540. I definitions? OK. I just wanted to add in, because I generally still have some concerns about the definition of family and home caregiver where it says, "...it's an individual who assumes a portion of the member's private duty nursing care." And I just worry that that wording basically says that the family or that caregiver is assuming those services and that liability and I mean, I think it would be at detrimental because there are a lot of parents that actually don't want to be their kid's nurse and they're very very few of us and leaving us responsible for that and putting that in there I think it would make a little bit more sense to say, "who assumes a portion of the member's care in the home while being educated you know about private duty nursing care." And having… and I guess my thought process is having the ability to have a resource in reference to private duty nursing care for their family members, and I don't even know how to change that to be honest with you, but that that was kind of my thing there. And then my other addition was again going back to that definition of nursing assessment. I just worry that it might be used in context in other areas and I think it would be helpful to maybe have "PAR nursing assessment" to kind of identify it correctly within this rule because nursing assessment is also an intervention and it's also part of the skilled nursing which is part of you know private duty nursing and so I worry and I know that you still have to put that in in definitions, um I just don't know how else to identify it a little bit more. And then my last input on the definitions was the uh the redefining of | Thank you for sharing your concerns with the definitions section.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>HCPF is concerned with straying too far from the State statute and the federal definition of Private Duty Nursing would change the meaning of the intended definition.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |
| Comment- Chat | | Erica Eisenlauer Drury | | 01-11-24 / 00:20:27 | Saying that the family caregiver provides a portion of the PDN care in the home is not always accurate, and possibly opens the door to argue that anyone can provide nursing care. | Thank you for sharing your concerns with the definitions section.The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent. |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 00:20:38 | 8.540.2.A.2 applies to adults and kids, and restricts the eligibility beyond EPSDT. EPSDT requires coverage for things that "assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living". | Thank you for your comment. This language will be moved under the adult section of eligibility so EPSDT requirements are maintained. |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 00:21:45 | Also, note the grammar issues in 8.540.2.A. which starts with "a member shall be eligible. . . when the member" but then includes clauses like "when a member . . . delayed skilled (2)" and "when a member . . . care are ordered (3)" | Thank you for your attention to detail in your review of the draft rule language. These grammatical errors have been addressed in the most recent draft. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 01-11-24 / 00:24:20 | Hold on. I can't… now I can't find it. Sorry. I just wanted to maybe have that definition be specific to state that you know because technology is going to continue to advance and so a lot of the technology dependent or medical devices are gonna be different as time goes on and so to identify it as a medical device that assists or maintains a body, a bodily function and that requires continued nursing intervention to advert death or you know worsening disability. Because the way that it's worded now, it's either that, or would require hospitalization and I just think that that's very restrictive to what that definition means. Like I can tell you, you know if I have a malfunction of a machine hopefully it's not life-sustaining to the point of actually going to the hospital, but like I have two backup machines. I have two backup oxygen tanks here at the house. And so this is why our kids have this level of care, private duty nursing care, so that you know we have access to those medical devices that they need. But it doesn't mean they will have to be hospitalized. I don't know. I don't know if anyone else wants to pipe in. | The Department continues to solicit feedback from stakeholders on how this definition should be clarified and the current suggestion is to remove the language around hospitalization and focus on intervention to prevent adverse health consequences or death. |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 00:23:47 | 8.540.2.A.9.b.iv. which applies only to kids, includes the clause "medically necessary to ensure member safety" and that is NOT a requirement of EPSDT, and is not in line with what EPSDT medical necessity is. | The Department agrees with ensuring that language is aligned to EPSDT requirements. The language "to ensure member safety" will be removed from the draft revision of the rule. |
| Comment- Chat | | Erica Eisenlauer Drury | | 01-11-24 / 00:24:58 | We agree that the PDN definition should include "assessment". PDN is more than simply just saying continuous cares, but is ongoing assessment of a patient's tolerance of nursing interventions which is a main difference between PDN and Home Health intermittent nursing services . | Thank you for your comment. HCPF is concerned with straying too far from the State statute and the federal definition of Private Duty Nursing would change the meaning of the intended definition. |
| Question- Phone | | Pam R. | | 01-11-24 / 00:26:33 | I just have a question about technology. I mean, does that mean it has a battery? That it needs to be plugged in the wall? I mean because technically…So a G-tube would be technology because it's providing life-sustaining function to a child? Is that what I'm understanding? Because without that technology they wouldn't be able to eat. I'm just trying to understand | Thank you for your comment. Technology is currently not defined that the technology requires a battery. However, it is recognized that the need is there to clarify the proposed language. The language that was workshopped during the last stakeholder meeting has been included in the revised language and draft. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Steve Cox | | 01-11-24 / 00:27:02 | So yes, a G-tube is a medical device and it's actually defined that way in medical journals and all types of supplies. So anything that's used to sustain someone's life, that has been put in, or put on, or is used to help sustain life, can be considered a medical device. So I think your definition of technology is spot on in that, anything that's used to keep their life, sustain their life. Without it could cause an adverse health consequence or hospitalization and the word likely is in there. So I mean it makes sense to me, but it may not make sense to everybody.<br><br>… I mean some people can potentially not have adverse effects. So I don't know that you could say, “would.” I'd say, “could likely follow.” " | Thank you for clarifying, Dr. Cox, and for the suggestion of changing to "could likely follow" for the definition of technology dependent. |
| Comment- Chat | | Andrea Reitzel | | 01-11-24 / 00:27:53 | Technology Dependent means the use of medical devices without which adverse health consequences, creating further disability, hospitalization or death would likely follow. | Thank you for capturing the stakeholder comments and summarizing. |
| Comment- Chat | | Galia Spychalska | | 01-11-24 / 00:29:40 | No, no, I'm here. Sorry. I just think that sustain life is… I think that a lot of the technology, like like a CPAP machine, right? It sustains life, but on a totally different level like and I think that that was what Pam was trying to say is that the medical device is there to assist or maintain a vital bodily function and then add on what Andrea said, I think that would be, I don't know. That's what I think. | Thank you for sharing your thoughts. Your suggestion has been noted. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Chat | | Pam R. | | 01-11-24 / 00:30:32 | I think that, I mean I think that it works to degree. I think that, I think that there's just a lot of confusion about you know what is a nursing function, right? When it comes to running that, when it comes to running that because I've seen kids who have G-tubes that got bolus feeds or gravity feeds denied PDN because they're not using a pump, right? And it's, so if you're saying that the technology is the two, but to be able to…but right. But then, but then we're we're saying that they're not on technology because they're not using a pump, right? Or, you know, right? So that's where I think the confusion comes in is where, where, what is the definition of technology? Because is it… and that's just my comment on it is that you know I've seen kids get denied because the technology to whoever's looking at it is the physical battery operated pump and because they're using a gravity bag, then it's not technology. So I think that's my bigger concern is that, you know yeah, if my kid doesn't get their G-tube feed it will not be well, right? But if they miss, to Galia's point, if they miss a night of bipap they're probably not going to die, right? So I think that's like the point is, I don't know what the point is, but I think, I think my concern is the definition of technology being gray in that, you know in the past technology means that if you're not on a pump, on a continuous feed for 12 hours it's not technology. Versus here I'm doing a G-tube gravity feed every single hour. Like is that technology or not? And I don't know that you're, like if we're talking about it like we just have been, the answer is yes, but when it comes down to getting approval for these things is the answer | Thank you for sharing your thoughts and concerns regarding the definition being clear on what technology can mean. There are several suggestions from stakeholders of wording that will be considered. |
| Comment- Chat | | Galia Spychalska | | 01-11-24 / 00:33:15 | Medical device or a procedure that requires monitoring and immediate intervention | Thank you for that suggestion to clarify the definition of technology dependence. |
| Comment- Chat | | Galia Spychalska | | 01-11-24 / 00:34:21 | Plus in pediatrics gravity feedings developmentally appropriate because they can tangle themselves and hurt themselves and obstruct the procedure | Thank you for clarifying and providing these insights. |
| Request- Chat | | Georgia Daniel | | 01-11-24 / 00:34:43 | Could we change technology dependence to medical device dependence to include NG tubes, syringe feeding and equipment that is battery powered. To prevent the confusion surrounding technology as a broad term. Medical devices can include a wider spectrum of technologies needed to sustain life and bodily function. | Thank you for this suggestion and will take this language into consideration when revising the definition of technology dependence. |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 00:36:45 | 8.540.3.C. uses the language "if the member meets medical necessity criteria identified by HCPF and used by the URC". Please change this to "if the member meets medical necessity". It's already defined above, does not need to be identified /used--these clauses serve to add ambiguity and are unnecessary. | Thank you for this suggestion. This language has been revised to remove the redundancy and refer back to already defined terms. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 01-11-24 / 00:37:35 | Hi, okay. I understand why the limitations need to be here. I'm going to go back and say yet again the 8.540.4.C "when a service can safely and effectively be performed or self administered without the direct intervention or delegation of a registered nurse or licensed practical nurse the service is not considered a nursing service." I really just want to reiterate that this needs to be removed. And the reason I say that is first of all, we've already identified our, excuse me, defined skilled nursing as it relates to the Nurse Practice Act in the definitions. There's a lot of problems with this. The first is, who gets to decide whether a service can be safely or effectively performed? Why in the PDN benefit are we defining what isn't a nursing service? And you know, even if a parent has learned how to perform a task effectively, a task effectively and safely, if the task is defined as a nursing task by the Nurse Practice Act or the nursing rules and regulations it's still a nursing service. And so I sort of don't understand why this section is here. And why it ends with, "it is not a nursing service." And again, it's, if a member has a medical need as defined for a service that only a nurse can provide which is defined in various laws that we've already referenced in the definitions, in the definitions then this is de facto a nursing service and it should be covered. | Thank you for sharing your thoughts. The Department revised the language for skilled nursing service to include reference to the Nurse Practice Act. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Pam R. | | 01-11-24 / 00:40:48 | No, I just, I just think that like just to make it clear. A nursing scope exists, like a CNA only has a job because, they're practicing they're doing nursing scope things, right? So as a nurse I'm saying, you know this isn't, this is an assessment, this isn't whatever, I've trained you well enough. I'm comfortable with your critical thinking skills. Whatever, right? But a CNA is only a CNA because they are doing nursing scope. That's it. Like without a nurse there's no CNA. And so I think that, like that gets lost sometimes because literally a CNA is doing a nurse's job that the nurses said you know, what I need you to help me do this part of whatever I've trained you. I believe, but it goes back to that nurse's license then, right? And so these you know home health companies have one director of nursing that's delegating to every CNA in the company, right? And so if I, like that's where I think it gets lost is that people don't… CNA is not a standalone job. A CNA is only a CNA because they are being delegated by their nurse that is to be supervising them and assessing it and that it goes back to a nurse's license because if a CNA screws up, it's not really the CNA's fault. It's a nurse fault. So I think, I think that's where it gets a little gray too because a CNA isn't a CNA without a nurse. | The Department will revise the language of this definition to reference the Nurse Practice Act that includes delegation of responsibilities of the nurse to the CNA. |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 00:41:28 | if this needs to be in here, then it needs to refer to the NPA and the regs, which define delegation. Like the definition here for "skilled nursing", which refers directly to the nurse's judgment. For 8.540.4.C. | The Nurse Practice Act will be added to the skilled nursing service definition. |
| Comment- Phone | | Irina Gorovaya | | 01-11-24 / 00:43:03 | Yes, hi. Just another quick comment, depending on how far we go and dive into the delegation piece. It's also important to remember that the providers have a choice in delegation, right? They're not required to delegate. They may choose to do so, then they have to very clear policy, how the process is going, how to identify staff that we delegate to that are competent in the tasks that we delegating whether it's whole set of rules for that as well. But the agency may say we do not delegate to have how far that goes into the utilization review and maybe assumption of the reviewers. Potentially the feeding could be delegated. But if I'm provider that doesn't delegate how does impact the decision on the part, just another thought. | Thank you. That is correct that agencies or providers have the choice of delegation. This will not change with this rule revision. The proposed change to the definition will include a citation to the Nurse Practice Act and in that Act resides delegation regulations. |
| Question- Phone | | Pam R. | | 01-11-24 / 00:47:58 | When you say like a 60-day transition, what you're saying is somehow that PAR approval is going to transfer to a company for 60 days. While they're doing… | The addition of the PAR transition period was intended to provide time for the new provider to gather adequate documentation to submit a new PAR while still providing services to the member. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Pam R. | | 01-11-24 / 00:48:28 | I guess, I guess my confusion then with that is then what's happening? Is we're just collecting and submitting literally all of the same information. So outside of the 485 right, when KEPRO comes back and says, "Okay now I want another 30 days of notes and I want the newest dietitian stuff and I want the newest GI stuff." Right? It's already stuff that they submitted if they are within a PAR period, right? And so it's just, it's a lot of work. Is there a way to like pull the information minus the 485? Because of 485 and the PAT tool or whatever, really the only things that are different per agency. The documentation for the patient should be the same, within that same period of time. | Thank you for sharing this insight. The Department's goal is to ensure that this process is not overly burdensome for all involved and will use that insight when revising this process in rule. |
| Comment- Phone | | Pam R. | | 01-11-24 / 00:51:43 | I think it's just a little scary too for, I mean if I'm a consumer, right and I'm working with the company that I decide no longer works for me or my family or something happens or whatever, right? And I want to switch agencies. If I, like if I fear that my kids are going to lose services it's going to be very hard and then I may stay in in a toxic situation for my family. Do you know what I'm saying? And I can speak from experience that this happened, right. I transferred one of my kids over, you know her her PAR was not even two months old. It was a permanent PAR. And it, we changed companies. It's literally all we did. She didn't change, there was no major updates in her status, nothing happened and she was denied by almost 50% just because we switched agencies even though she had a PAR for an entire year already, right. And that is mostly since been resolved. But as a consumer if I think that changing agencies is going to jeopardize my children's services I'm not going to do that whether it's working for my family or not, right. | Thank you for sharing your experience, as it adds insight into the actual effect of the process as it is now. This is the goal of the revision is to change this change of provider process so that it does not negatively impact members. Future iterations of the rule will take your comments into consideration. |
| Question- Chat | | Holly Fast | | 01-11-24 / 00:52:12 | It seems the PAR should follow the patient, not the provider. An approved PAR validates necessity of services for the patient regardless of who provides that service. So wouldn't it make more sense to just update the provider - not re-qualify the patient all over? | The Department appreciates the feedback from all stakeholders on this proposed process. After hearing further from stakeholders, the Department will revise the section to indicate that the PAR will follow the member in order to alleviate the administrative burden to both the member and provider. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Question- Phone | | Chris Russell | | 01-11-24 / 00:53:30 | Candace I'm not an expert on this, but would it be possible to… what do other providers think about the idea of if the new provider is not in agreement with the paperwork or with the outcome of the previous PAR, they could redo it? But if they are in agreement with it, and it meets their needs and they agreed that it's appropriate, that they don't have to. Because they shouldn't have to work under something that they don't see. Maybe something is written in there that they're not seeing the same way or I mean they shouldn't have to work under that other thing that they don't agree with. But if everything's the same it would be wonderful to be able to have the PAR follow the person. | The Department appreciates the feedback from all stakeholders on this proposed process. After hearing further from stakeholders, the Department will revise the section to indicate that the PAR will follow the member in order to alleviate the administrative burden to both the member and provider. |
| Comment- Phone | | Pam R. | | 01-11-24 / 00:54:20 | Or to shorten the process by giving the opportunity for an agency to say, “Hey like, we agree with everything except these three interventions. I don't think that's correct.” Or, “There's updated information.” Or like then to have to represent literally everything there. | The Department appreciates the feedback from all stakeholders on this proposed process. After hearing further from stakeholders, the Department will revise the section to indicate that the PAR will follow the member in order to alleviate the administrative burden to both the member and provider. |
| Comment- Chat | | Holly Fast | | 01-11-24 / 00:54:44 | Yes, Chris. The provider should be doing an assessment as well. And as long as they agree, and simple transfer should be sufficient. If they don't agree, then they can request a PAR revision | The Department appreciates the feedback from all stakeholders on this proposed process. After hearing further from stakeholders, the Department will revise the section to indicate that the PAR will follow the member in order to alleviate the administrative burden to both the member and provider. |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 00:54:54 | Because a PAR is a decision about someone's medical necessity, Holly's point is well made. If the medical necessity hasn't changed (because the condition hasn't), it should follow the member. | The Department appreciates the feedback from all stakeholders on this proposed process. After hearing further from stakeholders, the Department will revise the section to indicate that the PAR will follow the member in order to alleviate the administrative burden to both the member and provider. |
| Comment- Phone | | Holly Fast | | 01-11-24 / 00:55:06 | Thank you. So the PAR is really a decision about the medical necessity of the patient. So the PAR really should follow the patient and it shouldn't be independent of the provider. When we accept a new patient we should be doing our own assessment and if we don't agree with that PAR decision then we should be submitting a PAR revision. It should just be a simple transfer and an agreement of services or a revision. | The Department appreciates the feedback from all stakeholders on this proposed process. After hearing further from stakeholders, the Department will revise the section to indicate that the PAR will follow the member in order to alleviate the administrative burden to both the member and provider. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 01-11-24 / 00:57:00 | Hi, I wanted to talk about a different section and I'm sorry to get all lawyer on everyone, but the language here that says, "...completion of PDN tool does not go with the APA…" And I know that I've said this in the past the APA, the Administrative Procedures Act, it requires that if you refer to something you have to fully identify it by citation and date, it has to be available for public inspection, you have to explain where it is. And I know we went through this with the new assessment rule in the summer and the end rule ended up having the algorithm inside it because they realized that it was contrary to the Administrative Procedures Act to even put it in an operational memo and refer to that memo. And so right here, it just says "PDN Tool" it doesn't identify the tool. It doesn't say where you can get it and I just think that that's not going to work for the APA. So I would appreciate it if that could go back to whoever the lawyers are to make that call. But I know for the new assessment they had to really put it in there because the APA is really strict on what you can refer to in the rule without providing. | Thank you for your thoughts. The Department will review the Administrative Procedures Act and will work to identify the PDN tool as required for public inspection. |
| Comment- Chat | | Colby Kostur | | 01-11-24 / 00:57:53 | It would help with workload for the UM provider also | Thank you for your comment. |
| Comment- Phone | | Erica Eisenlauer Drury | | 01-11-24 / 00:59:33 | And sorry, can I just add one more comment to that is that? That is the tool really needs to match the rules and the benefit currently doesn't. The tool, you can't even calculate the total number of hours that are allowed under the benefit for under EPSDT. So just wanted to put that on the record and just say that we hope that the future tool will match the benefit and these rules and they can really be in sync with one another. So that I think to Katie's point, having them be a part of the rule would probably be the best practice in something that would be in line with the APA,but just if it could match the benefit that would be helpful for everybody involved. | Thank you for your comment. The ARPA project related to creating a valid and reliable acuity tool for services such as PDN will take into consideration medical necessity as it relates to the regulations. |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 00:59:51 | https://hcpf.colorado.gov/sites/hcpf/files/HCPF%2C%20FY20%2C%20R-9%20Long%20Term%20Home%20Health%20and%20Private%20Duty%20Nursing%20Acuity%20Tool.pdf In 2019 HCPF said "PDN services are currently requested using an assessment tool that was created to be a temporary pilot tool in 2003 for both adults and pediatric members. This tool is outdated and has not been statistically or clinically validated." It's been outdated for some time. | Thank you for sharing. The existing tool is a resource used to assist providers and the URC in approximating the hours that a member could qualify. The ARPA project's goal is to create a valid and reliable acuity tool to use going forward. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Katie Wallat | | 01-11-24 / 01:02:02 | Yeah, sorry. I was trying to make sure everyone else had a chance so I just don't keep raising my hand. I was just curious what the providers think about the sentence in there that says, "The home health provider should only request services for care outlined in the plan of care and under the PDN and benefit." And the reason I'm asking is in part because I think generally speaking I feel like it's the URC who determines what's allowed or covered, where the home health agency does not. And that it seems like the home health agency's responsibility is to ask for whatever the doctor think is necessary. And we know of many cases where the plan of care isn't enough and you know the URC is saying we need more documentation and so I'm just curious about that and it seems like it's not quite in line with the idea of just ask for EPSDT services, right? Just ask for things and then you know the URC or HCPF can tell you if it's possible. So I personally would change this to you know something like, "Home health agencies should only request PDN services consistent with the plan of care." But I was just curious if if the agencies had other thoughts on that one. | Thank you for your continued engagement. This language will be refined so the intention is clear in what should be requested in the PAR process. |
| Question- Phone | | Erica Eisenlauer Drury | | 01-11-24 / 01:04:15 | account? I'm just trying to think about it, but family requests as well. Because sometimes we have those things where the plan of care will outline a certain number of hours, but maybe a family wants less hours than that. Sometimes of course they want more hours than that. So taking into consideration family requests as well. | Thank you for your question. The agency should be working with the member/family to make sure they are involved in the plan of care that the physician or allowed practitioner has signed. |
| Question- Phone | | Galia Spychalska | | 01-11-24 / 01:05:44 | Well, I just had a question since we're talking about the PAR process. If we were able to integrate or include, because I had to leave for a little bit, if we were able to include, specifically for pediatric PDN PAR, that for however long that certification process was for, either six months or one year, if that was, since we're putting in here that you could do two home health agencies, are we also able to put in this rule that the PDN PAR with that certification period is transferable to another home health agency? Because I feel like our, the staffing is non-existent, right? And so a lot of us have to actually change agencies to even get staffing and so… | Thank you for your question. Members can utilize more than one agency to ensure that the medically necessary hours are staffed appropriately. The Department has also added a process for change of provider so that the members can choose a provider that meets their needs. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 01-11-24 / 01:07:45 | (in response to Candace Bailey's comment) Okay, thank you because that has been a really big struggle for our families. And so that in itself honestly is amazing because that's gonna help a lot of us have the opportunity to change agencies if we needed to for whatever those reasons are. Thank you. | Thank you for sharing your support! |
| Comment- Chat | | Katie Wallat | | 01-11-24 / 01:05:46 | This would undoubtedly require a broader conversation, but it would be great if the member, and not just the HHA, could request reconsideration at 8.540.8.C. We've heard of cases where the member has the documents needed, but the HHA doesn't request them, and the URC denies without those documents. 8.540.8.C.1 re: reconsideration of the URC's denial. | Thank you for this suggestion. It is recommended that the agency work with the member/family when developing the plan of care and, along with that, the outcome of the PAR process, including the results of determinations. |
| Comment- Phone | | Chris Russell | | 01-11-24 / 01:08:15 | Okay um, on the second segment there. I would ask if Katie would be willing to restate her, we have looking at it. Because I don't, I didn't pull out immediately what was different and I, there's a lot to this. But obviously we can't provide any services that would not have a signed order for, so the plan of care must be followed and it must be those services that are requested for those reasons because that's the doctor's order. The part about having this not involve other types of benefits or asking for DME or something supplies, things like that, I think you need to rewrite that part because I didn't pick that up at all from under the PDN benefit. I think you need to say, so that only the PDN benefit is reflected in the PAR request in the PAR. Because I don't think under the, I didn't get that was what you meant when I read it and maybe other people did, but that didn't come to mind. And there you go. | Thank you for this suggestion. This language will be refined so the intention is clear in what should be requested in the PAR process. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Pam R. | | 01-11-24 / 01:09:27 | My comment was just kind of along the same lines. I think you have to, you have to make sure that whatever it is you write, you know because like Chris said, the 485 and the interventions and the care plan or whatever, it is in there. That is the doctor's order, right. And what, you know I think what happens sometimes is when you when you trip up on words like that then you have agencies saying, “Oh KEPRO won't approve that, so we're not going to put that in there.” Even if that's what the child needs, right. And so I think that agencies should be getting information from families and doctors and and submitting them and not worrying about what they think is included in the plan and kind of to the point of I didn't I didn't get either that it was just don't ask for CNA in a PDN PAR. I think it more indicates that agencies are supposed to be worried about what's actually covered as opposed to just submitting and letting the URC do what they do. | Thank you for your continued engagement. This language will be refined so the intention is clear in what should be requested in the PAR process. |
| Comment- Phone | | Katie Wallat | | 01-11-24 / 01:10:44 | Yeah, I just wanted to echo I think Pam said that really well. That's my point in terms of the language for under the PDN benefit. I think the home health agency should be asking for what the child needs and I'm concerned, you know if you're saying that sometimes home health agencies ask for things that aren't under the PDN benefit that maybe indicates that they're not experts on what's under the PDN benefit and I don't think that's their responsibility. It's the URC's responsibility to determine, you know what should be granted. But I think the way this comes across, which I appreciate was not the intent, is that it limits what the home health agencies should be requesting and I think could have a negative effect that we don't want. Thanks. | Thank you for your continued engagement. This language will be refined so the intention is clear in what should be requested in the PAR process. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Galia Spychalska | | 01-11-24 / 01:10:44 | And I echo both Pam and Katie. I think it would be helpful to have something in here that would enable or accurately describe that the URC based on whatever submission of information also has the additional responsibility of stating this member also according to our medical determination and review has these additional services available under their benefits. Because I think, again like I haven't had a nurse in three years, it's just me. I'm exhausted. And if I had the ability to put in for maybe for some with another home health agency for a CNA to just literally let me take a nap, you know I would be eternally grateful. But I think and again just having the home health agencies just put in for this benefit. I think again just having the home health agencies just put in for this benefit I think it would be helpful for the URC to also provide and you know approvals or denials, these are the services that we see based on our medical review or determination that this member may like may also be you know available as an option. And I think that that would be helpful for us as parents to like… and my last thing that I wanted to add on to this part is that continuation of benefits. Only because I was in a nightmare situation as you know and I feel like it's really great to put this in writing, but not putting in a specific process or steps like the home health agency can like they for for as far as statute, as far as I know, they were not able to provide PDN services. Even now the continuation of benefits for that window is in place. They have no power to do that and so I feel like there needs to be a step-by-step process of how to continue those benefits. For that 30- | Thank you for sharing your thoughts. The goal of the APRA project for the development of the acuity tool is to accurately determine what services could be medically necessary for the member in the home. Continuation of benefits is dependent on the situation for the member and it is difficult to capture all situations in this language. The Department will review the proposed language to ensure an understanding of the topic on a generalized level. |

| Source | Topic | Stakeholder(s) | Section of Rules | Date/Meeting Minutes | Comment | HCPF Response |
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| Comment- Phone | | Georgia Daniel | | 01-11-24 / 01:15:06 | Sorry Hi, I was trying to figure out how to get off mute. And so I begin with a very different perspective. So I'm actually from the UK and I've just moved to the US. So this is all new to me. Like PDN service is a completely different but reading the rules as a complete outsider I get what everybody is saying, but I would caveat and say that it makes sense, the in the POC and under the PDN benefit, but I would add that you should provide them with the signposting to be additional services then if they are thinking, hey this person does need a CNA, this patient does need these other care services. But if they're only looking at your PDN laws and regulations, they don't know where to look for those. So if you're signposting them to them that would actually help everybody be on a level playing field and everybody would understand, hey okay this is for this service, but if you need additional services here's where to get them rather than shutting people off with the only for PDN benefits. You would be saying, hey yes just for PDN in this section, but I can help you get to the other sections if needed. | Thank you for sharing your viewpoint. In reviewing the rule, the Department will work to ensure that references are made to other rule sections as appropriate. Additionally, HCPF will work on identifying clarifying sections or frequently asked questions about the rules on the benefits webpage. |
| Comment- Phone | | Galia Spychalska | | 01-11-24 / 01:18:23 | I just want to put into your ear and in HCPF's ear that you know a lot of parents are actually educated and we're stuck at home. And so I think posting some of those positions on a part-time basis and inviting our community to really participate you would have more, a different motivation and a level of commitment to really educating our parents and our you know our community. And I know that sometimes you guys don't think of us in that way, but I think it would be amazing to have like a nursing or a community navigator through HCPF and truly involve our families to be a part of that so that we can not only educate ourselves but educate all of all of us and help us navigate. Because I think you're right. I think there's no responsibility from the home health agencies nor should there be. Like skilled respite, I know that is a thing that's coming up and I have no information about that or who's going to be able to override that, but my God again, I think about naps, I dream about and so it would just be really helpful to have you know people like that that are already part of our community that that could maybe do some of those jobs and I don't know. I'm just putting it out there. | Thank you for your comments. The goal of the Department is to involve all stakeholders in varying capacities of the work to make benefits and programs robust and sustainable. |

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| Comment- Phone | | Galia Spychalska | | 01-11-24 / 01:23:07 | I just wanted to ask this because I've been going to some of the Medical Services Board meetings and I've found that a lot of the rules that HCPF has put in actually don't do a full analysis of the implications of what these rule changes would have on the particular populations that they serve. And so I would just like to ask HCPF to do diligence and follow up with how this is going to affect the current process, and the home health agencies, and the URC, and the cost benefit ratios and all that. So that it it truly shows all of the hard work that you guys have put into this and because I think this is, I'm really really proud of the work that that we've all done over the past year and showing up and being a part of this process and I'm actually I'm happy to support this in Medical Services Board and I never am happy to support anything about it. | Thank you for your support and the Department will revisit the cost-benefit ratios as well implications that the revisions may have on members when presenting to MSB in the upcoming months. |
| Comment- Email | | Robin Ray | | 01-25-24 / 11:11 AM | Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br><br>Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104<br><br>Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |

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| Comment- Email | | Sarah Creech | | 01-25-24 / 11:26 AM | 1.) Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br><br>2.) Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104<br><br>3.) Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |

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| Comment- Email | | Heather Hubbs | | 01-25-24 / 11:28 AM | I would like my input to be considered<br><br>1.) Continuous nursing needs to be removed & replaced with ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous & intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing & providers are not available at all in Colorado for pediatric patients.<br><br>2.) Family/In-Home Caregiver definition needs to be removed, this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in care taker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104<br><br>3.) Technology Dependent definition needs to be changed - a medical device or procedure to assist & maintain vital bodily function which require substantial & ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law<br><br>Heather Hubbs, RN. PDN with Aveanna<br>720720-930-1234 | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |

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| Comment- Email | | Susan Root | | 01-25-24 / 11:38 AM | I am writing to express concerns regarding the PDN rule changes currently under review. These changes would have a detrimental impact on the special needs population and their families.<br><br>These are some areas that I disagree with the ruling:<br>1.) Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br><br>The home health nurse staffing issues for home care patients is huge in pediatric and adult population. Therefore allowing and encouraging parent participation in a paid capacity is essential.<br><br>2.) Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104<br><br>3.) Technology Dependent definition needs to be | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |

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| Comment- Email | | Rachael Sare | | 01-25-24 / 11:41 AM | To whom it may concern;<br><br>1.) Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br><br>2.) Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104<br><br>3.) Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law<br><br>Please act in acknowledgement of the families and lives in some of our most vulnerable populations affected by these decisions. These are real people we're talking | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the CMS definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |

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| Comment- Email | | Cristin Frizell | | 01-25-24 / 12:52 PM | Good afternoon,<br><br>I am writing to you as a nurse who is frustrated with accessibility to family provided home care.<br><br>1.) Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br><br>2.) Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104<br><br>3.) Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the CMS definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |

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| Comment- Email | | Holly Fast | | 01-25-24 / 4:31 PM | Hello,<br><br>I wanted to provide some feedback regarding PDN rule making. I would like to see the following updates:<br><br>1. Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br>2. Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104.<br>3. Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law.<br>4. PARs should follow the patient not the provider. Currently, the nursing shortage is severely impacting the ability of families to both find and keep PDN nurses. In | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting.<br><br>The Department has taken the comments around the new change of provider process that was proposed under advisement and will be moving to the PAR following the member process to relieve the administrative burden on both the member and provider. |

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| Comment- Email | | Deb Bowman | | 01-25-24 / 4:38 PM | Please incorporate the following changes into the Private Duty Nursing Rule Revision 2023:<br><br>1. Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br>2. Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104.<br>3. Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law.<br>4. PARs should follow the patient not the provider. Currently, the nursing shortage is severely impacting the ability of families to both find and keep PDN nurses. In many cases, families must switch agencies just to get PDN needs staffed. This has been problematic because | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting.<br><br>The Department has taken the comments around the new change of provider process that was proposed under advisement and will be moving to the PAR following the member process to relieve the administrative burden on both the member and provider. |

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| Comment- Email | | Debbie Bowman | | 01-25-24 / 4:47 PM | Please incorporate the following changes into the Private Duty Nursing Rule Revision 2023:<br><br>Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br>Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104.<br>Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law.<br>PARs should follow the patient not the provider. Currently, the nursing shortage is severely impacting the ability of families to both find and keep PDN nurses. In many cases, families must switch agencies just to get PDN needs staffed. This has been problematic because with each change of agency, the family must re-qualify | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting.<br><br>The Department has taken the comments around the new change of provider process that was proposed under advisement and will be moving to the PAR following the member process to relieve the administrative burden on both the member and provider. |

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| Comment- Email | | Galia Spychalska | | 01-25-24 / 8:01 PM | Dear Co HCPF,<br>Attached please find my input and outline for the PDN rule for your review..I want to congratulate you on all your hard work on this PDN rule this past year and I want to thank you for diligently taking in all the input from meetings as I am truly proud of having been a part of this process. I am an RN/FNP, a parent caretaker and a fierce family advocate and my voice will always be unapologetically loud and unbiased mixed in with many years of clinical nursing experience and clinical knowledge continuously advocating for our PDN families. Thank you for always allowing for my voice to be heard and for all that you do...<br><br>Please incorporate the following changes into the Private Duty Nursing Rule Revision :<br>Continuous nursing wording to be DELETED and changed to ONGOING-no definition in Colorado regulations currently with the only definitions by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br>Family/In-Home Caregiver definition needs to be DELETED - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting.<br><br>The Department has taken the comments around the new change of provider process that was proposed under advisement and will be moving to the PAR following the member process to relieve the administrative burden on both the member and provider. |
| Comment- Email | | Galia Spychalska | | 01-25-24 / 8:01 PM | PDN Rule Input Document from | Thank you for your thoughtful comments, and your continued engagement in this review process is appreciated. Most of the outlined changes proposed in your comments have been addressed above in response to questions and suggestions made during the Stakeholder Engagement meeting. All language will be reviewed under EPSDT requirements legal authority. This may lead to sections being reorganized to clarify regulations that apply to pediatrics versus adults. Terms used in the proposed new language will be expanded or revised to ensure clear understanding. |

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| Comment- Email | | Katie Wallat | | 01-26-24 / 4:07 PM | I wanted to follow up before the 1/28 deadline to include some comments and edits to the PDN rule draft. I have done so in bulleted form here, using the citations from the drafted posted in January. Please let me know if you have any follow up questions.<br><br>8.540.2.A: There are several grammar issues with this section, which begins with "a member shall be eligible for PDN when the member" but includes "when a member . . . (2) delayed skilled nurse level" and "when a member . . . (4) care are ordered." I suggest changing these as outlined below:<br>8.540.2.A.2: remove entirely (see below)<br>8.540.2.A.4: change to "requires care that is ordered per the physician's . . ."<br>8.540.2.A.2: In addition to the above grammar issues, this portion in particular brings up concerns regarding EPSDT requirements. Because this first (A) section of eligibility applies to all members, regardless of age, the rule cannot limit beyond what is medically necessary based on EPSDT. Care, without which "would result in deterioration of a chronic condition, loss of function, imminent risk of health status. . . or risk of death" improperly limits what a member 20 years old and younger can have access to under EPSDT. See CCR 8.280.4.E, which clearly states the goal is to "achieve or maintain maximum functional capacity", which is a very different standard than the one articulated here. I would | Thank you for your thorough comments, and your continued engagement in this review process is appreciated. Most of the outlined changes proposed in your comments have been addressed above in response to questions and suggestions made during the Stakeholder Engagement meeting.<br><br>Grammatical errors will be reviewed and corrected as appropriate throughout the rule. All language will be reviewed under EPSDT requirements and may be reorganized to clarify regulations that apply to pediatrics versus adults. Terms used in the proposed new language will be expanded or revised to ensure clear understanding.<br><br>Further conversation will need to happen surrounding the role of member/family and agency cooperation in areas such as plan of care development, PAR submission, and appeal process. |

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| Comment- Email | | Ali Maffey | | 01-30-24 / 9:15 AM | Please take the following feedback on the proposed pdn rule. Sorry I'm late on sending this.<br><br>1.) I did email about this one earlier but wanted to suggest a further change: Continuous nursing needs to be deleted and changed to ONGOING-no definition in Colorado regulations the only definitions are by Kepro the URC defining continuous and intermittent nursing. PLTHH intermittent home health nursing services is an identified benefit but is NOT provided by ANY pediatric home health agency in the state of Colorado therefore the service, staffing and providers are not available at all in Colorado for pediatric patients.<br><br>2.) Family/In-Home Caregiver definition needs to be deleted - this definition already exists in multiple areas in Colorado regulations, the state of Colorado cannot delegate or legally force any family/ live-in caretaker to provide private duty nursing services to a member as it violates the Colorado State Nurse Practice Act 12-255-104<br><br>3.) Technology Dependent definition needs to be changed - a medical device or procedure to assist and maintain vital bodily function which require substantial and ongoing nursing care to avert death or further disability, with exceptions for pediatric member population in accordance with EPSDT law | Thank you for your comments.<br><br>HCPF is concerned with straying too far from the State statute and the Federal definition of Private Duty Nursing would change the meaning of the intended definition. Long-term home health is an intermittent, task-based skilled benefit for members to receive medical care in their homes. This state plan benefit is available to all members of all ages. Health First Colorado served 20,891 pediatric members under the LTHH benefit from 9/30/22 to 9/30/23 by 186 providers statewide.<br><br>The Department agrees that the family/in-home caregiver definition needs additional clarification. The proposed language will state that the caregiver is responsible for emergent situations and support when agency staff is absent.<br><br>The Department also agrees with rewording the technology-dependent definition and will utilize the definition developed in cooperation with stakeholders during the meeting. |