



Benefits Collaborative Meeting: EPSDT Personal Care

Monday, February 10, 2014

2:00 p.m. – 4 p.m.

Department of Health Care Policy

225 E 16th Ave, Denver

Notes

Facilitators:

- Kimberley Smith, Benefits Collaborative Manager, Department of Health Care Policy & Financing (HCPF)
- Meredith Henry, Children's Policy Specialist, HCPF

Welcome

Kimberley Smith, Benefits Collaborative Coordinator with the Department of Health Care Policy & Financing (Department) invited participants to introduce themselves and reviewed the ground rules for this and future Benefits Collaborative meetings, they include:

- Tough on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/vibrate
- On the phone: Please mute your line
- Please introduce yourself when asking a question or making a comment

Kimberley provided her contact information Kimberley.smith@state.co.us 303-866-3977, to which participants can address their future questions and suggestions. She also reminded participants that the call is recorded and that the recording and this transcription are both posted to the Benefits Collaborative web site.

Benefits Collaborative Overview

Kimberley then briefly reviewed the concept of a Benefits Collaborative. She explained that the purpose of the Benefits Collaborative is to create a benefit coverage standard, which is the term the Department uses to refer to a benefit policy. She explained that The Benefits Collaborative is a process, not just a meeting or series of collaborative meetings; it begins with the drafting of a policy and becomes standard practice once the Medicaid Director signs it, after much public input.

She asked the group to keep the guiding principles of the Benefits Collaborative in mind: the amount, scope of duration of the benefit should be defined based on 1) what improved the health of clients, 2) whether or not the policy is cost effective and 3) based on evidence-based research and best practices.

Frame for Today's Discussion

1st Kimberley provided a quick overview of recent happenings within the Pediatric Assessment Tool (PAT) Stakeholder Feedback Meetings (which Kimberley referred to as the "Home Health Meetings"), last held on January, 2nd.

She then moved on to the Department's development of a temporary Personal Care Standard, so that there is something in place shortly after the PAT is implemented, to limit possible gaps in service. The Department collected feedback on the temporary standard at the Home Health/PAT Stakeholder Meeting on January 2nd. As she did on January 2nd, Kimberley informed the group that CMS did not give the Department a timeline by when the Department needs to provide personal care but the Department recognizes that time is of the essence. She then repeated that the Department also recognizes that robust stakeholder input is key to the success of any long-term personal care policy solution.

This is the second meeting to discuss the development of the EPSDT Personal Care benefit. At the first meeting (1-13-14) the benefit coverage standard was discussed. Participants looked at the EPSDT Personal Care Benefit Coverage Standard and also the associated Personal Care Assessment Toll (PCAT). Meeting minutes are posted to website. Participants covered most of the document. Kimberley will send out a link to this [website](#). A listening log will also be posted as part of the process. Any unanswered questions from the meeting or any suggestions made to policy will get a line item in the listening log. An official response from the Department will follow. This info will be posted so everyone can see the items as well as the steps being taken in relation to the issue. In addition, emails received regarding policy suggestions will also be included in the listening log. This is to ensure that the bigger conversation is being communicated.

As mentioned above, at the first meeting, most of the benefit coverage standard was covered, but a few sections were not discussed. The first part of this meeting picked up where the first meeting left off. Kimberley reminded the group to keep in mind that, after finishing this review of the standard, the group will still not be done talking about the standard. Kimberley noted that revisions will be made to the draft policy between now and the next meeting. This third meeting is as-yet unscheduled.

Meredith Henry, EPSDT Personal Care Benefit Manager, talked about when to expect revisions to the standard and when the listening log will be on the website. There are 34 questions logged right now. She is currently working to collaborate with people at the Department to get the questions to appropriate staff. Once this is done, responses have to go through the clearance process. Answers to questions should be available in about three weeks. Editing the

benefit coverage standard will be going on simultaneously, so they will be around the same timeline. Revisions and answers should be received in time to review before next meeting. If possible, Meredith would like to get another meeting on the calendar for next month. However, Kimberley is aware that there are many interested parties and 4-5 weeks out may not be enough time. A schedule Doodle may be created to ensure getting as many voices as possible back into the room for reviewing answers and changes made. Kimberley noted that George Lyford with the Colorado Center on Law and Policy wrote a letter with recommendations to the Department that is now posted on the [web](#) for your reference. Provide any further comments via email to Kimberley.

Kimberley explained that there were two objectives for today's meeting:

- 1) Discussion of the last few pages of policy—start at page 20.
- 2) Talk about pediatric personal care assessment tool. This tool is used to determine the level of personal care needs that an individual child may receive.

Kimberley took a step back to provide more context for new meeting participants; to define why the Department is doing this. Recently, the Department revised a Pediatric Assessment Tool for Skilled Choices. CMS mandated that personal care – previously part of this assessment tool – not be provided as part of this assessment. Now the Department is building a separate personal care benefit for children 20 and under, in accordance with EPSDT regulations and wants to do this as quickly as possible to make sure that there aren't any gaps in services – or at least mitigate the gap – so it can be closed as quickly as possible. EPSDT stands for Early Pediatric Screening and Diagnostic Treatment. The goal is to mirror the Pediatric Assessment Tool. The name of the new tool is the Personal Care Assessment Tool, or P-CAT.

Kimberley then paused and asked if there were questions or comments about what she has covered thus far.

COMMENT – Carol Meredith, Executive Director of the Arc of Arapahoe and Douglas Counties, asked: For the people who weren't at the meetings, and can't get minutes until tomorrow, she asked if there were major changes to the draft.

RESPONSE – Kimberley responded that no changes were made, but a series of recommendations were provided. These will be captured in the meeting minutes and the listening log. Kimberley reminded the audience that edits that are made are not the end of the conversation. Dialogue will continue and people will be able to review the changes before the third meeting (that is yet to be schedule). At that meeting the changes that are made will be discussed and explained. People will be asked to give feedback. Whatever the final product, it will be vetted through several other councils, various stakeholders and the state at large. At any time during this process, edits can be made. The process usually takes 6 months, but the Department is trying to proceed as quickly as possible.

Discussion of Personal Care Standard

Discussion started with the Prior Authorization Section (pg. 20). Kimberley explained that the assumption is that people have had a chance to look at the document ahead of time. As such, this is an opportunity to express comments, concerns, questions and suggestions within this section.

A question was raised about the section just above the Prior Authorization Section, concerning supervision:

COMMENT – Marijo Rymer, Executive Director of the Arc of Colorado, stated that her question was in relation to supervision. The section speaks to supervision by an “RN, Clinical Director, and Home Care Manager”. Is that the manager of a licensed home care agency? Is that what this refers to?

RESPONSE – Kimberley stated that she cannot speak to this, and the person who could best speak to this (Guinevere Blodgett) stepped out of the room momentarily. They will come back to this.

COMMENT: Marijo stated that the manager of a home health agency may or may not be a clinician. She is curious about what is meant by this.

RESPONSE – Unattributed commentator stated that you don’t have to have a registered nurse supervise a personal care attendant.

A comment was submitted in relation to this: the intent was to communicate that, if there are three different staff members going into someone’s home, you only have to supervise one of the staff members every 90 days.

COMMENT – Kimberley read the sentence under discussion, “at least one of the assigned personal care staff must be present at the supervisory visits at the supervisory visit”. She asked if the question is that one of those three people be a skilled worker.

RESPONSE – The same commentator responded that that is not correct. He stated that his question was if, when you have three unskilled staff going into the home at different times, you have to supervise one of those three.

COMMENT – Marijo Rymer stated that this is what the sentence states and that it would be impossible to have a skilled worker at every visit.

RESPONSE – Kimberley assured the group that unanswered questions will be addressed and clarification would be sought when Guinevere returns to the meeting.

Kimberley asked that they move on to the Prior Authorization Section. Time was given to look over the section before discussion commenced.

COMMENT – Jose Torres with the Colorado Cross-Disability Coalition wanted to make sure he was on the same page with the Department and the group. He noted that the document states that, when someone’s condition changes, it is required to request a provision in the client’s care plan. He sought clarification on the level of change that would warrant documentation. A child grows fast and he understands the need to document change, but feels that *any* change is a little excessive.

RESPONSE – Kimberley stated that as children grow, their needs change. She sought clarification; she asked Jose if his question was about whether or not one must do this for every little change or something like needing an extra hour of service.

COMMENT – Marijo Rymer noted that, in the document, it does state that a provision is necessary when “a change results in the modification of services”, *not* if they simply grow an inch.

COMMENT – David Bolin with Accent on Independence asked about item number 4 under this section. It talks about two staff people being present for transfers. The unskilled transfer protocol indicates a two man transfer is a *skilled* transfer, which isn’t necessarily personal care. He wants to make sure that what is being said relates strictly to personal care, not melding skilled and unskilled services together.

RESPONSE – Kimberley noted this.

COMMENT – Jose Torres with CCDC stated that one cannot use DME to replace a person for a transfer, you can maybe use a hooyer lift, but that would not replace a person. This is an important need.

RESPONSE – David Bolin clarified that if there was one person there and you need a second person, you can't use PMPM (per member per month) to replace the person.

COMMENT – Kimberley asked how this is related to DME.

RESPONSE – Jose then read the section of the document that refers to two person transfers and reimbursement, which reads:

“When a PAR includes a request for reimbursement for two staff members (excluding supervisory visits) at the same time to perform two-person transfers and/or two persons are needed for a task include documentation supporting the need for two people at the visit and/or the reason adaptive equipment cannot be used instead”.

Various people provided clarification. The purpose of the document is to define the amount, scope and duration of unskilled personal care, therefore, it is unclear if item #4 is needed, as written.

COMMENT – Unattributed commentator stated that the Prior Authorization Section also states Medicaid is the payer of last resort. There is some confusion perhaps with other Benefit Collaboratives. If clients retain personal care through a waiver, the waiver becomes the payer of last resort, not Medicaid. This needs to be clarified because Home Health Agencies were not assessing this and are telling families to go back and get personal care. She doesn't want people to have to go back and forth.

RESPONSE – Kimberley noted her concern.

Question regarding the personal care supervision section was revisited as Guinevere returned to room.

COMMENT – Marijo's question on the meaning of “Home Care Manager” was raised again. When she sees this, she assumes this is a Home Health Agency (HHA). The Prior Authorization Section that follows this section does refer to an HHA.

RESPONSE – Guinevere stated that this depends on the type of agency and care that is being given. Guinevere explained that there are two licensures given by the Colorado Department of Public Health and Environment (CDPHE). Class A is considered “skilled” and can provide many types of care, from nursing down to homemaking. Class B agencies can only provide personal care and homemaking.

So this means that Class A agencies need to send out a clinical director. They need to treat the personal care provider as though they were a certified nurse's

aid (CNA). They need to send out their Clinical Director to supervise. However, if it is a Class B agency, the person providing the service would be the “Home Care Manager”. This is the person who supervises the employee. This is why it is stated this way.

COMMENT – Marijo Rymer felt that this isn’t clear. On page 21, section 3.3 it states HHA, which seems to imply a Class A agency.

RESPONSE – Guinevere stated that it is probably a good idea to use the term “Home Care” for the purpose of this policy. CDPHE groups both Class A and Class B under “Home Care”.

COMMENT – David Bolin related that his organization was recently surveyed as a Class A/B agency and, at that time, he asked the surveyors whether or not personal care is precluded from billing. The response was that, presently, an agency must be an HHA to bill. There is a discrepancy between the two fields because only CDPHE uses the language “Home Care Manager”, Class A agencies do not use this. David continued to relate his story: he asked his surveyors if his agency were to provide services under Class B regs. but billed under Class A, what would they think. They said this is illegal.

RESPONSE – Unattributed commentator interjected that she had a conversation with Elaine on Wednesday that gave opposite directions. This issue will need to be investigated further.

COMMENT – Unattributed commentator stated that Class B agencies almost always have a separate Medicaid number than Class A agencies. Agencies can only bill under the class for which services are provided. Agencies can bill the Class B’s Medicaid number for services that occurred under B. If services were provided under a Class A ID, Class A can be billed. However, you cannot bill services provided in B under A, because Class A is skilled. If a client needs to receive personal care *and* skilled care, they need to have all of their services provided by an agency authorized to bill Class A services.

Commentator also explained that surveyors refer to program objectives to protect use of public dollars. If surveyors see something that indicates to them that an agency billed for services in one class that were actually provided by another class, this indicates a problem and the Medicaid Program integrity Unit is alerted. He stated that no one from Program Integrity was present in the meeting and believed that someone from Program Integrity should be present.

RESPONSE – Participants were then made aware that there indeed was someone from the Program Integrity Unit of the Department at the meeting.

COMMENT – Guinevere stated that she had a meeting with Elaine M. last Wednesday for the Home Care Information Exchange Meeting and this was discussed. The concern

is that you have to bill a completely separate UBO 4 claim. You can't bill it with the same claim you are using to bill skilled services. However, you can follow the rules of the Class B agency, because right now the Department is working on getting the Medicaid Management Information System (MMIS) updated to include this. This is so everyone who is a Class A agency, even those without a Class B license, who wants to provide personal care services, will have to get a provider ID that allows them to bill on the Fifteen Hundred (1500) Claim Form. This is where you bill personal care. She can get Elaine to clarify in writing that, if it needs to be on a separate claim form, or if dealing only with the personal care you are allowed to follow Class B regulations to provide that personal care. And if you are a Class A Agency, they would follow the guidelines of the Class A Agency with the supervisory and care plan requirements.

COMMENT – Dr. Zerzan stated that it would be helpful to put that within the Benefit Coverage Standard as well.

RESPONSE – The Department will have to think on this because, currently, this is a stop gap situation until the MMIS changes occur. The Department doesn't know if it makes sense to put it in the standard permanently, but wants to make sure that somewhere it is easily accessible and that it makes sense.

COMMENT – Unidentified commentator stated that folks will be more comfortable if the Health Department puts it in writing that this is okay. He doesn't think they are concerned what's in the Benefit Coverage Standard.

RESPONSE – David Bolin added to this comment. This doesn't mean as much as when they are being surveyed, but if you have Program Integrity and CDPHE sign off on it in a letter that goes out to providers that we can utilize this, then he think providers would be more apt to provide the service.

COMMENT – Carol Meredith asked to go back to item #4 in this section. She believes she heard a suggestion to remove two (2) person transfers from this section, because two-person transfers would be a skilled service. However, she doesn't want to remove the entire section with regard to two staff members because she can think of situations where two people could be needed. Perhaps two people are need to give a child with a lot of behaviors a bath, or dress them, etc.

RESPONSE – Kimberley noted that this can be found on the next page. It is number 20, where it states:

Two staff (any combination of RN, LPN, CNA, PT, OT, SLP or PCP) from the same or a different agency completing the same task or service for a single client during the same visit, except when two staff are required to safely complete the service or task and there is no other person available to assist.

COMMENT – Carol stated that number 20 is under the Non-covered Services Section.

COMMENT – David Bolin stated that, anytime something is mentioned that you consider a skilled task, it should be removed and not included as something would when a prior authorization is needed for personal care.

RESPONSE – Carol agreed. She recommended using language similar to the language used in item #20 under Non-Covered Services. David agreed that this makes more sense.

COMMENT – Jose stated that number 20 seems to contradict itself. Because RNs, LPNs, CNAs, PTs, OTs, etc. are people who provide skilled services, not unskilled services.

RESPONSE – Department staff have received a lot of questions about if they are allowed to have two staff in the home at the same time. Yes, it is personally reasonable, as long as competing priorities don't exist. For example, as long as you don't have the skilled CNA trying to give a bath at the same time the personal care provider is trying to feed someone. But, if there is a synergy happening, it is fine to have more than one staff member in the home.

COMMENT – Jose stated that this needs to be changed/clarified.

RESPONSE – Kimberley spoke to those that were joining the meeting for the first time. This is not necessarily a new topic. While the Department has not yet made changes to the draft, we previously identified the need throughout the standard to make a lot of changes with regard to the language around two people in the home and what it does and doesn't mean, and these changes will be made. David's point has been captured in the feedback. The Department needs to make sure that whatever we are putting is the standard meshes with other rules and, if it does not, we need to be willing to change those rules.

COMMENT – Julie Farrar with the Colorado Developmental Disabilities Council expressed that she doesn't want to see a situation where we make the changes that make sense to us (to be more efficient) and then somewhere else it can't be operationalized to make it uniform. She wants to figure out what the top document is where the uniform language needs to come from. Otherwise we will have the same problem, where changes are piecemeal and we are piecing together terms that don't match and people misinterpret policy because the wording is very different.

RESPONSE – Kimberley stated that her concern is well received. The Department is drafting a new personal care rule that may be lengthy and may overlap in parts with other rules. Part of what the Department needs to do as we workshop

these revisions is our homework to find out where the overlap lies. And we can come back to the group with those overlaps.

COMMENT – Julie stated that she is less worried about overlap than she is about contradicting policy/rule.

RESPONSE – Guinevere stated that everyone should keep in mind that the Department wants things to mesh as best as possible, however we are talking about an EPSDT state plan benefit, which is not the waiver personal care benefit. So, if we can't get complete agreement of the two, it is not necessarily the end of the world.

COMMENT – Sam Murillo with Family Voices pointed to an error on page 21, number 2, designate needs a “d” for “designated”. Also, number 5 says “medial” and he believes it should be “medical.” Also, in 3.4 he is wondering if that means that backdating is not possible.

RESPONSE – Kimberley read the section he was referring to, “Prior authorization requests that are submitted more than ten (10) business days after a start of care will be dated for services starting with the date the PAR is received by the Department or its designated review entity.”

COMMENT – Unattributed commentator asked if a PAR is submitted nine (9) days ahead of time, is that game?

RESPONSE – Guinevere shared that the general rule has been that you have ten (10) days to give the Department the PAR and as soon as that 11th day arrives, it is considered late. You lose out on those days.

COMMENT – Carol then offered a hypothetical situation: if you change the treatment plan and you submit it in five (5) days, can they go ahead and bill because that's the day of care?

RESPONSE – Guinevere stated that this is correct; if they send it in on day five (5), and something happens, and on day 15 it needs to change, that is fine because it is a revision for a *standing* PAR.

Kimberley asked if anyone on the phone had any further comments or questions on the Prior Authorization Section.

COMMENT – Unattributed comentator had a question about 3.4, where it mentions a PAR being submitted within ten (10) business days. Are these days Monday through Friday? And not the weekend?

RESPONSE – Correct.

The group moved on to discussion of the Non Covered Services Section (pages 21 and 22).

Kimberley gave everyone a minute to review this section. She reminded everyone that the idea of the Non-Covered and General Limitations Section is to call out things that are not part of the covered benefit that individuals might otherwise think are included. It is not an exhaustive list.

COMMENT – Jose Torres with CCDC asked about the minimum age of a caregiver.

RESPONSE – Eighteen (18) years of age is the minimum age for a caregiver.

COMMENT – George Lyford with the Colorado Center on Law and Policy (CCLP) made a general comment that almost all of the items within the section refer to services in different ways. For example, number 4 and 5 refer to services; 6 refers to tasks, 18 refers to personal care or homemaking tasks and 19 says personal care services. They all have subtly different meanings. If this is intentional then that intent should be made clear. If they are supposed to be the same, there should be a uniform term used throughout the document.

RESPONSE – Others agreed.

COMMENT – Marijo Rymer revisited the agency issue: in item number 4 it talks about a “Personal Care Agency”. We need to be clear, there are requirements for a home health agency and a home care agency, and she doesn’t know if personal care is separate, but it needs to be consistent.

RESPONSE – Guinevere responded but the response is not clear on the recording. This observation was noted and answered in the minutes above (page 7).

COMMENT – George Lyford raised a concern: number 18 precludes home health agencies from billing for personal care services if those personal care services are related to a skilled CNA task ordered in a plan of care. What if all of the services ordered in the plan of care are not actually being attended to? This would tie the hands of the personal care provider to come in and fill the void and provide a service, without any kind of amendment to the plan of care. He would like to hear from the home health care providers in the room to see if this is an issue they foresee arising.

RESPONSE – Clarification on the question was given from two participants. One commentator verified that, if a plan of care has both skilled and non-skilled services, but a personal care provider comes in to do non-skilled services, their hands are tied because they are blended on the same plan of care.

Another commentator also verified that, if there are personal care tasks that are being done as part of a skilled visit, then those can't be done separately by a personal care provider.

COMMENT – Guinevere stated that the intent was to communicate that, if you have a skilled visit along with personal care, they should be done together but that personal care providers should not be doing skilled care.

RESPONSE – George Lyford stated that his concern is about the differences between the services that are administered and what is prescribed in the plan of care. So what if the provider isn't administering every service? Number 18, which states that non-covered services include "Personal Care or homemaker tasks that are directly related to a skilled task ordered in a Home Health plan of care", would preclude the personal care worker from coming in and filling that void.

COMMENT – Coral Meredith stated that, it is her understanding, homemaker – with regard to skilled care – is only allowed in conjunction with those tasks, such as bathing and after-cleaning. It would have to be a regular service, like a skilled service or a personal care service.

RESPONSE – Guinevere replied that the wording can be changed to clarify this but that what number 18 is trying to get at is the fact that, if a skilled provider is supposed to bathe the client in the plan of care, they are not supposed to simply leave after the bath is done. They should clean up the towel(s), for example, after the service. So a homemaker/personal care provider shouldn't come in to clean up the towel, because that towel was associated with a skilled task.

Sam Murillo commented that the home health agency providing the skilled services does not do everything and George is wondering if personal care providers are picking up the slack. So, typically we are talking about skilled tasks vs. tasks that a personal care provider does.

COMMENT – George further clarified that he is referring to the personal care tasks that are related to the skilled tasks. He is openly wondering if cleaning up after bathing is not actually performed by providers, even though it is in the care plan.

RESPONSE – Unattributed commentator expressed her understanding that, in practice, the CNA doesn't always do what they were supposed to do.

RESPONSE – Kimberley stated that the Department needs to think more about this item, as it seems it would be hard to enforce either way.

COMMENT – Jose Torres commented on number 17, which states that non-covered services include "Personal Care or homemaker tasks that are directly related to a skilled task ordered in a Home Health plan of care". What does this mean exactly?

RESPONSE – A comment was made about what occurs in practice. Providers do not get reimbursed if they send two people in and one is there for training purposes. A lot of times agencies do pay those people but that is part of the start-up costs when hiring new people. Right now, an agency does not get reimbursed if they send a person in for training.

A suggestion was made to change the language from “sole purpose” to something like “if you want to bill for the service, you have to be providing the service at the time of the visit”.

COMMENT – Jose stated that a lot of the time, when someone is training, they are doing the task but not reimbursed.

RESPONSE – Guinevere added that the odds are that they weren’t doing the task, they were just showing someone else. So we reimburse for that visit, but not for the second person that was learning during that visit.

COMMENT – Carol Meredith asked a question on number 8 “services provided for a person in respite”. It bothered her as worded. She tried to think of a practical application for this item but could not. She offered “so, if I am leaving for work and someone comes in to do personal care for my son, and puts him on the bus for school, is that considered respite, since I’m not there”?

RESPONSE – Guinevere explained that respite is completely different. It is there to enable someone to step in to prevent caregiver burn out. So, if you go see a movie, a respite care worker will come to relieve you. That is not covered. We can put some clarification in there. It might not be a bad idea to define respite.

Kimberley asked if anyone on the phone had further questions/comments about this section. Hearing none, Kimberley then asked if there were any questions or concerns in general.

There was a brief discussion about editing.

Kimberley then stated they would move on to the Definition Section. She noted that it would not be a valuable use of their time to parse through 30+ different definitions of terms, instead, she invited participants to look through the definitions and come to the next meeting with suggestions.

COMMENT – Jose asked a clarifying question on page 22, item 21, which states:

Medicaid is the payer of last resort, except under certain circumstances as defined in the Medicaid provider billing manuals, the Personal Care rules and regulations, the provider bulletins and early intervention services.

RESPONSE – Kimberley stated that it sounds like Medicaid is usually the payer of last resort, but it sounds like there is an exception.

Someone interjected and explained that this is again referring to the issue of waivers being a payer of last resort, as Sheila Peil mentioned earlier.

COMMENT –There needs to be consistency throughout.

The group took a five minute break.

The group then moved on to discussion of the Personal Care Tool, itself.

Discussion of the PCAT Tool

When the group reconvened, Kimberley is turned the meeting over to Meredith Henry, who is the Benefit Manager for this standard. The group was encouraged to continue to send emails

with questions and comments to Kimberley.smith@state.co.us and she will make sure they are documented and answered. Meredith is the policy expert and will be making the changes.

Meredith commented that many of the meeting attendees have worked with the Department through the revisions that were made to the Pediatric Assistance Tool (PAT) for skilled care. This personal care assessment care tool (PCAT) was built off of the PAT tool, so it is going to look very similar. Meredith noted that the Department has not decided how this tool is going to be scored and how we will be assigning hours and is presently working with our utilization contractor. The input of this group on scoring and how hours should be assigned is very important to the Department.

COMMENT – Unidentified commentator asked if there are other states with a benefit standard like this.

RESPONSE – Meredith shared that New Jersey is developing their own version of the personal care tool and she is currently working on getting in contact with Medicaid staff in New Jersey to see what they are doing. This is the only one she knows of, however, if anyone knows of any initiatives, please share.

Meredith began the discussion on page 2 of the tool, as page 1 seemed self-explanatory. She then asked if there were any comments or changes to page 1. No one indicated there were.

COMMENT – Kimberley asked Meredith to take a minute to explain to the people on the phone (who may be new to the discussion) who is going to be filling out this tool and what timeline they will be working under.

RESPONSE – Meredith then referred the question to Guinevere. Guinevere stated that, for Class A only agencies, the tool will need to be filled out by a nurse. For those with a Class B license, the tool will be filled out by the person who creates the plan of care or the personal care task worksheet.

Meredith explained that the Department would particularly appreciate feedback from the group if they see anything that relates more to skilled care, and not personal care, in the tool.

COMMENT – Jose Torres asked if it might be necessary to add “RN” or “LPN” on the first page, instead of “nurse”.

RESPONSE – Guinevere explained that the Department is actually going to call it the “Home Care Manager” because if it is done by a Class B agency, this would fixed.

COMMENT – Unidentified commentator stated that, in the long term, it would be helpful if the Department drafted a letter to doctors who are going to be signing orders

for personal care, because they are medically necessary. Doctors are going to be confused as to why they are now signing this. He believes that a letter on Department letterhead would be helpful.

RESPONSE – This suggestion was noted.

COMMENT – Meredith continued on to the second page. She explained that this page talks about payment source, patient history, diagnosis, and home equipment use. She then asked for feedback.

RESPONSE – Carol Meredith commented that the home equipment listed here is used in conjunction with a skilled visit. So, the Department might want to think about adding other equipment that is not considered skilled.

COMMENT – unidentified commentator asked about the purpose of asking someone to identify “payment source” on page 2.

RESPONSE – Guinevere responded that this was included just to make sure the agencies have double checked to make sure Medicaid is indeed the payer of last resort. At times they have forgotten to ask, or assumed, and this is intended to be a reminder to make sure the client does not have any other insurance.

COMMENT – Jose Torres followed up on that point, asking what would happen if the client had an HMO.

RESPONSE – Guinevere stated that Medicaid would still reimburse what the insurance would not cover, but the Department wants to make sure providers are billing the other insurance first.

COMMENT – Unidentified commentator asked if there is a reason for the word “healthy child” in the notes.

RESPONSE – Guinevere stated that it is supposed to say “typical” but she will check this.

Meredith Henry moved on to page 3: Complexity of Care Modifiers. She stated that the definition herein – regarding a client’s ability to function – was first discussed and defined in the PAT Tool workgroup.

COMMENT – Sheila noted, under “individual characteristics,” she would like to change the wording “lack of ability to cooperate” and perhaps change it to “fully participate.” This is on the bottom of page three (3).

RESPONSE – Carol Meredith commented that the PAT workgroup went over this several times. The inability to cooperate in care is different from an inability to participate. Cooperation gets at people who are combative, etc. She actually likes “lack of ability to cooperate.”

COMMENT– Sheila sees “cooperate” as “compliance”. With someone who is combative, they may have the ability. It is more like the word “compliance”.

RESPONSE – Guinevere stated that the Department is trying to describe when clients have behaviors that interfere with care, without using those words. Instead it is called “level of cooperation”.

Guinevere continued that it is also getting at things beyond safety. Not necessarily fighting, but things like running away. She offered for the Department to do some brainstorming on this.

COMMENT – There was discussion on levels of cooperation and neuromuscular-status. It was asked if the language was a compromise to address when people can’t get their bodies to cooperate.

RESPONSE – Carol Meredith, speaking on behalf of the workgroup that created the PAT language (on which this particular PCAT topic/question was based), stated that, as worded, it was their best thinking that day.

The group moved on to Respiratory Status and Sensory Status (page 4).

COMMENT – Unattributed commentator expressed concern that, if talking about a person who has an unstable airway, this is a skilled care area and doesn’t belong in this assessment tool.

RESPONSE – Guinevere stated that the wording made her a little nervous as well, but she might be overly cautious. She then questioned if the home health providers had anything to add.

COMMENT – Jose Torres stated that he was aware that there are people who are not qualified, or who don’t have the license, but they are very capable of doing personal care, because they have had proper training for a specific client.

RESPONSE – Various people responded that any kind of airway problem that would require supervision for eating, would be considered skilled.

Carol Meredith noted that it is a concern if a client who needs help with their airway was not receiving that help as part of skilled care.

COMMENT – Ryan Zieger asked if there have been cases that have been declined, that have this definition (where clients have not been able to get skilled services).

RESPONSE – Carol suggested asthma might be one of these, not continuous O2 but asthma, perhaps allergies?

COMMENT – David Bolin expressed an earlier concern about these questions being asked by a Home Care Manager or a Class B agency that might not have much in the way of medical training but can provide quality personal care. These questions seem beyond their scope.

COMMENT – Marijo Rymer questioned if “visual status” and “auditory status” is preferable to saying “vision” or “hearing”.

RESPONSE – Guinevere stated that this is a different way of saying the same thing.

COMMENT – Julie Farrar commented that visual and auditory status can also include hypersensitivity. You may want to include this. A lot of people are flooded with information and it might affect their ability to function.

RESPONSE – Guinevere responded that it all goes back to the fact that, medically speaking, we have to know the respiratory status, the gastrointestinal status, and the sensory status and, since this language was carried over directly from the PAT, a lot of medical language and questions still exist in the tool that may need to come out.

COMMENT – Marijo stated that she doesn’t want the personal care provider to think they are expected to do assessments.

RESPONSE – Guinevere agreed this is not something she would want from a Home Care Manager.

COMMENT – Ryan Zieger stated that he thinks that it is a good question but he needs to think through it. Could he hire a non-RN to go out and do these assessments correctly? He then questioned if this is the Department’s intent.

RESPONSE – Guinevere responded that this is *not* the intent. The Department does not want people to operate outside the scope of their practice to do these assessments.

COMMENT – Marijo Rymer stated the reverse can also be true, that there might be an overload issue for people who have been filling out this form. They may think that it precludes their ability to function, when it does not.

RESPONSE – Julie Farrar spoke from experience when talking with parents: there is a big disconnect between what doctors think, what educators think and what home health agencies assess. This disconnect is causing miscommunications to and from families. She does not want to put the home health agencies in a bad situation. Also, the families were feeling left out, not knowing that they could turn in additional recommendations. She wants to be very clear how we communicate and message this with different audiences.

COMMENT – Guinevere wanted to speak to Julie’s point that there is some simplification that can happen throughout all of these modifiers. While, initially, the Class A agencies will take the brunt of this, the goal is that mostly Class B agencies will be providing these services. We want to create a tool that Class B agencies are comfortable using.

RESPONSE –Ryan Zieger sought clarification that it is not the intent to have an RN filling this out in the final product but, rather, that a non RN would fill this out. This was verified.

Kimberley pointed out that she was just made aware that the Department sent out a link to the PCAT tool, however the most current version did not post to that link. Therefore, the people on the phone and in the room were looking at different versions. In order to bring people on the phone into the conversation, the group then began to talk through each question aloud, section by section, starting on page 5.

COMMENT – David Bolin commented that, if the intent is not for a nurse to fill this out, are there references stating that they are able to request more information, as this is something that a Class B agency would never have. This tool is supposed to be talking about unskilled services.

RESPONSE – Guinevere thanked David for this observation and expressed that this is the benefit of having others review the tool.

COMMENT – Sheila Peil, with the Division of Developmental Disabilities, returned to the sensory status section. She thinks the question should be related to sensory integration rather than “how’s your vision” and “how’s your hearing.” Perhaps a clarifying question should be added.

COMMENT – Sue Brown questioned if she heard correctly that this is a non-medical program. So a non-medical person should fill this out? She stated she would have her non-medical person (who would be filling this out) look at it, and provide feedback for the next meeting. But, currently, her agency is not being asked to do evaluations on a lot of these things. They can report whatever the parents or clients themselves say, but this looks very medical to Sue, which confuses her.

RESPONSE – Meredith responded that, because this benefit falls under the purview of EPSDT, people will have to demonstrate a certain level of medical necessity to qualify for this benefit, which is non-medical. This puts the Department in an interesting position, which we are working to navigate, with the group’s assistance.

COMMENT – Sheila Peil stated that, under EPSDT, medical necessity is also contingent upon developmental disabilities so they need to be sure that they capture those where it says “b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability”.

RESPONSE – Guinevere clarified that it is up to the agency. If a Class A/B agency’s practice is to send a nurse out, then they need to follow their policies. The State will not require Class B licensed agencies to send out a nurse to do this assessment. It might be helpful to ask the Class B agencies to look at this and help figure out how to make it understandable and answerable to the home care managers or whomever will be doing these assessments.

Meredith then moved on to page 5: Expressive communication, seizures, pain, and weight. She noted, on number 8, there is the need to change “their” to “his/her.”

COMMENT – Sam Murillo stated that this number 8 looks pretty different from the first version of the PCAT, which had a 2 and 3 rating option (the minimum, moderate to severe rating). He asked why it has been changed.

RESPONSE – Meredith is not aware of why this was taken out and stated it must have been an accident. The Department will fix this.

Kimberley then read the section about seizures aloud.

COMMENT – Jose Torres asked if this assessment has to do with the number of seizures or the severity of the seizure.

RESPONSE – Guinevere responded that the answer should characterize the impact of those seizures. So it can be either/or, as long as it is the impact of the seizure on the care.

COMMENT – Sheila Peil recommended adding a section for cognitive deficits, and deficits due to mental illness, perhaps combining those.

RESPONSE – Carol Meredith was asked to help draft this question.

COMMENT – Unidentified commentator revisited question number 9, and the earlier discussion of distinguishing skilled vs. unskilled care. He wondered if this question is trying to capture the non-skilled part. He has a hard time thinking of a seizure situation that is not medical.

RESPONSE – Guinevere stated to keep in mind that a CNA cannot do anything more than a personal care provider can do for seizures. What this question is getting at is how it impacts the care. Does it take 30 minutes longer because they have to make sure they are constantly padded? It is not how they would intervene, it is how it can impact the delivery of care.

Carol Meredith further stated that all of these are modifiers so because of modifier “a” it is going to take longer.

Meredith moved the conversation to the subject of pain or weight. She then read that section aloud.

COMMENT – A question was asked about the need to include weight as a question with multiple choices. Why can't the number just be reported?

RESPONSE – Meredith explained that this was brought over from the PAT. Guinevere further explained that it gives weight a point value, which translates to care.

The group ended the discussion of the tool on page five (5). To be revisited at the next meeting.

Kimberley asked those who did not receive an email invitation or material from her to please email her, so they can be added to the master invite list for future meetings. Kimberley's future email will include a link to the Benefits Collaborative website where participants can find meeting minutes and also the most up-to-date PCAT. In addition, George Lyford's letter is also on this website. She will be scheduling the next meeting. She will most likely send out a doodle with 3 dates and whichever date the majority of people able to attend, will be chosen.

The meeting adjourned.