

# *Private Duty Nursing Benefits Collaborative*

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Benefits Collaborative Coordinator



**COLORADO**

Department of Health Care  
Policy & Financing

# ***Our Mission***

**Improving** health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**



# ***What is the Benefits Collaborative Process?***



# Benefits Collaborative

## Purpose

Why do we need Benefits Collaborative?

- Clearly define the sufficient amount, scope, or duration of Colorado's Medicaid covered services.
- Ensure covered services are evidence-based and guided by best practices.
- Develop working relationships and collaborate with stakeholders.

## The Process



### Step 1:

- Public Stakeholder Meetings**
- Stakeholders and partners review draft Benefit Coverage Standard (architectural framework).
  - Feedback is provided.

### Step 2:

- Benefit Coverage Standard Revised**
- Engage respondents for feedback, feedback.
  - Make revisions, if necessary.
  - Revisions shared with stakeholders and partners.
  - Additional public meetings are scheduled to review revised draft.

### Step 3:

- Advising Councils Review**
- State Medicaid Advisory Council and Service Advisory Council
  - Children's Advisory Committee

### Step 4:

- Public Comment Period**
- Public notice, announcing open and close dates, is sent to stakeholders and partners.

### Step 5:

- State Medicaid Director Approval**
- Benefit coverage standard reviewed internally.
  - State Medicaid Director signs benefit coverage standard.

## Coverage Determination vs. Medical Necessity:

### Coverage Determination

- An agency policy about what is covered for the entire Colorado Medicaid population.
- Example: Weight Loss surgery is covered by Medicaid.

### Medical Necessity

- Involves authorizing a covered service for an individual Colorado Medicaid client.
- Example: Client must be 1) clinically obese, 2) for at least 2 years, and 3) have made a previous attempt to lose weight.

## What is a Benefit Coverage Standard?

- Identifies what is covered by Colorado Medicaid.
- Issues coverage determinations for the Colorado Medicaid program.

## Objective

### Develop Benefit Coverage Standards

- Objective researchers draft the Benefit Coverage Standards according to evidence-based guidelines and best practices.
- Conduct an extensive review of the medical literature.

## The Format:

- Brief Coverage Statement
- Services Addressed in Other Coverage Standards
- Eligible Providers
- Eligible Places of Service
- Eligible Clients
- Covered Services and Limitations
- Non-Covered Services and General Limitations:
- Requirements
- Billing Guidelines
- Definitions
- References



# Purpose

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# Objective

## Develop Benefit Coverage Standards

- Subject matter experts draft the Benefit Coverage Standards according to evidence-based guidelines and best practices.
- Conduct an extensive review of the medical literature.



# What is a Benefit Coverage Standard?

- Identifies what services are covered by Colorado Medicaid.
- Defines the appropriate amount, scope and duration of a covered service.
- States determination of whether a given service is medically necessary.
- Describes the service.
- Lists who is eligible to provide and receive said service and where.



# The Format:

- Brief Coverage Statement
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### Step 2:

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- Engage respondents for feedback, feedback, and stakeholder reviews, if necessary.
  - Revisions shared with stakeholders and partners.
  - Additional public meetings are scheduled to review revised draft.

### Step 3:

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  - Children's Advisory Committee

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# Step 1:

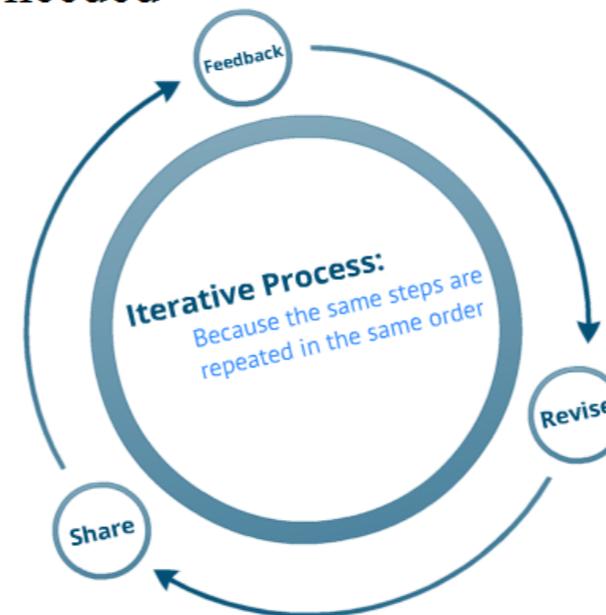
## Public Stakeholder Meetings

- Stakeholders review draft Benefit Coverage Standard
- Feedback is provided

# Step 2:

## Benefit Coverage Standard Revised

- Log and respond to feedback received
- Make revisions, if necessary
- Revisions shared with stakeholders
- Additional public meetings are scheduled to review revised draft if needed



# Step 3:

## Advising Councils Review

- Night MAC (State Medical Assistance and Services Advisory Council)
  - 42 CFR 431.12
- Children's Advisory Committee



# Step 4:

## Public Comment Period

- Public notice, announcing open and close dates, is sent to stakeholders and partners before the open date.

# Step 5:

## State Medicaid Director Approval

- Benefit Coverage Standard reviewed internally
- State Medicaid Director signs  
Benefit Coverage Standard



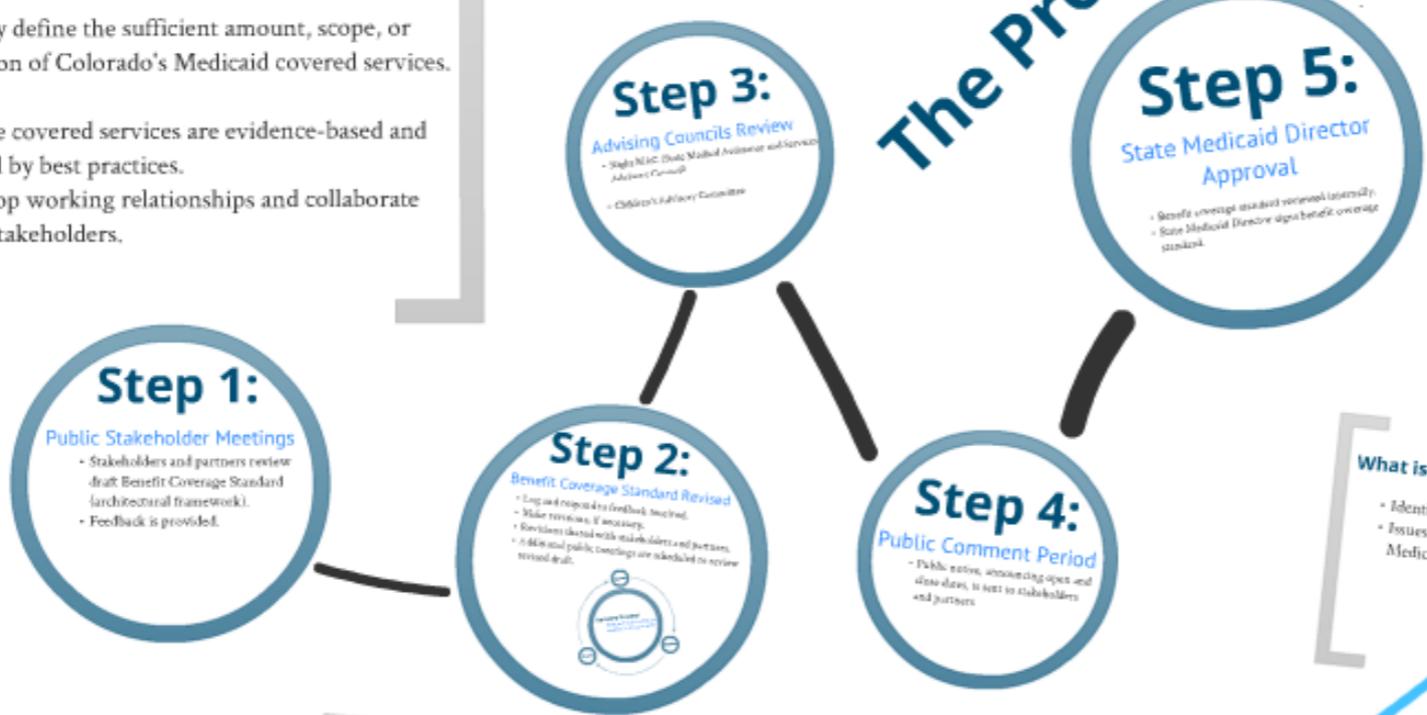
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***What's My Role Here  
Today ?***

***How Do I Participate?***



# Your Role

## Participants Are Consultants

Your role is to provide suggestions for policy improvement based on:

- Evidence based research and data
- Peer reviewed literature
- Knowledge of the population we serve



# Guiding Principles

## Policy Suggestions Adopted Will:

- Be guided by recent clinical research and evidence based best practices, wherever possible.
- Be cost effective and establish reasonable limits upon services.
- Promote the health and functioning of Medicaid clients.



# Guiding Principles

What is meant by “recent clinical research” ?

- A body of research based on consistent clinical results that speaks to the efficacy of a treatment.
- Fields of medicine evolve at different rates. Generally, research is considered “recent” when within the last three years.



# Guiding Principles

What is meant by “evidence based best practice” ?

- Best practices are generally defined by professional organizations, representing practitioners who administer the service(s) in question.
- Best practices are typically derived from the type of clinical research already mentioned.



# Guiding Principles

## What is meant by “cost effective” ?

- A service must be effective in relation to its cost.
  - Example: the cost of providing Breast and Cervical Cancer Screening to all clients with a family history is offset by the effectiveness of early detection and the money saved through prevention.

## What “cost effective” does not mean:

- Cost effective does not mean cheap or ineffective.



# Our Role

- To seek out the feedback of the population we serve and those that support them.
- To implement suggested improvements that meet the collaborative's guiding principles.
- To foster understanding in the community about how policy is developing, and why.



# Ground Rules

## Participants Are Asked To:

- Mind E-manners
- Identify Yourself
- Speak Up Here & Share The Air
- Listen for Understanding
- Stay Solution Focused
- Stay Scope Focused



# *Private Duty Nursing*

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# Review: Feedback from 2/20/2015 Listening Session

- In February, the Department hosted a listening session to explore the possibility of limiting the PDN benefit to vent-dependent clients only, and asked for your feedback on what that policy change would mean.
- As a result of the feedback received, the Department is not proposing that the benefit be limited to vent-only clients.
- The draft policy under discussion today is provider-generated and contains no significant policy changes.



# *Proposed Policy*



# Private Duty Nursing (PDN) Eligibility

Members who receive PDN services must be:

- Technology-dependent
- Medically stable
- Able to be safely managed in the home
- Not residing in a nursing home
- Eligible for Medicaid



# PDN Eligibility (continued)

- Able to meet one of the following medical criteria:
  - ✓ Need PDN while on a mechanical ventilator; **or**
  - ✓ Need PDN for ventilator weaning; **or**
  - ✓ Pediatric member need PDN after tracheostomy decannulation to stabilize patient; **or**
  - ✓ Pediatric member need PDN while on C-PAP; **or**
  - ✓ Pediatric member need PDN for oxygen administration only if there is documentation of rapid desaturation (below 85% within 15-20 minutes) without oxygen; **or**
  - ✓ Pediatric member with prolonged intravenous infusions including TPN, fluids, and medications



# What's New

## (i.e. not currently in rule)?

Refer to the *What's New* handout

### Highlights:

#### ➤ General Requirements

- Covered services are now defined in their own section
- Duration of services specified
- Scope/severity of clients' needs specified

#### ➤ Plan of Care Requirements

- Adds Plan of Care language from the Home Health BCS
  - For example, Services must be ordered, in writing, by the client's Attending Physician on a HCFA-485, or a form identical in content.



# What's New (i.e. not currently in rule)?

Highlights (continued):

- Non-Covered Services and General Limitations
  - Adds language to align with HH BCS indicating that Home Health services cannot be used in a shift-nursing manner to circumvent the daily maximums under the PDN benefit.



# *Discussion*



*Thank You*



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