[Please stand by for realtime captions] >>
[Silence] >> [Microphone feedback]
>> [Silence] >> [Microphone feedback]
>> Hello?

Hello?

Hey. Is this Chris?

They must not have started yet.

I am one of the board members, one of the pediatricians calling in.

Hello.

Nice to meet you. I am sure they are trying to get everything situation. I heard noise and thought I would check in.

I got you. I was not sure what the echoing was.

I am not sure either. I have been muting myself to make sure it is not our line but I know sometimes hooking up outside the building is more challenging. Are you guys having a gorgeous fall day up there?

It is beautiful out this way.

It is nice down here and nicer for my family in my -- North Carolina on the coast. We are waiting to see how our house survived. We have family beach house on the North Carolina -- border.
>> I am sending them warm wishes and hope everything comes through okay. It seems like a difficult situation right now. >> Yes, it is a big storm and unfortunate for sure for some of those folks that did not evacuate. We have a house on the barrier islands and everyone left.

That is the most important part, I think.

Yeah, the other stuff is just stuff.

I will put myself on mute . I suspect they are trying to work through stuff on their end and hopefully we will get audio from the room before too long.

Perfect.

Good chatting with you.

Yeah, have a good day. Goodbye.

Goodbye.

[Silence]

This is Kelly O'Brien. I am working with Chris Sikes to make sure we have audio. Is there decent audio currently? Can people hear me okay?

This is Dr. Fraley. I can hear you well.

Wonderful, Chris is working to get the audio connected on the webinar room and then we will get -- we will move forward on the meeting. Thank you for your patience.

Yeah, thank you guys for doing this.

You bet.

[Silence]
>>> You can listen to the hearing from your home or office. There are obligations to make the content of the meeting available, but to participate, we do not have people jumping in to testify.

Did not realize you would do that.

The question came from communications. We are limiting testimonies by U.S. mail letter versus email . I need clarification.

Currently, as it stands, just so you know, I confirmed with Kelly about the microphone.
Individuals can submit written testimony. They can do snail mail. It [Indiscernible] -- [Indiscernible] --

Testing, testing, testing. [Echo]

[Indiscernible] [Indiscernible]

[Silence] we are still waiting, people.

The echo literally --

Testing, can you all here is?

Yes, we can hear you, Kristi. This is a seal. -- This is
Cecile.

We will still start this meeting now.

I don't know --

I have one.

We can share.

We are right now in this room receiving a letter from Colorado Hospital Association in print. The committee has had communication while we are out here in beautiful Ray, Colorado, amazing, amazing interns, helping find us do these things. We appreciate her. I am going to call this meeting to order and we are going to do roll call, I think. All right? I think I am present.

I am here.

Cecile Fraley?

Here and unmuted and muted again. Thank you.

Patricia Givens? Simon? Jessica? Amanda? Charlie? David? Donna?

I am going to make the announcement that the date and location of the next meeting, the next one is scheduled to be held Friday, October 12 2018, beginning at 9 AM at the 11th floor, conference from -- I do not need to read that because this room is not the 105 capacity -- we do say turn off cell phones but we do not have service here. I would accept the notion for approval of a minute on August 10th.

I am going to ask -- corrections -- [Indiscernible] .

It will be corrected in the minutes.

I did not. I figured you would put it on record.

There was a typo in the minutes somewhere. I do not remember exactly where.

There is a typo and Chris has been made aware of it. The discussion we had around medication was not written at all on the minutes . It is not documented and I was concerned about that and had a question . Am I allowed? Am I allowed to ask to go back to the minute, the notes of the recording, and pull that information so it is recorded in the minutes?

Yes.

I asked Jennifer -- she responded for those of you on the phone who cannot see us, solid ask for that amendment to the minutes for that meeting. I would entertain a motion -- I would enter emotion and put it on the table .

Okay, all right, perfect. We will go on. Now we are on to adoptions for the agenda. We have five documents --'s -- six documents. I would entertain a motion -- who wants to read it?

I will.

Thank you.

The final adoption -- this is of 18-05-25-A. This supports HCBS Section 8.491 .

Document three, 18-06-20-B , provision concerning immunization benefits, Section 8.815 , document 18-03-07-A , provision to the medical assistance rule concerning pharmacists over-the-counter prescription authority, Section 8.800, then 18-06-12-A , with Section 8.100.3.G and Section 8.100.4.G and then provisions concerning income verification for continuing coverage, Section 8.100.3. We have a motion from Robert.

Thank you for doing that. That was wonderful. All in favor?

Yes.

Thank you, doctor.

We are now going to move on to the initial approval agenda and we are looking at documents seven. Who is talking to us today for document seven? Are you on the phone?

Yes, I am on the phone can you hear me?

Yes, can you use your outside voice?

Is this better?

Thank you very much. We appreciate that. You're looking marvelous today.

As are you. [Laugh]

I would not go that far.

We have humor in the room. Introduce yourself and talk to us about this rule.

Thank you, good morning Madame President and board members. Thank you for your time. My name is Jennifer Vancleave and IM the general eligibility policy specialist for the department. I am presenting a change to medical assistance eligibility rules concerning redetermination's of eligibility and transferring requirements. Currently, the rules guide individuals to review a user reference guide to consider timeline requirements when transferring a case to another county as well as processing eligibility redetermination's. However, the user reference guide is no longer used by the departments
and the deletion of the obsolete reference is needed to comply with an audit finding. The removal of the language, please remove the department user reference guide for timelines, will not change how eligibility is determined or who would be determined eligible. There are no cost to the department or any other agency as the update only removes language that refers to an obsolete dock -- document. Additionally, in this document, they indicate that documents received in relation to eligibility redetermination must be thoroughly reviewed within 10 working days. There are also 10 other training documents and processing guidance in place and eligibility have cases reviewed for timely processing of applications, redetermination and other changes. For the rule change, it will reduce redundancy and if it is not updated, the department will remain about -- out of compliance. They want to think: dignity health network for their feedback on the change and want to acknowledge the Attorney General's office for their review and approval of this policy change. Are there any questions I can answer?

Any questions? I see none here. Do you have any questions, Dr. Fraley?

None, thank you.

I see none here. We have no public testimony. I did not see anybody walk into the room.
Thank you very much. I appreciate that. We do not have any public testimony, so with that I would entertain a motion for the initial document seven [Audio cutting in and out] eligibility and transferring requirements, Section 8.100.3 [Indiscernible].

I have a motion. All in favor?

Yes.

Yes.

Opposed? Thank you, post -- sustained. The motion passes. We are on to document eight, a revision to the medical assistance rule and it is Russell Sigler, but I also have Richard Delaney here. Good morning.

Good morning.

Thank you, this is Russell from the department. He will be presenting this for the department.

Okay, but may I say you are looking very nice today?

You all as well. [Laugh]

I have been advised that I need to recuse myself.

Did you tell the people on the phone who you are?

I am Dr. Gibbons. [Indiscernible] discussion and debate.

You are recusing yourself from the boat? -- From the vote ?

[Indiscernible]

I think that is better.
I am serious.

Technicality is for facial expression, just could not say anything , somebody was asked for an opinion. We get this all the time.

My feeling is you should stay. You have done this yourself.

I would agree.

This --
this is a judicial setting, so there are a lot of rules we have to adhere to otherwise we can be challenged on the decision and we have to go back and start all over again. Be careful of the latitude you want to expand this.

She is recusing from -- she should not be risk used -- recused from the discussion. In the past, with the company, increasing rates, there was a direct conflict and they participate. So Dr. Gibbons has a motion to understand what is going on in the room. She has been recused from the vote in the conversation on this. We are not to the point of Mr. Delaney, would you please talk to us about this rule? >> Good morning, Madame President and board members, my name is Richard Delaney and I am a policy specialist for the department of finance. I am here to present this rule , Section 8.320, concerning community clinics and emergency centers.
I will give you some background about how we got here today. This goes back to the revalidation and enrollment locations of providers, which is a federal requirement and the department was behind on that until we got our new one up and running and then we started enrollment at each location and provided services to many. Our rules were to be enrolled . We started getting enrollment from locations , at hospitals, [Indiscernible]. They would have their application and you would review the enrollment and determine that the license did not meet our

definition of a hospital in our rules -- and our rules. So we published a bulletin article saying any entity with this has to enroll at an office, a provider. They don't get -- [Indiscernible]. This caused something in the community

and we had a special bulletin allowing the locations to continue to provide and get paid for outreach , for facility services, with the idea that we would work on finding out a way to get them into our rules and appropriately pay them. We are in a gray area right now. We are paying providers but it is not in our rules of their hospital -- if they are hospital. We have the special bulletin and we started working on the issue, we had a meeting , stakeholder meeting with hospitals and lawmakers and other parties and our intent at that time was to submit estate plan amendment to cover -- a state plan amendment to cover providers, different than outpatient service records, a professional provider, we could put our own payment methodologies into the clinic service provider types. We had to duplicate the hospital provider. And then we met with CMS and had an informal discussion about this approach. At that time, CMS informed us that their policy is a clinic service provider cannot be part of a hospital and we were using in our rule, car proposed -- in our rule, that [Indiscernible] certified as part of a hospital by Medicare . If we are certifying it as a hospital, cannot be in our services. That is their rule.

>> A clinic cannot be a hospital?

>> The location that is certified as a hospital by Medicaid cannot enroll under clinic services. That is a term -- they have to be an outpatient hospital or hospital provider.

So CMS told us we cannot use the clinic service provider. We went back and we look at our a let -- plan and redrafted the rule to make them an outpatient hospital provider and use the authority of the outpatient hospital provider type or the services of the state plan to get them on the map and that is why we're bringing this rule today. In December, they indicated they would move in this direction. The current accommodation we made allows them to build these services as a hospital, it is still in place until we can get a provider type in rule that covers this license. It continues in hospital . So that is where we are today. The background of the rule as it proposes that to the Medicaid program. It creates a provider type locations

of certain characteristics, which we have here, their licensed as certain kinds -- they are -- they have certain licenses, and there are locations that have -- they're not affiliated with hospitals and some departments will tell you these locations are not regularly inspected or public health safety protected. So we are uncomfortable treating them as a facility. We will tell them that their professional fee services, but

the definition of a provider type is that and one of the things about this enrollment is that it will allow Medicare crossover --

[Indiscernible] crossover and that is one of the issues that we had in the stakeholder meeting . We were talking about creating a new payment services , that they are enrolled in Medicare and they have an outpatient process. They would have to manipulate the claims in their billing systems correctly with a provider type that we create here. That will be changed like any other outpatient clinic. The rule does not cover inpatient services provided at these locations. Overnight stages, they will be paid for observation stay. It is outpatient hospital

services -- those are at issue. An outpatient hospital -- they are called off-campus locations, where they run -- it is not on the main campus. These are off-campus locations. They can render those services, and they are considered entities, off-campus locations -- that is in the definition of a hospital. They are selected and Medicaid certified. It is in -- impacted that way. We want to be clear this does not restrict enrollment of entities that hold this to that provider type. This is specific to those who hold the license and are certified to that hospital. There are entities that hold this license, and we are not -- we found out during this rule that mental health services also received community reform. They have treatment facilities and clinics and this rule will not require that license to enroll as this provider type or restrict them because they're not hospital enrolled. They can and role as Medicaid -- they can enroll as Medicaid. You can see stakeholder input on this new role. The original one had 24 hours of observation . This language has changed to match exactly what is included in the outpatient hospital rule, which is up to 48 hour outpatients . If it takes longer than 48 hours, will not pay for it in excess of 48 hours. The original language use the phrase to care certified or owned by a hospital -- used the phrase murder care -- Medicare certified or owned by hospital. If they determine they want to certify each license holder as an independent facility, our rule will not accommodate that because it is Medicare certified or by hospital. If Medicare makes a change, we will revisit our rule. The request -- we had a request to cover facility services and entities not owned by hospitals. It was more informational requests. They recognized it was not part of this. They wanted us to consider that and we are. We are working with the department -- with the environment on the certification of public safety issues relating to this. When they get their license, they are inspected by the health department, only at the time they receive their license. No other follow-up inspection on regulars Jewel is needed. -- Regular schedule is needed. We feel there should be more inspection of these facilities before we consider this. The other facilities, [Indiscernible] inspected on a regular basis and we are working with the health department on their licensing and if they do develop some sort of routine licensing , we are happy to include them as a facility provider. We can probably put them on hold -- put them in the clinic services that way. We will be able to . They have been changing the emergency definition. They wanted us to use a prudent person standard of emergency. This definition duplicates the same definition found in a hospital rule. We felt it would have confusion if we had two different definitions, so we declined to do that. We were reviewing what they propose to -- it did not appear it would change coverage at this location. Our coverage is if a present what they deem as emergency conditions, we would cover that. We do not do -- we do not determine emergency claims. We declined to offer or change the definition of emergencies . I suppose [Indiscernible] emergency services , changing our definition, but right now changing the definition would not affect payment or coverage or emergency services at this location or outpatient hospital location. Finally, children's hospital requested that they cover inpatient services for locations. This does not cover that with this provider type. [Indiscernible] Medicaid is unaware that there was any inpatient services deemed that at those locations. Children's hospital does not use specific locations to build their

services. They bill all their services from the main hospital ID, so when the claim comes in as an inpatient claim, they say it's the main hospital ID. It is invalid. In fact, the Broomfield campus, which is a community clinic, it's not an emergency center, it is not enrolled in Medicaid until February this year, so when this came up in hour sessions with stakeholders, they were surprised that there were entities delivering services at these clinics. They identified two locations that they were providing inpatient services at one was in the Broomfield campus and the other one was in the uptown campus, which is a community clinic and emergency center. They are providing inpatient services at these locations, particularly in the respiratory virus in order to maintain the locations. They have community clinics and emergency centers. So here is the rulemaking process. We have reviewed Medicare policy, the rules and have had discussions with [Indiscernible] facilities. This investigation led us to the conclusion that only outpatient services should be covered at facilities like this emergency center. As a side note -- what is called an emergency is an outpatient hospital visit. They have been treated in the billing system and paid. When you go to an emergency room, even at a hospital, it is submitted to us as an outpatient hospital clinic. If you receive emergency services off-campus or at a community clinic center, under this new role, it will be billed as an outpatient hospital service. So make this determination. It is with Medicare. Medicare will pay locations with off-campus locations when owned by the hospital.

Could you repeat that?

Medicare will pay locations [Indiscernible] as an off-campus location of a hospital when it is owned and certified by hospital. Medicare certified hospitals are identified in a different department. They can identify off-campus and Medicare is determined if you hold a license you can be identified as an off-campus location of a possible. They will -- of a hospital. They cannot provide -- they cannot pay inpatient service.

For clarification, if I can get this out --

This is a very complex thing and there are a lot of players. Just so we understand your confusion.

The hospital has an off-site campus, a satellite location , and it had to be either a CCE or -- you are shaking your head no. It does not have to be one of the two that we are talking about here? Then what more is there? Whatever definitions are there for a satellite -- what other definitions are there for a satellite location?

It can be off-campus locations, which is part of the hospital license, and it has certain criteria and characteristics of who can be a hospital license that they issue. They issue a license to a hospital and put an addendum which identifies all the off-campus locations affiliated with that hospital. This is not listed as an off-campus

location of a hospital in the licensing. And has a separate license type -- it has a separate license type from other entities.

Okay.

>> You are suggesting to add a category to better track some of the billing, you have -- you have that category between Medicare and the Department of health and environment -- so far, so good? And then this is for better tracking? Is that my understanding?

You need the holder in our rules in order to pay them. They are not licensed as a hospital. >> My understanding is Medicaid is paying them now under [Indiscernible] to allow observations . Observations -- it could be ER, we are painfully familiar with the emergency room and what happens. So I am curious, what are the options available because this is not an illegal act under a waiver. We tried to -- we wanted to create something and we got permission and we got a waiver and now it appears Medicaid is frustrated with what is happening and I am wondering what the options are now and 48 hours -- is not the only option or is 72 hours an option because knowing those types of emergency situations, the difference between 24 and 48 and 72 is massive and it can depend on the reality of patient care. Why does it need to be the way it is written at this moment? I do not understand that.

This is Richard. The reason -- the reason is our payment methodology, which is in our state agreement , is we have limiting observation stages in 48 hours. That is what will pay for, up to 48 hours. We are using that outpatient payment authority , the payment authority and methodology, to enroll these providers so we cannot go beyond what is in our current state plan. In order to -- it would take an amendment to R payment methodology -- to our payment methodology to expend -- extends the time.

Currently, it is 23 hours ?

Our state time authority allows us to pay for observations up to 48 hours. We are using that outpatient services money, the payment methodology, applied to this provider type . The observation stage is in the hospital setting. I apologize -- the hospital staff [Indiscernible] 48 hour observation stage. >> In my mind, I am curious where they are on this. Can they bring life to the issues? I am concerned about the care. Those things are in my brain right now and I'm putting that out on the table. Go ahead.

Know how -- this is Gretchen. I appreciate those concerns. I think everything here, we've got a lot of testimony submitted to the public process. There are couple things to sort through. Of course, we have long been and you have all helped us in many ways in our rules to allow providers who are enrolled in Medicaid to have a similar regulatory framework with what they are allowed to do at the division , you might recall we did that with the public health nurses, and that they could be practicing independently without a physician , running immunization clinics. We aligned those rules similarly. We have lined rules with the department of public health and environments. We are aligning our rules

with the department of public health and environment. This is facilities licensed by the -- that we do not have provider type in our system for them to enroll as. This rule is trying to create that path for enrollment. In doing so, we are aligning with the rule that allows for observation stage -- stay in the clinics and we are willing to pay for those observations days as an outpatient stay. It is allowed under the rules and we are willing to pay for that. There is alignment between health welfare and safety, which is the jurisdiction of that department

and our way we are trying to get providers to enroll with us and to then pay in alignment. Because this part of the room we are putting this provider type in his outpatient hospital, that is what we are able to in observation stays are always billed, as you described, as outpatient stays. It is an observation stay. That is what this will proposes and would align with that payment to happen. It is also my understanding that individuals -- this will have an extension for segments. This does not apply to their main hospital campus. This -- it is my understanding it has to be clarify that there are six beds impacted by this.

You are talking impact -- you are talking about the impact of this rule if -- it is not other parts of the state, especially rural communities, where we are losing more beds? Is that what you are telling me?

This rule would allow anybody who chooses to, who needs desk to meet this definition, -- meets this division -- definition to operate as a CC or CCE to bill us for services provided and if they have the ability through the license to allow for observations days, to a is for those. -- To bill us for those.

That is correct, the discrepancy between the rule in our coverage is that they will allow under certain circumstances observation stays at these locations . They have similar protection. Medicaid will only pay for 40 hour observations. -- 48 hour observations. That is on campus.

Are there -- [Indiscernible] -- we have -- [Indiscernible].

To pay for additional time beyond 48 hours, we require a statement and payment methodology.

That would impact beds. That would have a different impact in every hospital . It would be very different.

This is Kristi. I look at this through several lenses. One of my concerns is in access of care, especially with mental health at this point because we do not have enough of that service in the state. Does this have anything to do -- the reasoning for doing this is to carveout the standalone ERs? Does that have anything to do with that or is that not a part of this? Do you know what I mean?

This is Richard and it will allow some of these standalone ERs to enroll as a provider and say this is a -- an outpatient hospital. There are 60 entities that have these kinds of licenses. Most of them are owned by hospitals and initiatives. They are providing outpatient services at these locations currently. The only provider that has indicated they are providing inpatient service is children's hospital. This will allow those entities that hold those licenses some of the entities you see [Indiscernible] are outpatient hospital locations, provider types to give us authority to pay those outpatient hospital services . Right now, we will [Audio cutting in and out] have any authority to do that. So the pre-standing emergency risk -- do not provide inpatient services.

Are there any other questions from the committee?

[Indiscernible] I am trying to understand why to provide inpatient services because they're not enough beds at the hospital. They are getting their patient --

Help me understand that.

There are not enough beds and also -- they might come in with the ER mindset , that their reevaluating and trying to treat and get them out in. Of hours that's a period of hours and there are some cases where you need more time -- get them out in a period of hours and there are cases where you need more time. If it is far away, depending on the location, we have family that has to travel further, especially children, it is a nightmare.

[Indiscernible] .

Webers on the phone, can you meet yourself?

Yeah, thank you. There is a lot of background noise. Thank you so much, Kristi.

I guess part of the question -- [Indiscernible] -- because of the waiver under that, the question is can we do this -- I question why that is. Doesn't mean -- does that mean they will not take Medicaid? [Audio cutting in and out] figure out a way to make things stuff happen 100%?

Is this Robert?

[Indiscernible]

Excuse me, this is Dr. Fraley. Whoever is on the phone booking a medical appointment, can you please mute your phone? It is really difficult to hear. Thank you.

Thank you, Dr. Fraley. We could not identify who it was. >> [Indiscernible] the Highlands Ranch campus is licensed as a hospital. The Parker location -- it is licensed as a unit of their main campus.
They indicate they are changing the licensors for the situation. [Indiscernible] .

You had a question? >> I am trying [Audio cutting in and out] -- hold up. We have so much noise on this phone. Did you mood everybody -- did you mute everybody?

We are muting all the phones so that people can hear.

There is no one now.

We're waiting for all lines muted

All guests have been muted.

Now -- Robert, speak up a little bit more and everybody will be so much more happy. Thank you.

My question is when does this -- will this allow [Indiscernible] campus to come in or will we be able to or is there another entity that has to get licensure? Apparently, from my understanding come to get that okay, we have two be -- you have to have Medicaid license . They had an agreement . They will not allow that. They should be able to.
>> I am not sure why they ruled that in 2018 this year. We were unaware that they were providing inpatient services at that location. They provided claims from this location , that they were inpatient claims, and they reported -- they provided 123 inpatient ones at this location in 2017. That is not discernible from the claims. They're coming from the hospital location. So you are treating -- you are paying their claims as a hospital claim. They were not enrolled -- that location was not enrolled as a hospital at all. When they tried to enroll, we rejected enrollments with facilities like that one , that hospital provider type because of our rules. We have been providing inpatient services for many years but it is unknown to the department that they were doing it. We were -- we more or less understood this was being run at this location -- not as an inpatient facility. [Audio cutting in and out] provider type to provide observations. The rule today is going to be effective October 30. They cannot change their licensure status. By enacting this rule, basically, it is ending the practice of inpatient stage at that campus. They continue to pay for overnight stays as observation stays up to 48 hours.

Did you want --

That was all I would clarify. We are not suggesting you will not pay for the observations day. We will pay as Medicare payment policy and Medicaid allows us to.

Okay, I have one more question and then if anybody else -- what if we do not do this? What would be the downside of not making this change?

This is Richard Delaney. The downside is deferment of all the payments to facilities located at these locations because we don't have [Indiscernible]. We have upgraded since October 2016. It is a risk we are not willing -- we do not desire to continue that risk. The payments we have made to entities like them -- you risk that. Some hospitals do use claims differently. We could identify them and CMS -- they hold us to our rules, which is defining hospitals as entity licenses and not as an -- they could say we were in error , paying for hospital services at these locations, which would not be our definition of a hospital. We are in a potential deferment issue for close to two years. We went desperately want to resolve that.

Any other questions -- we want to resolve that.

Any other questions? We do have public testimony. We have Linda Michael.

[Indiscernible]

I am so sorry. You are welcome to sit. I got caught up in questions.

It is my bad. I missed that.

One of the issues that was brought up -- the licenses . I have the rule -- it is referred to how they license . The rule -- although they were created with public health and welfare and safety in mind and not reimbursement, their relevant to the department -- they are relevant to the department. It should be covered as a licensed facility. The license does use the term inpatient beds, which states [Indiscernible]. They have stated that the beds should be compared to observation hospitals. They ruled that it is for the provision of extended observation and other related services up to 72 hours. That is chapter 9 . The -- they rule [Indiscernible] . The definition of community clinics is a healthcare facility that provides healthcare services on a certain basis . The services are mandatory . They ruled specifically that they are not allowed to accommodate inpatient overflow from another facility under the rules , they are not licensed as inpatient providers. They do not survey -- [Audio cutting in and out] license . When Medicare is part of a hospital, they treat them as off-campus locations which cannot provide inpatient services. To review, Children's Hospital includes locations [Indiscernible] . They have identified six beds at the North

campus. They indicate they are over 123 Medicaid inpatient locations. They also identified 62 .

These locations cover overnight states locations.

Medicare does not cover inpatient services at locations. The rule identifies the services as outpatient services, the coverage of inpatient services as -- at outpatient services are not consistent. They should be provided at hospital . They -- they have issues with access to care with the beds [Indiscernible]. Physicians provide inpatient services at beds that are licensed. They should have facilities . This will likely incur costs to the department for transportation at the north campus. They should be received at inpatient care. It is not licensed at emergency centers. It is just for ambulatory patients. It is not advertised for licensed emergency centers. With emergent issues, we will more likely see emergency centers, you want to expand emergency centers located nearby hospitals about three miles away . [Audio cutting in and out] several stakeholders that have said they would provide support.

With that, ask you to approve this and to create the provider type as an outpatient service provider.

One question , we are working to ensure that Dr. friendly has access if you so choose.

What would the difference be if the patient at a clinic were observed for 48 hours and then had to be another facility versus 72 hours [Audio cutting in and out] . Am I asking the question right? If I understood what you said --

Mr. Delaney?

The question is a patient under observation for 48 hours, then is determined by the healthcare provider they need additional time, up to 24 hours, that it would be beneficial, and they can continue to provide care there understanding that Medicaid [Audio cutting in and out] pay them for the 48 hour observations day or they could transfer them to a hospital or -- at ambulance costs. They have completed the 48 hours

or 24 hours observation stage, in order to be treated at a hospital, they have two [Indiscernible].

It is under a payment model, all the services delivered during the observation stage would be rolled into one payment. It would be an inpatient hospital payment to children's for that stay.

Does that answer your question? Okay, do you want clarification?

I am trying to understand the difference maybe it is terminology as a clinic or observation.

That may be tripping you up .

Was listen a little more maybe that will become clear -- let's listen a little more and maybe that will be come clear -- become clear.

The kids that go to the clinic, they go to a hospital -- because their pediatric services. I think they would never go to a big hospital or clinic -- [Indiscernible] that is what we want, to go to your community and get taken care of. It will impact families if we use that service. Not if you have a choice. You do it if you have to, but like -- God help them. [Indiscernible] I wanted to make that point because that is not true. If you have pediatric services, it is different.

Any other comments?

I have texted her and let her know.

We are assuming Dr. Fraley has no questions as we have muted everyone. Maybe we can take you off mute and see but --

I have sent an email to the department to get them back. You may have better luck

Okay, do you want to take a minute to hear everybody unmuted? >> All guests have been unmuted.

Can you hear me? This is Cecile.

We can hear you. Do have a question?

Know I wanted to make a comment that they do not if it will help folks but the definition of observation is a coding thing that is kind of independent of the department. It is confusing. I know we get -- we struggle sometimes with defining something as observation versus an admission but I wanted to comment that that is -- if you are trying to wrap your hands around that, it is a little bit complicated and it pays less to be on observation then to be admitted for providers. But also that is not that definition. That is the definition of coding.

That is associated with that issue, correct?

A lower level of care -- it pays less but more than outpatient does. There is a regular outpatient facility.

The question -- what examples of observation versus requirements [Audio cutting in and out] actual cases be helpful?

I think the questions they were asking earlier, they wanted to understand why is there a need for inpatient and pediatric that does not exist in other parts of our state . That is the heart of the question I am trying to get to. We have observations , away , pass to

pay -- a path to pay for certain things. That could make a difference but there is a question here.

Are there inpatient beds? What happens if we give away the opportunities ? It is not fair.

It is about observation.

My understanding is it will not allow for observation beds, which are now only happening in emergency rooms if you can get that figured out. You keep them from going into a hospital but have a tremendous amount of medical care in that setting.

This is not considered an admission?

No, we are avoiding admissions.

Mandy Moore?

Sometimes will put a patient under observations because you think it is short-term. And that could prevent inpatient admittance. Sometimes they have an approach -- it is for children, they think [Audio cutting in and out] it is a problem. We are not actually ever using that as admissions.

Either observation -- I am not sure how they have been billed. I am not sure about that.

Is everybody ready?

Is there observations longer than 48 hours? [Indiscernible]

>>

They allow -- other insurances have longer observation periods? They have 72 hours . I have never seen this before. I think it is delightful but I have never seen this. I think it is a great idea but I have not -- [Indiscernible] .

>> Mr. Delaney, is that what you are asking? I just want to make sure I understood the impact of sick beds, that they will be affected -- if we do not approve this regulation. What is the other number on the other side?

If we do [Audio cutting in and out] schedules would be affected .

This is Richard Delaney. If you do what?

If we do not approve it -- it would be -- what is the other thing that happens if we do not do this?

The other impact -- clinics? [Indiscernible] this is Richard Delaney and the department will not stop paying them for their outpatient hospital services. We will do that and continue to respect that because we do not want the people of the system. -- A people of the system --

upheaval of the system. >> They are not inpatient facilities. They have emergency rooms .

We are out of compliance .

There is no authority to take entities [Indiscernible] as an outpatient . >> So getting licenses for children's -- it would be before November 30 but how long to get back?

That his a [Indiscernible] question -- that is a [Indiscernible] question.

I think we are ready for Miss Michael to introduce yourself and share with us your testimony.

Thank you for having me, Madam Chairman and members of the board. I am here today because my team had responsibilities for all certifications, licensors, and Medicaid enrollment for the entire system. We are a nonprofit healthcare system that services not only children in Colorado but in the surrounding seven state regions. Of the children we serve, approximately 45% of them are Medicaid beneficiaries. It is very important to us. We will tell you that it might be the last 15 minutes -- Mr. Delaney and Children's Hospital were in total agreement on 99% of them. We started talking about specifics and semantics and definitions of the recognitions -- regulations, and specifically how children can use these, how they are using them, whether we are using them in a manner in which they are aware of and have allowed us to do so, that is where we have significant. -- Significance .

This is the first hearing I have been to. I do not know how formal you are but if it is allowed, I would encourage you to stop me as I am going through this and asked me to clarify as it is very technical. I do this day in and day out 24 hours a day, so I think it is all very clear but it is obviously not. If it is allowed, I would rather you interrupt me and ask me questions as I make statements that do not make any sense so I can address them in the moment.

>> Acronyms drive us nuts, so --

Normally, the testimony does not go past a certain time frame. This is a very difficult one. I just hope we are cognizant of our time, to make it better.

You are correct. We have a time limit that is pretty strict.

It is your decision.

Do you have an estimate of what your testimony will run?

I do not. It depends on the questions.

We normally have a five-minute part for concerns and I think this is your first hearing, --

Madam chair, may have motion to not observe the time limit of the testimony?

Do I have a second?

I am not sure that is fair to every other person that has done this .

I can understand that.

I would make a motion that we allow for the five-minute testimony and then as usual our questions can last an hour depending on how many we have about the testimony but am not sure the testimony portion can be extended because we never do that. >> Can you say that again? That is not what you want to do. We have motion on the table . >> [Captioners transitioning]

I want to make two points upfront, I think they are very important, there is no other license or category for that North clinic, at this point in time, and, having this weird wacky CC and licensure category, we would be allowed under the CMS rules to provide all of these services, including inpatient services at those locations, and remote locations under the hospital so we are between a rock and a hard place because the regulation says if there is a licensure category that is services you are providing, and a specific physical location, you must license that location. So, we must license North , as a cc , where we cannot provide any services there under the state of Colorado licensure laws. If the state of Colorado did not require a CC license, did not have a category of licensure, we could provide all of the same services we are providing today as an off-campus location under our hospital license. But we do not have the options to do that, because we have the license

-- to license it as something, and the only thing it qualifies as is a PDE clinic.

They are under a single integrated care system, in addition to our main campus, where we have 18 network care locations, with the exception of the three that we are certified as CMS for freestanding clinic services in our southern Colorado region, all of the remainder of those network of care locations are enrolled in Medicare,

certified by CMS, the centers for Medicare and Medicaid services, as a single hospital type institutional provider, with a designated main primary practice location, which is in Aurora, and multiple off-campus remote hospital locations. That is very important. Because CMS surveys us at the state agency of CMS, as a single

under the participation for hospitals, and that all of the location, we must meet the same hospital quality care standards. Per

CMS rules, remote locations under a single CMS certification are considered to be one hospital. In other words,

all locations under a single institution provider are authorized to bill Medicare, and all judgments hospital Colorado locations that provide services that meet the medical necessity requirements for an inpatient admission are allowed to be billed to Medicare, and are paid by Medicare as inpatient hospital services. With the exception of dual eligible patients served in regional disease unit, Children's Hospital Colorado rarely treats Medicare patients, we will put that out there, we rarely bill Medicare patients, if we have a Medicare patient at any of our locations, where we have the building

code requirements met, provide inpatient services, Medicare will pay us for inpatient care services. The comments on the rule to add to the CC EC, we don't disagree with the need for

them to be able to distinguish what services are provided where, and by what provider type. But, you need to know that there was no requirement until we were required to enroll every single unique physical location where we provide care services by the end of March, 2016. We had to submit an enrollment for each of those physical locations, and enrolled them separately in Medicaid. Up until that point, we were allowed, and it was entirely proper for us to bill all services under a single enrollment

which was our main campus because that is our single CMS certification provider network. So, that was perfectly allowable. We do not disagree that it is important for them to be able to distinguish where services are provided, and by what type of provider they are providing. We absolutely agree with that. Respectfully, our disagreement is with the decision not to pay , not to reimburse, for inpatient services, when inpatient services are being provided when that level of care is being provided, until limit our observation care stays for these kids, especially in respiratory season, the 24 hours or in rare circumstances, 48 hours when these kiddos, if we can keep them up to the 72 hours allowed by the licensure regulation, or the 96 hours that we are allowed per waiver, during respiratory season, to avoid admissions,

we would like to be able to continue to do that, and to be paid for those services that we are providing to those kids.

I'm being generous, because I started --

It is true that we only have six beds that are licensed

as inpatient at North, we provide observation care and other areas because we are allowed to do so, so there are additional beds that are being used, only as outpatient, as for clinic visits for observation services at those locations. In 2017, we cared for 435 patients at an inpatient level of care across those two facilities. Those are all children, that would have to be transferred from our North location, to some other hospital, not necessarily hours. And it is important for you to know that if those kids are transferred to a non-children location, we still get paid for the outpatient care that we provided at North, Medicaid then pays for a transport, which if it is a basic level of care, it is around $400, if it is a critical level of care, which most would be, it is around $900 extra, and if it is a non-children's facility, you still end up paying for the inpatient level of care services that we are perfectly capable of providing safely and in a

quality manner in the location in which we have been doing it for more than 10 years.

Thank you, so questions from the committee? I'm seeing a lot of people.
>> So clarification, so the North campus on the CC license, and that license allows inpatient care?

We believe it allows us to provide inpatient level of care, and admit patients as inpatients, we believe that the language in the license that says other services, and further information, in later portions of that particular licensure category, that talks about the use of those inpatient beds , and criteria that are specific to locations that operate those inpatient beds allows us to do so , and quite frankly, we have been providing inpatient level of care services for 10 years at those locations. We have been continuously surveyed by CDP AG, they come and ask us to run our reports when they survey us, telling them how many inpatients we have, how many outpatients we have, they request records for X amount of inpatient, X amount of outpatients, they have asked to interview inpatient admitted families and patients when they have been surveyed, so they absolutely know that we are providing inpatient care and admitting those patients as inpatients have not asked us to stop doing so.

Does that answer your question?

Does this agree with that?

This is Richard Delaney , we disagree, we believe that the community clinics are for ambulatory care, the inpatient beds that are licensed are for observation stays only, and in our discussions, they indicated that they do not surveyed these on a regular basis, the CC or CCEC license is only surveyed at the beginning of the license, and only after a complaint is made, there is not a regular survey of these locations. And, if it is surveyed as an off-campus location of a hospital, it might be certified for Medicare, but the joint commission would be the survey, unless CMS deems it to be a survey, which is generally done if there have been complaints in CMS, which is for a different set of eyes to look at. So, we disagree that CDPAG regularly survey these.

As a matter of fact, at our last renewal for our relations for the North clinic in October 2017, CDPAG came on fight with a full licensor review.

We are getting conflicting messages.

We are very conflicting , I agree with your comment, and I would say, just because there is poor oversight, doesn't mean they are not in compliance, because you are saying they aren't regulated very much, they make the rule, they certify, they license them, how much they oversight is really their issue. It is problematic for many reasons, as you know, but because these services already exist , and have been paid for, and I guess that is the problematic piece right here for all of us around this table and various other people as well. These already exist, and

the licenses that have happened, and this new licensure category will change what has been going on for a long time. And, that piece I'm not sure.

It will change in which the way we are paid, but not the clinical services being delivered.

I think it would, if you go from inpatient payment to ops payment, that would change.

So it is just the payment that is changing? I am just trying to clarify, this doesn't limit services that are being provided in these facilities, it doesn't change any conical decisions that can be made, it clarifies payment policy that these are ambulatory care only, and that the pay is outpatient observation stays for the same things that has been discussed, these are observation stays , so I'm just clarify, this is really about payment, not about clinical differences.

I understand that clarification, but it makes huge clinical impact, having been someone who has to transfer someone, or has to go inpatient because ops time is up, or if they are an inpatient bed, that is different, the system is set up and that cannot wait. That is fine to say, it's okay, we are just going to deny you, and you can't actually have it free. It does impact, it is not that you are denying care , but, it does impact patient care, it does impact outcomes and decisions that you make clinically. It has to, because you can't just keep them for free forever. So, I'm concerned about the system that is already in place, with the inpatient payment model that has been approved from CDPAG no matter how much they do or don't regulated, it has already been paid by Medicaid, and I'm concerned about what is happening.

I see Ms. Roberts, and I'm going to ask a question , a clarifying question, when does it flip to inpatient? Are we talking hours, and that is when it flips? I take my kid to the emergency room procedures for a breathing issue, and sometimes you go upstairs and I know from a parent consumer, that is when we become an inpatient, versus hanging out in the ER, I never realized it was a timeframe , right? I just know it is a long time. But, with mental health, you are trying to stabilize , basically that is what you are trying to do. But is it 38 hours, then after that, you become inpatient? I'm asking somebody.

So, from the medical perspective, absolutely , from a process standpoint, here's how it works , the decision on what level of care a patient requires is a decision that is a medical necessity criteria decision, that is made by the appropriate caregivers in the moment, based entirely on the patient's condition after point in time of being evaluated. So for our particular purposes, they come in, they are immediately evaluated, the decision is made on that point in time based on their condition at that moment, does the clinical provider believe that they will be able to go home within 23 hours? Or, sometime close to that. And, then there is continuous monitoring of that child, certain kinds of care that is provided , that is observation level of care. Which again is very different from inpatient level of care. That is provided of until the point either where the decision by the medical

caregiver based on the condition of the child at that point in time is either this child is able to be discharged home, or this child needs to be admitted for inpatient care, or in our particular situation, because we have got 72, up to 96 in respiratory, that child needs two more hours of oxygen, or two more hours of
nebulizer treatment, or whatever it is. So we believe that in that observation status for that additional time. >> Okay, so it is a medical necessity when they go inpatient versus a time turnover, okay, thank you. >> This is Linda Michael, we can only admit them as inpatient if they meet the medical criteria for inpatient admission. So, if they go over the time, over 23 hours, over 48 hours, over 72 hours, we can't admit them just because that time has passed, we have to continue to treat them, and leave them in that observation status, until again, the point where you meet that medical criteria, or an inpatient admission , or they are ready to go home.

Is it that same patient criteria that changes -- so, it is just --

We don't automatically admit the patient to inpatient status, just because we are allowed inpatient care for that patient. It is just like our main hospital, the providers have to use critical pathways, whether it is North campus, or at the Anschutz campus. The decision-making process is the same, it's just, if this is passed as proposed, instead of us just saying, okay, stay in that bed, we have the capability with our staff, our equipment, our space to be able to flip you and leave you right there where you are at , and flip your designation, we will have to call in , we will have to load that child into the indolence, we will have to transport the child somewhere else where they are allowed to admit to inpatient status because that child needs that level of care. >> Dr. Cecile Fraley in the queue.

That is the point I was trying to make before, we do not have a payment for these facilities to provide that level of service. With the way it is written. So the question I have, and I don't understand hospitals tremendously well, why wouldn't you apply for licensure change?

There is no other cycle , there is no other licensure category available at this point in time, so the newest building codes do not allow us to meet the room size requirements for the emergency area that we have at North , so we cannot at this point in time, get a full hospital license at that location. We are working feverishly towards that. Which you can do at the other location.

Because you are converting your licensure at that site?

Can I backup just a little bit? So, somebody asked about the term satellite location, so satellite location and remote location of a hospital are very distinct separate terms under CMS rules, a satellite location of the hospital is a hospital unit or a separate building that lives on the campus of another licensed hospital. So, somebody mentioned our partner location. We have a hospital unit license for Parker because it lives within the licensed hospital from Parker, and uptown, we used to have a hospital unit license when Saint Joe's ED was right there across the street, because it was within 250 yards of

another licensed hospital, we could get a hospital unit license. When Saint Joe's moved there when the building tore down, and we were no longer within 250 yards of another licensed hospital, we had no choice, we had to give up, that hospital unit license, and license it in the only -- we cannot operate it as a remote location, because CDPAG has this clinic licensure category. So we had to license it as a community clinic. Whenever changed the services that we provided under the hospital unit license, to when we got to the CCEC license, again, because our understanding is that we can provide inpatient care and they are both under licenses. So, there is no other licensure category we could get.

Dr. Cecile Fraley said her question was answered, --

My sense is that it would be most prudent, because we are in alignment with CMS, as well as with children's, but CDPAG is out there in the periphery, and is responsible for the licensure, could we ask that CDPAG be present at the next meeting to provide some direction, or clarification so that we perhaps can come to terms with the dichotomy that is happening here ? Because, if they don't have a particular license available for children's, presently, there is the potential that this could be broadened to hopefully come out maybe to Fort Morgan perhaps, so that there are more children's beds available throughout the state.

I agree, Ms. Roberts, that just clarified for me, why it is so difficult to have the satellite , and access to care to some of our rural areas. And I agree , Dr. Charolette Lippolis and Ms. Hughes.

My understand -- understanding is that it requires license, is it doesn't meet any of the categories, and it didn't have to be licensed before . It wasn't a hospital license to begin with, it was the new license that required you to have the waiver. So --

This is Linda Michael, not exactly, so, CMS has a category of locations that are called remote locations of a hospital. CMS will say, you do not have to have a separate hospital license to be able to provide hospital services at those remote locations of the hospital. So, all of our off-campus locations, with the exception of the in-service Colorado once, on our CMS certification , as remote locations of the hospital, and as a matter of fact, we have written documentation on both North and uptown from CMS, that they are components of our main hospital campus. So, having this licensure category , we wouldn't have to be separately licensed at all, to be able to understand -- to be under CMS regulations, but the regulations say, if there is a category licensure available, you must separately licensed that physical location. So we do not have a choice.

Mr. Delaney, I also have Ms. Hughes. Do you have a question? >> Yes, the remote location is a facility with the main purpose for providing primary care, they only admit inpatient stays, so it is not the main purpose of that location, as inpatient care, so we would qualify under a remote location under CMS, at least that is our interpretation. >> May I give a response?

I actually have our CMS certification printed off yesterday, that was listed as remote locations at the hospital, under hospital enrollment type, and we have a cost report that lists them as remote locations, it shows they are main hospitals, so from our perspective, CMS is classifying them, and considering them remote locations of the hospital.

Okay, Ms. Hughes, and I have Dr. Cecile Fraley in the queue.

I will pass, thank you. I think my question would continue to muddy the waters. Thank you.

Dr. Cecile Fraley. >> I wanted to shift the focus and clarify something, if the patient is admitted to the six beds, and say it is [Indiscernible] and it stalls out, and within 48 hours, they need continued care, I just want to look at the cost, the Medicaid cost, so at that point, for children's to be paid, they need to go in the ambulance to the main children's facility, and then, is it bearing the cost of the ambulance transport as well? I'm just trying to understand the cost to the program, obviously for kids, if you don't have to move somebody, down here, even though we do frequently move people to children's for a higher level of care. But, if you could clarify that, because it feels like it is then what I would perceive as a pediatrician to increase cost, and involving transport .

This is Linda Michael, it depends on the acuity of the patient. So, if it is a simple respiratory , but that still requires an inpatient admission, and doesn't fall under the states trauma regulations, or the federal regulations, we can move that kid out in our system if we wish to do so, and there would not be an increased cost in terms of dollars to the Medicaid program. Unless, that child's condition deteriorates, due to the necessity of being transported , and the time it takes, and ends up with a higher DRG, inpatient admission diagnosis, and there would be a higher cost to Medicaid. Now, if we have a trauma patient that comes into the north location, and I'm sorry, somebody had mentioned, we don't get emergency traffic in that location because we are not a designated emergency center, our level of acuity is emergency in that location, because it is a remote location of our main hospital campus, and sees that level of acuity of patients, we are required to treat that location as if we had a dedicated emergency department. So, we must comply with all regulations at that location, we do get a high enough level of acuity that we are required to do that. So, we do get trauma patient, we do get emergency patients. EMS is just not allowed to bring them, but we take them, they present them all the time to us. If it is a trauma patient, that we are treating under the regulations, we have no control over whether EMS takes that patient. We call for a trauma transport, the EMS team determines the appropriate location to which to transfer that patient, based on the trauma algorithms. So, for North, they can take them to a Vista , it is a higher level of care. They can take them to good Sam's, to Saint Anthony North. They can take them to St. Luke's, Saint Joe's, to whatever other hospital or emergency room . All of those are higher level of care. Now, do they have specialized pediatric care? No. But the higher level of care, that is what the EMS algorithm says. In that

particular case, the department absolutely encourages additional costs for that patient, because we would get paid for our outpatient services, the EMS transport would get paid for the transport cost, and whatever hospital that child ended up would get either the emergency department outpatient payment, or more likely the admission DRG payment for that care.

This is Gretchen, let me clarify, if that happens where you walk into a pediatrician's office that was associated with Children's Hospital, and the child has an asthma attack, that is not controllable in that setting, we will transport also. So, in that situation I don't know that this rule changes that reality , that would be the right clinical thing to do, we trust you to do the right clinical thing. And we would pay for that under all circumstances, whether that happened in my local pediatrician's office, at Children's Hospital affiliated with the pediatrician's office, or one of your freestanding facilities.

This is Linda Michael, that is correct, there would be no additional cost because the physician's clinic is not covered, we would do in our facility transport of that patient, and so again, to Mr. Delaney's point, that initial care that was provided on the outpatient basis would be wrapped up in the charge to the department for the inpatient admission.

Another clarifying question, let me just make sure I'm asking a question that aligns with yours, I certainly appreciate the question, I guess I would also want to clarify that if the first 48 hours of the child stay in your field was paid on an outpatient observation, that would be a lower cost to the department, and there are a number of children that can be signalized and sent home appropriately. So that would be a potential way in which the cost would be different by being lower, certainly understand that if they don't stabilize, and you are worried about them, and you want them to have a higher level of care, either because the clinical status has changed, or you need some additional time, you would then require a transport, it seems unlikely to me that that child would be in a dramatic type transport, it would be a general transport, is that accurate?

Yes, and I just want to be clear, this rule has absolutely no impact on whether we are going to provide observation care for 48 hours if the child needs observation care up to 48 hours, this rule doesn't impact that. So I'm concerned because -- and I probably misheard you , but it sounded like you were saying, if this limits observation care for 48 hours goes into place, we won't admit children who might need inpatient criteria, I just want to be clear, we do not make decisions based on what we are going to get paid, when we are deciding whether or not to admit a child as an inpatient level of care, or to leave them in an observation status, and care for them at that level of care. What we get paid, who the payer is has absolutely no bearing on that, what is the appropriate level of care for this child in this moment that is right in front of our provider? >> I appreciate that, I think I was just trying to understand if children's in this north location was continuing to do what they have done in the past, and would it actually save an ambulance transfer? What I mean by that, you have a kid coming

in, they don't get sicker but they need longer than 48 hours, in the past, it seems like you could keep them another day or so, and we certainly, especially in the winter, we see these respiratory kits, they need to be in the hospital but they are not getting sicker, but they are not getting better. Especially the little kids. So, I'm just trying to understand, based on what has happened historically, you can keep them for 80 hours, at the Broomfield location, but now I'm understanding this correctly, they either need to be transferred by ambulance, if you want to continue to get paid, or they stay and you aren't paid, I think that is what I was trying to understand.

My understanding, from what the department is telling us is that, once we had the 48 hours, that is all they are going to pay for observation care, regardless of whether they are being treated. So the decision at that point in time would be on the medical provider to say, either the kid really needs to stay, or I'm going to go ahead and discharge them because we are hitting the 48 hours. I can unequivocally say, none of our providers would say it is 47 1/2 hours , I'm sorry, I'm going to discharge you because I'm not going to get paid if I don't. I will tell you, I'm not sure how long we can continue to provide services that we are not going to get paid for. And, especially --

The 48 hour limit provided at the main campus, would cap that limit on it.

I cannot speak to that, that has never come up in a discussion, I'm more familiar with how we have, how we make decisions , I get calls every day that say we are getting close to the 72 hours, is our waiver still in effect? So, those are the kind of calls I get in that, or we are reaching the 96 hours, we know we can't keep them, is that right, we have to transport them? Yes.

Mr. Potts?

We are going in circles, I would like to continue this in our October meeting, with the request of CMS and

CDPAG, for further clarification, it appears to me that this rule is being stalled because of one location is at stake. And we are not going to get the answers that we are asking today. >>

So, in process, I guess you could make a motion to table it, we could ask the department how they feel about that, or we can take a vote.

Ms. Hughes?

My thoughts on that --

There has to be a second. That was my motion. I continue it, I'm not tabling it off.

Thank you, Mr. Potts, I am making a motion at the beginning of that comment. Thank you. This Roberts, we have a motion and a second. Now, we can have discussion.

I was going to take a break at 11, but that would be fantastic. We have a motion , and a second on the table, so we must get through that, then I'm going to say we are going to take a break.

So, I feel that those conversations should've taken place during the stakeholders meeting, I don't feel like it is the board's responsibility to push forward these conversations with these other entities, they have a stakeholders process, and which ever entity is strongly enough to have those people present in their conversations, so tabling or not today, I would not be in favor, I would like to push forward with the decision on this issue. >> So you would like to continue it to next month?

Yes, and also the fact that --

I'm not telling you how to vote, I'm just saying, this is premature? >> Okay, I've got Jennifer Weaver. >> I just want to be clear what we are doing, because we are not tabling , are you asking that in October, the initial reading is still going on? Because, it is already set for October, where there can be more evidence. I just want to be clear. I'm asking for a second initial review.

I didn't realize it, the final week we can take further testing.

Yes, absolutely.

Also, they can ask the department to continue to work this out, because it seems there are different interpretations , and that matters, and we are trying to get into compliance , what has been out of compliance, and how do we get it into compliance all on the same page?

Thank you, so I would just let you know, and I think they can reflect their conversations with CDPAG, there have been multiple cover stations between the two entities, and I'm not sure we will find a different perspective, so, Randy who runs the licensure division has been on the phone , we have record of their conversation, I know there has been separate conversations with Children's Hospital so to your point, Ms. Hughes, that work was done extensively with multiple operators -- hours , we had a standing stakeholders meeting that was just around the hospital, and we had the review meeting that we are all required to have, and then you have follow-up conversations with children's and with a couple of other entities, that we mentioned the community health centers, Mr. Delaney made the references to the places where we changed the role based on some of that feedback, so the rule we prevented -- presented is the role we are operable with. And I think you heard a different perspective, we will certainly do what we need to as directed by the board, but we wanted to give you the full breadth of the conversation that involves all the persons.

So if Children's Hospital, because they have a waiver from CDPAG, to have somewhat different services than the specific role, could they potentially get away with us in the future for the similar thing, or is that not a potential avenue for them?

This is Linda Michael, I want to clarify, our waiver is not -- our waiver says, we are allowed to provide inpatient services for greater than the 72 hours as limited by the regulation. So, we don't have to limit our hours, for when we can keep the kids for 72 hours, we can keep them up to 96 for a specific time. So, it is not a waiver of the rule says we cannot provide inpatient services and the waiver says that we can, a waiver says that we are not limited to providing those services that we provided to that facility, to 72 hours, we can extend the ability for us to provide that level of care up to 96.

Mr. Delaney?

Just a clarifying question, the extension up to 96 hours, are they looking at that on the observation during the respiratory season, or are they looking at that into the license that you have and whatever services you provide?

Our waiver requests specifically says, providing inpatient care beyond the 72 hour limit, and the regulation. , And they have approved that request. We are currently not under a waiver now, we usually request that sometime in the January-February area, they give us 60 days, and allow us to request an extension under that waiver application. Some years, we need the extra 60 days, some years we don't, so we are not currently under a waiver of that 72 hour limit.

Okay, Mr. Delaney? And then we have Dr. Charolette Lippolis.

We disagree with children's interpretation that it is inpatient services that are allowed for the 72 hour waiver, the regulations I'm going to read for you, inpatient beds means the use of beds for the care of thickly stable patients who present for primary care services, but would benefit from monitoring by nurses and physicians from 12 up to 72 hours, except the 72 hour limit should not apply to clinics. Such beds are used for recovery, due to surgical services, or to accommodate inpatient services from another facility. These beds they talk about are for medically stable patients who are for observation, they are not inpatient.

Or for other services. >> I thought it just to find exactly what they are doing, help me understand, how is that not true? I'm asking Mr. Delaney. I thought what I heard, perhaps you should read it again. >> Of inpatient beds, they use the term inappropriate use should be considered observation, but the rule says, inpatient beds means the use of beds for the care of medically stable patients to present for primary care services, so it is not the emergency care patients, but they have to present for primary care services, would benefit from monitoring by nurses and physicians from 12 to 72 hours . So, CDPAG, does not consider these inpatient services, and consider observation services.

However, defining it as inpatient does seem to be something entirely different. Because it is defined as inpatient, so I just heard that and said, that is their definition of inpatient. So, what I understand is, there is a significant discrepancy between the understanding of

observation beds, and what is defined as inpatient beds, and CDPAG, using that definition as inpatient beds,
when you would rather prefer it to be a different name, that is confusing to me, because it seems that CDPAG would need to change that to an observation status, which is a well defined criterion in hospitals. I know it is well defined. So this is confusing to me as to whether it is meant to be observational, because it sounds like inpatient. That sounds like short standing inpatient to me. Opposed to ops, which is a lower level of care.

That is the reason I asked if we could table until next meeting, to take a vote. So, what you are saying, take the vote for the initial, and then bring it back next month?

We have a motion and a second. >> We are in the motion for the second that is on the table.

I understand that, but I thought he withdrew.

About a half hour ago.

For clarification on the measure that we need, is it continued?

So, what is the understanding right now to take a vote that we are not getting anywhere, take a vote for the initial?

Mr. Potts?

If we pass the initial, if we go into the final discussion, and we want something rewritten, or we want something added , what happens?

This is Jennifer Weaver,
you can make changes to the rule, on the record, if it is within the notice that we sent out to the public, or if you think there is going to be progress, which it doesn't sound like there is, it is an option , it will just have to go to the board. Does that make sense?

Maybe for procedurally, but if I would draw my motion , and I make a motion to vote on the initial today , with some instruction to get more defined testimonies from other departments next time, would be maybe more appropriate, then you are suggesting without telling me what to do.

This is Jennifer Weaver, I think that is fine to do that, just know that we cannot compel CMS to show up at the meeting, or CDPAG, that request can be made, we cannot compel it.

Really? I find that interesting.

I don't think I want to be in the presence of a two hour conversation, going back and forth either. And, that has already been the experience that Gretchen has spoke about.

Obviously, it wasn't taken care of, so it is up to the board to take care of things, so you've got to take the time it takes to get the job

done right. And, that seems to be the challenge we are facing today. Because, we have been here an hour and a half, and we are no closer to a decision, and it all seems to be information from CMS, information [Inaudible - lost audio]

Is anybody still on the line?

I am just on the line, and I'm wondering if the whole thing died, or if it is the board. I think it is the connection to the actual board, we lost connection.

Okay, can you hear me talking? I'm talking to you right now. Okay, we are good. >> [Indiscernible - multiple speakers]

So, I had emailed out, this is Chris,

sorry, -- last week, I sent an email notification of the upcoming board meeting to members of the public, it is my notification list, it is a blind copy list, in that email, I had indicated that for this meeting, we are going to create a Q& A part of the webinar, it is different from the chat, it was designed to be set up for individuals to remotely give testimony. And, I had discussed it with Kristi, and I just indicated this is the first time we are doing this, so it is going to be a little bumpy, but the goal is, I receive the Q& A as the host of the webinar, then the questions that are relevant, we have public testimony for document number eight, does anybody have any public testimony, they would type in a question. I would then turn the question over to Kristi, Kristi would read the question out, discussion would occur, and it would just be whether or not that answered the question, and hopefully the individual who submitted the question comes back and says yes. The idea being that individuals who are submitting any public comments, or questions are still beholding to the requirement that we must be up to identify them because this is a public meeting, and it would be part of the public record. So, that is what I explained to individuals. >> [Indiscernible - low volume] for this particular provider type, and any changes , the process outlined in the bulletin was that one step would be [Inaudible] the location who provides those services are licensed for that provider type, and a subsequent step was that the department would use data after that creation of the provider type, after the enrollment of those licensed facilities in that provider type, after claimed data using that provider type has been submitted to the department , then the department will use the data collected, and it would be a source relevant for payment methodology.

[Inaudible] after the providers enroll in that type, and submit claim for the approval.

[Inaudible]

There are no providers enrolled in provider type because it does not exist. So basically you go back and enroll in the provider type, the department collects data on all of the facilities that enroll at that provider type. And then makes recommendations. And really, what is happening in this particular role is that the provider type being created, and being changed without that piece in that enrollment, and that analysis of the database .

[Inaudible Question]

The current methodology is that you all are paying providers who are providing inpatient services, at inpatient rates. This proposed rule zeros out any payment for inpatient services, so that is a change in payment methodology.

I just think it is because the definition is different, in terms of what is defined by inpatient, as defined as observation, that would be my bottom line on what we are changing, because your billing for inpatient, that won't be available, and more because of status would be available only higher-level for outpatient services, I understand. So, I'm not sure that the ask will answer the question. In terms of what the board can actually do, I'm not sure that ask will answer the question. Because, they can study

observation payment, and it'll be the same because that is all that is going to be billed. If I understand this correctly, except this one thing. Is there an alternative exception, an alternative idea that could help this service that is already being provided, because changing this to Colorado is a totally different deal. And, so we all want to do something for the services that are already there, that have been provided under a surprising exception. So, because I'm not sure that your fix will fix this. >> The regulatory that is a process issue, I'm not sure there is a process issue, when the definition of inpatient differs between two institutions that are providing licensure payment >> This is Linda Michael, can I ask the department a question? The rule that is proposed is to pay for outpatient services that are being provided for cc and CCEC. I can write you 100 licensure rules, payment rules are not my thing, so my question would be, recognizing that we would not have to have CCEC provider type, we could bill for inpatient services at these facilities, so long as the facilities, so long as the building code requirements were met, and they are

available and appropriate for inpatient care, as long as our providers are able to provide that level of care, we can provide those without this license. For these locations that are properly providing inpatient care under inpatient admission. Then we can all have the argument with CDPAG, about whether the licensure category thing which needs to be changed to be clear, that there are certain facilities that can admit inpatient and provide inpatient level of care, instead of one category that applies to all the CCEC's.

So your question to the department, Gretchen or Mr. Delaney?

It is highly unlikely that they will find a way to provide for inpatient care for cc or CCEC's. We are performing the Medicare payment methodology for these locations, and providing outpatient hospital services that are not inpatient.

I want to lay this out, there is basically three options with this, you can take that vote , or we can merge into table, and to this again next month , with the correct answers , or the testimony . And the motion on the table right now is that we vote.

At that time, we cannot request from Chris to ask CMS , a representative from CMS and a representative from -- to answer our questions that we have concerns on. If they don't show up, I guess that is too bad, because this board is supposed to make some heavy decisions , and if we can't get our questions answered by the experts, how are we supposed to make the decisions? That being said, I will withdraw my motion .

And I prefer that we look at this at the October meeting as the initial rule.

That is a different motion.

Okay, so right now, with Mr. Potts withdrawing his motion, and Donna has made a second motion to table it this month and bring it back as initial next month.

Actually, that was my understanding. I still support that, bringing it back next month.

Okay, do we have a second for Donna's motion?

I don't understand Donna's motion at this point, he withdrew and she made a second. So, she made an additional. [Indiscernible - multiple speakers]

Mr. Potts motion was to withdraw that, and Donna's motion was to table it, not take a vote, and ask the department and everybody to come back next month , and hear it again.

So this is assuming additional stakeholder process? That would be my hope. Thank you, this is Donna Roberts, I would ask that the children's ask -- Hospital provide, if they have about with the waiver information, all of the license information, a list from CMS, so they have the delineation aborting exactly, and the Palmetto -- Colorado board saying that this entity is licensed as an inpatient, or not licensed as an inpatient, because then it would be very clear as to which way we would go with it. It is a dichotomy if HIPAA doesn't reimburse us, if they are not licensed as such, then HIPAA would absolutely just offered the observation.

Are you also asking for the additional testimony next time from CMS? And, does it also get the opportunity for those that have been on the webinar that maybe have not been able to ask questions because of our activity. So basically, do this again next month.

Yes, but have the additional people, the important people, meeting prior to the meeting so that everything is well ironed out and delineated well. >> Ms. Hughes, I don't understand how that is different from what they would do morally in the process. So, if we were to vote today, and next month, come back for additional testimony, which you are requesting different, because what I clearly heard is that there has been conversations at the table already, and we are like this right now. So we cannot request those other entities to provide additional information. I assume that we can request for those to go back to the

table, if we voted today, to have some conversations and then next month, do it again. But not start it from an initial. So I don't understand how your request is different from what we normally do.

I think it has to do with comfort level, that is my understanding. And, what I'm trying to do is, if we take a vote and it goes down, I'm concerned about that outcome as well. For the department, etc. So I'm trying to get everybody out and on the table so that we are sitting with a motion without a second, for this to be an initial next month with appropriate information and stakeholder activity, and hopes to iron something out. To get to a consensus. There are going to be times where we don't get to a consensus, and we have to honor that as a committee. So, do I have a second from this?

Ms. Roberts has to withdrawal hers without a second. It failed without a second.

I apologize, Donna.

We have a solution, okay .

Revision to the medical assistant concerning community clinic, and community clinic and emergency centers , section 8.320 , incorporating the statement of basis and purpose and specific steps toward authority contained in the records.

I have a motion and a second. Hold on a minute.

I'm sorry, we had somebody trying to provide comments online. >> Our challenge is the connectivity.

The dialog box is operational.

So is that comment -- okay.

I'm sorry, the individual's name?

Allison.

I thought you said you were not going to do that today, I thought you said we first came back, we weren't going to have that testimony today because we have so much discussion, there would be a second opportunity at the next meeting, if we move forward the max frame -- >> That is right. >> This is Jennifer Weaver, I think the technical difficulties we are having, this is not consent fun -- finally, and there will be ongoing, we will take a vote next, that would be a better time to add.

And in the meantime, any stakeholder is allowed to submit comments as well.

We can take Allison's typing and send it to everybody, that is another way to get her communication out. Okay?

I think we are in agreement to that.

Okay, we have a motion and a second, let's take a vote. All in favor? Opposed? Dr. Cecile Fraley? >> I'm sorry, I'm fading in and out.

If you can hear us, can you text Chris your vote, and we have one, which is
Dr. Patricia Givens .

[Event Concluded]Okay