



COLORADO

Department of Health Care
Policy & Financing

MEETING MINUTES
Hospital Back up Redesign Steering Committee
Department of Health Care Policy and Financing

303 E. 17th Ave.
7th Floor Conference Room 7B
Denver, CO 80203
January 27, 2016
10:00 a.m. – 12:00 p.m.

On the Phone

Tanya Gallery—TG	Pueblo County
Josh Fant—JF	Colorado Healthcare Association
Daniella Johnson—DJ	Avamere Malley

ATTENDEES

John Adams—JA	Vibra Health Care
Martha Meyers—MM	University of Colorado
Dawn Mowat—DM	eQhealth
Mike Modiz—MM	eQhealth
Dr. Deb Parsons—DP	eQhealth
Heather Fladmark—HF	HCPF/LTSS
Laura Russell—LR	HCPF/LTSS
Randie Deherrera—RD	HCPF/Rates
Erik Holt—EH	HCPF/LTSS
Joanna Vasquez—JV	HCPF/LTSS
Cathy Fielder—CF	HCPF/LTSS
Megan Roberto—MR	HCPF/Data
Chris Scofield—CS	HCPF

Italic font is summary of conversations and ideas presented by steering committee.
Regular font is actual dialogue.

Minutes are approved.

Heather informs the group of reducing the steering committee meetings from twice a month to once a month. The steering committee will meet on the 3rd Wednesday of each month and any subcommittee meeting will be held (when necessary) on the 1st Wednesday of the month.

Reasonable accommodations will be provided upon request for individuals with disabilities. Please notify the 504/ADA Coordinator John Barry at 303-866-3173 or john.r.barry@state.co.us at least one week prior to the NFAC meeting. www.colorado.gov/hcpf



*The location of the steering committee meetings will be:
1575 Sherman St.
Denver, CO 80203
6th Floor Conference Room*

Subcommittee meetings will be held at 303 E. 17th Avenue, Denver CO 80203.

Phone and room introductions.

Laura Russell--HBU Application: *Laura reviews the changes from last meeting with the committee. The biggest change around the application involves the checkboxes for the criteria. Laura is soliciting feedback from the group to determine if they want checkboxes in front of the criteria or not. A brief discussion revolves around the criteria itself; the criteria is intended to be informational, it is taken straight from rule and used for hospital staff as a high level application, and then the SEP and the SURC will do their assessments that will be valuable to Data. This application is not an automatic acceptance into the HBU program.*

The criteria is listed on the application because of the regulations; a case managers can say a potential client is medically complex or vent dependent but not equipped to choose from the criteria. That level of assessment will be determined by the SEP and the SURC.

Randie DeHerrera—Rates Form: *Randie informs the group of her intentions to go over the form in the meeting, and then send it out to the stakeholders for review, we will determine a deadline for the reviews to take place and provide feedback, a summary form will be provided as well to make sure everyone knows all the expectations and questions that must be addressed. Once agreement is reached on the rate process and it represent the cost of providing care we will be in compliance with the rules and regulations.*

- *Instructions and guidelines—walk through of what's in the document.*
- *Instructions on filling out the form are very detailed; the form is broken into each individual parts and identified all the areas that need to be completed and filled out.*
- *Itemizations and where they go on the first sheet.*

Randie is going to give the form to her staff and have them follow the instructions while they fill it in to check for mistakes; while the stakeholders do the same thing. There will be a check on the level of technology facilities have and the Department will make the necessary adjustments to the form for that. The rate form is for the nursing facilities only.

Guidelines—our rules state we will pay cost after a cost negotiated rate. We are currently not in alignment with our rules and the guidelines will allow us to do that. The guidelines are, currently, loosely written to cover a broad range of components. This form will not be similar to the Med-13, if a mistake is made on the sheet it will be changed without hassle. We will make an initial determination of these rates and then once everyone agrees, we will plug theses in and have them auto populate, that way each time you need to fill out a form for a new client.

Various components are already pre-filled on the form for the facilities:

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- *FRV*
- *Indirect Care*
- *Administrative*
- *General*

RD: the question with the FRV and Indirect costs is, will the total appraisal amount be divided by your total number of beds or will it be divided by the total number of beds being used. I am guessing facilities will want to use the number of beds being used, this will get you a little more money. These are the things we need to consider in order for all the facilities to agree, and there is a standardization level moving forward.

RD: The other thing to know, because we pull indirect care costs from the Med-13, some of the costs (physical therapy, social services) are accounted for in the HBU rate document in the direct care. We will remove those categories from indirect care before we do any calculations or rate setting. Please make sure I am correct on the categories, I need agreement from you on removing them from indirect care.

RD: administrative and general; will be the total cost divided by whichever bed count the Department decides on. "As filed cost," not the final audit cost will be used to avoid retro-actively adjusting the rates.

Guidelines for review—this is a description of how the rates and rate form will be reviewed.

- *Direct care labor*—we will look at wages and hours of care; unless we see your wage is over 75% (Colorado Standard), we will not question it. If it does go above, there might be an inquiry as to why.
- *Hours of care*—only issue would come if there is a significant excess. Example: if there is 8 hours a day of direct nursing care, then we will be asking why, and why this client still in HBU is.
- *Supply costs*—this section will be heavy of provider and facility feedback. There is not a lot of Department staff to rely on for the accuracy of the supply rates.

RD: please review the G-tube feeding supplies. The other big cost is the respiratory supply costs, please have your nurses review this section to determine if the rates are within reason. I will get everything out to for review and then send me your feedback so we can make our adjustments.

Specialty services—specifically the ventilator rental equipment. Rental prices are not set and vary based on:

- *Provider relationship*
- *Number of clients*
- *Number of beds and the cost of the beds*

RD: so because of how much variation there is, it is very difficult for the Department to know how to adjust the rates. So, just send me the invoice so I can make sure you get reimbursed on your cost.

If a facility does purchase rather than rent the ventilator equipment, an amortization will take place and make sure it is for the purchase price not a rental.



RD: again, I want to stress, we don't want to cut cost down and scrutinize, we want to make sure we are in compliance and we have supporting documentation.

Process—this is simple, every facility will have their own forms that will get an annual update and be sent out by the Department.

Adjustments--the Department will identify any areas where adjustments should occur based on the documentation provided, information included in the clients medical records, or Department clinical staff review. Any adjustments will be noted on the Rate Request Form in the column labeled Department Adjustment.

RD: facilities will have time to discuss, and review any adjustments and send back any explanations, clarification additional documents. What the facilities need to think about is the timeline for this adjustments. This process can get bogged down lasting as long as 6 months. But, if we decide on the deadline we will have to develop a rule and regulation to make sure due diligence is getting done.

Approval--upon approval of the HBU requested rate the Department will issue an approval letter to the provider indicating the approved rate, the rate effective dates, and the continued stay review date. The letter will include the approved HBU Rate Request Form for provider documentation.

RD: from now on, rates are going to be effective indefinitely. Facility costs go up, clients get better, all kinds of stuff happens that impact the rate. There will not be a change every time something little happens, so don't worry about the workload increasing. We need to determine a time period, how often are the rates going to be reviewed? Is "continued stay review" the correct term? So think about that.

Continued stay review--to ensure that the reimbursement for HBU continues to align with the care of the client the approved Rate Request Form should be reviewed and updated every 6 months. If there is no change in condition providers will not have to resubmit the request form. Providers will have to submit the HBU CSR Form to have the rate continue to be effective when there is no change required to the form.

RD: very important is the continued stay review letter. This letter needs to be filled out and signed stating that client condition has not changed and the current rate is still accurate. This is very important so that facilities and the Department have documents to reference that protect them in case of an audit; we both can say here are the forms proving that the rate and service plan are still accurate.

JA: are you going to adjust for inflation?

RD: we can talk about that. Wages change, unfortunately we look at the BLS data and they are about 2 years out. We need to discuss the time frames of when it is ok for you guys to make adjustments to your wages; we should be looking into doing that anyways.

Process and updates—this section was left blank because there is a lot of issues and concerns that need to be addressed and discussed and determine the timeframes.



RD: it's reasonable, every 2 years, for facilities to go through rate documents and update all their wages. Because we will be doing the pre-bulk with indirect care costs, administration, general and appraisal, that will be updated automatically on an annual basis from the new Med-13. So for 2016, submissions will be March 31st and by June 1st I can get your new forms out to you with your new prefilled rates.

DP: some of the high cost that you brought out, the vent and tube feeds are no longer in use when we perform our CRS; when the client is no longer receiving those services we don't catch that right away and we don't hear from the facility until the annual review.

RD: I would say do a review every six months to catch stuff like that.

DP: so would this 6 month review be done by the SURC or would it fall on the facility to do the rate review.

RD: If the SURC wants to look at client care in correlation with that review, I think that would be ok. If the patient's state improves for say 3 months, then things change and they regress, it's okay to keep the rate the same for 6 months. And then we can take it out during the next 6 months.

Heather Fladmark—Audits: currently the Department does not have a programmatic audit to cover HBU. We would like to put something together to fix that. Nursing facilities do a financing audit, CDPHE do a client care audit. Nursing facility auditors check the HBU program in the same way as a normal nursing facility.

The potential audit areas have been identified by the project team:

- *Document procedures*
- *Record retention*
- *Do clients meet criteria from prior care plan, i.e., are they still on a vent?*
- *Mandatory Reporting of Elder Abuse*
- *Per Diem Billing (Census, 5615, Account Receivables)*

MR: would an MDS assessment fit into this?

HF: I think that's a great idea. I think some of the information within the MDS may not be relevant. But if we can identify when an assessment has been completed by the facility, it will help with the claims aspect.

DP: do the financial and programmatic audits done by the department work simultaneously with the clinical audits CDPHE does?

HF: the programmatic does not exist yet, that's what we are trying to build. CDPHE do their assessments about every 9-15 months.

CF: the audits don't link up but we get CDPHE their report and review it to see if there is anything that would trigger an audit for us.

CDPHE does not focus on the HBU program itself, rather the client care and environmental factors over all.

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Heather Fladmark—HBU Training:

- *What is the HBU Program? Serves as a placement for medically-complex clients who can be discharged from a hospital but require high level Skilled Nursing Facility Care.*
- *Eligibility requirements, financial piece and functional piece.*
- *Medically complex definition and criteria needed to meet this level of care.*
- *Ventilator dependent definitions and the criteria needed to meet this level of care.*
- *Intake process for the SEP*
- *Intake process for the nursing facility*
- *Intake process for the SURC*
- *Intake process for the Department*

The ULTC 100.2 referral is filled out with patient demographics and doctor's information. The ULTC 100.2 assessment, is completed by case managers after a face to face with the client.

In an effort to improve the communication between NF and the SURC, the SURC is visiting facilities to improve communication. During a clinical review of a facility, the SURC would like the facility to pull the necessary documents beforehand. Second, if there is a denial, they will let the facility review it before it is sent to the Department.

Another issue, during the time it takes to fill out an HBU application and have it submitted, a patient's condition will sometimes improve. So the question becomes, does the SURC still need to send out a nurse to perform an assessment? And can the SURC withdraw the HBU application? Heather recommends mapping out the process for situations like this between the Department and the SURC.

A request of the time frame for the SURC during the HBU application was made.

