



MINUTES
Nursing Facility Advisory Council
Department of Health Care Policy and Financing

303 E. 17th Avenue
7th Floor Conference Room 7B
Denver, CO 80203

August 19, 2015
3:15 p.m. – 4:45 p.m.

On the Phone -

Mary Koertke Vivage
Kerwin Galloway Care Meridian

ATTENDEES -

Heather Kamper	DRCOG
Patricia Dean	Holland & Hart LLP
Larry Fortier	Rock Canyon
Ron Cook	Rock Canyon
Kathy Capell	Colorado Access
Kellen Roth	Colorado Access
John Brammeier	Vivage
Anne Meier	Disability Law Colorado
Lonnie Hilzer	Continuum Health Mgmt.
Janet Snipes	Holly Heights
Arlene Miles	Capitoline Consulting
Josh Fant	CHCA
Joyce Humiston	C&G Health Care
Mark Gritz	UC School of Medicine
Martha Meyer	UC School of Medicine
Angela Richard	UC DW of HCPR
Paul Landry	Life Care Centers
Doug Farmer	CHCA
Janice Brenner	Leading Age CO
Jennifer Reinheimer	Myers and Stauffer

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STATE STAFF -

Heather Fladmark	HCPF
Susan Love	HCPF
Joanna Vasquez	HCPF
Cathy Fielder	HCPF
Chris Scofield	HCPF
Danielle Culp	HCPF
Taren Cunningham	HCPF

Heather Fladmark (HCPF) - Welcome and Introductions

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- A. Introduction to CU presentation, but will begin with Taren Cunningham

I. Taren Cunningham (HCPF) – Revalidation Updates

- A. Revalidation will begin on September 15, 2015. If you have not seen which wave of revalidation you are a part of you are able to visit www.Colorado.gov/hcpf/provider-resources. All nursing facilities will be considered limited risk. Screening will include verifying licenses, federal and state regulations and data based information. There are no site visits and/or background checks for revalidation. If you are a DME provider as well; you need to be aware that DME is considered HIGH risk, so be aware that there will be high risk screening for these providers. When you access the website be sure to check each provider type that you are, because requirements are different for each. NPIs are required for each Nursing Facility. Make sure that you get your NPIs before going to do your revalidation. For each location there will need to be a separate application and an application fee will be required with each application. You are NOT required to have a separate NPI for each location, that's more of a business decision.
- B. E-Learning Modules: Ability to walk through the application prior to actually filling out the application.



- C. Provider questions/comments: Send questions via email to Provider.Questions@state.co.us

II. **CU Research Team (University of Colorado Anschutz Medical Campus) – CU Presentation: HBU Research**

A. Introductions

- B. This project is to report the review of the Hospital Back Up program. Project team included: Dr. Mark Gritz (PhD), Angela Richard (PhD RN), Martha Meyer (MPH), Heidi Wald (MD, MSPH), Kristen Stahl (Student), Meredith Smith (Student), L. Jane Stewart (JD, Student)

- C. The objective: To assess the current program status and identify future program needs. Then to develop options for program redesign for HCPF to consider.

D. Presentation included:

- a. Original intent: To reduce Medicaid hospital outlier days. To place clients with medically complex care requirements in an appropriate care settings that better meets care needs than never leaving acute care hospitals. Changes of client demographics have also been identified; clients are coming onto Medicaid due to needing the Hospital Back-Up (HBU) Program.
- b. Other Findings: HBU programs was widely recognized that this program is a much needed program for very frail and venerable clients who in most cases have very few options. HBU program here in Colorado is unique, no other program was found in other states that addressed vent dependent, medically complex and complex wound care. Other states have other payment mechanisms to care for vent dependent clients but this program is designed in a way that makes it unique.
- c. Identified issues: Intake Referral process is lengthy and cumbersome. Financial eligibility takes quite some time and usually leaves clients in the hospital while waiting for financial eligibility to be approved. Cost out and Care plan not being reviewed and renegotiated from initial. Alternative care settings/



Palliative Care models conversations are not being had with family members prior to clients transferring to nursing facilities, so addressing these conversations before transferring to the next facility. Vent weaning protocols are based on guidelines, however not required by facilities to have.

d. Recommendations:

- i. Centralized the Medicaid financial eligibility to one entity for the state as a whole. Possibly have a MA site complete all HBU applications (financial) that way the process would become faster and that financial workers would become more aware of the process.
- ii. Recommend Palliative care conversation to happen with families prior to the HBU application, this way family has a better sense of client's status.
- iii. Intake Referral process: Redundancy, and not many people have to deal with the HBU application process. Education for each facility to access online. Address the application process and redundancy.
- iv. Monitor and tracking system for the HBU population. Use existing data collecting process to set up more of an ongoing tracking process. Quality of Life matrix as well. Monitor, tracking and measuring of the HBU population.
- v. Align some facility certification. There is not a standard weaning protocol. There is currently nothing in the regulations, however if any other facilities were to come online to have CDPHE on board with having this as a requirement.
- vi. Expansion of provider base. Currently only have 4 facilities in the Denver metro area and need to expand on both the eastern and western areas of Colorado.
- vii. Modernizing: Changing the HBU framework is what that means. Redefining the target clients for this program. High



intensity acute care Medicaid clients (High flyers) utilizing long term acute care facilities. ELPACs (Enhanced Long term post-acute services) is a modernizing term that CU had come up with. This would be a much longer term thing for HCPF to look into, who constitutes as a high utilizer?

- viii. Providers to establish agreements with others for specialized services. Such as vent dependent clients who are not in a facility that has the ability to liberate the client but that they would have the ability to send the client out to receive these services.
- ix. Admission from non-hospital settings. This would need to go through regulation change.
- x. Revising the payment model. Currently each rate is negotiated with the facility for each client. The change would be go toward a more valued based/tiered payment model.

