Please stand by for realtime captions.
>> Is there anybody on the telephone?
>> Hi, there.
>> We're going to need one more.
>> And Dave, okay. That's it.
>> We've got quorum.
>> Okay, I called the meeting to order, and we are going to do Roll Call.
>> Christie Brinkley?
>> Present.
>> Patricia Givens?
>> Present.
>> Cecile Fraley?
>> Present.
>> Simon Hambidge?
>> Present.
>> Jessica Kuhns?
>> --
>> Charolette Lippolis?
>> An Nguyen.
>> Excused.
>> David Potts?
>> On the phone.
>> Donna Roberts?
>> Present.
>> The date and location of next notification meeting scheduled to be Friday, May 10, 2019 beginning at 9:00 a.m. at East 17th, seven floor conference room, Denver Colorado, 80203. Remind everyone in intelligence this is private property and around the edges of the room, turn off your cell phones in the meeting. We will entertain a motion for the minutes for the March meeting.
>> Thank you.
>> Motion and second?
>> Thank you.
>> Good job.
>> [Laughter].
>> All in favor of the minutes approved for March 8?
>> Aye?
>> Aye?
>> Aye?
>> Authory, thanks.
>> When we get
>> Thank you.
>> Good job.
>> [Laughter].
>> All in favor of the minutes approved for March 8?
>> Aye?
>> Aye?
>> Aye?
>> Authory, thanks.
>> When we into the rules I will call you by name rather than have you go . That brings us to my favorite part of the entire morning, and that is top David DeNovellis, and the update on legislation.
>> Good morning, Mr. David.
>> Good morning. Madam Chair, Madam President, B oard.
>> My name is David DeNovellis, department Legislative Liaison. We are deep into session with 21 days left as of We are deep into session with 21 days left as of today. I think we are tracking about 650 of them.

>> It feels that way. We do have a couple of department agenda those that are free but now. One house Bill 1302 will have first hearing on Monday. That would extend the breast and cervical Service Center program for ten more years. Also at another cancer treatment program. It's starting the process. Two other of our department bills, the senior dental Bill that will allow Medical Services Board and senior dental Advisory Committee to set the rate for all procedures, not just a a new once. JCC announce that as joint Bill and that to be introduced in the next day or so. Than another one that Medical Services Board might be interested in is extending access to civil monetary penalty find. Currently the Nursing Home integration those Innovation grant Board they recommend and the Department and everybody approved Nursing Home quality of life improvement grants. Statute has a cap of $250,000 for those grants. This Bill would remove that cap let the grants. This Bill would remove that cap let the Board recommended in house approved as much, as many innovation grants is amenable in a year. Those are the Department bills. We have a whole host of other bills we are supporting and working on. A lot of those focus on government . Lowering health care costs for people. House Bill ten-zero one is house full transparency that has been signed by has been signed by the governor. House Bill ten-zero four affordable healthcare option. That just passed Senate appropriations so it looks like it's on its way to passage. Senate Bill zero zero five top that is important prescription drug from Canada. Has passed Senate and well have house hearing this coming week. You probably know more of the affordable bills and I do. Transparency 1296 is going through the process right now. Senate Bill zero zero four of the affordable coverage pilot, that's going to the process as well. The we have a host of other bills that are definitely medicated related that we are supporting.1038 that dental benefits for pregnant women enrolled in CHIP that has passed and to be signed by the governor soon. Another one support for high-risk families, 1193. That's pregnant women Substance Use SC disorder issues, more support for them and their children, supporting that. House Bill 1233, investments a primary care. We are supporting their children, supporting that. House Bill 1233, investments a primary care. We are supporting that. 'S and the message primary care is important. Our ACC has been leading the charge on that for many years, on that for many years, and this is outlining that with DOI and statute as well. 1237 Licensing Behavioral health entities. This is a big one for us at. Streamlining regulations for behavioral health Licensing entities. From a Medicaid standpoint we think this is going to remove some barriers to access for providers. Medicaid standpoint we think this is going to remove some barriers to access for providers. One of the things we here is behavioral health benefits are relatively robust and Medicaid, but it's access to providers. Building up workforce, pulling up the places where people can receive the services we feel house Bill 1237 is something that will help that overall in the people can receive the services we feel house Bill 1237 is something that will help that overall in the State. Told you about house Bill 1302, told you about Senate Bill five. Another one up actually heading over there at this, Senate Bill 164, the sunset for In-Home Support Services that will increase or extend for nine years our In-Home Support Services in our -- waivers. It's pass the Senate already and at it's first house Committee meeting this morning. That's looking pretty good. That's the want to have on deck other than the -- Bill closed yesterday. Everybody's either happy or disappointed in whatever may have happened in Senate Bill 207. Happy to take any questions to expound on anything further.
>> Does anybody have any questions?
>> Anyone on the phone have questions for phone have questions for Mr. David?
>> I do not.
>> I have none.
>> Nope.
>> Okay.
>> -- Executive Director with a comment. David, want to thank you for all of your hard work. This is a record spinning a number of healthcare bills following 35 now and imagine more will follow in the next 21 days for all of you, or because you are interested in healthcare, take you for your does, testimony, thank you for being you for being part of the process and transforming o ut. Thank you, David, for being one demand, Superman, everything. Appreciate it.
>> I appreciate you.
>> It's a team effort.
>> Thank you, very much. We appreciate it.
>> This is the better part of the day too.
>> [Laughter].
>> Now, we have somebody that had an emergency. We have to do this first. We have to do final adoption consent first. Sorry about that. We're looking for a motion.
>> I'm just looking around the r oom. I'm tied to look to somebody on to somebody on the phone and you keep looking up.
>> I'm moving for final approval of Document zero five MSB 18-11, Medical Assistance concerning -- did I skip

something? Idea. Sorry.
>> Okay, I'm a final adoption zero one, SB 19-zero one, 17 A, Medical 19-zero one, 17 A, Medical Assistance were considering Federally Qualified Health Centers Reimbursement, six and a 700. Document two, MSB 19-zero one-20, a . Medical Assistance considering Long Term Acute Care and Rehabilitation Per Diem Reimbursement. Sections 8.300.5.D.3 three, Document zero three, MSB 19-zero one-zero two, -a. Concerning reimbursement rate increase for Direct Support Professional Workforce Stabilization. Section .505. And document 0.4 MSB-18. Division Two Medical Assistance Healthcare Affordability and Sustainability Fee Collection and Disbursement, section 8.2000. Based on purpose and specific statutory contained in the records.
>> I have a motion and a second. Allin favor?
>> Eye?
>> Sustained?
>> Pat Gibbons?
>> Aye?
>> Pat?
>> Aye.
>> Mr. Roberts?
>> Aye.
>> Anyone on the phone and did not call?
>> Okay, thank you. The motion passes. We are now to the Final Adoption Agenda. We're going to call -- up or not.
>> Good morning.
>> Good morning.
>> We are here to present the last changes to a .50.7 protocol. Last time that I was here I presented on -- in addition and did have some concerns from the ARC of Colorado after the presentation and additional changes they wanted to see in language and in content. We worked with changes they wanted to see in language and in content. We worked with them to -- requested changes and adjust our language.
>> First aspect the wanted to change was make language line better with the house Bill with says, people are at-risk of experiencing experiencing emergency rather than just people who are in an emergency situation. The Department agreed with that and made those changes to address that concern. They also wanted to add in some language about an individual receiving verbal notification from a family member about no longer living in the home for homelessness criteria. We did not make that change because we felt that the vagueness of the language that we had encompassed -- eviction notice and we did not want to specify -- eviction notice.
>> We also added in discharging from prison or jail to encompass more inclusive settings for people who are going to be homeless, not just coming from prison, but also from jail because there's a different between those two departments.
>> With -- incapacitation a primary caregiver, see one or two adding and language about primary care give our becoming homeless, having a history of homelessness, and of homelessness, and the Department did not incorporate their suggestions for that language into the -- to primary caregiver because the Department feels that that situation is covered by the homelessness criteria itself, and it would be duplicate that that situation is covered by the homelessness criteria itself, and it would be duplicate it if we put it into the caregiver criteria.
>> Questions?
>> ARC wanted us additional language and -- about person accepting or declining enrollment within 30 days. There was a request to add language that held the -- management Agency accountable to contact the individuals -- times making reasonable efforts if the individual doesn't have address or telephone number for them to be doesn't have address or telephone number for them to be reached. We agreed with some of their language, but ultimately did not put of all of their language in and rather added in that reasonable effort shall be made to contact the person, family legal guardian, or other interested parties. That did a little more vague contact the person, family legal guardian, or other interested parties. That did a little more vague more vague than they asked for because we feel these specific timelines and times they need to contact an individual and documentation of that contact is covered with any management is covered with any management agencies contracts, and other areas of regulation. We did add in their needs to be reasonable effort but not the specific language they are requesting.
>> The ARC also asked to put in an enrollment timelines of 60 days to have an enrollment completed. While the Department does agree with establishing and enrollment timelines we did not feel this was the appropriate time or place to add in that additional While the Department does agree with establishing and enrollment timelines we did not feel this was the appropriate time or place to add in that additional language to this rule. We feel more stakeholder engagement needs to happen over establishment of that enrollment timelines, and there may be a better place in our regulations to fit

that in that enrollment timelines, and there may be a better place in our regulations to fit that in rather than Waiting List Protocol, as it would end up applying to all of the waivers for a moment rather than just the DD waiver that has the waiting list at the moment.
>> The only other thing that they had asked for that we also agreed with was they wanted additional language at the very end of 835.37. I individual will maintain Order of Selection date to make that exceptional clear to individuals that will not be losing the order of selection date if they choose to decline initially offered to them. Other than those discussions with the ARC, we also had discussions with the alliance to -- support they provided last time to us, and they are still in support to my knowledge of all of the work that work that we have done, and any input I have received from other stakeholders in the community addressed in the community addressed through conversations, e-mails, and we really feel that this language as it is now supports the intention of the house Bill and addresses addresses all of our stakeholders concerns and questions, and it's really going to afford or access to the waiter individuals who need the services.
>> Thank in.
>> Does anybody have any questions for -- regarding this? It sounds like there's lots of work with stakeholders and -- set agenda. Thank you for that. Do we have anybody signed up? Anybody on the phone have questions while I'm waiting for the sheet?
>> Okay. I'm not hearing any. Christiana Sosa, please introduce yourself. I remind you you have five-minute testimony requirement.
>> And I do keep time.
>> Hi, everyone, Christiana Sosa. I know you have a packed agenda today so I will be quick. Simply show our support for the changes of the Department has been great to work with on this, particularly this individual sitting next to year. You know, we have 14 chapters throughout the State, and we really believe that this rule allows for the flexibility to be exigent in emergence needs of those on the waitlist. The changes before you I believe our critical in clarifying what constitutes an emergency, and adds sharp focus to the role and the circumstance of the primary caregiver. Yet age, health and capacity, and those three things are critically important. Thank you for your consideration allows for the flexibility to be exigent in emergence needs of those on the waitlist. The changes before you I believe our critical in clarifying what constitutes an emergency, and adds sharp focus to the role and the circumstance of the primary caregiver. Yet age, health and capacity, and those three things are critically important. Thank you for your consideration of this, and we remain aligned with the community and the other organizations supporting these changes.
>> Wonderful. Anybody have any questions for Mr. Sosa?
>> Anybody on the phone have questions?
>> I'm not hearing anybody so I am assuming not. Raise your hand on the phone if you really want to be heard.
>> Please introduce yourself and ever by do you got five minutes.
>> She brought her son. What's his name?
>> James.
>> It's not flat Stanley.
>> It's flat James. The morning for the opportunity to speak. Morning Welch, parent of future at-risk adult, and someone who will be looking for long-term support services when he turns 18. Certainly on the children services waiver. I have a lot of friends who are on this waitlist, and it's always a point of condition how long the waitlist is, 17 years right now. I'm also a -- Teacher. I taught in public schools and -- public school ended transition schools and public schools with a public search public school ended transition schools and public schools with a public search program, a wonderful to work program. One of the issues has always been issues has always been the waitlist issues. Remembering the rules there's world trade with very good things in h ere. My main main concern is right now the abuse of using emergency status by Adult Protective Services. Currently at Adult Protective Services is using the rules and regulations on the other branch of government of human services, their using a lot of the components of this rule to create an emergency to move individual from the -- waiver IDD waiver from -- and neglect. I'm really concerned that, I don't think it pertains directly to this rule but it's important this particular body understand that the waitlist has been impacted artificially by individuals moving from SOS Waiver to a DD waiver to emergency proceedings in the judicial department. I brought this to the attention of edgy, feel wiser. I was in -- last night and spoke to him at length. I also brought it to the attention of the Medicaid fraud unit, Bob -- unit, Bob -- over at the AG's office monitors five. I believe this is fraudulent to move an individual from a last costly waiver of the SOS Waiver over to the DD waiver fabricating there -- and usually those placements are made within the organization organization of the community center Board. It's financially benefiting to move out of the home and into a host home that is managed in the profit margin made by the community-centered Board. There is a conflict of interest here, and I know it is a pertain directly to the community-centered Board. There is

a conflict of interest here, and I know it is a pertain directly to this but I'm a full-time advocate with a website over 3000 people I e-mail. This morning I talked to three families before 9:30 all involved with Adult Protective Services and false fabricated narratives and they're going to lose their loved ones under these false narratives, and they're going to move from living in the home to a host home. Too me that's fraudulent and if it affects ones under these false narratives, and they're going to move from living in the home to a host home. Too me that's fraudulent and if it affects the people that have been waiting. Honestly need host on because caretaker HCUP homelessness of things legitimate. Thank you for this rule change. I'm happy to take questions but I think it's important to change. I'm happy to take questions but I think it's important to understand the waitlist is impacted by external forces you all should be made aware of. Thank you for the opportunity.
>> Anybody have questions for Ms. Welch? Anybody on the phone? Okay. I wanted to mention to you that, today, we are and were ready for any testimony via phone for the first time, and we had no one signed up, but it's available now, so we're hoping that the State starts to pick up on signed up, but it's available now, so we're hoping that the State starts to pick up on it.
>> I was going to make a comment on the open period since he didn't pertain to the rules but, want to thank you for that. That's incredible. I hope all of the Executive Branch is do that. didn't pertain to the rules but, want to thank you for that. That's incredible. I hope all of the Executive Branch is do that. CDS was the first to do that and wonderful to have people call him. Thank you.
>> Yes.
>> Thank you, they can very much. Goodbye, James. Okay.
>> Okeydokey. With nothing else I would entertain a motion for Ms. James rule. It's not just for you.
>> Document zero five MSB 181116 A revision to the rule concerning section section to the waitlist protocol, Section 8.50.7 incorporating statement of basis and purpose of specific statutory ability of the -- records.
>> Second.
>> I have a soaking -- emotion and a second. Allin favor.
>> Aye.
>> Everybody Everybody Sirte.
>> Those on the phone, Pat Givens?
>> Yes.
>> Thank in.
>> David Potts?
>> Right.
>> Donna Roberts?
>> Aye.
>> Thank you. So passes. Now we will go back to six.
>> Remember -- trying to be ahead of myself and now I'm just beside myself. It's not Matt. It says -- so who's coming up for this with me?
>> Whitney and Matt.
>> Come on down.
>> We are doing 12 now. We are doing document 12 as some of us are very important and have other things to do, Mr. Matt, right?
>> [Laughter].
>> Obviously IMAT and -- today [Indiscernible - low audio] regarding this rule.
>> Speak up.
>> These microphones are not as strong as on the other four. Please use your outside voice.
>> I'm here today to answer the question regarding this rule.
>> Good morning, my name is Whitney McOwen, compliance policy analyst for the Department, the Department, and I will be presenting the rule.
>> Okey-doke.
>> Where revising the transgender services rule primarily in response to feedback regarding permanent hair removal. While the rule is open we're also making some minor changes adjusting numbering, in clarifying the prior authorization requirements. The providers approach the Department with the feedback t hat -- rules surgical procedure requirements for hair hair removal presents an unnecessary barrier to care, and is delaying numbers from receiving transition surgeries by up to a year. In response the Department is moving permanent hair removal from the from the list of surgeries that 837353 and four, moving into it's own subsection at 8735 for any. With this change permanent hair

removal is no longer subject to the surgical procedure requirements that included the preferred gender role for 12 continuous months, and completing 12 continuous months of hormone therapy services. The language in the dissection and 3745 E still ties coverage to treatment of a surgical site, and it still requires plans too meet criteria Section 87354 A including dysphoria and the services medically necessary as defined in the rules. The Department engage stakeholders throughout the process, and made some edits to the draft in response to stakeholder comments. For example, the departments clarification to prior authorization requirements and the draft revision sponsor some comments. Including a comment from Colorado Center on Law and policy, see CLP, the Medicare that the revision was being perceived as imposing a new prior authorization requirement for hormone therapy services. So the Department clarified that prior authorization requirements for testosterone products and certain estrogen products predate the transgender services predate the transgender services rule that were included in the original transgender rule, and they apply the same across all benefits for all Colorado Medicaid members seeking hormone therapy services. And for the response to that comment revised prior authorization section again to just make that clear. See CLPE made one other recommendation the Department cover additional surgery such as facial Lemmitization surgery under this benefit. We cannot undertake that change with this rule revision. It's a subsequent policy change that requires additional research, more engagement with stakeholders and possibly seeking budget authority to make that type of change to the rule at this stage.
>> Any questions on this rule?
>> And the changes they are making. It's pretty straightforward the changes they are changes they are making. Any questions on the phone? I did not see any hands up.
>> Hearing none.
>> There's a clarification that electrolysis is restricting -- to surgical sites and not cosmetic in nature.
>> Okay, thank you. That is a good clarification. Thank you.
>> Did I hear somebody on the phone?
>> No.
>> I'm hearing things. Okay, then we would entertain --
>> That's right, testimony? There isn't anybody. In my brain and I already looked at 1014. Motion?
>> I am making you guys work today.
>> Make a motion document 12 MSB 181023 A revision a Medical Assistant rule concerning trends gestion services Section 837.5 basis and purpose of specific statutory authority contained in the [Indiscernible - low audio].
>> Second.
>> I have a motion and two motion and two seconds. Allin favor?
>> Aye.
>> Sustained?
>> Pat Givens?
>> Aye.
>> David Potts?
>> Abstain.
>> Donna Roberts?
>> Aye.
>> It so passes with one a bstention. Thank you, very much. Now we will go on to 12 -- six, and Chandra or Pat?
>> Good morning.
>> [Indiscernible - low audio].
>> The first rule I will be presenting is 19-zero one-31-A for the indigent care program rule. Provides discounted healthcare services to low come individuals and families. It's not a health insurance program, and healthcare services are provided by Colorado hospitals and clinics that participate in the Colorado indigent care program. The individuals that qualify the program legally reside in Colorado. They meet income Resource Guidelines, which is going to be at or below 250% of the current poverty level. There are not eligible for Health First Colorado nor child Health Plan plus, and individuals can be covered by Medicare or have other health insurance. The first change that we have will be on page 13, line 32.
>> This change brings the Colorado indigent care program rules in line with Health First Colorado regarding the Social Security numbers that are a health insurance program, and healthcare services are provided by Colorado hospitals and clinics that participate in the Colorado indigent care program. The individuals that qualify the program legally reside in Colorado. They meet income Resource Guidelines, which is going to be at or below 250% of the current poverty level. There are not eligible for Health First Colorado nor child Health Plan plus, and individuals can be covered by Medicare or have other health insurance. The first change that we have will be on page 13, line 32.

>> This change brings the Colorado indigent care program rules in line with Health First Colorado regarding the Social Security numbers that are required for the applicants. The change these individuals not eligible to receive a Social Security number, individuals who may or will be issued a Social Security number for valid nonwork reason in accordance to 20 C CFR 422100 for individuals who refuse to obtain Social Security because of well-established religious objections. And before going on any questions on that one? The next one is going to going to be on page 16. Question?
>> Your face the showing a question but I don't want to put words in your mouth.
>> [Indiscernible - low audio].
>> I did not know you can choose not to get a Social Security number, but you can.
>> I guess it makes sense.
>> Madame Co-Chair?
>> Dr.?
>> Is a common to claim religious objections?
>> I personally never heard that but since it is within first health Colorado, I'm under the assumption it has been done in the past.
>> So we just wanted
>> I did not know you can choose not to get a Social Security number, but you can.
>> I guess it makes sense.
>> Madame Co-Chair?
>> Dr.?
>> Is a common to claim religious objections?
>> I personally never heard that but since it is within first health Colorado, I'm under the assumption it has been done in the past.
>> So we just wanted to get in line with Health First.
>> Just copy language from another one?
>> Yes.
>> Any other questions? You may proceed. Thank you.
>> Next on page 16, line 25, we used to have an expected payment no later than July 31 of each year for the Colorado indigent care providers. Timeline of one month dividers notified questions? You may proceed. Thank you.
>> Next on page 16, line 25, we used to have an expected payment no later than July 31 of each year for the Colorado indigent care providers. Timeline of one month dividers notified payment know -- modified from July to August due to necessary data not being available until first week of August. That's the only change we had there.
>> Questions?
>> Yes.
>> Dr. Hammond?
>> Individual hardship by by providers for that month?
>> We do not. We brought this up in the Colorado this up in the Colorado indigent care Stakeholders Meeting and there is no individuals that had issues.
>> Any other questions?
>> Do we have anybody signed up for testimony? We do not. We don't, then were making a motion.
>> I'm sorry.
>> Please, go ahead and testify and you can sign up afterwards. Come to the table tell us your name and we will have you sign up afterwords.
>> Good morning, Allison.
>> The morning, madame present in the members of the Board. Allison has become a healthcare attorney for Colorado Center on policy. Wondering-- see CLPE non-profit nonpartisan organization that works to enter Coloradoans have access to quality healthcare and economic security. We support this rule change. I'm testifying today and thank testify and you can sign up afterwards. Come to the table tell us your name and we will have you sign up afterwords.
>> Good morning, Allison.
>> The morning, madame present in the members of the Board. Allison has become a healthcare attorney for Colorado Center on policy. Wondering-- see CLPE non-profit nonpartisan organization that works to enter Coloradoans have access to quality healthcare and economic security. We support this rule change. I'm testifying today and thank you department for being proactive in having sessions to the requirement for the Colorado indigent care program. The Department uses Social Security number to the requirement for the Colorado indigent care program. The Department

uses Social Security number to help verify identity and income. But in the community we have seen SSN requirement requirement has been used are can function to deter access to eligibility noncitizens to eligibility noncitizens in the community. Colorado, Colorado recognize is important of extending coverage to indigent populations cannot afford -- with federal rules allow. This has included extending eligibility to all lawfully pregnant women and children, not eliminating five you're bar for those groups. However, we groups. However, we hear through community partners' product eligible noncitizens have been turned away in some parts of the State without opportunity to apply. They are told they have to be citizens or provide SSN. Denied these lawfully present immigrants coverage violates the policy and federal law. Moreover the prize individuals of existing services unnecessarily increases economic burden for working families, and creates potential risk to public health. At the same time upswing nationally in anti- immigrant rhetoric and policy has created a whole range of possible in anti- immigrant rhetoric and policy has created a whole range of possible non- eligible citizens and family members who are understandably afraid of their rights of saying I shouldn't have to provide a Social Security number when they don't have when they don't have to provide one. 2018 see CLPE work with a family that had been turned away. Because they had to provide SSN to K-program and oversaw their application as it moved to the process Rick applicant had significant disabilities and both from case management and County staff we're involved. Conversations with staff at both Agency and County were able to document that certain staff members had turned away eligible noncitizen applicants, I were disseminating and accurate information about who could apply to qualify for coverage. At that point we were able to get, or to inform the at both Agency and County were able to document that certain staff members had turned away eligible noncitizen applicants, I were disseminating and accurate information about who could apply to qualify for coverage. At that point we were able to get, or to inform the Department and -- the Department with staff member so direct instruction can be provided. While it difficult to trace the roots of misinformation or evaluate evaluate role of biased judgments we we also recognize State Medicaid rules and Medicaid rules and some materials it states inform correct or outdated language that increases workers and applicants confusion. We think there is misunderstanding in other counties and other agencies. I next step was to turn to the State rules to address the confusing outdated language, that the Medical Services Board in January there was a rule concerning that address clarifying, or that clarified some language around who was eligible. And we were told to identify and C2 that moving forward that additional clarification will be made around the Social Security numbers. Currently say rules to require Social Security number or evidence an applicant has applied for one top and similar language to what's being proposed for CICP rule today to be added to Medicaid rules. We know that's moving forward and our grateful for that. These additional steps should be treated with numbers. Currently say rules to require Social Security number or evidence an applicant has applied for one top and similar language to what's being proposed for CICP rule today to be added to Medicaid rules. We know that's moving forward and our grateful for that. These additional steps should be treated with urgency. People of color in people with low-income have higher rates of low-income have higher rates of disease, mortality, and disparities in Q4 pregnant women and children. Those Colorado specifically bring to coverage, families don't know who to contact and understand every impressive -- apprehensive and children. Those Colorado specifically bring to coverage, families don't know who to contact and understand every impressive -- apprehensive and -- clarification to the State rules rules are really important to help.
>> Take you.
>> Any questions?
>> No, okay. Then we would entertain a motion. Thank you Thank you very much, Allison. We appreciate you jumping up.
>> I move the initial approval of Document zero six 19-01-31-A revision to indigent care program rule concerning CICP SSNs and clinic Payment Timeline Update, Section 8.0 -- Sections 8.904 and 8.905, present statutory authority containing to 14.
>> I second.
>> Motion into 2-seconds.
>> All in favor?
>> To 24.
>> Abstain? Okay. Dr.Givens?
>> Aye.
>> David Potts?
>> Aye.
>> Donna Roberts?
>> Aye.
>> Passes unanimously. You are backed up.

>> You are you're again.
>> We'll go on to document seven now.
>> We still have for those on the phone Chandra.
>> This will be for rule number 19-01-23-A concerning program for healthcare low-income seniors, dental health care program. Giving background Colorado Dental Health Care Program for Low-Income Seniors promotes health and welfare Colorado's low-income older adults providing access to dental care 860 and older who are not eligible for for dental services under any other dental health care programs such as Health First Colorado. This program is grant funded with general fund dollars only and funds are provided throughout the State to qualify grantees. With the recommendation of dental advisory Committee, proposed rule change incorporates the following procedure codes. The first one will be on page 8. Of this will become the 027, vertical bite wings. This will be 728 radiographic images. I know Dr., when usually I go into more detail, I am not sure if you all want me to do that with the others?
>> -- with a general question.
>> The general earlier David talk about there's a rule for senior dental plan. How does that relate or c orrelation?
>> It does correlate. It's for the same program and the same program and that Bill going forward is for the dental Advisory Committee to be able to set the max payments that the qualified providers can r eceive. For the simple fact of when the Department received those some of them are approximately 200% more than Health First Colorado, so we want to get a little bit closer and line so we can serve more seniors.
>> So the Bill it the Senate now is to include ?
>> It actually is to increase the number of seniors on community health, lowering the payments the current providers receive.
>> Okay.
>> Thank you.
>> Does that answer your question?
>> I think I'm going to get there.
>> Okay.
>> Any other questions?
>> Madam Chair?
>> Yes, sir, Mr. Potts?
>> In reading this yesterday, and I spent quite a bit of time traveling back in the 49 pages, can I get just an explanation questions?
>> Madam Chair?
>> Yes, sir, Mr. Potts?
>> In reading this yesterday, and I spent quite a bit of time traveling back in the 49 pages, can I get just an explanation on service the 0210, because it says frequently that on the same day, and I am trying to understand who can I believe is a full exam, and the rest of them are different or specific? Specific areas? I'm not even sure how to pose the question.
>> So, where do you find -- have you found that the page 0210?
>> Page 5.
>> Okay, hold on a minute.
>> Can you respond to him with that question?
>> I guess I'm
>> Can you respond to him with that question?
>> I guess I'm not quite understanding what the question is because the 0210 is actually a full mouth radiograph. Now, when you say not to be done on the same day, the correlating number for that one would be to 210330, as that's also a full mouth radiograph. So, is that the one you that the one you are referring too, Mr. Potts?
>> Yeah, a couple of places it says on the same day, and I'm trying to understand if you do A2 hundred ten, then know other specific areas can be done on that same day, so day, so if they come back the next day they can get the service provided?
>> I actually see where you are you are going with this. Okay, I'm going to go to page 6 of this going to be D 020 all the way through D 0274. What some providers will do, well do numerous radiographs, and and all of those up, and those will be more than the D 0210. Basically, all that is doing is if they do 15 individual radiographs, it does not allow them to charge more than the $125.
>> Okay, that's -- I just wanted to make sure that I was reading that properly.
>> Okay, yes. That's exactly what that is is for.
>> Okay now, does that clarify it, Mr. Potts?

>> Yeah, I guess it helps fraudulent services.
>> Yes, sir. Yeah, so armored -- overcharging. However you want to say that, yes.
>> Thank you.
>> Now to continue with what we were doing, D 0220 all the way through D 0274 you will see a minor change. That is adding the new procedure code in there. That also has two has two be counted if it's done Sunday, it has to be counted with -- within that $125.
>> The next change is going to be on page 22. This will be covered D 4346, scaling and presence of generalized moderate or severe to do well information full mouth evaluation. Any questions on that addition?
>> Anybody? Okay.
>> This is when we miss our dentist.
>> Exactly.
>> And then the final final procedure addition is going to be on page 43. This will be D 7471. This will be removal of O -- and basically all that is is a bone spur.
>> Any questions on that one?
>> Those are all of the proposed changes that I have.
>> Any questions?
>> Okeydokey. Any testimony on this one? Anybody in the audience that is dying to testify on this one, teeth?
>> I would entertain a motion.
>> I move the initial approval of MSB 19-01-23-A, revision to the Medical Assistance Special Financing Rule consenting does concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960, incorporating statement of papers and purpose a specific statutory Section 8.960, incorporating statement of papers and purpose a specific statutory authority.
>> Second.
>> I have a motion and a second.
>> All in favor?
>> Aye.
>> Sustained.
>> Dr. Givens?
>> Aye.
>> David Potts?
>> Aye.
>> Donna Roberts?
>> Aye.
>> Three passes. Thank you so much. We're on document eight and we and we will be looking for Jeff with Greg. Did I say it right?
>> You did yes.
>> -- good morning, everybody. Good morning, Madam President and members of the Board.
>> I like that.
>> I think I will tell my husband that.
>> I would say, I would bring up that kind of two slides to help explain what we are doing. First of all I'm here to present 19-02-14-A, Revision to the Medical Assistance Rule concerning Nursing Home reimbursement. Kind of the intent of the rule say it right?
>> You did yes.
>> -- good morning, everybody. Good morning, Madam President and members of the Board.
>> I like that.
>> I think I will tell my husband that.
>> I would say, I would bring up that kind of two slides to help explain what we are doing. First of all I'm here to present 19-02-14-A, Revision to the Medical Assistance Rule concerning Nursing Home reimbursement. Kind of the intent of the rule g oes -- does two different things. Rules you will see 21 pages with a lot of changes. I take this opportunity to clean up the language originally in the rules. We kind of felt felt this was an opportunity to better explain what we are doing, cleanup confusing and clear up calculation of both general motion and the addition of calculation of payment to provide a fee. With this 19 of the 21 pages in front of you are really just changes for clarity and understanding. No changes to methodology. Not changing how we calculate small payment and not changing how we calculate provider fee. Want to make sure we understand before moving forward will not have to go page by page, make

formal changes just clarity pieces. The big change of why I'm here is questions or concerns over those concerns over those revisions.
>> I'm looking. I did not see anybody's hand up or on the phone. I think we are good.
>> Okay.
>> Madam Chair?
>> Wait a minute. Data pots, yes or?
>> I've got a couple of questions before we get started so I can get my mind wrapped around this. On the statement of basis of purpose, paragraph three where it says, conversely -- make sure I get in the right place here. I guess it's paragraph four the last said that Scott in addition the amount the amount not reimbursed through MMIS will now be reimbursed as a supplemental payment in the same year, and when we go through this I would like to get clarification on how get clarification on how that is figured, because I'm sure we're going to have testimony that tells us that the averages our taken, and and then that's what's going to be paid, then I got real confused on how this was figured as far as the supplement was concerned. And then on the regulatory analysis on the next then I got real confused on how this was figured as far as the supplement was concerned. And then on the regulatory analysis on the next page, item two, the last sentence, I think there is a typographical error there, nursing homes will no longer receive MMIS rate greater than the core component per diem rate, instead of not, it should be nor will will they receive a rate considerably less.
>> Yes.
>> Did you get that?
>> Okay, all right.
>> Is that it, Mr. that it, Mr. Potts?
>> Yes, thank in.
>> Thank you for those clarifications. Good clarifications. Good reading. Good I.
>> We will go over how the rates can be brought rates can be brought into the supplement payment later on in my presentation, though I will answer your will answer your question later on. If I don't exactly we can make sure to go back to it.
>> I want to start off briefly explain how -- works on on the issue we are trying to address with that. Right now a nursing home is reimbursed a core component right, what they call Courtright. Their rate is established based on networking cost completed by each Nursing Home for prior previous is reimbursed a core component right, what they call Courtright. Their rate is established based on networking cost completed by each Nursing Home for prior previous year, Calendar Year. Right now that you rate is reimbursed through nursing homes are two subparts. The first part is through the interchange, interchange rates. This rate is reimbursed calling normal -- claims and -- reimbursement. I would say when combined it or paint and some we discussed, interchange represents 90% of all reimbursement. The bulk of all reimbursement -- and reimbursed using the interchange rates. Right now the interchange rates is calculated by taking a nursing homes prior interchange rate, increasing it by 3%. For example you had $100 interchange rate in 2017. Simply $103 rate in 2018. That 3% increase is a statutory designated amount requiring the statewide average interchange requiring the statewide average interchange rate increase 3% every year compared to the prior year State work average interchange rates. Just making sure -- average and if you need me to go back I can go back and clarify any confusion there.
>> The second part of the reimbursement is reimbursing a single for the difference between their core rate their core rate and their interchange rate, reimbursed to a supplement through the supplemental payments. Take the core rate, subject interchange rate, multiply by Medicaid Medicaid days that that rate was effective and reimbursed do Nursing Home and reimbursed do Nursing Home and the subsequent year. This kind of gets to the point point being made before. Before I continue I wanted to briefly go over the slides to help explain what is exactly opening your big you big you can see in column C to make things as simple as possible, every nursing has interchange rate of $100 per column D increase by 3% too get $103. You can see in column F, take difference between what the nursing homes rate is, what their interchange radius and differences reimbursed in supplemental payment. Any questions or concerns about that?
>> Question.
>> Bregitta Hughes, for ABCD, this is based on what?
>> This is just
>> This is just made up right now. I tried to make this as simple as possible. The right to very more than than that Scott I just wanted to try as clean as possible tell a story. These are simplified numbers. The interchange rate is about 100. I wanted to make sure we had enough time and can adjust. These are made up numbers that we would kind of see in the change of right to go rates.
>> ARC?

>> In this example, facility A would have to reimburse $25?
>> That's my next part, thank you. The current situation great situation great two separate problems. What's happening now is interchange rate increases 30% every year while core rate may increase or might stay constant. That means there is a disconnect between nursing home, rate and interchange rates -- sorry. The reason for this is reason for disconnect is how: Ratedisconnect is how: Rate is calculated. Previously calculated using prior year cost report. Current situation to receive, from nursing homes and finalizing rate, most likely don't have seven-one rate or core rate on 171. Process takes to long I don't h ave -- the rate Nursing Home by July 1. We had to create this alternate process to determine what the interchange radius going to be, that is what is what we take prior years interchange rate, increase by 3%. We don't have a rate on 171. For this whole thing and considerably trying to address this decade, pretty much. I going back to what your point is on the second, creates an issue on the whole section of Nursing Home reimbursement from what you're observing nursing facility A has interchange rate greater than the call right. What this means facility has paid above cost and required then to recover the money through the supplemental payment process in the next year. Somebody money through the supplemental payment process in the next year. Somebody says, this paid five dollars more. We need to subtract that off subtract that off of there supplemental payment and the subsequent year. The difficulty with that is every year of the number facilities in the situation go from five to ten. We now to four years of facilities to reduce supplement payment to account for the general, what the exchange rate will be on core rate. We actually see the size of recovery going to. There are a few nursing homes were recovery is larger than their total supplemental payment, so that has to pay as a supplemental payment every month instead of us paying them, which kind of goes what against the original tent of the program was to pay payment above and beyond normal exchange rate rate reimbursement. We had weird situation where somebodies paying us money instead of us paying them, because they were paid to much in the prior y ear. That was kind of the original reason we were trying to address the original concern to ear. That was kind of the original reason we were trying to address the original concern to identify the Nursing Home community two years ago. On the other On the other side of the spectrum --
>> Yes?
>> Christie Brinkley. When you're calculating your prior, are you calculating that with the supplement without the supplement?
>> I'm sorry, the prior year rate?
>> Yeah, you are basing on the prior year?
>> It's prior year interchange rate. Interchange rate is independent of what's happening with the supplemental payment.
>> So supplement is not on the table. It's just the payment. It's just the right.
>> Interchange, yes. Supplement does that for -- and core rate and pays out external to the rate change.
>> Okay.
>> Right now, regulate interchange rate later on calculate based on what that interchange rate is.
>> Understood, take it.
>> On the opposite end of the spectrum you have B through D where they are reimbursed -- reimbursed of a percentage of core rate core rate in interchange. You can see D in example made up, this facility is getting 98% 98% of their core rate of interchange compare to facility D, to facility D, only getting 82%. Getting reimbursed good portion of cost now and some are less. All facilities less. All facilities will be reimbursed for all intents and purposes. Core rate, just more in first year and lesson second year. You can see in this example B, supplement payment is only two dollars. And other is getting $22. We are seeing imbalances, some getting more on first year, some getting less, and they have to wait until the next year. Does that make sense?
>> Is it possible to make it more complex?
>> It probably is.
>> Hopefully the solution, we will simplify it. We will see. I don't know. We will go to the second page and it's our solution over what the new interchange rate calculate is. What we wanted to do, what we now are doing is we are taking the actual core rate using that to determine a nursing homes interchange rate. We are going to be multiplying the core rate by a certain percentage in that calculated rate will not be what they are being reimbursed by the interchange. You can see on the second tab on column D, it's now column B, go rate multiplied multiplied by 93%. You can see the amount on 16 are now more tied to what is happening with the core rate. The piece I want piece I want to point out is we are still -- we still increase the average stay Nursing Home rate by 3% per year, so you can see column Home rate by 3% per year, so you can see column D under average, it still 103. We get that 93% back into that amount, so we still meet the statutory requirement for interchange rates per year. That's how we get to the 103. If you change of these number the call rates might be 92. so we still meet the statutory requirement for interchange rates per year. That's how we get to the 103. If you change of these number the call rates might be Might be 95. Really depends on what's

happening with the core rate core rate in that year. We're able to do this because we're revising also how we current calculate core rate. As we said in the past it was prior year's rates are prior rate, support. We are now using crossover from two years prior. That allows more time to cross calculate so we have seven rates on seven-one. We're also making -- accounting for inflation, changing cases, et cetera, too make sure we try to get the right as close to what is happening and experienced by the Nursing Home as possible. By doing that we can now have the rate calculate interchange rate based on the core rates. Kind of the go back to my example you you see column E, every facility is now being reimbursed 93% of their call -- Corey. There's no 105%, no --, equitable across all nursing homes. In addition, if you go to column F, the dollar amount now being paid as supplement payment if you go to column F, the dollar amount now being paid as supplement payment is less. You now have $6.85, a dollar $0.75, negative and still seeing less variation. The point you can see the averages -- JG. Total dollar amount supplement payment not changing, and just more in line with each other instead of having giant swings on either end of too much or too little. That's going to change -- Let me see. I have this up but I'm not following it anymore. The thing I want to point out now that we have a seven 1A on some when we can calculate that as supplemental payment as supplemental payment in the year. In previously we would have to wait to the next year to reimburse that difference. Now we know in this year to calculate and pay it so calculate and pay it so everything's happening in that y ear. In this example facility getting 90 -- changed in the year there getting the remaining 7% or roughly 7% in supplemental payment also in that year. We're making it awfully easier for facilities. And I've done. Take you.
>> Any questions? making it awfully easier for facilities. And I've done. Take you.
>> Any questions?
>> Not hearing and not seeing. Bregitta Hughes, any testimony?
>> Would you say every year nursing homes get A3 % increase?
>> Increase in interchange rates.
>> Outside of nursing homes do all other departments just -- okay.
>> This statute established like interchange rate will increase 3% increase 3% every year. I would think the commercial group would most likely have that in statute or have that 3% increase.
>> Any other questions?
>> Anybody want to likely have that in statute or have that 3% increase.
>> Any other questions?
>> Anybody want to testify? Don't see anybody.
>> I would entertain a motion.
>> I move initial approval of zero eight MSB 19-02-14-A, revision to Medical Assistance Rule concerning Nursing Facility Reimbursement, Section 8.494 -- a .400 incorporated into statutory authority included in the records.
>> Second.
>> I have a motion and two seconds. Allin favor?
>> Aye.
>> Oppose or abstain?
>> Pat Givens?
>> Aye.
>> The pot?
>> Aye.
>> Donna Roberts?
>> Aye.
>> Thank you very much. It passes. Thank you, very much. We appreciate your time and expertise and what your doing. We'll go to document nine and that is Lindy Wilson and Kendall Smith. There she is.
>> You do not have Kendall Smith where you today.
>> No, it's just me.
>> Welcome, introduce yourself. Let us know about the rule.
>> Good morning. Good morning Madam President and members of the where you today.
>> No, it's just me.
>> Welcome, introduce yourself. Let us know about the rule.
>> Good morning. Good morning Madam President and members of the Board. Lindsay Westlund, Benefit Specialist in the office of community living and -- services management division. I'm here today to present document nine MSB 19-01--08-A, revision to Medical Assistance Rule concerning Family Support Services Program or FSSP regulations as Section 8.613. The Family Support Services Program exists to provide additional goods and services to families who are

the primary caregivers and support persons for an individual who has an intellectual development of disability or mental health disability. That the program. We do not received any federal match for the expenditures of this program. And this program is administered through the 20 CC across the State or community center [Indiscernible - low audio] across the State in cooperation with there unique family support counsel. FSSP currently serves about 3500 individuals, and there is a waiting list for this program. Fluctuated from 1500 individuals to 2500 individuals during any given point during this last fiscal year. Last year's/Current PIPs allocation for this program was about $8 million. Historically department guidance and expectations on the implementation of this program has relied upon limited regulations and a lengthy the manual. In order for department audio] across the State in cooperation with there unique family support counsel. FSSP currently serves about 3500 individuals, and there is a waiting list for this program. Fluctuated from 1500 individuals to 2500 individuals during any given point during this last fiscal year. Last year's/Current PIPs allocation for this program was about $8 million. Historically department guidance and expectations on the implementation of this program has relied upon limited regulations and a lengthy the manual. In order for department to have proper oversight of program and ensure compliance, department compliance, department is moving manual guidance into regulation. Because the revisions to a .613 are quite extensive, I will provide a ll -- overview but welcome questions from the Board as we jump it.

>> Section eight, the Department has added administrative responsibilities of CCD. At section Aye the trench of expanded on family support counsel for FSA. Section C Eligibility criteria edits including references to lawful presence, and residential and residential requirements. Section D, requirements for operationalization waiting list. Section E, at a privatization for funding to regulations, including standards for assessing assessing family n eed. Section F, additional work -- Additional Requirements for allowable services and supports funded through FSSP. This section we garner quite a bit of stakeholder feedback on. I will address that stakeholder feedback as we get to the end.

>> Section G, case management has been defined as management as management in general activities for CCD. Section H, expansion on criteria of the family support plan. What's require, purpose, implementation and identification of duplication of services, or media families need. Section-addition of rules using emergency five. Section J, expansion of billing and payment procedures, which require increased documentation, including receipts. This is an area that is also garnered what a bit of stakeholder feedback. We're going to address that after the section changes. Section K, expended on requirements of Program Evaluation. El we have new sector completely that adds performance and quality measures for the program. M, finally, we have addition of requirements for FSSP Annual Report created by CCD. As you can see there is no 6.3 that wasn't touched through this revision process. Department began Stakeholder Engagement for the rules in 2017, the most recent opportunity for Stakeholder Engagement was F ebruary 2019. [Indiscernible - low audio]. Department has created listening lawful feedback to be able to capture comments we received over a couple a couple of years. This has been distributed to many see CDs the provided feedback. It will also be available online if not already provided feedback. It will also be available online if not already this morning. It is quite lengthy. Probably due to formatting but about 80 pages. It is there to review. And before we review the stakeholder feedback, the Department's goal in in revising regulations and taking on the rule revision was to improve upon FSSP's intent to provide services and supports to the families most in need. Want to ensure the services and supports for the family are related to the extra incurred expense and stress that a family has or experiences when an individual in the family has an IDD or developmental dens like -- delay, and also aiming to maintain program flexibility as much as we cannot local level with the family has an IDD or developmental dens like -- delay, and also aiming to maintain program flexibility as much as we cannot local level with CCD, while still ensuring prudent management of funds. I'm going to pause to see if there are questions if there are questions from the Board.

>> This is Christy. In the payments, previously it's been money that has been given to the family. And now the family is at receiving money. They have to pay up front? Or get an invoice?

>> Well, for that section --

>> Help me understand that because oftentimes this is, I go out once a month with my significant other because it doesn't say [Indiscernible - low audio].

>> See CDs and families had the flexibility to decide how monies or funds will be dispersed to that family. Families decide how monies or funds will be dispersed to that family. Families can request advance disbursement of funds. They received those up front and then provide and then provide documentation in arrears, so divide invoices of receipt of expenses incurred. That is one option that families have. They can ask CCB to pay for goods or services, so they don't have to mess with any documentation. Or they can collect the receipts and then ask for reimbursement, as long as it's as long as it's already been identified as a service they're going to receive.

>> All right, thank you. That clarifies it.

>> Okay.

>> Also any questions?
>> We will keep going.
>> As mentioned, stakeholder feedback. We have been receiving quite a bit of stakeholder feedback, even up to this morning. We're definitely reading through it and recognizing stakeholder comments. We have some things to stakeholder feedback. I would like to touch upon the us and look at where the Department was able to make changes based on feedback, and where we were unable to make at where the Department was able to make changes based on feedback, and where we were unable to make changes. Initially the Department received feedback that excluded waiver recipients from FSSP eligibility. That was excluded in our rules. However, we removed that exclusion, so if CCB or CCB or Case Management Agency find a family is most in need of these funds, even though they have someone in their family receiving Waiver Services as well, CCB can make that determination to prioritize funding to the family. We have given that responsibility to CCBs and have removed that from the rule. That was a change we were able to make. Initially the Department had excluded all over-the-counter medications. But based on feedback we incorporated over-the-counter medications to be included, as long as it aligns with our stapling policy on over-the-counter medication. We've aligned that we do have the opportunity to pay for over-the-counter medications following that policy. The Department received feedback for the billing and payment section because we did remove part of the rule that said, assigned a statement. Although expenses will be allowable from families to show aligns with our stapling policy on over-the-counter medication. We've aligned that we do have the opportunity to pay for over-the-counter medications following that policy. The Department received feedback for the billing and payment section because we did remove part of the rule that said, assigned a statement. Although expenses will be allowable from families to show how documentation of funds will be used, at least on best practices for practices for auditing and accounting purposes. We are looking to have a more definitive receipt with more information about how the funds we're spent. Invoices received and we outline those two include information -- in the rule.
>> And then finally, department received feedback about the exclusion of recreational center pathways for family members. Also zoo and aquarium passes for families through FSSP, as this departs from current CCB practices. We have -- that includes personal memberships for the family. It does include purchasing members for the family member with personal memberships for the family. It does include purchasing members for the family member with IDD or DD. Apologize. And there was quite a bit of feedback and discussion about this. What about children that need support persons to accompany them to the rec center? And how to manage support persons to accompany them to the rec center? And how to manage that. We attempted to do due diligence to look into policies of rec centers and how they deal with support persons. We called look into policies of rec centers and how they deal with support persons. We called around to many Metro rec centers and we did reach out to a few of them. Most of them have policies in place that allow support person to accompany a his that needs supervision or assistance into the rec center without charge. We really to a few of them. Most of them have policies in place that allow support person to accompany a his that needs supervision or assistance into the want to encourage case management agencies and CCBs to work with recreational centers to find out what their policies are, and to inform families when they should accompany somebody that needs assistance, and then worked for that. Really, the Department does have a responsibility to balance the needs of populations served with limited funding, and we are using to limit the scope of this provision in order too meet the needs of other families other families that have expressed need for this program who, again, who, again, have a waiting list and we have a limited set of funds. With that, thank you for your time and I welcome any and I welcome any other questions.
>> Does anybody have any questions.
>> Dr. An Nguyen?
>> How many people and how long is the waiting list?
>> From -- Den2 1500. Some of that varies so much because of increased funding or maybe another family chose not to use their funding maybe another family chose not to use their funding so [Indiscernible - low audio] another person. Some CCBs are using other funds, no levy fines, other funds that kick in later in the other funds, no levy fines, other funds that kick in later in the year for services folks are wanting. There's a variety of reasons they fluctuate.
>> How much time is it typical to is it typical to be on the wedding last?
>> I don't have that specific information, so I can get that for you.
>> Part of our new can get that for you.
>> Part of our new regulations do outline how we want waiting list.
>> I've asked Candace to come up so we can answer the question.
>> She was winking at me.
>> Wasn't a full week of the partial.
>> The morning, numbers of the Board, madam President, community section manager. I wanted to answer your

question. Because this is a State general fund only program, all individuals on this we is a State general fund only program, all individuals on this we assist annually, there's a not a maximum amount of time. It really varies based on fiscal year basis, so we don't track amount on waiting list as we assess on annual basis based on allocation [Indiscernible - low audio].
>> Go ahead.
>> Individuals with more severe disabilities will get on more quickly, and those with less severe maybe on quite less severe maybe on quite a while?
>> Correct.
>> Okay.
>> What I didn't hear was the changes we are making is not going to help the changes we are making is not going to help eliminate the waitlist, or did I hear that?
>> The changes we are implementing to help alleviate and and set standards for a waitlist, so we want to see families reassessed annually to see who is most in need to see how things have changed it for them to reprioritize funding for their waiting list.
>> The assessment something new?
>> have changed it for them to reprioritize funding for their waiting list.
>> The assessment something new?
>> No, that is a requirement where more consistent on -- and regulations. What Lindsay has done is she has taken a very lengthy manual that we have now been able to put into regulations so we can better enforce, better track cost better audit, and have overall better oversight of this now been able to put into regulations so we can better enforce, better track cost better audit, and have overall better oversight of this entire program. As part of -- as far as waiting list those are based off general fund allocation on annual basis, so we cannot change number of folks that are waiting just based off of the regulations without additional money from the general fund.
>> This is Christina. I want to clarify there are times manager goes and starts working with the family and find some needs. They may be able and starts working with the family and find some needs. They may be able to address those needs to different programming, not just the family support, but the family support is a unique -- I'm going to call it even a safety net because those rely on that support or whatever it does for the individual and their family.
>> [Indiscernible - low audio]. Thank you for putting this together for us. I think there's a little little typo in and ministration to the first one or the second one.
>> I think they just forgot to put it on CCB.
>> Which one, the second one?
>> 8.613, the first page.
>> Number two.
>> first one or the second one.
>> I think they just forgot to put it on CCB.
>> Which one, the second one?
>> 8.613, the first page.
>> Number two.
>> CCD administration?
>> Is that the intent?
>> It just says crossed out.
>> Something you can review
>> It just says crossed out.
>> Something you can review later.
>> This is Christy. One of the things I am struggling with is you said you were still getting feedback, which feels to me feels to me we should not put you on the consent agenda so agenda so there is wiggle room between now and next month. Are you an agreement?
>> All right, than I just, that was my gut. I wanted to clarify with you guys Rick I don't normally do that, but I needed to do that. Thank you.
>> Testimony Rex.
>> We do have testimony. Stephanie Garcia.
>> I am sure you are just thrilled.
>> Our next one my gut. I wanted to clarify with you guys Rick I don't normally do that, but I needed to do that. Thank you.

>> Testimony Rex.
>> We do have testimony. Stephanie Garcia.
>> I am sure you are just thrilled.
>> Our next one is Maureen Welch, I'm calling because I think she I think she let but I'm calling in case she is down in the is down in the parking lot and going to pop back up. I'm giving up. I'm giving her ten minutes to get up here.
>> Good morning.
>> -- and not Stephanie Garcia.
>> I got testimony from Stephanie late last night and here to share today. I am Executive Director for ARC. She is for the ARC a problem. I want to say very supportive of department oversight and in additions for the rule. What you guys -- gave was income only. Input so far. Many of my concerns relate to inconsistency that will be created across Colorado. Each CCB will develop procedures on specific polity such as defining emergencies, maximum amount of family receiving and procedures for how families Part A family receiving and procedures for how families Part A size for FSSP. [Indiscernible - low audio] c ounsel. Members and a process for addressing disputes. Although the the rule states the majority of Council Members should be Family Members with person of IDD, -- and conflict of interest between members and CCB. Stephanie gave example related to human rights were CCB Executive Director's wife was wife was on the HRC human rights Committee counsel. There's nothing that could prevent that nothing in the rule to address that. She remains on HRC. That's-- CCB. But there was conflict She remains on HRC. That's-- CCB. But there was conflict events interest.
>> Counsel also responsible for monitoring for all services and other duties conflict free as issue. The procedures for determining individuals are involved in the FSSB procedures for determining individuals are involved in the FSSB program. Specifically individuals shall not be placed on FSSB waiting list automatically. The most request replacement [Indiscernible - low audio] informed a position on waiting list. We know families don't know this. Many times their told sorry, and without being told they cannot be placed on waitlist. It's been a pretty big challenge.
>> It's in conjunction with FSSP for procedures described how families shall be prioritize, and notified of prioritization and notified of prioritization process, the process will be applied equally and accessibly for all. However you can have 20 different process with as many CCBs as we have so it does so it does not provide consistency. -- Case Management is an issue. We understand this is -- for the program and not under auspice of issue. We understand this is -- for the program and not under auspice of changes that Medicaid is making to our other programs. We also consider this is still a conflict of interest. Also-- more transparency. Rule requires roster for counsel includes names of Council Members made available to department requests. We think that should be placed on website as well. Recommendation MSB is requesting think that should be placed on website as well. Recommendation MSB is requesting -- rules for consistency for families across Colorado, and always our chapter is in ARC Colorado will continue to work with the Department. -- a little this morning about that issue to further ado look at look at ways that can be more transparent across the State. Thank you.
>> Thank you.
>> Any other questions?
>> Maureen Welch has a question Maureen Welch has a question or a comment.
>> Go ahead.
>> [Captioners transitioning] A part of this program gives the flexibility in which the area they serve, the needs are different across the state and we want to maintain that flexibility. We understand the need for consistency. We have added a couple of sections that we can talk about more, like the quality assurance and review, so that the folks know what the department is reviewing for this program, and to provide that level of oversight. To ensure that kind of consistency -- and that goes through the prioritization process, we want to make sure that there are elements of this from CCB, and a part of the reason for the regulation as well clearly we can keep tracking of conversations, making sure we implement that correctly.
>> We are very open to working with them.
>> Thank you for the great work, we appreciate it. With that I will entertain a motion. [Indiscernible - multiple speakers]
>> Will be initialed document revision to the medical assistance room with family support of this program, FSSP , regulation section 8.613 incorporate the statement of the basement of purpose and statutory authority.
>> A motion?
>> I second.
>> All in favor?
>> I. Okay we will stop. Okay, Dr. Givens.

>> I.
>> [Indiscernible] I.
>> Thank you very much. It passes. Thank you ladies, I appreciated. Let's take a 10 minute break. Your chair needs to stand up, she needs to stand up. Let's take a 10 minute break. Thank you very much.
>> Madam chair, would you ask Donner and Dr. Givens if they are having sound over sounds on their end, as far as the reception?
>> Okey-doke.
>> I am not having any problems.
>> Neither am I.
>> Okay, thank you.
>> Okay we are putting you on mute. Take a break.
>> [BREAK - 10 minute break]
>> Okay, we are on document 10. We are going to invite John 12. -- We are going to invite Diane Byrne . Thank you very much.
>> Good morning. I am here to present 1901. Yes there are others, which Chris has put out for you this is the revision to medical assistance long-term services and supports, HCBS benefit rule concerning supportive living programs, section 8.5.5.8 five. So just a little background, SLP is a residential service focus on people with brain injuries. About 250 people per year this change is a fairly mile technical change. We are adding licensure at the request of [Indiscernible]. Ensuring the sustainability of our existing providers, while maintaining oversight for the health safety and quality of service. Again, the focus on this changes to ensure sustainability with existing providers cannot expecting a client or budget impact from this change. Revision that happened late in the game, is moving from adding a class a license with the certification as an acceptable licensure type to adding any type of homecare license, with the SLP certification on top of it as a acceptable licensure type. This was the long-term plan originally, and a bit complicated because of qualified medication and administration involvement, or cube map if you are familiar third in order to use a class B license we need to up date the q-map statues as well as the rules . Which I have done. What will happen, for now a class a will be allowed, and in the future, once the statue has been updated, it will allow either all class a or a class B with the use of q-map . The main change is on page 4 of 15 if I am correct. In the original it was [Indiscernible] I believe it is different now. Let me look at the one that Chris has given me instead of my own copy. Okay on page four of fifth in, now lines 32 through 42 and they have been highlighted. The only changes allows homecare [Indiscernible] and then a subsection which has been added. That references the homecare rules, the q-map rules and statutes. The office will be reviewing this again to ensure that the newer citations are correct, so there may be some minor changes for next month as well, I am not expects desk expecting them to be [Indiscernible] but correct citations. This change is happening to prevent future changes to the rule. Now this rule is ready to go as well as the q-map being updated and we will not need to make additional changes. Without this change, the Department of prevention and control were unsure if the licensure was a sustainable path all of our existing providers if it was not change that would reduce the available providers for individuals with brain injury Tuesday residential services, without this change, [Indiscernible]. Welcoming any questions. Any questions?
>> I am not seeing any questions, you have explained so well. Okay. Do we have any testimony? We do have some testimony. Does anyone get confused with the SLP language with speech language technology? I am curious. It might happen every once in a while it took me a minute to get my brain around the SLP. On occasion it does happen, they are fairly different with their scope.
>> Actually gets confused more frequently with the SLS waivers. Which we will hear about on a little bit. Okay, we have Lindsay Westlund . Jump right up here. And identify who you are. And all the good stuff. Tell us all the good stuff.
>> Do you want all the bad stuff first? [Indiscernible] our chapters across Colorado provide [Indiscernible] earlier this week we met with [Indiscernible] sharing concerns. I do not think any of this will be unknown. I think many of us were surprised about the lack of rules and dealing with rights all the time with advocacy. [Indiscernible]
>> Okay, wait a minute. You are reading the wrong role.
>> We are on SLS which is number [Indiscernible - multiple speakers] we are on number 10. Okay. I have already passed out the things we already had, isn't that great. You do need to sign. For the last one. Do we continue or go back to the agenda?
>> You need to sign on a different one. You signed on the wrong one. This is SL [Indiscernible] okay. We would love to have you come down and talk to us. On document 10. Are you with us on document 10? Okay, good.
>> Good morning. It is great to be back. It is odd to be on this side of the table. Many years on that side of the table. But

agendas like today when you have 13 rules, reminds me of how much time -- thank you for the work you do, it is extensive my name is the [Indiscernible] I am the chief executive officer in Grand Junction, we have been a longtime SLP, supporting the program. And it is intrinsic -- it is interesting, to say SLP. My wife is a English-language pathologist. We appreciate your time and effort it has been a long road coming as, with Pat some turns -- we appreciate everything that the department has done. Definitely with your hard work tran 12. Even way up to last night. The way the rules are written now, we have no concerns with them but it goes a long way for the sustainability. And different clients that we serve answer for many years. And continuing to be able to do that, we appreciate the department's efforts on this and we continue to work to redefine and make sure we have the services as best as they can be.
>> Wonderful. Any questions? It is very nice to see you.
>> I would like to say thank you very much, speaking from Western Colorado. We want to get the word out so people are aware.
>> They need to let us know in advance.
>> Hello my name is Chris Sykes medical services coordinator , the information is on the medical services public website, and also on the [Indiscernible] email. Basically what we ascot individuals that would like to do testimony over the telephone, if they could email me obviously the name, and their telephone number that they will call in on, and the roles in which they want to testify on, and we can be certain to get them in the queue. Basically, right now our current software does not allow us to go on the fly. But that is a great step, and I appreciate it very much. Thank you all.
>> In the SLP regulations you have to either have a class a license, or a class B license, is that what you're saying?
>> Right now it will only be the class a or ALR. Assisted living residence license, it is the more typical one. We are adding class a for now, to allow the sustainability. Once we get that q-map updated, a class B will be able to be used, however because of the most practiced act and restrictions about medication administration we cannot allow class B into the q-map statue all three will be desk and one of the other -- yes. All three will be allowed. They are allowed under this rule change, however you will not be able to administer meds under the class B license until the q-map statue has been updated.
>> I cannot speak to the timing of statutory changes, it is something that we have been discussing with SLP provider community.
>> Okay, a motion.
>> I move the initial approval revision to the medical assistant long service [Indiscernible] supported living programs, section 8.515, incorporating statement of basis and purpose and specific statutory authority contained on the records.
>> I motion, all in favor?
>> I. Smack okay. Dr. Givens.
>> Mr. pot.
>> I.
>> Roberts.
>> Dr. Givens. Donna Robert. I will ask again. Dr. Givens. Donna Roberts. [Indiscernible]
>> [Silence]

>>
>> We are in a holding pattern. [Indiscernible] sorry guys. I have a question while waiting. [Indiscernible]
>> I have not looked at the last changes, they are pretty minor. We are good for 10. [Indiscernible - multiple speakers]
>> I have a question mark on seven do we want [Indiscernible] to see that? Those were my questions. Do I have six, eight and 10 so far?
>> Five is final.
>> These changes would not be substantial enough to warrant. [Indiscernible - multiple speakers]
>> We do not have a six.
>> Donna said she had to return to work, she just text me back.
>> She has to return to work.
>> Okay.
>> David is somewhere. He's counting. He's here. We need to table this, I am sorry. It was looking pretty good. [Laughter] you can do it really quickly next time.
>> We have the first, we have the second but we do not have the third.
>> Okay, gets frustrating. At this point, we need to table the rest of the rules, and closeout of the rule agenda. We will see next month.
>> For the ones that have already passed, can we do it by email [Indiscernible]?

>> We cannot move with the consent right now.
>> Chris can set the agenda.
>> We can double check later. I am pretty sure we can.
>> My understanding is we can't move.
>> Cassandra and Adam, I am sorry. It will set us back a month with a bunch of stuff. If I could generate with one pouf, I would. [Laughter] I still have the nameplates. [Laughter]
>> Okay. We can create some other problems -- okay.
>> Okay, document 12, 67 and eight.
>> 12, six, not seven. And eight. [Indiscernible - multiple speakers] we will be here to review that one.
>> I thought it was nine. Smack [Indiscernible - multiple speakers] 12, six, eight and 10.
>> We cannot put 10 on because we do not vote. Thank you.
>> Okay let's vote to a closing. All in favor, you just made that.
>> Robert said I can call in again. I have a patient in about two minutes.
>> We get two votes.
>> If Donna can stay we can finish out the two rules.
>> We will let Donna tell us.
>> [Indiscernible] that would save Diane, she can get to her agenda perhaps.
>> [Laughter]
>> [Indiscernible] I was reading my book with my son about a shopping mall. I had to explain to him what a shopping mall was. [Laughter]
>> [Indiscernible]
>> Hello, it is Donna.
>> We have never been happy to hear from you. [Laughter]
>> I am sorry, I have patients right now. I understand.
>> If you can say on -- stay on for two minutes. We did a motion on document 10, and we need a vote on document 10, with the changes for the supported living program. We will motion in a second. We have the votes at the table. And we have David's. And we are waiting for you. Smack yes
>> Yes, I.
>> We can put the document on the consent agenda. And also we will do the consent agenda motion,.
>> We post bold oh we postponed roles.
>> [Indiscernible - multiple speakers] okay, let's go ahead and do the agenda. You can go see your patient. And then we will switch things around.
>> Okay nevermind. Donna, call us back when you can. Call us back as quickly as you can. We will come back to you.
>> I apologize. I am blocked out for only two hours.
>> Yes, this meeting is not just for two hours.
>> Okay, thank you and goodbye.
>> Okay. Diane. We will put that photo on a little bit later. We are not going to do a closing motion because we are not going to move the rules as a part of the meeting, and we are going to go to updates and all of that.
>> The only person registered for public comment is Maureen, she is not here. And we will keep going. Would you give us the department -- can I stand while I do it?
>> This is for the department. I am referring to a PowerPoint which is up on the screen for those that are here. Just a couple of interesting things that we covered down the pike. All the things that are going on right now. 35 bills in healthcare right now.. This is an interesting budget. [Indiscernible]. The adults will be in senior space. Workforce development WorkStream including training, tracking workforce against needs, $20 million budget action for 2019 20. We will have CIVHC foundation support, $4 million funding, including 2.5 million in the budget, which funds the AP CD, advisory board refocus. And employer data. I'll double down increasing inspectors. That is inside the agent's office in collaboration. And member of service technology, and increasing availability to pay providers in a more innovative way. On page 3 we have a lot of budget request. A $10 million budget. And the states total funds on the fourth of the states general funds. We have some more interesting items. The focus is to get to universal coverage and on page 4, we talked about Lieutenant Governor's new cabinet, to have lower healthcare costs to save money on healthcare. This is a summary of the roadmap. A lot of specifics, it takes the information and incorporates into an even bigger vision, like insurance and hospital price transparency, and more. On page five, the focus honestly in controlling cost is to get this key factor which I had on the reason Tatian, two meetings ago -- it underscores the fact that the third state budget, going to healthcare, and typical families who have [Indiscernible]. If they cannot pay for the benefits, it is hard for the family

to get from here to there without federal subsidy. This is what it underscores. In the importance of all of us being the part of solution of lowering healthcare costs, to be part of the solution. On page six, five parts of the affordability roadmap that we have shared before. We have some details. Prescription drugs last time, [Indiscernible]. We would talk about alternate methodologies on hospitals, emerging systems and strengthening data, maximizing innovation. On page 7 is one of the emerging alternatives, working with regions to see if we can [Indiscernible] on how a hospital [Indiscernible]. We talked about a hospital. If we can do this at our department, and inside to have a lot of different procedures. And the objective if you look at the cost on the x-axis, and quality, which is this complication. It makes it low on the Y axis, you want to have the hospital's [Indiscernible]. And so if you look at number 32, hospital with 32 of those types of procedure, on the right-hand corner, you want to [Indiscernible] we want to pay them to defer. This is a change in how we pay hospitals moving forward. We are working with them to figure out the statutes that allow us to have this collaborative dialogue with hospitals. It is a different way of looking at things. It helps the patients with outcome, helping costs go down, put small volume in the hands of those hospitals can be centers of excellence. And some hospitals that are not very good at it. It will take some time but we have had a fifth conversation with the office. It is in the hospital transformation program. And we are trying to work with all hospitals to figure out to do this. And best outcomes for all of us. More to come on that. This is a big slice of the pie.
>> Are there similar programs in other states?
>> No. On the next page. We need to talk about the added network. The house bill on the table. And the testimony that I will be testifying on behalf of. The executive director as healthcare expert, and to make sure that there reimbursements for those providers that out-of-network art in line and appropriate, right now it is not uncommon for some hospitals to have 14 times with a collect within network, 8 to 14 times as the range. We want to pull it down to normal areas. And a lot of areas were positions are [Indiscernible] three-year providers charging enormous rates, taking advantage of loopholes. [Indiscernible] reimbursement should be less than 1000. They are getting paid three times higher than the shirt go. -- Surgical. [Indiscernible] on the right, hospital transparency, community health needs assessment transparency and community towards engagement. Their profit margin is an construction. Some very good insight. The roadmap dropped yesterday, the advocates have been instrumental. Gaining insights. We have a lot of individuals representing community on the board. And talking about investments, and how you invest within the community of health needs assessment. Having transparency with the information. It in -- it empowers the community. And those two things help to drive policy moving forward. I am very excited about those parts. The transformation program. Taking the 1.2 billion provider fee redistributed so in the way in collaboration with CMS. And our Colorado hospital association and department to encourage hospitals to involve the ways that meet the needs of the community for an example, last time as we talked about standalone arrangements. We converted something that community does, treating opioid, addictions, and for an extended primary care. On the next page, we have specialty drug impact hospitals. We have had addendum's to this conversation going in the right direction. And the level of collaboration with the industry, making sure we are doing the right thing to help lower healthcare costs talking about pharmacy. In that department we have one billion-dollar pharmacy before rebates for manufacturers. The good news, within the last 6 years, generic class are down about 8%. [Indiscernible] branding drugs about five percent, 90 percent [Indiscernible] we can handle that it is not terribly concerning. The next slide is specialty pharmacy. Those of the high cost, magic molecules, often customized per person, often in the industry by manufacturers to address disorders, and for [Indiscernible]. This is really expensive stuff go $1 million drugs. 400,000. [Indiscernible - low volume] this is a big deal. Just to put in perspective. 1.25 of Colorado Medicaid prescriptions, specialty drugs, are so expensive, they are consuming less than 40% of Medicaid's arts resources. It is not surprising that it is 2% across the country. It is a national problem. We are national leader, and we want to help address this. If we do not address it is not slowing down. Slide 11 is critical, manufacturers are investing in these drugs and we must address this, or it could cripple us. We can pay up the entire budget with specialty drugs. We want to point out on page 12, that the PAL United States General accounting office found that 350 different drugs experienced hundred 51 extraordinary price increases, at least as doubling in price to year-to-date. [Indiscernible] it is not just the specialty drug, it is a problem. [Indiscernible] this is a big deal as well. And on the next page you will hear rhetoric about Reeser. On page 13 it is intended to say, $40 billion a year more on marketing and straighter expenses than on research and the new development of drugs. Department released May, [Indiscernible] trying to figure out why we touch money into hospital, provided the, load uninsured rate, a ton of money coming into the system. It is important that we have collaborative partnership across the state, so we make sure that the right policy emerges from those dollars, and the policy is in place to lower health care costs, and benefit caller audience. And we will have support on the big Pharma. A book has been released, and it is running around. A very good researcher. We pulled all good data. And we have some charts and drafts throughout the report. Digging into rebates. Hundred $60 billion in the industry with big Pharma. And through the middleman and to offset drugs. The department

has about 500 million, [Indiscernible]. To offset the price paid by taxpayers in the federal government. That is a perfect example of how we semi-pharmacy benefit managers and insurance companies we are trying hard to push those monies through to help offset the cost of [Indiscernible] to lower health costs to save money. [Indiscernible] we should have that contract in the third quarter, CMS needs to approve the proposal. It is on the table to negotiate. In process shortly. We have already identified vendors. It will allow physicians to understand customer drugs before they prescribe it, to understand the payer. Whether CIGNA, or United. The reimbursement programs are to help people with health. [Indiscernible] it is a program not just a pill. We say that this person has a higher propensity to become addicted copy careful as you prescribed opiates. It is a wonderful game changer. Prometheus is a tool that goes to providers, helping us guide care hire quality and more productive providers, and helps identify where opportunities are to reduce complications and costs. We are excited about that. And focused on trying to move the Jensen's medicine. That is my error. [Indiscernible] the universe is helping us create that roadmap. On page 15, we have a lot of work screens to be in collaboration with the governor's office to lower healthcare costs. And we are collaborating with other payers we do not want to be on an island. It makes it hard for the providers to go one, and a different way for five other large commercial carriers. We want to do lots in collaboration. The chart for example do we want all payers to pay. Not just Medicaid. On the last page we talk about a bunch of those. The ones that we did not talk about is the public plan, and to clarify that is not -- a plan recognizing with industries struggling to get people covered and how it can rise to meet those unique needs. We have the transportation bill. It will allow us to import drugs from Canada. I was on the phone with the governor of Florida, and it is our intention to limit Florida. That is the bill that he likes, we are making sure that we can do it as close as we can it has a language that says you want import from other countries as well. We cannot do that to start because we have a single subject constitutional rule. [Indiscernible] and the second round is the [Indiscernible] and to have a bunch of behavioral health bills on the table as well. Do we have any questions? That was 10 minutes or less. Any questions?
>> Thank you for your leadership and your dedication to keep Colorado being a visionary for these programs are you able to talk a little bit about that telehealth and around that?
>> First of all, is to make it easier with people in relationship to their prior it is a uniform. We have areas, we want to help rural Colorado have better access all around we want to help those with disabilities who have a hard time commuting. And to be able to open up that avenue for them, for wearables, monitors, and a lot of ways we can do it. We want to open up specialty access, to everybody. Especially access with rural communities, and disabled disabilities. -- Individuals. As well as behavioral health. It is very important that we access and create relationships, allowing people to be relationship their physicians. [Indiscernible] smacked can I add one less population group? The senior population. They have difficulties getting out and family members are trying to assist. They could in effect from being at those meetings. Smacked absolutely. We can do for seniors as well it is so important. Thank you for bringing that up.
>> Any other questions?
>> [Indiscernible - low volume]
>> Can you come up and tell us your name? And who you are? So people can hear you on the phone.
>> I am a nurse. I did not hear anything about levels as far as PAs. [Indiscernible]
>> I did not say anything about that but I do have a PowerPoint.
>> Telemedicine technology is great. [Indiscernible]
>> The Colorado Hospital Association, the 23rd, with the Lieutenant Governor who is over the cabinet, just disgusted. And he added parts to say to make sure to focus on nurses, and not mid-level, to make sure that we are not just focusing on purchasing of physician group, but messaging folks every day. Relying too delivered critically important care to patients. The project was approved last night. Is a whole lot of increases that address the area that you just referenced. I do not have it at my fingertips. [Indiscernible]
>> It is important for these guys to have provided care in these areas.
>> We want everyone to operate on the top of their license.
>> I have another question to follow. Is there a limit to the type of care that nurse practitioner provides? For refills a summer [Indiscernible] is this something that the state is thinking about?
>> Hello, this is Pat and I am back on.
>> I have not seen any open to set passes for this year.
>> [Indiscernible]
>> We are looking for the next legislative agendas top priorities. We can look at that. You can send me a note on that.
>> Do you have a question?
>> It is just an observation, I would recommend not using the term mid-level with any of your PA, colleagues. It is not a preferred term. As many of us have learned. We like advanced practitioner.

>> Thank you.
>> I need to leave at noon.
>> Okay we have Pat Gibbons on the phone. Thank you Pat for joining us. We are going to document 11. That is Cassandra. Cassandra, come on down. And present to us.
>> Thank you. My name is Cassandra Keller I am in the benefits section, I am the supervisor. I previewed for this role last month, basically what we are doing this manually change to the transportation [Indiscernible]. One of the waivers for community health support, spinal cord injury and [Indiscernible]. Medical transportation is a service available under those waivers, and the service allows individuals to not only go to and from subscriber to access their communities so they can use it to go to places, the grocery store, the community center, visiting friends and family. That is the basis of this service, the change that we are making, is to allow for the provision of former transportation to be utilized. The department has partnered with RTD, to have individuals having the option for public transportation. A combination of public transformation and provided based transformation. And how manager C best fit for their needs. This allows us to include this and allows us to provide that additional service. Any questions?
>> Okay. Would anyone like to testify on this? I am not seeing anything. Okay I would entertain a motion.
>> Under the initial approval of document 11/for the elderly blind and disabled rule, [Indiscernible]. I have a motion. All in favor?
>> I.
>> Okay, Dr. Givens. Is that and I?
>> Okay, thank you. Donna Roberts?
>> Okay she's back. Thank you. This passes. We will go on to document 13.
>> Mr. Adam Tucker, welcome. Not last but not least.
>> Thank you madame President and the bar. I am aware of the time. I will try to be as quickly as I can. This is a big pretty significant change in regulation. Just so you know, this is MSB 18 11 07 a. This is section 8.501 for the states services. This is not community-based labor, this is state general funds, just like FSSP which you heard about earlier. This program is not designed to support people who are over 18, who also have developmental disabilities. This program has in existence for a while, and we are trying to do through this regulation, is to put some better boundaries around it, including changing some service categories, as well is being able to implement quality assurance regulations. We have something that we could make sure that this program is being administered in a quality way. This program is because of statute, administered by the community boards, and in total there are now four different service categories. For service category, it is designed for individuals who are working to get onto the supported living services, over the actual label. Through data and through speaking with different community members and stakeholders in genuine, that is what happens, somebody can be eligible or is eligible for the community-based waiver, but it still takes time to write down that service plan to get your set up, and all cases together. That person is going for a time during that period, where they are still not getting services but still need that. And so this program is designed because of the [Indiscernible] that it allows you to be eligible for this. It will support people as a work in progress, to get onto the full waiver. The second and the third service category can be seen similarly. Really along with this entire program, actually it is designed to enhance some of these independents, and and tell the independence of immigration the second and the third service category designed around supporting someone who was staying in a home where they run into temporary hardships, they fall behind on things like utilities, or they have a pest infestation. This program can actually be used to support people, and mitigate some of those circumstances. Whereas that third service category is designed to support people moving into more independent housing, moving out of group homes, and finding more independence within the community. Things such as including things like mental applications, but also food pantry set up, rental applications, those types of things. The idea is to continue to support the individual and strengthen independence within the community. That final service category, it is designed for that corporate of individuals, who are either over resources, or they may not need services every 30 days. There is a stipulation within the community-based waivers, that they need to have a service every 30 days. We have individuals who need services, I want to support them in that and not falling through the cracks. And by giving them sporadic services, maybe once that needed every 60 days or every 90 days. This program is to support those individuals. That will also extend to individuals who may be working, and making just a little bit too much money, and so they they [Indiscernible] services that is also included. Finally the last part of the regulation that are in front of you, those are responsibilities around case management, and a lot of that parlors we see with community-based waivers. But also about transfers. And thinking about individuals who may move from one area to another, and how to work with that. One of the issues when we think about this, two things that I think it is important when thinking about that transfer -- state general funds based on a yearly state fiscal year allocation. Also on top of that, really the idea for all of these services are that we really do want people to enroll, where they have the opportunity to

enroll in more permanent funding. Like a waiver or a home community-based waiver, realizing services and supports within the community. Really this is a last resort, but we do want people to have access to the things that they need as far as this evolved over time, through stakeholder engagement. We started engaging around last September, and listening to what funds were being utilized for, within each community, and we started to build service categories, and how the program will actually run from that place. We then had very robust public meetings in the stakeholders, and I want to point out that we actually had a draft of this regulation, and we actually gave it. We have a PowerPoint as well as regulation. And we are actually giving detail, people are looking at it. We look at a .5. We talk about how it is fitting in with different processes that are going on within the whole regulation. And what that allowed us to do is to make sure that this can as easily as possible, to be administered correctly. Making sure that these processes were actually being requested by stakeholders, making sure they were sent to ones that can provide services. All the way down to a laundry list of different changes that were made. We also have continued to have stakeholder engagement, back and forth with conversations, even as early as yesterday and today with ARC. And we are continuing to work with stakeholders to make small changes over the next month, making sure that this program is as strong as possible. Thank you.
>> Does anyone have any questions for Adam? This is Kristi. I will make one recommendation in the definition area you put the word [Indiscernible]. Provider approved service agency. It is not in the very [Indiscernible]. Smack I will absolutely. Smack just one little thing. Does anybody have any questions at this point? We still have activity, this will not go on the agenda. The consent agenda. This has changes. We are just making sure. Any questions? On the phone, any questions? Okay.
>> Hopefully next month we will have more time.
>> Yes. Okay, Linda this is when you come up and we will look at the handout. It is a really nice paper.
>> 13 has a different title. [Indiscernible] I think she just signed up for everything. We are in support of supporting the rules. I think I will point about the issues. [Indiscernible] a lot of Adam spoke about, we will have more consistency across the state the current thing is to talk about affordability, but they do not guarantee it. If you have services in Adams County anyone a move to Weld County, because it is cheaper, there is no guarantee that you will [Indiscernible] even for the current fiscal year. That is one of the things they are concerned about. And something we are trying to do to launch that third I think we are also asking for [Indiscernible] we have added several categories. That is the priority for us. Trying to look at that better. And set up contingencies. Right now [Indiscernible] services that they will provide -- does not mean Weld County will provide the same services as Adam County. We are looking for that kind of continuity one of the bigger challenges that we have, they can decide who will have access to [Indiscernible] they can pick and choose individuals needed. And it depends on what the system wants to do and does not want to do about this. That is another concern that we have. And it looks like Adam [Indiscernible]. The state needs to have a protocol to address issues. Consistency across the state and how we can work together and come up with ways to make changes.
>> Any questions?
>> The balance between consistency, and those community boards being able to have freedom -- that seems like a really hard balance.
>> So yes, absolutely. We definitely want to ensure that there is flexibility. Communities across Colorado, urban area, Denver, it is different than what you would run into in Alamosa or Southern California. -- Colorado. They have research on the pulse of what is going on and I think we can find some -- making sure we keep flexibility and addressing issues. I do not think that would be a substantial change. Smack keep in mind, it is the state SLS. This is the state only. There are two SLS programs. It's hard to keep your brain around them sometimes.
>> Flexibility is important. Also continuity. Hours have chapters across the state. And chapters that can get a sense of what is going on for community support. Thank you very much.
>> If there are no other questions, I will entertain a motion.
>> Initial approval of document 13 18-11-07-A medical assistant benefit rule considered section 8.51 incorporating a statement of basis and purpose on statute on the records. Smack
>> I second.
>> Dr. Givens. I.
>> David Pat, I. Smack Donna Roberts.
>> Consent agenda.
>> Thank you.
>> I second motion. I favor.
>> Pat Gibbons, I. David Pat's, I. Okay. All the rules adopted. Go ahead. All groups adopted. [Indiscernible] a consent. Okey-doke. We still have one more presentation. That is Joslin. She will talk about another waiver. You will talk about this. Do not be offended. [Indiscernible] is going to leave.

>> I have clinic on Friday afternoon.
>> If on the phone, we would love -- if you are in another state, and trying to attend a conference, we understand if you need to leave.
>> Thank you.
>> Thank you for having me back, my name is Lindsay Westlund I am a benefits restless. Back in December when I presented on the HCB is children's extensive support waiver we asked for an update. We have received it during the meeting. This is the update. On page 2, our mission. We will jump right into it. This is a waiver serving children with intellectual and different mental disabilities, or developmental delay. And there is a criteria that we have. It is reviewed to determine overall eligibility for this waiver.
>> The children in this program need to -- the main criteria for eligibility, it is different in that we require a demonstrated need for complex behavioral, or medical need by the child. And that need needs to require almost constant line of site supervision for the child in order to be eligible for the waiver. And services available. Just a few statistics about the waiver. Currently we have about 1850 children on the waiver. There is no waiting list for this waiver. And we have case management agencies that are community centered, that are doing the assessments and enrollment for this waiver. We also have one utilization review contractor, contracting with the state to review the additional targeted criteria that the waiver requires for eligibility.
>> Our stakeholder feedback, that is what we were looking at. I will summarize the things that we have heard. On slide seven. What we did is we had taken the feedback, we created themes and guides from stakeholder meetings that we had. And so these are basically the things that we found. One is to develop some plain language to have the eligible criteria, and it is hard for folks to understand, and to understand that their child would need criteria. We want plain language to document the program. Also to improve the ability to access the program through the enrollment process. The CES waiver has an additional application outside of the level of care assessment, and that helps families identify what those extensive medical and behavioral supports and interventions are, paper application and it is quite burdensome for families. That was definitely the feedback that we heard, and went to work on. And we want to ensure consistency through the implementation of guidance, the regulations, that govern this program. We do have a lot of folks involved, advocates, case managers, state reviewers. We want everyone to be on the same page on the implementation of the eligibility criteria, so folks do not get Ms. -- mixed messages about the waiver.
>> These are the dates that we have held engagements, January 30th, then again in March, and the last meeting in the series was actually Tuesday of next week.
>> I just want to talk about the outcomes from each meeting that we have had so far. Again, we want to develop some plain language for this program implementation. We did present a draft document, and we have stakeholder feedback, and now it is in a clearance process, and should be ready for distribution shortly, to case managers, families, advocacy groups can use this information document. Additionally, we have operational memo. Not quite available but forthcoming. It takes regulations found that this section, and it gives the department guidance on interpretation. That is to give everyone a solid foundation and how the department interprets criteria, specifically focusing on criteria [Indiscernible] it is always hard for folks to understand. And maybe inconsistent across entities involved, we want to have guidance that highlights how the department wants that to go and how it to be interpreted and enforced.
>> Hello I have a question. Is that going to be available in other languages?
>> Yes, that is the feedback that we have heard. Sometimes the eligibility criteria does not translate other languages, and difficult to understand. We want to have an appropriate document that can be translated.
>> On the next slide, the second meeting talking about that feedback application that we have for CS. The outcome of that meeting, is to get rid of that paper application, to remove the burden. We are going to do that in a phased approach so far we have taking the application down to the necessary pages, and that will be used in this interim process, as we train case managers and our reviewers on where to find information, and the level of care assessment. Case managers are ready during the LOC assessment and they will document the extensive medical and behavioral needs, that the child has. And the reviewer will look for the information to determine eligibility, instead of using this paper application. That was the outcome of the meeting, that is what we are moving toward. We will have an operational memo also. It is forthcoming. It will give folks guidance to start using this application until we complete all trainings necessary to remove it completely.
>> This is outlining our phased approach would covering all trainings that we need to do to make sure everyone is on board with this pretty significant change process. A meeting is next Tuesday, it is going to review the work that we have done, outcomes of the meetings, and look to how we are going to move forward. And identify rules and responsibilities that folks have been implementing this process. We also want to make sure everyone is aware of their role and responsibilities within the enrollment process. We will probably ask for more information about how to develop the

trainings that we need, to move forward with the elimination of the application we will touch back on that during this meeting next week as well.
>> This is outlining again, the operational members that are forthcoming, and the deliverables from this project. Those are outlined. We will have the first memo, given the guidance about how we want the regulation interpreted, the second operational memo, that is talking about removing the CES application and using the other version hopefully the summer operational 2019 guidance to stop using the application in its entirety.
>> On the next page, some other news that we are excited. That eligibility criteria that require families not only to report the needs of the child, but then to also get third party written documentation that corroborates that report by the parents. This is also burdensome, especially if the families reporting nighttime criteria. That is not something third-party will see our accurately state if it is happening. This is a part of the eligibility criteria that we were able to review that does not have any budget impact, and we are going to look removed from our role and go through the rulemaking process provision. And we will present that hopefully within the next few months and we would like to remove this requirement of third-party documentation. That is also a forthcoming outcome to our engagement. I feel like that was pretty quick.
>> But the nighttime criteria is going to stay?
>> Yes it is. It requires quite a bit of fiscal impact.
>> I saw all denials due to nighttime criteria.
>> Those are just two examples. We reviewed the denials each month, and some are not due to date time criteria, or combination of both, not having the appropriate DT at the time of application. These are examples. Another outcome of this work is reviewing those denials, more in depth with our reviewer.
>> Thank you I am sorry to have rushed you. Does anybody have any questions? Thank you very much, we appreciate it. Okay. For the listening audience. [Captioner transitioning]

>>
>> THERE IS ONE PERSON SIGNED UP BUT THEY'RE NOT IN THE ROOM WHICH IS WHY I DIDN'T CALL ON PUBLIC TESTIMONY.
>> WE HAD THE PUBLIC COMMENT ON THE AGENDA.
>> WE HAD PUBLIC COMMENT. ONE PERSON SIGNED UP.
>> Somehow it went to March.
>> I refreshed.
>> I just need to read this.
>> You're welcome to it. It's part of the record because it has been submitted.
>> So we are looking at Richard Wallace's letter to medical services board records.
>> Then we may adjourn. Thank you very much for putting up with a very long meeting.
>> Did you need any other approval?
>> No. We appreciate you more than you'll ever know.
>> Thank you.
>> What happened to the Richard Wallace email: we discussed that at all?
>> I just committed that the documentation. It would be part of the public record. But I didn't read it per se. We admitted it to public record.
>> So the board will not have a discussion on it then? Or did I miss something?
>> We weren't going to discuss it.
>> Okay.
>> Did it need discussion?
>> I just had a question on his concern. I didn't understand the fact it look like they're trying to cut down on the number of clients so the provider can make more money per clients. Until I read that wrong?
>> I didn't get that. Hold up and we will get that back up.
>> I wonder if we can refer this to a staff member to answer.
>> Hold on one second.
>> It's a reimbursement issue and an invitation. You sign up for the services you will provide. It may be that is limited in not providing certain services. Why don't we do this? Why don't we identify somebody on staff that can work with this parents to figure out, there's more than one issue in this letter. Does that make sense?
>> There is more than one problem. We need a couple of people to sit down and figure out is this a rule issue or provider capacity issue or where does everything lie? There are a couple of issues here.
>> Certainly. According to the letter, the way I read it, this Mr. Wallace and his wife were going to look into starting a

home that would provide the services their son needs and other potential people that could need this service. Than they were told they couldn't do that.
>> Candace will help answer questions. I think her staff will have to get their brains around some of this. Opening opening that is not the easiest.
>> I'm sure it's not. I would like to have it on next month's agenda so we can discuss this or get a report.
>> We can get a report. Candace at the table.
>> This is Candace Bailey, I am the community options benefit manager. I saw copy of the letter. It was a little confusing. My staff and I were going to reach out to him directly to better understand what his questions were and hopefully we can answer his questions and alleviate some concerns. We are hopeful with reaching out to him directly we will be able to answer his question if the board would like to bring it back. I have concerns about specifics around children. We would be happy to come back next month and explain that we had a conversation with him.
>> I would appreciate that very much, thank you.
>> This also bumps up against, this kid will bump up against the waiting list issue and the criteria for getting on to the waiver. The parents are in their 60s.
>> Some of that needs to be addressed as well. With this family, they may not know what we just passed. The ins and outs of a waiver.
>> They may not be getting all of the correct information. We want to reach out directly so we can guide them in the direction and answer questions.
>> I'm all in favor of decision to have the staff or reach out.
>> Candace will reach out to Mr. Wallace and we will take care of it. Is not being swept anywhere then on the front burner for all of us to address.
>> We have that on our to do list.
>> Have a nice afternoon. See you for dinner next month.
>> Okay.[Laughter] Thank you for addressing that.
>>[Event Concluded]