[PLEASE STAND BY FOR REALTIME CAPTIONS]
>> Audio check.
>> Good morning. Are you on the phone?
>> Have you joined us?
>> If you're talking, you are on mute.
>> This is Charlie. I am on the phone.
>> Okay, Charlie you are on the phone. Is there anybody else? Would you like to identify yourself? Charlie is definitely on the phone. Charlie I have a whole pot of decaf for you.
>> I am so sorry, my day fell apart. I apologize.
>> That is okay.
>> I am on the phone, so anyway, thank you. Okay, it will be consumed.
>> [Indiscernible] the ones that did come in. The hale and hearty. We have six point I was just trying to finish a little more [Indiscernible].
>> I usually bring my laptop.
>> Too much to carry.
>> Okay, we will get this meeting started. It is 9 AM. Good morning. You are at the medical services board and we will do roll call.
>> Ready? Christy Blakely, present. Cecile Fraley, on the phone. She is going to be on the phone.
>> Patricia Givens, on the phone. Simon Hambidge, excused. Bregitta Hughes [Indiscernible] Jessica Kuhns, here. Amanda Moorer, here. Charolette Lippolis, here. An Nguyen, here. David Potts, on the phone? Donna Roberts , on the phone.
>> The date and location of the next medical services board scheduled to be held Friday, March 8, 2019 beginning at 9 AM at 303 E. 17th Avenue Denver, Colorado. [Indiscernible] everyone in attendance. Private property. Please do not block the doors or stand around the edges of the room. No cell phones in the meeting. [Indiscernible] on the link to rejoin the meeting. The question and answer feature is enabled for the webinar, please submit questions and answers for each tool on the open form time and in the agenda. Please identify yourself with your comment as they will be part of the public record. Identify yourselves when speaking. If you are an individual testimony sheet for the form and is [Indiscernible] if you need help finding [Indiscernible] please ask the staff. You have a five minute time limit for each testimony. I will go to the approval of the January 11 minute.
>> We have a motion and a second. All in favor or approving the minutes for January 11 X
>> Aye .
>> Aye.
>> Anyone else on the phone, please speak up. Oppose, sustain, so passed. If you are wondering, we do have a quorum here so we are safe as far as that goes. Legislative update, we are looking for David to [Indiscernible] let's move on and we will capture him when he walks in, okay? If that works for you guys because I want to do the final adoption. I would entertain a motion.
>> I move for final adoption of document one, [Indiscernible] medical assistance rule concerning prior authorization for drugs, section 800 dot seven and eight dot 16, document to [Indiscernible] revision to medical assistance roles, and citizenship requirements, section eight dot 800 dot three [Indiscernible] Inc. statement of purpose and specific statutory authority contained in the records.

>> We have a motion and second. All in favor?
>> Opposed, sustain? Dr. Charolette Lippolis?
>> Aye.
>> Anyone on the phone, speak up.
>> Dr. Cecile Fraley, aye. It passes. Let's go on to the initial -- Dr. David DeNovellis is not here yet. The omission initial approval of the agenda, okay,
>> He knows he is supposed to be here. I am glad I'm not him right now. Okay. Moving away so you can understand what I did I will go into each specific change. The first change at 8.590.1 is the definition section of the durable medical equipment rule. The start of service has been added and defined as the date that the ordering practitioner signs the order for durable medical equipment, which requires face-to-face encounter. The second change, section eight . 590 .1 N.1 and N.2 expresses the requirements for face-to-face encounters. A face-to-face encounter must occur no more than six months before the member [Indiscernible] equipment. This reference the start of service definition and must occur no more than six months [Coughing] overall providers request that the department clarify the meaning of start of service [Indiscernible] stakeholder community. Are there any questions?
>> Anybody have any questions?
>> Dr. Charolette Lippolis, do you have questions for Christina? Dr. Fraley, do you have any questions
>> No thank you.
>> Okay, with that, do we have any public testimony? No. Is there anyone here who is dying to talk to us about this? No. Okay. I expected a little more discussion, but with that, I would approve a motion or accept a motion.
>> Sorry, the confusion is providing an update to Donna's question last month about the continuous testing strips for people on type one diabetes.
>> For those that are on the phone, [Indiscernible] motion and vote.
>> The initial approval documents, [Indiscernible] revision to the medical assistance rule concerning durable medical equipment start service, section 8.590, incorporating [Indiscernible] [indiscernible - low volume] we have a motion and a second. All in favor?
>> Aye. Opposed or sustained in the room? On the phone?
>> Dr. Charolette Lippolis and Cecile Fraley ? Aye and aye. Anyone joins us on the phone X motion passes. Thank you. Now January Montoya is going to answer question that we had last time for Donna Roberts .
>> From our [Indiscernible] visits.
>> Understood. Thank you to the board, as well. I apologize for my late entrance. I was [Indiscernible] jumping through while I try to answer these questions. In brief, the question was posted to the department is [indiscernible - low volume] glucose monitors [Indiscernible] monitor glucose in the blood level for people with diabetes. The question is when or what the status is of expanding the [Indiscernible] type one adult and currently the glucose monitors, CGM are covered under the early [Indiscernible] diagnostic and testing benefit and for members of until the age of 20. However it is not available for adults after that age when the age out of that. The department has been looking at a place and time and have been working with our stakeholders and looking at this clinically for the last two or three years. That is the amount of time I have been a part of it. [Indiscernible]

our understanding of the population, we were not able to expand the benefit at this time. It will have significant fiscal impact [Indiscernible] however, we are also looking at the potential of covering this in the future and we're going to continue to monitor. Ms. Montoya, it is treatment, not testing. Any questions?
>> I'm assuming you did a fiscal as far as the cost of going to and from the ER with that monitor? A significant impact? Saving money?
>> Thank you for that question. If I'm understanding your question, you're asking about whether or not the department is to asked ad cost saving and the potential for [Indiscernible] unfortunately, the data we have does not [Indiscernible] ability for us to support that cost savings. For example, practical sense if a member [Indiscernible] ER say they're having a diabetic episode. Chances are not diagnosis codes, but what comes over on the claims or what we see in an office visit, fatigue, nausea, dizziness, shakiness. The symptoms that go with that. It will be identified as a diabetic visit. The difficulty identifying those things. As far as what the department has done looking at the cost savings and how to provide it, yes. They are giving it the best.
>> Thank you.
>> Anyone in the room have questions? Anyone on the phone have questions? For Ms. Montoya? Thank you for coming. We appreciate it. So thank you very much. And we have David DeNovellis to give us a legislative update. We know you are a busy guy.

>> Hold on one second. Hold that thought. We will go ahead and do closing --
>> The agenda is number one.
>> I would like to add [indiscernible - low volume].
>> Rates, and closing motion.
>> Sorry.
>> All in favor?
>> Aye.
>> Those on the phone?
>> Aye .
>> Aye , this is Dr. Cecile Fraley.
>> And let's have someone read the closing motion.
>> [indiscernible - low volume] Department of healthcare policy meets the criteria [indiscernible - low volume].
>> Second.
>> We have a motion at a second, all in favor?
>> Aye.
>> Those on the phone?
>> Aye.
>> Aye.
>> So passes. A promotional ready.
>> Not a present, members of the board, good to see you. My name is David DeNovellis and I'm a legislative liaison for the department and I want to come today to give you an update, legislative update, the department bills come other healthcare bills that are going through the Governor's priorities may not be introduced but things are well working on as the session moves forward about a month into it now, it has been fast and furious. There are 86 more days left in the session, not that anybody is counting. Some of the bills that are moving through

the process, hospital 1001, hospital transparency is past the house and this is a bill that will require the hospital provide the department certain data, staffing requirements, beds, financial information, the department will then prepare a report and release that a chair with a chase board and the world. That is through the first house and should be introduced in the Senate sometime soon. Representative Kennedy was sponsored it in the house and in the Senate it is Senator Marino and Senator Rankin. We look forward to keeping you up-to-date on that. Another bill the department has been working on and is very supportive of is bill 005 which would require the department to set up an impartation program for Canadian prescription drugs from Canada. Assuming the bill passes, it will direct the department to come up with a proposal and get approval from the Secretary of Health and Human Services, and importing certain prescription drugs from Canada. [Indiscernible] help lower the cost of prescription drugs, and some leverage we can pull to bring those costs down. Another one we are working on is passed out of its first house committee, 1004, portable public options. That will direct the department along with the division insurance to come up with a proposal for an affordable public option to help lower healthcare costs and increase coverage. I will be working with the division insurance to submit a proposal to the General assembly and then a 1332 waiver to [Indiscernible] implement. This one that you will probably see soon assuming it passes, it has passed its first house committee, hospital 1038 will stand dental government on the Chip program for pregnant women. Chip currently covers dental for the children, but is not currently covered for pregnant women. This bill will expand that to [Indiscernible] oral health for the mother leads to better health outcomes for the child they are expecting. We are expecting 800 or so folks who will be eligible to receive the service when the bill passes. Our department agenda bills are still in process. They are currently on the potential list of budget committee legislation so it is still going through the process there. The breast and cervical cancer treatment program, that is a non-Medicaid program at the department administers for men or women with breast diagnosis of cervical cancer that don't have insurance or insurance does not cover the treatment for breast and cervical cancer. We do get a federal match to pay for that and there is a breast cancer license plate fund and the states share that. The program itself expires July 1, 2019 and we're looking to extend this program. As the affordable care act and Medicaid expansion, the numbers of people eligible for this program have gone down. There are still around 152-200 people per year and they are still eligible for this. This is a program that takes care people in a very vulnerable time, cancer treatments are incredibly expensive and knowing there is a way to get that taken care of is something that we support and want to continue that program. Another one that will also affect medical services in the future, right flexibility for lower income senior dental program. You all get recommendations from Chandra and the senior dental advisory committee and you approve the rates for you, procedures in the dental program, this will give you the ability to approve the rates for all of the existing procedures, two . when the program is transferred in 2014 from [Indiscernible] there was a statutory provision that said the rates to the program then had to say [Indiscernible] are, and what that has led to a some of these rates are much higher than Medicaid, other ones are not even up to Medicaid yet. We think letting senior dental advisory committee take a look at the existing rates, make some recommendations, and bring

them forward to you would be able to serve 500-800 more seniors per year with the existing appropriation. A lot of the times the grant monies run out sometime around September or October, so that would lead to a waitlist for the dentist and the grantees are providing services for free. There has been discussion with the senior dental advisory committee, roughly a year that it is a good idea to have some flexibility for those rates all across the program. We are working on that and will keep you up to date on how that goes. The governor's healthcare priorities are in process and moving. The department will be behind reporting our agency and the governor's office has been moved. When that just happened this week, House Bill 1127, that allows Lieutenant Governor to serve as the director of the office of saving people money on healthcare. That is its first committee. Lieutenant Governor Primavera will serve as the director of that office concurrently with her Lieutenant Governor position. Another bill that was introduced last week, last Friday, is the [Indiscernible] insurance bill. This directs the division of insurance to set up reassurance programs and helps with the high cost of insurance, especially on the western slope, we have heard there are incredibly high premiums. A lot of moving parts but the department is working in tandem with our sister agency in the governor's office to move forward with that. Yesterday, out-of-network bill was introduced. A surprise billing. [Indiscernible] NPR did a lot of stories this summer. You go in, in network, everything is supposed to be paid for through insurance, and you get a bill for the out-of-network services. This is going to division insurance will be the lead on this one again to address each out-of-network cost to help the consumer. To know what they're paying for and not be hijacked with a large large bill at the end of the day. Another one that is in process and is part of Governor Paulson's healthcare agenda is pharmaceutical transparency, as well. It is still making its way to the process, but he will be working hand-in-hand with our agency and the governor's office to move this forward. [Coughing] with that, I'm having to take any questions [Coughing].
>> This is Dr. Tran 19 Cecile Fraley. I was billed 1004. Is that a public option to buy into Medicaid? Is that what that is?
>> Hello Dr., this is David DeNovellis again. We have to come up with a proposal, a study to show -- so Medicaid by an may be one of the proposals that come through, a Medicare buy-in, something that is an affordable public option to help increase coverage a breakdown costs. There have been studies and similar legislation in Mexico and other places to do these kinds of studies. We are working with our consumer partners to see what kind of proposal it is going to be and that should be if the bill passes, we would be releasing that to the general assembly and the public on November 15, 2019.
>> Okay, thank you so much. As a western slope member, I will say it is nice to see someone looking at rates for our region.
>> Any other questions? Thank you very much for your time.
>> Thank you. It is good to see you all.
>> Let's open the public forum. We don't have anybody. Okay, all right. Let's go to [Indiscernible].
>> Apartment updates. We have a lovely PowerPoint. Two we do. [indiscernible - low volume]
>> There is a presentation -- on the screen. As you heard from David, affordability is one of the governor's top priorities. We have had numerous teams engaged in how

we find efficiencies and healthcare policy and financing. That is really important because in this budget request that is under consideration now, [Indiscernible] and the governor [indiscernible - low volume] 33% of funds. For us to be efficient it is really important to all agencies. Our intention is to get help [Indiscernible] passionately to help the states most vulnerable which touches 22%, 1.3 million and other safety net programs. We always want to put them in line with [Indiscernible] efficiencies but we want to [Indiscernible] predict and prevent [indiscernible - low volume].
>> Last year, we had a bill passed through all of the committees and the house and the Senate and that was 18-266 in the second bullet there. That was a product of all of the good work from all of the passionate employees of [Indiscernible] and reflected those [Indiscernible]. Those programs on that bill are being implemented right now. [Coughing] Prometheus is a great example of cost improvement. Prometheus is an innovative tool and it finds potentially avoidable complications inside the care delivery system. You can use [Indiscernible] software to look at potentially avoidable complications [Indiscernible] primary care level, hospital level, so we provide the tools and we have a goal for the department. All of the RAE's . We use it to intervene [Indiscernible]. We have given it to hospitals and we have a goal to have 85% of hospitals understand the tool and have exposure to the tool so we provide the data but they use the tool and say where complications, for example [Indiscernible] comp locations with infections when they come back in every admissions. They can evaluate themselves against others to say well, my potentially avoidable complications are higher than others. We can use this time as a society with civic and healthcare costs and financing to say some of these are really good [Indiscernible] and quality and cost. These are centers of excellence. [Indiscernible] remember we have signed another 400,000 individuals to primary care [Indiscernible]. Now they have tools that help them manage the higher-quality organizations. I'm pretty proud of that tool. There are other states doing it but [Indiscernible] a great example that is being rolled out now. A physician prescriber tool that went through a [Indiscernible] tool, now we have identified the carriers and hospitals stepped up. Our department [Indiscernible] it's it's it's either electronic medical record and helps them see reimbursements for all the major payers. If the person in front of them [Indiscernible] drug alternatives that the record provides them, now they can [Indiscernible] cost of those drugs on the patient side, the co-pay, and the cost to the payer. [Indiscernible] and not just from the drug sales out the door, but the actual cost of the drug alternatives subscribed to their patients. That electronic medical record [Indiscernible] and physicians get more savvy. [Indiscernible] cost and quality. At the same time, we are adding modules. Our artificial intelligence does a cost comparison. They can make decisions from that based on whatever they want. There are still mandates that they use to lower costs, but it gives them [Indiscernible] recognizing that pharmaceutical costs drive 20 to 25% of employer costs and [Indiscernible] Medicaid every year. That is a wonderful example. We want to make sure the physician [Indiscernible] risk of addiction if they are thinking about opioids? And available through entrepreneurs, in fact coming out of the state, they can say this person in front of you as data that we can see [Indiscernible] that make them more susceptible so be extremely careful as you prescribe. You want the delivery system not to be part of the problem but the solution. That is protecting families and

were very proud that we can reduce the number of opioids prescribed to the population in the last three years by 10% roughly each year. So we are 30% lower in three years. [Indiscernible] on target to do it again this year. We are proud of that but recognize in 2015, 2013, we were [Indiscernible]. Around the country have a [Indiscernible] pills and a bottle in every single household in this country. It sound like we are dropping but we have a long way to go to get to where we are supposed to be. We are very excited that that tool will help us with opioids and addiction and give physicians the help they need. It will help on pricing and efficacy and the third thing we are doing on the actual is asking all payers to load their programs, their health improvement programs, so if you are an Aetna member and you come in and get your blood pressure, the doctor can prescribe both of Aetna's cardiac management programs or heart disease management programs [Indiscernible] to the root of the [Indiscernible] instead of treating the symptoms. We are very excited for this tool to be nationally leading and proven quality and giving physicians the tools they want [Indiscernible] entrepreneurship in their states and continue to drive Colorado to help care innovation for the country and approve patient quality and health. This is a tool we should see in the second half of this year in implementation. Those are innovations that came through this bill. The next two are ketchup's. That is catching up with the industry suffer 32 years, they have been replaced on the commercial side we have not had that and when you don't have [Indiscernible] other level of care to get their care and it means we have not been able to give [Indiscernible] notice [Coughing] [Indiscernible] helping them stay well. We have not been able to give those people notice of when they went in and what they are getting treated for [Indiscernible] now we have information more accountable for members in the state. [Indiscernible] coming back to the hospital to get them well. They get medication in accordance with the treating doctor and make sure they follow up [indiscernible - low volume] two things that are in a much better place and back to thriving. That happens March 18, and we are working through a modernization of our claim edits. We did not go to extremes, we just went up one level, the average of the payers [Indiscernible]. Innovations and catch up. We also established an office under my direction. It has been staffed now. It is now the cost control and quality improvement office. And you can see drivers and do analytics. All of the clinicians are under that so there is focus and clinical insight and cost control in an integrative model. [indiscernible - low volume] implementing and on top of all of that. Now I will go into the bigger picture. Affordability, so on page 3 [Indiscernible] long-winded. According to CHI, our health Institute, about a 6.5% uninsured rates. That is fabulous compared to the rest of the country. Obviously we have a very strong exchange and that has helped us drive our uninsured rates down. If our quest under our governor's direction is to [Indiscernible] healthcare, you have to define what that is . universal healthcare. We have to start analyzing what we do to get there. If you look at pages four through five, there are couple of things . when they went through, they did some wonderful things. They helped people get covered. In 2013, we had 28% and those were for small employers. [indiscernible - low volume] uncovered and the ACA brought another 19%. Pretty darn cool. One and three, one and five, uninsured. We are pretty happy with private but we have some work to do. That is an area where we need to get better as a nation and we need to study that insight Colorado with how much of our uninsured comes from [Indiscernible]

they were not included. They were not exempt from the [indiscernible - low volume] help that part in Colorado providing that coverage. Rural area by rural area by community by community and on the right-hand side of the page, you see what we're studying. You can tell by ethnic groups, community, income level, industry, industries that are moving, so on page 5 it is really saying we are working through a child serving right now. It will be available with the results to us by September 1 and that will inform what is going on. We are comparing questions answered in the last year [indiscernible - low volume] address David's introduction to you that we have to figure out what a public [Indiscernible] might look like and figure out what to do and what is wrong.
>> One thing I have learned with, sometimes companies provide healthcare for the employees, at affordable rates [indiscernible - low volume] the family to buy-in is quite a bit higher, so therefore that is why there were uninsured people. The employee can get it but not the family.
>> I appreciate that insight. There was a clarification that came out on October 23 from the federal level that said payers can put money into health reimbursement account tax-deferred at $5000 per person and allow employees to purchase products from the public market. But the federal government said we will give you $10,000 per family. And they did except the average cost is about $23,000 per family. So [Indiscernible] a couple areas we have to explore. If you get some federal stuff changed, [Indiscernible] we have to study that.
>> That is on your radar.
>> I am rallying it and trying to figure it out.
>> We have several people in that position.
>> You feel like saying yee-haw, don't you?
>> [Indiscernible] individual coverage, you want to be careful getting to the solution without really knowing [Indiscernible] so if you think about --
>> They can be complicated.
>> Proposal. A proposal. More than one. How do we get all of the programs identified in the proposal. The work team will be affordability [Indiscernible] and the knowledge of where the uninsured is coming from, the solutions we can address those two things, and so take a lot of thoughts, so bring on your interest and creativity because we have a lot of work to do between now and November. The next few pages are just about getting through affordability to address universal healthcare. That is where the driver is and it accesses a problem here or there. [Indiscernible] roadmap I spoke to you several months ago. It is in full regalia. It has five parts . hospital prescription drugs and when we need to get prescription drugs, that is part of the transparency goals. [Indiscernible] helping to inform that legislation. If you saw the cost shift report that came out last month, what it said is that a 70 page report done by our department, increasing costs [Indiscernible] was not necessarily Medicare and Medicaid paid less and increasing costs on the hospital side was largely due to strategic divisions decisions and they can make different strategic decisions to lower that cost. [Indiscernible] Hospital Association has been working very hard on a couple of fronts, one is to help recognize those strategic decisions, and on January 23 Hospital Association [Indiscernible] but it gave them 12 areas where there were opportunities. I would like to share that with you, like administrative comps for hospitals [Indiscernible] 2017 and last month, 2015 data that showed $.46 on the

dollar for prescriptions. $.54 on the dollar for care. We would like to get that down. More like $.30 on the dollar. [Indiscernible] four cents per dollar. Carriers at 13 and half cents per dollar. There is an opportunity to be more efficient with the provision of care. Hospital prices, prescription drugs, we are all over it. We are mostly on high cost specialty drugs and getting those under control. New technologies, Pharma tool, opioids, and maximizing intervention. On page 8, that roadmap finding. Hospital costs grew more than 58% during the period since the provider fee or chasing the billion-dollar [Indiscernible] ACA went into effect there, too. Patient volume is not growing. Hospital margins increased by 250%. The cost shift is really harming an opportunity [Indiscernible] across the country so we are all over that. We have an opportunity to make different strategic decisions to increase the engagement with hospitals forward make decisions, especially in the not-for-profit with construction [Indiscernible] transparency I would encourage everybody to understand the transparency information. 1001 that went through the house, it is moving through the Senate now, get behind that. We have some charts on page 11. They are important to us because as the expenses for hospitals go up we want to go down because we have mergers going up. Mega mergers are building these huge systems. Centura , the largest not-for-profit, part of the largest not-for-profit system in the country. UC health is now 11 hospitals and yesterday in a press release they are going to build a 12 in Aurora. That will be an industry leader [Indiscernible] complex procedures. Banner went from 2 to 5 hospitals. [Indiscernible] negotiating leverage cost to consumers. We are holding accountable that transition and we have a meeting coming up with the Attorney General to identify -- how can we pay differently? We look at this graphic and the right-hand corner, the top, we would have more complications for lower quality and higher costs. The Y axis is complications metrics that went lower and the X axis is prices. Each bubble is a hospital and [Indiscernible] position is cost and quality performance. On the upper right-hand side, we want to take a lesson from agriculture and pay them not to plant. If we have excess capacity, 32 system there, people are not doing well and you are costing too much money, so we are paying you not to plant. If someone comes in [Indiscernible] refer them to a hospital in that left-hand corner. How can we shake the system up. The hospital that gets paid to do the right thing, that is unusual in the system. There are better outcomes. The centers of excellence gets more volume and the costs come down. When, win, win. We set that out in front of the hospital Association in July and we are poking and prodding. They are now looking at that with her board chair's approval and that is looking quite attractive to them in this environment we are in, now. We are pursuing this with the Attorney General because we are stepping into antitrust land. We are asking the hospitals to look at data and [Indiscernible] together as a system. It is different than I we thought about things before. We have to make sure we are coloring inside the lines but we are trying to shake things up to better everybody and we appreciate your support. Here we go.
>> [indiscernible - low volume] what about the E! network contracting. We're jumping over a whole lot of things [indiscernible - low volume] you know what I mean?
>> It should be aligned. All of this in a perfect world would be with everyone in the same boat. If you think about out-of-network, it happens [Indiscernible] better or worse on where the bubble is. There are folks inside the continuum of care that

may not have a contract, so you might get assistance searchable bill that is three times higher than a surgeons bill. [Indiscernible]. What that bill is trying to do is get more getting at the actors [Indiscernible] three times more? Why is the anesthesiologist [Indiscernible].
>> But if you are taking someone from 32, the top right, and taking them to the bottom left, that referral may be out-of-network.
>> You should always strive whenever referring care, --
>> Okay, that is what I was getting at.
>> Thank you Meta president. When we are focused on specialty drugs, that is where the money is to be made and Pharma. In 2017, [Indiscernible] 42 of the new drugs, 75% were specialty drugs and we are spending more on specialty drugs. [Indiscernible] inside Medicaid right now. 1.25% of prescriptions we fill and pay for are considered 40% of our expense. That is how expensive they are, 1.25. Everything in the pipeline. [Indiscernible]. The reason why we are so focused on the right drug in the right place and this transparency [Indiscernible] the transparency, [Indiscernible]. How much of this [indiscernible - low volume] third-party payment and the middlemen get your drug in the market. We need to address those things. This is critically important to the sustainability of the health care crisis that we have overall. For us, it is $1 billion spend for the drugs and for employers it is 20 to 25%. This year in HIPAA we've had the kitchen sink. [Coughing] did really well in generics. [Indiscernible] specialties went up to double digit rates because it is such a hard area to control.
>> Relative to that, we want to do a better job and consider the claim database to make sure we have the right information so we can make these charts and see the data and all the money that is changing hands. In October we had an executive director, [Indiscernible] I asked the database to change two things. One is you providers up at your ultimate payments, those capitation inside [Indiscernible] the whole picture, not just a partial picture. That data [Indiscernible] three years. We also said all of your compensation between you and Pharma has to be disclosed. You can get to the bottom of how is that compensation pushing along. We can figure out the impact hopefully to utilization of which drugs. So, much to come.
>> Put in denials, too.
>> All claims database does not capture denials. So if you really want to look at a good picture to see what is being said --
>> What is your outcome on [Indiscernible]?
>> There are so many, I can't even begin to tell you.
>> It is a quality issue and also a cost transfer issue. Insurance and Medicaid secondarily and denied by private insurance, should be paying for it? And it is going off to Medicaid. Quality and cost, because I think, you know, doing without sometimes leads to other things that have negative -- right?
>> Absolutely.
>> That is the best I can do. Okay, APCD. We have a budget request in. We're putting a couple million dollars more into that. [Indiscernible] employers across the state can put in their data, which means those bubbles we showed on the chart will be a lot more comprehensive that is critically important as we identified centers of excellence and most especially in our rural communities so we can tell where the caret is going. Very excited about that. That will allow us to [Indiscernible] cost and quality and allow us, that technology will allow us

publicly available graphs for consumers and everybody to see. We also have lab data if members are not getting the proof they require appropriate care, we can actually graph them out and stratify them and say we have an opportunity to prove this person needs evidence-based medicine protocol therapy. At the same time we can see [Indiscernible] cost-effective care. Those are incredibly powerful to drive affordability for all. [Indiscernible] catching up to have the right data to coordinate care and provide the same level of services as commercial membership would have.
>> The governor has asked us to get more modern and bundle payments we are working on that. The one that is most modern and ready which is in your packet is the hospital transformation program. We will hopefully submit that in July, 1115 waiver using the Chase state. As we study the affordable roadmap and we learn where consumers [Indiscernible] change, we put those as a priority around 25 areas for hospitals to change. As an example we would pay the more [Indiscernible] shut down that nonessential emergency room and transform it into something the community wants. We will pay the more they are following opioid prescribing guidelines, as an example. There are 25. The stakeholders, the advocates, physicians, federal qualified health centers, chambers, other employer representatives, saying this is where we want to see change. Innovations, the health fair innovation [Indiscernible] we have challenged the University through an agreement to write some roadmaps for us on E consults. I will be poking them in a meeting coming up in the next 30 days to say how you are doing because this is critical to rural communities. It is important for mental health access. We can rise if we can improve telehealth and E-consults. Very excited about that. [Indiscernible] [Coughing] most of them and there is a lot more. The good news is we have rolled out the affordability roadmap on 16 November. We picked the mountain community and picked Grand Junction because it is a single source rating area. There is a wonderful consortium that is an example for the rest of the communities to follow. Physicians, hospitals, player organizations, there are about 40 people sitting on one consortium that can help work with the state. Everything you can do. They went through a five hour meeting [Indiscernible] every single thing. And handed out five more. And we are ramming through all of those things that we talked about today. [Indiscernible] work together as a state to identify things [Indiscernible] rollout in 2019 all sorts of new [indiscernible - low volume]. Legislative update. As a department, it is part of my job to watch threats and opportunities. I want you to know that on page 19, in combination with a cabinet, with a Texas ruling takes place, they say the ACA may be in jeopardy. 400,000 people in the state. We need to pay attention to that. The block grants and everything else of the federal level, we are watching and making sure that we are thinking about what would happen [Indiscernible]. Rising cost of specialty drugs, declining health of populations, there is a lawsuit which is attacking the Chase fee. The Chase fee as part of a pace for our expansion. That decision will be by Dr. Buchanan in the fall in October. Holy cow. There are risks and threats that we are paying attention to. On the left, opportunities to pursue universal healthcare and hold hospitals accountable to better treat substance abuse and approve quality and help Medicaid [Indiscernible] with that, I will conclude my remarks. Any questions?
>> I know. There is a lot going on. Welcome to healthcare.
>> Not a gifted speaker. Anybody on the phone have any questions? [Indiscernible]

there is a lot going on in healthcare and we can change [Indiscernible] in the next few years and we have a plan to do it.
>> You need to meet belts on the chairs.
>> I am looking forward to seeing what is next . there is a lot of good change I'm excited about coming up.
>> Grades, thank you Kim. We have a stakeholder engagement [Indiscernible].
>> I do.
>> Meta-president and the board, medical services board core Nader care the department and what you're looking at now is a 30,000 foot view of the stakeholder engagement opportunities during the public rulemaking process. Myself being a visual person, it helps me to lay it out like this. But really, this encapsulates I would say on average about a six month process is what you are looking at here. It begins when a subject matter expert [Indiscernible] the department determines they need to revise a rule. It could be from a change at the federal level, there could be a change of the state level, or it could be a department initiated through conversation with stakeholders level this revision is being made, and 2011, the first stop there is the executive order, 05. In 2011, the governor instituted an executive order saying hey, rulemaking agencies and the state of Colorado, a lot of times you don't really take into account our impact on local governments. So governor Peggy Looper set in order that said when you are doing public rulemaking, reach out to our local government, friends and partners, and engage them. [Indiscernible] what that is going to be for them kind of thing. When a rule request is initiated, I will send out an email to individuals that are signed up in the government world and they have an opportunity to engage with the department and then the new author will reach out to stakeholders as they are developing the rule and they will continue convene meetings on benefits, collaborative, meta-president, you have been present at many of these.
>> Yes, I have. So as the role gets developed and that is all internal, there is a lot of negotiating a back-and-forth that is going on. Once everybody settles, this is the path forward we would like to go, as Kim stated earlier, we have different problems we have to solve and possible solutions. Then you have to fit it in to the regulatory world and move forward. Once that gets all figured out, we publicly notice [Indiscernible] this is when the administrative receipt or act actually takes over in the public rulemaking. So statues. From there, we file a notice of rulemaking with the Colorado register and there was a Senate bill cast passed, I can't remember which year, but it was passed and stated when we file a notice of public rulemaking, we must also upload draft language to the Department of regulatory agencies. It gets placed on their rulemaking page. The Department of regulatory agencies and the Colorado register asks that the Secretary of State's office have public lists that individuals can sign up for if they want to get noticed about any rulemaking that the Department of healthcare policy financing is doing, if it is healthcare related, they actually have selections so they can get noticed about different agency actions. But also about specifics of the only want to know about crediting. They can just select that. Once those get published in the Colorado register, again, we then go into our department run meeting which is a public rules meeting and the public rule review meeting his monthly meeting that is held or rules that are coming next month. This is an opportunity were department staff meet in the conference room, 7A at 9 AM, the second Monday following this

meeting. An agenda goes out on Wednesday and it says hey, these are the rules that are coming to MSB next month and is an opportunity for individuals to have a face-to-face conversation with the rule office and discuss the role. From there, you would see them as an initial rule of medical services board. In January or earlier. They go through the initial meetings and they come back for final adoption. Basically what I wanted to show is that throughout this entire continuum, individuals can engage in the rulemaking process and it is actually written in statute that individuals are allowed to encourage and reach out and work in conjunction with the department and agencies. So I feel -- I felt myself, as a medical services board coordinator, since I am the rule administrator, I sit on, I do the Department of -- I handle you guys, I do the public rule review meeting, I do the executive order, so you know, the thing is in my book, I see all of this, but for you guys and for the public, it is disjointed. So I really wanted to put it out in one image to say this is how everything fits together and given the colors on the chart, they were purposefully put that way. Obviously, if you're getting in on the rule development collaborative side or anything like that, it is much easier to discuss possible revisions. We see as it comes to medical services board, things get a little bit harder and things are little more concrete. So I was thinking of as cake making because I like cake. On the left you get to decide if you want chocolate cake, carrot cake, or red velvet cake. When we get all the way to the right, we are talking about what frosting we want. You cannot make a chocolate cake carrot at the end without going all the way back to the beginning. Are there any questions?
>> Bregitta Hughes. [indiscernible - low volume] putting it all together. For the stakeholders here, they obviously have missed opportunities so how can they get caught up? Not only that, is there a venue where if folks are unable to get to that location for that meeting, they are available through the phone or Colin or something like that X
>> Thank you for that question. This is Chris Sykes again. I would encourage anybody, anybody that would like to -- I have an MSB notification which is an email list that I send out blind noticing the public about upcoming MSB meetings and also the public rules meeting. If an individual would like to send me an email, I would add you to that list. I'm personally adding people. I encourage that. You can sign up to the Department of regulatory agents these, the Colorado register, the Secretary of State's office, if there are any questions, anybody can email me and I will get you to the correct site. Then, for this image, it is on the public MSB webpage under our stakeholder engagement area. Then we actually have stakeholder engagement protocols and that is something the Department of regulatory agencies require that all agents put up. You click into the engagement protocols, I went to the images also there. Getting back to your question about phone opportunities, that was very fitting because those are on two of my update arguments. So when the regulatory agencies information is uploaded, it is very similar to the rule information that you have in front of you. The rule authors name is associated with it, so there is contact information through there. And the public rule review meeting, the rule authors information is actually hyperlinked and will generate an email to them so at the public rule review meeting, it really is if we had five rules coming to you next month, there would be five rule offers sitting in the room. The conversations go on simultaneously. Having a: option at

that meeting, does not necessarily work well just because there would be one voice going across the whole room and really Brigitta, if you were a rule officer and I talked about rules, I might want to speak to Jessica about her future rule revisions. We do encourage individuals to reach out to the rule authors if they are unable to make that ossified meeting to facilitate another conversation. You can do it by email, or they can set up a phone call or set up a face-to-face meeting with a rule author themselves. That is a mutually beneficial time.
>> This is Kristi. This is the first time I have ever heard of the 9 AM Monday meeting. Is the agenda? How do you know -- I mean, most of the roots I know, the spreadsheet that we are following with physicians on them and all that, can help to have that or something similar for what is going on and what is coming up to the medical services board so you can monitor it.
>> Thank you for that question. On our medical services board public page, you will see at the top before you go into what the meeting agendas are and your bios and all of that, at the top it says related committees, cantilever the exact wording, but the public rule meetings is linked up there and also the try board meetings, staff meetings we held in the past. There is a link to there. when you public click on the public rule Ribeiro meeting it takes you to a separate page that is just for the public rule review. The agendas posted on their and as I said, I sent out an email to a blind copy email list and that goes out on Wednesday prior to the Monday. And actually it was cc LP . it was brought to our attention, especially the times when we had seven or eight initial rules. Friday is not enough time to digest everything and come around it 9 AM on Monday. We moved back to Wednesday and hope that assists everybody.
>> Anymore questions for Chris X?
>> This is Charlie. I wanted to say thank you because that was extremely helpful to me to understand the process, particularly the stakeholder process and what that looks like in a formal ongoing way. I also did not understand rule author was the person who needed to reach out to everyone, in terms of stakeholders, so that is very helpful and I appreciate you taking the time.
>> Absolutely.
>> I would recommend we put that in the community board member packet. I also would love to have a timeline to show what the tentative timeline is. I know we have a timeline between when he goes public and so many days we have to keep it, but then what happens with the original and would have to come back for the final and I would love to see those in some way.
>> I can absolutely accommodate that.
>> I'm sorry?
>> And color coordinate your ties.
>> I'm sorry, I have one more. I am not yet finished. I apologize. My next update is actually about the public testimony through the telephone at medical services. It has been brought up and we had the department do agree that it is an access issue and we would like to bring in this technology. So currently I am working with our member contact center and we are developing a way that individuals and [Indiscernible] signing up to public testimony sheets here. Obviously we can't just -- we would not be able to understand what line discernible
>> seven people say I would like to comment, kind of thing. We would not know what order and make sure we get everybody. So we are currently working on that. It

should be, and my goal is to have it for the mark March 8, it will be available on the next medical services board meeting, so we will be having public testimony over the telephone at the next medical services board meeting.
>> Great, thank you for that.
>> [Indiscernible] pushbuttons.
>> [Laughter]
>> Love you, I will bring you chocolate. Okay, let's go on to Carly.
>> I apologize. [Indiscernible] he is giving an update on his face to --
>> I need to leave at 11, so may we have Karli? [Indiscernible]
>> Good morning, thank you for doing wonderful work. We appreciate the work you are doing.
>> Last month I met with the board to review, pilots, projects undergoing, to take a closer look at rules and to improve the readability of stakeholders and also providers and numbers as well as internal staff here. The purpose again is to examine these goals and see what we can do to make modifications, substantive and nonsubstantive.
>> What I want to say today is an overview of what these revisions look like. They have not been adopted -- they are simply testing and piloting a range of roles to determine what that would look like if we intended to go through the entire rule section and update them according to all findings. As it stands, when you open the rural range [Indiscernible] this is what you will say. We have modified the table of contents so you can immediately understand what the content of this Pages. I will toggle back. When you land on this, you don't know what to expect and there is only a blurb as to what to expect. The table of contents is a simple way to help our stakeholders and numbers and providers understand the contents of our rules. [Indiscernible] and what follows are excerpts of other rules and this is the unedited version on this particular section. When you toggle over, we have highlighted areas and citations to every clause. When you toggle back you can see the difference. We've also modified language that is not been adopted yet but simply modifying some language and also [Indiscernible] department. To get feedback on how the rules [Indiscernible]. Another section is unedited and this is a dot -- we can add some citations. A through G for these definitions. That way they stand out and help them understand what they're looking at right away. In the last section, it is unedited and is a couple pages long but I will toggle through these. It is a wall of text and that sometimes is the nature of the rules and the way they are written. But the revised version, they come with citations on every page so it is easier to cite and reference our providers numbers and stakeholders. The language here is verbose, I will admit this, I'm not sure how much can be done to limit that verbosity. But it is a step in the right direction I think for the department to examine these rules and then make them more readable.
>> The pilot has sparked interest [Indiscernible] on Monday the 11th, there is an exploratory meeting to explore the structure of the department rules divisions committee. We have not met yet and we only have the date on the calendar. We will get a perspective on what this committee should achieve.
>> Any questions? It looks so much more readable. Having read a whole lot of this over the years, I love it. Thank you. I appreciate your time and your eyes on helping us do a better job.
>> Questions or comments?

>> [indiscernible - low volume] nevermind.
>> [Indiscernible] joy. [Laughter]
>> Thank you very much. We appreciate your time.
>> Thank you.
>> Now we can have Karli.
>> Thank you.
>> Good morning, my name is Karli Cheatham and I am the intake and eligibility lead in the case management unit in office of community living and I'm here to see the order a preview of the rule that will be presented in the next few months. It is an action 8.500.7, protocol for the community-based services for individuals with developmental and intellectual disabilities. Currently we have a waiting list of just under 3000 individuals were waiting for residential services. We have an exception to that waiting list protocol where individuals in emergency situations can request a waiver from the department. [Coughing] [Indiscernible] protocol, abuse or neglectful situation, danger to themselves or others. The rule we will be preventing presenting next month will add an additional criteria into that emergency meeting [Indiscernible] individuals were experiencing caregiver capacity concerns where they have lost their caregiver and have an agent caregiver, health and welfare at risk or their health and where from is at risk because their caregiver can no longer provide an appropriate level of care for them. In addition to adding the new criteria we are looking at revamping the homelessness criteria that we currently have two make it a little bit more specific and also adding in a 30 day timeline for an individual to attract or decline the office of enrollment and if they require, they can ask for an extension to that 30 days for an additional 30 days.
>> Any questions? Bregitta Hughes?
>> You said there was [Indiscernible] -- 3000 waitlist?
>> Just under 3000 .
>> Is that low? Has it been worse?
>> It has been worse. In comparison to other states, it is fairly low. There are other states that have 10,000 people waiting for services and primarily the individuals were waiting for this waiver are looking for the residential component of the waiver. That 24 hour access [Indiscernible] supervision or other waivers that serve individuals with IDD do not allow [Indiscernible] residential services. Those people who are waiting are receiving other Medicaid services and are on a waiver currently [Indiscernible] held elderly waiver, or they are receiving medication Medicaid services, State plan Medicaid services. There is a small percentage of people who are on that waiting list for not receiving Medicaid services and that is for various -- they may have a trust that they are using right now. They may have natural supports in place of the don't require the Medicaid services. The majority of --
>> Thank you for clarifying that. They may be living with parents and at 18 or 21 they are asked if they want comprehensive services. If you don't get on, then you go to the bottom of the list. You need to go on?
>> No.
>> I was always told you continue to circle Chicago because otherwise you will never land. That is what I was told 18 years ago.
>> Actually, it works a little bit differently. When an individual is determined to

have a developmental disability, they are given what we call in order collection date. As a child you come to us, your order collection date cannot be prior to your 14th birthday. If you are determined after that [Indiscernible] that day that you are determined, [Indiscernible] if you choose to be on the list, you are telling us you will take services as soon as they are available to you. You can also see a timeline. If you're thinking you don't need services. You always keep your order selection date. The order is that it is a very fluid list. One day you might be fifth on the list and the next day you might be pushed down to 20. People change their timelines. Because they have an earlier selection date than you. They will go to the top. You don't go to the very bottom of the list. We will change your timeline to safety net. When you do want it you will come back up to wherever that order [Indiscernible]. It is beneficial for some people and on beneficial for other people.
>> I appreciate that you are doing this. With this agent caregiver because I have several clients that are in that sweet spot and did not fit any of the others criteria. Do we expect any response on this?
>> We both have the same question.
>> We did a lot of stakeholder engagement on this and over the course of the last few years we served on how to do it and we have made a few adjustments from the initial language based on the feedback we got. It is not really sitting in the well with the community. We do get some pushback on the age and we have 75 instead of 65 is an age. I think people were very excited to gain entrance into the waiver. And it allows more people to have access to the service.
>> I appreciate it.
>> Last but not least, we have Brian and he will talk about increases.
>> Guess.
>> We have a handout. Everyone should have a handout. A fact sheet.
>> Think you made a present, members of the board. I work for the department as a program administrator. I'm here to preview a role, not present, but review a role for the increase in [Indiscernible] regarding the direct support professional workforce stabilizers. This is a preview and I don't want to bore you with details. I want to develop this. I want to target the key . that we have with the proposed regulations. First, 1407 requires the department to go 6.5% increase in reimbursement rates. This is supposed to be earmarked for the increased compensation for professionals. This reimbursement rate only applies to specific services identified within that statute. Three waivers. The supported living service waiver, extension support waiver, and intellectual individuals with developmental disabilities order. There is a list of services on your fax sheet. I'm not going to go through all of them because some of these I do have problems pronouncing them.
>> Those are the specific [Indiscernible] 6.5% increase. With regulations, we will be implementing the 6.5% on March 1 and in a few days by December 31 [Captioners transitioning]So they are using them they must use them with -- between end of fiscal year. In order to determine base rate of compensation this was set in 1407. What they're going to do is look at what a direct post dose is a professional set in 1407. What they're going to do is look at what a direct post dose is a professional may June 2018. Anything about that they can use the increased funding to provide increased compensation. Now, within the Bill there is a couple of gaps

in there for our enforcement authority. Within the regulations, if somebody failed to report, we are now allowable for the regulations from the [Indiscernible - low volume]. If you - low volume]. If you take these funds and failed to report how you use them, we can now recoup them, but I will go through a process. You will see from the regulations that will have appeal rights, that will have all them, we can now recoup them, but I will go through a process. You will see from the regulations that will have appeal rights, that will have all of the rides to apply correction. It's not immediate recruitment if they failed to report. It's not intentional. In addition, in the failed to use the find appropriately, you can recoup those funds. That is something identified within the statue. Now, how to use the funds can recoup those funds. That is something identified within the statue. Now, how to use the funds is something replaced within the regulation. We added information regarding what we call the direct benefit. We want to ensure that the increasing compensation is strictly benefiting the direct benefit. We want to ensure that the increasing compensation is strictly benefiting the direct support professional. Last failed to allow us to audit, we can work up those lines. Those go through all of the same on a procedures we have a than other regulations. Once again, we will file a plan of correction. Bill the information for them to appeal and have same on a procedures we have a than other regulations. Once again, we will file a plan of correction. Bill the information for them to appeal and have formal reconsiderations. Now, when you look at your fact sheet on E, I looked at department develop and regulation to clarify requirements. We have held extensive Stakeholder Engagement beatings. Right now, we have final regulations that is currently posted online, so we can allow for more public comment period, so we can understand if there are any other concerns. The primary concerns with the regulations, which we did fix was ensuring providers have flexibility on how they can period, so we can understand if there are any other concerns. The primary concerns with the regulations, which we did fix was ensuring providers have flexibility on how they can use the funds. So if they are having problems stabilizing the workforce and workforce and one service, rather than another they can use the funds to target that increasing compensation so they stabilizing the workforce rather than this even equitable distribution that they have that flexibility. In addition, we didn't want to make a punitive, so there's a lot of questions of can you offset caused by increasing wages? And although this Bill is not a direct -- it's a caused by increasing wages? And although this Bill is not a direct -- it's a compensation increase the you can increase other means of compensation such as paying for health insurance. If you choose to increase wages, you could offset your payroll t axes, because we do find that those payroll taxes such as Social Security tax and Medicare Security tax and Medicare tax is a direct benefit to the individual receiving that tax. And last, Service/Agency is may be audited. So, within the Bill there is no requirement that we ought to pick we have no enforcement authority on their, so we have to ensure that what these providers report within our reporting tool, that we could audit that to make sure that these funds were actually used appropriately. So those are to pick we have no enforcement authority on their, so we have to ensure that what these providers report within our reporting tool, that we could audit that to make sure that these funds were actually used appropriately. So those are the key points in the regulations. At this time top I will open up open up for any questions.

>> I'm sorry. This is Christie. I've got questions. Can the money be used to give them something towards providing there own health insurance, offsetting their cost of health insurance?
>> Yes, that was was one of the questions that came up that was directly of the Bill. One of the questions in rural areas where health insurance cost is increasing, these individuals, the providers receiving 6.5% could actually increase health insurance and offset the cost of the employee by using that increased funding to pay for of the questions in rural areas where health insurance cost is increasing, these individuals, the providers receiving 6.5% could actually increase health insurance and offset the cost of the employee by using that increased funding to pay for that. So there's a lot of different options options that you could use for the increased funding such as health insurance. You can provide bonuses. You could pay taxes taxes for them. You could increase the wages. We want that flexibility that, that they will work together, work with direct support professionals to identify what is the best way to increase their compensation so that they will stay in provide the services. So thereby the services. So thereby increasing access to the services.
>> So this is Christie again. So, I'm probably going to ask offline some of the things, but I just need to be clear. It starts March 1st.
>> The rate increase does.
>> That's the rate increase, that's going forward for what you built per unit, et cetera. But going back is where you are saying you have to report how you use the money because, I mean, it's obvious you are using the money if you are only appropriate it supported community connections, right. If you are only doing that the that's how you are using the money. I don't understand what you are saying.
>> Thank you, madame President. I will clarify that. So you're early reporting increased funds and how you use that for increased compensation. So you see the money The rate increase does.
>> That's the rate increase, that's going forward for what you built per unit, et cetera. But going back is where you are saying you have to report how you use the money because, I mean, it's obvious you are using the money if you are only appropriate it supported community connections, right. If you are only doing that the that's how you are using the money. I don't understand what you are saying.
>> Thank you, madame President. I will clarify that. So you're early reporting increased funds and how you use that for increased compensation. So you see the money March 1st, 2019 until June 30, 2019. That period you you have increased funding. So you had to report how you took that increased funding and increase the compensation of those individuals.
>> Okay, Thank you cost so took that increased funding and increase the compensation of those individuals.
>> Okay, Thank you cost so much.
>> You are welcome.
>> Anybody else have any questions? Okay.
>> With that, thank you so much. We look forward forward to a very lively conversation.
>> Thank you.
>> Next month on this. So we had the -- coming forward next month.
>> Okay, Thank you, very much.

>> All right, with that I'm going to adjourn our meeting.
>> Thank you, very much.
>> Wow, look at that time.
>> Out.
>> I might make my next meeting.
>> We will see you guys.
>> Thank you very much for attending.
>> Thank you.
>> Thank you.
>> [Event Concluded]