Please stand by for realtime captions
>> Do we have Mandy and Cecile on the phone?
>> This is Mandy. I am here.
>> Thank you.
>> Cecile, we know you are in Durango. It is far away.
>> Maybe not yet.
>> We are calling the meeting to order December 14. Let's call role.
>> [Roll call]
>> We have a quorum.
>> The date and location of the next meeting is scheduled to be held Friday January 11 2019 beginning at 9 AM. 303 East 17th Avenue Denver Colorado 80 203 in the 11th floor conference room for you are now. It is the policy of this forward to remind everyone in attendance this is private property. Please do not block the doors or stand on the edges of the roof. If you are listening via audio please click again on the link to rejoin.
>> Please submit questions and comments at the open forum time and agenda. Identify yourself as the comments are public record. Please identify yourself when speaking. There are individual testimony sheet for each rule if you need help finding the rule that you are interested in, ask a staff person. I remind you that there is a 5 minute limit for the testimony.
>> I would entertain a motion for the approval of the minutes for the November 9 meeting. There is an ever on page 4 when it said we denied --
>> Yes, I reviewed my notes.
>> That's great. With the correction to that error I would make a motion to approve the minutes.
>> I have a 2nd period all in favor -- Aye
>> Opposed? Abstained?
>> Amanda?
>> Aye.
>> Cecile, are you on the phone yet?
>> We are into the final adoption consent agenda document 1 in 2.
>> Does someone want to read the motion?
>> Madam chair move the final adoption of document 01 MSB 18 -- 09 -- 07 -- A revision to the medical assistance rule concerning FDA approval of Stripentol section 8.800 -- and document 2 MSB 18 -- 09 -- 12 -- a revision to the medical assistance rule concerning the dental health care program for low income seniors section 8.960 incorporating the statement and specific statutory authority contained in the records.
>> I 2nd period
>> I have a motion in a second it all in favor?
>> Aye.
>> Opposed?
>> Okay.
>> Amanda?
>> Aye.
>> Cecile?
>> Okay, this passes. Now we are into the initial approval agenda. We need Elizabeth Quaife.

>> Good morning. tell us why you are here. We are not sure why we are here.
>> Thank you, board mentors for hearing me today. I am Elizabeth Quaife the specialty hospital analyst and hospital liaison.
>> The movie will go over today is the 18 -- 07 -- 23-A. This is for freestanding long-term acute care hospitals and freestanding rehabilitation hospitals. I know you have the document on your tablet and you should've gotten additional documentation from the site. This can be obligated. The old methodology to the new methodology so we created a note to explain what we are doing. What you will see is the text that directly correlates with the page number from the role to make it easy to see.
>> Thank you.
>> At the end of each section if you have questions or statements or anything or clarifications, let me know.
>> Currently now with this rule there will be and impact to 11 different hospitals. That was a hospital that will come on line -- ultimately the time the rule goes into effect there will be 12. That break down into seven long-term acute care hospitals, 4 rehabilitation hospitals and one newly designed hospital treatment specialist. These three are broken down into justifications. We have long-term acute care also known as the LTC H hospital. This definition was upgraded from the current rule and there have been additional vacation and we wanted to come in that definition so I will point out a couple of -- the certified is carried over from the old rule this requires long-term care services including but not been to two respiratory therapy and complex care and antibiotic treatment and pain management. These are the main cases this is also designed to play into Medicare and we wanted to bring our definition more current. We want to create a clear picture of what we expect.
>> The rehabilitation hospitals initialed SIRS -- no change to that definition. It is currently as is and the rule. We are happy that it aligns with Medicare and it is detailed and we left it out.
>> The main point we would like to discuss is number three math -- this is a defined area we are creating. This is the brain injury treatment specialist -- IRS or L AP. It could be a licensed general hospital -- or a CMS rehabilitation hospital. They can qualify for the designation they are tested as a not-for-profit hospital as determined by the CMS system and for the most recent financial fiscal year.
>> A hospital mainly serves as patients requiring long-term acute care and extensive rehabilitation services. Essentially this facility a hybrid of the two -- long-term acute care and rehabilitation. That is what makes it unique and that is why we have created this category. Additionally on top of that hospital discharge is calendar year for cases with receipt payments from the Medicaid program with previously grouped to the old methodology numbers 40, 44, 55, 56 and 57.
>> This is the spine injury and spinal disorder and brain injury. These must account for at least 50% of the annual discharges and they must maintain the 50% moving forward in order to this designation. It is a higher per diem which we will see on the backside. And because it is such a hybrid, distinct facility we want to make sure that that level of care continues throughout the. Before I move on, any questions or comments or concerns about the definitions we have updated as well as the new category?

>> Common hospitals in Colorado. This is Simon. How many hospitals in Colorado fit this category?
>> Currently only one and only one other in the nation that qualified. This is a special thing that was initiated and we were part of the team that has done the research and determine that these hospitals says shall move forward with that exemption. They are specialized hospitals. If you look under the CMS website there are even stricter guidelines than we impose. You have to take a minimum of 20 other states -- you can't just take your home state -- you have to go national. This is with the exception of pulling from other states -- we found this hard to verify -- just to make sure so we kept the others.
>> So, just to clarify there are two in the country?
>> Yes, and we are fortunate to have one of them. The other is in Georgia.
>> I'm wondering what the comments are about this. Is this something that makes Craig Hospital happy?
>> Before we moved to the methodology in 2015 they had their own code. They were already separated and they merged. We are simply separating them back out. We are happy to have the distinction. If we had not incorporated them, they technically -- if we had kept them together it would have cost them and it would have hurt them to do this and we didn't want to do that with a specialized facility. Additionally, one
>> [Indiscernible - low volume]
>> Excuse me -- please mute your phone.
>> If you don't have a mute it is*6.
>> To add on to this, if you were to ask -- we did more than a year of research and monthly meetings with the stakeholders. All of the hospitals and rehabilitation hospitals, Craig included, we did cite this is to the facilities. We had private conversations and had a lot of engagement for this. If you ask those hospitals about this they are recognized as special and deserving of this. Not only to we see through the research through CMS but also through their peers.
>> Thank you
>> Mr. Potts?
>> Thank you, Madam chair. What is long-term? Year and -- years and years, potentially?
>> An average length of stay of 21 days.
>> Then what happens?
>> Typically we will see them discharged to home or go to a skilled nursing facility.
>> Most of the time this is someone who has been on a ventilator and they wean the patient off the ventilator. Maybe wounds are not quite feeling -- healing in the hospital. They have special wound care nurses. Also patients that might need long-term assistance -- these patients as well.
>> We have an average length of stay of 24-28 days.
>> Can there be an extension?
>> That it goes for review as medically necessary and they could stay longer.
>> That was [Indiscernible - low volume].
>> Cecile, have you joined?
>> Yes, I apologize for my delay.
>> Who else has joined?

>> I keep hearing beeps.
>> Doctor Fraley is on.
>> Thank you
>> The next thing we wanted to go into -- this can be a challenging methodology to understand. We wanted to hit the main parts of what is currently not working with the current methodology. That is the next section I would like to go over. This is more additional information to understand why we are going with these changes. With the grouping logic the rates vary from hospital to hospital. This means that the race rate is multiplied by a weight which is the ultimate reimbursement amount. If you have a hospital with a $6000 base rate in another hot -- another with a $10,000 base rate we have now created an inconsistent system where one hospital could take more patients versus the other one. This levels the playing field.
>> Right now we have an interim billing system allowing reimbursed charges over $100,000. Again with the inconsistent base rate this means one hospital could reach this quickly and the others might take two months. Again, we are trying to eliminate the inconsistency.
>> You have the logic for crossover -- that's the same as the carryover. The big thing I want to understand is this chart below. You see the different types -- you'll see the LTAC and the rehabilitation and the spine and brain. These are the primary ones. With LTAC you will primarily see code 130. That is the highest severity. 1 is the lowest and 4 is the highest. It is at a later support for many hours. You would take this base rate and multiply it by 6.72. That means from day one until day 62 -- that is the flat fee they get. They get nothing else. The average length of stay is 22 days. That means if the patient stays 10 days they get that. If they stay 22 days they get that. If they stay 45 days they still get that. They don't get additional payment until then. These are patients that are very sick.
>> Second, the rehabilitation. We will see 860 -- this is the rehabilitation code. The severity is 3, the second highest level. A high weight and the average length of stay is 15. At that point they would get no extra pay until day 40 -- a long time for rehabilitation.
>> Finally, the APR -- DRG 40. This is a spinal injury. It is a weight of 3. Most cases that we see at Craig Hospital -- the average length of stay is 30-40 days. They don't get additional payment until day 21.
>> Any questions about the current methodology and the gaps we are seeing?
>> Why a per diem? You will find this under the rule pages 3 four.
>> -- Three have a four.
>> And the research we reached out to our partners and sent you are national. How are you reimbursing other states? We also went to the contractor and got some information from them. In total we were able to pull 30 states including our own. Out of that 17 had per diem. It is standard to pay these hospitals out of per diem. This would create an equal reimbursement for each classification at the hospitals. All the long-term acute care hospitals get the same opportunity. All the rehabilitation hospitals get the same opportunity. They are out there on their own -- they don't take that many cases.
>> This is important. This is budget neutral meaning that we do not gain any money as a department and we do not lose any money as a department. The same thing with the providers. It should be equal for them. How this will occur is that -- it

decreases the department costs on the short stay while creating a higher reimbursement for the providers on the longer stays because we illuminate that turning point.
>> We went over the next bullet point with the methodology regarding this and we've got the chart showing examples of that. The next thing is -- this is the second bullet from the bottom -- it's easier to [Indiscernible - low volume]
>> It's easier to calculate a payment versus the methodology. When a hospital tries to decide if it is sound business for them to take -- if they are going to lose X amount of dollars can they compensate that? It can be hard, as you can see, from the other side to calculate the payment. They have to put the patient information and try to come up with where they think the coding will land and the severity and how long the patient will be there and there are a lot of moving parts for the hospitals to calculate the reimbursement. With the per diem It is very straightforward. We know we are going to keep the patient 24 days we know where we will fall and we have a calculator online on the website to help the hospitals. They can plug that in.
>> This makes easier placement for the client and it's better for the hospital and better for the client.
>> I have a question -- Dave Potts. How do you know a patient is going to stay 24 days?
>> They know this -- regarding -- there is an index depending on how sick the patient is. They get a report from the hospital. They also look at diagnostic codes and procedure codes. They know from being in the program and the program highlights how long the patient is there. For example, if a patient has been on a ventilator and in a coma two weeks at the hospital you might imagine that a ventilator would take 3-4 weeks in that case. Versus maybe for rehabilitation if you had someone in a severe car accident that needed to learn how to walk again you might expect that patient to be needing 4 weeks. Versus a more severe stroke patient that needs help learning how to do basic things again. Thank you
>> Finally, one of the reasons we want to push for the per diem is that this gives us a better condition to for additional components such as quality measures. Currently with this methodology, this belongs to the provider and we are limited as to the modifications we can do. Any modification that we do in this world -- we all share the same coding. These hospitals are not designated -- they share with the general hospitals as well. With the per diem we are pulling this back and we can start to add it in. We tried adding in the case mix to this. We didn't have enough information to adequately do that. We said we will give you a good base and start from here and now we have an amazing foundation to build on. That is why we wanted to go to per diem. Before we talk about the actual component, are there any additional questions or comments?
>> [Indiscernible - low volume]
>> It sounds like if it's budget neutral -- some will see a decrease -- to help balance this out.
>> The idea, really, is that right now the system actually incentivizes the short stays but the clients that needed are the long stays and they are harder to place. Ideally we would like to see some of those short stays go down a little bit and a spot could clear up and we've had verbal confirmation saying they are able to take higher need patience.

>> -- Patients
>> Next, this gets down to the nitty-gritty. The per diem methodology components -- what the per diem will be built on. This addresses document page 23-24. We have broken each of the per diem stashed there will be three total -- each is built with 4 tears in mind. The reason is, as the patient gets better they need less care and less management. But setting up these we were able to deduct 5%. There are two reasons -- it matches the cost and we took the cost report divided by the length of stay to show that it does decrease over time. We have confirmed this with the hospitals as well as working with the financial officers. We confirmed this -- like if the patient is only there 10 days we don't want them to keep them there 20 days. By decreasing this amount we monitor this as well.
>> Next, we made changes to the interim billing. Hospitals for now able to bill every 30 days. We did a lot of research on this. We did a lot of research around the country. Many hospitals and the length of stay. The ask their opinion and got our own input. It was determined that once you hit the 30 day mark you potentially can put a higher impact on the hospital financially. Allowing them to just do a flat 30 day bill, this guarantees a reasonable reimbursement within a reasonable amount of time.
>> The last thing is, we wanted to give you what this would look like. The bottom table shows you what we plan to put into effect July 1, 2019. As you can see -- on the long-term acute care from day one that-21 the TIER 1 rate -- that is per day. That drops starting on day 22-35. It decreases again day 36-56. Anything greater than 56 would be the final per diem at that point. This is calculated using the median with a standard deviation. After talking with the hospitals we realized it didn't quite form right so they got the input and we did some adjustments just to make sure there was an even amount. For rehabilitation, they are not weekly -- their stays are so short that putting them on a weekly hurt the per diem and it removed what we were trying to accomplished. They are not on a weekly. Like the other two. They have a shorter stay.
>> They get a flat rate with a decrease starting on day 7-10. Another decrease on day 11-14. Finally they have a final redeemed for 15 days and longer.
>> The last component is the spine/brain injury treatment specialist. 1-28 take it the first per diem. Day 2949 they get a decrease of 5%. 50-77 is the second decrease and finally greater than 77 days. Looking at the rules, this language would be hard to match --
>> [Indiscernible - low volume]
>> When I read it it makes sense to me but I don't know if it does for anyone else. We want to make sure that you have this for public knowledge. We want to make sure that the board has this so that you understand what we met. -- What we meant.
>> That's all I had to share on the rule. These are the driving points of what we want to do this. What it will look like and what we would like to do in the future based on this methodology.
>> Any questions?
>> Bregitta?
>> What was this billing before?
>> Under the current methodology
>> [Indiscernible - low volume]
>> It is on the third bullet -- you will see interim billing allowed if reimbursed

charges are over $100,000 and Medicaid is the only insurance.
>> This is Bregitta. My initial question is -- you said they switch to the billing and now they can bill every 30 days. What were the billing before?
>> They had to reach the $100,000 threshold. Some hospitals, depending on what they were reimbursing, they could hit it as quickly as 15 days and in some cases it could take longer. This had to do in the difference in the base rate. This is to eliminate the issue with the base rate. Let's say we had a really sick patient in long-term acute care. Let's say they stayed 4 months. You could have a hospital that takes the reimbursement of 250,000. They may be able to bill regularly. The next hospital below that may only get $150,000 for that same patient. That will take a long time. That is six months holding that patient and they can't enter a bill at all. They do not get any financial reimbursement. That is why we went to the 30 day billing. It is more realistic. We thought about keeping the $100,000 component but because the rates vary so much for rehabilitation it would take 45 days. We didn't believe that it was appropriate to tell them that they had to wait 45 days.
>> We wanted to make sure everyone had equal opportunity.
>> Thank you
>> Any other questions?
>> Doctor Fraley? Amanda? Any questions?
>> No, thank you.
>> If anyone signed up for testimony? Does anyone want to testify? Nobody? Okay. I would entertain a motion.
>> I move the initial approval of this document the provision to the medical assistance rule payment for these hospitals with inpatient services for the freestanding long-term acute care hospitals and freestanding rehabilitation hospitals, sections 8.300.1. And 8.300.5.A and 8.300.5.a little seat and incorporating a statement of purpose in the specific statutory authority.
>> A motion?
>> Yes.
>> A second?
>> All in favor?
>> Aye.
>> Opposed?
>> Doctor Fraley?
>> Amanda?
>> Aye.
>> It passes.
>> Thank you very much, Elizabeth.
>> Next -- [Indiscernible - low volume]
>> Come on down.
>> Good morning. how are you this morning?
>> What have you got?
>> Hello, I am Lindsay Westlund, a if manager at the offices of community living. I am here to present document 18 -- 08 -- 24 -- A. To support the HCB as benefit rule concerning the children's extensive supports CES waiver. As a proposed revision this will affect 8.503 point for and specifically it will have language for behavioral services and personal care and vision services. The removal of these

services is a final cleanup to a process already completed for assistance available to members under the state plan and early [Indiscernible - low volume]
>> The department received initial guide meant for the CMS. Services and personal care and vision services. This prompted the department to take the necessary steps in engaging in a larger, longer process to make these services available. Since the implementation of the services the department has taken the steps to remove these services from our approved waiver. For the regulation the services provided under the waiver cannot duplicate the [Indiscernible - low volume]. In August 2018 CMS approved the department waiver application which included the removal of these services. The proposed revision of the rule is to align the rule with our application. Impact is to have an approved application. The department will no longer have authority from CMS to operationalize these services under the waiver because we have the authority to operationalize these services.
>> We want to ensure that our rule reflects the changes that we made. And that it doesn't cause any confusion in knowing where the services are available.
>> Thank you for your time. I welcome any questions.
>> Any questions?
>> I don't see any. Must have done a good job explaining that. Doctor Fraley? Amanda?
>> No, that's clear. Thank you.
>> Okay. Is anyone signed up?
>> Yes.
>> Equi vacation. Are you a doctor, Ms. thank you for the opportunity to testify. On them with the Colorado Center on Law policy. I appreciate Ms. Westlund being receptive to the comments we made in the past about potential work that could be done to improve some of the eligibility issues that have come up the last years. I understand that the changes made to the world today are to conform with the waiver fees. This makes sense to me. These services must come up that are available now. My only comment is that for the therapy services I understand there are some provider access issues. Providers who have provided the service under the waiver have not made the transition to regular Medicaid. I think there is some work to be done on that. The larger issue is that we have asked for other changes to be made when the waiver amendment was put in. I understood that they could not be made immediately. We made comments on this amendment and then again in September about the criteria involving eligibility. We were told after the first comments that the department evaluate a process to determine eligibility for the waiver and that the evaluation included the application efficacy and the QIO interpretation of rules and eligibility determinations and the consistency in the process and the rules that codify these processes. On not aware of what has occur. We made similar comments in September when the waiver was again amended to take up these services. We are in a catch 22 because we have asked for changes to be made to the waiver. Have been made and now it comes to the rule making process and we need to codify the changes made but it's not clear how to get this process moving more quickly to look at the criteria. The issue with the targeting criteria is that as written it cannot be systematically applied. So, for example, a requirement of nighttime services on an average of every 3 hours. This is not manageable. It does not take into account the length that the child might be up at night. There is one child that is up once a night for three hours that would not qualify. Another child who

has a milder nighttime disturbance is up 45 minutes -- that would also not apply. These are families who may be desperately in need of respite and other services. We have asked many times over the last few years as have others in the disability coalition -- to look at these criteria and make sure that the families needs are met and that it's not such a complex obscure process that only the savviest of families can access these services. They should be acceptable by families that are not the most educated in the most connected. That is one of the hazards of having this criteria. That is our comment. I understand that changes will not be made today but we really want your attention to this.
>> Miss Westlund ?
>> Thank you for your feedback. At the time these amendments were submitted we have received feedback during this time. We have had some turnover at the department [Indiscernible - low volume]. Since this time the department has made a point to gather other feedback that has been coming in. It is our intent to take the feedback and to start holding more robust conversations with our stakeholders about how we can make changes. That is our goal. To start working on that in the coming year. Again, in the short time I have been working on this it would be remiss of them to jump in and start making changes without engaging more stakeholder feedback. All the barriers the community might be experiencing. We want to take the time to gather that feedback.
>> This is Christy -- we have been talking about this criterion -- we have kids that if the parent provides melatonin at night then the kid is asleep. They are doing harm in some ways to the kids in order to get onto the waiver. It's ridiculous. We have been talking about this a long time. To make the adjustments to the waiver and not take that into account -- with all due respect it is not okay. I want that out there. I am frustrated. I understand but when we had one bite of the apple we should have looked at this. We know it is a problem. I can hear Julie shaking her head -- it's the problem. I guess I'm asking, what is the department's going to do about that? We need to do something because we got a lot of kids whose families are falling apart. Do you want to come up? It is the problem.
>> Do you want to hear my outside voice?
>> I can hear you perfectly.
>> Thank you. I am the manager for the community options benefit center where this waiver lives. I want to touch on a couple of things that we have heard. Your comments are well appreciated. First, of the big things that we heard a lot is around the application and how lengthy and time-consuming and difficult it is. Somewhat repetitive. In general it is a long process. That is one of the first tasks that Lindsay took on -- trying to how to make this more family friendly and faster and better all around. That is well within our authority and she has had multiple authorizations about this. -- Conversations about this. That is the first step.
>> The other thing, I agree -- that is not within our ability to change. We opened the waiver we don't have the budget authority to make those changes. Begin any sort of adjustment to the targeting has an impact and we have to go to the appropriate budgetary process.
>> Do you plan to do that? This is Christy.
>> This is Stephanie. My question is -- I struggle to find clear statutory authority. I did as much as I could looking through 1990 on, not a specific statue.

I would appreciate understanding better how -- whatever statue that we have -- how it is limited.
>> Thank you.
>> Again, it's not just the legislative piece but the budgetary process. As a department if we are going to authorize or do changes that would have an impact one way or the other we must make appropriate budgetary authority through the legislature and the general assembly. We can't make a change without that process. It is a prescriptive process. The budget is clear with processes I have to follow.
>> Any other questions or comments from the board?
>>
>> This is Simon. Are there plans to put this forward?
>> I work with -- the budgetary process started months ago. It is not something that the department has put forward this session. That doesn't mean this would inhibit other sessions. It depends on the Governor's budget. Is not currently on the docket this year. The question is, does it need to be requested in advance and that's why it's not on their? Then we have to request it now for 2019-20 --
>> The next session.
>> That would be 1920?
>> 2020.
>> This is 18.
>> So, the request now will affect 2020? That is a long time. There is no ability to clarify it somehow? Or somehow modify it? I'm just thinking -- kids sleeping through the night -- it would be logical to say nighttime interrupted by 90 minutes or more. That would capture everybody having these problems. I'm wondering, where is the flexibility in that?
>> One thing we've tried to do -- asking for specific guidance that would be more clear to help our contractor with this. This is something that Lindsay is working on as well -- to provide something that is publicly available so that individual families can understand the expectations and the expectations that we have of our contract. This is something we are working on -- providing clarity. We can't do it outside of our authority of making changes to the way it is written.
>> So, it is truly broad where it says -- every 90 minutes -- that would fit within the guidance. Providing clarity around that specifically. We couldn't make any change that would have a budgetary impact. We are committed to providing clarity. That would be publicly available.
>> There is a clarification process that could impact this or patients and families in the next two years. This nighttime waking thing -- it is clear to be the issues it could cause. The difficulty in meeting the criteria. Or the total night -- this could be interpreted more broadly. For example, if this is your child we are describing.
>> I think it is a combination of the two. I think providing clarity would help the situation.
>> Next?
>> Do you think -- because this is already a funded activity that a presentation to the joint budget committee could alleviate us having to go back to re-legislate?
>> It is a possibility. We could look at this in a supplemental process but we would still have to hear the process.
>> Madam chair, the only reason I am pushing this is because we are on the spot

this morning.
>> Interesting point.
>> We are being put on the spot to make major changes. I agree they are necessary. I can't understand why something this basic can't -- has to go through a two year process.
>> This is Donna Roberts. I totally understand the impetus to get it changed but it sounds like it is more of a budgetary impact. Instead of maybe 1000 year -- of thousand kits you have 2000 kids. Have there ever been or is there an opportunity to go to the legislation and have the budget amended? So they could find some wiggle room somehow?
>>
>> Yes, we have the ability to go back and look at the supplemental process and amend the budget. I think staff will probably listen to this recommendation and try to take appropriate action. I can't commit to what they will do. I'm sure that they will take this into consideration and try to move forward.
>> Next?
>> One of the other things we want to consider and we want to do this in an appropriate way is the stakeholder engagement. We need to have a plan of what we want to change it to. We are not prepared for this because we haven't had the opportunity to go through the process with our community stakeholders to say what should this look like? If we are going to make changes which we are hearing loud and clear -- what should we make the changes to? Without knowing that, we won't have a clear idea of what the impact could be. We are not to the point where we can go -- starting January 1 -- to say let's make this change for a supplemental process when we don't know what we want to change it to. We would want to make sure that we have the appropriate time to conduct engagement with our community to ensure that if we do propose a change that we do with the right way.
>> Do you have a response?
>> Thank you. We will be happy to assist in this process. We have a communicative lunch of people who are ready to go. We would be happy to help with that.
>> I have missed cues.
>> From time today -- from time to time we allow for emergencies. Would disqualify as an emergency? It sounds like there were other stakeholders and something happened and things were dropped. I'm concerned about this. I don't feel comfortable way laying this for two years.
>> The stakeholder process has not occurred. It must be a driven process because while the stakeholder engagement you may be referencing is the feedback we have received. Written feedback. We haven't had a chance to go to the multiple meetings and said if we made a change what should we change it to? All we have is, yes make a change. We need the second half of that conversation as well.
>> The other part of my comment --
>> This Hughes do have a rebuttal?
>> This may classify as an emergency but maybe not. Is that correct?
>> Mr. Massey?
>> I will let her continue. She is on a role.
>> From what understanding as far as the emergency process this would not qualify.
>> This is Jennifer. I agree that there would be steps to go through first.
>> Thank you

>> I have Ms. Roberts and then I will put in myself.
>> Then Mr. Potts.
>> The timeframe would be more elongated. I didn't mean for us to go into January or whatever. I was told that the engagement of the stakeholders -- they could probably help you write the initial application. This is so that it could be in place.
>> Mr. Potts?
>> [Indiscernible - low volume]
>> In my tenure I don't remember asking for a status report on any given procedure.
>> Is that a question?
>> Yes, that is a question.
>> We have asked for reports on things.
>> Yes, we have.
>> This is a process.
>> Yes.
>> Can we asked for a 3-4 month --
>> You can ask for anything you want except $1 million.
>> I'm just not sure about the procedure.
>> The procedure is, you may ask for a follow-up of 1-12 months on this issue.
>> What would be appropriate?
>> We would have to ask.
>> Thank you Mr. Potts. We would be happy to come back with an update. Obviously, some of the things we would have to be cautious of as far as making promises around the budget -- we would be happy to come back. Pour months would be -- 4 months would be fine to give you an update.
>> This is Christy Blakely. I am going to make some comments that maybe talk to here. I would agree and disagree that we've had stakeholder input. We had multiple stakeholder input and I re--- I respect the amount of work that you've done and I also know the families out there dying on the vine because they are trying to keep kids in a home that 20 years ago would have been safe for the lack of a better term. These families need help. We don't have a way to help them at this point. We need to get this moving. I would say sooner rather than later. I would pull up the stakeholder stuff that we arty have and pull this off the back burner. Honestly, you would rather drive it then have your advocates start to drive it. You have a lot of them. I'm going to put that out there. I'm going to say let's all work together to move this forward faster.
>> I know the department knows this -- this keeps kids out of the hospital and out of long-term care. This keeps kids, I don't know how to say this. Besides, all of that, it saves money. That is cute. -- Anything that prevents the high level of trauma services which I call dramatic -- going to the ER -- I want to throw that out there. This will save money. Besides all the other positive thing.
>> Thank you very much.
>> Mr. Massey?
>> Deck. We have received comments, obviously. This is why we engage in stay colder comments. Obviously, you have our attention and we will make every effort to try and mitigate this situation. Obviously, our staff is attuned to this. Thank you for your comments. We don't want to feel like we are shortchanging anyone but by the

same token we want to make sure that we have a robust incompetence of stakeholder engagement process.
>> I don't feel like we have engaged in this bully. We understand the timely nature of this.
>>

>>> Thank you.
>>
>> Where you are in the process with the stakeholders -- is a just on eligibility or broader than that?
>> Determining criteria and other things.
>> Are you familiar with the list? Could you spell it out?
>> The other things to take on is what she is asking.
>> One Widbey -- would be to make sure that we have a list so everyone in the community has a chance to see this. I think we have a great start and we know what we would like to say. I think there is a chance that there are other things as well for which we want to provide opportunity. We plan to come back in 4 months to give you an update that will include other things that we have heard and the meetings and the dates we help them and the next steps in the process.
>> Can we expect this in 3-4 months?
>> Absolutely.
>> That was one testimony. Does anyone else want to testify that didn't sign up? Please pass this down. Please stay with us.
>> Thank you. I I represent the Colorado accessibility coalition. I appreciate your comments and the comments of the Bored. The department has a triple aim and they took about being healthy and all of that. I think it's important to understand what you are requiring for the families to get on the program. The primary caregiver never gets sleep. We need to do away with the nighttime criteria. If a kid is waking up that much we need to pay for overnight respite. Think of times when you don't get enough sleep. We tell people to do that every day. What we see our families with premature heart conditions and cancer and devastating illnesses because we are forcing people to do a 24/7 job with no sleep. Maybe they will get a respite once or twice a year for a weekend if they are lucky. Usually that does not happen. Also, I will provide this, we represent these families. These people -- the reviewer suggested that my client should meet -- should leave her son lying in his waist overnight and it wasn't medically necessary to change in. Because of his condition he picks at his skin and stuff gets it. I will provide you the transcript. We can provide a. If you need to go to the legislature we can provide a lot of families talking about what this is like. We need to do away with nighttime criteria. This is urgent. We can't say that we care about health and tell people that they should be healthy -- going without sleep is worse and more dangerous than smoking. That's all I have to say.
>> Any questions?
>> Please sign the testimony she. Are we ready to vote on making the changes they are asking for -- with the removal of the behavior? I would entertain a motion.
>> I will move for initial approval of this document. The revision to the Medical assistance --
>> Sorry, wrong one.

>> I am moving for the initial approval of this document regarding the Medical assistance long-term services and report concerning the children's extensive support to remove behavioral services personal care and vision services -- specific to the authority in the record.
>> I will second that motion.
>> All in favor -- Aye.
>> Opposed Rex
>>
>> Opposed.
>> Abstained?
>> Doctor Fraley?
>> Aye.
>> Ms. Moorer?
>> Aye.
>> Thank you so much.
>> We are now -- if you wanted to sign up -- I apologize. I got ahead of myself.
>> Good morning. Please identify your self and tell us who you are.
>> I'm Shannon Guscott from the financing division -- I'm here to present a change to the school health services program claim submission.
>> The school health services program in public schools and education services -- matching funds for services that they provide to children for individualized education programs. These are services such as physical therapy, occupational therapy, nursing services, professional services. These services -- the reimbursement methodology -- they are paid interim payment as a test as well as a final settlement. This is not month after the end of the fiscal year. Currently our rules .2 the state rule on the filing commission and we are doing an adjustment to take away pointing to that to make it clear to the school district that claim submissions must be done within 120 days after the end of the school year to ensure that we can meet all the requirements to finalize the final payment. Within the state and federal regulations.
>> Okay. Any questions?
>> Seeing none, do we have any testimony? Does anyone have any testimony regarding this rule?
>> Seeing none, I will entertain the motion.
>> That was easy.
>> I move this document -- the revision to the Medical Assistance Rule regarding the school health services program claim submission and interim payment section 8.290 .0 point D incorporating the specific statutory authority.
>> Second.
>> All in favor?
>> Aye .
>> Abstained?
>> Opposed?
>> Doctor Fraley?
>> Aye.
>> Ms. Moorer?
>> Aye.
>> This has passed. Thank you very much.

>> [Indiscernible - low volume]
>> I am looking at October --
>>
>> Let's take a 5-minute recess.
>> [5-minute recess] We are coming back together.
>> Kristine Gould ?
>> -- Kristine Gould, come on down.
>> Hello.
>> Introduce your self and tell us who you are
>> We need to get a sense of humor.
>> Good morning I am Kristine Gould, the pharmacy policy specialist and I'm here to present a vision to the pharmaceutical services rule number MSB 18-06-20-A. I will address three separate sections that I have changed. So I don't have to keep seeing -- saying MSB 18-06-20-A, I will say something.
>> Stakeholders have requested -- it was not clear which drug category the department doesn't does not cover. This will was modified to clarify what parts may be covered. And what the department won't cover.
>> The second change -- agents used for cosmetic purposes and hair growth.
>> This addresses drugs --
>> Can we start to use B and D?
>> Some may not be able to tell them apart because you are saying it very fast.
>> Yes.
>> I'm nervous.
>> Don't be nervous. We are nice people.
>> We are here because we care.
>> These -- section four point be Mac addresses classes of drugs which may or may not be excluded from coverage. Section four point
>> Addresses items that are not pharmacy recommended. These drugs are being moved because of the department should never recover these -- should never cover these products. We have never covered these drugs and therefore and administrative revision language.
>> The last revision is in section 4 point D Mack and we are expanding coverage of the drugs which are in addition to clarifying the specific drug categories. Currently the wording is gray -- vague and this has created some confusion. Therefore we are listing the truck categories to help clarify which drugs the department may cover. Any questions?
>> Any questions on the phone?
>> No.
>> Ms. Roberts?
>> I noticed that you covered [Indiscernible - low volume]. As well as decreasing gastric output.
>>
>> I would have to take that back to the clinical community and as. We have specific categories and the drugs within the categories gets into the city pretty.
>> I can get back to you.
>> Regarding the proton pump inhibitor -- I thought maybe they would use the [Indiscernible - low volume].
>> [Indiscernible - low volume]

>> Thank you area
>> We don't have any public testimony. Does anyone want to testify? If not, I would entertain a motion. I would entertain a motion.
>> This is Simon Hambidge. I approve -- I submit approval.
>> I second it.
>> A motion and a second. All in favor --
>> Aye.
>> Abstained?
>> Doctor Fraley?
>> Yes.
>> Is that an Aye?
>>
>> You can tell she is in Durango.
>> This Moorer?
>> Aye.
>> Okay -- it passes. Thank you very much.
>> I think we need more coffee here.
>> Next -- Alex Weichselbaum.
>> I think I am pronouncing it incorrectly.
>> You got 2-for-1.
>> Please introduce your self and tell us why you are here.
>> I am from the [Indiscernible - low volume].
>> Use your outside voice.
>> I am here to present the speech language pathology rules. Along with the policy specialist. The purpose is to see an approved program for clients by having mandatory documentation requirements and by clarifying the payment methodology that exists between the out patient and the benefits.
>> [Indiscernible - low volume]
>> Since 20 17th approximately 18,000 clients have utilized this. Young the specifics of the rule replaces documentation language.
>> The following mandatory requirements are imposed by this rule.
>> The initial evaluation the providers must show the factors influencing the treatment prognosis and the discussion of the relationship and the diagnosis of the disability. These plans must cover the longer than 90 days so the time frame documented will be in this plan. All documentation must follow the objective assessment and tool -- not the tool but the format for each visit.
>> This will also clarify that outpatient speech therapy provided as a part of the requirement -- which you heard today -- is not separately reimbursable. Medicaid directly reimburses school districts under the school health services program. Providers employed by the school district they may not submit separate claims for those services. This has always been the place but we want to clarify this rule to make it clear.
>> Finally there are miscellaneous updates for expectations and terminology. Outpatient speech therapy providers could have mandatory document Tatian requirements and they also came from having clear locations from the department on these documents.
>> The class will benefit from more robust [Indiscernible - low volume]. The department shared the proposed rule with the speech and language hearing

Association. We request a [Indiscernible - low volume] for the Colorado chapter and we proposed these rules for our website and the comment period closed in September. The majority comments were concerned with reimbursement for outpatient speech therapy required under the requirement and whether outpatient speech therapy may be rendered in addition to the services provided under the school health services program. The department responded that reimbursement for outpatient speech therapy under the school health services program is not [Indiscernible - low volume] and therapists may bill for outpatient therapy in addition to that provided under the school program. The individualized program does not identify the services that the school should provide. And to the services as medically necessary. Thank you for time. Please stand by for realtime captions [Captioners transitioning]
>>Two people on the phone have any questions?
>>Regarding the documents, can you give us an idea if I'm a speech language pathologist how much extra time per visit is going to be allowed?
>>I am Alex S, on the program administrator for the boat program speech administrator. The answer is not very much time at all. These documentation requirements are already in place. What is changing here is, instead of being an option to use the sub format it will be a requirement. The majority is used for the sub format anyways. And industry standards format for taking notes. What we have encountered in the past that prompted this was, during a documentation audit, our auditors encountered instances where the documentation is almost nonexistent. When they went to educate the provider for what the expectations were, it said providers should consider using this format but it did not say must. So there was ambiguity and it wasn't good for us or for the provider. So what we are changing here is to get rid of the ambiguity. The Mac we had the conversation about this on Wednesday at the children's disability advisory committee and we appreciated your time. Working with us. And at that point there was discussion about stepping in this process so you won't get 19,500 called the same time and also that be healthy and aware that different goals and objectives may be on different pars that kids sometimes see speech therapist for multiple areas. Like if they've been swallowing or articulation through an augmented device. I'm just saying that because that was from the advisory board. The Mac I move the document of seven -- revision to the medical assistance role concerning the speech language pathology section 8.200 point 34 incorporating the statement of basis for purpose and specific statutory authority contained in the records. The Mac I second that. So make a motion to second that. All in favor.
>>Tran9.
>>Dr. freely.
>>Tran9 this time. Miss Moore.
>>Aye.
>>So it passes.
>>Think you and I appreciate it. Let's talk about the consent agenda. I am thinking number 7 and number 6 there I will do consent and then we will do emergency I will give you a moment to read so let's take another break in order to read since we got it at 430 yesterday. I am looking for help with the consent agenda. What else should be on the agenda?
>>I think all of them. Just to clarify. Are we still consenting even though were

asking for updates. Just clarifying that.
>>We passed what was presented but we are asking for additional information on a further case.
>>So should we go to consent or not to consent.
>>To consent. But there coming back.
>>So yes. If you are okay with what they are presenting here then you can go ahead and consent. The Mac all of them. Then I make a motion that we moved to at the document 3, 4, 5, 6, 7 to the assent agenda. Motioning I need a second.
>>All in favor Aye.
>> So we were going to take a break before we did the emergency. We were also waiting for [Name indiscernible] . Do we need a break or and the other thing is I want to do process -wise it was suggested to me that we merge the two together and then do testimony on only 1. The staff has asks that we don't merge them that we Them separate. So let's keep them as separate rules and hear them but you can come up the first time and testify for both or you can wait and come up. I'm going to limit you to 5 minutes the matter what you do.
>>[Indiscernible - Low Volume] I was told not to merge them.
>>I am not asking to merge them I'm asking for 2 presentations in the testimony. And then back to adopt or not adopt.
>>All right, let's do that. Do we agree? Let me hear a shaking of heads. Good. Then we will call Sarah R. And Bonnie, thanks for joining us.
>>Mr. Cortez picks two do we want to call it the second roll presenter? The make sure, come on down.
>>Everybody looks lovely today. Cereal looking gentlemanly. I'm just having fun with this, it is the holidays. Introduce yourselves before you talk.
>>Hello Madam President members of the board Bonnie S the interim director for the office of community living. My team and I can before you October 12 to present them with three separate and related rules. And at that time I committed to provide some leadership continuity between those rules so I'm technically not a presenter today. Some of these rules presented were around sustaining our money called Colorado choice transition. A federal demonstration program helping people transition from disability based settings to the community. During the presentation of these rules the borough word dashboard heard testimonies. And because of this I requested at the time that the rules be tabled until we can do additional work. The third rule defined case management agency and case manager qualifications. Stakeholders expressed concerns around the areas within that rule that weren't being presented. So the board at the time moved to not push the rule forward. So we will present 2 emergency rules that if approved will provide regulatory authority necessary to show that there isn't a gap in the service [Indiscernible] This third rule around case management agency and case manager agency corporations will be presented back at the medical services board in June 2019 for 2 reasons. First is we did some stakeholder engagement and because of changes that we made as a result of that engagement that rule actually no longer ties to these rules and does meet the criteria for emergency presentation. When they talk to people who came and presented. The broader concern was around several prioritized rule changes. So in June those rules will be brought back in addition to others that have been prioritized. The Colorado choice transitions program is a five-year grant funded demonstration that the department has worked with stakeholders over several years

to sustain a plan. Prior to this meeting the department held more than 20 stakeholder meetings to inform our policy development and implementation. The testimony expressing the concerns indicated that undoubtably or engagement was necessary. So over the past 2 months this team has worked with stakeholders and CMS to develop solutions for the most significant concerns that we heard. We believed we came up with the best path forward to show that there is no gap in services come January 1, 2019. When individuals can no longer enroll on the Colorado choices demonstration. This 120 day period between when the rule is effective, if passed, and the final rule is in place. We will engage stakeholders on certain issues to be able to present a final solution. We acknowledge that the rules today are not final and change can still be made. Sarah and Tim will be going into more detail about the actual rule they are presenting and the specific changes from what we heard on October 12. Are there any questions of me specifically before moving to the presentation of the rules?
>>Seeing on and hearing that we will proceed.
>>Good morning I'm Sarah the unit supervisor in our section of MCL. The rule that I am presenting today is for transition coordination. Benefit under the [Indiscernible] As a result of house Bill 18 26 which directs the department to continue to provide transition services for individuals who live in nursing facilities or receive services from regional centers and would like to move back into home or community based settings. This rule is inserted in sections and 8.763. Those are the two sections you have before you in the draft. The proposed rule makes coordination transitioned permanent. Specifically this will create a targeted case management benefit to provide transition ordination through transition coordinations that we call TCA. Included are the minimum qualifications and requirements for TCA and for transition coordinators. The establishment of pre-and post transition and monitoring activities will be associated with this benefit. As mentioned transitions were provided after the Colorado choice transitions program and as a September 30 426 members have transitioned under the demonstration project. 90% are living in the community when you're after transition. A huge thing to celebrate. [Applause] The last date to enroll his December 31st. This allows us to continue services without direction. We've been busy since October working with the many people in this room to develop solutions and are pleased as a result of our work with stakeholders we resolved several remaining concerns. The park -- [Indiscernible] Before I list out what we have heard and what I have done I will ask if there are questions?
>>The questions thus far.
>>The first thing we heard was the primary issue is that there would be a conflict of interest for transition coordinator agencies to provide case management services. The TCA would not be able to authorize both the H CPS waiver services and provide the services for the same individual. Under the demonstration project we've been able to support the transition as well as the additional services that members receive. So the member has one point of contact under the demonstration. We heard the separation to be cumbersome and inefficient for clients and some stakeholders were concerned about the dual role of advocating for clients and for presenting the department for an appeal of denial or discontinuation of services. So what we did was remove the requirement to provide case management. We carved out that piece of the service. This will continue to be provided by case management agencies. In

doing this it allows us to retain the case management structure so that department can still serve the broadest base of members to ensure they have the support they need during and after transition. The second piece we heard was that 240 units were transition ordination and is not enough time to transition for some clients. There were concerns it would cause an unsafe transition. We propose an exception process for members who need more than 240 units of transition coordination. That will be based on documented health well Sarah and safety concerns [Indiscernible] The third thing we heard was that some of the minimum requirements we put forward were not appropriate for these agencies once they were no longer tied to the same case. We heard that some of those altercations were expensive or difficult to implement and no longer appropriate for the scope of work we have proposed. So we created a modified set of minutes from -- minimum qualifications. As a result there's one thing that did not change. And there is a list of things that did change. What did not change is that agencies are still required to employ transition coordinators. Contractors are not allowable. This is to ensure the sustainability, consistency, and quality of services. What did change is the agency will be able to substitute access to a line of credit equal to no less than one month of acceptance for financial reserve for one month of expenses. Agencies may substitute an equivalent financial statement that they do not perform an annual financial audit. Particularly for a private for-profit organization. Agencies performing these services before December 31st 2018 are exempt from the agency minimum of 2 years experience to recognize the work that they have done under the demonstration project. There's a process for coordinators that don't meet to be hired by TCA. So subject to the department of approval they can request that as they view it eligible. Based on a combination education experience that includes the experience. As a result.
>>As a result of these efforts to come forward today to show the best possible avoidance of gaps in services. That's January 2019. And overall it's very exciting by the numbers that the part department reviews for person centered services highlighted under estate plan and labor. There grateful to stakeholders, those who participated in the process. As you know some people in this room are responsible for a 40 year history of transition in Colorado. The passage of money follows the person and ultimately pilots the program successfully in our state. In addition to the transition coordination benefits the next requested change builds on the [Indiscernible - Low Volume] individuals would be able to access the services they need transition ordination to transition from institution to community. Individuals experiencing a change in life situations like moving to a more independent setting may also qualify the services based on identified case managers. An example is an individual moving from their parents home to their own apartment. [Indiscernible - Low Volume] first I will ask for questions.
>>Are there any questions at this point?
>>We will wait for public testimony until the end.
>>I am the service development evaluation manager the role that I'll be discussing momentarily is the company rule to the one that you just heard from Sarah regarding, I'll be discussing the company rule to propose a medical assistance emergency role to implement transitional services through home and community-based services waivers. Reporting this role of the Colorado code of regulations. CMS, the department expands these services to include [Indiscernible] To include support

for a change in circumstance if the member requires additional support to maintain their validity the services are authorized the expanded access moving to these institutions would be in an adult with disabilities who has lived with her parents their entire life, has never had to cook for themselves, one parent abruptly dies, another goes to a nursing facility leading the person with no ability to meet their daily nutritional needs are have daily think skills necessary to thrive in the community. This person would benefit from these services. Another example is for a person receiving these services, has a lengthy hospital stay and is absent from their community. May require services to reestablished independence in their home. Transition services rule is comprised of services set forth to the demonstration showing to be the most successful services transitioning or affected by change circumstances. For additional support an individual may need to transition from settings to maintain and thrive in a community setting for life circumstances. These are life skills training. The service was previously needed to transition independent living skills training, training on skills for living in the community as independently as possible. Home delivered meals, this is access to nutritional meals for those with special dietary needs. The services support the shared experience with community living. The transition set up as a one-time expense only available for members transitioning from an institution. As mentioned, the proposed services roles were tabled in order for stakeholders for the development of services associated rules. Heard from stakeholders that there were issues to address surrounding provider qualification of lived experiences. Looking back at the October 12 meeting. For life skills training. We heard that the experience should be a minimum qualifier qualification. It's been added in. Her class a or B services will cost template for providers. The department must ensure the health, safety, and welfare of individuals receiving skills training they acknowledge the current licensure structure may not be ideal for the service. Accordingly the department has removed the licensure for the time being and works with the Department of Health environment on an oversight solution as well as conducting stakeholder meetings over the next 120 days to finalize the service. Home delivered meals, we heard that the older Americans act language in the service was too restricted so we removed that language. Heard that there needs to be an ability to be reimbursed for the transition set up coordination. The department created a new set up for this service. A new direct service not reimbursed in the demonstration. The coordination of the setup will be reimbursed separately from the setup expenses. Peer mentorship. We heard this requirement limits providers from developing and projecting their own programs that it's too stringent. The core competencies and set up an overall heard the rates and limitations are too low for some of the services. These were based on the average utilization of the demonstration and legislations for increased rates in the demonstration. Despite these limitations the department does have exemptions to ensure health safety and welfare if needed. Part of the November 1 Governor's budget includes rate resistance for several services subject to legislative and CMS approval. Let's talk about next steps. A part of the emergency role process will be to hold a series of stakeholder meetings for the next 120 days to solidify the service design for life skills training and that appropriate oversight. The meeting fate the dates will be sent out shortly in the following are the dates and times for post. January 15, 10 AM to 12 PM, second meeting January 29 from 11 AM to 12 PM. Third meeting February

12 from 10 AM to 12 PM. All meetings are at the department and we welcome all stakeholders participation. What to think you members of the board for your time today. Your consideration in approving these emergency rules to avoid the gap in services come to a 2019 it's too a significant success story why Colorado is choosing to sustain these valuable services positively to impact members lives. The department is trying to expand the broadest population to have the biggest impact people we serve including all disability communities. All long-term services and support populations and to improve upon the demonstration where possible. We are committed to our stakeholder process in our continued work of the 120 days to finalize the aspects of the rule to develop the burst test best services for people we serve. To be committed to this process to provide thoughtful feedback looking forward to our continued feedback. At this time I open the floor to any questions.
>>Madam chair, just a statement, physically [Indiscernible] In point 3 of your document CCT program has demonstrated that as of 2017, 328 help first Colorado members transitioned into the community at a savings of more than $2.8 million to the state [Applause]. To make any more questions or comments then we will do some public testimony. Please come join us and introduce yourself. Does anybody else want to testify? If so, tell me and we will get you the paper. Looks like you are it. Two good morning I'm candy B the executive director of Atlantis community. I'm here on behalf of the Colorado cost disability coalition and adapt. In October I along with other members of the disability community testified in opposition of the rules that were presented at that time. Since October we have had several meetings with the department including a small meeting with Don and as a result the department addresses are concerns. We think these changes will result in a higher quality and more sustainable transitions program. [laughter]
>>For those on the phone with got people [Indiscernible - Multiple Speakers]
>>We support the rules as presented to collaborate in the department to work on any remaining pieces. We appreciate the role as medical services board in October and appreciate the work that the department has put in. Thank you. We look forward to partnering with the department over the next 120 days and moving forward so that we can create a model state for transition services. Thank you. Any questions?
>>I want to thank you. The hard work was done by you all and the department in making this happen. We get the pleasure of saying wait a moment. It did work and it was a success. Thanks for all the hard work the places you have been in the last few months. I know people have worked very hard and it's for the betterment.
>>I echo my thanks to all of you. One of my inaugural services on the board Josh testified when will implement the [Indiscernible] Act. I went home and read it I appreciate the fact that everybody there has stuck in with the department and worked so seamlessly. With vigorous debate, but thank you all for what you have brought forth to the department for doing what they do.
>>This has been a time when I feel like our role really does matter and we were able to be helpful in this process for stakeholders as well as department. I'm not the only one who's not excited about getting those roles last night but it's an in product the tremendous amount of work. I'm pleased to see what was presented. I didn't know what happened in the interim time because it does not always happen. I feel service has been done in conjunction with who we want to be working with. The stakeholders. Tim happy about how all of this has turned out. Thanks.
>>I entertain a motion on document 8. [Applause]

>>Thanks for making a comment about Colorado being a leader for transition and other states will adopt this. So I move the emergency adoption of document 8 revision to the medical assistance rule concerning targeted case management transition services section 8.519 and 8.760 incorporating the statement of basis and purpose for statistic authorities contained in the record.
>>Move the emergency document 918 -- 821.8. Revision to the medical assistance rule concerning transitional service section 8.553 incorporating the statement of basis than the specific statutory authorities contained in the records.
>>All rules adapted find the immediate option compared for federal preservation of health safety and the compliance with CRS, contrary to the public interest. All in favor. Opposed, abstained.
>>So it passes. Thank you.
>>[Indiscernible - Low Volume]
>>Let's go on now to the department updates. Nobody has signed up for public forums let's move on to department updates.
>>Morning I'm Kim a few updates. We are in the middle of joint budget hearing committees it's important to get the resources we need to serve those who we care so deeply about. Those dates are Monday with the main hearing at 9 AM. Behavioral health briefings December 11th, the hearings are on the 19th and the community living briefing took place this week. The hearing will be December 19. It's a very busy week for us coming up. IMac on that comment I want to thank Don and Candy and Julie and Josh and adapt and all the representatives it was quite beautiful. Healthcare is very hard. Meeting the needs we couldn't do this without collaboration. It's an outstanding example of bringing the best minds together dealing with things every day. For those who have the passion to make rules to meet the needs of all the individuals, thank you for being exemplary and I encourage us, some things in the economic forecast are shaking a little bit it's going to get harder not easier, this is the sort of brilliance that we need going forward as our seniors are growing. The rest of the population is about 14%. We need to make sure that funding is available to take care and it's so important, let's get amen to that. It's important that we have that and with that we are coming out of Thanksgiving and into a holiday season so on behalf of the department and myself I wish each of you a new year that is more than you imagined. A new year where your dreams come true and all the things you have been working so hard for is the best gift. Have a wonderful holiday and we will see you next month. [Applause] Thank you all very much. And with that I wish you a Merry Christmas. And if the granola is still good in January I will bring it [laughter].
>>It's still good I'm positive. And if not you can just make us a new batch.
>>Save the extra for me just in case.
>>We are returning.
>>Adjourned. The Mac
>>Thank you all and happy holidays. [Event concluded]