COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
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Children's Extensive Support (CES) Waiver
First Renewal Meeting Closed Captioning
Meeting Date: August 23, 2018

Disclaimer: Below is the closed captioning dialogue captured during the first CES Renewal meeting held on August 23, 2018. The spelling, names, and language may not accurately represent what was presented but rather what the Caption Colorado staff member heard through audio. Should you have further questions or comments please email HCBSwaivers@state.co.us.

We are putting the final touches on getting ready to go with the CES portion of the IDD stakeholder meetings. We are going to let people get settled and there are a couple of people still joining us after the lunch hour. We will get started in two minutes.

I think we will go ahead and get started. Thank you for joining us. As I said earlier my name is Dennis Roy I work at the department of health care policy and financing. My role is the home community-based services federal policy liaison. With me today is Julie Masters who works with me on the HCBS federal policy. Sarah Herbie the supervisor of the waiver administration and compliance unit and Kelly Brian who is handling all IT things. For those participating on the phone if you were on the meeting this morning thank you for joining us again. I hope we have overcome some of the technical issues we had this morning and we will be able to have full participation from everyone on the line. Thank you for working with us through some of those issues.

To get started we want to remind everyone of our mission of the department of health care policy and financing is to improve the health care access and outcomes for people we serve while demonstrating sound stewardship of financial resources. If any of you have participated in any presentations I have given before today when we are talking about the renewal of one of our HCBS waivers we are focusing on compliance. With federal partners for how we operate it waiver. Much of what we will talk about in today's meeting as well is the subsequent meetings throughout the stakeholder engagement process is how we write our waiver application so we're meeting all requirements of our federal partners. Also accurately demonstrating how our programs operate. A couple of housekeeping notes.

Most of the people in the room were here this morning. Just for your reference there are restrooms across the call. We are thankful to the Colorado health foundation for hosting us. This is a beautiful room. Additionally for stakeholders it does provide a parking lot which it does make it easier to participate in meetings. Thank you for joining us. For those online please note we have muted all of the lines. We anticipated high participation via webinar. We have muted those lines just to prevent any circumstances of one person talking over another. We very much value the input of those dissipating remotely. If you have any questions or feedback please feel free to type those into the chat box within the Adobe connect interface.

Julie and Sarah are monitoring that chat box and we will use that for answering any questions as well as identifying issues. Maureen?

I am getting text from people that the webinar is crashing so they cannot type in the Bok's. They are hearing because it is -- but it is garbled.

Thank you for the feedback. Terry are you listening in?

Yes . Expect how do I sound?

You sound allowed in good.

[Indiscernible - multiple speakers] >> Please tell me if I need to slow down but I am notorious for speaking to slow. -- Fast.

They can hear you but it is going a lot.

Kelly is on it and will adjust it.

We will keep posted on the audio issue. I do want to go over a couple of ground rules for everyone's reference. A lot of material that we will cover is Dan. A waiver application at minimum is 130 pages. For some waivers it can stretch out to 190 places -- pages plus. I will do my best to explain the dense material in a easy fashion. I will as that everyone holds questions and so we get to a breaking point. At which time we will take questions from people in the room and on the webinar. Also more ground rules across this engagement process. What we're doing is to really try to engage stakeholders on what is actually in a waiver application. There are two components to these meetings. One is explaining how an application works and the other is explaining how the program works. Feedback on those two component we have to different ways to provide that comment -- feedback to us. If you have anything on the process or how the meeting is organized please send that type of feedback to the email address HCBSwaivers@state.co.us. However, if you have any comments or recommendations for the waivers themselves and today we will talk

about the children extensive support waiver. If you have any feedback on that waiver itself you can send that to LTSS.PublicComment@state.co.us that email address is our official email inbox that we use regarding all comments on our waiver actions. Anytime a waiver is out for public comment periods we add that feedback to our listing log for that particular action and then that comment is responded to with an explanation of yes we were able to make the change and will make the change in the application or an explanation as to why we cannot. Any questions on the ground rules? >> The next slide is to talk about the meeting purpose. Maureen, I did not remember if you participated with stakeholders to the process and other different parts of the application. This process is similar to something of that I did about a year ago regarding the children's home community-based services waiver. We received feedback that it was helpful to take this approach. What were we doing? Today we will be talking about appendices -- Appendix A, Appendix B and Appendix C. We will spread these out over three meetings. Each meeting is broken down to specific parts of the waiver application for the purposes of explaining all stakeholders how the application works, what is in the waiver application according to each waiver and also how we ever in the language to explain to CMS how our programs work. That is our meeting purpose.

As I said this morning I do want to dose it is not a disclaimer but it is is part of the renewal process that I want to make clear. What we're doing is preparing these actual waiver applications to be submitted to CMS next year for approval for anticipation of the report expiring on June 30. That process is independent of some of the other policy efforts stakeholders may be aware of or involved in. Most notably are some on the slide such as the waiver implementation counsel. That counsel is examining and changing different services to three different IDD waivers. Individuals with developmental disabilities. That counsel is talking broadly about different things to change the entire system. The work completed within that counsel will come to us as part of a waiver action in the future. Whether it be through renewals or a subsequent amendment thereafter. I do not know how that will go. Understanding is they are still looking at getting statutory authority and budgetary authority. The way that process works is they will take care of their things and work with stakeholders to propose different policy changes and it will get passed on to Julie I and Sarah to implement in a actual waiver of -- waiver application. Some other areas are the HCBS settings transition where providers adjust many policies and programs to meet the CMS final rules. Any statutory changes. There were a lot during the past legislative session and we anticipate more coming up. Those statutory changes, unless they are specifically worded to be included at the next waiver renewal, they are not part of this process. This is a independent process for the most part. The one caveat I do have and it is more of a disclaimer/public service announcement is the second bullet about current waiver amendments. As we develop the slides and presentations for the stakeholder engagement process a we did write the slides and present information towards the currently approved waiver applications. Starting next Saturday, September 1, the

department is starting to plan a public comment period for amendments on the DD, CES and SLS waivers. I will make note of what we will be requesting from CMS in the amendments that will go out for public comment next week. Any questions about all of that?

Nothing online? Audio still working okay? What I would like to do is spend a little time giving a basic overview of all of the home and community-based services. Today we will focus specifically on children's the extensive support waiver. Before we go into that I would like to cover a little bit of the background of what a HCBS is and where the authority comes from. Some of you may have participated in stakeholder groups are for or worked with some of us who are within the home community-based services operations. You may have heard us use the phrase it is a 1915(c) authority or under a 1915(c) waiver . What 1915(c) is is a specific cause of the Social Security act that allows a state to waive other requirements of the Social Security act in order to operate a particular program. When we say the word waive your what is being waived is the other requirements of the Social Security act. Here in Colorado we have adopted the habit of referring to saying things like a child got onto a waiver. Which is completely understandable. What they are actually doing is getting onto a program that provides services through Medicaid that is waving part of the Social Security act. And that 1915(c) clause what they have said is that a state can waive those requirements under the sub bullets of the slide.

We can establish a waiver program for individuals who were first found to be at risk of institutional placement. We will talk more about that later. The purpose of HCBS waivers under 1915(c) is to prevent instant -- individuals from being in a institution . To really allow them to remain in a home or community. The second part waived is those individuals have to be part of a defined target group. We will talk more about the CES target group in subsequent slides but the examples easiest to understand is here in Colorado we operate waivers forge traumatic brain injuries or spinal cord injuries. Individuals with those Andrews -- injuries are part of that group we set up services for. There is one other topic that I would would like to remind people of is under federal requirements 1915(c) our federal partners have established instead of -- federal statute that an individual must receive one of the waiver services every 30 days. Because they waivers additionally provide services beyond a state plan. That comes up often especially in the context of the children's world. Making sure children are maintaining waiver eligibility. To participate in the CES waiver they do have to use one of the defined waiver services every 30 days.

About the waiver application process. What is going to come up here for stakeholders is that when a waiver is constituted or implemented there is an initial waiver application. A waiver is approved initially for three years and subsequently placed onto a five-year cycle. We are currently at the end of a five-year cycle for the developmental disabilities waiver, supportive living services waiver, children extensive

service waiver, and children's rehabilitative residential program program. All waivers are due to be renewed next year. Have -- as I have a litter to do to stakeholder engagement DD and SLS we had morning meetings to discuss those components and we have afternoon meetings to discuss the CES waiver. For the CHRP waiver it is getting its own stakeholder engagement process due to recent real -- legislation that just passed. What has also come up our that occurs here in Colorado is we are now operating 10 different HCBS waivers. Turns out the way that those 10 different waivers are on cycles instead of different -- we have for waivers up this year, to next year, one the year after that and three again in the fifth year that the -- we just renewed. My point bring that up as you may hear about waiver renewals every year. --

For this renewal process it is important to note that technical guidance from federal partners at CMS have said that waiver applications must be submitted at a minimum of 90 days prior to their effective date. Unless there are certain circumstances. For renewals specifically CMS is requesting they be submitted 180 days in advance. We will talk about time lines in a moment. Here in Colorado we are going to try to compromise and meet in the middle. While we talk about the scope of these waivers we are submitting I want to be clear that when renewing a waiver there are some things that we can change within a waiver application. We can correct grammatical errors or any type of technical language errors and every now and then we will come across a situation where language was put into a waiver application. It has just never been edited and might not be the most person centered language or might not match operations. We can make those types of changes. Things that we cannot change our any type of existing contracts or delegated authority's we have within our waiver applications. Those contracts have their own timeframe. We are merely explaining to CMS how those contracts are operated. The other thing that we cannot change in the renewal process is any budgetary allocations that come from General assembly . The General assembly or Colorado legislator approves the budget annually for all of our waivers. We have to stay within that budget and explain to CMS how we explain -- spend that money.

Here are the important dates that stakeholders need to be aware of for this process. We are currently intending to have an official public comment period that will run from the end of January through the end of February next year. Then we will turn around and submit those waiver applications on 1 March. That way federal partners have from 1 March to June 30 to go through a review period. We received a question this morning on what if we received questions at last minute before a waiver is submitted between February 28 and March 1? As a department we try to respond to comments are sinners they come in. Within 24 to 48 hours. The response to those comments are often an explanation of saying thank you we have incorporated that into the waiver application or an explanation of why we cannot do that right now. It would require additional allocations from the General assembly or require a longer-term

project in order to potentially get a provider work -- network set up or changing provider qualifications. Any components that go into delivering a service to an individual through a waiver. We try to respond to those questions as soon as possible. Every now and then we do receive public comment that does the way our process. If there is a delay in responding to the feedback we have received it would delay our submission to CMS.

With that I will pause for any questions about the process, how this work -- works or anything to that nature.

Everyone heard me talk to the same slides this morning. Any questions online?

As the slide says here today we're going to talk about the three appendices. Appendix A is the administration and operation, Appendix B the participant accessing eligibility and Appendix C services available. Appendix A is about how does the state operate its waiver. Who is in charge of running the waiver and what type of duties in the operation of the waiver are delegated to other entities. This is where we write all of that out. Within Appendix A of the CES waiver. At the end of the day HCPF is the single state operating agency. There have been different times where for or five years ago the department of health care policy and financing was the single state agency at that point. We operated the overall Medicaid program as a department. HCPF operated the waivers. However, [Indiscernible] was responsible for the waivers but the Department of human services operated it. It was in delegation of authority from HCPF to DHS. Now that HCPF is a single state agency is delegated down to the office of community living and through our division which is the benefits and services management division. We have one unit that handles waiver administration and compliance and another unit that controls all of policy surrounding waiver benefits and services and providers of those services. Within CES we have a number of contracts with different agencies that we delegate the administrative authority to. First and foremost is partners over at the Department of Public Health and environment. They aren't charging -- ensuring that all of waiver provider types are fully licensed and receiving both the initial and redetermination of the licensure. There are a couple of provider term -- types that do not require full licensure but approved through other areas. The next big delegation of authority we have is the delegation of the evaluation as well as the planning processes. That is a delegated that goes -- is delegated to the 20 Community Board Ctr. boards across the street. They are operating within a geographic area to conduct and finish all of those evaluations as will -- well as the full planning process. Those last few entities are the physical agent -- fiscal agent which handles all Medicare claims ends well as the PPR and QIO. QIO is with the EQ health. It is a contract to EQ health to do all CES waiver application reviews as part of the utilization review process. >> At the end or as a part of every appendices in the waiver application we are required to have a quality improvement strategy section. Work UIS. That is CMS's requirement that the

department has performance measures to ensure the fact that the waiver is operating as defined within that particular appendices. As an example, within Appendix A the quality improvement strategy must assure that the Medicaid agency retains alternate administrative authority as well as how we remediate any issues we have with those administrative authorities and contracted agencies. What we have is a series of performance measures that are in the CES waiver. The number is increasing as we have more contracts for our waivers. There is now a performance measure specific for quality improvement agencies to ensure that EQ health is meeting the standards of their contract. There is also performance measures to measure the fiscal agent.
>>
Basically CDPHE is ensuring that providers are license?

Both ensuring and conducting the license.

[Indiscernible - multiple speakers]

Whether we call it a licensure or certification, it does vary from servicing provider type. We have delegated that they will conduct all of the surveys and provide as as a single state of decay the agency the information as to whether that provider does or does not meet the licensure requirements.

That is some of the issues that we have been talking about in stakeholder meetings for 18 months around the licensure requirements that are making it so kids were having a hard time getting [Indiscernible - static] under this waiver. That is something we cannot change because it is a contact that we cannot change with this renewal.

Because of our technology issues, can someone accessing remotely that they can hear Carol and her questions?

Please repeat the question.

Carol can't tell me if I miss state this. The question is whether or not we can adjust our relationship with Tellegan to address the fact that children cannot ask -- children cannot access care due to the licensure requirement.

Within Appendix A of the waiver we are telling federal partners at CMS that we have a interagency agreement with CDPHE to monitor all providers. There are performance measures to monitor how they are doing. What I think you are referring to is the licensure requirements for the care agency that would then be held in two different places. One would be in the roles and regulations of CDPHE for a class a or class B licensure I do not know the ins and out. That would be more on the CDPHE side as well as the provider demonstrations that we qualify -- [Indiscernible - static]

Can we propose changes so kids can get [Indiscernible] ?

We can propose it. I am not a subject matter expert to know what magnitude that would be to address that but if you are willing to propose it we can get it into the public comment log and try to address it with further conversation.

But it may be Appendix A or Appendix B?

Appendix A and Appendix C. More than likely it is Appendix C.

Said the other question I had is EQ health is the quality improvement organization, correct?

Yes.

They are one of two.

Is EQ health the quality improvement organization for the CES waiver? The answer is yes and because we do have two QIOs they are a quality improvement organization for conducting grid use of CES applications and for conducting the utilization review. We also went into contract with a second QIO and that vendor's name is Tellegan they came on board 1 July and are doing reviews of case management agencies to make sure case management agencies are completing administrative functions and they are also doing other functions as a QIO organization. They are reviewing current incident reports. CES has two now. To QIOs.

EQ health is the thing I keep hearing about from people in the community. It is a denial of eligibility. They are the people saying no a kid does not qualify. And that it requires time and effort by a variety of people to appeal that decision. Most of the time we prevail in my experience. I'm not saying the whole world but the contract between EQ house -- health around eligibility is in the waiver application?

The fact that we have that relationship with EQ health is in the waiver application. What we demonstrate and the waiver application is that we have a QIO contract or contracts we do not include the specific vendor because as many of you know we have a lot of statute that we have to adhere to around contracting with agencies. Contracts can last no longer than five years and then have to be renewed and go through the competitive bid process. Within the waiver application we designate more the generic contract multivendor. -- Not the vendor.

How do we fix this eligibility problem for kids and families? I'm trying to figure out where it is and if it can be fixed through this process or if it needs to be fixed through the contract between EQ health and HCPF.

Can we table that and so we get to appendix B.

Right.

[Indiscernible - low volume] the reimbursement rate is two -- is too low for most agencies do feel they can afford to provide especially with licensure requirements.

We include the waiver service in a -- we include the rationale for the reimbursement rate in Appendix C. We will also talk about the reimbursement rate and appendix J on September 20. That reimbursement rate can understand this -- that is set through the ratesetting process with the joint budget committee and the ratesetting process is its own animal that has some methodologies within appendix I. If it is okay with Linda I would like to table her comments until we get to appendix C only talk about definition of services or appendix I or J.

I have a follow-up. CES does not cover skilled respite so rate is only for unskilled care. Skilled respite that's paid a decent rate is a huge need.

Correct. That is something we will talk about when we get to appendix C.

Linda was fine with that. She will follow up with Carol regarding respite limitations . >> We do have some managers that will join us when they get closer to that section so they can provide more feedback and information at that team does time.

Who is responsible for training EQ health to ensure they adhere to HCPF guidelines? >> The answer to that is complicated. In a nutshell every contract the department has with a vendor has a contract manager that tracks all deliverables outlined within that contract to ensure those Deville rules -- deliverables are on time and incorrect format. It is the way the performance measures are written in Appendix A. Stakeholders should know that those deliverables are written in a way to ensure that the contract. Is meeting any applicable regulations or requirements. If there is any type of issue with a contractor -- the community center boards have it written into contracts of they are required to maintain a grievance law. And does anyone if they have a problem with the policies of that CCB staff member or any grievance the first step [Silence] >> If it is any type of potential change in the waiver application that need certification that still keeps the application in line with your rule or statute you may do that type of thing. However, any type of proposed waiver application or change --

[Indiscernible - low volume] common examples of things are because a waiver application is so long all of the -- [Silence] >> Implement services approved through the ending of the program and implementing the services with the waivers. Next Saturday [Indiscernible - static] when we start the public comment period we will be accepting feedback on the conversation the service definition provided types and qualifications. At that point the service definitions have been [Indiscernible - multiple speakers] >> Our people online now hearing me?

Yes.

Thank you all for your patience. Funds have been hard today. My sincerest apologies for that.

We did positive conversation. There was a proposal to do standup to entertain people in the room. I did deny that proposal so we will continue forward with the discussion on contract entities. Were there any questions about Appendix A?

Can you repeat the amendment waivers for Saturday? Back what I was talking about was a brief overview of the waiver amendments that the public comment period will begin next Saturday. For everyone's reference they will be a informational memo going out Thursday. As well as fact sheets and typical standard public comment process on Thursday to start on Saturday. The primary reason for the waiver amendments is to put the transition services into the DD SLS CES waiver applications that were authorized by the general legislator after the ending of the community choice transitions program on December 31 of this year. The intent is to have them start on January 1.

Does not include behavioral therapy moving from the behavior to state plan? Is that what you mean?

Thank you. No copies will -- CES will not get the new services discussed. We are mending CES at the same time these transition services I'm referring to are the transition services that will aid individuals from transitioning out of a them back into their home. Where there any other questions about Appendix A?

We will move on to Appendix C where we define who receives a waiver and it services. What Appendix B does is as as a department or state we document the target group is , how the individual meets functional requirements of a particular waiver, as well as things like the number of participants that can be served by waiver as well as limitations on that number of people. Technology does not like me today. Within the CES waiver the targeting criteria component is first and foremost that the child must be between the ages of zero and 17 with a developmental disability where the definition is right there. Tying him with the conversation about next week's

amended -- amendments one of the primary reasons for the application is to add language to add [Indiscernible] as part of the devil a mental disability definition. It will match the bill that was passed in the last session. That was one of the targeting criteria for the CES waiver. The next component of the targeting criteria of the CES waiver comes from regulations that were long-standing. As well as some statute. These are the things that most people talk about when they are concerned about qualifications for the CES waiver. Is that the child has to have extreme behaviors that go beyond being at risk for institutional placement or just being functionally eligible. We do have a waiver here that is referred to as the nighttime criteria. We have to receive the human intervention at least once every two hours with a weekly average. This is where it is defined within the waiver application for the more strict targeting criteria.

How do we change that?

This is an area that would require a very dense a process. This language is in the waiver application as well as in the role. I also believe it is in statute that we were designated to have strict enforcement. I know that it is in regulation.

Does it require action from the General assembly?

Think you. -- Think you.

I hear we have questions online. I am going to advance one more slide then answers a question because I want to show the conditions as well.

We have a question from Shannon. Are you changing the word retardation?

Yes we will be. I will get that by 4:00 today. Will we be removing the word retardation. That is something we will do. That is another one of those areas that we try to update with current person center language especially at the time of the renewal. Any other questions about the targeting criteria of CES?

This slide says conditions should be evidenced by written third-party states.

The way this close here is that they have those behaviors and medical conditions. The behaviors are medical conditions must be considered what is age-appropriate. Due to one of these conditions and we have to have documentation of all of the above. Does that answer your question?

Yes that's where it is. When you have to have a third-party statement to prove that you are up all night that is hard to do. That is where EQ health goes crazy. That is part of the appeals issues that we are running into. Unless you have a doctor in your

house on my long it is hard to get a third-party statement that EQ health will accept for the nighttime criteria.

Can your doctors say that the parent reports it? It is nothing firsthand knowledge it is saying a statement.

This is Candace. What the third-party evidence and statement is required to do is to signify one of these the three things not necessarily that a child is up all night but that there is a pattern of self endangering behavior or serious aggressive behavior or constant vocalization such as screaming. There is no requirement that it is all night. You need to talk to EQ health direct. I am 100% on board with you but that I think will be different. I don't think it will require a change here. If you want to make a change to this a goes back to the original comment of how to do that. That is an acquired action from the General assembly. Specifically for this to we have other processes we need to work on the backend, absolutely. Please note that it is in process right now.

Any other questions online? >> The number of participants also contained in Appendix C. I will not go in this because it discussed at this morning. The CES waiver no longer has an -- a point in time a Roman cap. It has been gone for a few years. I do like to point out that if the stakeholders reading the waiver application they will see this part in Appendix B where is says the number of people served in a physical year, that necessarily isn't the lament. In the event the department is monitoring the program and it looks like we will exceed those limits we will have a waiver amendment to raise that number.

Financial eligibility. In order for an individual to be on any of our HCBS waivers they have to meet the requirements of three areas one is the targeting criteria, financial criteria which is the slide. For children they are required that their personal income and resources cannot exceed re-hundred percent of the federal poverty guideline. There are very few children who get near this level. In five years at the department I just received my first notice of one earlier this week. For the most part we do not consider a parents income towards that child contribution to the 300% line. The circumstance I encountered this week was related to a trust. 99% of the time children will not exceed the 300% line.

We talked about current targeting criteria and functional criteria and financial criteria but does targeting criteria and financial Kadir and the third part is functional criteria. Our level of care here in Colorado is to determine through the evaluations and re-evaluations by case managers. Case managers go into a individuals home to conduct a universal long-term care 100.2 assessment. The outcome of that assessment is to determine whether a individual is at risk for institutional placement and that waivers applicable level of care. Within the children's extensive support waiver it has a

intermediate care facility for individuals with developmental and intellectual disabilities level of care. When a case manager is filling out that 100.2 assessment the child's needs and different areas of activities or supervision of daily living plays that child as institutional risk based on placement into a ICF. Any questions about that? A lot of times when people talk about how to become eligible for a waiver unfortunately circumstances where someone might take care of two out of three components but it does take all three components to receive services.

Spat this is Carol Meredith. This is something I'm seeing a lot in the community. The level of evaluations required to get into the waiver are so intense that many families are finding it too much considering they are also in a situation with a child with a severe disability and difficult -- pull together all the paperwork is creating a barrier to access. I think it is very concerning especially when what I am hearing is from people in the San Luis Valley and other place where they need to waiver and services on the waiver but just say I cannot do this I have to take care of my child.

To clarify I think what you are referring to is to from parts of the eligibility criteria. One is the 100.2 assessment completed by the CCB. The case when it comes out and assesses that. The additional assessments is the targeting criteria to demonstrate other conditions and other aspects. Is that accurate? >> So that check was or application that is used is satisfying this part of the targeting criteria requirements.

Yes, what you are referring to is the CS application which is another application. That is not specified on how we do that in the waiver application so it does not need to be addressed at the renewal. Lindsay and I are looking at that and looking at ways to address that outside the renewal. [Indiscernible - low volume] [Indiscernible - static] expected everyone on the line follow that conversation quick dose quick --?

What level of training is required for case managers? We have found significant inconsistencies between case managers and high turnover in these positions.

That is a great question. I believe it is in Appendix B to . -- 2 Is a part of the waiver amendments being put out for public comment update application to regulate . Expect part of the eligibility criteria has been the nighttime interventions have to be life-threatening episodes so even if caregivers are getting up every three hours it is not to prevent life-threatening event then you are not meeting the target criteria. Will this be addressed or be changed?

This is Candace Bailey. Thank you, Shannon. I think part of it can be EQ and their interpretation of the targeting criteria. The other pieces going to have to come from the General assembly. I think there are several parts not a yes or no. But to change the cart -- criteria that has to come from the General assembly.

Those types of comments are excellent to put into the public comment even box -- inbox.
>> HCPF today 100.2 training in November 2017 and we can send out the training materials. That was done to help create more consistency.

In addition to that 100.2 training conducted in November at the end of November -- October 1 part of November case managers were provided training on age-appropriate guidelines to ensure case managers are considering the child's age when completing the assessment. It also provides a point of reference for case managers.

Within Appendix A -- Appendix B we have to document how individuals have the freedom of choice. This is an area where the individual has to have the freedom of living in a institution or in their home or community. Within the context of this waiver if a guardian of a child one of the individuals wanted to live an institution that is the first step of their choice. The second is their choice of what services they will receive. If they want to receive that service they can assuming there are available for writers. Neither choice is what providers can provide the not service.

[Indiscernible - low volume] >> Is that institutions outside of Colorado's that look at the kiddos?

We do have a few facility-based one. I do not them off the top of my head. Know we have covered the out-of-state placement from time to time when necessary because there was no facility and state that could serve the individual. If a family can show that there is no willing or able provider within the state of Colorado we will cover the cost.

It is a heavy-duty to get everyone there to agree to make that happen while the child is unmanageable and bouncing from respite provider or to the hospital and back and forth and not stable whatsoever.

That is a huge gap we have all been talking about. One of the things we are working on with the CHRP expansion to help address some of the situations. It does take some time to fix it entirely but it is outside of this particular waiver itself. Karen has been front and center to help move these missions forward.

You just can't say in Colorado that this freedom of choice exist. It does not exist.

I want to clarify that this is written within our federal construct. That waivers are designed to prevent an individual from being in a institution. When we do get to the point where a child is potentially placed in the institution whether it would be and state or out-of-state, want to point out that they are crossing over two different

Medicaid authorities. I just want to be clear because it often gets complicated in conversations and the reason why -- every Medicaid program is all operated by the state. When we start providing services outside of the state it is still Colorado paying for the child to be there and that payment is funneled through the periodic screening diagnostic and testing -- does that make sense to everyone? I think that is the most important part of these disengagement we are going through now.

I just want to bring up the point that freedom of choice for case management does not -- exist in case management in Colorado.

Think you very much understand what you are referring to. I think most people are aware that there was a pillow pass to address that as well as federal requirements put in place 2014 to address that. The bright side is that we are under a time line to have conflict free case management intimate -- implemented by 2022 as well as the choice of case management agencies does vary based on whatever -- waiver.

The only choice we have now is to be in conflict. There is not one CCB in the state of Colorado free of conflict in serving direct service providers and targeted case management .

[Indiscernible - low volume] is that choice only for children?

As I said earlier there is a cause of the Social Security act, for two as EPS CT. Children elbow for Medicaid the state is required to provide medically necessary services to the child. >> When I asked about freedom of choice they separate a choice is consumer directed a sentence services option. This should be added to children's waivers.

Thank you for the comment. >> Our quality improvement for the CES waiver we are required to demonstrate that we have processes and instruments to evaluate and reevaluate a participants level of care consistent with what we have in the application. Within Appendix B we have three different performance measures. These are to make sure the qualifications of the case manager are appropriate as well as the 100.2 assessment is being used when determining functional eligibility.

Appendix C is participant services. Within Appendix C we talk about what the services are specific to the waiver for that population. I think in our conversation this morning something a did not touch on enough was that when they individual is on any waivers that as long as they meet the three components of eligibility that were discussed in the last section, they are eligible for both the waiver services on that specific waiver as well as the planned service. Within HCBS -- Appendix C is where we see what those services are. Services provided in the waiver and policies as put -- we have as college from the community options benefit section to join us to where if you have any

specific questions about services we can do our best to answer them. Within the CES waiver there is a list of services. We do not have a snuff -- enough time to go over every single service definition limits scope or provider types. I do want to provide a heck of her interview -- high level overview of the services. For each service the state defines the service definition. We have limits placed on the amount frequency or duration, we use scope frequency or duration of the services, the service delivery type was included this year because of this something included in the waiver application does it anticipated direction or agency-based service.

Within the section we also document how we have to have the criminal history are background investigations for each provider.

This slide is referring to within the CES waiver we have a limitation that within a service plan period there is a limitation of how many -- the total expenditure for the child services. That is another thing being adjusted in next week's waiver amendments to increase that limitation based on recent increases. As rates went up we needed to raise this limit. That will be adjusted next week. We also have a $10,000 limit over the life of the waiver which is something that people ask questions about. You talk about the openness section in this meeting a waiver is on a five-year cycle. A individual can receive up to five years worth of a combination of home accessibility, adaptations, vehicle modifications and assistive allergies within that five-year cycle. The current cycle will end on June 30 next year and start over again on July 1. I will pause there for any questions.

You are saying we do not have time to go into the services? As a consumer that is the most important part of the meeting to me.

I do not have enough time to go through each service line by line. If you have a specific service we can try to adjust it now but --

One of my biggest complaints is HCPF therapy is limited to two HCPF certified people but there are therapeutic writing specialist that can do the same type of services for someone a little less physically challenged. I would like to see that considered to be expanded to HCPF therapy or therapeutic horseback riding because there is a certification for that. I cannot find anyone within 50 minutes of my home. My son has a sleep disorder so if I put them in the car for 50 minutes it's going to put him to sleep and then it's going to mess up his sleeve people more than accessibility for services to be person centered needs to be expanded for therapeutic writing. I also have an issue with assistive technology because it is very subjective for the case managers to decide what is off the shelf and adapted. It is not clear and the language. They can say you can buy a noisemaker to help him sleep which is off the shelf but then when I want to buy a off-the-shelf tricycle that is not adaptive because he doesn't need support for his back that is denied. I think there needs to be more

for verification about the intents. I am appealing it and learn how to do the whole office of administrative courts [Indiscernible] and that the last own would be moving behavioral services out of the waiver and into the state plan. We have talked about this and I've gone to the medical services ordered but the benefit is not comparable in the state plan. I am concerned and working on a benefits collaborative group but have not heard anything from them. I have not heard anything for a long time. I think it is important if we're taking something out of the web -- waiver the comparable benefit be offered in the state plan. Those are my three points for the section on actual services. As a consumer this is what they should be focused on getting feedback on families from. If there is a word in there like HCPF therapy it is a barrier for my son to get something he needs. As a barrier of one word that we need to change that word.

I have two thoughts first and that I will defer to anyone. First, I agree 100% with your closing thought that it is the meat of the where in the services. I think that is largely why the office of community living get a restructure a year ago to have the specific benefit managers to address that component and look into those details. I think our approach for the waiver renewal processes that those types of conversations are extremely important and almost beyond this type of meeting to go into the weeds of all those specific limitations or potential opportunities.

So when do we do that if it is not today?

I will at the benefit staff talk about that.

They need to know that we have input.

Absolutely. The other thing I want to point out and clarify as we go into the next amendments, as many of you are aware we have waiver of nations for the -- applications that were approved by CMS earlier this year. They just went into effect yesterday. We demonstrated in the waiver application that we were stopping operation of the behavioral therapy services, division services and personal care services within the CES waiver. In case you are reading the waiver application, we have to maintain those services in this waiver application for the purposes of cost neutrality. If you pull up Appendix C in this waiver application those services will still be in there but in appendix J we will show how we were cost neutral for the waiver for the first four years [Indiscernible - low volume] >> It's more to show that we had expenditures for those services from the first four years. It actually has its limitations so we cannot delete it from one year and leave it in the others if you delete it in one year it is gone. It is to show that services that expect -- exist we have expenditures and they were there. Not so much to show that [Indiscernible - low volume] [Indiscernible - static] but to show that they did exist in the past. I would love those comments on benefits. For some of those things what we need to do is

research and digging and actual workgroups. Diane is looking at putting together workgroups around the adaptive equipment and home modifications. To see how we can improve the process and make sure there is clear understanding on the process. I think it may take more time than the renewal. The point being is if we decided to make changes this is a one-stop [Indiscernible] we probably will not have enough time to flush out the proposed changes in time for the renewal.

We would have to do research on that to see the classifications. [Indiscernible - multiple speakers] >> A comment like that so we can say we looked at it and found no implications or we found implications we will pursue it in the future.

Is a consumer we are told we have to wait to the waiver renewal to bring these up and now you say we had to do another worker. I've been enough workgroups to know it takes another 3 to 5 years.

I hear your frustrations and I apologize that you have been told that you have to wait for the renewal. That is not how we do things in the office of community living at all. It is not a one-stop. [Indiscernible - static] [Indiscernible - low volume] we do have to do our due diligence to ensure that we have financial accountability and not just increasing expenditures without having the appropriate [Indiscernible] from the General assembly. If we can show us not to change or increase the cost then we can throw it in now.

17,000 last time I checked and is 37 a year. We are already under utilizing.

Again I'm not disagreeing with you but we need to actually do the research and diligence.

Let me know when the meeting is I will be there.

Absolutely. What we are probably just have Lindsay reach out to year around the HCPF therapy so we can get the exact language if it is something simple we can throw it now at the renewal and not make changes to cost projections and expenditures than absolutely. I 100% agree especially if it will make it more accessible. There are just things we have to look at. >>

And several Mike therapy is officially out of the waiver. [Indiscernible]

It has been silent for a while.

We have had a great discussion on the chat box. People are answering each other's questions. An individual's at the $10,000 limit has not changed in many years. That would be an area that needs to be increased to address cost changes. Someone said

people can go for that exception. And then someone asked where can you find out how much you spent and where you are with that money. And someone answered your case manager should be able to do that. The difference between assistive technology and adaptive recreation is very unclear. What falls into each category is a constant point of confusion.

The things that came up were changing the caps for inflation then exceeding the cap. There was when I missed and assistive technology versus adaptive therapy.

For those on the phone this is Diane Byrne.

My name is Diane Byrne I am over some of the benefits. Mercifully environmental modifications and medical equipment. Anything where there is potential for overlap with durable medical equipment will probably come to me. Or if it needs a drill to be installed. Change in the cap for inflation is something I am excited to start looking into. I understand those caps have been the way they are for a very long time. Again, anytime you change it have your going to one thing is I have been managing the modification program for the other waivers that have access for about four years. I am pretty familiar but it is a different benefit. I think there are pros and cons to. I would like to bring us together looking at the caps and whether they are appropriate is a high priority for me. So over the cap stuff there is a process to request to accede to go over the cap for home modifications or assistive technology. It is tough because every time we spend over the cap that is less money we have to spend on other home modifications. Not just you have X dollars and if someone spends more there is less dollars to spend on someone else. We are allocated a certain amount from the state legislator and federal partners. It is a balancing act to make sure that we are giving people the tools they need to stay in homes and communities. Also that we are not paying for things like luxury upgrades. Or things that are covered under other benefits. So we frequently see things requested under the home modification that are like a toilet frame. That is being recorded -- requested but is DME. Durable medical equipment. Since home identification is a limited pot of money than the durable medical equipment it is disappointing to me that these limited funds are being spent on things that could be paid for elsewhere. That is one of my top priorities, to make sure people are accessing the correct pot of money so we can conserve more limited pots of money. I worked very closely with the DME folk's and it is a big project of mine. Utilization yes you can ask your case management what you have used before. For these waivers it is a five-year renewal also goes back to 2014 and will reset and the middle of 2019. Lindsay do you want to take equipment? I did want to mention that remember when sentenced does Candace sent the equipment thing to me

[Indiscernible - multiple speakers] [Indiscernible - low volume] >>[Indiscernible - multiple speakers]

Adaptive therapeutic equipment we definitely know there is gray areas to be more clearly defined. As we change our roles Lindsay is now over adaptive therapeutic wreck equipment and fees. Candace accidentally sent a question to me about the equipment.

There are gray areas between the two and if we can work together to come up with better guidance to provide case managers share with families then that may be what we need. There is a lot of one-off situations and those will probably continue. We will be happy to fill those emails. Keep this coming try to do our best to provide to distinguish better between two. >> I say that I think one of my pet peeves is that case managers are giving verbal and email denials and. -- It lead back to a discussion about case management training flying my flag quarters 14 managers. I have six for that I asked for justification from therapist and they were all denied. I think it is a combination of case managers not knowing and they are very nice but and they are not following proper protocol and rely on lateral information. Which is never always accurate. I think that is another issue within the department. I have asked Britney since 2014 to work on it and now we do not have a D IDD. Leadership thought that we don't deserve our own division so now we're scattered amongst more people and it is difficult to establish the needs of the community.

We had a comments about the respite care per DIMM that it is paid at a different rate than individual respite care. Which is paid per unit. Can the per diem rate be removed or increased?

We cannot do rate increases. This is Candace Bailey. We cannot do a rate increase it has to come from General assembly. Can it be moved? I think we would need to dig into that more. To see if that makes the most sent going forward. There are a lot of things with respite that we need to work on. Maureen said it was an overtime issue. But we need to work on respite across the board and across all waivers. [Silence] >>

I think those are all the questions online right now.

Is the audio and webinar recorded for those people that were not able to tune in? Or is it just the PowerPoint?

The PowerPoint will be posted. Anyone with additional questions [Indiscernible - multiple speakers]

It is being recorded.

Some people have trouble logging on. I was wondering if we can get access to listen so they can hear the questions not just the PowerPoint.

We can do that.

[Indiscernible - multiple speakers] I would also like to request accommodation of all the text box dialogue to be put into a dog commit -- document that can be accessed online.

>> We are setting up a trios for questions or comments on the formal programs. Please submit those comments to LTSS.PublicComment@state.co.us, if you have questions about the meetings being arranged or how to ensure you are on a distribution list going forward please send those to HCBSwaivers@state.co.us. The next meeting will be September 6 we will be discussing CES from 1 PM to 3 PM. We will be in the same room. We will be discussing DD and SLS that morning. The third meeting will be on September 20. Here is our contact information. Please feel free to reach out to us if you have any questions. This morning I gave them 15 minutes back and it looks like you're getting 10 minutes back.

[Event Concluded] [Event Concluded]