Please stand by for realtime captions.Charlie, are you on the phone?
>> Take yourself off the mute.
>> I am going to start the meeting. We are going to get started today. It is Friday It is Friday, November 9. We are going to do a call for and will call.
>> Christie, Cecile, Patricia, Simon, -- excused. Jessica, excuse. Amanda, excused. Charlotte
>> Present.
>> An. She is on her way. David. Donna -- excused. Good thoughts to those who are excuse. Summer traveling and doing wonderful things. We have announcements. Date location of the next medical services board meeting. The next meeting is scheduled to be held Friday, December 14 beginning at 9 AM, 303 E. 17th Avenue Denver Colorado in the 11th floor conference room. That is where you are right now. It is the policy of the sport of the department to remind everyone attendance at this facility is private property but please do not block the doors or scattered around the edges of the room. Please silent cell phones while in the meeting. If you're listening to the audio stream and lose connection, just click again on the link it to rejoin the meeting. You may ask questions and we will give you answers maybe. Please submit questions or comments for each role at the open forum time in the agenda. Please identify yourself and your comments. They are part of the public record. Please identify yourself when speaking. There are individual testimony sheets for the open forum for each of the rules at the side of the report there is a five minute limit for testimony and also an open forum to comment section. With that, we're going to begin. I would entertain a motion for the approval of the minutes
>> I make a motion that we approve the medical services board meeting of October 12 as presented.
>> Second.
>> All in favor?
>> Charlie. It passes. All right. We are going to go to the emergency adoption. We're calling Richard Delaney to the table. Just so you know, we are going to do the emergency adoption and move to [Indiscernible] for the final and allow him not to bounce around.
>> Good morning. I am a policy specialist with the Department of healthcare policy and financing. Today I am presenting rule MSB 1806 15 as an emergency role. This -- rule. This was approved back in July and then we brought the official rule but failed to bring the second reading in October . So the emergency rule will expire in December and the second reading will not take place until the end of December. So there is a gap and we need the emergency rule to retain the ability to pay the candidates for mental health degrees as in the FQHC. Any questions? Charlie, did you have any questions? Raise your hand.
>> No questions.
>> Thank you. Any public comment? Or testimony? Okay. We will have a motion then folks.
>> [Indiscernible] MSB revision to the medical assistance rule concerning adding provider types to FQHC section 8.700 incorporating the statement of basis and purpose specific statutory authority contained in the records. All in favor.
>> Aye.
>> Aye.
>> Okay. Any opposed? Okay. It passes. Now, we get to do the next part. Just stay with us. [Indiscernible] we need to read all the rules adopted including finally put go ahead and read that please Bregitta so it is on record.
>> I did not realize it was not.
>> She read this part but did not read as part. Read the top part please.
>> Absolutely. [Indiscernible low volume] all emergency rules immediate adoption is imperative, necessary to comply with the state or federal law or federal regulations or for the preservation of public health safety or welfare and that compliance with CRS would be contrary to public interest.
>> Thank you very much. Okay. Now we have -- we are going to skip down to C. And we're going to do Richard Delaney again. Isn't this fun? Keeping everybody on their toes today.
>> Members of the board, my name is Richard Delaney. I am the policy specialist at the Department of healthcare for policy and financing. I'm presenting the second reading of the rule to add candidates for licensure as eligible provider types at the FQHC. This rule was originally presented in the emergency form to the ACC changes for the six behavioral services done in the medical setting. This allows the FAC's to continue -- to continue to use candidates for licensure to provide those services. And they have the support of this rule.
>> Any questions? Okay. The final adoption is at the bottom of that page. If someone would read it please.
>> -- Sorry. We have any testimony for that one? Okay. Gentleman that just came in the room, do have public comment

for document 6? If you have public comment you can sign up over there. Carry-on.
>> Moved to final adoption of document MSB 1806 15 a provision to the medical assistance rule concerning adding provider types to FQHC section 8.7 incorporating the statement this is the purpose for the specific statutory authority in the records.
>> All in favor.
>> Aye.
>> I second.
>> I am flying through this. I want to be out of here by 11. I am joking. Sorry Richard. You don't appreciate -- Charlie?
>> Aye.
>> Okay. It passes. Thank you very much. Enjoy your Friday. Because we all well. -- Now I am confused as to where I am. Timeout. Now we're going to go to Consent Agenda. --
>> Somebody needs to read the motion.
>> Thank you. I would like to move for final adoption of document MSB 1808 MSB 18 0808 a provision for medical assistance role concerning adding community or facility based [Indiscernible] to respite services section 8 section 8.054 [Indiscernible] revisions to medical assistance, long-term services and supports of HCBS benefit rule concerning section 8.51 [Indiscernible] document three MSB 18 0 to 12 revision to medical assistance role considered -- rule [Indiscernible] section [Indiscernible] incorporated the statement of basis and purpose and specific statutory authority concerning records.
>> I have a motion and a second. I just woke up. All in favor.
>> Aye.
>> Opposed? Charlie?
>> Aye.
>> We're good. So it passes. Now we're going to go on. We are on the initial. I don't want to do Richard Delaney again. No offense. Document for, MSB 18. Christina.
>> -- You are fast.
>> Good morning. My name is Kristina Gould, the pharmacy put policy specialist. I'm here to present a revision to 18 0907. Travertine used to treat a rare genetic dysfunction of the brain has been updated and improved. The department study will continue to cover travertine. This change is a technical cleanup to delete designation as a non-FDA approved drug. Overall, the impacts, this will align travertine with the FDA indication of the drug meeting there will be no drugs that the pharmacy unit covers as investigational or experimental. Any questions?
>> Okay. Do we have any public comment? Nobody loves us today. I would entertain a motion.
>> Move the initial approval of MSB 18 [Indiscernible] revision of the medical assistance role considering -- rule considering the FDA travertine -- Stiripentol regarding specific statutory authority.
>> Motion and second. All in favor.
>> Aye.
>> Opposed Charlie?
>> Aye.
>> Thank you. You barely have a voice. It passes. Thank you very much. I wish you a good Friday as well. Just wishing people good Friday. Chandra. Come on down. We are going to look at document 5. I understand they're just moving codes around.
>> Pretty much. Good morning Madam President, members of the board. I will be presenting MSB 1809 12 for the dental healthcare program for low-income seniors. Just to give you a really quick update. This is for individuals that are 60 and over that do not qualify for Medicaid or have private dental insurance, lawfully president -- present of the state. Every year the American dental Association codebook comes out and the usually have some changes in their book. When those changes happen, if any of the codes are listed in our appendix a we have to make the changes. So on page 28 4D 5211 there was just a couple of deletions in the procedure description. On page 29, 5212, the same changes as on 5211. On pages 36, 5630, once again, just a deletion of class and then adding in retentive materials per tooth. Page 42, 90 to 19. They are adding in moderate sedation. And then on the very last page, we do have some grantees that are not [Indiscernible] however they farmout dental work. I went ahead and added them as services and the codes to the service to make it easier for them when they fill out invoices.
>> [Indiscernible low volume]
>> I appreciated, says the provider.
>> Anybody have questions?
>> I have a comment. In the sustained comment I have left a. I think a consideration for -- is there a way we can do

these benefits that you don't have to come here every single time?
>> Actually No. Initially when we did this I tried. We wanted to keep it out so we would not have to do this every year, however, legislative legal came forward and said it needs to be in law.
>> We like seen her.
>> I love seeing you all. [Laughter]
>> All the way around.
>> [Indiscernible low volume] [Overlapping speakers]
>> No other questions? Do we have public comment for this one? We do not. Nobody loves us. I would entertain a motion. We're moving to MSB 1809 19, revision to the medical assistance rule considering the dental health program for low-income seniors section 8.960 incorporated a statement of basis a purpose and specific statutory authority contained in the records.
>> We have a motion and second. All in favor.
>> Aye. Opposed, abstained. Charlie?
>> Aye.
>> Thank you very much. I appreciate it. have a nice Friday. We are flying through this. So the Consent Agenda four and five. Everybody in agreement.
>> I moved to add that to a Consent Agenda.
>> Okay. Took us longer to get here than it did to do this meeting today. No. We have lots more coming.. -- You are making me nervous.
>> I need more than an hour.
>> -- I will try to be more quiet.
>> Let's do a closing motion. I love fight
>>. -- After you. I move that all rules adopted at this meeting of the medical services board Department of healthcare policy and finance meet the criteria the state, administrative procedure act incorporated by [Indiscernible]
>> I have a motion and second. All in favor.
>> Aye.
>> Opposed? Charlie?
>> Aye.
>> Charlie, are you going to stay on with us? I need to do public comment, but are you going to stay on with us during the updates and everything?
>> And to hear the rule previews. If I am not talking, it is fine.
>> Great. Do we have anybody signed up? Nobody? Anybody have the urge to send love?
>> Why is everybody here?
>> Ask them? I am just here for the reason I am here for.
>> So much knowledge from us.
>> You want them to tell you some more knowledge today? [Overlapping speakers]
>> Very entertaining.
>> She keeps us going.
>> I keep you on your toes. That's my job. Look at this. Let's do department updates.
>> That was quick. [Indiscernible]
>> I like to have as least as long as it takes people to get here so they feel like it was worth it.
>> [Laughter] [Overlapping speakers] obviously, we have made it through a new election with a new governor. So we will be trying to acclimate to what any changes in direction for the department will be. Very shortly.
>> But, the new lieutenant-governor used to be an employee here.
>> Yes. Diane. Our customer service center. She is familiar with the department and share the health committee in the legislature that we worked with Josh was the chair of the health committee in the legislature. We have a very strong working relationship with her. So that is good. Obviously, we had a lot of transition with the department. Gretchen moved on to greener pastures. Probably not, but she still think so. She was great. It will be difficult to replace her. She was an outstanding Medicaid director. Now we have the interim director, [Indiscernible], many of you probably have met her. She has been in here. Bonnie will be the acting director of the office of community living. We know who will be our next Executive Director. We will continue having them as the interim director's moving forward. We feel very strongly that the policies and the focus of the department has not -- [Indiscernible low volume] healthcare with such a significant issue with the election, and everything we are doing we feel is very nonpartisan in the sense that if we control cost, we can continue to not diminish benefits are eligibility and offer a higher level of service, higher-quality.

That is the real focus at this point. I think we are very committed to that to create efficiencies within the programs. I will try to work with her providers and networks to make sure we have network adequacy and everyone is funded at a level that is sustainable. That is where we are going at this point. We do have some new policies that we are implementing. New prescription opioid policy will be implemented November 15, limiting the total days allowable for dental prescriptions for short-acting opioids to forgo date -- 24 days and limiting the total -- four days and limiting 24 tablets or capsules. That goes into effect shortly. Members that are undergoing more complex dental procedures such as major oral facial surgery, the Dennis can plead preauthorization and they can have additional coverage for up to seven day supply, six tablets. We feel that is a step in the right direction. I had a personal experience with that. I had oral surgery last year. The Dennis was like let me give you some pain pills, and I so give me one or two if I need them, and they are like, you have got to get this 30 day prescription. It is interesting the fact that we can now limit those. It is a necessary step in the right direction. Pharmacist administered vaccine and OTC prescription effective November 1, 2018. Pharmacist can a role with the department and can prescribe specified over-the-counter products. They can also enroll with the department and can administer specific vaccinations in the pharmacy. Obviously, Walgreens doesn't incredible amount of flu vaccinations. They come in to do our department as well. It aids that process along and will save time and money for a lot of [Indiscernible]. A good thing. Accountable. Collaborative phase 2. We are well in the midst of the implementation of that. We are working with our providers, contractors, stakeholders to identify and tackle any questions or concerns or problems they are having in the implementation process. Most common issue has really been related to member attribution within the PCM P and the raise. We're working through that on a daily basis. The attribution issue, I think we're making process, but it takes type of
>> It is based on their PCP.
>> Yes.
>> That is why, especially when you get up -- you can really get -- it is based on where they have been singing.
>> -- Seen.
>> Yes. That is what we're trying to reconcile. Like everything else, major system changes, we have to work through the bugs and we are getting there. Probably a little slower than a lot of our providers are happy with. We are doing the best we can at this point. We are also providing assistance directly to the health first Colorado members to change their PCM P to their assigned one. So we will continue to work on that. Anyone that needs resources and wants to get online, Colorado.gov ECC phase 2. It is out there for public consumption. So please take advantage of that. I'm also going to give you a little overview of our legislative agenda. We tend to be a little more pedestrian because the next the ministration wants to set their own legislative agenda, be it Boulder or continuing the pedestrian manner right now to see that our programs move forward. The way we envision every day.
>> We have a new liaison meeting with the governor right now.
>> David is our legislative liaison. We actually hired him away from legislative counsel. He had staff from the Senate health committee and he has been with us as our federal rules manager, and now he is in fact our legislative liaison. It was a good transition for him. Strong relationships with all legislators. Very even keeled guy. It is worked out very well. Hope to see him continuing into the next administration. We have for bills that of been approved by the current administration. First is to extend the breast and cervical cancer prevention and treatment program. Second is the Colorado dental healthcare program --
>> We have a handout.
>> You have the one pager.
>> Chris pointed it out to me.
>> The dental healthcare program for low-income seniors. This had previously been administered and was paid at CDP achieved rates. The rates did not match up between the departments, so we are actually going to pay our rate which will later see more seniors and work on waiting list to make sure to get more seniors treated under that program. Increased authority for oversight of individual residential services and supports. These are host homes. We've seen a lot of issues. We're trying to make sure that we do have statutory oversight to be able to create registries and some administrative function. The other is expanded access to civil monetary penalty cash fund that deals with nursing homes to make sure there is news -- nursing home innovation. We don't -- a fund is built up to a point where we want to make sure that the feds don't sweep that. We would like to keep it in place to take care the civil monetary policies. Enforcement has been more strict in years past, so we want to be sure to have the ability to provide more grants for innovation and to cover all the potential civil penalties. That is our legislative agenda. We will undoubtedly be doing a lot of [Indiscernible] with the change in administration. I think one of the tasks we will undoubtedly see is how we tapped down the desire to -- takedown the desire to increase benefits significant. We have to integrate those to pay for them in the future. We have seen that before we have one particular political party that controls all three houses down the street. We tend to get very

ambitious and will have to make sure that we work within those confines a do things we can afford to do and that fit well within our structure. Josh will accept the money for all those things of course. With that, that is really my report. I am happy to take questions if we have questions. Josh Block is here to go through our budget ask.
>> Can we go through the timeline of -- with the new administration in the process of hiring a director. The appointee is by the governor. Does Kim stay?
>> We wish we knew for sure.
>> I wasn't on the committee during the last --
>> Every administration doesn't a little differently. We anticipate that the new administration will make -- at least announce appointment somewhere around different -- December 1. This is very arbitrary. But we hope to see those appointments at least announced by December 1. The new administration will not be sworn in until January 12 -- January 8. What is interesting is the legislature starts before that. This is the first time we have seen that. The legislature will actually start January 5. So we will have Governor Hogan loop are still as governor for three or four days before the the swearing -- the passing of the torch. But we fully anticipate we will see the announcement somewhere around December 1. And then, the new directors will be sworn in subsequent to inauguration. And they have to go through the Senate confirmation process. You mentioned the transition team. Typically, they choose that team and that is who makes the recommendations?
>> It is fair to say that is true in most instances. But again, we don't know at this point. We're still a little fresh to know who and if there will be a formal transition team. You know there's going to be one? Good. Because we have not heard that officially. We know some people have been tapped in the advisory capacity. [Indiscernible] anyway. I hope that helps.
>> How many positions are appointed by the governor?
>> Within [Indiscernible] with all the senior executive team people. They were appointed by the governor. We serve at will. It is really up to the administration who they want to carry forward. Every transition, every governor does it a little bit different. In the last one, the actually asked everyone in the senior executive team to turn in a resignation, and they reviewed those and said we will accept your spending pending day in March or April or we don't want you to resign, or thanks for your service, see you later. I don't know if this administration engages in that process. [Indiscernible] in other words, we don't know a whole lot at this point.
>> Thank you for going through the process.
>> Absolutely.
>> Thank you.
>> You bet.
>> We have Josh Block who is going to do the budget. You do have a handout on that. And then just so everyone knows, and I am totally transparent, I am going to allow Maureen Welch who has come in to do her open forum because we did it so fascia did not get here in time. So I'm going to let her do that and then we will go to the rule previews for those of you waiting for that part of the meeting. Good morning.
>> Good morning. Thank you Madam President. It is a ledger to be back. I am the budget director for the Department of healthcare policy and financing. I am going to give you a rolling tour of the 1920 budget. I will go through request and give you high-level overviews. There are some slides going up. We will have the slide deck available.
>> The webinar sees what you see.
>> So because of I am the budget director I like to start with a summary table full of numbers. Everybody favor. But don't worry, it will be relatively painless. Last year the appropriation was a total of $10 billion, general fund to point I believe dollars. This year the total request bring that up to $10.6 billion and $3.1 million general fund, an increase of $462 million in terms of total funds. In fact, the budget request is a little bit larger than that, things that were approved in the prior legislative session will actually bring the base budget down by $80 million. That include savings from the implementation of the capital care collaborative phase 2, Senate Bill which is the Medicaid cost-containment bill and a few others. It is all set a little bit by increases from provider rates and things like that. So the total request in terms a new money is actually closer to $542 million. That is a pretty significant some. When we talk about where the --
>> Where are these funds being derived from?
>> Most that we receive is from the general fund. Actually, not most, about one third, the remainder is either cash funds such as the healthcare affordability and sustainable fee which are previously hospital provider fees but the majority is actually federal funds. Funding, through title 19 of the Social Security act or title 21 Medicaid and Chip respectively.
>> [Indiscernible] another question, you are basing the 2019, 2020 request on funding that has not been approved by the federal government yet?
>> In some sense, that is correct. It is more that the funding has not yet been approved by the state legislature. The rules

on drawing federal funds are actually pretty clear. Some things will require federal approval any form estate plan amendments and then require further approval in terms of medical services board. But for most administrative spending and things like that, while there is paperwork we need to go through and ensure that the federal government is okay with that, at this point in the budget process we take that as a given. It is not quite pro forma. Not something -- but it is also something we take lightly. A lot of work still has to be done.
>> $222 million out of the general fund is going to be a pretty good ask.
>> A fairly significant number. I will get into it in the next couple slides what is driving that.
>> Thank you.
>> Karzai breaks down where the funding is going. Justin the high level, the vast majority of the money we are requesting is for services. This is the increasing cost of the caseload, the programs we have, less than 50% goes towards department and administration. When you look at the general fund, only about 7% of the total amount we are requesting is going towards department and administration while remainder goes through to the says. -- Goes to services. Breaking out further, you can start to see where the money is going back I will give you these in more detail in a moment. 77% goes towards funding per capita and caseload. 5% goes towards Medicaid management information system, IT systems. 11% towards provider rates, 4% other agencies and only about 3% actually falls into the category of discretionary requests. Things we are asking new permission from the general some way to do for the new initiatives and decision items. I will talk about how we are finding our existing programs. I will not get into this that
>> Quick question. Are the hospital fees in the slice of the pie with provider or do they fall elsewhere?
>> The actually fall in both spots. We talk about hospital provider fees, the funding coming from the Colorado healthcare affordability and sustainability enterprise. That primarily goes to funding services and other commitments to hospitals a small portion of that is reserved for administration by statute that can be moved no more than 3%. -- That can be no more than 3%. Talking about existing programs. What it actually takes to fund the Medicaid program. The chips programs. These are budget requests. In total, we're actually was about $417 million in new funding. That is covering the cost of caseload changes, change in trends, mandatory rate increases such a statutory required increases in nursing facilities, federal required increases or changes in cost related to federally qualified health centers, pharmaceuticals, or capitation's, they also continue to incorporate the policy of covering home and community-based service waiver and Pro -- program enrollments. Maintaining the policies of having the waiting list for the supportive living services and also children extensive support waiver. We continue to make progress on reducing the waiting list for the HCBS DD waiver. It include funding for emergency enrollments to ensure that people in those type of circumstances can actually get services. Overall, in terms of getting people a high level of what is going on, the graph here is total caseload over the course of a little more than 20 years you can see the line in the middle or on the right-hand side of the chart is when Colorado expanded Medicaid under the affordable care act. You can see it caused a rapid expansion and caseload. But since then, after a few years of growth, it is flattened and in fact declined a little bit. If you take a look a step further and change the graph to only be about 10 years, this is the projection on the actuals on adults and children with the redline being the projection. You can see that it had a high point of around 1.2 million people in fiscal year 16 and we anticipate will actually come down slightly in the next year and then start to grow. The total caseload here is approximately 1.2 million Medicaid and another 60,000 people on-chip. The interesting story about why Medicaid continues to grow and what drives the growth is actually the caseload where we are serving people who are elderly and disabled. PTC -- you can see that this graph does nothing to show any signs or effects of the economy or things like that. Is a pretty steady growth. And we have forecasted it to continue to be that. The biggest driver for the request to increase funding here actually comes from these populations and funding just the additional growth along with the growth in the long-term services and supports such as they home community-based waivers. Long-term home health, private duty nursing, nursing facilities and also expected cost increases in the future include the national terms of acute care and things like that. The high level and what Medicaid funding is, lots of other smaller stories, but if I wanted to all of them we would be here until it was dark. So I am going to focus on what the budget request are. Discretionary think we are asking for to move programs forward. We have 11 of those. I will fly through them quickly. Least often asked me if you have any questions. First discretionary request is called locally ministration transformation. The biggest thing about this request is the department request to implement a consolidated return mail processing system. Hopefully modernize something. Right now return mail is sent to counties and whether or not the open and are able to work the cases is a function of the staff available and we know it doesn't happen too often. This leads to circumstances where we don't know where people are, and as a result, we have automatic payments going out the door based on where people supposedly live. We would like to make sure that if somebody qualifies for Medicaid, we can actually find them. Additional part of this request we also have additional incentive funding for counties and also we are requesting to implement a more statewide and comprehensive framework around nonemergency medical transportation benefits, which outside of Denver, is being

administered by counties or designees. We would like to provide something more coordinated related to that. The next request --
>> I empathize as a pediatrician trying to find patients. I'm just curious if there is any discussion about actually going to tech as a source of communication versus mail? Or if that is even an option. We find that texting is far more successful with 50% of the Medicaid population.
>> A little out of my area of expertise. At a high-level I can tell you that the discussions about using text and electronic communication, even emails and other forms, we are pretty rapidly moving in the direction of more electronic communications. More rapid response, on my chat and things like that. So we're really trying to -- online chat and things like that on top of that moving towards plain language as well.
>> I can give you more specifics. Implement Toronto -- [Indiscernible] is working on some budget requests for prioritizing the hours within the IT systems. We're trying to do exactly that. Push messaging and messaging around electronic Medicaid cards and the like. Because I actually had a few meetings with accountings -- with the County recently. They're worried about this mail program. We arbitrarily cut people off, do they lose eligibility? We want to make sure that does not happen. The best platform for that will ultimately be digital. That is in the works.
>> We have been texting people [Indiscernible] just boots on the ground experience.
>> Next request prioritizes primary care alternative payment models. In this request to build on the work that was authorized by the General assembly in house bill [Indiscernible] the bill that authorized of the accountable care collaborative phase II and also gave the department authority to some types of [Indiscernible] we are in the process of implementing some alternative payment methodology and models inside of the ACC right now, but this request is to actually take that a step further. In particular, for providers were a little bit more financially Seavey and can have -- savvy and could have were risk. We are asking federal partners to get approval for a demonstration we were to implement APM track to, a fancy way of saying we will share risk by providing payments upfront. No particular authority for this type of methodology inside of the Social Security act, so it requires a waiver from CMS. That will take a couple years. We are also looking for funding to help develop electronic clinical quality measures to ensure we can pay based on outcomes as opposed to claims data. And finally we would like to provide funding for the multi-payer collaborative to ensure that the measures that were developed and shared across the entire healthcare sector are not specific to Medicaid and create a additional burden on providers that way. The benefits and technology advisory committee. This request is similar to things that happened done in Washington and Oregon and New York State. For years, the department had the benefits collaborative to found -- [Indiscernible] this would be a new addition to the framework growing on the work of other states to establish a more formal committee with dedicated members and support to evaluate evidence-based research and benefit design. As you can better, staff here at the department are not necessarily experts in all new emerging technology from the healthcare sector. We have to make a decision about whether or not we're going to cover and would like to make sure that we do so not just with expert advice but also with the stakeholders and understanding how this technology and benefits impact membership. So we requested funding for that. Moving forward, the next request, long-term home health and private duty nursing acuity tool. Long-term home health and private duty nursing are a growing and sizable part of the budget. Right now we want a valid tool to assess the need. We want to leverage the work of other states and other states have done this. Right now our tools for private duty nursing are actually getting close to 20 years old. They have not been clinically validated. They don't seem to provide a great framework for determining whether or not people do need services. So we would like to make sure we are doing something that actually is reflective of needs people have. And possibly diverting people to a lower form of care where instead of requiring around-the-clock care from a nurse or some other skilled labor, a person with a medical degree rather, may be able to substitute with personal care home aide services with state money that may also be better for the client -- client as well. A multitier initiative. We want to make sure that programs like PDM are reserved for people who actually do need 24-hour support. Transforming customer experience. As I'm sure many of you have heard, with the implementation of the new system and also with the growth in the caseload, member contact center has been pretty inundated with a lot of calls and wait times have been unacceptably high. The goal with this request is to meet those wait times to make them go down to make this easier and ultimately improve the experience of members by getting the more information, better and more timely information. Wave number of initiatives including increasing staffing, improving the knowledge library, funding of around [Indiscernible]'s plain language, continuing the work from two years ago which was not quite fully funded because of the ability to improve our correspondence to get away from unfortunate bureaucrats speech. Training improvements and also more dedicated funding for member experience advisory committees to ensure we are getting proper stakeholder feedback.
>> I just want to add. The membership advisory committee. This is been an outstanding thing for us. I am amazed other states going to the we have been one of the leaders and it gives us great input into the programs and services. It has been

a big success that we want to continue. It was originally grandfathered and we want to continue this. Another thing we're really proud of and are trying to work on whether our customer service center is working very closely with the disability community. We have had these work requirements or work programs. Because it is a tough job staffing, call centers in general, that is a terrible job because you listen to complaints all day as you are trying to solve problems and people are generally very disgruntled after waiting for 30 minutes or so on hold. We are working with her disability community to hire more of them to staff our call centers because they tend to like the job, stay with the job, folder acuity level and speak and know the programs much better. We are working very actively right now. We're testing some of the different technologies and how we integrate that into the call centers. I think that is going to be a big plus for us as well.
>> Great.
>> One other than, next week in Washington DC the national Association of Medicaid directors is meeting for their biannual get together. One of the members of our member experience advisory committee will be there as part of a panel talking about their experience and hopefully getting national recognition for some of the work we have been doing their. Really looking forward to seeing what goes on with that. We are going back to the joint budget committee and asking for more funding for the all payer claims database that provides a significant amount of value to the public by being able to provide actionable information about and insights about health and utilization outcomes, cost, but it is unfortunately beset with funding problems. What we're looking to do is make sure that there is proper funding for it, including state investment, since we are going to ask for a significant state only investment here. We are asking to change government structure, provide more steady control to ensure that we have a little more oversight over the quality of the work products to ensure that our state partners can get access to the data, improve some of that data and make sure that it is actually being used or is available to researchers and other institutions around the state to actually provide better access. We're looking forward to that. We did not receive as much funding from the federal government as we want to. We did a budget request on this last year. So now we are faced with making sure or finding ways to make sure they can continue. It is important issue to make sure they get funded. If they run out of money, they have to delete everything. All the data that they have. So we want to prevent that from happening. It has a ton of value across the state. A technical request. Medicaid enterprise operations. This is actually pertaining primarily to our Medicaid management information system. But believe it or not, it is broader than that. The last time we did a reprocurement for the MMI as, everybody remembers the implementation the how that went and believe it or not, we actually have to start planning for the next procurement. To do so we have to make sure we are fully engaged with CMS framework on procuring what they call the Medicaid -- Medicaid enterprise. Larger than the MMIS. And includes utilization management structure, pharmacy, and federal governments to make sure that is all coordinated. This request would help us get down the path to ensuring we can maintain compliance with that. Is incredibly important to us. Federal government chips and 75% for operations in terms of all of these functions and actually 90% for development and design of these programs. So we have to make sure that we are in federal compliance and hit all the deadlines. Without upending the entire system. We also ask for supplemental funding and other discretionary funding to ensure that we can get the system certified. Again to make sure that we get federal met and also hours to ensure to improve the system and make changes as new policy happens or new legislative mandates. And also to make sure we can fix anything that is wrong or otherwise [Indiscernible] the process. Provider rate adjustments. This is one of the years where I come back and say we are looking to increase rates. It makes my job so much easier than what have to show up and tell you that we are requesting decreases. Much happier this time. In this case we are requesting $61 million total funds in fiscal year 2019, growing to $82 million in 2021 with a few critical initiatives. The big one that we have right here at the top is that we are requesting to index personal-care and homemaker rates to the minimum wage and also requiring a pass-through of those rate increases to wages. We know the personal-care and homemaker services a particular affected by the minimum wage. The Colorado Constitution requires two more very large steps in the next two years and then drops down.'s so we would like to do a permanent index so that as the minimum wage raises so does the wage for these services. The people who are providing these services are disproportionately affected by changes in minimum wage, more so this is the place where we have the most competition in the labor force. People working close to minimum wage have a large choice of where they can choose to work, retailer food-service or other types of jobs. Knowing how difficult personal-care and home a jobs are, it is critical that we ensure these wages are competitive, particularly considering it is a life and safety issue for senior citizens, parents and grandparents as they age. We also have a series of targeted rate increases related to a number of different services based on recommendations from the Medicaid provider rate review advisory committee. We have to make sure we are up-to-date on acronyms. That one is a pretty good one. Increases include home and community based services, maternity, dental, transportation and a few other small things around the edges we actually also have some targeted decreases based on the conditions including anesthesiologists who are paid significantly more and also laboratory and pathology services also being paid more the Medicare rates. Initiative the target increases,

requesting across the board rate increase of 0.75% impacting almost all providers accept providers who have some other rate methodology. Such as a nursing facility that has essentially guarantee 3% rate increase. Plus pharmacy, they would also be exempt as well. The next request, primarily internal operational. This is about the office of community living governance. Requesting resources related to ensuring that we can comply with case management regulations, brokering, additional funding for preadmission screening, the standard access to the CMP fund, a civil monetary penalty fund, a grant program. For nursing facilities to help them modernize and improve their operations. IRS as oversight with the Department of local affairs. That is individual resident residential services and supports. And also extending the person who works to coordinate the behavioral health and crisis pilot program. That program is actually set to expire at the end of the or. We asked to continue that -- the here. We asked to continue that. Operational compliance and program oversight. Number small initiatives related to ensuring that we are doing our job properly and receiving Medicaid program it. includes eligibility determination reviews to make sure we evaluate the system prior to the office of Inspector General. Oversight for peace programs and managed-care organizations related to hospital backup program. Resources to help us with sub recipient monitoring, which primarily applies to [Indiscernible] and internal resources to help us with audit compliance and review of claims for intellectual and developmental disability waiver programs. Finally, one last initiative. Employment first initiatives and state only programs for intellectual and developmental disabilities. This is a contractor with the vocations rehab at Department of Labor. We would establish the office of employment first in conjunction hopefully with one of our university partners. There is a large acronym there. It is a program such as JFK partners where we would actually establish this and address some of the other recommendations from the employment first advisory committee -- advisory partnership established a couple years ago. They made a number of recommendations, in particular around improving the state workforce and making it more accommodating to people with disabilities of all kinds. And hopefully making state agencies themselves more friendly to people who have disabilities. There are number of other recommendations in this provide funding for three years to help address those. Again, more of a statewide effort than just healthcare file -- policy and financing. In addition, we also would like to use funding available to eliminate the current waiting list for the state SLS program and also provide additional funding for the family support services program. The funding for this request is actually coming from a cash fund known as the intellectual and developmental disabilities cash fund. That program -- that fund does not have dedicated revenue. It is one-time fighting we will spread across three years and see what happens. Hopefully find out other ways to fund it. I would be happy to take any other questions you have about what is going on. If you're interested in the details or can't sleep, all the budget requests are on the website that the easiest way is just to do a Google search. Chris can also provide you some links. If you have any questions beyond today, you are always welcome to give me a shout up -- out.
>> This is a third time I've done this exact presentation. So Michael today was whether or not I had to -- the question was whether I had to look at my notes. I glanced a few times but the next time I will try to do it with my eyes closed and maybe juggling at the same time.
>> You could invite us for that.
>> Paid admission.
>> That is where the money comes from.
>> Got to get it somewhere.
>> Question about how you establish priorities.
>> The priorities are developing to junction with the Executive Director. One through five historically have been reserved for things we need to do for funding the base cost of Medicaid programs. It doesn't really indicate any sort of discretionary sort of thing. One is funding mental services premiums, the $7 billion [Indiscernible] the remainder is done through internal discussions with staff. And then in conjunction with the governor office. However, it is not always a perfect indicator of priorities. And we bring it to the joint budget committee, and they don't -- they don't generally use it in terms of how they make their funding decisions.
>> If I am hearing you correctly, one through five are just the basic and then everything else here is priorities. Are they funded by item? By request? Or is it approved and then you decide allocation?
>> You are correct. Once or five, that is just funding the cost of the existing programs. No changes a methodology. -- In methodology. The remainder, the joint budget committee will go as they make decisions item by item and make decisions on each of the items individually. For us, the internal process, the department develops requests to work with the governor office to decide what we can and cannot do and then after we get across the different initiatives, we establish the priorities later on.
>> Thank you very much.
>> Any other questions? Comments?
>> Just to elaborate. They do an outstanding job, but it is vetted through the department. We start with a much broader

palette and then work your way down to what is practical and what we think we can get the. And we have to go down the street to file approval. Keep Josh and his team in your thoughts because this year it is very protected. Between the time actually have the hearings -- protracted. Between the hearings in the questions, any time actually have to go in and present is about a week. A lot of late nights and weekends to try to sort through this. Think of them when we're having to do the [Indiscernible]
>> Normal is about a month.
>> A couple weeks.
>> This is more condensed. Quickly, since you brought it up, the joint budget committee briefings where the budget committee will be briefed by staff with issues related to the department, those occur on December 10 and December 11, Monday and Tuesday. I am not sure exactly the times. I believe the Monday meeting is in the afternoon and Tuesday is in the morning. And the department will be but in front it -- be in front of the joint budget committee on December 17. That is in the morning and again on December 19. December 17 will be they majority of department operations. December 19 reserved for behavioral health programs -- programs.
>> I have an educational question. This is coming from try to understand a little bit more about the available funding as the models changed for primary care. We are appreciate of of with all the focus on suicide prevention right now across the population. My question is, is that -- as the visits have come under Medicaid where we can have six visits as the way supervisory rule over -- the BHO, does that change -- I don't really understand how the money has changed during the process. And if that now falls differently are not. I didn't see it reflected here. I don't need specifics, just the broad picture would be helpful.
>> High level the money has not changed. We did go through the budget process a couple years ago to get additional funding related to the ACC and adjusting some of the -- more case management. However, after negotiations with stakeholders, we left the risk base capitated of nature alone. Those competitions which are paid on a per member per month basis that cover virtually everybody in Medicaid. Those are still paid in the same manner. The funding itself continues to go up with caseload. But overall, the financing mechanisms are still pretty much exactly the same as they were prior to phase 2.
>> The only thing I would add to that is we are asking for more integration with the rates as they move forward to be responsible for the integration, the adequacy networks. More of it is following [Indiscernible]
>> Government question. Or JVC members like you're talking about the are very active in December, are any of them term limited so January 8 they are done and there is a transition so this work is done by one team that is going to be taken over by some other members? Or appointees?
>> Yes. In fact, we will have a full new JVC members -- Aye new JVC members out of six immediately. Yesterday the leadership elections were for both the houses, the house and senate. New JVC members have been appointed. They will start going through the training immediately. They will be seated prior to even being sworn into office. They will --
>> Prior to -- yes. We will be educated, not just presenting, for new JVC members. We will make every effort to get in front of that and set meetings early on to do the Medicaid primer so to speak. But we will have Aye new members. The carryovers are Bob and Dominic. Everyone else will be new. Matter fact, one of the JVC members from the Senate is actually a freshman senator. So that just was elected.
>> What a learning curve.
>> Yes. We will be dealing with that this year as well.
>> Oh boy.
>> Any other questions?
>> Just a point of clarification because, as we all experience out there, we have Medicaid covered people in healthcare and then we have those that can afford insurance regardless of what it costs and that we have those that are caught in the middle. What happens with Medicaid people that get -- that have catastrophic medical conditions? Is there any money that goes to help cover expenses? Or is it all covered through the program?
>> This is Kristy Blakely. There are a couple things. First of all, there are co-pays for adults and things like that. But if an individual that is on Medicaid has a catastrophic, there is also the ability to go back after their home or things like that to offset the cost.
>> Even in Medicaid but
>> Yes. So there are ways to recoup. And -- but most of the folks on Medicaid are living at a poverty level threshold. So it is not like there is a lot of money there to go back.
>> They could have a home.
>> The could have a home. There allowed a home and vehicle. No vacation homes.
>> I understand. But their basic home.

>> Yes. They are allowed that.
>> There are folks in the middle ground that get caught the end up losing their home and life savings. And everything else.
>> Right.
>> We also want to add, if it is a catastrophic, like a car accident, Medicaid will also cover insurance. I understand that. I meant somebody on Medicaid that comes down with stage IV cancer the nobody caught or whatever. Things escalate so quickly.
>> Yes.
>> If a person who is on Medicaid or becomes eligible for Medicaid three catastrophic event is in that circumstance, then their healthcare costs are covered for by the program. So once they become eligible for the program, other than what are hopefully nominal co-pays, patient visits, physical therapy, any other pharmaceuticals, those are covered by the state and federal government through the Medicaid program. It is only after they pass away and only in certain circumstances were Medicaid has a right to recover from an estate, including the home, but it is also worth noting that for somebody who has a community spouse, say that I on Medicaid and had a catastrophic illness or event and ultimately passed away, if my wife was still living in the community, then Medicaid would not recover my house or assets until after my spouse passed away. So there are provisions inside both federal and state law to prevent what they call spousal impoverishment. Because without that, you can end up in some pretty dire circumstances for people --
>> Thank you for that. I appreciate that.
>> That goes to my point that with those caught in the middle, they lose their homes. Look at the news on the local networks last couple of weeks about things happening.
>> Just to elaborate. There are programs. As Josh was talking about, we don't acid test for Medicaid, unless you are in long-term can -- asset test for Medicaid. In their vehicles like Medicaid trust where you can work through different programs. We would be happy to actually have staff come in a brief you all on that if you desire because it is an issue. But again, if you want us to come in and do that I
>> I just wanted a quick synopsis. I think I have a pretty good handle on that.
>> Any other questions?
>> I just want to make a comment. I say with the expansion of Medicaid, we serve a good part of southern Colorado. The number of kids that are self-pay has decreased like 10%. So between CHP and the Medicaid expansion for kids that you describe your, a lot of the -- unless they are undocumented, for the most part, many people are covered now.
>> The kids are.
>> [Indiscernible] some of my grandchildren are on-chip. I understand that completely.
>> It is great. I am appreciative as a pediatrician watching families go through -- the huge economic diagnoses, accidental or genetic, -- it's great that we cover this.
>> Thank you very much.
>> Thank you for having me.
>> We are going to go back to open forum. Lauren Welch. She has testimony for herself. And how is Robert Hernandez going to do it by phone?
>> For those of you who are listening, Lauren Welch is handing out a document talking about transparency which she will be talking to in the follow-up from last month. Go ahead.
>> Thank you. I am a parent. I have my son James age 11 and he told me this morning I need to get a new one because he is much taller than that now. He will go of in a height restriction. Anyway, [Indiscernible] first of all, I wanted to say that I put on my contact information on the top and would be more than happy to engage in any outside discussions about anything that I talk about. I always offer that and never hear from anyone from the department or from board members. I just want to state that verbally so everyone hears it again. I am happy to talk to people. I do have two Masters degree, when in elementary education and one of special education. I am also a certified nursing assistant for my son. That is the only income I received. I'm not paid by anyone else to be here. I have no obligation to bosses getting upset with what I think number one, it was great to see the scanned document of comments from the October it was great to see the scanned document of comments from the October 2018 meeting. Posted online. I submitted multiple comments over the years which have never been scanned or posted on the website. So I think that is a great thing and should be happening at every meeting in my opinion. Or every posted board meeting. A second, it is great to see the close caption archive online for accessibility and the public record. I know it is not perfect because it doesn't always translate, but I think it is a great accommodation for people with hearing impairments. So thank you for doing that. I do want to number three have a demand for accommodation that the audio file be posted as a simple MP4 file. Right now in the still Adobe connect so people who don't have a computer or the ability to download apps to their phone cannot

listen to it as easily. So I have spoken to your tech expert about that. I would like to say that I requested this multiple times. So I really hope that you will comply with that. I have also -- also, I just made a note here. It is not under she. Sheet. The presentation today on the budget was not posted in advancement of the meeting. So people at home that were calling and were not able to participate and follow along. I would really recommend that the board post the presentations online prior to the meeting so people can participate if they are not able to call in a computer to do the webinar and on the phone, they want to see the document. Remote telephone comment. This is the third time I requested this to the medical services board. It is possible other [Indiscernible] it is a way to accommodate public comment for full and equal enjoyment of participation, which is under the Colorado antidiscrimination act for people who live far away or cannot come due to caregiving or their own disabilities. This is something perfectly reasonable. I know you already have the phone set up for your members that can't come, so Steve poured over it CDH us went ahead and do that. I will have to file a charge if this does not get implemented because I've asked multiple times. Demand for accommodation is putting the department having one main public calendar online. This will make public accommodation a full and equal enjoyment of public meetings easier because right now there is -- you can go to the homepage and they have every single public meeting for today posted. If there is a cancellation or time change, you just have to go to one place for all the meetings. Right now here you have to go to every individual group page or have already contacted the staff person that manages the constant contact to get the emails, to get connected with the agenda. It is really not easy for stakeholders the way -- I recommend that the department implement that as well. It is reasonable accommodation and I oppose this determination because it is preventing full and equal enjoyment of public meetings. And a follow-up from last month, I really feel that there are so many issues going on. I have talked to a couple people, if you like we are imploding. It does because we have had -- the D IDD was stolen away. They eliminated that. Gretchen with one email eliminated an entire department dedicated to individuals like my son. We have had leadership changes. We have no communications director at the department. I am really hoping with this change of administration we fell some slots and get some support in there because it is very lacking. When I contact the Executive Director and am told that I cannot talk to anyone except her legal staff person, it is not a warm and fuzzy feeling for a stakeholder to be told to call the legal department. She also referred to him as her attorney. Exley works for the department and in my opinion he cannot give a full an objective legal analysis of things because he works for the department and have to please the person that signs his paycheck. The general -- the Attorney General office, those are the people that are giving true equal and objective opinions. I have file two civil rights charges against the department. One was because I was denied membership on this fantastic membership experience group you're talking about but they only want well-paid stakeholders. They continue to cherry pick people that have dissenting views and keep them off. The only want well-paid stakeholders. One minute left. Almost done. That is a concern I have. What you are presenting is not the experience of people on the -- in the community. I am bringing that your attention and appreciate the public comment. Under the follow-up, the denial of the rule packet is a clear message the department needs to rework the rules. It is been an entire month and not one person contacted me. Not Britney or Bonnie . They know I have been involved in the topic since 2014. To continue not to contact me back I have reached out to the director and finally have a time to meet with her, but I've been told I cannot talk to her about most things. She will only listen to me because her legal advisor has told her that she can't talk to me because I filed a civil rights charge but that is actually not true. She has the full authority to talk to me and even offer me a settlement. That is from the director directly. Full interest, the denial of full participation and interest of stakeholders continues. I received a survey sent out yesterday through John Perry that is faulty. A person could take it multiple times. The entire data set will not be accurate. I'm concerned that that will generate information that is not true. I currently have three charges. Both the director and [Indiscernible] have no idea. They say it doesn't make sense and will not discuss it with me. I don't understand. I'm deeply confused as a stakeholder but if the civil rights division of Colorado has taken my charge and said it is legitimate, then they need to proceed with that. That is my last item. Perfect timing.

>> I actually gave you eight minutes.

>> Thank you.

>> Thank you for the accommodation purchase to give you an idea, I met with the sheriff this morning because my son has a remote monitor on his ankle. That I had to do my CMA -- CNA shift with him and talk to his provider and transport him to his location for behavioral therapy. That is why I was late. And that is just a day in the morning of my life. So thank you for that. I appreciate it.

>> I understand. Anybody have questions or concerns?

>> Curious on follow-up from last month on item number five. The denial of full participation of interested stakeholders.

>> Go ahead.

>> I have offered myself multiple times to Bonnie and Britney and you heard me last month you that. And they failed to contact me. They are not including me as a stakeholder.
>> I see. I thought we were -- we are very extending to anybody that wants to participate. Okay.
>> It is more on the department staff level.
>> I have taken notes. We will see what is doable and follow-up with some of the things you have asked.
>> Thank you.
>> Anybody else have questions? Go ahead and phone in Mr. Hernandez. He will communicate asked himself.
>> I will put in the middle.
>> Go ahead. Hopefully we will hear you.
>> Mr. Hernandez. Will you please identify yourself?
>> Thank you for the opportunity to have public comment. I will try to be brief as I believe we only have five minutes. Two things I want to touch on. The public rule held monthly and a particular one held on the 22nd. I emailed Chris Sykes and asked him for accommodation so members of the public can phone in and civil rights laws don't indicate only for people with disabilities. It also requires full participation so that everybody can enjoy access to their government. He never called me back. But I will tell you, on the one rule I had, you have to show up in person. What if you just can't go or can't attend? That should be some data standard, especially when you're creating rules to go forward to the services board and the legislative servicing committee. So it is something that needs to be taken into consideration. I never heard back from Chris Sykes and he never even [Indiscernible] the other rules, if the staff -- they just left. I never had an opportunity to speak on those. I even there in person. Somehow we need to change the nature on how the members of the public a call in or have a webinar and it should be done so in advance
>> Reporter: Should not just be based on accommodations with people with disabilities. Civil rights is very specific and requiring access for everyone to I just want to point that out because I should be change going forward. One other issue I want to touch on is this whole idea of a host home registry. The civil rights division and mentor others considered the registry [Indiscernible] here is why, because it is so arbitrary when you decide someone is on their for whatever reason. That someone has done something criminal, that is different. But the idea of the registry speaks -- it is based [Indiscernible] here is a case where the state laws in appellate court basically said -- I will read the appellate court, three judges wrote this disposition. They said such entity should not be insulated from liability and seized power [Indiscernible] they can't eliminate the right of host home providers to be [Indiscernible] arbitrary action of such entities. More and more people are going to be citing case law. That is something that needs to be taken into consideration before you move forward and ask for [Indiscernible] because most legislators are aware that that is all I have for now. I don't want to dive to typically -- to deeply. I could spend all day talking about the appellate court case but that is all I have for now. Thank you very much for allowing me to speak remotely. Hopefully for individuals to speak over the phone or have a webinar, the access of the medical services board.
>> Thank you. Does anybody have any questions?
>> -- Okay. Thank you so much Mr. Hernandez. We appreciate your time. Thank you for bringing your son again.
>> Maybe we can do the phone.
>> We're moving in the right direction. We have the webinar going. We're moving in the right direction.
>> Human so versus wants the text.
>> We are trying. We're really trying. Okay. Let's go on to -- Elizabeth. You're going to talk to us about a rule coming up next month on long-term acute care and really visitation hospital Perdiem.
>> Thank you. I am the special day hospital rates analyst and hospital liaison. I came here today to provide a quick preview of the rule we plan on bringing next month . A change in reimbursement methodology to our freestanding long-term acute care hospitals as well as our freestanding rehabilitation hospitals. Within this we have also created a new group called our spine and brain injury treatment specialty hospitals as well. We would like to move them off of the APR [Indiscernible] reimbursement methodology for inpatient and move inpatient only to a per diem methodology.
>> Questions? It will be fun reading next month.
>> [Indiscernible low volume]
>> The advantage right now is both to the department as well as to the hospitals. Right now under the reimbursement methodology, you have what's called a trim pointed that means that from the first day to that time you get one flat reimbursement. It doesn't matter how long the patient is they are. So if the patient goes to a long-term acute care facility and get a relapse, they're only there for a couple days ago back to the hospital, the get the full payment. It doesn't matter that they have only been there a couple days. If the patient is a little more of a severity to where they require longer stay but doesn't quite hit the trim point, they're still only getting that one flat payment. So there is a disadvantage as to both our provider community as well as to the department in this reimbursement methodology. With the per diem, we can

guarantee the department is paying more true to what they are actually treating our Medicaid clients for. By switching to that Perdiem. So if they are only there for a short stay, we're only paying for that short stay. However, for the higher acuity patients which are harder to treat, they will now be getting a more accurate long-term payment. So it does actually -- this is actually a budget neutral and that is where we find the balancing act. We are paying less worthy longer stays we pay more, which is more true to the care the clients receive.
>> Very helpful information. Thank you. Thank you for that good question. Thank you so much. Any other questions? We will be reading next month. You are more than just a pretty face but very true. Lindsey. We're going to talk about children's extensive support waiver.
>> Good morning. I am a benefits manager with the office of community living. I am previewing a proposed rule change regarding the home and community-based services on children's extensive support waiver rule to align it with our waiver application. This includes changing the rule to remove behavioral therapies, personal care and division as these services are now under [Indiscernible]
>> Questions? Okay. We're not removing any services. Under the whole claim pool. The benefit. Okay. Thank you so much. Jeremy.
>> Timely filing requirements. -- You are going to do the school health services. I am your for Shannon as well. I am operation supervisor here to discuss the timely filing requirements Pro for providers generally and then I have a blurb for the role from Shannon that will be different than the general filing requirement. So the proposed to change originally and currently in the rule timely filing is 120 days. Providers have a difficulty during the transition into new systems and the department offered an initial extension of to 240 days. That was then later extended to the max federal allowable amount of 365 days. The proposed rule change makes that extension a permanent extension, bringing us more in alignment with the federal guidelines and supporting the provider community better. Any questions generally?
>> Okay.
>> So the difference in the change that is happening to the school health services rule is that that will remain 120 days. School health services gets paid in a very unique manner, and to shift it up to 355 days could disrupt their actually payments -- their actual payments. There is a whole process that pays the actual health services entities, and not having the claims come in within 100 days could disrupt. That is the concern and reason we are now bifurcating the rule.
>> Okay. You're good to read that next month.
>> That will be interesting.
>> We have a lot of numbers.
>> [Indiscernible low volume]
>> Thank you very much. We appreciate that. Elizabeth and Russell. Last but not least. We appreciate you sitting through everything else. Just to do that's.
>> Happy to be here. Good morning. I am the compliance analyst for the department all here with Elizabeth who is the psychiatric residential treatment facility speaker. -- Residential childcare facility. Elizabeth is the policy specialist for that benefit. We are here to present a brief preview for the rule we will bring next month.
>> Residential therapeutic option primarily for youth in the child welfare system. CCS are licensed by child welfare and monitored by child welfare to ensure they serve the needs adequately. They are carved out of the behavioral health capitation. So they are paid for fee service. The CCS our 24 hour psychologist level of care. [Indiscernible] are 24 hour medical, MD level care. Not too many people are aware of this. The systems are confusing because they cross two agencies. So they have a whole set of rules over at human services for licensing and then a Medicaid payment rule over here.
>> I just want to give a brief explanation for the impetus of the rule. I am sure you're familiar with the regulatory efficiency progress -- process. The purpose is it is being updated to incorporate regulatory efficiency updates to basically -- identified as part of the regulatory efficiency review process by the department and proposed by stakeholders. Additionally updating the rule to reflect current practice align with the Colorado Department of human services, the licensing body for these facilities. The planned changes include moving outdated and inaccurate information, language and references to align with current practice, updating the assessment tool to allowing with upcoming changes to the Colorado Department of human service regulations, and clarifying language that further clarifies explained current factors and ultimately removing the [Indiscernible] requirements. That are more appropriately housed within the licensing body regulations. Department of human services. We're not entirely removing them, just siding back to the Department of human services and the federal requirements. The department is making the changes at this time to fulfill our requirements of the regulatory process. And to ensure that this rule reflects current practice. We do note there are other policy implementation initiatives going on at this time that may impact this at a future date such as the implementation of 254. Any further changes stemming from those initiatives will require

additional stakeholder engagement and will be brought before the board at a future rulemaking. That is all I have unless you have additional questions.
>> Any questions? I am saying none.
>> -- We have one from the audience. You have to talk here.
>> This is Maureen Welch again. I had the opportunity to talk at the public rule meeting with both of you over the phone because I cannot come in person. And also we spoke on the phone for almost 2 hours. We went through every single rule. To me, that's what a stakeholder engagement is. Actually go through every rule. So thank you for doing a. I know it was over your lunch hour. I do have serious concerns about many things. I didn't have time in my public comment to go over them. When it comes next month, one of my biggest one says the question I asked you about going up through the 21st birthday because this is a childcare facility, and then we are talking about in the rule it was up through the 21st birthday. To me, that raises a red flag with Adult Protective Services and child protective services and the co-mingling of agents and populations and use -- and you said you were speaking to -- the CS person? [Indiscernible] Gina Robinson. I'm very concerned about that and there were other concerns in there as well because of the co-mingling potential of populations with the chip labor populations with the chip labor and the RCC after populations and using different meds for different people. Those are still big concerns. Even after the two hours on the phone and the our at that meeting, three hours, we did not get clarification from Gina on that. I am hoping we can.
>> If you wish to engage between now and then, thank you. I should not have done what I did. I am too lenient. Thank you very much for having your comments heard, and they will follow through.
>> Couple housekeeping things. Electronic version?
>> Electronic version of the budget.
>> And also a question about emergency adoption rule. I guess we do them frequently enough. Actually going into effect.
>> The emergency adoption that you did at the very beginning, that goes into effect on November 9. And then you did the final adoption at this meeting for the rule, that will go into effect on December 30 . You guys have passed the initial emergency rule back in August. The emergency rules have 120 days lifespan. And then if nothing gets done, they just drop off the emergency is over. At the August 10 meeting, you did an emergency rule. That lasts all the way to December 8. So as I indicated in my email, a filing issue on my behalf, that made it necessary for the emergency rule to come back today because the final coming back today -- there would be a 22 day gap in coverage.
>> Providers are providing services now. So they are going to be paid all the way through or just started that
>> Starting on August 10. When the department initiated this methodology, when Richard brought the three separate -- and basically, now it is just not going to stop.
>> We just extended today.
>> For 22 days per correct.
>> Thank you.
>> I am going to read the closing mission because I think I far -- forgot that.
>> Two quick --
>> We did.
>> Okay.
>> Just to reiterate. Our relationship with this body. This is a rulemaking body, nodded department oversight body. I want to clarify that. -- Not a department oversight body. I want to clarify that. For your own records, if you need to reach out to any of these people, our legislative liaison, our analyst, Katie Crozier, our -- Rachel writer, external relations manager, which includes our communications team under her purview. Mark Williams is the public information officer. And the Attorney General office is the attorney of record. We take our legal advice from the Attorney General.
>> They can talk to them. [Indiscernible low volume]
>> I will make sure you have the contact information.
>> Thank you.
>> Give us a separation of what you just said as far as we are not a department oversight committee, we our legislative committee because there are so many times we get testimony that the department is not doing this or that, what is the chairman supposed to do in these situations?
>> Run out the door. Is about the answer?
>> As diplomatically as you can, I guess you're supposed to say, we are a legislative committee. I am sorry, but then if Chris -- this is the person you need to contact and relay that through the chair so you don't get caught in a situation of trying to help something that we are not empowered to even consider.

>> It is a statutory authority issue. I will say we pride ourselves on the fact we want to be responsive. We want to have a lot of stakeholder engagement, and we need to listen to the good and bad. No question the chair is doing the appropriate thing and allowing comments to go on. You just don't have the statutory authority to act on those comments. Again, you do have the ability and we're always happy to provide you with the appropriate contacts within the department that can address specific issues. But I don't want to shut down the dialogue by any means, but you need to have the resources, thank you for your comments, here is the best person to actually --
>> And maybe you have, but I don't remember that information being made available. Does that make sense quick
>> Yes. We have put it out. We also kind of help you all by saying, instead of knowing all those names and contacts, call Chris. He will connect us, but I probably should have today said several times we are rulemaking, we don't really have authority over make sure that we have comment, things like that.
>> But we didn't give a solution at all that I feel gave those different people with different authorities to hear those challenges. We need to give whoever is doing that public input or testimony that information.
>> I will make sure Chris provides you -- it can be posted online. We are public servants. We will make sure you have access to the right people you need to contact for specific issues. If this -- concerning this issue, this is your contact person. I think that would be wonderful.
>> Some of the reason we are here with think that would be wonderful.
>> Some of the reason we are here with us webinar today and that we've been doing the webinar is because Charlie was saying, we need to do better outreach. We are working for the state. The whole state. There are reasonable things like that.
>> Especially when McCone from rural -- well Mequon from -- when we come from rural communities.
>> We will look at making that a reality. We do want to entertain these comments, but again, we [Indiscernible] we will make sure you have the information at your fingertips that you need.
>>
>> I just want to say thank you for that and clarifying the boundaries. I do want to ask a related question. If in the testimony there is a perception that stakeholders are not heard, because we are rulemaking, do we not have an obligation to ensure that is the case? I recognize we don't have any authority over the department, but as we are hearing the process of the testimony, which is part of this process, I just want to clarify that. In which case then we would either vote in a different way or we would -- whatever it is. Is my understanding correct in terms of the responsibility by this group quick
>> --?
>> It is a very appropriate,. We obviously want to do whatever we can to accommodate stakeholder engagement, but we do have prescribed processes for doing that. We sometimes get outside the boundaries of that. Again, in the interest of serving our clients and stakeholders, we engage in that. But there is a limit to how far you can engage.
>> I am not questioning that. I'm just questioning -- just wanted to confirm that is part of our obligation for absolutely. --
>> Absolutely.
>> That people have an opportunity.
>> You need the best information available to you to make the decisions. I just wanted to clarify that.
>> I appreciate that. As far as that rule coming for our next month, the beginning of your [Indiscernible] have stakeholders been engaged. We heard testimony to the opposite of what you said, then we have the right to ask that. And this committee has asked that things happen because -- before it comes back the second time. So we have that right. That was a good point you made. Anything else for the good of the group? I just want to point out we are before 11 o'clock. I should not be -- this is very important. We need to take as much time as possible. But after the 4 1/2 hours last month, I toasting by the time I left here. We did the closing Russian. So we are done. -- Closing motion. So we are done.
>> Thank you. See you next month. [Event concluded]
>> [Event concluded]