] >> Is anybody on the line? >> I don't expect anybody on the phone I'm not anticipating that. >> [Indiscernible - multiple speakers] >> We will call the meeting to order. Good morning. >> Good morning. This is medical services, we are convened, we will do rollcall .

Okay. Christie Blakely? Patricia Givens? David Potts? Donna Roberts?

Good morning. Thank you for joining.

Certainly. >> Thank you very much. Thanks for being here. The date and location of the next meeting is Friday, September 14 beginning at 9:00 . This is the policy of the board and the department is to remind everyone in attendance that this facility is private property. Please do not lock the doors or stand around the edges of the room. Please turn off your cell phones while in the meeting room.

I am looking for a motion for the approval or corrections for the June 8 meeting.

>>

Any corrections? >> July 13 was the last meeting. I'm sorry. You need to make that motion. >> I approve the minutes for July 13.

Second.

We have a motion. All in favor?

>> That passes.

We have moved some things around, for those of you on the phone, we have moved the emergency to be somewhere around 10:30, Kimberly wants to join us.

I apologize if you're here and have to wait but we will do the final adoption, the initials, the rule agenda and we will do the emergency. We will accommodate her.

I will ask --

final adoption?

I am looking for a motion. >> I move for the final adoption . Revision to the medical assistance rule concerning children with autism , rescind section 8.519.

Second.

All in favor?

Opposed? That staying? >> Thank you. For those of you on the phone, Patricia Givens has joined us at this point. She is here.

Going on to document two, the final adoption agenda, is nonconsent.

>> You have done a lot of work with the stakeholders. We're in a good place.

I believe so.

Good morning everybody. I am one of several benefit specialists, we have made a couple of changes and revisions to the rule since suits was dosed -- since last month.

We have stated in ACF must be integrated into the community,
the second change was in regard to the staff and repeal of section 8.491, as well as the definition section.

We created the definition the auxiliary staff which has staff members such as kitchen and staff to the client .

But we have concerned , with untrained staff, providing emergency care and assistance that we will have unqualified staff doing those things. What we have done, we have made a change in defining what a staff member is rather than auxiliary staff, we have the definition of with a staff member is, what training they have, and if they meet those they can be part . If someone is course train, if multiple titles, such as office staff, and as long as they meet the requirements, and if they have the skills, they can provide emergency care and assistance.

That compromises [Indiscernible] and stakeholders. Those of the big changes that we had. Everything else, there were some minor tweaks and there were some typos and that is it.

Any questions?

Good morning. Thank you.
In the definition for the auxiliary staff, does that mean it is across the board when you look at other services, we will have that definition?

We deleted the auxiliary staff, we may need to do that for other services and we will look for the regulations, these are the specific changes, that is why it is important to have those here. And maybe something we can address later on.

I want to bring to your attention we got a letter of support from Colorado community health network, with no other questions, any public testimony? >> We love to hear from people.

Thank you.
>> Please come up and introduce yourself.
>> I will provide the Association presentation, I am here to support the rules and thank you for working with us and making the changes and the changes to the staffing addresses the concerns of our members. I want to express that today and thank you.

Thank you.

There is no one else. Anyone else want to give testimony to the rule?

I would entertain a motion. >> Move for the final adoption , revision to the medical assistance rule concerning facilities.

Second.

All in favor?

Opposed?

This Roberts? >>
Okay. Let's move on Document number three.
>>
I am Cassandra Keller, here are the revisions to the services rule, I bring that to you today, we have worked with her stakeholders on the issues that were raised at the last meeting, we have consensus on those items, we are pleased with the outcomes, I want to review with you the changes that were made.

As with the HCF regulation we have changed the language for the adult day center it must be integrated into the community, the second thing we have changed is the staffing ratio, we have removed the definition of auxiliary staff and replace that with the direct care staff member. >> The last thing we can change, document 8.491, which describes the requirements for nursing services, the department was concerned with allowing nursing services contracted by the staff, the rules are specific, and how the agency is to oversee contract of care and coordination of care.

The requirements are not part of the overall regulation. It was spoken at the same level, it creates the potential of an are not providing oversight and supervision that they are required to provide. After hearing the concerns, regarding the difficulty of the staffing, and rural areas,
we determined the employees would put these providers at jeopardy in the operations. The provider can employ the contract out to the nursing services, or an individual nurse, it is the responsibility of the provider to make sure the services are being provided.

Care planning and communication is taking place. The provider is not providing that proper oversight of the agency, the department may provide regulations to incorporate those contracting details.

There were a couple of other minor changes that were made from the feedback including clarification on the service that it would be written or verbal and a small change to reimbursement requirements.

Any questions from the board? >> Do we have testimony? >> I believe this is the letter we have for support from community health network.

Good morning. I represent Colorado, we have members who are adult day providers, we want to express our appreciation for your work ,

especially early on, we appreciate these changes we think it will give our members the flexibility they need, especially contracting services.
>> You want to be able to go in with a contract nurse, all these changes will work well. Thank you for making the changes.

Thank you, very much. Anybody else that wants to testify?

I will entertain a motion. >> Revision to the medical services and support, concerning adult day services, incorporates the state -- and purpose for the statutory authority contained in the records.

Second.

All in favor?

Opposed? >> Okay.
Richard Delaney? >>
Please introduce yourself.

Good morning. My name is Richard Delaney, I am a positive -- I am a policy specialist. Today I will present a revision to the physician services rule, the revision will add pharmacists as a provider type that can be paid as a medical provider in Medicaid.

We have received estate plan amendment to add them as a medical provider type and will put this rule in place , this rule as the provider types , this will define the scope of what we are going to be paying. There are some other changes where we changed the word, shall, we revised the rules for making the changes. This change will align Medicaid with what is being paid from other payers, the plan and change will allow Medicaid to do that as well. Any questions?

Any questions from the committee?

The other rule, [Indiscernible]
>> We should be consistent. The general assembly , they are getting rid of the word, shall. >> One point of clarification, this change will not permit clinical pharmacist who are integrated with the medical practices.

It will allow pharmacists to be paid in a retail facility. It will be covered in the other room.

I know folks when you're talking, you know who you are. But we do not know who is talking. I want to remind you, please identify yourself.

Any other discussion ?

Who just joined? >> They might be on Mute.

Any testimony?

I will entertain a motion.

I want to move the approval to medical assistance rule concerning adding pharmacists and the provider type. Incorporating the statement and the purpose of an authority contained in the records.

Second?

All in favor?

Opposed?

Thank you. We are good.

Thank you very much. >>
Good morning. My name is Whitney McOwen. I am here to present the immunization services rule.
I am a policy specialist. I managed immunization benefits.

The services rule will codify the department's existing practice which are captured. We will bring the rule as part of the overall department effort to move away from medical coverage standards and incorporate a line pharmacist to administer -- and allow pharmacists to administer immunization.

We will administer three vaccines, this change will increase access for the members and for pharmacists who are already having authority to administer vaccines under their licensure and who are doing this already for private insurance clients, this is a step in the direction of aligning practices, during the stakeholder engagement we may changes to the definitions, we added a couple of definitions, there were two changes that were requested that we cannot make at this time.

One is to require a rule that providers use the Colorado immunization information system , we cannot do this at this time because the Colorado Department that I have the capacity to -- does not have the capacity.

The other was to add influenza as one of the vaccines, and there are analyses that it would not be cost-effective to add that as one of the vaccines.

We discussed this with the stakeholders, they made the suggestions and their supportive of the rules as written. >> Questions from the committee? >> In regards to the flu vaccine, the cost avoidance in terms of hospitalization, was that considered?

Yes. >> The department analysis considered the likelihood of adults who were less engaged in the medical model. They were generally healthy. If they had increased access to the flu and we increased expenditures, it would not necessarily develop cost savings down the line,
those that are more medically complex and engaged in a medical home, and in a medical frequency does -- and in a medical environment, there is the care.

The pharmacists , they will not be covered.

That is correct. >> To be clear under this rule, it is the same three vaccines that are covered.

It is those three. Previously pharmacists were not being reimbursed. And we are starting with these three.

I am supportive of this, I have concerns about expanding this into vaccines for young children, in conjunction with the vaccines. >> Yes, we at the department agree that the vaccines are more appropriately administered in a medical home setting. That is why this change will allow pharmacists to administer some vaccines is good.

Any other comments or questions?

Any public testimony? >> I will entertain a motion.

We move the initial approval that the document is verified, revision to the medical rule concerning immunization benefits.

Second?

All in favor?

Opposed? >> Okay. It passes. Thank you very much. >>
Good morning. My name is Christina Gould. I'm here to present a revision to the services rule, this rule revision allows pharmacist to prescribe specified over-the-counter products as codified in the rule. High-level pharmacist can enroll to prescribe products in the pharmacy will receive reimbursement. Getting into the more specific detail changes, on page 7, in the definition section,
I added the term, prescriber, to capture any healthcare professionals who are licensed in Colorado. The second change on page 16 in the billing procedures section, I added the term, prescriber and deleted the term, prescribing physician. >> The last changes on page 21, the basis for reimbursement. I added language to describe there are specific drugs that pharmacists may prescribe which will be posted on the department's website, and stipulate that pharmacist does [Indiscernible] the rule has impacted all parties involved in a positive way. Members will receive increased access to medication. And we will be in compliance with the statute.

There were concerns raised. And after seeing the ruling, they no longer have concerns. Any questions? >> Anybody from the committee? >> Donna , did you want to make a comment?

No thank you. >> I will entertain a motion.

Any public testimony? >> I will move the initial approval of document six, revision to the assistance rule concerning over-the-counter prescriptions.

Second?

All in favor?

Opposed? >> It passes. >> We are going really fast. We have a timeline of 10:30 for the emergency rules. Everybody, take a deep breath.
>> [Indiscernible - multiple speakers] >> Good morning. Thank you. My name is Ana Bordallo. The purpose of the policy change is to add clarification to our rule for members enrolled within a child category, receiving coverage. When a member is not compatible this means the income is below the standard and there is an interface and that is above the income standard.

The discrepancy is that when a member is not reasonably compatible, and they are given a reasonable opportunity to provide an explanation, if they do not respond to this notice, the benefits will be terminated. Currently the Colorado benefits system is aligned with the policy, and the department reached out last week in Colorado, they received feedback and we supported their feedback and incorporated that into the rule. Any questions? >> You said if the income was lower then what?

Higher.

The income -- there is a discrepancy. If it is too high they are getting pumped out.

Correct.

If the income is lower, and it is verified, it is higher.

Families are confused. There's a lot going on.

It can be confusing. >> They can talk to the caseworker to clarify things. They can send in paperwork or email us.

They can either provide documentation or an explanation to the caseworker or they can provide the information online. >> Okay.

Any other questions from the committee on this rule?

Any public testimony? >> I will entertain a motion. >> We will move the approval of the document , revision concerning income verification .

Second?

All in favor?

Opposed? >> Thank you very much. It passes. >> Hello again. My name is Ana Bordallo. I am the eligibility policy specialist. Anybody receiving coverage and whose income is not compatible, if they are not

compatible, the self adjusted income is below the income standard limit. The discrepancy notice is sent to the member and we give them an opportunity of 90 days to explain , if they do not respond to the notice the benefits will be terminated , additional changes were added or made to sections 430.2, by updating the language to align with our Medicaid language,

the Colorado benefits system is in compliance with this verification.

We worked with the family center and we received feedback on the language, any questions? >> A process question, if they do not complete or determine within 90 days, do they have to start all over again?

If they do not respond to this notice, we would determine the eligibility using the electronic interface, they would get terminated with pending notices and they would have to reapply. >> Also a process question, the notification, does that consist of one mailing?

Yes. One mailing and it is said -- and it is sent to the head of household.

What percentage of mailings in general are successful?

At the time I am not familiar with the data.

>> Any other questions? >> For the continuous coverage, is this really determination?

Continuous coverage means any child who is receiving continuous eligibility or a pregnant woman who is enrolled, into Medicaid, they are guaranteed 12 months of coverage. We have to make sure to verify the income at the initial application. >> It is for the initial application, once they applied and we get the first interface, we need to make sure they are eligible.

>> If it happens again, there is another determination. >> [Indiscernible] >>

If the person knows they are applying right now, it is not some random male -- ran the mailing. -- Random mailing.

The interface does not happen at a period of time after the initial application, once we run the interface, if it is at that time the discrepancy is noted, there can be a delay in the process because we do not run the interface daily.

Is the person receiving benefits in the meanwhile eligible? What if they are not eligible?

At that point we provide ten-day notices, we do not retro close them.

Thank you. >> Any other questions/comments?

Any public testimony?

>> I will entertain a motion.

I move the approval of the document , revision to the child health plan concerning income verification .

Second? >> I have a motion and a second. All in favor?

Opposed? >> Thank you. It passes.

Considering we have -- is there anything different?
>> We will add documents three, four, five, X, seven, eight.

All in favor?

Opposed? >> That passes.

Considering where 45 minutes ahead of where we thought we would be, -- we are 45 minutes ahead of where we thought we would be, we will go on and do the updates and then we will do the previews.
>> We are waiting to do both emergencies.

Yes. >> I want to attach a note to Jennifer I need to recuse myself around the discussion concerning document 10.

It tells me that Kimberly is on her way now. Maybe we can take a five-minute break right now.

Let's go on a five minute break. >> [The event is on a five-minute break] >>
We will do the emergency rule in order. We have Mr. Delaney at the table.

Good morning. My name is Richard Delaney I am a policy specialist. Today I am presenting a document, which adds the definition of provider types that can generate a visit at health centers.

The type we are adding our candidates for licensure for therapy services. The reason we are presenting this rule is because on July 1, on July 1, 2018, we change the policy on certain behavioral health services, and they are now paid as a medical benefit
and do not have to be received through the managed care entity.

Prior to July 1, the services were covered but only through the managed care program and when they were in the program, FQHC was receiving payment for candidate visits. This is not a change in the policy, they are still being paid but in order to pay them through the medical benefit we have to have the rule that the licensure candidates cannot generate a billable service. >> We're bringing this rule as an emergency will because the federally qualified health centers are unable to provide the service without reimbursement and policy change. >> The clients that see services a qualified health certain services we want this rule applied as soon as possible.

We repeat that definition only including the candidate therapist and we are changing information in the course report allowing the salaries for these candidates be included in the cost report. >> We work extensively with the health centers to make this rule change, they are in support and the thing you should know is that candidate services in the fee schedule service, there provided through doctors offices, they are reimbursed for those visits so this aligns with the payments with what we are doing in the fee schedule. Any questions? >> I appreciate this rule coming forward, I am in psychiatry and I appreciate the need for being able to use these candidates and they are used extensively in a positive way.

I appreciate that the department concordance with this center.

>> I want to voice appreciation for this, especially with the rapidly changing health policy in our state, this helps us keep ahead of things. Thank you.

We have some public testimony. And we have a letter of support.

>>

Members of the board, I am a policy director, I am here to express our verbal support for the revision, you have received a copy of the letter and I want to reiterate and thank the departments as well as others, these changes were the result of collaborative work to maintain practices that exist under the structure, this make sure that the access will continue by recognizing the important roles that the supervisors provide, and another important piece is that allows us to continue contributing to the professional development of these professionals and generate providers throughout Colorado. >>

Any other public testimony related to this rule? >> Any other questions?

I entertain a motion.

I move the adoption of this document , revision to the rule, concerning adding provider types incorporating the statement of purposes, be maintained in the records.

Second.

All in favor?

Opposed? >> It passes.

Thank you. I will call Kevin Martin up. Please introduce yourself.

Good morning. My name is Kevin Martin. I'm the inspection manager. I am the director. Good morning.

We will be presenting an emergency rule associated with the payment for certain specialty drugs within the outpatient hospital methodology . Any opening remarks?

For the record, thank you for your time. The first and we talked about refocusing the department on the three pillars of our mission , this new

rule would focus on all three, if you remember I reviewed focuses and areas on cost control, there were 12+ work streams in the department, one included pharmacy, and there was a separate WorkStream that was a roadmap for the state, inside the roadmap we focused on pharmacy.

You remain remember I showed you a slide -- you may remember I showed you a sly, 40% of the benefits , would be specialty drugs.

We set the emergency drug is one of the major areas of focus that we have to figure out how to manage this system and technology coming forward. >> The data, the 40% has been updated in the last several months, it is now 50% will be specialty drugs.

Today's rule addresses the fact that current methodologies attest to finance drugs in the current environment and it will be innovative.

We used to talk about generic drugs in the $10 range, and the brain new drugs were around $60. The specialty area, you're familiar with a chore that came through -- with a chore that came through. The demand was addressed, the drug dropped to 25,000, so we have concurrent interest as we look at this rule, the rule is intended to allow us some time to have the discussions with those that are delivering these new drugs.

If I put this in perspective, it addressed millions of Americans and these drugs deal with individuals in single digits. When you look at the challenges that we have, you can look back and say we have learned from the value-based payments, it comes back to the payer much larger so they have an incentive to make sure the criteria is written.
>> They had a financial interest.

We want to learn from that, on how we consider that going forward. When you have an individual that you're dealing in single digits with, it is harder to have an insight into the efficacious circumstances and the outcomes to have more intense dialogues with manufacturers.

When you are dealing with drugs, two of them are more expensive, and two of them are 10 times more expensive. We are dealing with small populations and higher costs and the ability to govern the value-based payments to inshore efficacy and have transparency with manufacturers to say is this the right price. >> So holding all parties accountable, the prior authorization around that, it has a key insight into the appropriate use and dissension of that and the financing so when you have all that moving at once, on drugs at an incredible course, there is a capability dealing with single digits, we seek time and we want to have time to work with CMS and experts and partners that have the authority to dispense these drugs.

That is the background of where we are. Then we want to say what is the rule. Thank you. >> At this point I want to go over the rule, we were hammering out details of this over the past few weeks. We have different versions, but we have here in front of you, is the new rule for the outpatient hospital services.

There are a few changes here, if you go to the top of page 3, you will see the area where we define hospitals and drugs . >> Is this updated on the iPad?

You should have that at your desk. >> What page?

The top of page 3. >> There are copies over here.

If you are testifying please sign up. >> At the moment we are defining outpatient hospital specialty drugs, we are defining those. These are the drugs that we had actual questions about
for real individuals. These are the ones we know of right now. We are introducing these as part of the emergency. We hope to make the definition more robust in the future.

The other piece is going to be on the last page, at the ending of the document. >> This is describing the payment methodology, effective August 11, effective August 11, 2018 for services meeting the criteria, that would have otherwise been compensated through the methodology, hospital must submit a request for authorization prior to administration of the drug and if the request is approved, the payment will be negotiated on a case-by-case basis.

I understand that is light on detail, we were struggling to come up with a methodology in the short timeframe we had an it is something that would be beneficial and flexible to all parties involved and this is the only thing that was feasible in the short tame -- in the short timeframe we had. We hope to make this more robust in the future and it puts more defined guardrails around it. This is an emergency rule so this is effective for only 120 days regardless.

Any questions at this point? Should be go to public testimony? -- Should we go to public testimony?

We are rushing to get this out. How long is normal for something like this to get approved?

At least in the pharmacy area, they are required to respond within 24 hours,
is that true for the medical side as well?

I do not know.

Thank you. >> Anybody else?

We will have a discussion. Any public testimony? You need to sign up. >> We know every Medicaid agency,
are reimbursing for the whole amount. Is it the intent to be able to negotiate a rate that will cover the extra cost to the provider of their choice? >> Thank you for the question. The rule allows for the flexibility to negotiate but there are a lot of considerations, be it market influence, the historical reimbursement methodology for how much we pay is around 72% of the costs. We have supplemental payments to

augment the level of reimbursement, we've not analyzed the methodology , that is something we need to come

to continue to partner with, so I do not have a concrete answer, I would say it is part of why we're making this rule and we are working for reimbursement.

>> Is it possible that you can work directly with Novartis to get some of these drugs , how could other states enact that? >> Thank you for the conversation. It is our intent to have a conversation directly with the manufacturers, they have agreed. We will visit manufacturers around the pricing for the good of all Colorado people. I appreciate the partnership with our providers . >> Any follow-up questions?

No thank you.

Public testimony? Jeff Harrington. >> If you want to testify, you need to sign up.

Good morning. I appreciate you allowing me to be here to support this ruling. I've been told to stick to the script. Children's is a nonprofit medical center, where -- we are the largest provider of Medicaid, because of the care we provide, we have the ability to transmit or provide drugs as we are on the front line and we also do research. These drugs are used to treat rare conditions, they are truly an expense class all of their own.

We have seen an increase in these drugs available to treat a small handful of pediatric conditions. Most of these conditions are life-threatening. These drugs are bringing new book to children they can alter the course of child's lives in a positive direction because of the expense. In the case [Indiscernible] you may have seen a little girl walking to the hospital and came out using crutches and was able to walk.

>> It was a $125,000 cost and requires four treatments per year for the rest of her life. It either works or it does not. If it works, you need to stay on the treatment for the rest of your life. If it does not, you do not receive treatment any further.

There is another drug that must be given every other week at a cost of $27,000 per dosage. This is a great expense. >> Another gene therapy which could replace bone marrow transplant, this is a one-time cost of $425,000 for leukemia. There has been great success, about 85% of children has seen long-term remission. >> Under the current payment methodology,

we will only receive about $14,000 for any of these drugs. You can see the dilemma which we are in, which is why we support this rule. We understand the difficult position you are in, we want to work together to find a solution. >> Others provide these drugs, there is a small population and they have less people to spread the cost over. There are children who need treatment today and tomorrow and we want to get this rule approved so we can begin the negotiations on a solution, we want to work with the team and we will do that.

I ask for your support for the passage of this rule. I am advocating for similar rules in the future. Some of the patients there are not well

enough to be in the outpatient setting, there are implications to deliver the drugs. Thank you. >> Any questions? >> We also have Jeff Thompson. Please identify yourself. >> Good morning. I am vice president of government license health. I will be very brief. We feel the same way, we have the same concerns and are willing to work with the department and working through this issue. We understand where we are, the high price of drugs, I want to be on record to say we have two drugs, we want to be at the table as we talk about how we deal with these issues.

I do not think, if we have any current Medicaid patients in the pipeline requiring these drugs. Any questions? I am not a doctor.

>> What is the approach of private insurance?

I do not know if I have an answer but I can get back to you. >> When the drug was first introduced we negotiated single payer ranges, they did not have the ability to approve this drug. We held off treating any patients until we received approval and reimbursement. So now it is a covered benefit in 90% of the plans. They pay the cost of the drug. >> I'm curious if Medicaid covers this.

They are pediatric.

We treat adults that have certain blood cancers. CMS has some serious concerns about these drugs and originally they had a rule that was looking at this, I don't know where that stands right now. I think they did approve it for coverage. But I cannot tell you what the coverage rate is. >> I do not know if you are at liberty to share this, can you share the percentage, a rough idea between the cost you have negotiated with private insurance? >> We set our rate, we set the charge so we can only cover our cost plus a small handling fee. It's not like -- we are getting $125,000 plus a small markup to handle the drug. That is what we are doing with all the high-cost drugs.

>>

On the inpatient side, it is a different reimbursement that could get them. >>

The analysis says two hospitals, Medicaid pays about $.58 on one dollar. Partial pays about $1.54 11 dollar. The supplemental fees, it brings us from about $.58 to about $.72, then the next what you have referenced, that happens to align with about [Indiscernible] when you think about commercial reimbursement and they pay higher costs, that would be standard in the industry.

>> [Indiscernible] in the state we have roughly 49% of cost being covered by employers about 6.5% on Medicare and the rest are public payers. >> Concerning Medicare, for high-cost drugs, they pay a cost +6%. The more they raise the price of the drug, the provider get 6% more at a higher price. >> I was wondering,

there is a disconnect if the private insurance is paying for this and Medicaid fails to, the provider will have to make the determination which exit a two class patient and it makes it a problem for the access to care. Presently [Indiscernible] they may be sent out of state to another organization that reimburses them 100% and that terrifies me because of the fact that they are traveling, there is more cost, it

seems like there should be some way we can work things out so it is equal across all sources. >> Hello. I want to clarify one thing, we authorize out-of-state services for both children and adults when the service is not available in the state of Colorado. We negotiate those prices in a similar way, it is in our rule, in many ways what we are authorizing in this rule, is not dissimilar from the ways in which we negotiate single case agreements with hospitals or other providers outside of the state. There is philosophical alignment in what we are asking for this rule and the way we approach the negotiations with other providers outside of the state.

Thank you. I appreciate the clarification.

Any other questions? Conversations?
Any other public testimony?

Okay.
We need to do a motion. >> Thank you. What we are dealing with here is the lack of movement on the federal level and the state level as well. We want to catch up with the science We want to catch up with the of these drugs. It will only get worse.

It is really untenable. I will support this today. I imagining a hypothetical scenario, -- I am imagining a hypothetical scenario, if we can save one child's life that would ruin the entire budget, we could not do that. Where is the line?

That is what we need to avoid.

We need to govern in a more holistic way the importance of what you just said, if we say costs, the importance of what you just said, to hold our partners accountable to bring the leadership to have dialogue in the absence of leadership, and to lead from the state perspective, the state has a collaborative nature unlike any other.
I appreciate your collaboration. I appreciate your leadership.

I will close with our mission, access, quality and sound financial stewardship, this is being put to the test. We have to work together. >>
Anyone else? Comments?
>> Where is this getting authorized? [Indiscernible]

How do we know who is hearing the case? Is there a broad discussion? Who is the expert who hears this case? I am concerned about the liability and what that looks like for the department.
>> This is Kevin Martin. We do not have any of our pharmacy partners at the table but I know the process. Our chief nursing officer, our clinical manager, and one of the pharmacists are reviewing this and the FDA puts out very specific guidelines around what the drug can be used for.

Just reviewing the actual case and the information it is receiving and comparing that to the FDA approval, is the process. >> There is ongoing work . There is much more complexity and there are multiple conversations going on back and forth. >> How sustainable is this?

[Captioners transitioning]

We are really wanting to treat these patients. It's about a $4 million in cost per year. So you can see we had to be very careful as well. Talking about sustainability. Certainly do not want to do that. The cost Children's Hospital that much and we have very efficacious is the way we cover benefit all children. Ethical decision and I know the University is working together well school of medicine, to come up with ethical guidelines as to how this should be done.

There's roughly 7 that are all specialty drugs. When we use the word sustainable. Reason we are looking at temporary negotiations is because we are trying to get a framework knowing that we got the next 18 months ahead of us and what it looks like. We do not have a Kenai have to have fluid conversation in the federal and local level. And the disparity between commercial and public payers. These are issues of concerned areas.

This is Kristi. The way these children [Indiscernible] Knowing that their treatment. I think of the doctors and think a doctor can go into commercial tell have a full toolbelt and not look back. And that weighs on me. I think the conversation has been robust and been positive information sharing. I think it's huge with the handout.

I think my direction focused to the department. What you perceive at this this role is approved getting back to no longer an emergency draft.

The rest of the process here. Correct me if I'm wrong. The emergency rule is valid for the next 120 days. That means we need to present a final rule no later than the October MSB.

This is Chris. It should be four months.

Yes but we need to present the official role in October so it can receive its initial hearing and the final hearing in November.

Nope. This is Chris, the process is, there is the emergency adoption and then you go over to final. You don't go initial and then final. We go to the procedures that we will do public notice, then you will come for the final adoption of the emergency rule.

Depends on changes. The rules are so completely different than we might want to start over. >> So follow question is. If the rule is approved today. The kids who are out there waiting today. Will have access to this?

Starting tomorrow. Then we would have the authority to begin negotiations starting tomorrow. Us with the rule gives us the ability to pay different. Gives us the ability to purchase a different methodology starting tomorrow.

We also do need to get federal authority for this. So we have our public notice that goes out today. That's also the date of the tribal we can submit 30 days later and we are talking with them in the interim. So hopefully we can expect that process of getting approval.

But we submit them September 9. They will have 90 days to access formal information, or to approve it. But we are working hard to reduce that timeline as much as possible to get federal approval sometime in early September. Will

Based on that federally painful timeline we could hear the rule again with decision from CMS. This is Kristi. With the emergency of this rule. Will those children get that service if they are appropriate for that service? >> As federal authorities can be applied retroactively. I think that the impetus is on us to have conversations about what's being proposed. I would say that I've spoken with the central and regional offices multiple times. We have had conversations explicitly about this. They themselves have proposed this solution so I believe there is a strong support from CMS and I think it will expedite it.

So There are other states in our region that have been authorized to CMS?

Is ashamed. I'm not sure within a region but certainly within the nation. I know that Washington has a policy different in other phases as well. They were approved in June. For almost identical processes but it was only for both to. >> Robert?

Yes, I want to think Kevin and the CFO and CEO and whomever else in the department side who tackled this egregious problem. Will we are all concerned about the health of these children. I know the department is working very hard with them into be able to come up with some plausible solutions so that providers are not held responsible for the entire cost. So thank you for all your work. >> With that I entertain a motion. For the correction whoever reads this motion,
the other thing is I would like to disclose to the court that I am an employee of Colorado hospital UC health. I do not have financial gain from this conversation.

So we have one closure.

Now I entertain a motion with that.

The emergency adoption for payment methodology for outpatient hospitals incorporating the statement basis and purpose in specific statutory contained in record. I second that.

We have a motion 2 seconds. So all in favor.

Opposed.

Estate. Thank you gentlemen that passes. Thanks for your time and dedication we appreciate it. We will watch as this continues. Thank you. We will do the closing motion and then do open forum.

We talked about that and individually [Indiscernible - Multiple Speakers] second, all in favor [Indiscernible - Background noise]

Do we have anybody signed up for testimony is there anybody who wants to say something? Let's move on to department updates. >>

Thank you, I will keep update brief. I think the conversation we just had is exactly the kind of conversation. We appreciate your having this with us. The other conversation we had is how we can do better support to align our physical services that are provided to the state Medicaid program. My date is mostly as it relates to the launching of the accountable care collaborative and it's second iteration which is no longer bifurcation of those administration entities but the bridging of those into single regional accountable entities, the program you've been briefed on for the last 2 years. I won't go over it but don't recall the goals were aligned to bring in and share in the administration for health services for medical relief to try some new innovative payment policies which you heard referred to earlier to increase access and acuity to begin to better address and bridge between community health services and traditional delivery systems. We successfully procure those entities. They passed all of their readiness review and on July 1 we were pleased to begin operating under this structure. The major areas that we are continuing to work through, mostly are around attribution of members to primary care providers. One thing that you need to put in place when doing an accountable entity is telling them the population for whom they are accountable. That individuals need to know who are the primary care and healthcare providers who are available to them to provide services should they need health advice. So the attribution has been the biggest area. Some of that related to systems work. A few things did not flow through the system correctly and others related to our attempt to try different approaches to attribution. In the past people were attributed based on geography. We know in places where you live on a county border or border of array, that made no sense. So we used an attribution methodology oriented towards where people had received care. So the update on that is that we've got 1.2 million people enrolled in the accountable care collaborative. We had to reenroll everybody so it was a bit of a list people were attributed based on those claims. 24% stays on proximity. We did find that computers are only as smart as the human to organize and manage them. We had a few things that we proximity. On a computers mind that made a lot of sense. But when you look at MAC or a map that has mountains and rivers. So what that proximity was laughable. So we are working on how do we fix the knowledge of the system to say that it seems that would be a possible thing. So those are some things we are working on. And individuals have the individual opportunity to change we've had 4% providers that enroll with us in their system are done by business name. They often operate in community by a much friendlier name. So they are with us you know John Smith MD. In the community they are Sunnyside pediatrics. So patients call and say you know I want to see Sunnyside pediatrics and then we say we've got nobody by that name. So our enrollment broker has to build quick knowledge of what we are building off of that's what we are working through. The other attribution is, identifying the systems related issues. There is a series of attributions that relate to patient dividers. We have some providers saying that the patient's be attributed to us and our claim history shows that's been claimed more recently. That stuff we have done with the first collaborative care. Of the like when we launched the claims system. What's broken

what stuff we just need to figure out because healthcare is messy. So we are working through that. We do have statistics on the number of issues and the numbers of the enclosed. Kim has brought a lot of focus on making sure that the plane payment system and those working through the attribution are working on that. The other thing we've been tracking is the number of people who are billing us on the new six visit billing. What tried to do was have seven behavioral health codes we are allowing to be built and that primary care fee-for-service side. And hoping that a mom you might be experiencing pregnancy related depression or child is struggling, you know pediatrician could bring health resources to bear for that patient but not have to go to the behavioral health program. We've tracked the number of people who bill us for those as well as generally tracking behavioral health claims that are being processed. This process required everyone to sign new contracts and build new networks and all those things you would anticipate. We are tracking those and as of now we've had 240 of those short-term behavioral health visited that's where we are with ACC phase 2 launch. Are there any questions?

I heard feedback of some of the reimbursement be lower under the new rate. Is that common or just the person I've talked to.

For behavioral.

That's a part of what we are working through. So when we We do that at a per member per month or per year rate. But actually defined and found. Working with behavioral health networks and determine what that payment policy is going to be. We are aware that some people have been questioning the payment rate for some of those services. So we are monitoring that closely. That's allowable and part of the process. One thing we're hoping, and I think that we heard in response to this that we were going to integrate physical and behavioral health. That there would be more places for people to get services and that might not be as narrow as it was in the past. So I think some of that is the network we are tracking overall. That's our responsibility. We are having behavioral health people who are trying to broaden the network or change the payment to bring more value to behavioral health services. That's the most. Refer that as well in a few places we've had some significant we intervened. >>

So what advice to give them?

Contact Ray and they can also fill out a form to submit things that are not going well. That's one thing we learned in the launching of the new claims system is that when concerns are launched into 19 different places it's hard to keep track of them all. So we created a different portal where it can be put together. That's on the west side pics to make any other questions

Thank you very much. We are now going to go into the rural previews. We do this so that we have a headset. Are asking Jennifer . >> I'm here on behalf of Jennifer to provide reviews. This proposed rule change to remove an incorrect document reference. Currently the rule refers to the user reference guide when transferring the case to another county.

As well as processing and eligibility determination the user reference guide no longer used by the department and the deletion of the obsolete reference as needed to comply with an audit finding. Currently it's already indicated that documents received in relation to eligibility determination must thoroughly review within 10 working days. Other training documents and processing guidances are now in place and eligibility has cases reviewed . For those applications for redetermination and other changes. If the rule is not updated the department remains out of compliance. The deletion of the language will not change how eligibility is determined or who would be determined eligible. Additionally there is no cost to the department as the update only removes language that references obsolete documents. That's all I have. Do you have any questions. >> Thank you to the auditors for being so thorough.

Are seeing no questions. Thank you all very much and we look forward to seeing you are Jennifer.

Russell. >> Russell Zigler.

Welcome and share what you're bringing.

Good morning Madam President and board members. I am the compliance for the department. Bringing the rule next month September 2 community clinics, community clinics with emergency centers. Facilities that are licensed by the Colorado Department of Public health environment. This rule creates new provider types so we can roll those facilities into Medicaid. It's short and sweet. If you have questions let me know when we can follow up next week. >> Essentially these are all hospital facilities. The facility the purpose of this rule is to create a new provider. I think that this is a separate issue.

This is a super confusing piece of regulatory and payment. So what we've been trying how do we make sure if there's a provider type recognized we've been careful to work closing the regulatory framework that focuses on health, welfare, safety, and those type of things. We are trying to figure out payment policy by at a minimum getting these aligned. Those that are just sitting up there at the pop-up store. We are trying to get all the regulations of how they enroll with us and tell their life lines.

It sounds like this is more narrow than what I was talking about.

Richards the expert.

Good morning president and members of the board. On the policy specialist with the department. The non-affiliated entities that have a license, it would only be able to enroll as a physician office.

In urgent cares if they enroll with us as a physician's office they are not independently licensed under some framework. We pay them as a physician's officer so there's no differentiation revisited and urgent care. Because there's really no distinction in the state regulatory licensure. So we are trying to make sure our payment policy aligns the

way providing health, welfare, and safety. Any other questions or concerns?

We look forward to reading that.

With that. Chris will give us some direction about travel for the next month and then we will adjourn this meeting.

This meeting is adjourned. Thank you very much. >> [Event concluded]