COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
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Persons with Developmental Disabilities (DD) Waiver
Supported Living Services (SLS) Waiver
Third Renewal Meeting Closed Captioning
Meeting Date: September 20, 2018

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Please stand by for realtime captions.
>>Audio check.
>> Good morning, everyone. This is Dennis from the department. We will get started with the third of three meetings to discuss the renewal of the persons with developmental disabilities waiver also known as the DD waiver as the -- and also the SLS waiver. We will be discussing four different appendices of the waiver application and these are going to be a dependencies G letter HI, J. To get started as a reminder the department's mission is to improve health care access and out comes for the people that we serve and demonstrating sound stewardship of financial resources. As I said at the first two meetings, for this particular stakeholder engagement, we are talking about the waiver applications, this really boils down to making sure that we are keeping compliance with our federal partners so we don't risk any type of matching funds or disallowance is from our federal partners.

>> Quickly, because this is the third meeting. I will skim through our opening sections a bit. For today specifically, I think all four of these appendices are incredibly technical. We have to go into a lot of the details and the weeds. I will try to walk a very thin line before having a high level lower -- overview as well as helping everyone understand what the concepts are in the appendices. For that reason, please try to hold any questions or comments until the break. All of our phones are unmuted for the moment so if you want to ask a question you can over the phone. But I do wait until -- asked that you wait until a break. Additionally, if you're just accessing the of the webinar, you can ask questions in the chat, and we will respond to those during the breaks. As a reminder, and I have set it before, if you have any questions about the actual stakeholder engagement process, the prior meeting that has already occurred or anything about the actual stakeholder engagement process, you can send an email and and if you have any type of formal comment on the waiver application themselves as we are going through this renewal process, if you want to recommend say a change to

a waiver or change a language or something else you can send that to ltss.publiccomment@state.co.us. We will take any email sent there and log them into our formal listening log and then respond.

>> Our purpose of all of the meetings that have occurred now is really to inform stakeholders, both consumers of these waiver services, advocates, providers, everyone that is involved in the functioning of a HCBS waiver about what the application is and how that waiver application meets the requirements that the centers for Medicare and Medicaid services have issued. We try to explain the content of these waiver applications as much as possible. As well as provide examples of how certain language in certain parts of the applications illustrate how the waiver works. As a reminder, for anyone that has dissipated in the prior meeting, this waiver renewal does occur outside of some other different policy efforts that are going on and many of you may be involved in the waiver implementation counsel that is looking to restructure specifically the DD and SLS waivers and I do they notion -- know they are doing some works on the CS waiver. It is independent of this waiver renewal. When that implementation counsel receives any type of statutory or legislative authority to move forward with any changes, the language that is developed in that process will then be passed along to myself or Julie masters who was in the room here with me and she works with me and many of you know Sarah Hurley who is Julie and my boss and between the three of us we handle all of our federal actions around any of those waivers. So if the waiver implementation counsel receives authority for doing some type of change, they will pass it on to us and then we will do that within the waiver applications themselves.

>> There are some other efforts here that I know are going on related to the waivers. I will use this as an opportunity to plug the fact that right now the two waivers that we are discussing this morning are out for public comment period. And that public comment period began back in September 1 and continues through September 30. This particular waiver amendment that we are accepting feedback on right now is to implement what we are referring to broadly is just transition services, a set of four different new waiver services that will be put into these waivers to aid when individuals are transitioning out of an institution and back into the community. These services came from the community -- Colorado community choice transitions program and that was a pilot program for the last few years and has now received full funding from the legislature to continue as a full waiver services. So those amendments are out for public comment right now. If any stakeholders have any feedback on those amendments, please submit them to the ltss.publiccomment@state.co.us inbox.

>> This is a slide that I had for the last meeting that appeared two weeks ago. It was an explanation based on some feedback that we had received regarding what is the nature of the waiver application and its renewal versus what is any type of rule changes that get Ron or statutory changes as well as at the federal level, federal rules and statutes. What is really complicated but really important to understand about the

functioning of a HCBS waiver is that it takes all five of those areas are all five of those policy sources to impact what is actually being delivered to the member who is receiving those waiver services. So you can see here that I tried to put up this then diagram to show that the waiver application, and that light bluish circle this is supposed to demonstrate that the waiver application is the bridge between our federal requirements, both federal statute as well as the federal rule and our state-level statue and rule that we will be -- what we frequently find that there is some discrepancies and nuances to weigh these policies in Iraq and we try to iron out those variances through the waiver application.

>> This next section I will skim through quickly. As a reminder to everybody that these are HCBS waivers . The HCBS waivers -- of the waiver is the authority that the federal government has given to state governments to implement Medicaid programs outside of the plan benefits and these programs are intended to target very specific populations and provide those populations with specific services that allow the individual receiving them to remain in the community as compared to an institution.

>> Real quick. We are hearing some feedback over the lines. I am asking people who are participating on the telephone to please nude your phone line in your room there so everyone else does not have the conversations occurring.

>> The slide I have up right now is a timeline -- is a point we are hoping will be the timeline for the waiver renewals as well as these -- at a very minimum, I guess. Let me answer it that way. We had some discussions since our prior meetings of possibly adjusting this timeline a bit. So want to encourage everyone to recognize this is a tentative timeline but this is what we are hoping to do as a department. CMS has a requirement that all waiver actions he submitted a minimum of 90 days in advance of their effective dates. For renewals, ask for 180 days. What we're doing here with this timeline is to try and split the difference a little bit and submit these waiver renewals at about the 120 day mark and there has been some movement in the last few weeks to accelerate this timeline a little bit. As a department, we will be very open and transparent about any adjustments to this timeline moving forward. So that the official public comment period, those 30 days that we have been currently been publicizing to 128 to February 28, if we adjust that at all we will be sending out communications to let everybody know.

>> With the timeline and what this is doing, are they just running parallel and you guys are doing your piece and when that comes they will submit a new application?

>> So where the WIC is right now in their policy effort, we are kind of in a crunch that we don't have any type of statutory authority yet for many of their efforts and what their proposals are but we very much under a deadline that these three and actually for waivers to expire on June 30 next year. So since we don't have any statutory authority

yet to implement that, what is more than likely going to happen is that we will submit these renewals as they are right now as programmed and there will be some changes and it won't be a complete copy and paste of the complete program into the new one that we will submit them and receive approval of these and you'll -- renewals and then have future waiver amendments and/or future other waiver actions that would implement the priorities of the WIC once the statutory authority is received. Specs of the WIC doesn't have to wait another five years.

>> Not necessarily. We run amendments as an example for the elderly, blind and disabled waiver, it was just renewed this past year as well for a July 1 effective date. Since its renewal it is also a public comment now for its second amendment already within its first year of operations so, no, you don't have to wait five years and what is important to understand about that process is that when a state submits a waiver amendment within the five-year cycle, the negotiation and the back-and-forth between the department and the state and CMS is just on the focus of that particular waiver amendment so if I can you see tutee is an example what they will be focusing on our conversations for approval of that waiver amendment and just on those services and making sure we are compliant with federal requirements around that. At the renewal time, CMS can ask questions about anything in the entire waiver application, appendix a Mac through K neck. And we do get questions about every single active section within that waiver application. Does that make sense?

>> Yes. Were there any other questions online?

>> Not Safar.

>> Okay. Today we will be talking about four different appendices. This is our guess chunk of appendices as far as that there are four of them. The previous meetings we have only discussed three at a time. These four dependencies -- appendixes are short some along and some of them are dense with technical details and we will try to keep moving through it as much as possible but if there are any questions feel free to interrupt me and we will talk through that.

>> So the first is G, which is participant safeguards peer as a state we really explain to our federal partners how we monitor the delivery of services to ensure that the individuals, their health and welfare is protected and we monitor any type of situation that occurs for those waiver participants and also I will take a moment to announce that we do have a subject matter expert here in the room with us on safeguards, and Andrea Binky is here so we do have any questions about those, I may ask her to chime in.

>> So it has four different sections and one is our response to critical events or incidents, the other is safeguards concerning restraints and restrictive interventions and

meta-can -- medication management and administration that we tell our federal partners how we oversee our areas. As a reminder from previous meetings, department of health care policy and financing is a department that operates our waivers picks at the end of the day we maintain oversight of each of these areas but we often use some type of delegated authority to handle the day-to-day operations of each of these areas.

>> Within appendix G of the DD and SLS waivers we put together this slide is a visual of how the reporting of critical incidents occurs and it doesn't always happen exactly this way and the source of critical incident and I think Andrea will chime in and say they can come from different places but as a rule of thumb or systems are set up so that the flow of critical incidents goes this way. By that I mean a provider will be serving a waiver participant and either observe or learn about critical incident occurring for the participant and they will then report that incident up to the community center board who then will place it into a system that has been reported to the department and sometimes the service providers may not necessarily be the first ones to find out about a critical incident and it could be something that an individual's family member observes or find out about and they reported direct the to the CCB case manager. There are little nuances and additionally sometimes the nature of critical incidents can go out -- outside of service delivery. There could be some type of law enforcement involvement or potentially Adult Protective Services involvement that could occur outside the service provider and that would be another route that would go directly to the community center board. But as a rule of thumb we set up our systems to occur this way and it gets initiated or observed by the service provider.

>> So what is considered a critical incident? Within appendix G, we define those as being any of these different bullets that are up here. People probably frequently hear the acronym abuse neglect and exploitation when discussing critical interest -- incidents because it is one of the more volatile and unfortunate scenarios but it is worth noting that there are these other categories. Obviously, any time a waiver participant passes away whether that be unexpected or expected death, that does get reported as a critical incident as well as these other categories related to the individual's property or even just injury and illness to the individual and the other areas here. These are all considered to be critical incidents that must be reported to the department as soon as they are determined or found out about.

>> I want to take a second to dive into these a little bit more to explain ANE and why does not necessarily why but some of the background of abuse and neglect and exploitation from a HCBS perspective. Just about a month ago, a few of us from the department were in Baltimore, Maryland, for their home community-based services conference, where critical incidents is a very big topic, especially around abuse and neglect and exploitation on a national level right now and this is as a result of multiple federal level audits that have occurred over the past five years. There was an office of the Inspector General audit, as well as an attorney general's audit around critical

incidents within the HCBS population. As a result of that audit, and I won't go into all of the details of the findings other than to say that those audits were pretty concerning. But as a result of those audits, our federal partners have really put a lot of emphasis on two states, Colorado being one of them but also many other states under critical incident system and making sure there is both the reporting of critical incidents as well as follow-up and potentially prevention of critical incidents moving forward. So again, I just bring that up here because I think appendix G, especially around critical incidents is an area we can see a lot of movement in the future of potential system changes in reporting requirements because I think with case managers and I think there are some here and online, you know that we as a department put out a few different trainings in the past in the last year or so we put out a training around critical incident and really tried to explain our processes around critical incident. I would also just say that is an area that could also see some for the change in the future as we continue to adjust and connect all of the various systems that are out there that have critical incidents and them in one way shape or form to get them connected so we can monitor.

>> A question?

>> In the slide you showed where the flow goes, just wondering [Indiscernible-low volume] sometime within the five years of the next renewal. Do you envision that it would still funnel up through the CCB so it will have to be submitted to a case manager and [Indiscernible] and then submit to the state? Is that kind of somewhere else?

>> I think from a strictly business operation perspective, I think that is 100% accurate. And I don't know that is all that different from what it is now other than we do have service providers and CCB being the same entity . Even in an ideal scenario today, you would hope that any community center board that is delivering services through a contractor some type of contractor provider and if a critical incident occurs it should go from that arm of the CCB delivering the service to the case manager so up to the state eventually. I think that conflict free case management interact with critical incidents specifically will be along the lines of any type of strengthening of those systems to ensure that -- I may need you to help me out with an example, Andrea. If there is any incident that happened as a service provider location and let's say that that incident unfortunately and let's use a worst-case scenario. Some type of Adult Protective Services involvement to make sure that the service provider is working with them around critical incident to make sure that that case manager finds out about it and I think that is one of the biggest challenges here with in Colorado as well nationwide is that sometimes the case managers don't find out about those scenarios or situations so that with the appropriate channels reported. I think that happens both ways. There are sometimes within a Medicaid long-term care services that may be a is our channels appropriately but maybe it gets to Andrea's desk at some point in time and Andrea says you know what maybe we should have had Adult Protective Services involved here. Or if it was a child we should've had child protective services involved and what I think the

biggest change on critical incidents that is coming is looking at integrating those systems so that way the EPS and CPS, even some of public health and environment so all of their systems are integrated so that we are on the same page around those critical incidents that are occurring. Does that help? Back I guess what I was trying to figure out is if we are adding another layer because you have individual case management. It just looks like if we are trying to streamline it and get it more -- more information shared faster and globally and you are adding in another layer of case management, [Indiscernible-low volume] the newer slowing it down in some way.

>> I don't see it that way. Andrea, I don't know if you want to --

>> No. I actually think [Indiscernible] shouldn't be changing at all regardless of any of the different types of case management. It would still be -- in this way I think communities are awarded being used interchangeably with [Indiscernible] because the CMA's are actually the people or the agency that submits reports directly to the state so that is what I was trying to get it.

>> Your CCB would actually be the CMA.

>> So it might be that but you are not adding another layer.

>> Yes. Correct. So I think that is a great question because it is not another layer. It is just basically an interchangeable thing at this point because of case management agencies being part of CCB it should not all at another layer. It should be pretty much the same.

>> You will address the critical incident [Indiscernible-low volume] when that is being so that everyone is having the same baseline?

>> That is the goal and that is what we are all working toward in the department, especially if conflict free case management is being implemented over the next five years or four years and we are working toward that and really hoping toward streamlining that and keeping it consistent regardless of CCB single entry point. I love that Andrea here has changed her to case management agencies as well because I think that will be part of the overall culture change within our long-term care services here in Colorado, getting away from saying [Indiscernible] or CCB and going for case management agency.

>> This APS is going to cooperate with the [Indiscernible-low volume]?

>> Do they need to legally cooperate? Depending on the case there would possibly be joint investigations, because of Adult Protective Services and child welfare or child services are investigating authorities they have no obligation at all to share any

information with any case management agency or anything. So it would be similar to like law enforcement. A policeman would then share details of an investigation. So EPS -- they are not legally bound to share anything but to make sure members safety. A lot of times there is a joint investigation. When that happens, EPS and law enforcement would take the lead but a service agency or case management agency would work on that members services support and then within their own agencies there is something with the situation that maybe we could've done systematically, but there is not legally anything that would tell CPS they would have to do an investigation with the CCB . I think that is the question you are asking. But they would be the lead authority. They would be asking you as a case management agency how and sometimes service providers they asked to assist with some of those -- the investigation. Does that answer your question?

>> Yes.

>> Okay.

>> To add on, I think the response for how complicated critical incidents are because in addition to having all of this investigative authority, you can understand the need for confidentiality around investigations like that. On the Medicaid side we have a lot of HIPAA health information priorities and protecting those at times and I think Andrey would agree with me that there are times when those are both I don't know if they are in conflict of one another but complicated to one another and we are trying to work through that from various angles. Were there any questions online?

>> No questions online.

>> With an appendix G, we have a section where we as a state need to explain how any waiver participants are trained and educated around any type of critical incidents, specifically abuse, neglect, and exploitation arete -- as well as mistreatment. What the rules of the various people and individuals lives are for helping to protect those individuals. So as an example, if there is any type of family caregiver that has a legal responsibility, they then are given training on how to report critical incidents, both through their case management agency and what the role of their case manager is. We explain all of that in one section of appendix G. There are also notations in there for circumstances like within the SLS waiver, if an individual is consumer directed attendant services, their authorized representative has a role and you can see here that we do explain that and that training has to be done both initially when an individual comes onto a waiver as well as annually thereafter. And typically that training and information is delivered as a part of this whole planning process.

>> So we have alluded to this a little bit, but the responsibility for the review and response of any type of critical incident within the waiver falls down to community

center boards are program approved service agencies and they required to identify and report all critical incidents and I will use this as an opportunity to go to the detail so everybody knows exactly how this works. When that critical incident is reported to the long-term care case management at the CCB or even this is still true within our formerly known as L TSS waivers the single entry point waivers that once a case manager finds out about a critical incident, they are required to fill out a form within the benefits utilization system or the bus as it is known and putting that incident into the bus does two things. It documents the case manager was aware of that incident and what that nature of that incident was and it is also notification to the department that the critical incident occurred. So there are time frames that the case manager has to follow up regarding any outstanding questions of that critical incident. Andrea, as well as another one of our colleagues at the department, review all of the incidents and determine whether there is -- what type of follow-up may need to a core does occur or not. All of those business processes for completing that follow-up are all documented within the BUS and the communication goes from Andrea and Michael is the other gentleman's name to the case manager of what that follow-up should be.

>> It is important to note and we do explain with appendix G, what the roles and responsibility czar but this is another circumstance were ultimately the department is the ultimate responsible entity for the oversight of all critical incidents and within those waivers the use of restraints is pretty well documented and a little bit more robust than what we have had in some of our other waivers, specifically because the DD waiver has residential rehabilitation and it has caused us to really document these policies and what the statute around these areas, what it really did dates to us and then us explained to our federal partners. As it says here, as a state we do allow the use of restraints at times in an emergency, specifically to prevent injury to the individual or others, but those restraints can only occur when alternative measures have been tried and failed, and again to protect the participant. You can see there that an individual, in an emergency, it is defined as any type of serious, probable, or imminent threat or bodily harm to the self or others. In those circumstances they -- the provider would be allowed to use a restraint. Again, the department maintains the ultimate responsibility over the use of restraints and setting a policy around restraints. We have designated to providers that they are allowed to use it.

>> Similar but still different than restraints is the use of restrictive interventions. These restrictive interventions are commonly referred to like situations where an individual may be isolated to protect themselves or others and very similar to restraints, it can be used but it has to be as a last resort or not even last resort, but as long as -- less restrictive interventions have to have failed first before any type of restrictive intervention could be used so we document that an appendix G. And I may have misspoke a little bit. I said isolation. I want to be clear on that. Within our statute, we have completely prohibited the use of complete seclusion. I believe the way this works, and Andrea, please chime in, but the way this works is that individuals, we can have

restrictive interventions to prevent them from being a danger to others but we can't completely isolate them in a seclusion room. I think an example would be a restrictive intervention would be telling may be an individual that in order to keep your friend safe you need it stay on the side of the room but you can't lock that individual up in another room in order to prevent them from hurting themselves or others.

>> Seclusion and any sort of prone position is completely not allowed so if you were to [Indiscernible] assembly is locked in a room and unable to get out of their own [Indiscernible-low volume] it is completely not allowable but any sort of place where a person to be in a prone position I believe that is [Indiscernible-low volume]. Allowed in the waivers.

>> And so the last section that I wanted to mention that we have dictated our policies and procedures for medication management and administration to individuals on the waivers and many people are aware specifically within the IDD community there are many different prescriptions and different medications that these waiver participants utilize and failure to utilize them appropriately can sometimes cause very dangerous situations. So we do have different policies that are outlined here for was responsible for administering and monitoring that medication as well as what should happen if there is any type of medication error found to have occurred. So it is that last section with an appendix G.

>> At the end of this appendix we do have a quality improvement section where we have to demonstrate that we have designed an effective system for making sure that health and where far -- welfare. We have some performance measures designed to ensure that that system is adequately occurring in these performance measures go through -- where the state is demonstrating is that we are monitoring and tracking from a data perspective the rate of critical incidents occurring and how we are responding to those incidents and as an example, we have one performance measure that a number of critical incidents were substantiated and addressed appropriately versus just the number of total critical incidents. So we -- when we see some type of substantiated abuse, neglect, or exploitation occurring, we are following the correct follow-up and making sure that that is not occurring again and there is also performance measures around making sure that when a death has occurred is that if there is any type of abuse neglect or exploitation involved in that that we have follow-up in this is getting into us making sure that we are tracking all of the numbers and demonstrating to CMS that we are tracking all of those numbers to make sure that critical incidents are followed up on. I will pause there to see if there are any questions about appendix G

>> We will dive into appendix H. It is a good transition into appendix H because it is the shortest of the different appendices in a waiver application and it is where the state we demonstrate the different systems that are involved in monitoring all of those performance measures that we talked about in the other dependencies and also where

we document any type of future changes that we are planning to improve that overall quality system. As you can see here we included this slide to demonstrate that all -- although it is interwoven for all of these other five dependencies in each of these other five dependencies have different performance measures at the end of them where we are actually showing CMS what we do from a data perspective as well as measuring the quality of our programs and measuring the operations of our programs.

>> Within that appendix H what really have -- the biggest four systems that I think a stakeholder should be aware of around are quality improvement systems is the interaction between our various I.T. systems. Most notably, mentioned already was the benefits utilization system, BUS. Our Medicaid and Medicare information system or the M MIS currently any providers just know that the inner change is the technical name of the system and the DX he is operating but the official name of our billing system that we explain to CMS is the Medicaid and Medicare information system, or the M MIS. We also document here the role of the Colorado benefits management system or the CBM us and that is a system -- CBM S. That includes age CBS programs as well as the Aspen system that monitors providers licensure and any type of occurrences that have been reported to providers. What we are trying to get to and what the opening part of more the appendix G was talking about is we are trying to interact -- not interact but trying to weave between each other all of those various systems which are very large systems to get to a point where they're all talking to each other enough that we can make sure that all critical incidents, and even the other quality components of a HCBS waiver are being aggregated in one spot and we don't have different silos of data here in data there and it gets very complicated. We are trying to work through that. I am not saying that we are close to actually having that dream realized, but here in appendix H we document what we have currently as well as what we are working towards.

>> Any questions on that?

>> The next section is financial accountability. Similar to what I said before with appendix G, I will point it out to people on the phone that I have a subject matter here. Pat Nelson is here and he will help me out with any technical questions around how rates are determined. So appendix I is about accountability, demonstrating that the state maintains control over how a claim is Dylan paid into make sure those services paid for were followed up on. A lot of different sections to this appendix. It is unique among our waiver applications and that it has a lot of sections here, but in Colorado, we really only use the first three sections. Four through seven we don't really use those various sections a whole lot. So the predominant volume of information within appendix 20 does I -- I is between one and three.

>> Along those lines, number one is very demonstrate our financial integrity. This is where we demonstrate that all claims for HCBS services are funneled through the M MIS system and we explain how providers are required to submit their billing in that

way so that way it gets funneled through there as well as how we conduct what are called post-payment reviews of those claims to ensure that if we have a state paid for a certain delivered service that we do follow-up to make sure that service is actually delivered and we are not just taking the providers 100% word for it. The provider has maintained adequate documentation that they delivered to the service for that waiver participant on a particular date and time that they said they were doing their billing. So providers are probably really familiar with those payment reviews. We are actually in the process of getting new vendors set up for conducting post-payment reviews right now and announcements will be coming out more formalized for that in the coming weeks I believe is the plan. We have conducted post payment reviews in the past and providers have been very cordial and cooperating on writing that date and allowance.

>> It is also worth noting that in this appendix we also document how the department handles any reports of waste, fraud, and abuse. And we have a investigative unit in the department that conduct both those desk reviews anytime we receive a report of any type of Medicaid fraud and they are required to do a desk review in certain circumstances and also going into the medical records or an on-site review to determine the validity of that claim.

>> Continuing with that, all of our services in Colorado are reimbursed on a fee for service basis and within the SLS waiver we do document here in appendix I further detail of how that is scored, that skill and how it interacts with their service rate. It's really more of a documentation. An individual who receives a level III on that scale it gives the right allocation of services they can use within a year and we document within appendix I how that fee-for-service payment to providers interacts with that particular limitation that the individual has.

>> So within appendix I you have a quality improvement section at the end. This is -- I will back up for a second. So in the first part of this appendix, we really demonstrate and I believe it is number two, it is where we demonstrate how rates are determined. We have a very specific rate methodology that is within appendix I 2 that is been a discussion point between the department and CMS in recent years and by that I mean the last 4 to 5 years whereas a department we have really strengthened and it is really to the thanks of Scott and his unit and is it Rick's unit or division.

>> My team is the rates operation section within the payment form division and our division includes [Indiscernible] outside of the context of those waivers but the HCBS waiver rates [Indiscernible-low volume].

>> Okay. My point was Scott's team has worked a lot in the last three or four years, specifically to work out the language within this section of how our rates are determined to walk a very in line of how rates work within Colorado and within the federal requirements of how our rate methodologies have to be documented and is an

example of this I would point out that I think many providers and case managers would be well aware that HCBS rates have got a lot of targeted rate increases as well as across-the-board rate increases during recent legislative sessions and I believe in the last three years we have received at least an across-the-board rate increase for those services and there's also been some very focused targeted rate increases I think in the last three years. What we have done as a state here within appendix I , we really have designed some rate methodology language that is in the appendix that allows us to have the flexibility that when the General. assembly approves some type of rate increase, we are very easily able to implement that within our waiver application now. That did not used to be the case when I first came on board with the apartment -- department. If the legislature gave the department authority to increase rates, our methodologies were else is often out of alignment with what the General. assembly had directed us to do. So we had to have a much longer conversation with CMS about how we were implementing those rate increases. Now thanks to the work of Scott's team, it is relatively simple to the point I would point out that we are talking about the DD/SLS waivers today. But earlier this year the General. assembly approved a large increase for the alternative care facility rate within the EBD and CMH us waivers and we were able to implement that rate increase for an October 1 deadline which was really a quick turnaround considering this Bill had just passed at the end of April and first part of May. We were able to turn that around. I don't know if we can do that every time but it is worth noting that we do have a methodology here that gives us that flexibility to where if we have to we can do that type of policy change.

>> So within this appendix we have a long series of performance measures to really demonstrate to CMS how our financial integrity is monitored and these are what you would consider to be relatively -- at least what I would consider to be relatively simple performance measures. It is things like if the number of waiver claims under particular waiver and what our numerator numerator would be would be the number of known claims paid appropriately, that they -- the providers are reimbursed at a rate that our waiver says. We do have some performance measures to make sure that all waiver claims are getting prior authorized first so that would be the waiver claims for example that we are prior authorized and divided by the total number of waiver claims overall and it should always be 100% because waiver claims are always required to be prior authorized and a number of different performance measures that demonstrate our financial integrity. Any questions about appendix I?

>> And this is a I group today. These are also very technical sections. Some of them I think are boring and I won't say that because that would be saying that my job is boring and I don't find it that way at all.

>> Our last appendix is the discussion of appendix J. This is the demonstration of cost neutrality. I will ask everyone to bear with me on this section because there are a few concepts within the section that are incredibly detailed and complicated to both explain

as well as understand. I will do my best to dive into it and hopefully explain it to everyone. I will do it in a way that is not completely boring.

>> So we will talk about some different concepts first. In order to demonstrate our cost neutrality, but I will start there. What cost neutrality is within that waiver is the state demonstrating that it is cost effective or at least cost neutral for an individual to remain in the community under this waiver program as compared to being in the institution that they were deemed to be at risk of. So for the DD/SLS waiver it is the states demonstration that it is cost effective for an individual to be in a community as compared to be placed into intermediate care facilities for individuals with intellectual and developmental disabilities . We have to prove it is cost effective for that individual to be in the community. The first concept and demonstrating all of that is what we call our unduplicated count. This is just sickly the number of individuals that will receive a waiver service within the particular waiver year. And I point this out here because when we demonstrate cost neutrality, we do it on the aggregate ASIS. It is across the entire waiver population. We don't restrict that individual A can't be in a waiver because it is not cost-effective for him or her to be on a waiver as compared individual B. What we are saying is that a and B total expenditures are cost-effective compared to both of those individuals having been in an institution. We have to monitor our unduplicated account because it ties into some of the other numbers that I want to explain in a second. The other factor that is out there is our average length of stay. As a state we have to demonstrate to CMS that we are monitoring the length of time that an individual is receiving those services over the course of a year. But we don't use that in the actual technical calculation of cost neutrality. We have to demonstrate that we are monitoring.

>> This is a tough part. Feel free to interrupt me or ask any questions if you have them as I am explaining this. There are four different factors that are used in the formula for calculating cost neutrality. The first is factor D. This is the average per capita total expenditure of waiver services. So the way the math works on this is we take all of the total expenditures for all waiver services so for DD/SLS . DD to do residential [Indiscernible] and various employment services that we haven't behavioral services and it is adding up all of those total expenditures and dividing it by our duplicated account or the number of people on there for the year and that is where we get factor D. Factor D prime is our estimate of what the annual per capita cost for all of our services would be. So it is all of the physical therapy and all of the speech therapy and all of the durable medical equipment costs and all the state planning cost that this population would use or that we estimate this population would use that is factored into prime. We do divide that by the number of persons on the waiver so we have a way of getting down to a per capita level. That is the prime. I will show in a little bit that is the left half of the cost neutrality equation and the right half of the cost new -- neutrality equation is factors G and G prime. And they are similar to D but these are our cost of what they would be of the waiver didn't exist. So factor G would be what people would

commonly called a per diem for an individual to be either in a hospital nursing facility, or intermediate care facility. That would be all of those per diem costs divided by the number of individuals and that is per capita for the prime so dividing by the number that would be the state plan costs so these would -- they would be those services that would be outside of the institution. It would be any type of maybe pharmacy cost that the individual would be occurring outside of the per diem rate of the institution. That is G prime. So we do all of this math or each of those four factors. In order to ultimately answer this particular equation there. D plus D prime has to be less than or equal to G plus G prime .

>> If I understand it you have almost a year to Bill now be on the 120 days [Indiscernible-low volume] so are you doing this really in arrears like a year or two later?

>> It's a great question. Bear with me for a second because I have to explain it overall. So for here within the context of this renewal process, what I was going to explain on the next flight is that I can't show you what we are going to have for our cost neutrality and renewals because we have not done all of those calculations yet. What we will be doing is doing projections for those five years and we have to do it for each waiver your but all five years we have to do it for. We will do projections to really say to CMS that we expect the waiver to be cost neutral. We have to be cost neutral because you have to -- at the end of the day we are doing projections. In addition to those projections in the waiver application, CMS requires us to annually submit reports that are called 372's and you may have heard of them before but those 372 reports have to be submitted six months after the end of a waiver. So now because we no longer have the CWA waiver it is easier for me to explain that all of our waivers are on fiscal year cycle. So the way it ended up happening is that the fiscal year ends on June 30 and by December 31, we have to submit our 372's to CMS and we actually do lag reports of that. So I am feeling the urge to grab a marker and draw it. But when we submit the December 31 report we are submitting for 18 months prior. So that when we are making sure that all claims that when out occurred and if there are any discrepancies or adjudication that had to occur for a particular claim we had 18 months to resolve that and that is we report than our actual to the centers -- to CMS to compare our actuals to what we projected and the other way around. How did I do explaining that because there are a lot of details?

>> I got you.

>> Any questions online? Those of you that are participating on the phone, you are being remarkably quiet today.

>> Okay. So in an effort to try to further demonstrate what we actually have in our waiver application as far as cost neutrality goes, the numbers that are up on the screen right now are the four factors -- this is for the DD waiver and for the current fiscal year

we are in today. This is waiver year five and current DD application so what we have projected to CMS is that the per capita expenditure of waiver services is that $68,000 on that is the total of the waiver expenditures per person across the DD waiver, and we expect them to spend about $10,000 with the state plan -- let me rephrase that. We expect them to have about $10,000 worth of state plan costs associated with their care. The other side of it is that if we were operating for all of these individuals on the DD waiver, we would expect there costs for being in that institution, there per diem costs over the course of a year would be about $272,000 with an additional $68,000 worth of state planned costs. So we are very cost effective on the DD waiver and it ends up being that [Indiscernible] about $280,000 cost effective on a per capita basis and I did my math there right. Similarly here is the SLS waiver factors and you will note that factor D for SLS is significantly lower and that is due to SLS not having the residential rehabilitation services and that is the biggest difference in the variance but otherwise they are relatively simple -- similar and we went through these much faster than I thought it would today and I will take any other questions that we have about these four dependencies and the stakeholder process and any questions that anyone has. We can take those now.

>> I was wondering [Indiscernible-low volume] and how that has been beneficial?

>> Do you mean since just implemented where we have enough time to do any type of analysis within the SLS waiver? Is that what you mean? I personally don't know if there are any plans for that that would fall into our participant direction. I will take the question back to the department. I don't know that the implementation will affect our cost neutrality protection has of the timing you're talking about but I will say that I think about a year from now we will probably be looking at it again because there will be subsequent waiver amendments even after these are renewed when the WIC is moving forward with some of the other policy efforts. I think it future amendments we will look at that impact on cost neutrality at the time of these waiver amendments, I don't expect having that. Does that answer your question?

>> Okay. No questions online?

>> No questions online PICK

>> [Indiscernible] the replacement tool you're talking about is there a quick [Indiscernible] you can potentially and it's obviously not [Indiscernible-low volume] but 10 or 15 level because they want smaller jumps between levels. With that have significant impact -- how would you project that? Do you know what I mean?

>> That will be a product of future contract with an actuary and consulting firm so we can project those costs and potential impact on our participants. So we won't have an

answer for you on that -- I can't talk timeline but we are working on that [Indiscernible-low volume] now. Does that answer your question?

>> It was just out of curiosity. Thank you.

>> I will say that -- one of my priorities, as I said before, as we go through these meetings has been to explain what is in the waiver applications in case when we start one of our public comment period, to say here is the full waiver application and please review it and provide feedback and you open it up and it is 250 pages long and people are wondering how do I digest all of it. When the situations come up, I have tried to explain exactly where those are and for your question, where that would really impact the waiver applications that right now for the amendments that are out for public notice if you go into the appendix J of those, you will see appendix J of DD/SLS is longer than some of her other waiver applications because we do some of our cost neutrality according to the success level summary predict how many people are going to be at each SIS level for each service. So as an example for the DD waiver, we have group residential supports and services and we put GRS in their level I and level II and level III, etc., and then we project our number of utilizer's on each level and what the rate will be on each level and the number of units to get our total expenditures and all of that is split up in the waiver applications which is a long way to say that if the SIS is redeveloped or bigger or smaller, I don't know enough about that work to know what it will be but we will adjust our waiver application according to the outcome and what that vendor determines. That is a lot of information.

>> I am stalling because I am giving you 50 minutes back.

>> If the WIC is there one thing and they have changes and then the SIS tool people [Indiscernible] is that a different amendment or eventually will kind of be -- will it all go through is one amendment?

>> I honestly don't know enough of the timelines to be able to comment on that specifically. What I would say and maybe I will just throw it out there is a hypothetical. We have some very pols -- big policy efforts moving through the state right now on very different timelines. We have the new long-term-care assessment that the department has been working on with stakeholders for the last two years and we hope to have a pilot coming out. When that long-term-care assessment is implemented that will impact all 10 of our waivers and that will have to be one amendment process down the road, potentially within a renewal and depending on what our final implementation for that will be and I believe that will be in 2021. We also have conflict free case management out there that we still have some loose ends but we are working diligently on and we are hoping to get that implemented sometime by 2022 with the potential that it may be earlier or slightly later. I am explaining using those is an example because it could be that when we get to 2021 or even 2020 we can look at that with

the final dates and try to time any type of waiver application to make them in conjunction with one another to minimize the number of public comment periods and the interactions and that because just going through the renewal process or the amendment process, although we have gotten pretty good at it as a department, there is still a cost associated with doing that but as much is possible we try to have them have it in conjunction with one another. We try to make it happen. Does that help?

>> Yes. And you have mail of these things that may contradict or cause problems and how do you manage your resources.

>> It gets complicated. There have been interactions in the past that the department learn from and I would go more backed over to the LTS site on certain changes happened to CDAS especially went from 1 to 3 vendors and we had three vendors and two different delivery options even within their and we did all of that and there was some policy change that caused other waiver amendments and we do our best and I think it is one of the reasons why we had as a department we reorganize the office of community living about a year ago now to set up a system where it is just Julie Sarah and I that are coordinating waiver actions and all the policy specialists from other parts of the department come to us to try to get those different efforts on a similar timeline. Because in addition, just implementation of these different policy experts -- let me rephrase. The detail is that we always have to be conscious of rules, statute, and our waiver applications been as close in alignment to each other as possible. We have to keep those timelines as well and that is why we try to work so [Indiscernible-low volume].

>> If there are no questions, I will let everyone go early. That is great news for everyone. If you do have any questions, because this is our last meeting for this renewal for DD/SLS, if you have any formal questions or comments on the waiver applications, please submit them to ltss.publiccomment@state.co.us . As I said, any e-mails sent to that email address will get added to the listening logs for these renewals and the -- we are then required to post them publicly as well as provide it to our federal partners to explain what our stakeholder engagement was surrounding specifically these renewals here but also any type of waiver actions and if you do need to contact myself or Julie specifically here is our contact information. I will point out one thing. We have been busy with in our unit over the last month since we initiated these meetings. What we do have a plan to do is to take the meeting, the captions from each of these meetings that have occurred so far, including any questions that we have received from stakeholders during these meetings and get them put together into consistent documents and post them to the website. We have a stakeholder engagement webpage on our site. We will get all of the slides and all of the closed captions from these meetings as well as potentially the audio from these meetings and now that they are wrapped up we will get them posted for stakeholder reference if there any questions or if you remember something or you said let's see what he said back then, we will have it

posted there hopefully in the next week or so and we have just been really busy with these meetings as well as some other efforts here lately. So we will get that up here. Okay?

>> Thank you to those who participated online. We look forward to hearing from you in the future and seeing the next meeting. Otherwise, have a great day, everyone.

>> [Event concluded]