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
Second Renewal Meeting Closed Captioning
Meeting Date: September 06, 2018

Disclaimer: Below is the closed captioning dialogue captured during the second DD/SLS Renewal meeting held on September 06, 2018. The spelling, names, and language may not accurately represent what was presented but rather what the Caption Colorado staff member heard through audio. Should you have further questions or comments please email HCBSwaivers@state.co.us.

Please stand by for realtime captions.
>>We are going to get started with a meeting in a few minutes and we will allow more people to come here in person if they would like and going to the room and we will get started at 10:05.

>> We will get started hearing about two or three minutes am I want to make sure that everybody has gotten signed and the webinar. While we are waiting. If you are working in your office right now, could you please mute your phone? We are getting some feedback that way. I want to have that taken care of and that gives us a double check to make every should -- sure everyone can hear me right now and all of our audio is going to the webinar right. If you do have any issues with the audio as you're listening to me talk right now, let us know via the chat line on the webinar and we can adjust accordingly. Thank you.

>> Greetings, once again, everyone. This is Dennis from they department of financing. We will get started with our meeting for this morning and thank you very much for those of you on the phone that are joining us. What our purpose is today, to make sure you are in the correct meeting is to discuss the renewal and we have one of three meetings to discuss the renewal of the persons with development disabilities waiver as well of the supporting living services waiver.

>> As we do typically to get started we will go over the mission which is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial services. Throughout all of these renewal meetings our focus will be on the compliance of our particular programs to make sure that all of our waivers are operating within the confines of rules and regulations of our federal partners and we are not risking any type of federal match disallowance. And a few

notes for housekeeping. We are predominantly attended today via the webinar. Suffer everyone's reference, we do have the lines open right now to where if somebody is on the line, and you want to ask a question, you can do that through your phone line right now. I would ask that you please wait for breaks in the presentation. Some of the materials that we will be discussing today are rather dense. I will try my best to cover all the nuances of those different components. And these different sections. Please wait until breaking points before asking questions. You can do that through the phone line but also ask through the chat box. Just as a quick introduction for everyone. Once again, my name is Dennis Roy and I am the federal policy liaison and in the room with me on my team I have Julie Masters and Sarah Hurley who work within compliance and administration and they will be answering and relaying to me any questions that we do have in the chat box. We also have other department employees who are experts in different areas of waiver operations and services. We will call on them as we need to today to discuss this -- the various aspects of the waivers. More housekeeping. As a reminder, this is meeting number 2 of 3 throughout the renewal of the IDD waivers. In the morning session we will be discussing the DD and SLS and this afternoon we will do the CES waiver and in two weeks we will have a similar day were we will discuss the last dependencies -- dependencies of the waiver application and that will be two weeks from today and I have the dates and details of all of that through the end of this presentation. Additionally, we have a view -- through the webinar right now and to the departments website, and outline that will assist in the understanding of the various parts of the waiver application and it is an outline that goes through dependencies letter a through J with all of the different subparts so that way it will be easier to reference and any stakeholders can use that to help in any type of public comment they want to submit. Potentially as a reference for asking any type of questions. For those of you in the room, there is a hardcopy.

>> So some quick groundrules. I have already touched on this briefly. I do -- we hold off question is in comments until the break in today's presentation even more so and for those of you that attended two weeks ago today is more regimented in the fact that appendix D and E and F cover specific parts of the waivers operation and we get to the end of those dependencies -- dependencies -- appendices. We will monitor the questions on the chat. Will answer questions that way or we do have the line open so if you have questions you can answer that way. As a note for this entire renewal stakeholder engagement process what we tried to do is set up ways for stakeholders to provide input into two different categories in the first is if anybody has any questions or concerns about these meetings or the way they are set up you can email hcbswaivers@state.co.us as general questions that way. If you do have a formal comment or suggestion regarding our waivers we asked that you submitted via the link. It is an email address we use every time we have a waiver that is out for public comment and it is ltss.publiccomment@state.co.us. Right now we just started a public comment period on Saturday for the waivers and amendments we are going to be requesting and that they be effective on January 1. We will talk about that later in more

detail. I pointed out that that same email address will be used to collect public feedback on this entire renewal process. If you have any questions or see some type of language changed in a waiver or any type of comments on the waiver application and the way it is written, submitted via that email address. So our purpose of these three meetings or these three days worth of meetings that we have been holding is primarily to inform all stakeholders of the waiver renewal process and to provide some insight in -- and more knowledge and background on what are the centers for Medicare and Medicaid services or CMS and what they require inside the application and we will explain the content of our current waiver application, and then specifically, as much as we can with in our time restrictions explain how those applications then illustrate how the programs operate. We do frequently throughout this process and we learn to learn this a lot for the meeting a few weeks ago. We can go into some details but other parts of the waiver applications there is just too much information there to dive in all the way. We will do our best based on the way the conversations are going. But the average waiver application is about 180 pages long. We only have about six hours worth of meetings for each of the different population groups so it is hard to get through all 180 pages in the six hours. We will do our best though. A few slides to set some boundaries and awareness for everyone.

>> This renewal of these waivers that we are doing right now is completely independent of some other efforts that are going on throughout the department and I want to highlight a few of these just to help us in our conversation and explanation of these. So the waiver implementation counsel, many stakeholders participating today maybe also are on that counsel. And that effort is independent of these renewals. A few slides I will explain the timeline we are on and that implementation counsel is on a different timeline. What will happen is some of those efforts of that counsel and what they're working on, once they receive full statutory authority to do those they will relay that onto Sarah and Julie and I is the administration team to implement those changes into the waiver application. I have another slide that I added in probate here that will talk about the different authorities of waivers in more detail, but do know that a lot of the efforts of the implementation counsel are dependent on receiving statutory and budgetary authority from the Colorado General. assembly.

>> But I think everyone is aware of, I do want to highlight specifically in today's meeting, is in regard to conflict free case management. I know that many stakeholders have been involved in the implementation of CFCM and making sure we meet the federal guidelines for what that is. I do have to say that we will talk through many of those aspects today and we will talk through how we as a state are trying to comply with the federal policies around CFCM. But at the same time, I have to say there is legislative bills that are related to that and there are different parts of conflict free case management that are outside the scope of this renewal process. We will try and talk through that later but I want to point that out. We can get feedback and have a

discussion but I can't necessarily make any particular changes right now because of the other moving parts.

>> Any questions about those other efforts? Including anyone on the phone? Continuing the conversation about scope. Again, there are some things that we can change throughout the regional process. We can correct any type of grammatical or technical changes within the waiver application that anyone identifies. As a department, the department staff is going through all of the subject matter experts that are related to the various parts of the waiver application and they go through these to look for any type of grammatical changes or any type of updating language. Two weeks ago it was pointed out that we had some outdated language for referring to people in the target population and that we will change that as part of the renewal process or how we refer to people and we can certainly change things like that. But there are other things we can't change that would have any type of secondary effect. We can't change any type of existing contracts. A lot of operations have a waiver and they depend on third-party vendors and they have gone through the procurement process in order to go into a contract with a vendor and the renewal process cannot change those contracts. Additionally, the renewal process does not change budgetary allocations. Those come from the general assembly and we can't change that just through the renewal process. Continuing with that, this is the slide I added for people who participated a few weeks ago and I thought it was my fancy way of explaining how complicated it is to operate a waiver. Really, what it boils down to, in order for a waiver program to exist, there has to be authorization from five different sources of authority. We have two that are on the federal side, and I'm starting at federal statute at the bottom. Cat Congress and ask laws that let states modify their Medicaid programs and the setters centers for services will then enact rules that will further clarify whatever that federal law is. At the state level, our general assembly will issue a statute saying the Department of Healthcare Policy and Financing is directed to go do this, so we as a department and staff members go do it and then we refine things via state rules. Kind of in the middle of those two sides is the actual waiver application and to me, as am trying to demonstrate here, that is the intersection of those five different points, what our members and what either people who are advocates or providers or have other contacts with the people who are accessing the services, that Centerpoint of those five areas is there. I want to put that out there because there are always efforts to say we needed changes about the program are due this about the program and their are sometimes we can take Windows to change it within a waiver application and sometimes we can take efforts to change it within state rules or state statutes. At the end of the day then we'll have to adhere to whatever our federal partners say. I hope that helps explain this a little bit more. As an overview for HCBS I went over this before but I will skim through these little bit today but I want to remind everybody of what the homing community-based services are and how they interact with Medicaid. So HCBS is a component of Medicaid that Medicaid as a whole is a portion is given authority through a part of the Social Security act were states are allowed to elect whether they operated Medicaid program.

All 50 states operated Medicaid program. Within that Social Security act there is a clause that is called 1915 C of that act and that is the authority for state to operate a waiver. What the authority does is allows the state to waive other parts of the Social Security act in order to operate a program that is focused on a targeted group of individuals and serves them with specific services so that way those individuals can avoid being placed into an institution. There are a lot of details about that waiver authority and Mykacet I did go into this in more detail last -- two weeks ago at the last meeting and we can talk about this now if you want to but for the second time I will skim this just a little bit.

>> So the waiver application process so that everyone is aware is that when a state wants to implement a waiver program there has to be an initial waiver application that goes to CMS and that application would be approved for a three-year period and for those of you that may be aware of this, it was just a few years ago that the spinal cord injury went through this and it was approved for three years and at the end the states are allowed to request a renewal for up to five years and then waivers are put onto a five-year cycle after that in this particular year here in Colorado, for 2019, we are seeing that four of our waivers are up for renewal and I -- are at the end of their five-year cycle and those waivers at the bottom in a typical year we may be discussing the CHRP waiver in the process but there was some legislation passed during the last session that required us as a department to do a separate stakeholder process for that waiver but everybody should be aware that this will be on that same renewal cycle. Again, those for waivers, they are set to expire on June 30 next year and is a part of that renewal process, we will have to update all of our waiver applications for any of those technical and grammatical things I talked about earlier as well as responses to the evidentiary reports that the department submits after the third year of each waiver cycle and any other guidance that has come out. We are required to submit a waiver application no more than 90 days in advance of the effective date for renewals. CMS 180 days. For everyone's reference we will try to split the difference on this particular renewal process with CMS and try to keep it around 120 days. Our current timeline as it stands, like today, is that we will have a public comment period for these waiver renewals from the end of January of next year through the end of February. We hope to then turn around and submit those renewals to CMS right around 1 March. That way we can have 1 March until July 1 with CMS to discuss any changes that they request and a little bit of a negotiation process back and forth there to go into the weeds of our waiver applications but we do need those to go into effect on July 1, otherwise, we will be risking our federal match because those waivers would not be approved anymore.

>> I will stop there to take any questions anyone has on the phone or in the chat. Or in the room as well.

>> We can make some changes to this waiver application, but because of the conflict free case management issue, we can't make major changes. If that was not holding over our head, we could make bigger changes, correct?

>> For my references, can someone who is accessing the webinar make sure they heard her question so that way if I need to repeat questions moving forward? But to try to answer the question, it will complicate it and it goes to that vignette I had up there earlier in a perfect world CMS would like us to rewrite our waiver applications to be exactly in line with what the federal requirements are and federal rules. They would want us to do that. In a perfect world our state legislature would want us to do exactly in conflict free management that makes sure they would always reimburse us for the services that we are doing. The reality is they have to go somewhere in between and that is why for conflict free case management we are on a timeline to be compliant with that for 2022. With all of the federal requirements because we have a lot of moving parts that we have to get into alignment before now and then. How did I do there with answering that question?

>> That is part of the reason [Indiscernible].

>> Part of it. And I will rephrase this and be more explicit. We can't change it all the way in our waiver application right now to meet the federal requirements because that is something that is not the weight our programs are operating. So if we put it in there now and we have some type of federal audit that came in and said in your waiver application you say you are doing this but we have documentation that you are actually doing this or that. And then that could risk our federal match right there. So it is better that the waiver application be used as a middle ground before a federal requirement and what is actually occurring in the states. This is to talk about the transitions of the programs. Does that help?

>> Did I make that more confusing?

>> I guess you can't change the conflict for case management issue within the waiver application. But say we wanted to add a completely new service to the SLS because we in the community said, this is really a whole and people are missing and they need this particular thing. I have been hearing is that we can't do that until 2022. Is that incorrect? That is incorrect.

>> This is Sarah. So we would need to -- we don't have to wait until 2022 to add a service. We do have to make sure we have the appropriate funds and all of that. It is not contingent on [Indiscernible-low volume] that you can't do that. We can start a brand-new waiver until we are in complete compliance. We have to make sure that people are aware of why we can't. Unless we are in complete compliance with all of the

federal requirements we would have to use the existing waiver application to make those changes.

>> I think is a practical example of that. For everyone's knowledge, I will use it for the public comment period that we did all three of the waivers that I will be talking about today across the two meetings and they went out for public comment on Saturday and the primary purpose of these waiver amendments is to add the for new services related to the transition of community choice transitions, those services, into being explicit waiver services. Hopefully after these waiver amendments are approved by CMS those will now just to be waiver services as compared to them being pilot programs that were operated under federal grant dollars for [Indiscernible-low volume]. Does that help X

>> Yes.

>> I would like to also add, we can't make changes [Indiscernible-low volume] and that is not accurate. We do several amendments throughout the year. If there are some [Indiscernible] meeting with certain groups and saying the service is desperately needed here and we need to add this. It doesn't have to wait for a waiver [Indiscernible] time.

>> Okay. That is very helpful.

>> It is a practical example of that so doing a PSA will have another public comment period that will be starting next week on September 15 to add services to the CMA chests BISD I waivers to add those services into those. And those waivers obviously are not up for renewal right now. So they were just renewed.

>> So if you wanted to get rid of a waiver service you could do that as well? Expect that is little bit -- not TRICARE. But if we decided I'm not having a waiver service because maybe you don't have a provider we have to also do a transition plan and how they are using that service. So you can't just take it away and say we are done with that. You actually have to show CMS this is how we [Indiscernible] people throughout the process.

>> Any more questions on the chat box? So we are going to be discussing the appendixes. It will be D which other participants that are planning and service delivery. Commonly referred to as our support and service planning section. What it identifies is that -- I won't read off my slides. But it really is to define the process for setting up an individual support planners service plan, whichever phrase you are using and the way I like to explain to people about appendix D is that for you who participated a few weeks ago B defines what are popular this population for a particular program is. It defines what services are available to the population and utter D is the explanation of how the population then it's to those services and it is the bridge before that.

>> We are getting some feedback. Can I ask anyone on the phone commute. We heard some things shuffling around on the desk for a second. The phone line will remain open but if you can mute your phone so not everyone participating will hear that. These are the primary sections of the appendix and we have that handout available and it is also posted to the website and that goes into the subsection of all of these three-part and it is a complicated appendix and it has probably the most subsections of any of the different appendices and that was the overview of everything that is there in the two primary parts and I think I want everyone to be aware of is it explains how the original service plan was developed and written in the second part is how that written document then implemented and monitored moving forward. One of the first things that comes up it demonstrates who is spitting -- completing that support plan and what the qualifications of that support plan are. We have this on the slide and I want to add a flag to that slide but this is the qualifications for case managers as we currently have out and those amendments of for comment right now. These are not the approved case management qualifications but these are what we have proposed to CMS to have her qualifications be in order to meet some of the requirements of the conflict free case management as well as to clarify our operations. We have been using these qualifications for a long time that this formalizes a little bit more within our waiver applications and I will also point out that these qualifications are the same qualifications -- let me rephrase. Default are in appendix D to demonstrate what an individual has to have in order to complete the support planning process for any waiver participants. It is the same exact allocations that are outlined in B of the waiver application for anyone who's completing the initial evaluation or the reevaluation for an individual towards waiver eligibility. So we are going to have the same qualifications for complete ineligibility processes as he will have for support planning processes.

>> There is a question from Mary. This is Julie. Is there going to be a type of certification for case managers? Expect Heather or Victor?

>> This is Heather. We have been exploring that with our stakeholders and as a department we have been looking into options of certification. There is no official decision on what that looks like right now.

>> There is another question. If an individual wants to get PAS a certification are the required to meet the case manager qualifications. Expect [Indiscernible-low volume]

>> Case management and service provision are completely separate and it would only apply to the case managers [Indiscernible] that Dennis is talking about.

>> For your reference, if anyone was interested in getting that certification or reviewing what the detail is of that within a waiver application, all of that information and that narrative is a -- obtained in C Mac where we talk about the specific services and providers for each of the services so a PASA is a particular provider type that we

have within the IDD related waivers and that certification is a provider type certification that again would be in appendix C a not related to these that are in Appendix D. Good questions.

>> So the next section of Appendix D is the discussion of the service plan development safeguards how we have those safeguards built into our process to ensure that an individual is provided with the appropriate services that are available in their area and to make sure that the participants health and welfare is protected throughout the support planning process. So within the DD and SLS waivers we are talking about today, there are three components that are really explicit and they are defined as being administered by our community centered boards within these three waivers. So within these three waivers that we are discussing in this process right now, they are all operated by the community centered boards asking is the case management agencies and they are delegated to the support intensity scale assessment and that service plan must be placed into the BUS. And they have to assist with the selection. From my perspective from administering the waiver, I think our case managers, most waiver participants are most concerned with the third component here of finding service providers and I think that is one of the more technical parts of the case managers job because they both have to find the services the individual wants as well as and having knowledge of what type of providers are available within a particular waiver participants geographic area and be able to serve them. The next part.

>> The participant, they are obligated contractually and we put in the waiver application that is included in the contract that the participant is informed of potential services and those other supports that might be available as other resources in the area. And we explain what the exact service processes and the what and when and where of the support planning process or service planning process. I made a note to myself as I was reviewing the slides and I wanted everybody to be aware that this is one of those sections that is already impacted by the final rule adopted by CMS in 2014 and a part of that rule is there is conflict free case management Elton there and there were settings that were built into that last part. And the person centered planning part of that final rule, that was required to go into effect immediately back on March 17 of 2014 and as a result, over the past two years, every time we have had one of these waivers out for an amendment or renewal, this is one of the areas that we really had to change some of the language to really explain specifically the what and when parts and then we have had a lot of conversations with CMS about the where as well in sharing that are case managers are holding these support plan meetings at a time and place convenient to that person receiving the service.

>> Again, as I said earlier, they do talk about that risk assessment and mitigation part of the support planning process explaining what the support intensity scale is and who is completing it and this is where we explain to CMS what our case managers responsibilities are to document any type of safety concerns for health and safety

purposes and this is where we talk about the contingency planning that case managers complete and the contingency planning, in my mind it crosses between those safety concerns as well as having a backup plan developed along with the individual for should providers and should things change in need an adjustment made a cow what steps should be taken and having conversations with the participant themselves or the participant, the caregivers for how to adjust if the caregiver becomes ill and is no longer able to provide those services and what would be our next step. So that way if the case manager this is where we put the emergency contacts of the case manager has to be that first responder to a situation they are gathering those phone numbers and that contact information for whatever the next step needs to be. And CMS requires us to document how we as a state make sure that waiver participants maintain an informed choice of providers. This is an ironic slide for me preparing it because it looks so black and white it is easy to have up there. It is a complicated process to ensure that waiver participants are informed of their choice of providers and the current operations around it are to require the case managers present a piece of paper to the waiver participant and have that waiver participants sign off on the fact they were informed of their choices prior. We do have a full section that talks about what our processes for ensuring that at the end of the day support plans are always subject to the approval of the Medicaid agency which in the state of Colorado is the Department of Healthcare Policy and Financing is the single state Medicaid agency. So as a result of that, case managers are required to put this information into the BUS, which is our care in case management system right now and this has to be in there at all times so that way we as single state Medicaid agency can review or audit or provide any guidance on how service plans are developed, how case management monitoring is going, as well as looking at the long-term care assessment from [Indiscernible-low volume].

>> I will pause to see if there are any questions?

>> We have a question online. She says she is a case for the individual and services and family and says that the 100 point to be completed at the day program and not at the home. Can this happen?

>> Thank you for the question. Victor can you respond?

>> [Indiscernible-low volume] the assessment cannot -- the service plan that is set up [Indiscernible-low volume].

>> I will clarify that. I think what you are saying is the assessment itself has to occur in the individual's residence. However, the support planning process can occur at the time and location of the individuals choosing. As a reminder, the assessment and the support planning processes are two separate processes.

>> They can happen together but our standalone processes [Indiscernible-low volume].

>> I hope that answers that question.

>> Anything else on the line, Julie?

>> We now go into the quality improvement section of Appendix D. Two weeks ago and we discussed a BNC, I felt after the meetings were over and I felt like I skimmed over those sections just a little bit and I wanted to slow down today to discuss the portion of appendix D because it goes into more detail of how we measure the support planning process and have some of those assurances are covered and I wanted to talk in more detail about those particular performance measures so what we are required to do is to demonstrate that we designed and implemented a system for reviewing the adequacy of service plans and we have done that through nine different performance measures that are all contained at the end of Appendix D. These measures I think are some of them that mostly impact are waiver participants. I just wanted to run through three out of the nine measures to give every dish everyone a scope as to what we are measuring as a state when we talk about these. The first one are the number of individuals whose service plans address the needs that are identified in the 100 point to assessment. As an example, this particular performance measure, the numerator is the number of service plans that address the needs that identify in that initial evaluation assessment or the reevaluation assessment. So if that assessment identifies that an individual needs a system they should identify what services are being provide that individual with [Indiscernible]. The denominator is the total number of individuals on that waiver. We are measured to make sure we have enough individuals whose support plans are connected to that assessment versus the total number of people. And something like case managers we are consistently working on that to make sure there is that connection there. Another measure I wanted to provide is the number of individuals who service plans address health and safety risks through a contingency plan. This is something where again are denominator here ultimately is the number of individuals receiving waiver services our numerator is the number of individuals who service plan demonstrates a valid contingency plan to protect that individual's health and safety. So as a department we are reviewing those service plans to make sure that is there and the contingency plan has been filled out appropriately and adequately. The last performance measure I wanted to point out is that we have one where we demonstrate to CMS the number of support plans that are revised in order to address the changing needs. This is a circumstance where an individual had a change in their life circumstances, whether that be a change in their medical condition or housing situation or whatever that change in their life is, that it change their needs. We want to make sure their support plan is adjusted in order to account for whatever that changes. So our denominator is actually the number of individuals that had a change in their life that required a change in services and the numerator then is the number of individuals

whose services or changed accordingly. This is really a lot of times were a lot of case management agencies as well as a lot of different parts of the department focus on these particular performance measures at the end of Appendix D to make sure that all of these services are being delivered adequately and to address a person's needs as well as to prevent -- do as much risk mitigation as possible.

>> The question is from Sarah and she is asking who evaluates the validity of the contingency plan.

>> Good question. We are adjusting that right now. We did just hire a vendor that one on board on 1 July to be our quality improvement organization. We designate their duties in appendix A they will be completing what was formerly known as the administrative tool to make sure that case management agencies are completing all of their processes that way and they will largely be doing the desk reviews remotely to make sure that those plans are validated and we also started within the last few years to have a team of staff at the department who are going out to do on-site reviews of case management documentation and a part of that review they are conducting on-site is to look at those contingency plans and make sure they have been completed adequately.

>> Could you go over the first part of what you said we talked about something the number of qualified providers divided by whatever.

>> I am sorry.

>> My name is Mark [Indiscernible] of a child with significant psychiatric needs.

>> Each one of these performance measures in this appendix has nine different ones. In the waiver application we have to designate exactly what our numerator for that performance measure is as well as our denominator. So going back to the first example that I gave that was a number of individuals whose service plans address the needs identified in the 100 point 2 what we designate to them is we do the numerator as being the number of individuals who their support plan or service plan exactly matches the needs that were identified in the 100.2 as compared to the denominator being the total number of waiver participants on the program. So I will use that as an example because it has relatively round numbers. To use this exact same performance measure within that waiver application and it has approximately 100 different waiver participants. So when we report this particular performance measure to CMS, either at the annual 372 report which I can dive in as if we want to or during the evidentiary reports at the end of the year, we literally provide CMS with the calculation of those 100 waiver participants that were that year as the denominator and the numerator would then be the number of participants who support plan addresses the needs that are in the assessment. How did I do there? Is that okay? Any other questions online?

>> Our second appendix for today is going to be participant direction of services and I am happy that we can discuss this is part of this meeting today and I want to call out the fact that we do have subject matter experts to discuss participant direction for Appendix E. For those of you that may not be aware, participant direction is the opportunity for waiver participants to completely control the delivery of their service to them rather than going through an agency based model of care. So what we have to do is if we are granting the authority to waiver participants to direct their care we have to demonstrate to our federal partners what that opportunity is and all of the details of how that is operated. So Appendix E within a -- the application is similar to Appendix D with all of the subsections and it may compete with to -- Appendix D for all the subsections that we get an overview and what the opportunities are.

>> With the two waivers we are discussing this morning, the developmental disabilities waiver does not have any type of participant direction. Everyone of its waiver services are agency based, meaning that all of the particular providers at the agencies for all of those various services, they control the selection of their workforce for who delivers the services to the individual and they control the scheduling of that workforce and they have the full employer authority over that workforce. But with that waiver we have federal approval received it about nine months ago to operate that program within the waiver and we just recently have gone live with all of the system changes to implement CDASS. The rest of our discussion of Appendix E will focus on CDASS within the SLS waiver. So as part of the overview, we demonstrate to CMS that the participants have the ability to recruit, select, discharge, and or fire, whatever term you want to use, train, schedule, and have full authority over that attendant providing them with services as well as at the wages for that attendant. A caveat that does come up and we have to explain to CMS is that participants receiving that service to have to live in their own private residence or with one of their family members. A word of note for myself. For everybody that is aware, because it is a relatively new thing, we designed it here to mimic this within the CMH us and the other previously known as L TSS waivers.

>> Individuals have the right to elect to whether they are going to receive participant direction and I have a background working predominantly in the children's world, quote unquote and I worked on the waiver were we did have participant direction there and it is up to the individual to whether they want to choose to receive participant directed care are just go through traditional agency based care. We demonstrate in our waiver application here and Appendix E they have the choice between the two , and as a bullet says, prior to the participant actually receiving CDASS they have to be informed of all possible choices for agency based care.

>> We also explain within here for those of you that are aware of participant direction, it is possible for an individual to receive directed care through what is called an authorized representative. This should be a circumstance where an individual wants to direct their own care but due to some type of circumstance they have to have an

intermediary or someone to help them in making some of the choices that go along with participant direction and in Appendix E we explain what that authorized representative is as well as what their role is and make sure those requirements are met being an authorized representative.

>> And then I also explain what type of the services are available within the participant directed service within the waiver and I wrote a note here for myself to explain to everyone that within the SLS waiver there are four components to the CDASS program. There is basic homemaker enhanced, health maintenance and personal care. You will sometimes hear of these referred to as the activities within and I want to make sure we know the terms because those are services and our waiver application says they are services but they are really components of a larger waiver service of the waiver application. So a lot of times you will hear people refer to it as the activities. Okay? They are the subcomponents, if you will. Second there is a question online. She says I have been informed by ACC be -- that they will inform individuals and families about CDASS who they believe would be good candidates are they required to inform all individuals and services received the SLS waiver about that option?

>> They should be informing all participants on and SLS waiver. Whether it is a now or after the next CSR or contact that should be a discussion.

>> I am sorry. I am Katie McGuire. I am with the participant direction apartment.

>> Where is the service plan authorization limits described in this waiver application?

>> That is in Appendix C .

>> So you don't have to talk about it here? Of course, it does limit -- it does change her budget under the service plan authorization limit. For participant direction and the ways at other waivers that you mentioned are not impacted.

>> This should not impact the plan for authorization because the reason is this is an option. Example basic homemaker and enhanced homemaker and personal care if they decided to select agency based, that would still already be impacting for support plan authorization limit and what it offers here is a new service or activity which is skilled care and that is outside of this. The impact of the actual [Indiscernible] of increasing the level or service going on it would either be the agencies that was a support need and they would have to work within this to receive it just like participant direction. So, either way, it is still impacting.

>> [Indiscernible] three of the services are within this. And all those other waivers you talked about that had CDASS there is not that in this. So it seems a little bit unfair that the other waivers can get all of that plus state program plus that without affecting their

budget. But in this waiver, unlike us, you can only get so much because of your SIS level and [Indiscernible] level. It doesn't seem zero and uniform to borrow from school district language across our long-term care system.

>> I think the best way to respond to the comment on that is to say that the SPA L stands for that was historical policy that was implemented and technically for the purposes of our conversation today we did define it within Appendix C to refer to all the other waiver services and as we have alluded to cut those other three areas were already specific waiver services and during the implementation of participant direction, in order to keep CDASS and SLS equal to CDASS as much is possible to CDASS and the other waivers, we did do the carve out to where HMA does not count towards that SPAL anymore so I think to restate what Katie said, they can receive these activities or these other services between the two variations of homemaker and a personal care and that those are already counting towards SPAL , but HMA does not do the formation of CDASS.

>> That was pretty good, Dennis.

>> Wasn't HMA always available to SLS as CNA care outside the SPAL?

>> So health maintenance is a service [Indiscernible] option of what would be traditionally skilled care. So that is outside of the service plan authorization limit and it is a different delivery method than the one we are offering.

>> To follow up on the other question, if she would like to submit an [Indiscernible] of that CCB, we will follow up with seven make sure that they are aware that they need to share with every participant the option for customer directed services.

>> Now we move into the technical parts of participant direction within the waiver application. Because of the nature of participant direction, we have to have an intermediary and is that the best way to describe?

>> Financial intermediary.

>> That is the full title you often hear, the financial management services, and I just referred to as the SMS. Currently we have three that have participants have the ability to choose between those three and they have these duties here that they have to perform and I think most profoundly that is how participants are paid and any type of timesheet under the CDASS program go through the FMS so that way that those who Mr. timesheet and that FMS passes the money back to the attendant and then the FMS bills with the department accordingly to whatever those allocations are delivered.

>> Further explaining participant direction a little bit more. The case managers are similar to -- still required to assist the participant with developing their support plan or service plan including the participant direction part and the department does contract with a training vendor to provide CDASS participants with training and help keep uniform knowledge and understanding of what CDASS is because CDASS recipients are not going through an agency the way that they would in a traditional agency based care. And very similar to what we have in our more traditional waiver services that are agency based. We have to outline the way an individual can voluntarily or involuntarily and the receipt of services. So as it says there, voluntarily, a person can choose to terminate their CDASS services if they would like to but they have to just notify their case manager and a case manager would assist them in getting them back to traditional agency based care. If there is involuntary termination of CDASS, I don't know an example of the top of my head but it doesn't require department approval before an individual could be involuntarily removed from the reception of CDASS.

>> I may defer to my two experts in the room on this, but here in Colorado we have a little bit of history with the participant and employer relationship under our CDASS services and relatively recent history there are a few models that participant direction can be implemented in within the states and many of you might be aware that there is a spectrum between traditional agency based participant direction on the left-hand side of that spectrum and on the right-hand side would be full-blown CDASS in here in Colorado in the middle we have in-home support services available in some of her other programs. With in-home support services, the waiver participant still goes through an agency in order to do things like skills validation and have some of our basic health and safety safeguards there, but at the end of the day within IHSS, that waiver participant or their guardian still choose with that participant is and how they schedule that participant and those types of things. With Appendix E, getting back specifically to SLS, what we do is define what that employer authority is because, as I was trying to explain , that agency is still processing the paycheck and doing the skills validation, and they are the employer of record for that IHSS. Within CDASS, the participant is the employer of record. So they have full duties to set the wages as well as do all of the scheduling and training and everything else.

>> Should reexplain in the waiver application, informing the participant of what their budget amount is, because an individual receives an allocation towards their CDASS and how they can then spend that money with their [Indiscernible].

>> I will pause for any questions on Appendix E.

>> [Indiscernible-low volume]

>> The phone is open if people want to ask questions. Please feel free to do so over the phone. Please announce herself and who you are if you do.

>> A question came through. How is the participant informed of their rights if they feel their allocation is an adequate?

>> This is Katie. Once they are going through the worksheet, there should be a mutual discussion between the participant that is interested and also if they have a legal guardian or family member or support system. This should be always, whether it is CDASS or another service, there should be that open discussion. Part of SLS is looking at what services they have and what supports are within their task worksheet, which generates basically how many minutes per task that support needs are being met and the attendant can be reimbursed for. If there is a discrepancy, that discussion needs to occur between the case manager and the participant family again. It should not be a surprise when you are getting this worksheet is that communication is happening.

>> I was going to say. This is Dorothy from developmental pathways. Within the confines of the service plan authorization limit, I think our next recourse would be notice of action.

>> Perfect. That is where I was going as well. The participant always has appeal rights which would be the 803 that would be sent out but they do have that option to submit an appeal.

>> We will go into Appendix F and how we protect those via the waiver application. This is where we explain -- that was a good transition question. This is how we explain to CMS what types of recourse a waiver participant has in the event they disagree with the decision regarding either their eligibility for the services and how they are delivered to individuals. Facts of the technical parts are what is in an -- opportunity to request a hearing, any type of additional dispute process they may want to operate as well as the state level grievance and complaint system. Within Appendix F of our waiver application we use number one specifically reexplain that notice of action process of how case managers, any time that a service is approved or disapproved or decreased at what type of processes happen and what we do here in the state of Colorado is when that is happening, a notice of action, also noticed -- known as a 803 form it is sent to the individual and the notice of action form provides the individual with the timeline if they choose to appeal that decision and what their timeline is and the technical details if they are currently receiving services and they are being stopped or decreased and what their timeline is for continuing those services until such time the appeal has resolved or just what their final date is or where they need to send those appeal documents in order to exercise their appeal rights. All of those notices of action are maintained on the BUS. And case managers read them there and stored there. If an individual and their family does decide to pursue their appeal rights, the office of administrative courts is required to maintain those documents, including the notice of hearing and any other type of master record that was submitted by either party regarding the appeal. We do have an additional dispute resolution process documented within our waivers that this

would be separate from the formal appeal process. I want to make a note here that there is sometimes some confusion around this that individuals or stakeholders will see that we have additional dispute process within our waivers and how do I get to it or do I have to appeal first and within our waiver applications are due explain going through this additional dispute process is not a prerequisite for ever starting a formal appeal. We explain within our waiver application under this additional process that individuals can go to their community center board or their program approved service agency in order to resolve any situations or disagreements there prior to starting the formal appeal process. As I mentioned a few weeks ago at our last meeting. Contractually we do require that the CCB maintain a grievance login respond any grievances they have for med agencies and this is an additional explanation of that that CCB has to maintain that and we would consider that even slog to be the additional grievance dispute resolution process.

>> We also explain [Indiscernible] if an individual has any type of dispute with their program approved service, the agency, we would prefer that that dispute was between the waiver participant and the agency directly, but, if need be, they can always go back to the process as documented in F1.

>> She said I have never seen an 803 when a person is determined not eligible for services. Does a complaint need to be filed to correct this because it is systemic?

>> I am not sure at what point in the process she is referring. But if it is the point of determination, that is not establishing whether or not the person meets the criteria for disability as a written regulation. That would not be an appealable action. The CCB -- completing that determination should provide in writing in some form the out come of that for the individual. If through the assessment process it has been established that they met the criteria but then they don't meet the criteria for [Indiscernible] services, that would be [Indiscernible] a person should receive the opportunity.

>> She actually followed up with having a complaint filed in the log in the written complaints needs to be filed or can it be verbal? Back this is contractually obligated to report all grievances, written, or verbal or otherwise. And then [Indiscernible] the department.

>> Okay. One person just had a question on what is an 803.

>> It is the notice of adverse action that the system generates a letter that goes out to the individual notifying them of their decision being made that they then can appeal if they so choose.

>> To expand on that and to expand on the explanation I give earlier. The 803 is the formal number that the document is titled as. It is officially within our waiver application

a notice of action. On that notice of action form and throughout it, the case managers will put things in there like what that decision was that initiated that notice of action to be sent or whether it was an eligibility determination whether an individual was meeting for instance the 100 point to criteria and if they were determined not to be functionally eligible for a waiver or determined not to be at risk for institutional placement, the case manager would designate that on the form and then designate what type of regulations from the Colorado coder citation is that that decision comes from and provide that type of information as well as then all of the appeal rights and how to exercise those appeal rights, including the timeline and where to send the documents.

>> There was another one. Participants notified or reminded of advocacy resources when an action or dispute is initiated?

>> I am trying to think. I don't think there is a requirement for that to occur.

>> Can that determination be appealed because it can be highly subjective in many years of experience, and is it consistently applied?

>> You could appeal that and you could get a notice of action [Indiscernible-low volume] process but you could potentially --

>> I will rephrase that harassed feel free to chime in on the phone or through the chat and if I don't rephrase your question appropriately. I think for the purposes of appealing that determination because that could fall under the additional dispute process to where either going through the CCB itself or maybe it was subjective.

>> I think it is a great avenue because that leads you all the way through the ranks of the [Indiscernible] and department and we can take a look at that and see if a rule was applied perhaps in some guidance and have some discussion informally about it before it escalated to that.

>> I hope for whoever question that is I hope I rephrased it okay and eventually got to the answer.

>> So far so good.

>> Good.

>> Does risk of jail meet the definition of institutional placement?

>> I will try to answer this I. Within the policy realm we consider jail or prison to be incarceration. The waiver authority does not provide any type of funding mechanisms from the federal level to prevent incarceration. It prevents institutional placement in

places that falls into three different categories, either acute-care hospitals and skilled nursing facilities or intermediate care facilities for individuals with intellectual or developmental disabilities. There are those different levels of care, and incarceration is not included in any of those three levels of care.

>> So within this additional process we do explain to CMS that these actions that are going through their are written with the intent of providing that participant some type of resolution within 15 days in the writing. And any time that some type of dispute is escalated all the way to the department, the department is responsible to review that particular dispute and decision and we monitor that through that agency and we also have an agreement with them to monitor those disputes with the agency as well. Ultimately the department is responsible for doing all the grievances and complaints, whether that be the formal complaint log contractually obligated for them to maintain or anything regarding the agencies through the agreement and all of those rules describing those requirements are documented within the CCR.

>> Those are actually all of my slides. We ended a little earlier than what was anticipated. We will take any outstanding questions or concerns now and it looks as though people are typing in the computer. So I will use this as an opportunity to remind everybody that if you do have any formal feedback on the way our waiver applications are written are structured, and you find a typo in a waiver application that we have missed at this point or potentially outdated language, you can submit those types of feedback to ltss.publiccomment@state.co.us and we actually received a few different comments since our meeting two weeks ago to that inbox that those comments have been logged for the renewals, so they will be included in that when we put those waivers out for formal public comment during the first part of next year and you can continue to submit comments that way as we go through these today as well as the remaining ones here in a few weeks. And I see that the typing has stopped. Are there any questions online.

>> There is actually a good question. Is there a way to make the closed captioning portion available for this webinar?

>> We record our closed captioning portion and we will make that available for individuals who have joined late.

>> I think that is a good segue for us and a disclaimer for something I do want to bring up a few weeks ago. There was a technology error with both of those meeting -- meetings and the one in the afternoon and we do have those closed-captioned and we will be posting them some. My apologies that they have not been posted already. We had a very hectic schedule the past few weeks where Julie and I have only been in the office for three days since that last meeting. We will try to get caught up in the next few days.

>> If there are any other questions, I will remind everybody that our next meeting will be on September 20 and that is two weeks from today. Again, we will follow the same structure of doing that in the morning and the next section will be to discuss appendix G which is health and where fell -- wherefore -- warfare. I is for quality and as well as J which is our cost neutrality demonstration and we will be discussing those here in a few weeks so feel free to join us either in person or via the webinar and we will be at the same location here. If you have any other questions, feel free to use the email address that is here for either Julie or me to contact us. Thank you very much. I will give everyone the gift of about 30 minutes.

>> We are posting the website for people to access the closed captioning and we will do that in the chat box and we will send it out via email.

>> I will probably likely due to that point is send out the email when everything is posted up to the website and when we have that back and up to date from both the meeting two weeks ago as well as today's.

>> Thank you, everyone.

>> [Event concluded]