Please stand by for realtime captions.

Good morning. Happy Friday the 13th. I am going to do rollcall.

Christy Blakely , Cecile Fraley, Patricia Givens, Simon Hambidge . Bregitta Hughes,
Jessica Kuhns, Amanda Moorer, Charolette Lippolis, and Gwen, David Potts, Donna Roberts.

We have core. Quorum .

The next meeting is scheduled to be held Friday August 10, 2018 . Beginning at 9:00 a.m. at three of three E. 17th Ave., Denver Colorado 80203. For those of you who are confused this morning, that is where you are right now. In the 11th floor conference room. It is the policy of this board and department to remind everyone in attendance that this facility is private property. Please do not block the doors or stand around the edges of the room. Please turn off your cell phones. Audio stream, if you lose connection please click again on the link to rejoin the meeting. Identify yourself once begin. There are individual testimonies she in the open forum and for each rule if you need help finding the role there is somebody in the back of the room that can help you. You have a five minute limit. We moved it so it is on the south side of the room now, not the north side. That is important for you listeners. With that, I will encourage and approval of the minutes from the June 8 meeting.

So moved.

Do I hear a second ?

Second.

I have a motion and second. All in favor? Opposed? It passes. Now we are ready for the rules portion . We have three documents on final adoption consent agenda. And normally we would just offer that of four I am motion. I understand Pat Cook would like to say nice things. We always like to hear nice things. Is Pat cook in the room?

Right here. 'S the Mac would you like to come up ?

We are rolling them up. We will make one motion.

I am Pat cook and I am a nurse practitioner retired. For low income seniors and without CICP folks would not get the care they need. They do not have a co-pay . Housing has taken up 60% to 70% of the income and struggling a lot trying to meet their needs. I know that the work I do, without the CICP program I wouldn't be able to get their needs met. People with chronic diseases, diabetic care, that type of thing. I really appreciate that we are holding out for the CICP, moving it forward and serving the needs.

In queue Pat.

I would entertain a motion to do the final adoption of this agenda. We can do it all at once. That would be great.

I move the final adoption of MSB 18-03-01-A, revisions to medical assistance role concerning special connections reimbursement. Document to ,MSB 18-04-04-A revisions to the medical assistance role concerning CICP state administered audits, section 8.902 . D. Document three, MSB 18-04-05-B revision to the medical assistance role concerning family support services loan fund, rescind section 8.613.1 , incorporating statement of basis and specific statutory authority contained in the record.

Second.

I have a motion and second. All in favor? Opposed? Abstained? It passes. Off we go to document 4, MSB 18-05-15-A
Kristina Gould?

Those of you in the audience, you are missing it.

Members of the board my name is Kristina Gould and I am the pharmacy policies restless that the department. I present for final adoption MSP rule -- MSB 18-05-15-A , and just the purpose of the rule change the department 8.590.7. A the incorporation by reference of the federal statute that comprises the administrative procedures act and secondly the reimbursement rate will increase by 1% pursuant to the fiscal year 18/19. Are there any questions at this time? We don't have anybody on the phone . Just checking on that. If we don't have any questions I would entertain a motion. Do we have anybody signed up to testify? Thank you. Are you managing that over there? Thank you very much. I didn't know who is managing those.

Final document , MSB 18-05-15-A revision to the medical assistance role concerning durable medical equipment reimbursement.

Second .

I have a motion and second. Thank you. All in favor? Opposed? Abstained? Yes, good, good, it passes. Thank you. That was hard work. You dressed for success and you got it. Document five , MSB 18-04-05-A Candace Bailey. You also look professional this morning. This is fun. I can't wait to see Kathy, she is up next.

Good morning Mdm. Pres. and members of the board. My name is Candace Bailey and Emily section manager for the community options and benefits section. My section manages all the agency benefits and so I am here today to present to you the children's autism waiver rule, section 8.519. I will give you a little bit of a background as to why we are rescinding these rules and then answer any questions you have. All the way back in 2015 during the legislative session, proposed an expansion to this waiver and it passed through the session, it was very exciting and I'm part of that process we were required to speak seek approval for Medicare and Medicaid services also known as CMS. Our federal partners, to approve any changes to our waiver program. On September

14, 2015, I will forever remember that date, CMS disapproved our request for the expansion to the waiver. And in that disapproval, they stated they were going to require the department to include pediatric behavioral as a -- under early triage screening diagnostic and treatment as we could not limit this benefit to just children under a certain age with a diagnosis of autism. And so as this was the only benefit that was offered to me waiver and program -- federal regulations , it has to be not date plans that service, we were going to move forward with shutting down the waiver after we were able to bring up the benefit under the state plan. Since that time, we have been working to bring up this brand-new benefit and it was in record time that we actually had children start receiving services. The first child darted receiving services in September of that same year. A lot of hard work. We worked tirelessly on this. Once we had the benefit up and running, providers getting paid , [Indiscernible - low volume] we felt confident we could move forward with closing down this waiver . We held many stakeholder meetings about the years and provided documentation to notify them of what is happening to this program and services are now available to not only children with autism but actually all children for behavioral services. We have been a huge ask mansion from 75 children prior to this change to well over 400 children receiving services. This is a really exciting asked tension. In a different manner than what we had originally thought. With that we have submitted our request and seek approval from CMS to actually closed on the waiver . That happened last year. We have notified all families who were wired all the case manager to submit to us individualized transition plan. Every single child on the waiver. About the time when we stopped new enrollments onto the program there were 54 children on the waiver. There was an estimated 39 children that would actually move on to a different form of Medicaid services whether it was waiver or -- services or the buy-in program and about 15 of those that were going to actually be a little bit more in depth work with Kate's management agency on how to access services whether private insurance or how they will do that . A number of different avenues. We received all those transitions in April from the case management agency and the case manager agency -- they have done a wonderful job to stay up to date and make sure children have services as long as they path we can and transition as effectively as possible. As of June 30 , 2018, the waiver shut down. All children were transitioned off of the waiver and this is the last step of that process. I would be happy to answer any questions . Are there any questions

About the

Those kids have a case manager I get the complexity and what services they may be eligible for

We did see a number of cases were children that decided they had utilize services as much is necessary and they stopped paying for services altogether.

But those aren't these 15?

It includes some.

I just wanted to make a comment. I'm a pediatrician and I am just appreciative that we are covering these kids . I think behavioral health in general can be challenging, the funding, and I'm glad to see these kids getting coverage. A lot of challenges in families separate from that.

Any other questions? Do we have testimony? Okay. Maureen Walsh. As a reminder, five-minute limit. And on your testimony. Maureen does not come by herself. She comes with a full-size actual size poster of her son as that is the world she lives in. He is quite cute. Very dapper . Don't you think? With the plaid and striped tie. He looks very American. And you have done something to your arm. I am sorry you.

My name is Maureen Welch. Thank you for allowing me to be today. I live in Arapahoe County and my son James receives behavioral services through the state plan now. I just wanted to thank [Indiscernible] and all the work that has gone into that benefit. However it was because we were in violation. Those services were being denied people that or individuals who needed those services were being denied them because they want eligible to get on the waiver for whatever reason. Although my plan is on the CES waiver having these date plan pick up the behavioral services has been a huge benefit for our family. I used to run out of my family six months I used to run out of my money six months into my plan because I spent all my money on behavioral services for him. Now that those funds have shifted over to the state plan, and has allowed my family to access things like massage therapy, and other therapies that benefit him as well is some respite for our family and community connect which allows provider to take my son into the community and be with typical peers. Things like that that require transportation. I just wanted to thank the board for that but I do also want to raise that the benefit -- for this new benefit and I do see some serious issues with the way that the service is being offered now . I will probably be back another time to talk about that at I did want to express my gratitude and some of my concerns. Right now the benefit is very limited. It applies to behavior analysis. If you read the definition of the benefit it is behavioral therapy which is much more comprehensive and I feel like we are in violation of [Indiscernible] are not offering other alternative therapies . Many people do not respond to ABA. This benefit is no longer limited to artist. We have people who are sexual abuse survivors, PTSD, radical attachment disorder, a lot of the foster care kids that come out of the system. ABA is very traumatic for a lot of those profiles. We really need to look at that benefit and make it more comprehensive. I have opened with the fact that I am a recovering teacher myself. Elementary education and also special education. I know all the -- I am not doing that any more. I receive no money about the CNA money I get for taking care of mice on. I do this all for free but I do know there is a lot of individuals out there that could greatly benefit. But the type of therapy they need is not being offered within behavioral therapy. If I am not being clear feel free to ask questions. I will be back to speak on that another day .

Thank you for your constructive insight into the behavioral health although it doesn't impact the rescinding of this waiver.

However it is a benefit.

However the benefit that the individuals who are moving off of the waiver, they are receiving this news date plan in lieu of the waiver. I do think it actually ties into this tool . As a stakeholder I see it tying in. As a consumer.

Candace ?

I want to clarify the benefit is not limited to just ABA. It is specifically behavioral therapy and what we need to work on is a little bit more clarifying language around that. I want to make sure that it is not limited to just ABA therapy. We can certainly -- there is work to be done .

Absolutely. We will work on that a little bit more.

I have been involved with a lot of that work. For the last several years. And the definition is very broad. However, the community is very tight and stringent in what they perceive as behavioral therapy and the -- I was shut down in silence by the power of the [Indiscernible]. As those are not legitimate therapies. I have been working with Kimberly Smith on getting more articles posted on the listening log so we can have more of a constructive conversation on -- who volunteer their time.

Anybody have questions for Maureen? Okay. Seeing none, thank you so much. Happy birthday James. Thank you so much. I would -- if there -- I don't have anybody else in the room. Then I would entertain a motion for this. For this role.

I will move for the initial approval of this document. Document ,MSB 18-04-05-A revision to the medical assistance concerning children with autism resend.

All in favor? Opposed ? Abstain? So passes. Thank you so much.

Now we have Cassandra Keller who has the next document on long-term services and report , HCBS benefit role concerning adult day services .

Good morning. Welcome.

Thank you. Good morning. My name is Cassandra Keller and I am one of several of the benefit specialist in the office of community living. I am rooting for you today -- the revision to medical assistance long-term services and support concerning adult day services which is section 8.491 as 491 as well as revision to the medical is still for elderly blind and disabled alternative care facility section 8.495. I am bringing the roles together as they did last month . We will start with adult day . We worked extensively with our stakeholders for the past couple of years on these rules calmly getting ready for MS the. We believe that this has provided great clarification to our providers and

bring into alignment with other regulations . And the outcome of our collaboration together. The major changes that we are putting forward in the adult day rule is we are providing clarification and updated language throughout . Including final rule requirements by CMS which would include things like new requirements and care planning , community asset , integration and participant right . We have enhanced environmental standards, making the adult day center eligible for individuals as well as --. We have updated on medication administration and monitoring. The new -- regulation. We are clarifying critical incident requirements for our providers. We've also make clarifications to reimbursement. And whether a person receiving adult day services lives in residential settings. So clarification on how it will be combined. This regulation went for public comment last week and we received several comments and suggestions. We are to incorporate in the language changes before the final adoption. There are a few other ones that are more complex and we don't believe we can't make at this time.

Let me remind the folks we do have comments in front of you as well. I know some of the folks in the room definitely have -- Carrie and Cassandra. Excuse my interruption.

We receive suggestions about a definition on environments. We have not included that in this version of the rule. We were waiting on trying to get more clarification from CMS on the final rule requirements and how that can interact within an adult day setting. We plan to reopen this rule much after this. We weren't prepared to do that at this point in time. We also were asked to include brain injury section of adult day. We were not ready to do that either but we planned when we address the environment to bring the Rick Berman from the brain injury into this all in one place . A couple of things we plan to address in the future. There are a couple of comments and suggestions in regards to requirements that we just don't believe are appropriate and should be made. One of them is that nursing services could be provided by an actual nursing service or volunteer after our conversations with [Indiscernible]. It would be best if those services were provided by staff of the center. To ensure proper oversight and supervision of personnel providing services. We consulted quite a bit on that and believe that it should be the staff members. The last comment is that for staffing are mobilitiesmobilities. And preparation staff, office staff, maintenance personnel, we believe it is in the best interest of the participants that staff included in the staffing ratios include direct care staff and not staff that is [Indiscernible]. Those are a couple of things that we have comments on an address those when it comes to minor language changes and the more significant once we plan to address at a later date. Questions for adult daycare now .

Let's do one at a time.

Stay with documents six minute.

I do have questions about the not using a service -- a staffing service. I've been a medical director and knowing the shortage of nurses, not using a service or use of a staffing service is quite concerning to me. Particularly because that particular job is necessary.

So those services, the assumption is whomever is in your answer to tuition, you supervise them whether a program that comes in and I have hired amazing nurses through those services. I am curious why -- the oversight, that is confusing to me. The expectation is whomever you employ in your answer to tuition is under your oversight whether they are temporary, permanent, whatever type of person , I am very concerned about this. In both of these.

For what we have received as permit is when it comes to nursing services, if there is a nursing entity -- an agency is hired for that. And to be clear nursing services are required for those nationalist adult is like like they don't have to be performed. When you are looking at a personal care agency, there is pretty -- requirement. On how that is utilized. And it's they were to contract with a specific RN, we can add that requirement later that they can contract for us to civic RN but their concern was in contracting with an overall service agency.

I get it.

I'm going to second that. Many healthcare agencies -- I guess -- I have a similar concern and that many healthcare agencies employ external nursing and other resources but to the point that requirement in terms of back on checks and immunizations and all of those dings and there is a responsibility for the level of care that is provided and the same concern I would have is that not having that is part of this would limit your capacity which then limits the care that we can offer. I guess I just --

Sure. I will certainly take this back to discuss about how we can better address this. What oversight might look like.

You may have better control with an agency then contracting with an individual professional. There is -- by the agency . That would be my concern.

We also have [Indiscernible] in the queue.

Inc. you Madam Chair, that was one of my concerns as well.

I would just add in rural areas in particular, we struggle sometimes to find -- I would wonder whether the licensor question -- rather than -- obvious you will check and make sure people's licenses but there is a -- I don't have a good feel as a pediatrician for this but I would just -- I feel like you guys are always trying to outreach to folks but from the rural areas, just make sure this is not a further challenge for them . Just because there's not a lot of nursing programs. I know in our practice we hire there is a real shortage of folks. I'm not as familiar with the adult world, and I know you guys are really wrestling with this but I would have this concern and add the rural overlay and then pass back.

[Indiscernible]

I would echo that I would think it would improve capacity rather than diminish excellence and having one nurse at the center. I am just going to go that and I do live in that world. We do have some -- you are still in the queue.

I wasn't white sure what you are saying about receiving services in a residence. That is part of the role now?

Sure. We do
--

What you are saying is that you can receive adult daycare services in your home ?

No, sorry. It is on page 14.

Maybe give the --

Under reimbursement.

Page five of 15.

What we have included in here is how a person if they are living in a residential setting, a lot of times
versus and then adult a setting. What requirements to receive both of those services. Adult Day services can only be provided in a day setting. About how those services can be combined.

Did that clarify? IMs dosing a front.

Can you give me an example of what that would look like? May also go to adult day services. So they split their reimbursement ?

We allow for both of those to be reimbursed . We might have someone living in a residential program and they might go to an adult day program . Where they would receive some gate therapy and various types of services would be available to them in their assisted-living. It would help to augment whatever services they are receiving their. We don't split up that per diem. We allow both of those services.

Is that new?

We have always allowed it but what we have done is clarify how a person is eligible.

Rate, thank you.

Are there any other questions pop if I don't see any, we will go to the testimony on document six. Deborah is the first person . Leading age of Colorado. Written testimony and comments on this role. Good morning, how are you?

Good morning.

You may want some water because you are going to be here a while. I see more than one. Would you introduce yourself?

I am Deborah lively. Leading-edge Colorado, director of public policy and Janice is our [Indiscernible]. She does policy consulting for us.

We also have some of our members with us today.

Welcome.

We are a statewide organization and continuum of long-term care services. Nursing facilities, assisted-living which includes those who take Medicaid services and adult day services . And we do support adult day services rules. We are very aware it needs to be up dated. And for the changing needs of adult day services for clients. And we have participated in all of the stakeholder meetings that Congress had over the last few years and we have met separately and she has really listened to our concerns and we appreciate her attentiveness. As you can tell from our written comments we still have concerns that we wanted to bring to the board today. And I will say that Cassondra addressed many of them are ready and her initial comments. I was going to talk about a couple that we mentioned in our comments. The first was the adult day services, past the legislature in 2010. Provisions for secure environment and from our perspective, we absolutely support another stakeholder process on that. Secondly, we just wanted to talk about the auxiliary staff requirement. And that is where it can't be counted in the ratio for adult they services and our assisted-living, our alternative care facility, the same requirement. And we have some concerns about that. We think that if you have a cross trained individual or someone is trained in the provision of care , to meet the needs of the residents when there is an emergency, that those individuals should be able to be counted in the ratio. I know our members are very concerned about use of state dollars and it is a limited reimbursement that both ADS and providers get from Medicaid. And so they want to be able to if they can utilize those individuals and I think it is particular for small alternative care facilities and those in rural areas. And I think from my membership perspective we are not asking for all of the staff in the ratio to be auxiliaries Daff. That is not what we want. But if there is a caregiver there who is cross trained, that is our request.

Let me ask a question. We will take it one at a time. Dr. Givens .

Thank you. The question I have is what kind of roles are you talking about and what kinds of training and what you mean by -- an example of emergency situations and training that you are talking about and what is direct care in your definition and what goals ? Direct care can be anything from bathing, toileting, feeding . I would like to understand this.

I will try my best. And this is really just -- [Indiscernible - low volume] I think we are talking about in the evening. If they've got a

maintenance person who did -- CPR certified for an emergency, in addition to what we consider the direct caregivers with the new rules that came out , there is a very specific definition of a personal care worker. Someone who can assist with ADLs . Just to have maintenance staff be there who can also was on to an emergent the and call 911, and be able to provide CPR services and help that resident.

Basic life support for your team members and they would respond to those kinds of things. The ADLs concerned me, having a maintenance worker worker helping an elderly individual toilet or shower or some of those personal-care things. Just having heard several of the incidents that have happened at other agencies with individuals that are vulnerable and aren't able to describe what is happening. A clear definition of what personal-care means and who can do that?

I didn't bring my -- the rules, there is a very clear definition of what personal-care services are and then the personal care worker who can provide those

Is somebody else raising their hand?

Who wants to go next ?

I question is definition of an emergency. As a psychiatrist a -- an emergency is an assaulted staff. Kitchen staff coming out to help restrain someone, that would be an emergency at any facility I've been in. CPR , I get that. That is very different from restraining someone which is in my world is typical. I am curious is -- it requires training and also ideally some kind of ongoing relationship or something . I am concerned about that piece. Hands-on in a not trying to get your heart beating way but we are restraining you because you are violent kind of way. When I think of ratios, that is is the emergency I am thinking of. That is not an insignificant -- typically you need some type of basic services, I am wondering if that is also something that would be considered to be an emergency that these ratios would be applying to.

From a perspective, we we are not advocating there be a time that they're not ever be direct caregivers on staff . We just want a little bit more flexibility if somebody calls in sick or somebody is late because of the snow that they can count those as being compliant so they direct caregiver can get there. We are not asking that there would be anybody there. That's not what we are advocating for it's a way to do it. It's a heck of a lot cheaper. Serious clarity. Clarity around what that means nonclinical and that ratios it's a huge deal but I would with restraint five people. What does that mean more does specifically, I wouldn't want to have
that could all very will be the plan.

I agree we are asking consideration for some more type. As I recall that came in particular are some other roles. Universal worker who does everything. Let's go on with the rest of your testimony. We are going down the five minutes. We have comments. They will incorporate no problem. And still in discussion.

Identify yourself.

Wanted to identify the auxiliary staff as defined to exclude volunteers. In the definition. Volunteers are included. Some of these protocols, the volunteers are being trained in emergency procedures. Ours are not so typically restraint. Emergencies are more likely to be false, that type of occurrence. Your point is well taken, that it certainly could be -- I think the volunteers appreciate what we want to bring out.

Thank you for the clarification. Perdita Hughes.

Incorporating the services and referred to more of the normal because that is a whole different bucket.

On to your point, this is Christy Blakely. I wouldn't want anybody picking an elderly frail up off the floor either. There is some training necessary there because you could grab under the arm in arm very easily. We just have to be careful. When we cast that net we can't capture everybody or let people out of the net with that unintended consequence.

This committee is very concerned . I can see everybody shaking their heads. Dr. -- did you miss an opportunity ? Thank you very much and we will bring the rest of the folks up.

Thank you .

Engage in conversation. Lively conversation.

Missed -- would you like to come up? I remind the committee members that we do have a written testimony or comments from Jerry --.

Thank you for your assistance. We are very patient.

Thank you for hanging onto those rolling chairs. I don't want falling on my watch.

One thing we don't give -- mobility issues. Good morning.

I had sent you copies of my test Moni but I wanted to preface it by saying I am Jerry -- and my testimony, I am going to give today is written by Robert -- who is a policy analyst for the developmental disabilities Council of Colorado. An individual who utilizes Medicaid waiver services. My main point or his and her main point is that we don't feel that document six and possibly documents seven really comply with the CMS final -- rule. And for that reason, I would like to suggest that the board consider delaying this, because this issue plus other issues which have been brought forth might be able to be figured out before there was final approval . The example that I really want to highlight here is if we have an individual who is participating in adult day services and they have a person centered plan, which is required now, and there person-centered plan says there is an agreement , twice here be assisted and supported to get a gift for a loved one.

And this type of individual accommodation does not fit with the current definition of adult day services. Adult day services is much more -- a center -based around that service or a group of people. It is counter to an individual's needs. The suggestion that we had for the language was hundred 2 C where it says services to be provided. A suggestion of the change would be services must be provided in an integrated community-based -- with CMS 2269 F which is the reference for settings final rule . Which is a lot of these rule changes. We are trying to be in compliance with the federal CMS final rules. So the settings are looked at differently. Settings are consistent with an individual wanting a certain kind of individualized assist and support, and that has been agreed to in their support plan. There person-centered support plan. But does not fit with the goals and the way the adult day service program is facilitated. So by changing to say services must be provided in a integrated community-based -- consistent with CMS final rule, you more or less ensure that an individual's individual person-centered plan actually happens. And for that reason I would hope that maybe the board would agree to do for this so that a lot of these issues and ones previous to this be looked at further, and we consider actually meeting what the federal settings rule is expecting of Colorado . And I don't think that currently is.

Do we have comments, questions?

Use your outside voice because we can't hear you. 'S the Mac thank you for coming.

I don't know where that is, the final final settings rule. Where is that? Can you give us the direct -- how to find -- I want to understand what she is referring to in the document.

Sure. In the settings final rule which is applicable to all the settings we have day settings , rehabilitation, residential programs . And so one of those many requirements is that a setting has to be integrated in the community and whether that be it has folks go out into community, or if folks come into the day setting, and needs to be more inclusive into the community . Adult day services . All of the residential programs. So there is not a specific -- where she is describing adult day services. Specifically 8.491.4. Describes some of the final rule requirements that must be included.

Thank you for that.

We are happy to make the language change that says that they must rather than the suggested language. We are happy to include that. That shouldn't be an issue.

Okay.

Thank you Madam Chair meant. There are a couple of people on the -- staff who are the working experts on the federal CMS final rules. So they could also be utilized to give information.

Your comments were to the alternative care facilities. We can make the changes there.

You are saying -- does not meet does not need to come up she has comments we can address . If she has further comments.

Rather than coming up we will just have you yelled ditto from the back.

Ms. Keller and the whole board , because these settings final rule are extremely helpful for individuals , I think all of us look at the Medicare system as wanting to be quality for individuals. Thank you very much.

Jerry, thank you for your advocacy and ongoing work . We appreciate it. Maureen, as as long as you are helping her up and out, then you can sit down because you are -- we are calling you next . James is coming back to the table, here comes James. He is walking around. He is starting to move fast. Introduce yourself.

My name is Maureen Welch. I wanted to comment on this rule and change the language in the rule to better reflect the intent of CMS in the final rule. I just want to remind the board that not everyone is elderly. Don't forget the intellectually and developmentally disabled. Don't forget the brain injured. 22 -year-old skier that hit the tree. These aren't all elderly people that receive these benefits. I think it's really important. When I did my CNA training everything was around geriatrics. We really need to make sure we up date that a little bit more. Also I wanted to ask more of a 30,000-foot question. Is adult day services a place or is it a service? And it brings back to me my specialist training. Is special education a place or a service? That's what the final settings rule is trying to get it. Individual needs rather than a provider and place. System centered or moving to person-centered? And seven years my son will be in the adult world. He is 11 now. I'm not sure he will be on the waiver or if they will be on a waiver on the DD. I am not sure what the system will look like and seven years. However I know regardless he will not been into a geographic room called a day program. My son is unable to proceed in a classroom setting and we have created a community-based setting for him. So today he goes out in the community in Lafayette at some of our farm. Which has animals plants with one-on-one provider . Highly trained , a behavior therapist and a community connector. That's the type of individualized service that people with complex communication needs , my son does not have language. He has difficult support needs, psychological support needs, he will not have his needs met in a day program anytime soon. This is true on most I know now. The individuals who grew up in an inclusive educational system will want the same when I graduate when they go into community adult settings. I want to make sure the board remembers that. That CMS final rule wants people in communities and the other statement no longer allows the geographic setting unless there is a documented level of nursing care. Keep them in one place. Everyone else has to be in the community all day long, every minute of the day. I cannot bill community unless my son is in the community. If he is at home doing recreational things, that is respite. We need to shift that into the adult world where someone is in a day

program if they need to be in the community, that's that's where they need to be. And I have one last comment and then I will wrap up. I was at a friends house last night, and her son called her -- I happen to be there on the phone and they talked about a day and what they had for dinner and all the things they talked about was adult son and he said what do you do in day program and we stayed [Indiscernible]. This is a young man who is very able to go in the community. It is easier and cheaper for the adult day center to keep them all in one room when this young man should be out practicing his social skills . That is his strongest deficit. Not sitting in a room with individuals who also had challenges. He needs to be in the community and that was the example . He is an example of being in a restrictive environment that is not community-based. When his plan doesn't reflect that. His mother said his plan said he will be in his community all the time. Thank you very much.

[Captioners transit ioning; please stand by.]

Does anyone have questions for the committee? I think that your reminder of making sure that we have the population that we are talking about is very well taken . Thank you for reminding me of that.

If I like to make a comment, we need to make sure that we understand that we have the adult day centers and services that are provided. We also have services that are offered to the community. We have the services provided to those populations. We have a very different reimbursement for this programs. While I understand that we're talking about predominately elder populations, we're expecting a mix. There other services that require the waivers, so they are separate and not necessarily comparable at this point in time. Unless the dramatically change the way the adult day services are centered and a benefit, however may be. Certainly something that we're looking at. The two previous models have day services.

I agree that there are two different plans and that the same individual can be in different silos. I did job services with mostly autism. And an individual at this level , the lower level requiring direct care, they actually got more money through the waiver in their budget than if they went without the waiver. So a lot of individuals are electing to go into the waiver even though they have a developmental disability that would help them, because it is financially better for them. And they have different silos. Really, it is the same thing. It is the same program. On paper, and on billing, they are different, but in reality, they are actually the same.

Thank you very much.

I'm going to remind us that we're still on document 6. Want to remind us that we have some agreements on language, but we still have some differences and a lot of work at on some of this.

I wrote down this because I saw you , but I thought he was not going to catch you, and he want to make sure. You're the only person in the room with a green shirt on. So you're welcome. Introduce yourself. I'm reminding you have five minutes. I will do my best to keep the five minutes.

Let me introduce myself. And the director
of the respite resource Center. In that position, I have oversight over three adult day programs. They are fairly large adult day programs in the wheat Ridge site. Both of them specialize in adult senior populations and individuals with dementia and Alzheimer's. I also have oversight over program for younger adults with intellectual disabilities. That is the most recent topic. Does actually accept both waivers and so we have two different sets of regulations that we follow. One is the one that we're talking about now, and one is the other that we follow. I just want to echo what Cassandra pointed out, there different payment methods for these two programs. There different structures for those two programs. The program that is merged, the same thing has happened. We're still out in the community everyday with the waivers. We're still have built the program to meet individual needs. There are a lot of those out to the integrated community outings, so to say. What I would like to talk a little bit more about is that often overlooked and in this conversation, incorporating the final role. Are those individuals with dementia. They are the core that they have builds the programs on. I personally believe that the adult day service is the community. These individuals live at home with their family members and then getting out into the community means that there in an adult day program. We have outings, and we certainly bring people into the center to do educational, fun, music, all sorts of things.
But really, for most people, that environment is what they need. They cannot be left home alone because they are not stable to be left home alone. They need to be in a supervised, and maybe some point secured -- we went on that road later, environment.

I want to make sure that we are not forgetting that group of people as well, and so when we say things like in a care plan, it must include integration into the community, I don't disagree and we can provide integration in the community and if it makes sense for the individual, we should do that. But I think we pride ourselves on that before there was a final rule that said we had to be, but when you change the language as Jerry has suggested to's read "must" include, people with significant dementia or Alzheimer's, they will say I need to go home because I need to get to work. We could go on and long -- on about what we might think they need.

And one last a little bit, which is person centered is important.
But was of a group environment that we have to provide. I have to look at the group of individuals who come from different walks of life

and all require very different things. Not to make into a group environment. I think you can do a good job of that, but you have to give us a little room to maneuver in order to do so. The reason I started this

is just to reiterate what many of you mentioned, which is that there is a hiring crisis in Colorado. We have a 2% unemployment rate. I cannot to find qualified individuals without literally digging very deep to do so. The people who work for us, do so because it is a passion. It is a calling. They do not do it for the money. They do not do it for any reason like that. They are few and far between as we start to look around. We have an RN who is amazing, but prior to bring a on full-time, we have a woman who volunteered.

She works one hour a week at different sites. And she drives. I don't know any are and who will take six hours out of her week to drive to three different sites for $20 an hour. And that is doing it for the money. She was volunteering and we paid her for her gas. Let's be honest. We were so fortunate to have her for 5 years. When we were able to make the change to look at our budget and higher an RN, I was lucky and found one. But if she decides to move on, then I will need someone in the interim to fill that role. I really do think it is limiting to not allow us to use volunteers . You have 30 more seconds?

Yes. >> Want to talk for 30 seconds about using other staff in those places. I'm not suggesting that a person who works in the kitchen is called in for person-to-person emergency. I'm telling you all of my staff receive the same training. There are all trained on CPR and working with specific populations. They learn about each one of my individuals. My administrative assistant who can do billing, can also do this. Her job titles administrative assistant, so she is doing direct care. If I have to limit her just because of what her title is, not because of the work that she is doing, I think that will be very limiting to what we can provide. And very big program. I cannot imagine the impact on small programs. I have moved in adult day programs for 18 years.

Does anyone have any questions? Does anyone have questions? Thank you so much for your comment. We appreciate it.

We have Lori Sanchez from MorningStar adult. Come up and introduce yourself and

Hello. My name is Lori Sanchez, and I am the program director at MorningStar adult day program, which

is a state of Aurora program. We are a small program, so our perspective would be coming from a smaller program. We serve on average between 16 to 18 people per day. Our program is designed to meet the needs of individuals who are older and have dementia or Alzheimer's. It doesn't mean that we don't have people with other diagnosis, but that is not what our program is targeted for. A couple things that I wanted to address that was covered , I wanted to point out that the first thing about the staffing is that our regulations are very clear and it does require the same training for all of our staff and the staff is

paid and not paid. They're all required of the same training with CPR. I think it is going to be included. All of them are trained to the

same. Obviously nurse has more training. If you have a social worker, which we don't, that person has a little more training. But all of the staff will receive the same amount of training. I don't have a person who works in the kitchen, so to give you a bit of perspective, we don't have anyone who answers our phones or at our front desk. We cannot afford it. Our staff is very small. We have CNAs because we run programming all day long and we have a nurse. That is it. We cannot afford anything else. Our reimbursement does not allow us to have that flexibility in our staff. It limits us on how -- who we can hire and how much. If I have somebody who is auxiliary , that person might be someone who

might be working in the kitchen, but they are also doing programming. They might be working in the kitchen and answering the phones, so it really depends on how it is defined. That is just how our program works. May not work for a larger program, but that is the only way that we can operate. We have a doing it for 30 years, so we been operating pretty well. Also wanted to point out the difference between the waivers. There are different funding sources. I think we get people who attend our programs who have developmental disabilities and we have some folks who are younger. A lot of them have been with us for over 15 years because of the waiting list that they were put on so many years ago. And then some of them, once the name was called up, they chose to stay with us. Those services allow funding for therapeutic swimming lessons or horse riding therapy. That is where that funding comes from. We're talking about an adult day program for a certain specialized population, we don't have the ability to provide that much, we don't get reimbursed to the -- do that, either. We do not have the funding that will offset that. We don't have that. I think that's it.

Under the time. Good job.

We appreciate your passion and everybody.

Thank you for coming and sharing this with us. I was wondering, are you saying that by people coming to your programming, it becomes their community? Because what Jerry was referring to was that we must indicate that they go out in the community, so I'm wondering if you are in agreement in saying that by coming to your place, it is considered being in the community and if you take them to extra activities outside of that, you can possibly , when equitable or feasible, is that your thought process as well?

I think about it a little differently than she does. We do have our events to go out into the community. We do the Rockies games. We will take them out to lunch, we will go for a scenic ride in the mountains. We will do that. We cannot do it on the level of community-based programs where that is where they are designed to do every single day. Day programs are not, it's just how they are designed, the philosophy of them. I'm not saying that programs should not do that. There are some day programs that do have that ability to go out into the community daily. Generally more with the senior population, but it all comes down to resources and our funding.

Any other questions? Seeing done, thank you very much. We appreciate this.

Cassandra , we're on document 6. We seem to have come to some consensus, but we still have what I see as a significant amount of work. We are charged, you are charged with composing a role -- rule that will work for very different populations. I don't know if it will always get consensus, because what we want for our young adults disabled is different then dementia due to safety , so how do you want to proceed? Do you want to proceed with this rule, do want to pull it for a while?

How would you like to proceed? I would like to talk with them and make some changes and see if we can come to some sort of consensus. If not, I would like to bring it back, if that is okay.

What is the thought of the board?

It would be hard to do initial approval today with so much on the table. There has been a lot of amazing work, which is not always common, but there is a lot on the table that seems very unclear to me why have concerns about being able to say yes, we will have the initial approval and bring it back. It feels like we need more work before initial approval for me personally.

Bregitta Hughes. I agree that they really need to get back together and work out some of these before moving forward.

With their be a problem by delaying it one month? Do you have any concerns by not pushing through for initial approval today?

I do not believe so.
I will be on maternity leave at that point, so I may have to pass it to a colleague, but I don't think so. There is nothing in there that would delay, I don't think.

I'm going to come back to you.

I will take another stab at that.

Thank you very much. I appreciate that. Okay. Let's move on to document seven. I'm sorry, you have to make a motion and table it. Amanda is amazing when it comes to keeping me in line. I think her for that. I would entertain a motion to table it.

I moved to table the initial approval of MSP 18-05-25-A.

I believe so.

Will then she'll be home with her little one.

Let's move on to document 7. I'm going to be a human right now. Cassandra, if you're eight months pregnant, do need a bathroom break? I can see from eyes over here that we have a number of people who are signed up again.

That is very kind of you and I would actually appreciate that.

Let's take a five-minute break, please. [The event is on a 5 minute recess. Captioner on stand by.]

This is what we get for giving you five minutes. We're back, and so we will be able to listen better. If you will proceed with document 7. These are revisions. Many of these things are what we saw in the adult day services. We have aligned these regulations with the regulation that went effect on July 1. We also include final rule requirements, enhanced environmental standards, safety and other requirements are more robust.
Tread three clarification, and request for staffing. Again, we received a lot of the same comments . We are happy to make a lot of the language changes. Looking at the issues of auxiliary staff. I think we can address putting some kind of language in their of how a single auxiliary staff could be included . I think we can come to some kind of agreement. I'm a little hesitant . This will be in effect July 1, because I want to issue this is the all of the citations do not sit with the -- regulations. Some of them are in conflict with each other, so we have regulations past, so I am hopeful that we can make the changes that are necessary prior to a final adoption. Any questions?

Questions?

Bregitta Hughes. It talks about requiring staff to be on 12 hour shifts. That is bothersome to me, particularly for the small assisted-living facilities, because my understanding is that most of them incorporate staff better if they are allowed to be a 24 hour shifts.

I am wondering what was the reasoning behind that? Why are we required 12 hour shifts?

This is more for the staffing ratio issue that we're looking at. I'm looking at G on your provider requirements. What it says is that each facility will devise a 24-hour day in 12 hour blocks. That is how they differentiate the staffing reports for nighttime. I think that is what the 12 hour is in relation to, not with the stuff -- staff hours are. Trend three

The 24 hour shift is still okay?

Yes.

Thank you.

Any other questions on this? That I think we need the stakeholder comments.

We have Pat Cook.

I do a lot of work in this arena and re-fear a -- I'm working with people for the majority of my career. In the world, we have some major social issues at this point. We've lost several facilities with the state. I am working with the Department of Corrections we have to issues that need to come out. They need to be back in the community. We have no place for them that is safe. And we have consumer issues. I am concerned . I know that you are under a lot of pressure to get this done quickly, but we have the same issues that we have some cleanup to do. I think it can be done in a month, so I want to talk about page 13 8.49 5.6. I'm going to talk from it consumer and family voice. Has anyone found it yet?
You said 8.49 5.6 .

Page 15.

I was not even close.

A real the same page?

That is G.

At the very end of your reference, is there a letter to the section that you are on?

I am looking at section B.
We can see if we can get some consideration. >> a lot of issues with people acting out and go to the ER . This is their social setting, this is their life. Recently, we had a challenge because we have new rules about 24 hour visitors and we have to a therapeutic environment and now we have the therapeutic work. So visitors have been bringing in heroine, alcohol, we have these issues that have started to surface in the last three months. Because of this 24 hour visitation and not following the social standards. I know. I have a big family, and I would not allow anyone at my home after 10:00 at night. I really struggle with this issue. I think this is one of the things are talking about. The discharge issue is still not clearing. In the settings, which I have put along amount of work in this. We don't have a tram three -- [Indiscernible - low volume] . They are few and far between we need more

than 30 days . Hospitals are discharging people to the street. If you are aware, we are

-- a great deal of the adult world are mental health issues. People are sleeping in their cars. They would all benefit. I cannot place any of these spots in this industry.

I spent hours and hours helping families trying to find places. [Indiscernible - low volume] >> I am asking that we have the amount of time to allow adjustment to figure it out, or send people to different states. They are not dogs and cats being shelter. They are human beings being sheltered in the community. We would have an ethics board review . We have a conflict case management reporting out, and we can use whatever model. But some sort of managements that we can look at it to make sure that we're doing the right thing for the right reason at the right time. That is our model -- when people are in this, in a therapeutic environment, if it is not complete, it is there for a reason. If you are able to live in the community, you should be able to live in the community. If you cannot live in the community, you should be in a situation where we can address your behaviors, get the right people around you. A great deal of the people are delirious. It causes delirium. I just had -- [Indiscernible - low volume] that is what I am asking for. And I will add that staffing is miserable. They cannot find the right people who will work in this industry for minimum wage. And that is throughout the Medicaid world.

Thank you for letting me say my peace.

You have any questions?

I'm wondering on the business side about extending it beyond 30 days. Perhaps someone in your facility who was uncooperative at any point, whatever the reason is for the discharge, how are they sustaining that person's services? >> Sometimes, out of the heart, they do it, but they don't even know where to start, and if they don't have the ability to help them, they is a delay . They will say call 911 or the police, and send them to the hospital. When they return, they are trying to get discharged . All the facilities have proposed, we did not have -- [Indiscernible - low volume] it could be perceived as another pop opportunity for those who are close, but could be reopened with a different focus on meeting the needs or building high-rises that are private.

And are not going to come back.

I think 30 day -- I think the majority people I work with would be welcome to have a little bit of an opportunity, if had better clarity of the actual plan. This is two-pronged and people the industry are not necessary going to match the ability to think this through. That is my experience .

Any other questions?

What time frame would you propose?

I think 45 days to give us 15 days to identify the case manager . Get the crisis team involved. Get the medical clearance. Adjust the

medication. We're going to have put people on respite for medication adjustments. I recommend that when I go to see them that when they are in skilled care, they are not ready for assisted living. The respite program , we do not have a really good flow. I would like to see if we have a better flow.

Bregitta?

I believe that why the patient is getting treatment or any services, they are holding the bed and they are not getting reimbursement for that. Is that correct? So the first 30 days .

There is a hospital role, there is a respite rule. But these are not the only factors. Again , think that 15 days gives them a better chance. Again, I'm looking at it from the consumer and family side. I know that it is struggling. But I know that the people coming to my office and the families that I help. I am presenting the business side, because I think it is important that the board recognizes how this is for the people who want to provide services. If we make it so difficult for businesses to be part of our community, then we will really be in trouble.

Let me understand what you just said. Did you say that for the first 30 days, they are institutionally somewhere else --? >> That the assisted living facility is being reimbursed ? Or just for the 30 days?

I'm not sure about the regulation, but it should be your very last page, that if a client is receiving Medicaid services in there in the hospital then assisted living would not be able to do that this time. It is a matter of holding a bad. >>

It would be D 2.

May be that is some additional thinking.

We need to take care of them. This is their home.

Anything else? Thank you. We appreciate that.

We have leading-edge Colorado. She is not just alone. We have a new one. Introduce yourself. I work with Deborah lively.

In the interest of time, I know there's been a lot of discussion on this. Our comments, we have the written comments. It was really on the exhilaration staff issue that we had a lot of discussion.

Does anybody have questions? Anything further?

Thank you very much. >> I am still concerned, because we are not able to completely understand for adult day services. And we have tabled

that. So if the auxiliary staff is still an issue with assisted living, I don't know that we can make those quick leaps within 30 days. In order to have this part fix. That would be my question.

I think we need to ask Cassandra that.

I think we could deal with the auxiliary staffing. I think that we are little more complex and would take more time, but I would like to ask for the providers perspective .

I believe
-- is in the licensing rule.

Thank you for that. Did that answer your questions? In document 6, there is more work to be done. But in auxiliary and staffing issues around document 7, they feel that they can do that. And get that straightened out.

Thank you so much. We appreciate it. >>

Ditto!

All right.

I have one question as it relates to both of these. It is for critical incident reporting, are you comfortable with it being within knowledge of the incident, as opposed to the kind of incident? Incidents are not always recorded.

I think the ones that they have knowledge of.

Okay. How are folks feeling?

One question. Jerry's comment about the must language change, where is this one, you were going to consider incorporating that as well, so if we do make a motion, are we including that in this rule?

Or does that require a little more discussion?

I think it comes down to the rule and the setting within the community and as a mentioned, in the day setting, it's the setting that we have not currently built into the community. So things must be integrated, then the current model is integrated, so I think we should try to have that change, not requiring that every single day all day, that an individual needs to be in the community. Thank you.

Folks, I would entertain a motion with agreed for document 7. That we have more consideration more concerns.

I move the initial approval of document 7 18-05-25-B with the approved changes. Revision to the medical assistance home and community-based services for elderly blind and disabled rule concerning alternative care facilities section 8 pull -- 8.495. It passes. We will hopefully hear changes, but we will not see you probably.

We will see.

Unless you have a crystal ball.

With the changes , you will work with folks?

Okay.

All right. So, I'm looking at the consent agenda. Number 5 is the only one that I'm seeing is a possibility. Everyone in agreement on that?

I have a question on that.

Moved to add document to the consent agenda.

All in favor? Aye. All right, then I would entertain a closing motion and then we will go to Marine Welsh, so you can set move your way up here for the open form conversation.

I move that always adopted at this meeting for the Colorado apartment of healthcare policy are incorporated by reference.

Second.

A motion and a second. All in favor? Aye.

Maureen? I just want to let you know that James was turned around at one point and I felt like I put him in a corner.

During the break, I turned him around because it felt like I had punished him and I didn't want to be punishing him. We have a comment. Marine.

I am back. In 2014, I was with the case management staff court. A combined might business background and I'm not paid to be here today. These are just some general comments that I wanted to bring to the board today. Number 2 , I wanted to preclude to it , where wanted to complement the amazing transcriptionist that is happening on demand. I would like to hear more about this for the human services board.

Many thanks for being told that we need to go back into this century. We now have live transcription and conversation going on in the committee. Which is pretty amazing and yes, I would say, could you maybe suggest that two other groups about doing that with other departments? It is a wonderful opportunity.

I think it would it take that back as well.

Thank you.

And the number 2, I also have a request in a similar vein of transparency and requesting that this board consider allowing people with notice to make public comments over the telephone. This is something that the state Board of human services has done recently and a lot of people who cannot come because of caregiving duties, or their facilities, , I didn't tally it, but I saw six different comments about the rule. With a good be a great way to offer accessibility .

The state board over human services did it. I was priced how many people were requesting it, particularly from a distance. Moving on to number 3. I have a question about appointments for various committees that exist. Right now, I count about 20. Since this basis on input, I wanted to share with the stakeholders publicly, I think there is some cherry picking of the voting members. This is of grave concern to me. There is a lack of transparency of the methods used by the staff. It is discriminatory and it shows that the intent by the department is to silence .

When I asked why, I was told that I was on too many bodies. But I've only been on one going back to 2014. That is an inaccurate justification for the language. I have experience with discrimination and retaliation for my activism as a volunteer lobbyists. I was a lead stakeholder with representative young to increase the transparency of the centerboard. I was on the Council, which I have been attending in the past as a volunteer, and I was not chosen. Asked for more details to have context for that, and I was told that I had to make a request. The answer that I received had me redirected to ask Josh again for the question. I requested to see my own rubric because it was talk within the rubric two-way input into choosing members. I was told that it was a hip a violation . It is wanted to see the rubric. In general, my conclusion , I'm the only one has the nerve to come and say this in public, but HIPAA only wants to hear from paid stakeholders. I come from a long line of strong women who do not get intimidated. I will be coming back and hope to get more involved in the different processes here. I have been a little busy . Thank you very much and I will be happy to take any questions.

We appreciate your advocacy and the times that you do take . We do appreciate that.

Thank you.

I don't know that any on the committee are really well behaved.

We don't just rubberstamp things . And I want to say

that we've been accommodating with working with our rowdiness at times and I appreciate your willingness to fight the good fight, because I feel like you have a more receptive audience than you think. This computer stuff sure. We are very appreciative of your comment and that

is how we have worked to be inclusive , despite the massive machinery that it is.

I would like to make a comment. I'm disappointed to hear that sort of feedback. I apologize. Anything that we have done , that we accept that you feel that way. I will tell you that there are always more people who would like to be appointed that we have people -- positions available. I often receive feedback from those who are disappointed. It is not uncommon. I have not heard the word discrimination. I have heard people say that I wanted to be chosen, I like I was the best and I am mad about it and I want to know why. We get that a lot. I am pleased that we have so many people who want to be engaged. I am proud that we have so many people who want to be engaged. I'm sorry that you feel the way that you do. If you would like to send me something specific, I will be happy to look into a. But I cannot make any promises because I cannot please everyone. But I apologize for the way that you have been made to feel.

Thank you for that. When I use the word discrimination, I think it is because of my strong belief system for person centeredness. So when I use the word discrimination, it is about the values that I bring to the committee. The other thing that is frustrating is that when I go in as a nonvoting member, there is never sufficient time for us to make any input or public comments. We always run out of time. >> It is intentional, in my opinion. It is perfectly intentional that it is not respectful of people volunteering their time to go. By not allowing voices like mine to be on the committee, they are actually silencing divergent opinion. I'm hoping that it changes and I am happy to hear your statement, however I feel that there is a clear pattern. The other thing that has been disappointing is that now we have no department . Now they have different names. There's a different quality assurance claim. That is a message to our community that we are not enough to have our own recognition. There have been some other conditions that feed into the feeling that we are second-class citizens within the system here. Thank you. My contact information is there. I don't want to take up any more of your time.

Thank you. We appreciate it.

We are going to go on. Marine was the only one signed up.'s or anyone else in the room for the open forum? I don't see anyone jumping up and down. Let's go on to the department update. And we're also going to review, or preview 4 rules.

How much time do need on that?

We can take as long as required.

We can go past noon if you have to.

You may go.

You are the important one.

I'm sorry . If I was offended every time someone said my name, I would not have the urge to do anything.

You have a PowerPoint . I will move for that.

Thank you. It has been a joy to spend time with you. I appreciate your service and I appreciate your interest and I appreciate the views and our drive to be better. On the first full page here, there is something interesting. We have 23% of Colorado's population. It we are not 22. We have a number of beautiful beating hearts that we serve went down by 10,000. That moved us right in line with where the rest of the country is for Medicaid service. Where we were talking about workforce challenges, it is still a key role. There is 5% unemployment. It's gone down a little bit. Is one of the lowest in history and it is a beautiful thing that we are given an opportunity to rise, and fill those roles, but it also means that the workforce is a struggle. It is a very interesting opportunity. Moving on to the next page, we can see as we look at our population. 6% have his abilities. 3% are older citizens. We talked last time about the 3% doubling over the period of 20 years and how important it is that we continue to move our I to have better services for seniors. That his mom and dad. They are a growing needy population. In the 1950s, Willie had 1% of people. Over the age of 85. We talk about Alzheimer's and dementia . The needs of our community are changing. And I would say the last time I was here, the children from the CHP program was lighter. And the growth and CHP is because of the movement into different economic classes that is wonderful. We continue to serve the populations. When we look at dollars, everyone tends to do more with less to meet the needs of the communities. I've heard so much verbalized today. So 9% of the population is frustrated -- they consume the resources. -- Anyway that we can deliver care more efficiently and maximize technology, it is important that we find a new way.

Looking at all the diverse money . We are ahead of the curve. We can improve our school systems and how we take care of sees -- seniors. How do we do that? How do we find technology that does that? How do we work together with the other agencies to help people rise to get ahead of the curve. And find better ways to do more with less. That we talked about where the money goes inside Medicaid . I am spending a reasonable amount of time challenging hospitals. I want to talk to you about that just a few minutes. It is important to meet the needs. Not enough beds. We're going to talk a little bit about that in a minute. Again, on this next slide, the focus is off to the right. We are able to export innovation coming out of this great state. But healthcare expenses go down because we find better ways to do things. So these are three areas where we're trying to get through this. We're going across all the spectrums. Trying to find ways and trying to find the inefficiencies, and root them out. Find more efficient ways to deliver so we that we can do more with less. I gave you some of the areas, but we're talking a government agency overlap work. I ran into Reggie's group, and they're saying I will give you this. Trying to find different ways. If

not, we are laughing at each other. And good ideas from our other partners that are working together in collaboration

with our request to do things differently and more efficiently. It is been two or 3 years in the workings. We sent out the bid and thought about what we needed. And we gave birth. So far, so good. So, we moved to regional accountable entities. There's a lot going on right now, so we integrated the behavioral care management. We look down at the claims experience for 18 months with those in primary care and attributed those to the different groups and then sent daughter -- dollars to them. And looked at it by geographical location based on where they received primary care. Now for the places that they do not see positions at your, are attributed to somebody. It is opportunity for the future, but also means more money going out of house in primary care payments, capitated payments , but it means that money is going out of house. It is important that we help the member understand the important way to build the relationship. For the efficiency change and also quality changes in the relationship. A great change for the system. But more money goes out to begin with in order to get the advances going forward. Good investments, but we need to hold everyone accountable. Witty people to reach out and build that relationship. Nice changes in the system. More to come on that. The last part we did since we last spoke, we did pass a law and the governor signed it in May . It is a cost control law with several components. It has a department that focuses to make sure that we look for efficiencies. We want to get the 34% of the right level. I am pleased to say that we did extend an offer for a new director inside Medicaid, on par with Gretchen and the CFO and so that level of director . They will be reporting into me. We made an offer yesterday, and she accepted. So we're very excited. She will start to build that unit, also the review program is that we are working with -- to see we're not just falling with the industry does. We are not the industry. We're Medicaid. We want to not do so much work where we know we can't improve something. We're interested in opportunities. For example, the claims that were not sepsis. How do we identify, how do we correlate that to which hospital is do that. What are the best practices to change the behavior? Very excited about doing the hospital review again. The point of the review is to make sure that we have the right care. He said that 30% of our funding is spent on dollars -- spent on hospitals. It is the most expensive and it is a place of contention. The other issue, that is that when people are most vulnerable, they go to the hospital. We want them to know when they are in the hospital and when they are discharged, state can be taken care of. Want to help people in vulnerable circumstances not be readmitted to the hospital. Make sure that we have the right staff. We have some claim status. There are some edits being monitored -- modernize for the next several months. The edits that are standard in the payer industry for the patient level. Will be going through that process to put us on par with the rest of the payers in the straight. And then to very exciting modernization. Medius , my CFO says it is a free tool the cost you $1 million to implement. 2 years later, we're now official for our primary care locations with the tool that says before you refer, make sure where is the setting that you can admit to see a person has better care and of better healthy outcome. Potentially, what it will cost, they will show you the readmission. So when you're creating your clinical pathway, you know it's a very robust tool that has loaded all of

Medicaid's data and the providers can really look and see, where do I really want to refer? Hospitals can use the tool to see where I'm I next to my competitors? What I need to do to improve?

3 years now, we would like to see the hospitals talking to each other and sharing information so that we can build sentence -- centers of excellent and maximizing what they are really good at. We will talk about that a little bit more. Prometheus has a lot of neat things.

There is a provider locator. That would help a member find where to go, not just based on proximity to their home or where they work, or they have to spend time, but proximity for the answers to what is the best outcome?

This new tool. We're very excited about what it can do for us.

Is that going to go to providers?

I've created a department to goal so that 80% of hospitals need to be educated on the tool in the first year. I'm very excited about that. Primary care and hospitals. And then there will be quality incentive payments.

In Prometheus, will help us in the mental health world in finding facilities that will be taking or accepting certain populations?

Let me get to the next one that we will talk about that. >> The other thing is, is there any work done for the 45% with disability and elderly that the money is going towards, is there any look at that 45% and how much of that is the 30% of the hospitalization? My guess is that it is not hospitalization, it is community services. You can use the tool for both.

You can use it to determine how the hospitals are treating that 45%, you can also turn it around to say what is the cost by person that we're going to have? You can actually make a list for individuals based on the quality challenges. That is any way to show this. We could sort by person in order to improve their care.

That was area 1. Inside our own house, how do we do things better? We are moving forward. The next area is talking about the hospitals and get 31% of our dollars. There's something about the hospital transformation program. It has been law now and we're working towards the hospital association. How do we bring the provider fees back in two distributed differently ? Not just to make up the shortfall, but to see where hospitals are being -- behaving in a way that is not good for the community. So in essence, it tries to recognize, that I want hospitals to do differently in my community. It can give you the detailed portion. But this is the negotiating document that I'm sharing with you. It's about 30 pretty in this is a big part of everyone's pot. We have been working with several input sources, so this is healthcare policy . I asked our staff to bring in all of our carriers. All of the carriers

showed up. This is a combination and in the second column here, you can see where the source is coming from. You can see the all the carriers that are providing input. What is the issue what can we do about it? Where are they upset? A little team of geeky healthcare people that I surround myself with our helping with this. What behavior should be changed? So here are some examples on this focus area. The emergency departments. They say

we want to moratorium. The hospital association went a little crazy on that. And nobody wants to be told

no. Is a longer primary care. Settings with radiology and lab. What about mental health services? So what I am saying is that we take all of the input and now we have this active negotiation. We don't want to talk about transparency. Because it is hard for the hospital. They have done an impossible task. Right now if we're speaking, they are speaking. They are trying to duke it out amongst each other to come back. That was over a five-year period. Using this money differently. Here we go. Let me go to the last page on here. This bill was signed in May. [Indiscernible - low volume] . I just had a look around. Do we have enough bed space? With a $174 million. We would fill the gap. We need to do something different. We made sure that the governor had a write up about the bill.

We need the providers, especially -- to expand their scope. Whether it is opioid or alcohol, or whatever it is. And for dual diagnosis the issue is going to get worse because of the coverage improvement that we just made. We need to recognize this and say that we have 2.5%. We need to find very creative ways to maximize how we use the delivery system and on the next page, we're dealing with hospitals. We have 10% of the overall state budget. We want to walk in the hospitals shoes and see how it is changed the uninsured rates. We're down to 6 1/2%. On the hospital side, in a real community, we have a commercial, which is there. That in 2017, with 50% in commercial. That other public of Medicaid and Medicare is $.71 on the dollar. That is good news that the uninsured is going down, but the bad news is that Medicaid and Medicare is getting so much bigger. But the disparity of income is not moving equally. There is some economic issues that we have to address, but we still need to walk in the shoes of the hospitals , especially in the rural communities. Now where the last page here. That we have hospital focus, parallel to getting at the 40% of the budget. In the 3 to 5 year roadmap, want to remind you that down the road, we have analyzed pharmacy, we have analyzed hospital. We have discussions going on about seniors. That is a longer-term issue. The governor has appointed a senior Council on aging.

Innovations. Seniors, hospital , Pharma. Long-term services. It is a big bucket of what we have to address as a state. At the end of August and September, we're working with the health Institute here in this building to message and put together any work. The cabinet is on their health cabinet. We're on the third meeting on looking at those. And the roadmap and input. At the beginning of August, they will have a four hour meeting for the roadmap. In the we will start into the market and the general areas. There will be some interesting things like pregnant mothers on WIC . How do we get them all on WIC? That might be a rule. Another role might be we must make more stable the pricing on the exchange for the individuals charge. Might hit large claims differently.

We might go towards Medicaid versus commercial. Hospitals might go crazy, but we have an issue with the cost-effectiveness when you have 86% of the people having reimbursement from federal subsidies. It is still reimbursement. We have to look at that. How do we pay differently? Some big at the not -- economic drivers there. Is a whole hospital transformation program. We need better alignment. I'm feeling good about where this is going. As we do a roadshow with the community, we should be included in this. We should have a well orchestrated approach for employers . Here are the 10 levels . We are starting to get a consensus of where these things are. If we stop allowing the advertisement on TV .

Can we do that? Can we say that rebates in the sectors over a period have to all go back to the ultimate payer?

I think there is tremendous work and where things are going. This question is not just about healthcare, but it protects all of us wherever we are. How can other organizations work with our community, because in terms of bringing this, our unemployment rate is very low. Bringing people to this community to provide care and live at the facilities with the issues with staffing. With the salaries people are making, they cannot afford to live. There so many social determinants that are very complex, but how are the various departments working together to address that? It is great to do all this work, but if people cannot afford to live and work in the community,

We have to be careful this. Everything I say is recorded.

Our recorder person is smiling over there.

Maybe this will be after the mini conversation. I'm not asking to put you on the spot, but I'm just raising this is an issue. This is great work, but in terms of employment and insurance and all of these other things, this is such a huge factor.

The issue of disparity, with everyone moving at the same rate. There's an article in the Denver business Journal.

It goes on record.

With the issues that you are saying is that the difference from the haves and the have-nots, the article that they had just as last week with the difference in what is the difference between the average wage and the wage of the CEO. There are certain areas of the system where the disparity is greater than others. Healthcare is 80% of the economy. It is growing at 4 1/2% per year. I would like to make sure that healthcare is part of the solution, not part of the problem. I can't boil the ocean. But I can say , where we pay that we are paying so little ? Where do we become part of the problem? I have a multitude of meetings it is important for us to show both sides. I'm very proud that we have 100% support from every single voting person for the Medicaid . That means that we have listened to both sides of on the

right way to get things done. Do we have to rise up and say that if we pull people off the Medicaid roster, which lowers the taxpayer burden, and improves the economy, how can we show that without being politically insensitive? But I know exactly what you're saying, I'm just trying to find a way down the middle to get everyone to see, yes I can support that. It is very difficult. But it is so necessary. If we don't have affordable housing, the millenials will stop coming. We can have affordable housing because we haven't construction deficit. Everything is going in the right direction . I appreciate your indulging me.

Now the only have one minute.

We thank you.

It is brilliant. We should spend more time talking about these things.

It is really important.

Without recordings.

We truly need your input. Thank you for everything you do every day. I'm looking forward to it.

Thank you.

We're going to do our previous for next month. And the over-the-counter prescription stuff. Richard Delaney is coming up as well and then you are going to go on with physician services.

We will give you -- introduce yourselves. Come on! It is had so nice to see a happy panel.

I'm a quality specialist.

My name is Richard Delaney .

I am the policy specialist.

I will start us off with the preview to the authority rule. The statute . This goes for the revisions. It will allow them to prescribe over-the-counter products under the statute. The role will clarify that it shall abide by the pharmacy rule when prescribing medication and that there be a list of over the county medications that can be prescribed by pharmacists. [Indiscernible - low volume] I'm working on creating a website to walk providers through the process and the drugs that they can prescribe easily. The feedback I've gotten so far is that it has been very supportive.

I have some feedback on over the counters. Since we have gone under Magellan, there things are getting kicked out. These are people

unlimited income who, as Kim are saying, we want them healthy, we do not want them in the hospital. If they cannot get their over-the-counter vitamins or whatever it is, we will have them in the hospital. If they can't get the vitamins that they are being denied by Magellan, so if you need examples, I am fearful that the folks that I am hearing from, which are the disability community, that they will begin on this role next month. I'm giving you this heads up in case you want to do work ahead of time.

We plan on meeting with the disability community internally.

Awesome. If you want to be part of that, just let me know.

Are there any other questions?

I want to clarify. I am Dr. Fraley. Our physicians needing to be going through this? Are you talking about pharmacists?

Pharmacist. But with all of the OTC drugs that they prescribe.

That is already the case.

If there are no other questions, we will move on .

My name is Richard Delaney. Continuing on the pharmacy team, we're adding pharmacists as a provider type for medical benefits. That is what my group is doing. We're in the stages of allowing them to administer . They would have to be put in as a services provider.

That makes so much sense. That just hit me. Why, when I take my daughter and her significant to the pharmacy for their flu shot, the pharmacist will say that Medicaid does not reimburse, but my doctor can bill insurance.

Hold that thought.

Actually your question clarified it, because our pharmacist is doing it for free. I just realize that they are not doing it for Medicaid now, and this is what the role would be addressing.

This is Dr. Fraley again. Just repeat the question. There is a track for kids were 18 and under,

21.

At this time, DST will not be open to pharmacists in the program.

So 16-year-old could not going to get that done at the pharmacy?

Does that answer your question?

Yes.

Any questions regarding the pharmacist? I think that is great. I think anyway we can open up more opportunities for people to be vaccinated is fabulous.

We want people to have the shots.

We know in the health department, we're talking about immunizations for such a big thing that they did, but it can also sign though care out of the medical area. But I think in general, offering people the opportunity to get vaccinated is the way to go.

We're not encouraging people to step aside from their medical home, but if that's what happens, all of us are all for it.

Do you want to go to the immunization now? So, we are required -- immunization policy had eventually been a coverage. I will be presenting on the immunization role next month. That role will be vague on the topic of provider type because the pharmacy -- will have the physician services rule. Were bringing in at this time, because this rule will not exclude pharmacies as a place. The benefit covers standards that had previously excluded pharmacies. We would bring it into a role that it would no longer be the case. And the inclusion of pharmacist will be in that.

Going back to my question, flu shots will be covered by Medicaid?

At this time, the pharmacist administration of vaccines will include adult only and only 3 vaccinations. Flu shots are not there. Shingles. IPV .

How did IPV get in there?

This is Dr. Fraley. That came out of stakeholder comp work. That is my understanding.

It was also decision made by our chief medical officer. Other than that, I can't really say why that decision was made.

Okay.

This is Richard. In the physician services rule, you would have to go to the other rules to determine.

By not including flu shots,
-- specs
>> I think we anticipate confusion every time Medicaid is involved.

The medical staff determined that the cost incurred by limiting access to adult flu shots would not initially be a wise investment because there would not be significant savings from expanded access to adult flu shots. A 20-year-old will not incur significant additional Medicaid costs, so if we're looking from a whole different perspective , it would allow -- and don't mean to make assumptions about 20-year-olds, but in general allowing largely healthy 20-year-olds flu shots will not save Medicaid down the road, as opposed to putting that investment into older adults.

What about the unhealthy 65-year-old? Or 67-year-old who has Medicaid? Because the flu is dangerous.

Flu shots will still be covered
in a physician setting. So someone getting frequent healthcare will have more access to that.

Okay. I have one more comment. I think it is great, does listening to knowing that Medicaid has more. But the more things that mirror the private industry, the more confusion. How is the 57-year-old would be plugged into the home , not just floating out there.

That is the theory.

I think vaccines are such a big issue and if we as a country choose to go to partial plans where vaccines are not covered and are not the traditional ACA covered thing, there more areas where people get left behind and are unable to access pharmacies . I think that is a benefit. There are more options.
>> The convenience he does increase vaccination tremendously. And thinking of the man who saying I'm not doing that , because of not going to go to the doctor. But am I going to Safeway .

So far we are all in agreement.
>> Whitney, do want to give us yours?

We're working on it together.

So they just brought you for fun?

I have one more comment. I'm glad that you are doing this for people who live in the adult world. You might not think about this, but we're always trying to get our parents vaccinated. Mom so they are pregnant, will typically get vaccinated in the OB office, which passes immunity. Then if you go to Boulder, there a lot of people not vaccinated at all. We have increased pertussis and new board population. We're costly trying to send people, dads especially, because the moms will do it. That if they cannot coordinate their life
with the health department, this will help their life. This will make a difference. I think there's a lot of savings potential there.

I'm going to asked the committee -- I've suggested to Chris that we move -- hang on, Richard. I didn't mean to step on you. That we move you guys in the agenda next month before document 7 it so that you don't have to sit through all of the discussion that I am anticipating. If that is okay with you.

Unless you want to come and listen, but you are little bit more straightforward and I'm not seeing as much testimony and discussion. So I'm just thinking that it means you might have to truncate your coffee, you can have the long coffee in the morning, you have to be in and ready, but I'm just thinking that. Does that sound okay with you all?
>> Not that I value one over the other, but I'm thinking time management.

Richard,

I will be bringing in the emergency rule to allow candidates for licensure to be paid for services. This comes from the transition on July 1 of what we call the short-term behavioral help, which came out of behavioral health and it is here in the state plan program.
They are paid when the services were done. This would go to a licensed clinical social worker. We ran it through a bunch of stakeholders, and at the last minute, we were asked about the licensure candidate and our responses that they are not able to generate a billable encounter. And they said they were going to stop delivering therapy services because they would not be paid like they were of the HMO work covering it. It is going to change the rule to allow licensure candidates for therapist to generate a billable encounter and we have strong support from the community.

Any questions regarding that?

Thank you all. Thank you for coming. I am going to adjourn us at this point from the nay. And to tell you all to sit for a minute. [Event Concluded]