[Please stand by for realtime captions] >>
Good morning. I will call everyone to order. We will start roll call. This is the medical services board of Colorado.
Christy Fraley . >> Simon Hambidge . Bregitta Hughes. Jessica Kuhns. Amanda Moorer. Charolette Lippolis. An Nguyen. David Potts. Donna Roberts.

Patricia Givens.

I am on the phone. >> The date and location for the next meeting will be November 9, 2018 beginning at 9:00. It is the policy of this board to remind everyone in attendance that this facility is private property. Please do not lock the doors or stand around the edges of the room. Please turn off all cell phones. >> The QA feature is enabled for the webinar. Please submit questions and or comments for each role. Please identify yourself and your comments. Please identify yourself when speaking. Their individual testimony sheets for the open forum and for each of the rules at the back of the room. If you need any help finding them ask someone. There is a five minute limit for all testimony.

With that, we can move on to the approval of the minutes from September 14.

I move that the minutes
be approved as presented.

Second.

All in favor?
>> It passes. >>
I need a motion for the August minutes as corrected.

I make a motion.

Second. All in favor?

Aye. >> That passes.

We will open up the rules part of the meeting and the first of's -- and the first is the final.

I want to say the minutes were quite excellent. It reflected the conversation and discussions we had and I appreciate the work that went into this. We had a lot of great discussion.

Well done. Well done, Chris. >>
Jennifer, nevermind. >> Motion for the consent agenda on the first document.

I move the final adoption related to medical assistance Incorporating the statement and purpose and wording continue in the record.

Second. All in favor?

Aye.

Now we will go to the final adoption agenda for the second document.
>>
Please identify yourself and tell us who you are. >> My name is Kevin Martin. I am present in the -- I am presenting the final adoption. This is the enhanced ambulatory rule, it is very similar to the emergency rule, the biggest differences instead of listing the individual drugs, we have move that to the website. That seemed like a reasonable request, something that was suggested by CNS.

We had the 15 day -- initial conversation with CMS whenever we submit estate plan and that happened last week. They had a lot of questions at this point, that's to get them up to speed, they have a lot of questions around the negotiated part, they want to have more structure within the state plan so as we discussed with them and continue to discuss with the hospitals, we have not come up with a final negotiation with them, we are trying to leave the rule more flexible.

That's why it has not changed much.

Any questions? >> Or any people signed up? I would entertain a motion.

I move the final adoption of document 02 revision to the medical assistance rule concerning drug payment methodology for outpatients,
incorporating the statement of the purpose and specific statutory authority contained in the records.

Second. All in favor?

Aye . >> Doctor Givens?

Aye.

That passes.

We will move on to document three.
>> We have a team of people you can come up and introduce yourselves and identify yourselves.

Good morning. I am the section manager for the benefits management section, I have with me the hospital policy specialist, we are presenting the second reading. >> We're here to present the second reading , regarding community clinic and emergency center provider types. We are bringing this back for the second reading, the purpose is to create a Medicaid provider type for hospitals on facilities that fall into license or categories. The rule has not changed since the last reading and we want to address the concerns.

Good morning.
The role has not changed since the last reading, we want to address concerns. The board asked us to [Indiscernible] regarding

clarification for their ruling. The department of public health responded to the letter The board has a copy, we want to highlight a few sections regarding the terminology.

I am going to read a few paragraphs starting with the first bullet, and the second paragraph, the regulation defines CCEC as healthcare facilities that provide health care services on an ambulatory basis.

In doing so, they are committed to operating inpatient beds for the provision of extended observation not to exceed 72 hours.

Inpatient beds is defined to mean the use of beds in the care of medically stable patients to present primary care services will both benefit -- that will benefit . Consequently the use of the term inpatient does not mean inpatient as used in the hospital setting, the inpatient beds that are permitted to operate under the type are more appropriately compared to an outpatient observation that of a hospital.

Observation beds are not considered inpatient beds. They want to discuss the timeline of these beds, and the waiver elements, on the second page. >> They say the waivers do not serve to expand the scope of the services permitted for a license CCEC and are not a basis for inpatient care. The letter goes on, to the children's North campus, as a license holder at the Children's Hospital North campus provides healthcare services on an regulatory basis and operates inpatient beds at the facility for extended observation Scott not for more than 72 hours. Clinics do not provide emergency services at the facility. This location is not licensed to provide emergency services at the facility nor is it licensed as a hospital.

With that statement, we feel confident in the exclusion of inpatient services from this rule, and it is appropriate.

The board asked [Indiscernible]

>> We were not able to have a representative but all the publicly available information lets us know regarding the remote location of the hospital, all locations of the hospitals must comply with applicable state laws so if it is a remote location, a licensed as a community clinic they have to meet certification requirements as well as the state licensure. Additionally you ask for access to care information got we did the data pull.

Was a question whether or not hospitals could address needs, within the Denver area 41 hospitals provide outpatient care and 29 provided inpatient care to children under the age of 20, with our speed diagnosis from July 2016 until December of until December 2017. There are several different diagnoses that could do that, 50% or not Children's Hospital. There is access elsewhere.

Colorado Hospital Association, they received right after the last meeting, they expressed concern by excluding services and only paying

for observations up to 40 hours we were changing the payment methodology. There is no change in the methodology.

The methodology for this type is identical to the hospital outpatient type.

We are submitting services as confirmed by the letter. The board also received a letter from Children's Hospital. The hospital noted they disagree but they decide to align the services with this rule. We will participate with them and we will have collaboration with Children's Hospital as well as all the other providers.

We ask you approve the rule as stated today. >> Any questions from the board?

I'm trying to recall, I thought the challenge was [Indiscernible]

Identify yourself for the board.

One of the challenges here, what will get paid for and what will not. 48 hours is it for what has been paid for for observation status. And during the special Period it will be 96 hours. At this point those will be unpaid times if it needs to go beyond. I want to say I appreciate
the hard work and thoughtfulness that went into this, you Children's Hospital very concerned along the rest of us to share their worries about this and although it seems tiresome this was about six beds, was about more than that all of us.

The department is included in that, they were helpful and they were clear for verification. I think it's one of those times where you can see, different agencies use different terminology and the type of sticky situations that can get patients into this so we will have a little bit of a transition but I appreciate your comments. >> Thank you. I agree and thank you for the rural setting. Core doors are considerably different and thank you. >> Any other questions or comments from the board?

I have a question, if the Children's Hospital goes beyond the 48 hours, and they don't bill for that, but then the child needs to get transferred, is that okay?
>> It doesn't necessarily create a gap, if that happens, if they were staying at the hospital, the same thing would apply. [Indiscernible] it might be weird but that is what it has always been.

It would not create -- like a setback for them?
>> [Indiscernible]
>> Thank you for your comments. We do not have any public testimony. Anybody in the room that wants to testify regarding this rule today? We will take a motion. >> I move for a final adoption
for the revision to the medical assistance rule concerning community clinics and emergency centers.

Second.

A motion and a second. All in favor?

Aye. Doctor Givens?

I am abstaining.

So that passes.

We will go on to the initial approval agenda. I'm having somebody different.

>> Good morning. Good morning to members of the board. I am a benefits specialist .

On behalf of the office of community, I will present documents for MSB which is a revision to the medical assistance rule concerning adding community or facility-based care to respite services . The waiver aims to support children and their families Robin diagnosed with a life limiting illness. Under this waiver children are not restricted to palliative care or treatment but instead are encouraged to receive both if they choose. The services offered provide children and their families the support needed to keep children in the setting of their choice. The proposed revision affects one service waiver which is respite.

The amendment will add little community and facility-based respite options for the members. Currently respite is allowed only in a member's home so community and facility-based respite options were removed from the rule at the direction of CMS 220 utilization and providers, however the department has received feedback that we have providers who are providing facility-based options.

Based on the information and the feedback the department proposes adding these words to the rule, so the members have more flexibility and access to this important service. I appreciate your time. >>

Any board members have any questions?

When was this removed? >> That was removed when the read -- when the waiver was removed in 2015.

Thank you. Thank you for the families to have a break. Things can be difficult.

I would second those comments. Thank you for making respite more accessible for families in the state. >> Any public comments? Anyone in the room that wants to make up public comment?

I entertain a motion.

I move the initial approval of the documents concerning adding committee-based care to respite services contained in the record.

Second. All in favor?

Aye.

Doctor Givens?

Yes. >> Okay. Thank you very much for your great work this morning. We want here document number five, good morning.

My name is Diane Byrne and I am a community-based services specialist, I'm here to present MSB 1807 revision to the assistance long-term services and support rule concerning programs There are no substantive changes to this rule, it's updating citations, for some background the SLP is a residential service on brain injury waiver conserves about 200 people per year, each provider is required to be licensed as an assistant living provider those rules were with the public health environment , they updated their rules effective June 14 of this year, after a two-year stakeholder engagement process.

CDPHE requested we update our citations this not just a technical adjustment, we're removing some passages, there is no client or budget impact expected, when updating these there will be provider confusion, it will be difficult to cite, and difficult will force -- and difficult to enforce.

Any questions regarding this rule? >> Doctor Givens? You will speak up if you have a question I assume.

Correct.

Anybody want to testify?

I will accept the motion. >> This document, the revision to the medical long-term services and support rule concerning supportive living programs, incorporating the statement of purpose a specific statutory authority contained in the records.

Second.

All in favor?

Aye . Doctor Givens?

Aye.

That passes. Thank you.
Document six, we are looking for Trevor . >> Please identify yourself.

Hello. Good morning. I am an analyst, I'm here to present an update to a .470 which is the reimbursed facility serving client to meet the hospital backup level of care, hospital backup program is for members been stabilized in the hospital are still too acute for a skilled

nursing facility setting. This rule updates the reimbursed methodology from a negotiated cost element to an acuity based reimbursement. Extensive stakeholder engagement was done surrounding this rule provider six rest their support. This rule is person centered for the provider and the members. >> Any questions?

>> Once again I will challenge this for the rural hospitals, the survey might do well in Metro districts, it works better for the rural hospitals, just pointing that out. It does not work for all the hospitals even though the big hospital groups have gone along with this. >> Do you want to respond?

This reimbursement update does not affect hospitals, this is skilled nurse facility, there are currently five providers enrolled in the program and they are located all along on the front range within urban areas.

Miss Roberts?

I have a question that will you have rural providers participating , many do not have 24/7 coverage.

Yes. This rule does not address this, this is only updating the reimbursement methodology and we do not have any rural providers for this program.

Any other questions from the board?

Any public comments?

Does anyone want to comment?

Thank you.

All in favor? Motion?

>> Okay.

This is quite exciting.

Okay. I move the initial approval , the revision to the rule concerning reimbursement of nursing facilities . Incorporating the statement of the purpose a statutory authority into the records.

Second.

All in favor?

Aye. Doctor Givens?

Aye. That passes. Thank you Mr. excitement.

On to number seven, Brittany? >> Please introduce yourselves. >> I am the Medicaid director, today is my last day at the department. I was pleased to be able to spend that with you. This is one of my favorite parts of my job, I've asked Bonnie Silva who will be the interim

director to come join her team at the table in part because part of the role I have played is to serve some continuity. Since I will not be here on out be Bonnie's job.

Is a three rules are presented, but he will be here to provide the office of community leadership perspective so I want to introduce her to let you know this is the beginning of the passing of that responsibility. >> Would you like to introduce yourselves? >> I am the entry point section manager . I am the base management specialist. I am the access supervisor and the program manager.

My name is Matt Baker I am a policy advisor.

I am a community-based advisor.

Good morning. My name is Bonnie Silva. I am the interim director.

Did you leave anybody in the office?

There are a few folks holding down the fort.

Okay. Who wants to begin?

Today the office of community living is presenting three separate rules connected and required by different legislations. I am presenting the rules that implemented changes for home services management these rules create qualifications for consent with agencies and managers. My colleague is presenting a rule benefit and estate plan that supports individuals transitioning from the nursing home or regional center. This will add additional requirements above what I am presenting.

This will support transitioning. Matt Baker is present the rules for new transition services that will be added to a goal community services these services are additional benefits available to people who will be transitioning.

I will begin with a case management service. >> Can you please pull up slide number five? >> We will vote individually on each one. We are hearing document seven. >> I wanted to clarify for myself.

>> Brittany can begin.

Thank you. It is important to understand what case management is, it includes the following activities, assessment of needs, development of the service plan, referrals and other activities, and the monitoring and the receipt and delivery of the services along with the help of the individual.

The government, or CMS requires the agency provides case management as this is a conflict of interest, in order to further departments requirements, the Colorado assembly has passed House Bill 43, this requires the department to implement conflict case free management for individuals with this typical -- with disability. In order to do that the department works with experts and stakeholders to develop agency and consent of qualifications, through meetings, along with an informal comment Period to provide feedback, the department has taken into consideration recommendations from stakeholders and they changes to what was presented to what you see in front of you.

Once the qualifications were complete the department needed to add the functions and functions, we can the section that has -- aside from the need of the agency, we have to use the existing language and regulations to develop what the work is.

The department removed language from the existing section, and added that to the section 8.519. The department recognizes there is language and inconsistencies that need to be done in the near future to the other sections. >> In order to comply with the requirements the department needs to develop these sections to incorporate the management agency qualifications. The department requires regulatory review process . This will allow the opportunity for revisions, stakeholders have provided feedback to the department on some pieces of the qualifications and they have some questions one of those sections is the agency qualifications to have a physical location in Colorado.

This was changed from the first meeting to give feedback from stakeholders some did not feel any facility was necessary to be a case management agency, other stakeholders fell the physical presence in the community was required. The department created the requirements to have a physical location in Colorado to try to address concerns.'s but -- another area is the requirement of the agency to serve anyone who chooses them as long as the person resides in the county in which the agency is serving. >> The position is that we need to make sure individuals are receiving case management, they cannot access any of the waiver services without having case management since agencies are the ones to assess the needs and develop a plan.

We received from feedback on potential changes and will continue to work with them prior to the next meeting to make any changes.

Another area where you have received concern is required ADT still have one month reserve for financial fine, this has changed from the previous meeting, the qualifications at that point was to have three months reserve and due to the feedback , that would be too prohibitive and it was changed to one month reserve. The position is still an agency needs to have one month reserve for sustainability and continuity.

As well as to the employees and the staff of the agency, case manager qualifications, we received questions regarding the requirements to have a bachelors degree in the behavioral science field. We heard from many stakeholders over several years about the need to professionalize managers. Many agencies already have this requirement and we are providing management, other stakeholders fell requiring a bachelors degree, [Indiscernible] the position
that a degree should be required however acknowledges some agency may have some communities and a waiver can be requested from the department showing this person has experience. >> What you see before you, this existing current regulations. We received concerns about the requirement for background checks every three years. That may have a financial burden. Where work with stakeholders to provide thoughts and

feedback on how to change that to make sure it is happening at the beginning and should something happen,

employment can be seen at some point so we are working with stakeholders on the feedback and looking to see what changes we can make. We want to make sure they are hiring staff that passes background checks. >> We will review this over the next couple of weeks.

Any questions from the board?

Back to qualifications, who will determine in rural areas that this is qualified? >> The current operation is that agencies requesting the waiver, they send that to me and I conduct the review. Any transcripts with education, I am looking at the work history, the work history is that the long-term services. We look to see if they have experience or any educational classes. >> Do you do a one on one? >> I do not. The agency managers send me the information and I review that and I reply via email

that this person does or does not meet approval . >> Questions from the committee?

Doctor Givens? Any questions?

I do not.

We have public testimony. If anybody wants to sign up, we will accept that.

>> Thank you. I represent the Colorado coalition, the majority of us are Medicaid clients is. A lot of issues with this, I want to thank Gretchen for all of the support and advocacy she has done over the years.

There are a lot of issues with this, we support case management and we support criteria because that's been a problem however there's a lot of stuff that will cause problems. There are definitions ,

which were outlawed, that has to be fixed. Coworkers should not be in the list of natural support, that is a labor law issue. On appeal rights, it says they have to give a notice for 10 business days but they do not say the client has to get 10 days in advance.

There's nothing about reduction of services even though that is an adverse reaction.

>> [Indiscernible] it does not say who notifies the client regarding, it says it is grounds for termination of the waiver if somebody needs 24 hours, have the client on the waiver need that.

You need to remember a .503, it does not say if the clients are removed if they are detained in a correctional facility after a certain number of days, case management definitions, authorized reps need to distinguish [Indiscernible] why is the comprehensive assessment always a reassessment, it does not differentiate about the original assessment.

In terms of the conflict of management, the case manager cannot be employed by the same company and individuals that provide services to enjoy -- to employ the conflict, the corrective action is from the

department it is not preclude city PhD, financial ability says after resources it should say it is applicable to get the Byam The level of care, other than the DD and specialty waivers does not include diagnostic information and is not have to continue review.

The website should have information on how to reach electronically even though it is the law should say be accessible at the ship at sexual orientation and gender expression, it's a little bit of overkill for the regulations, if you will have these patterns, they will require hiring clients. >> This is about keeping a copy of the degree of transcript is still higher case managers, will not be an issue in hiring older people? I don't know that people have original transcripts over a certain age.

We want to see
similar philosophies for training requirements, supervisor experiences, why is that not in training? You never define service and support coordination which is the most important thing they do. They describe as a function, to provide conflict of interest. I don't know if that is the service.

And targeted case management, it is only in DD waivers but in other rules you have to change that I don't understand how that goes together, we're thrilled about this but we want to know how this will be enforced and how things will be addressed and this is around
the set if they do not do their job, [Indiscernible] this rule is not ready for prime time. >> There are issues with the appeals and the dates are wrong. You bring up a lot of really good points. I saw Anna shaking their heads at the table, anybody have questions ?

I'm thinking of the stakeholder process, there was about a year or so ago that ask about what your qualifications
be like, there was not a process about legal issues. That came out in the rule.

There are concerns.

Is a possible to go back and work with the state holders -- with the stakeholders on this rule?

Want to say all the pieces you're mentioning about some of the language, the only pieces we attached were to remove some management and to add a couple of definitions, we are aware that the language needs to be cleaned up. That will be part of the review process. To get the agency qualifications done we could not touch all those pieces, we have a 95 page document. A lot of extra work needs to happen. Most of those definitions already exist in the regulation so we do not want to create new definitions again to have continued consistency everywhere, the work for case managers came from existing regulations, we did not do stakeholder engagements about changing the role of management, and the work came from existing regulations.

We're hoping to doing feedback in the future to look at the functions of case management. We need to have something at this point for

management agencies for the qualifications. >> Again, the stuff around appeals and dates and deadlines is concerning. In terms -- the qualifications that were not considered during the feedback, submitting the rules with all of these problems adds to confusion especially on the dates and the appeals. Bringing things altogether, a lot of this preexisted but when everything gets broadened together, it is confusing. I do not know why it would be 500 pages. When you say business days, just make that clear, you can put at the beginning, the appeals rule supersedes all of this if there is a conflict. That would be a simple way to do that.

What is difficult by the presentation of this rule is that to do the revisions, the entire section had to be reassigned new numbers so they did engagement specific to the two different components that was present at the day, there is a broad workplan to address all the elements. >> We have not done stakeholder engagement on this rule in its entirety, there are changes that need to be made. They are on the list of things we need to do.

>> My question is, is there an urgency around this? >> Most of these people are here around this rule, I am curious if slowing things down a little bit now to address these concerns would allow us do not have all these come back in six months which is what I am hearing. >> There was a commitment made to stakeholders in the General assembly in 2017 that we would have the agency and qualifications within 18 months from July from July 2017. That is right around this time frame. >> That is why we are working to get this piece done, as well as the secondary piece in order to become conflict free , it requires this done -- this be done by 2022, we are asking the department for updates of where we are. Establishing these qualifications allows the creation for those agencies

[Indiscernible] for the transition to get people -- to comply. >> Any other comments from the board?

Thank you for your testimony.

>> Good to see you. Please introduce yourself. >> I am the director and we promote and protect human rights . We are in support of changes to the case management rules, CMS has settings,

the 14 chapters across the state less the American Association on intellectual disabilities held a long position that management systems should be independent. We believe that as well. The choice of case management agencies is critically important, this summer I traveled the state

to Grand Junction, Durango, Pueblo, and this was pronounced in the rural areas of the state.

We believe that case management's should be consistent through community boards and entry points and for decades, taskforces stay orders, different agencies have been discussing recommendations around us.

Clearly the devil is in the details and we are supportive of more time if that is necessary, to clarify some of the comments that were raised.

We are supportive, of more choice and quality providers, and the qualifications. The 14 chapters have been working on about 30 points of clarification in terms of some of the rules as you see them today, we will continue conversations in the months to come.

Any questions ?

Thank you.

>>

Good morning. He is in his firefighter out there. He is 11 years old and he wants to be a firefighter when he grows up. He is in the community today with his behavioral team learning how to function. I come here as a parent, no one pays me to be here. I think it is important for the sport here and untethered viewpoint of somebody who does not have a initial interest. I have an interest in that my son's outcome after receiving services is essential, I want to give some background to the board. I did not realize there were 95 pages in the document.

I go to a lot of different boards, I go to human services, I'm used to reading documents but I was disappointed when I read this one.

I served the 2014 on the conflict free task force is appointed to serve and I met Britney and I believe she was new to the department so we are coming on the same entry point. I feel like we can speak on the same level.

With all due respect I agree with Julie, this packet is not ready for prime time. I see a lot of influence from the current words and the lobbyists,

and not from people like me. That is the message I want to get across, these rules and the packet was brought here after 12 stakeholder meetings, but was not given back to the community to review. We too hit the pause button on this packet, there needs to be a safe place to give feedback to these rules for survey that is anonymous not through a face-to-face meeting where we are intimidated because the rooms are packed. It is not a safe place for people to sit and share opinions.

A lot of the things that we said, the biggest one was the law using the word [Indiscernible] a rule needs to be stricken and replaced with intellectual disabilities. There is no longer a division of intellectual disabilities in Colorado which breaks my heart, the department unilaterally had a conversation after they make that decision without any input from the community, that this empowers our community, it's difficult to access the department. We have to call many people to address issues. That was a poor leadership decision. >>

Page 38, in order to be approved as a case management agency, the agency shall meet all the qualifications, have a physical location in Colorado. What does that mean? Is that a home address of a sole provider? That is really vague. If we are providing choice I want to choose someone that is one person agency that does all the case management, I don't want this to become another choice of Walmart I want to have a Main Street with medium-size stores. And that is what choices about. >> I want to -- I went to half of the meetings. People had a lot of concerns and they are not reflected in this rule, that's

why this rule packet -- you need to create a survey, I have a 3500 person mailing list that I managed, I can send that out to the community and we can control how many times people click so there is one entry per person, get a real sense of whether or not the community supports this rule.

Staffing patterns, this is discriminatory against smaller agencies, to require someone to have a clerical reception staff will not allow a single person to provide services.

Page 41, case managers shall attend any mandatory training as required by the department. This is my biggest one. Britney and I , this is the one thing I wanted to have was a curriculum from the department on what a case manager is, every parent like me change their manager, one after the other, we do the work. We need a state certification for case management and that is not in the rule which is my biggest disappointment, we talked about this for four years.

Also it says the provider -- this is another big one, the management agency is responsible for choosing the case management by one client. It's not possible for us to choose our management right now because we are limited by the final rule.

There was something here, page 51, line 10, agency shall provide clients and the guardians an opportunity to review the proposals if requested. The Pueblo report which I read regarding the CMS citations, so request for proposals are not acceptable by federal standards because the provider is choosing the client. The client is not choosing the provider. Make sure you do that. Thank you.

I appreciate you letting me go over but I have no way to say please pause this please let people like me calm. I had to get coverage today so many people want to give input let us do that through a survey so we can get accurate information to you. Thank you.

Any questions? >> Thank you. My question is what I'm hearing, this is not a perfect rule, this is a fairly weak attempt to address two areas, and your raising issues with the entire rule, is it really better to pause the whole thing rather than improving those two sections while ongoing work continues?

Thank you. I was thinking to go to the human services State Board they do a much different approach they do now or rule carvings and maybe if the agencies need to have the qualifications we should hone in on that initially and leave the other things about physical location, training, things like that for future rulemaking. Why are we trying to do everything in one packet?

If there is a timely need to do that, we should do a specific part but there are so many issues with this. It is not ready for prime time. If something needs to be carved out I am supportive of that so we can continue to provide management.

Anybody else? >>

We can look at some piece of of this, we have to have the qualifications, if you have the agency and qualifications that go into effect, and a new agency wants to come on board, where will they look for the actual work that they are doing? That is my concern of that piece. >> I don't know -- how that would happen. >> Thank you.

>> We will call upon you next. You can sign it after your testimony. Please introduce yourself.

I am with alliance, a statewide nonprofit association, we provide services to people across the state. Alliances in the process of reviewing the packet and analyzing the provisions further, questions and concerns --

ECQM -- alliances in the process of reviewing the rulemaking packet and analyzing provisions, the remaining questions and concerns relate not so much to the case qualifications but some provisions have been pasted from other sections, to understand if a person needs to keep consistency across those sections Some of those provisions were created under the basis of different structures so we want to take more time to consider how those make sense in the context of new CNAs coming on board.

Staff are being responsive in answering our questions, we will continue to work with them between now and final adoption.

Any questions?

Thank you. >> Please state your name and your affiliation.

Good morning. My name is Robert Hernandez, I am independent. I am not being paid to be here.

I work with stakeholders in the past. There are serious concerns regarding this rule, there is perception from legislatures and this is being pushed through without robust discussion or thinking about the consequences of what can happen so I agree, there's a lot to be discussed first and if you have a robust stakeholder discussion, you do not want to push it through because there's a deadline, you want to do this right.

I can tell you what is happening in Kansas, you can have a small group,

in Kansas, they said okay because you are a rural state you do not need exemption so you can have small areas that you cover. Most of these manageable cover areas of about 80 miles. Garden City, Kansas, there are two managers and they cover about 30 people. >> The state comes in and they review the files and they say you have done everything, there is no third party, no middleman, the state will say we want to see you so there are proper ways to do this without all of his bureaucratic machinations.

I would agree with some of the previous speakers that say we need to hit the pause button and do robust stakeholder anticipation. People want to provide does once this is the Council, it will take a critical hard look at this, you want to be able to make sure it has a smooth flow through the process.

With that, we should have robust discussions. Thank you.

Any questions?

If Kansas has this document, why is Colorado reinventing the wheel?

And we raised that.

We hit resistance. This is not complicated. It should not be this difficult to do. Other states like Wyoming and acted this immediately, New Mexico, all the surrounding states, we stand out like a thumbprint, and Britney is correct, CMS says when are we going to get there, and we are not there yet.

There are always delays in processing, we do not want to push something through that will be rejected. We need to take a look at other states, okay.

Any other questions?

Anybody else in the room want to testify related to this document? >> The department hired an outside expert to do research for the qualifications. They invite recommendations to the department. Changes were made by the expert with the final recommendations, so we have done a lot of work. I have talked with some other states, about the way in which they deal with case management and they are struggling in terms of the number of case management agencies which are single case managers as far as oversight and consistency so what the department wants, we want to create a system that we can get quality managers in and that is what the recommendations were for talking with other states. >>

As a newer board member,

is there a mechanism to narrow this down a little bit?

That is what I am hearing but if there were more narrow, there might be less dissension.

Is there a mechanism to do that ? >> Certainly , that would be up to the department to figure out which sections have deadlines.

>> Thank you. There has been a lot of great testimony that is specific to the overarching rule but we have a workplan for a longer-term strategy to revise the rule. The changes that we are putting forward today are narrow in nature. We are not looking at fixing everything. We would agree, there are many laws in the rule, we have a longer term plan to fix things. I would consider moving forward around qualifications and we can provide something in writing that says here is the broader plan within the rule and we can do the engagement necessary to make changes in different areas. >> Those are things that are on the radar that we can change. There has not been work to date around them -- I do not want everything in the rule to be revised.

This is an imperfect rule. What's being presented here, seems to make it less that. I am concerned that pushing the pause button to improve things with the lay making it less bad.

>> I am sworn, does I am torn as a parent who receives case management, I agree with conflict free case management,

I don't want to push something through that is imperfect. >> I am appalled that we are using language that is not appropriate. That is my comment. >> To Charlie's point, there has been testimony to this part of the rule, that people have concerns about. If we were to narrow this down, there are still challenges. Things need to be addressed.

We need to take the time . >> My comments are the same. There are issues. [Indiscernible]

I did not ever hear a hard deadline. I don't hear anything that will make my heart beat slower right now about saying, yes, let's move things forward. I'm not feeling it. I know we have hard deadlines. There is so much to figure out, within the scope of what you do today, I have serious concerns about moving forward on this. I know how the process works.

This is our chance for the initial approval to all our community engagement to be at its fullest. I am concerned about moving forward at this point when I think there is more discussion that needs to happen even if the discussion is to narrow things down . >> If the department decides to focus on one segment, which they attempted to do today, is that something that they will make that decision on? What is the next step?

Will we have the opportunity to say yes or no to this rule?

Can we have another meeting?

Thank you. We will both yes or no on this. We have the right to suggest to the department to take over this work. I did not hear the department say, you can change some language.

That is where we have the right. The department, would you like to table this rule? Should we vote? I know I am putting you on the spot and I am sorry. >> We need some clarity. Aside from the additional testimony we have heard on the entirety of the rule, from the testimony that for today, what are the concerns on only the parts that we are changing for today?

>> Has the dialogue today the new as far as the rule and the way you're presenting it? >> What was presented was -- on what the qualification should be.

You had mentioned the possibility of having a timeline for the next meeting that would include stakeholder engagement and when the rest of the imperfect -- imperfections would be made. >> We can talk about the changes that need to be made

separate. I will reiterate, there were 15 stakeholder meetings around the qualifications , there was a public meeting around this. Some of the things I'm hearing, this is something that we are not considered, is there a technical mistake?

>>

It might seem we are not moving a whole lot, give us your feedback in writing. Let's make sure we consider things. There are no technical areas, the rule as it is written, is our position on moving forward. Absolutely we agree, there are a lot more changes that need to be made and we need to have a timeline. >> That would help alleviate some concerns if people knew when and where on how to address some of the other giant things that have been brought up. >> Okay. We will go for a motion.

>> Mr. Hernandez, you may be released.

I wonder if there is a modification to the pieces that Bonnie and Britney just put out, we can commit to the initial adoption, we can work with the Attorney General and stakeholders to find the places like outdated and offensive language, potential confusing due process, we can make targeted changes to get those most egregious components of the rule removed so you can vote with confidence if this were to move forward.

You have not put your stamp on a roll that has components that make you uncomfortable. I don't think -- we did not do a full stakeholder meeting and process on all 95 pages,

however outdated language, and things that may cause confusion in due process are things like other conversations that could allow us to make those tweaks between adoption and final adoption.

They would not mitigate travel full process, -- to mitigate a full process, we go to a statutorily required review process and these rules are in the process now.

>> We will look across all the home community-based settings so that would be another commitment.

This is Kristi. This is your last day.

I want to really hear that. >> I am serious about this one.

I would echo your commitment, if there are confusing languages around technical components of our rule, offensive language, between now and then we can make the commitment to put the pen to paper and make changes.

We can have a plan to do more stakeholder outreach for other components of the rule. >> If we deny this today, and this is brought back for a first reading, are we just delaying this 30 days?

>> Whenever the work happens. It could be longer. >> [Captioners transitioning]

I entertain a motion and a vote.

Madam chair, I proved to deny approval of 08/20 4B medical assistance section 81393. Eight 500 8600 and eight 700 to incorporate the statement of basis .

Second that.

A motion and a second to deny this rule. I'm seeing if you are yes vote will pass this. Just clarify for the point of order. All in favor.

Dr. Givens.

Yes. Opposed. Of stained. There is one abstention and unanimous denial of this rule. Appear in this initial. Whatever that time comes. Thank you for the hard work that you are doing. We will see you again. What I'm thinking is, even though there are only 3 stalls I think we need to take a 5 minute break. We will start again at 20 after the hour.

[Captioner standing by during break]

We will wait just a few more minutes because I did not realize that the people in wheelchairs had to go to the pool court to use the restroom. Here's the point of the organization. We are going to do introductions of the people who are here to present these next two rules together. I got some good information from the people testifying and all the public testimony is going to cross over. Rather than do this twice we are going to do it just once. So we will heal just here rules 8 and 9 then we will do testimonies and I will give you a maximum of 7 minutes instead of five so that you've got a little more time so we are not hearing the same thing twice. So can you please nod to confirm that agreement. Offer go. Please introduce we've got new faces at the table. Please introduce yourself and who else you have at the table with you begin document 7.

Or document 8. I am Sarah Gray sure the transition Colorado manager. This is Tim he's a manager of the program service development. Good morning I'm met Baker policy advisor with the office of community living. I will be presenting on document 9.

And Joshua community-based services policy advisor.

I'm Sarah, I'm here for the 08 16 a a rule that is related to targeted case management services. The first thing I want to call out is that this rule is meant to be directly presented in references the provider qualifications and training requirements for all case management agencies as encompassed in that rule. Based on the denial of the first rule that we heard today or document seven, know that our rules point to that rule. An alternative method that we have available to us is that there is also a section of rule related to targeted case management that addresses this rule. Because of this it simply points back to the qualifications of 519 because this rule was more appropriately put it to that session. It does not have a timeline. Specifically this will change as requested in support for transition from institutional settings. It directs the department for transitional services for individuals who live in nursing facilities for individuals with intellectual disabilities served by regional centers who would like to move back into homes or based settings. These services were provided on the transition program which is a federal demonstration program funded by Money follows the person.

[Applause].

There are several people in this room who helped make this a reality. As of September 30th 400 and 26 people have -- 426 people have transitioned back into the community. A percentage of those were still living successfully in the community after giving bad.

Unfortunately demonstration project is coming to an end. The last day the department can enroll is December 31st 2018. This rule allows us to continue services without interruption. If because this rule is interchangeable and linked as opposed in this graphic to the case management rule. We would like with the board's permission to proceed with the reading today. Noting that it's likely that we will be back with an emergency rule to be back next month. With the board's permission would like to continue. Beginning in 2015 the department worked with stakeholders to develop a sustainability plan for these demonstration services. We did that in cooperation with the advisory Council and we widely published that sustainability report approved by both the community as well as the Center for Medicaid and Medicare services. That sustainability plan was a part of the proactive planning process that laid out the mechanisms for sustainability. We put that in last fall and led to the passing of last spring. And since then we have held more than 20 meetings this year to get feedback in moving these programs and services from demonstration state into sustainability. After those meetings we published the frequently asked questions documents for practiced stakeholders and what we heard from them. What actions we heard as a result. We heard that we were unable to change and why. After publishing the FAQ we held additional meetings to entertain questions about the FAQ to clear up any meetings about the ideas that we have for the programs moving forward.

The rule for targeted case management services under that the department would be able to serve the members to ensure they have the support that they need before, during, and after a transition to move into a community-based

setting. This is important. Because under the demonstration project, providers were only able to be paid after transition occurred to receive a one time payment. Common theme we heard from stakeholders is that it's hard to provide these services when we don't get paid until the end. Targeted case management fixes this concern. The benefit is also the avenue that allows us to continue to provide case management services once somebody is living in communities. Under CTS the program would stop and we would no longer be able to provide services. They would receive community services but not for case management and support the case manager survives -- provides. We know that the first 30 to 90 days that somebody is living in community. Is the most vulnerable and at risk for going back to an institution. There has been stakeholder concern expressed about meeting these qualifications as well as the unit limits that are put into place with these programs. These are 240 units. We understand that moving from this demonstration project model to a sustainability model creates changes that are difficult for some agencies. We are willing to review data about transition to make sure that in the future we can evaluate these requests to navigate for our stakeholders. We requested this data and asked about an appropriate limit for stakeholder meetings. We

found it was a tough question for people to answer. People were not necessarily tracking their hours and we did not have the data so the rate that we provided aligned with other limits that we have in the department such as intensive case management that lined up with the benefits and costs that we saw in the pilot project. It was our best estimate with the data that we had for what needed to be successful. Overall it's very exciting for members that the department is able to continue the flexible person centered services that we piloted under this project sustainable services under the Colorado Medicaid state plan. We are one of a few states who continues this. The only one that's able to move forward . At this benefit we believe the oldsters the capacity of our case management network overall as estate and ensures a quality service that is recognized along with the problems we are trying to figure out that you would hear from stakeholders today. In addition to the targeted case management services benefit the next requested rule change deals with specific transition related demonstration services that are slated to go into the adult waivers. If there are no questions from the board I will hand it off. >> I am here to report and document 9. This concerns the revision to the medical assistance rule four transition services 8553. The transition services are new services. The department designates rule 8 to capture these services.

Committee, you should be looking at the handout that you have not your iPads. >> The transition services were initiated by house Bill 18 36 which was passed this spring. Pursuant to the bill the department is to implement through adult waivers transition services to eligible persons in their transition from an institutional setting. Let's clarify that, nursing facility, regional center or ICF I I. Transitions from these settings to home community based setting. These services uphold Colorado's commitment to the federal precedent established from the U.S. Supreme Court ruling in Olmsted that under appropriate conditions individuals with disabilities have a qualified right to receive state funded support and services. Including the community setting rather than institutions or institution -like settings. The need for the new rule is further justified by federally required assessments which indicate that more persons a living in institutional settings expressed an interest in transitioning unity based settings that currently have it available to them. In order to ensure access, continued access to successful transition support such persons will need ongoing services and support after the transition. Not only to enable their transition but to the health and develop skills and resources for resources. Physician services is a broader category. Will find them but transition services include for specific type of services. This first is independent living skills trainings. Home delivered meals and peer mentorship. With that -- if you have a challenge for now educating -- navigating references [Indiscernible] Not only is it a large rule but we have proposed changes to those rules that it will affect and we begin with existing rules. Primarily these rules are existing waivers in the changes that we are making to these rules. It indicates that the transition services that we have incorporated. So that's the impact. It's just to indicate waivers. This is followed by the actual transition services proposed rule and like any other rule it begins with definitions followed by service

authorization which explains how soon these services are authorized. And then the type of eligible members who get services authorized. These are followed by provisions representing each individual service. Beginning with independent living skills trainings. These are trained on skills to rehabilitate into or develop new skills that promote successful community communication and activity. This includes the coordination for expenses to set up a basic household community for items to create a livable setting. Home delivered meals provide individuals with special dietary requirements that don't have resource to access those meals. The availability of this nutrition is vital to their health. For transitioning into the community. Peer mentorship are services provided by a peer of the client somebody with common shared experience that the peer member can draw from to support the member to advise and guide in their transition and adaptation. With that I hope that framework is helpful in discussion. Let's move on to stakeholder process. Process for reviewing services that began with 2 stakeholder meetings this summer followed by most recently meetings pertaining to the rule draft. This draft has been updated a few times. Updated over the past week and that's the draft you have in front of you. This draft that you may have looked at earlier this week reflects the same substance policy the intent is to get this is close to CCR as possible. So those are the primary changes to this draft. I will present changes throughout the process which begins with changes from current existing services and providing pioneering version of these transitions.

I suggest that before you move further. If we have questions maybe we could address those now. It seems like it's getting further away .

Just in general. Of never seen that we had a mentorship. If you could explain to me how that works.

You have not seen that proposed before because it began as a pilot in the CCT program. Student this includes it as a service. As mentioned it's brand-new to the waivers in the CCR. If you want a deeper dive as to what it means.

We were here earlier discussing how it had to be approved and the agencies were looking at who is authorized and do we have strict regulations coming forward in regards to who can be a mentorship person and how that looks for the person receiving that mentor ship.

Let me direct to in rule. Provider standards .

Is that information sufficient in terms of what you were trying to understand. >>

This is exactly what I was looking for. It's a provision . Scenic any more questions? Otherwise we will let him finish the presentation. The first change want to point to. All avoid the acronyms. The transition independent living skills services. This first is that in the proposal

the class a license is for services for medical tasks and class B is for agencies providing personal care with medical elements.

Activities and daily living. The reasons why you want to heighten the standard to these requirements is to align with what is essentially the same service, same spoke that exist. That's one waiver that we are not at transition with. We want to align with requirements in that waiver, to increase provider access. We want them to carry on and be available to provide other waivers. Sharing instant access to services. Another reason is we are adding stronger personal care element to this service to align the requirements for the personal care qualification. We feel a strong need to require such licensing. So that's the first change of the article. This second one is stakeholders have emphasized

lift experience. The qualification transitioning themselves to the community. We recognize the value and deep insight that a provider may have. We at this juncture want to align with our current requirements and move on to explore further the efficacy and need for framing and experience on a particular specialization of training itself. If you want to transition set up what's been emphasized. Expanding the scope of the service to include basic pantry set up items. Personal effects. This is a step in the direction of expanding access to essential items they need to survive from the onset pertaining solely to security deposits. Getting that set up and paid for. Moving expenses. Want to recognize that there are other essentials related to living environments. These key personal items. We are making these items available to members. >>

We have a lot to transition and a lot of people to hear from can we finish up these changes so that we can move on. Scenic thank you, I will just highlight the titles.

Transition set up. Another change to the service is limitations, services. $1500 in transition expenses. 500 is needed.

I just heard the number 1500 for transition services does that include [Indiscernible] Basically that doesn't seem like very much money if you're in Denver. Just curious.

Most of our members who transitioned receive housing voucher. Typically a security deposit and things like that come out of security expenses. So I apologize for the break in process.

Just understanding what I'm hearing. It could indeed come out of that.

I understand. But almost all of it just understanding the reality of what transitions looks like for people. >> The change here is a change among our drafts. It's understanding the qualification standard for peer mentorship. Offering providers flexibility. Those are the key changes and with that I conclude.

Thank you Mr. Baker. Does the committee have any questions on document 8 and 9?

Other than that was a lot.

If I understand correctly. Document 8 was the experimental pilot process. Document 9 was the changes that are being requested to the pilot project as it goes forward.

Not hundred percent. The reason we wanted the picture is that we are correct in saying that.

It's important to know that both of these rules pertain to the work that the department did in collaboration with the general assembly and stakeholders to take what we learned from the demonstration and to embed that in. Both relate to that move from services that will be available now to the state program. The first relates to the case management services. As Mr. Baker went through the document. It relates to finding the 4 services that we are taking from the demonstration and putting it into the state planned waivers so there's case management and in some ways they are all related to that there are different services we discussed in these documents. >> Going back to the previous document that we declined. I don't understand why and what's being presented to us for 8 and 9. We can't approve those. How were they tied so closely together that you cannot do 8 and 9 separate.

The reason that these tied closely together is that what was sentenced. The way we have them typed together as it requires us to move forward to reference a different rule. So this is brand-new target case targeted specifically to people who are transitioning out of the traditional setting. We wanted to have alignment with this structure as it exists today in this new version. This doesn't move forward so it doesn't change what role we reference so we can make sure that if the board approves these rules that there is a gap in services.

We have case management defined in our rules. As it relates to document seven. To move this forward we have to change the reference of the rule number to go to our currently written and approved confided in the code regulation case management definition. We will have to re-toggle it to a different rule. It was approved or disapproved over time and then when we come back with document 7 in a different state that is more complete. Perhaps that moves forward then we can switch that peace to go to the new rules. Those are minor technical changes that we can only accomplish.

Any more questions from the committee? If not we go to public testimony. Public testimony. Let me give you your order. Speaking order. So your aware. Taking the people in order to when they signed up the first person up is Lisa Payne.

If there's anybody else who wants to sign up you'll need to speak up and let us know.

I'm giving your 7 minutes instead of 2. Does everybody understand. When you're close to that I will give you a one up.

Can we have Sean come up with us? >> Introduce yourself and tell us who you are. Where you are from and we operate just like everybody else. So don't you know we are here for the reason you are here. And that is Colorado and what is happening.

I am Lisa, the owner and administrator of the CASA transitional services based in Pueblo. We serve El Paso, and Fremont County and we also serve South to New Mexico and East. We are involved in a lot of rural counties. I'm here specifically to address 8.519 functions of case management for transition services. >>

Document 8 519.2 7B. We will also go into see this. We are here to present in reference to what Ms. Fraser talked about earlier with the units that are proposed for these services. Which is 240 units that translates to 60 hours. We are finding as transition agencies that this is not going to be enough. There is not a one-size-fits-all for clients. I got numbers that we ran for unsuccessful transitions within the last six months. We've averaged about 18 hours per member which averages to 70.7 units. For successful transitions, we are fairly new agencies that we've only got 6 months worth of data. For successful transitions our average hour is 98.3.

Which is for a six-month period. So if you break that down further we actually have a client who is in the bar Colorado that's about 2 hours from Pueblo. We are currently in a six-month time period at 820 units. This is somebody who is high risk. Somebody who has had .

Excuse me. That translates to about 200 hours.

You cannot exactly take a six-month timeframe and double it. Because the vast majority of these hours that are being used in the beginning comes from a lot of the background stuff we need to do to get them out. As time goes on and they are in the community. The number of hours drops. This person does not need the same interaction with us. We are not taking these individuals to the Social Security office and waiting for 6 hours to be seen. It's a much more lower involvement at that point as Tim goes on. So projected out on that particular person. Looking as if everything goes well. Our standard average visits with her over the next six months will go from 198 hours 205 hours at the six-month wait and were probably only going to add another 60 hours of interaction with her so that rings up to about 260 hours per as far as units go that translates to 1040. If the change goes and we are stuck at 240 unit. That's simply not enough time to do it. She's a bit more intense than other members that we have. She is not astronomically difficult. She is probably middle of the range for what we see.

It's not enough hours but that's legislative budgetary restriction. So just for the point of information.

So the legislator has already This?

It's already been put into motion.

I think as testified the department had a budget request last year that's enabling us to transition these demonstration services. As sick just to we have an annual budget process and there are opportunities but the department does not independently get to at as it relates to appropriations.

The questions related to this. A part of my concern and interest in looking at this is that these amazing demonstration projects had incredible salt's. It's time to put the money where your mouth is and move forward with the service. Wondering if there's flexibility a agencies. Those agencies have this many units or is it just a member it's much more difficult to use that when you have a member in Lamarr and a member in Pueblo. So right there I already know is going to take a ton more time based on where there located. One of my biggest concerns with these roles is how we streamline them. Making everybody the same which it. Wondering about that peace. Is this a member or is there flexibility for these dollars within the agency. We have budget flexibility to be able to work with that.

One thing we looked at after doing an assessment is risk mitigation. Most everybody is a risk of higher medium. Obviously the goal of this is to be low risk as the end of the year comes. Talking about our client whose very high with comparative low risk. As I said before. It's not a one-size-fits-all. Every client is different and even if we place somebody into the community that is a moderate risk. There is no guarantee they will go from moderate to low. We had a client who discharged and went into the hospital a week after she discharged. She's got no family and we strive to be available for our members 24/7 for the first month. Because sometimes we are the only person that they have. It's 60 hours, that's not enough. For us to give the quality of case management. We are very excited to go to targeted case management. We cannot accomplish what needs to be accomplished in 60 hours for the entire year. So the time that I have for doing questions.

Thank you. Have you denied taking Fuchs because you already know that you've got enough case management?

Nope, because I am a go-getter. I try to give everybody what they need. We have denied people based on ability. Because if there are two independent they don't qualify for the program.

The units that are given at 60 hours. Are those shared by chance are the only per-person.

You can't go over somebody who's more needy versus the other.

This is not help extend the service hours? >> I want to take the opportunity based on this question to provide a larger framework. The hours are in addition to management hours. There's an additional 240 units for the targeted services. Those hours are meant to be specific to the elements related to the transition. Not for general H CVS -- HCSB. Risk level goes down. They go through the transition and when they successfully transition through the community it kicks backend. One thing we saw on the pilot project what structured was we saw the transition services were kind of blurring are aligned with peer mentorship with some of the other supportive services we were providing. This provided us an opportunity to offer clarity in terms of the different pieces and elements of the transition versus services that are conflict free. Our hope is that because this has been a flat rate model our answer rate is lower. Because everything is combined so

our commitment is really to take this data. It's due for us. To look at the first year under the new model of sustainability and figure out what this looks like under the sustainability model and come back with an appropriate budget request or once we have good data there wonderful and gives us a lot to think about

the vision appropriate. Meet the member where they are at. One thing I love about our network is every TC I know will go above and beyond to make sure that a successful transition happens. It's a lovely thing. We appreciate the love. It takes a team to do this.

We've got 60 for the first few months and 60 for the next.

It may only take 9 months to get the other level of management. It's a budgetary legislative issue .

So you actually got hundred and 20 the first year?

Essentially hours.

Yes to convert it to units. If you need the intensive transition services like you've got the other 60 necessarily. It depends on which services you are using. Except for the money part it may or may not take longer to do the transition. >> When you traveled your using it.

We cover our big counties like El Paso and Fremont. For the one person in Lamarr. That's an entire day. There were small agencies. Our entire day is focused on that member. >> Think you for allowing me to be here. As stated since December 2000 or 2017 the transition is a savings for Colorado 2.8 million. Comes by way of the functions of the case manager on pages 2 and 4. It really doesn't define the length of monitoring time that is needed. When the member has successfully transitioned they are at a low. Everything is great. For those who want to go help move these things out of the partners or Department of Housing to dispose of however the member wishes to get rid of their belongings. Transition agencies have been doing that. I stated 240 units does not even cover that. My concern is that the numbers are skewed because as stakeholders it was never asked on what we do after the transition. The work that we do after that is based on the time of referral at the time of discharge not monitoring peace.

After transition is when things can break down. The same as when people discharge from hospital or when you have this real window of you know keeping it together.

We haven't heard this specific point quite yet. >> I am adding some people on so we have now got 8 people because there was a bad URL. >> The document in the web link was not working and it's been corrected.

Welcome back. I'm Juli I welcome the ability to talk. I'm going to show you the big picture. We are very concerned about this pool. Been involved with nursing home transitions, it's a very important and complicated process. This program has been wonderful but it was not always wonderful. The biggest baddest thing in this program has been intensive case management. It's been a nightmare. What has been the

best part of this program of housing and set up money. That's the most important part. But also the transition coordinator role. That's what really makes it work. Taking something that has worked well and moving it into a case management model is quite frankly disaster it does not seem to make sense. Have similar concerns about the whole IL ST. It's very important particularly are independent living centers. Doing how to do it and make it into a home health license model. There's one provider. Most have stopped doing the work quite frankly it's a disaster. The kind of stuff that people need when they transition are things like if I'm a doctor if I go see the doctor with the client so all the prescriptions get written the day that they leave. Taking people to look for housing in areas where there may not be a housing navigator. Dealing with Medicaid which is always a special activity. I don't feel I know that several the independent living center directors are going to speak. People who have done this and do it every day in this current environment. I'd like to say why do transition coordinators need to have 5 years but case managers only 2. Skills and requirements. Do they not need to understand the independent living possibility for how it messes with your head? Those are important skills there making them have skills that don't matter. The transportation related restrictions. With all due respect. However wrote them does not understand how it works. It's not going to work you may have no gap but you will have providers either. Because a lot of people won't do this work. When we don't have a coordinated program we go back to the way it was done before. We are still going to do transition. We won't coordinate were just going to call up the steps and say you need to figure it out. Is not a good way to do it that's what we will go back to. This does not work. We are taking the worst part of the things and making them permanent. >> What's your recommendation.

You are immersed in this. I want to know what you think. Because I can see in the committee size that it's a concern for them. Give us your recommendation.

It's not about being imperfect it's about being fairly flawed. My concern is that we listen to the people who are doing this every day. The independent living centers. We have been doing this since the 70s. Listened to them and have a definition of targeted case manager with qualifications or transition coordinators, they're not targeted case management. We call them something else [Indiscernible] We don't do a medical model and have a home health license. We use the independent living definitions. We've got this skills training but we can take and provide that payable to Medicaid. It's already vetted by federal law and state law. Take that is the independent living skills training and take the transition coordinator job description of what they actually do. Put that in and if we have to target case management, find. Is a huge conflict of interest when making these independent living centers these legal issues. This can be done but that's how it has to be done.

When looking at how we can fund services for looking at home community services we have authorities and targeting case management is one

type of authority that we were looking at. There is a lot of flexibility and how to define that service.

We chose targeted case management because it had the most flexibility in terms of financing. One thing that we heard from stakeholders is they weren't getting paid in a timely way. Working with clients four months without receiving any type of payment. And then when they did , because it was a successful transition. The transition didn't fail and they didn't get paid at all. Targeting case management was a way for us to look at how we can finance the pre-transition work that they do. Then we can pay them after the transition to do the monitoring work that they do. The way it was structured . I think we can look at refinement to better align with the TC do. I say that under transition support they would still only have a one time benefit. There's going to be some things that Medicaid typically won't pay for it those services. I think because TC got that one time payment, while we have some flexibility certainly there are going to be some limitations on how things will be built. >> Is there any flexibility in the rules education experience. She indicated there was a huge disparity.

I'm not sure where the five years is from. The rule targeted points directly back to the case management rule that was document 7 which we reviewed. Four years of combined professional experience and education.

What we have and document 7 and working with people in the long-term services world or a combination of those. Or if we didn't have the educational environments.

I will speak to the 5 year requirement transition coordinators. This reflects our alignment for the [Indiscernible] .

One hearing there's some agreement . Really with the department's training to do

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having capacity statewide for providers intellectual development abilities who want to transfer out is not an area where we have a lot of providers step up and see we want to claim that space. So we look at how we leverage the most providers across Colorado to leverage as much as possible. Understanding the target regulatory authority perhaps the most flexible and There are requirements that are [Indiscernible] It's the one that gives us the opportunity to offer a sustainable model to providers and access as many different types of providers across the state of Colorado. I would also say with that ILST training I think there's proposing that doesn't incentivize what we want to get out of that service. There should be alignments in our rules. It currently exists within the regulatory frame . Not to delay moving the rule forward in an effort that were not going to get license type or certification type in a few months. So we can agree to do that quickly to engage people. We do want to move forward without any oversight that's not an option for us.

If there is no more questions, thank you very much we are calling candy burn him from -- [Indiscernible] Please introduce yourself [

Indiscernible] >> This is not an accessible room for somebody with a hearing impairment.

I appreciate that and I am asking people to use their outside voice.

There are some seats up here if you're wishing. >> [Background noise]

Good morning I'm candy B with the Atlantis community. I'm the executive director. It's a center for independent living in the Denver Metro area that transitions people out of nursing homes. We are the home of adapt. I'm here representing the Atlantis community and other facilities in Colorado. Sales are certified by the federal administration and the CDL to provide services for independent living skills training and peer mentorship. Sales are consumer led across disability organizations that operate with a deeply held philosophy that people with disabilities have the right to live in a community without unnecessary processes that prolong access to or prohibits that right. It's this philosophy that led adaptive skills across the nation to work of hetero legislator is money follows a person. The changes proposed will remove [Indiscernible] As a provider for the services that we helped to create. Board portly the proposed work for consumers who have benefited from the unique transition styles that sales provide. We believe this model is unsustainable [Background noise] for agencies providing services. Attached was a list of the rules. I did not realize the document had come out so they may not align exactly. I'm happy to answer any of those but I will highlight the major concerns. The first one is around case management. The proposed changes required agencies and transition coordinators to become case managers. The process to become a case management agency is a ministry -- Adamson financially. These agencies are required to have one month financial reserved capacity. It's decreased from the three months and we appreciate that. However, for small nonprofit organizations even 1 month is difficult if not impossible. The rule does include a provision exempting case managers or agencies from this requirement prior to January 1, 2019. It does not address those agencies that want to provide transition services after that date. The second point is, disability organizations such as SIL cannot function as a case management agency because of the appeals process.

When the case manager denies or suspends a service the consumer has the right to appeal that decision. During the appeal hearing the case manager defend the denial as a representative of the estate. As an advocacy organization we advocate for consumers during this to ensure the get the services that they need. There is no ethical way to represent state while also advocating for the consumer. There is also a fundamental difference between advocacy and case management. As a case management agency you must follow the rules. [Indiscernible] While it makes sense in a typical management case model it does not make sense for short-term services. Separating the transition for set up expenses will further complicate the experience for both consumers and providers. ILST is currently provided. It's beneficial to consumers but the current requirements are so problematic that there's only one provider in Colorado. It's not a provider base. There isn't a single provider in the state of Colorado. The proposed rules continue

knowing the flawed design. ILST is not a medical service but it requires a class B license from the health department. As evidence by the lack of provider requirements to maintain licenses for undue burden of agencies. The [Indiscernible] It's required to keep people safe. It's important to note that licensure is not required for other services such as supported employment for people with intellectual and developmental disabilities. It's illogical to require licensure to teach people the skills to live independently. Stakeholders have repeated continuity across waivers but continuity should not take priority over effective and meaningful services. When there is a flawed program or definition is to be resolved not replicated. This would've been a great time to work with us to develop a service that can be implemented in the waiver and expanded. The department has known about the issues for at least 3 years. I appreciate the department's commitment to re-examine ILST however it's not to the providers or customers benefit to implement flawed policy even temporarily. Peer mentorship. The purpose of this is to connect with somebody who has similar lived experiences. Through this connection people learn about resources, techniques, benefit navigation and developing community relationships. The proposed rule does not accept lived experience as a minimum qualification. If somebody has a spinal cord injury they live in their own apartment and have navigated through Medicaid and other processes. They are involved in their community and can get training. The lived experience should be [Indiscernible] This no other degree or license that makes somebody else more qualified in that situation. We are deeply concerned about what will happen to people who want to live in a community of these rules are implemented. If the department moves forward. Atlantis will no longer offer these services. We will continue to transition people into the community and providers will have to follow through with the transition once we move them out. We respectfully [Indiscernible] We've provided the department with our suggested solutions which will be shared in detail in an upcoming testimony. Thank you. Any questions? >> A point of clarification. It's certainly intended within the definition of what a mentor is. If that shared experience peace it's who we are intending to provide the service. It might be a matter of drafting that needs to be emphasized. >>

Can I respond?

Yes you may pick

We have provided that comment that is exactly why we are here. Know that this has been addressed. You had to go through an extensive training process and get a certificate . One agency in isolation. I'm glad it's been removed. But I agree with your. There are language changes that need to happen in that role. >> We appreciate the patient's everybody showing it has been a long day.

I Maureen I am commenting on document 8 and 9. Acknowledging that document number 8 was not available online. So in my opinion it wasn't properly publicly noticed I couldn't review it until I arrived today. I think that's a logistical question but it seems like the department needs to be more careful about making sure information is available to the public. My biggest beef in all of this testimony so far in this

whole meeting is that I keep hearing, transition services are being lumped together and in my opinion the centers are different than a nursing home transition. I did not hear any of the data pulled apart to look at these populations differently. It's mainly because those individuals are making a lot of money and they don't want to discharge them. I don't see any work in this pilot that focused on that group. The elephant in the room is that the most deceptive work that's being thrown around is the word stakeholder input. I'm disappointed that [Indiscernible] Is not here to hear this. But there needs to be a better definition of stakeholder input. I don't know how many people here are untethered like me. But the lack of input for the people that these roles are being written for is very concerning. It is usually providers, case managers, agencies, or direct service agencies. Those are not stakeholders those are people making money off the back of James. They are not members and people receiving the services. Somehow this department has to get more creative about creating a safe place to get feedback from individuals like myself. In this room I have CEOs of organizations that I receive services from. It is not reasonable to expect people like me to come forward and speak out in opposition to things when the very people that my son's life depends on, or in this room. So how do we create that save space? The board and leadership would be wise to ask that question and convene a special task force. I'm happy to serve on it. On how to create better input for stakeholder process. Stakeholders are not just providers. There are people competing with services. Transition works for some but I did not hear anything about regional center residence. I have a website that I fund myself and a newsletter. I've got 6 families that I am in direct contact with. We have loved ones who feel they are incarcerated. We've been trying for years to get them out and there's only one way I note that they have been discharged. [Indiscernible] Deaths is not the way to get out of of regional Center but right now is the only way that I know of. How did this pilot address that population in this issue? I feel it's very disingenuous to talk about this being successful when regional centers are being marginalized and not pulled out a specific -- a specific population. As a parent of a potential regional center individual because he's got behavioral needs and intellectual disabilities. I urge this board to figure out how to get more input from families. Ask those families from the regional centers if they benefited from those pilots. I know families who could not access services for mental health that the pilot was claiming to offer to families. It ended up being the whole part of the pilot that happened. I appreciate the leadership. I'd like this related to her that there needs to be something about getting individuals involved in the safe space. That is it an thank you.

I want to note that we did hold stakeholder engagement as noted in the concerns are laid out as well.

Thanks for saying that. These very families feel unsafe speaking these things in the regional center meetings especially when you have staff and leadership in the room. How can they stand up and say something. I think that's very unreasonable to say that. There needs to be safe spaces. Thank you very much. [Indiscernible]

Is your concern with the pilot program a lack of transitioning or are you concerned with the new proposed rules and abilities to do that.

The only transition I know out of from regional centers are deaf.

Mr. Baker does that answer your question?

Yes. It's something we need to talk about.

Stop incarcerating the intellectually disabled that have mental health issues. It's a deaths sentence. That's all that I'm saying.

Mr. Bolden. Please sit down and introduce yourself. Don Russell will be up next and then we will go to Edward M.

He left. >> And David Boland I'm with [Indiscernible] We are licensed home health home care agency. I have 27 years working in independent living as well as home care transition. We figured out the funding got them housing and in 2002 my organization center for disabilities was the lead contractor for the nursing facility grant that the department got from CMS to transition people out. We did that statewide using independent centers goals they had to meet. It was a very successful program. We had some housing vouchers. A little bit of startup money and we were paid out of the grant which kept us going. We hired people. We did not look for these requirements surprisingly enough that's the real skill. In 2004 with the department we passed a piece of legislation instituting community services and waiver. That was pretty successful and kept the same format as we already have. Working with Mr. Cortez and met pushed hard to get some particular aspects that very successful in transitioning people out. Peer mentorship. Meaning a person with a disability mentoring another person with a disability. And then independent learning skills. Talking primarily about 8.553. Which is an independent living skills training. First of all we are training people. Independent skills is teaching somebody how to do it. Is not doing for. It's teaching how and coaching. Letting them try and letting them fail. Going back over what happened. That's the training that's how we all went to school. Nobody did it for us in school. Our parents hopefully taught us independently so we need to teach people skills so that they can live independently and be in control there's no need for home care license. We used to be the only independent -- to do the program they lost money for many years on that program if they hadn't changed the rules I would've home care is hands-on personal care. That's not teaching. Is providing CNA services. Providing nursing. It's not teaching should not have to be increased cost for no real reason to an agency with transitioning people out of nursing homes and doing independent nursing skill. Their personal care industries that will go in and help there agencies out there there are 700 licensed agencies and Colorado they won't teach skills. So I think the whole license partners to go away. Make sure that you say you cannot do personal care. Because then you do have to get a license. If you're just teaching skills. Those are really important. I to say that the 5 years of experience whenever I read there's got to be a certain amount of experience I think that the department has a small room where you blindfold somebody, give them a

dart and throw it and hit a number on a wall. Whatever is closest. Whatever you need to be in ILST coordinator for lived experiences. It's better and I have no idea. College does not teach independent living. At least a college I went to. I guarantee they are not teaching. I see people graduating. Life experience and especially knowledge of how to do a successful transition. We've hired a lot of people and you just have to figure out how to make it all work.

Sorry we have got 7 minutes and 20 seconds. Can you please wrap up.

This needs to be reworked. Just this one section is exceedingly medical model and does not fit the reality of what works best in transition. It's too prescriptive. You're going to lose providers because agencies and rule areas in independent centers. If they don't provide home care if they are not going to be licensed.

My understanding of this and what would be a new requirement around this, under the name within our regulation as case managers. That's what's creating this medical model piece. Is there a workaround for that?

Who wants to answer that?

Mr. Cortez.

So when the department looks at this we are looking at the waiver program. There life skill trainings. So the expect we were looking at was how does this work across looking at 6 waivers. Since the requirement was there for the VI program and required oversight. We wanted to look at the license as being something that would be a common denominator across different waiver programs. Recognizing that's not a perfect fit we look at working with stakeholders as to what is the right qualification for the life skills piece. To make sure that we do have standards of alignment in the future rule revision. Having the agencies provide the service we would no longer enroll people at that point.

So this is to be enlightenment with what the brain injury waiver is doing. Is there terms of difference? For clients being served. It seems like there might be a difference if you have a brain injury. Versus I'm not sure. Just wondering if that matters, is there some reason to have these different skills training if you have or need different skills. Curious. Is there a reason for that and doesn't have to be replicated.

I can speak to that. The primary is a threat for application. Alignment with the I waiver consistency of members experience. Per population. To have the same experiences as someone in the SLS waiver. The difference in this already has you know the ILST is already in existence. It was intended for people with brain injuries in developing and sustaining skills throughout the population maintenance to take constant practice. It is not only development but long-term maintenance that's provided by transition. That need was established earlier on that's why it exists. The need for transition independent

living skills training. It emphasizes a specialized context which is to develop one's ability to adapt to the community. To learn the skills that are essential to ongoing living. Whether it be a need for rehab or just learning the skills that they don't know. Things they don't know about living in the community. There are 2 different relative areas of need. Spoke with the ILST it's broad enough to allow for transition. The difference in provider training. Targeted towards learning and competencies and best practices with serving the population. We Did pretty broad and just said training requirements for competencies. Does that answer?

So the last part seems like it would answer all the concerns of the people who are saying now you are asking us to do trading which is not what we have been doing. [Indiscernible] That's a broad flexibility I have not heard. Just making sure it's a real thing. That seems like it would answer every question just taking away oversights.

That requirement would be in place. That's a requirement. You've got to have one of those. And then on top of that. >> Training for your license has nothing to do with the specific disability and nothing to do with any of these. They also if you're going to have a license, and you're trying to prescribe licensing rules. Then those rules are controlled by the board of health. We shouldn't cite them or we should cite them rather than trying to write them down. But I disagree because [Indiscernible] Is different. It does require much more time than what this program is. Transitioned many people with brain injuries and it works by just teaching the skills. It's just way overboard and follows a medical model that is not necessary.

Ms. Silva.

I like to remind the board that our intention is something to replicate what we have to make sure that in the short time we've moved forward that there isn't a gap in service that we have oversight of whatever service we are pushing for. We engaged with our ILS T providers a little further back. So it was implemented and put into place. There is an agreement from the department that perhaps we create something brand-new. It doesn't have to be licensure. We don't have the time between now and when these rules need to be implemented, to create really what should be in place and not move forward without any licensure for oversight. Class a or class B is not an option.

You already have to be certified. So you get a license but that doesn't mean you're certified to get a license. So certification is already in place.

Working with our local partners to make sure the services provided are high-quality. Doing it in a better way but in our truncated timeline.

Mr. Hughes and then Mr. Potts.

I was a part of this board when we approved the brain injury waiver for SOP and licensure. I think what I heard in these conversations was that we now only have one provider of the SOP for the brain injury. So

I'm concerned. Because prior to that it appeared we have a lot more providers during that time. So are we trying to adopt a regulation piece that's bailing in another already established waiver and why would we want to do that. That is my confusion. Is it true we only have one provider and why are we moving forward when we had what appeared to be a handful of providers prior to making the class B licensure.

In the response? >> And the section manager for the community option. Diane is our expert just clarifying we have many more than 1 SOP providers for this service for brain injury. We do have a limited number. One thing that's getting messed is the part of the proposal for increasing that rate for the ILST providers as well for the significant increase which we think will help request access as well.

If we have providers that we have lost providers in the last couple of years. Possibly for this and what I'm hearing now is that it's due to financial reimbursement for trainers. The hope is moving forward with this higher reimbursement rate. The other thing is we have to have oversight with what we have to demonstrate.
Scenic last comment Mr. Bolan.

Just a comment on that. For as long as I've been in the state of Colorado we've had oversight over every provider there paid to do surveys of those providers for every certified provider. And they do.
For certified agencies we are already being served and there is the oversight for every certified provider you've got many providers who are not licensed in any shape or form.

We request we take the oversight structure that we propose. Doing the deep dive with the stakeholders for people who did want to qualify was there any way to have that be extended. It's undoable for any agency I'm curious about that if it's put on paper if there's any agency is. I'm extremely concerned about agencies and thing. Putting on requirements, this creates a lot of work. Just curious about that.

This is Matt Baker. This deadline is for providers who wish to enroll in ILST who have not provided it for CCT. That's extremely new for providers on board. For providing
we are sensitive to keeping on board
there's a 6 month grace period -- they don't have to dive into that and worry about not being eligible to apply.

To apply? Scenic yes.

Thanks, that's helpful and has not been brought up until now.

Thank you Ms. Silva. This has been a long day.

January 1 2019 is when we will no longer have ready to enroll people. So we recognize that the providers in the demonstration program might need time to get that licensure. We've created that grace period to continue to provide the service. We need to have the service authorized January 1 to make sure there is no gap in the service. You said for

them to have their license by July 1 and to apply. I know those are very different statements so I'm curious which one it is. >>

Apply by then otherwise it will be to some fault.

I'm going to call on Ms. Fraser because she's got her handout. You mentioned case management. We will also be offering a grace period for case management agencies for people who meet those qualifications. We have a training schedule developed by which we will start treating people as early as November of this year. We are committed the first half for technical assistance necessary for people to be able to meet those qualifications.

All right, thank you I'm going to call on Don Russell.

Next up is Amy Dixon. Then we got Paulette. >> Please introduce yourself.

I'm Don Russell
and I cannot read -- we visited that area and as you go out the door this cannot pass as it is. >> You asked about the picture. The description. This is Mark McClellan the head of the agency
outside the White House. This is why we are here today. In February 2006 reporting for National Public Radio, Joe Schapiro told a story of how legislation came about. Over the summer federal officials announced the changes in the way the government pays of Medicare and Medicaid. These people need a nursing home. Instead of paying for delivery. That decision came because of for disabled activists in wheelchairs who came to Washington. There trying to get themselves arrested . They ended up listening to us. The change began 4 years ago when about 200 people in wheelchairs rolled into the intersection closes to the White House I was working in the office of 15 other issues since Mark was at the time a member of the presidents Council on economic advisors. I said Mark There are people outside blocking traffic at the intersection of 17th and Pennsylvania. It's coming up on rush-hour so go fix it [laughter]. We went outside and met demonstrators. Bob [Indiscernible] It contrasted with his gray hair and his beard. The two men could not be more different in terms of the political place. But on that rainy day outside the White House they found things in common. The administrator and the activist. Both coffer and McKeown are fascinated by the policy detail of how the government cares for elderly and disabled. But also believe that individuals often make the best choices about their own care. After the president -- the head of the agency met with them for 4 times a year. Earlier this year the White House proposed legislation to start a program which gives states extra money to move elderly and disabled people out of nursing homes and into their own residences. Congress allotted 2 billion over the next 5 years . This is the biggest change in long-term financing in decades. Somebody recently announced their resignation. They will be most remembered for setting up the new Medicare. It's one of the proudest accomplishments to adapt. I was there. Remember the lightning and the thunder denouncing freedom from nursing homes. I watched this historic event as all of us were drenched by the rain but that didn't hold us back. Adapt will not be held back now. Adapt will not tolerate

the department making policies. They exclude Atlantis and other shields from providing transition services. Transition services included as HT PS waiver services are exempt seals from becoming case management agencies since they already have state and federal certification. The licensure department for ILST including the waiver. Include lived experience as a minimum while vacation for all transition services. We are people. One thing I wanted to say was I have to acknowledge that adapt is here. And the rest of the disability community in the country. I want to say that I'm lucky enough because of Atlantis and what they have taught me. Lucky or not to transition 53 people out of nursing homes in Colorado. I cannot say loud enough, no licensure certification, whatever that is, it doesn't compare to the experience, the lived experience. To add to that,
ILST shouldn't need a license because , oversight.

Let me ask you a question Dawn. I know this board and timeline is an issue. December 31st we stop services. I asked Julie the same thing. What about passing this verse is not passing this because we've got issues with it.

We know from experience is that when you go forward with a bad plan, getting rid of that plan takes forever. Long enough to get it right is the better option. This is not going to stop somebody who is currently transitioning from getting out.

Think you for your passion and your opinion and for all the work that you have done. I understand where you are and what your passions are.

Are there any questions for Miss Russell? >> My concern is license -- I'm hearing from stakeholders that it's better to not go forward and have that gap into go forward.

I want to acknowledge in your question, the Department of Public Health and environment is the licensure agency. Acknowledge that set of rulemaking and that stakeholder process that involves engagement with the Colorado public health environment. When we negotiated [Indiscernible] Rule. We put together Medicaid payment policies and policies that are different than ours at times. So while we to work together there are other components. Acknowledging and representing that we don't agree is the only policy. While it can feel like too much structure, we hear that we are working on it. We also have responsibility for oversight that's both federally dictated not just by our internal desire to make sure people receive services in Safeway's. So no harm is done.

Amy Dixon come on up. You are next. During the demonstration period what was used?

I think this is the piece where we were correct in saying demonstrations give us the flexibility to try things. We understand then how they work. We are one of the first states in the nation to figure out how to take what we learned work and transition it into the Medicaid framework. There was no direct oversight, if you will, in this way. Because it was a part of the demonstration. The authority granted

allows us to waive certain requirements of the Social Security act to test whether or not there are better ways to do the work. The federal government can change that very reason. Some of the federal structure is not sobbing as well anymore. When we move from the demonstration environment into the structure of a waiver or state plan. To have modifications for the way they work. Doing it carefully with the right approach. Those are just the facts. Speak S not a lot of people mentioned this is --

[Indiscernible] We provide medical care is that provide why we are adopting the model for transition that may not always be considered medical?

This is Gretchen. I think the answer is complex. In many ways Medicaid is a medical program. Colorado is trying to limit community-based living for services that are not medical in nature. Sometimes regulation whether it is state or federal does not move at the pace of innovation and care. We know there are some emergency transportation providers provided support. We've had a hard time figuring out the right regulatory as an example. Is not just here it's and other places . How do we find a better way to think about that. Speaking to the concepts of certification that continue to be explored. There are components of truth but it's with a strong commitment.

Medical icing. I found personally and professionally a part of the challenge of hitting people out of the nonmedical stuff that doesn't get paid for. And that's what we need. It's my concern for medical icing it keeps you institutionalized. Because you can't get the nonmedical services you need that allows you to transition. [Applause] . I'm curious about this role. Curious about which parts you know where it seems like we are going through medical model. I just like verification on that.

The licensure piece is different. I've heard flexibility around accepting lived experiences. I've heard that we will look at that. I've got no experience in how to transition myself as a spinal cord injury patient. It sounds like there's flexibility and I'm concerned about the licensure piece, I'm concerned about that. [Background noise] The difference of how your staff and how it looks like. In terms of meeting of qualifications, it's a lot of work that goes into it. Not serving your patient clients. Concerned about that. Though I understand you want to get the money. Just remaining a concern.

Thank you I appreciate the testimony the state and community that not the had a lot of common. That's a lot in common and what we are trying to accomplish here. So why we did not come here with the class C licensure is I don't know. I think the concern was raised for us relatively late in the game. It was brought to our full attention and we do think we can have a different path forward but we won't have it in time for the deadlines. So far as the best path forward is to move with what we have already in place. What is specific to the service as it exists in the Medicaid program. And to make a very public commitment to work with stakeholders on what is the right type of oversight for

this service. >> To the credit of Dawn, not saying where my position is, , passing bad does not make things go forward.

Mr. Potts just quoted Dawn Russell. Just appoint. We are starting to lose people. We don't want to not have forum for this vote. So Miss Dixon, read those pages as quickly as you can.

I am Amy I work for the center of people with disabilities as a transition coordinator. More importantly is I am a person to a split with diabetes since I was 7. I had a stroke at 30 and I taught myself how to walk again. My family took care of me to tell recovered. It was a very long recovery. I want to be there for my consumers. Hoping we can figure out parts in this. As somebody who spent 7 years and a nursing home they're not going to care if they have to spend another six months while people figure this out. But in the meantime I start transitions they don't finish. To work in this program is fine. What's not acceptable is if we put them up to fail. Quickly, I want to note. Is your solution going to be for the sales to be protected in the role of advocate and still be transition coordinators. Also think about this fake security that you think a CNA working for a home health agency is going to be able to do skills training. I'm working with this right now. I talked to the CNA and say please don't put the dishes up in the cabinet there's a reason he leaves the of the counter I'm sorry if that bothers you that looks messy but they are available to them on the counter and when you put it in the cabinet he can't reach it. I can't that into their head but you want the same people to do independent living skills training. Where do you think your average sine's training comes from. It's 3 weeks. That's what you're saying is qualified to do independent skills level training. I'll tell you who do really good at this. People who tutored kids in school. I used to tutor. Those are people who are good at teaching independent skills training. All of our CNA's are working at agencies that are hammered. I only have 3 agencies of people who will take my
people. That's what it looks like out there. I am doing this, this is my job. My job [Indiscernible] People that are here are people that care. They are there because they believe in our mission. 85% of the people who are there on there because they believe in the mission. Let's do that for the CNA and home health agencies. I guarantee you 85% of the people that are there are on their way to a different job they don't care they just need a paycheck. And you want those people to do our independent living skills for our people? I am sorry. It does not work. It's not going to work. If it takes a few months to get a working program. Please do that. Our people have been a nursing home for decades and they would like a fair chance. [Applause] >> I want to provide assurance that this does show your concern that in our provider qualifications we do have requirements that they are experienced in training individuals so including training individuals with disabilities. I encourage you to take a look at these and see if the competencies gained through these would apply to the values in the competencies that you see a need for. >> You guys are not going to find that. This only one place that is set up to do this. You're not going to find that. People that worked there are there because you have personal experience and care about this mission. When you're trying to get a square peg shoved into a round hole is not going to work.

As transition coordinators, we are not there to fight for our own people. I really want you to think about the logistics. It's nice to come up with rules and it's nice to think you have oversight when you really don't. But look how this is going to trickle down how will people think for this service.

Thanks for your perspective and your comments we appreciate it. >>
This is Josh I wanted to provide a point of clarification between the provider standards specific to the type of qualification from employee who provides the service. Is 2 different standards . With the ILST licensing requirement. The intention is to cover potential activities of daily living for handover hand assistance to show a type of modeling for that. As a training component I used to work in the [Indiscernible] There is many times where I did have to model and help provide a person that [Indiscernible - Low Volume]

We keep saying that everybody in this room has talked about those feelings. You say things like that, that's just not true with the 40 years, we have been doing this for a long time. The first people did it and it still carrying on just stop that.

Enough. Let's move on. It's time to move on.

Martha Mason has written [Indiscernible] I am Martha Mason the executive director at Southwest Center for independence in Southwest Colorado. Our main offices in Durango I submitted written testimony but would like to make additional comments. Please be aware that document 8 is not available online. The rules have changed in part because stakeholders indicated that the actual hardship is in being paid for the Medicaid system. They'd rather be paid at the end of the service then not at all. If we were paid for our services it wouldn't be a hardship to wait until then. She says Mr. Baker indicated that home health certification for revision of personal care is necessary to get consistency but it's not showing any level of care so the rule is unnecessary and overkill. That's her testimony. >> Good afternoon I'm Paulette I live in Littleton Colorado I was introduced to CTS about the same time CT came in. I was in a nursing home. And the reason I chose it was because I did not need intensive care case manager I was independent enough to go out on my own to find a place. I was introduced after being in a nursing home for a year and a half. Don Russell not only assisted me with my transition but she recruited and trained me to become an transition coordinator. On the only one that ever existed inside a nursing home. I have gotten out of it because I am now out in the community. I don't need the stress anymore. With everything that's been discussed I just did not need it any longer. It was a long process with the gathering. It took a year and a half. A total of 3 years in a nursing home. I had my left leg amputated in 2009. Being on that waiting list was weary and tedious. I was offered hope that I could one day be independent again. With all the differences we have here there is still hope for people. This stuck with me. I'm living proof of that. In June 28 2013 it was my move day into my own apartment and historic downtown Littleton and I'm still there today. The first week I cried so happy. I had quiet, my own space and the ability to have my own choices. The first month it was

getting used to so much space for myself. The nursing home was the smallest I've ever lived in.

I enjoyed the new sounds of life in my community and the freedom to shop, and cook my own meals. The first year of my calendar was filled with doctors appointments and it entailed arranging medical transportation for these appointments. Outside of those appointments I pretty much stayed at home. I was still adjusting to having my own timetable to do what I desired. That's a real shift in mind thinking. I was fortunate to be on the side of my building that overlooks Main Street were I could watch from my living room window, the parade and activities. At the end of 2013 I was able to secure my power chair and it led me into independent living. My aide helped me experience public transportation on the bus and light rail. My second year till now, I was healthier. Due to being in my own place and being more independent. That brought me health. My calendar had fewer doctors appointments and more to these with friends. I could breathe again and felt like my old self. It was almost like a light switch went on. I am no longer watching the parades and community activities from my window. I am now down on the street active and involved in what is happening. Functions to the local library and considered volunteering for several board positions. I opened my home to family and friends and I cook, bake, and share with neighbors and friends. My aspirations. I am a contemporary artist and have had an exhibit creating artwork for the 2008 presidential and vice presidential candidates. I planned to have an exhibit at the local library and this level of living and artistic expression brings a fullness and wholeness of self that is stifled in a nursing home. It brings great satisfaction and joy. In June 2017. I was nominated to be a member of the disabilities committee. On August of this year I was elect to become chairperson which I know serving. It's been an experience. There a valid emotional things. The intangibles that need to be considered when transitioning. So thank you for hearing me today. Thanks for your voice we appreciate you coming. I'm going to quickly read more from Martha Mason and then we will hear from Ms. Silva.

Putting people on a waiting list will ensure that people get out and many will die before moving out. The division has known this issue is coming for a very long time. So it's somewhat disingenuous to say that is somehow has to be done quickly and will be fixed at some later date.

Can I verify the housing?

That's true. That's something that has come up. Based on the introduction for housing. That they were afraid they would be unable to fund additional vouchers and maintain the vouchers that were present without an additional budget request. There is a pause that was put on housing vouchers for individuals over the age of 62. Individuals who are under the age of 62 qualify for section 811 which is a different voucher program. There are currently 78 people who have a voucher who are looking for housing and we are keeping a wait list. The division of housing will go before the budget committee in November for a budget action item and will have an update on that. For the assurance for individuals for housing vouchers will be able to continue. It's

unfortunately out of the department's control. We are working closely with them in collecting data. Scenic I think at this juncture I'd like to put on the table and offer. Clarification for the rules. I think that while department is engaged in many of the stakeholders around the process. It appears that it's occurred.. Not having a gap in services for the ability populations and settings have the support to do that. We want to make sure however that we have the best path forward. Even if it's not perfect. I propose tabling the rules. We can meet and discuss some different paths forward. And come back . [Indiscernible] Dr. Givens are you still with us?

Let's take that as a note. -- Let's take that as no.

Motion passed [Applause] .

Consent agenda. I've got [Indiscernible] >>
The medical services board and the Colorado Department healthcare policy and finance by the state administrative procedures act incorporated by reference.

Seconded. >> We do have someone signed up for public comment. [Event concluded]. . We are back and hearing public testimony I made a lot of public comments. There's a piece of writing, the general areas that I summarized for today is that I was appointed to the 2014 case management I was the only person who was the sole representative of parents and even though they have those 12 meetings mentioned earlier they never reached back out to us to look over those roles. So thanks for turning that down. I think it is important for the board to know that when the department people come to you and say that they have stakeholder meetings you need to ask did it get back to those individuals I find it disrespectful that Britney you know I come to all these meetings to reach back out to those thoughts. There needs to be some serious outreach and respect. The department has obligations directly. I have follow-up from my last testimony. At that point I requested the medical services board to post a document with the entire closed captioning with this meeting online regularly as a part of your public posting. I think it's a great way to accommodate people who may not be able to listen to an audio if they have a hearing impairment. Since it is already generated though it's not going out.

It's a great way to create text and record to create dialogue between people. I noted on my thing here after Mr. Bolan's comment that the board should also consider doing amplification during the meeting. I think it's a real issue for people who don't have hearing in the back of the room. That they need to be able to participate in here the meeting in real time. I'm all about accommodations here. And I request that the number two medical services board follow the lead of the rule-making body of human services and allow telephone about Comet for those who live far away or who cannot come to to caregiving and their own disabilities. This is a reasonable accommodation to ensure equal participation as accommodated under the Colorado antidiscrimination act. So that state Board of human services agreed that a person should be able to call in on the numbers set up and be able to let the administrator over the meeting know that they have been called upon on

the telephone to make comment as if they were here in person. So if you live in Lyman or somewhere else you don't want to come in and sit until 1:30 PM like I am, to make public comments. So I'd like you to consider that it could be a motion or I don't know what the protocol is to adopt that into your bylaws. I believe the human services board just made a motion and they started doing it in their meetings. So that's something that I would like to get more information upon. I continue the state that I oppose the unlawful discrimination of the protected class of people, the disabled, and those who advocate on the behalf of their strong creed. The department continues to deny full and equal enjoyment of participation in meetings and inclusion in the design of these proposed rules. This is a violation of the Colorado antidiscrimination act. I currently have 2 filed charges of discrimination against this department. Ones for the denial of full and equal enjoyment in the inconsistent criteria for 2 bodies and apply to the waiver implementation counsel and the PIAC. There is room Terry picking on these boards they don't like people with consenting views to sit on these ports. Because when you read the recommendation from a task force and you assume it's upsetting stakeholders. It is not. I also have a second charge of discrimination against this department because I am unable to currently receive fair and equal case management due to my advocacy. I passed with the help of many advocates and some great legislators Senate Bill 1638. You might want to mark your calendar. Because the audit committee is going to put all 20 CCD up on the risers in room 271 is the full statewide audit to see if they're complying with this department. Right now I have to choose my case manager by statute. I'm asking the department to service case managers. That's your agreement with the federal government. Now been denied case management as a last resort. Got 2 charges against this department against the Colorado antidiscrimination act. There's some serious issues . It's very important that stakeholders be involved.

You are not signed up.

Okay. Please go ahead and get her testimony then for public comment.

Rob Hernandez. [Indiscernible - Low Volume] I've been dealing with a lot of these issues. What surprised me was not much has changed since I left in 2002. So it's kind of astounding. I stayed active with the people from cc DC, adapt, and from all those organizations. Atlantis. I had working relationships with them. Those are valid groups that have a lot of juice in the capital. It was wise of the board to table this to have the rule revisited. People who are quadriplegics were

you have tertiary stakeholders but you want to make sure you encompass them all. Not just one segment of them. It's important to do that. Because if they go to legislator and say they want to participate in the department. Some of those meetings were held by navigate. So how do they know to show up you have to list it that way. To say it's listed that way is somewhat misleading. Provide written documentation or Sharon King who does independent target case management in the state of Kansas was one of the first states to be in compliance. She lives in great Bend. She does not use the drivetime to charge. She says is just a part of what I do. She started off. Because when case management

came about she was just going to walk away. She stayed involve small caseload

in Wyoming the legislator within six months of the final rule of compliance. I haven't heard any problems. If there were problems I think it's important for the department to document it. It was a wise decision to table that. So with that I would like to say the department needs to take a closer look at how you expand stakeholder processes. I'm willing to meet with leadership to help them set that up to work with the stakeholders for all affected parties. That's all that I have. Thanks for staying and I appreciate it.

Before we do department updates, we have an update. This is [Indiscernible] Last day . And giving the table over to those who want to send a farewell message.

Farewell Gretchen some of my favorite moments moments you would not expect. She was opposing views and one of the many public forms it was always in these moments that Gretchen spoke of clarity and it was apparent that her knowledge was broad. As a public servant she protected all of our voices. The voice of her staff, the board, policymakers, and also provided course correction discussion needed to nudge us back to what was most important. I'm a better leader for having listened and learned in Colorado is a better place for Gretchen's service. Thank you Gretchen. >> I have been here for almost 4 years. Maybe longer. I want to thank you for being a mentor. Coming from a conservative background. I have learned a lot. I wish you all the best in your next adventure. What ever that might be.

The people you need are sometimes a blessing and sometimes a lesson. I think as I crossed paths with her over the years. I think you. Your leadership has been wonderful and your sense of human importance than what we are doing is never forgotten. So thank you very much.

Gretchen I want to thank you for your leadership. Since you came here you've been a great voice of reason. Your knowledgeable about all of this for us coming from different backgrounds we do that in a very eloquent and professional way that does not lead us. I think it's moved our board and a nice direction I'm going to miss your guidance and your leadership. And all honesty you have been a real treat to have on the sport and I thank you for that.

Does anybody from the department want to stand out?

I wanted to say thank you you've been on board since I've been on and I have admired your ability to serve in your role. It's not always easy to do I appreciate and admire and hope I can grow that skill and myself. It's obvious of my hard-earned intentions. I'm sure this particular meeting has made it easier to slip away from work.

Democracy takes time.

I appreciate you and I know Colorado is still lucky to have you.

How about department updates. It's my last day.

Tom will be representing the executive leadership of the department moving forward. He will do that and then director staffer will come on a regular basis. Kera will serve as interim Medicaid director and also the director of the health programs office. And Bonnie will be the interim director. So those will be here here to help shepherd. Honestly I love medical services. In my early days I was learning as much on that stateside I got to know the department better it's been a pleasure and I look forward to you all continuing your great work.

And with that let's adjourn. >> [Event concluded]